

“Managers’ and clinical leads' perspectives of a co-production model for community mental health service improvement in the NHS: a case study.”

Name: Hayley Bamber
University: University of Salford
Course: Professional Doctorate
Student Number: @00094300

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Abstract

This study evaluated a co-production model used in a National Health Service (NHS) Trust, in England which was introduced due to increased workloads and reduced resources. Through reviewing drivers/challenges and determining staff knowledge, skills, and attitudes a greater understanding of co-production's implications for practice was achieved. **Aim and Objectives** - This study aimed to evaluate the implementation of a co-production model within an NHS Trust in a community mental health setting. The research sought to determine and define what co-production was and which model was used within the Trust; to identify how core characteristics of co-production were implemented within the Trust; to gain an understanding of clinical leads and managers' knowledge, skills, and attitudes towards co-production and how this affected implementation; to offer recommendations to the Trust and the wider research community to enhance co-production in practice. **Methods** – A thematic analysis of literature gaps and a descriptive case study illustrated participants' co-production experiences. One-to-one semi-structured interviews were conducted with senior managers ($n = 3$), middle managers ($n = 5$), and clinical leads ($n = 5$). Service users were not included in the sample to reflect the design of the model adopted by the Trust. Verification interviews supported the credibility of emerging underlying thematically analysed themes. **Findings** – The following five themes emerged: corporate machine, continual revolution, power, interface, and attitudes to co-production. The analysis found that organisational culture impeded co-production, with significant knowledge gaps present which hindered effective co-production. However, participants believed that co-production supports service delivery. **Conclusion/Recommendations** – This case study provided evidence that redistributing power and allowing individual's ownership of the model would improve co-production's success in practice. Additionally, including service users in the model design is critical to engagement in co-production. The formulation of a working definition afforded organisations some clarity to communicate their co-production vision.

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Abbreviations

- NHS – National Health Service
- CMHT – Community Mental Health Team
- UK – United Kingdom
- STR – Support Time and Recovery
- PD – Personality Disorder
- LCC – Lancashire County Council
- BWD – Blackburn with Darwen
- BC – Blackpool Council
- CCG - Clinical Commissioning Group
- NICE – National Institute for Clinical Excellence
- CQC – Care Quality Commission
- CAT – Cultural Assessment Tool
- GP – General Practitioner
- ECDP – Essex Coalition for Disabled People
- SCIE – Social Care Institute for Excellence
- COPM – Canadian Occupational Performance Measure
- QOLs – Quality of Life Scale
- CINAHL - Cumulative Index to Nursing and Allied Health Literature
- MEDLINE - Medical Literature On-Line
- US – United States
- CASP – Critical Appraisal Skills Programme
- FREDA – Fairness, Respect, Equality, Dignity, Autonomy
- CEO – Chief Executive Officer
- NRES – National Research Ethics Service

- EL – East Lancashire
- CeL – Central Lancashire
- NL – North Lancashire
- SM – Senior Manager
- MM – Middle Manager
- CL – Clinical Lead
- CPI – Co-production Interpretation
- CPI-SM - Co-production Interpretation – Senior Manager
- CPI-MM - Co-production Interpretation – Middle Manager
- CPI-CL - Co-production Interpretation – Clinical Lead
- MDT – Multi-disciplinary Team
- IPA – Interpretative Phenomenological Analysis
- EBE – Experts By Experience

Chapter 1 - Background

1.1 Introduction and Background

This descriptive case study explores the phenomena and implementation of a co-production considering key professionals' perspectives. The Trust's model incorporates managers and clinical leads co-working to deliver service outcomes. Literature suggests that when effectively implemented, co-production can enhance partnerships, equality, and ownership among the population (service user or professional) involved in the process (Social Care Institute for Excellence, [SCIE], 2013). Co-production is highly valued in modern healthcare arenas and is beneficial to service users and staff groups. The aims of this study are to establish what exactly co-production is, how effectively it can be implemented, and whether the above-mentioned enhancements were achieved within a community mental health setting. Thus, determining a definition of co-production is important for implementation and applicability to practice as well as for replication by others. The working definition helped understand the context in which co-production was implemented in a local community mental health team (CMHT). The thesis considers the role of service users in co-production's conceptualisation, and it emphasises the reasons they were excluded from the Trust's co-production model.

1.2 Thesis structure

Chapter 1 identifies co-production's drivers in healthcare – focusing on a local setting in the United Kingdom (UK). The co-production model is explored with key concepts arising from an initial review of literature. A theoretical literature review of co-production is then presented in Chapter 2. Thereafter, Chapter 3 presents a concept analysis, seeking to explore co-production's origin and identify core characteristics, and Chapter 4 explains the descriptive research method used to analyse co-production in this setting. A case study demonstrates this practically with reflexive accounts of the research journey. Chapters 5 presents the study findings. This is followed by a discussion of those findings in Chapter 6. Finally, Chapter 7 presents a study conclusion, including recommendations for practice and policy, as well as areas for future research.

1.3 Purpose of the Study

1.3.1 Aim

This study aims to evaluate the implementation of a co-production model within a National Health Service Trust in a community mental health setting, shaped by managers and clinical leads' perspectives.

1.3.2 Objectives

The objectives of this research are as follows:

1. To determine and define what co-production is and which model of co-production was used in the Trust;
2. To identify how core characteristics of co-production were implemented within the organisation;
3. To gain an understanding of clinical leads and managers' knowledge, skills, and attitudes towards co-production and how this has affected implementation;
4. To offer recommendations to the organisation and the wider research community to enhance co-production in practice.

1.3.3. Original Contribution

1. The case study provides a focused evaluation of a specific co-production model used in CMHT settings in a mental health trust in England.
2. A concept analysis of co-production and a working definition is formulated.
3. Unique insight into how organisational culture can impact the implementation of a co-production model is offered.
4. Challenges with implementing co-production within community mental health settings, which has not previously been a focus of research, are highlighted.
5. Core characteristics of equality, assets, capacity, catalysts, networks, and reciprocity are outlined with findings demonstrating the need for an outcome measure to be developed in the future.

6. The challenges and drivers of co-production demonstrates the model's feasibility to benefit the NHS, highlighting the requirement to address systemic challenges to enhance success.
7. Provision of a descriptive model (Chapter 7) provides a practical guide to employing core characteristics during implementation.

1.4 Professional Biography

I have been an occupational therapist (OT) since 2006, completing an MSc in Advanced OT in 2010. The MSc focus was on OTs co-working with support time and recovery workers (STR). I have worked in mental health since qualifying, with the past 12 years based in CMHTs and the past 6 months as a lecturer at Sheffield Hallam University. My broad area of interest has been service development and staff wellbeing. Co-production piqued my interest because of its alignment with my professional values.

1.5 Prevalence of Mental Health

1.5.1. National Prevalence

To contextualise the case study, an overview of the local prevalence of mental health issues within Lancashire were compared with national demand for mental health services. It was estimated that one in four people will suffer from a mental health problem each year in the UK (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009), with one in six reporting a problem every week (McManus, Bebbington, Jenkins & Brugha., 2016). Every six years, a survey is conducted in

England to determine prevalence of mental health conditions (the last one completed in 2016). Results from the most recent survey are filtered into three tables, one for general mental health conditions (measured annually), one for bipolar and psychotic illnesses, and one for suicide and self-harm rates (measured over an individual's lifespan). Table 1 illustrates the breakdown of general mental health conditions. Tables 1, 2 and 3 were adapted from information within McManus et al. (2016).

Generalised anxiety disorder	5.9 in 100 people
Depression	3.3 in 100 people
Phobias	2.4 in 100 people
OCD	1.3 in 100 people
Panic disorder	0.6 in 100 people
Post-traumatic stress disorder (PTSD)	4.4 in 100 people
Mixed anxiety and depression	7.8 in 100 people

Table1: General Mental Health Conditions

Given the lack of annual measuring for bipolar affective disorder and psychotic illnesses, the figures provided in Table 2 are the reported estimates.

Psychotic disorder	0.7 in 100 people
Bipolar disorder	2.0 in 100 people
Antisocial personality disorder	3.3 in 100 people
Borderline personality disorder	2.4 in 100 people

Table 2: Prevalence of Severe Mental Illness

Finally, the survey collated reports of self-harm, suicidal thoughts, and actual suicide attempts illustrated in Table 3 below.

Suicidal thoughts	20.6 in 100 people
Suicide attempts	6.7 in 100 people
Self-harm	7.3 in 100 people

Table 3: Prevalence of Suicidal Thoughts and Self-harm

Table 4 provides a context for the number of reported cases of mental health conditions.

Self-diagnosed common mental health disorder (CMD), professionally diagnosed CMD, and presence of professionally diagnosed CMD in past 12 months, by CMD in past week								
All adults					2014			
	CMD in past week ^a							
Depression								
Ever had	74.5	79.4	81.7	86.1	56.5	60.0	67.2	27.8
Ever diagnosed	62.0	70.0	72.1	83.0	43.8	46.5	54.8	20.9
Had in last 12 months (diagnosed)	51.2	63.2	61.1	71.5	36.8	29.4	41.3	10.9
Postnatal depression								
Ever had	12.2	14.7	15.2	13.3	7.5	9.7	10.9	5.2
Ever diagnosed	10.4	13.2	14.5	13.3	5.6	7.6	8.9	3.7
Had in last 12 months (diagnosed)	0.8	0.9	1.7	2.8	-	0.5	0.6	0.3
'Nervous breakdown'								
Ever had	16.6	22.0	24.0	17.8	5.4	9.4	13.2	4.0
Ever diagnosed	10.6	16.0	15.4	12.7	3.2	6.9	9.1	2.7
Had in last 12 months (diagnosed)	1.7	5.8	7.0	2.3	1.3	1.0	2.0	0.4
OCD								
Ever had	10.7	11.1	13.4	19.8	6.2	7.4	9.5	3.7
Ever diagnosed	5.2	7.1	7.9	13.2	-	2.1	4.0	1.1
Had in last 12 months (diagnosed)	4.8	6.1	6.3	11.3	-	1.6	3.4	0.9
'Panic attacks'								
Ever had	54.0	52.7	60.7	54.9	60.5	36.4	44.6	17.9
Ever diagnosed	41.0	42.7	45.5	41.9	22.3	22.0	30.2	10.4
Had in last 12 months (diagnosed)	29.2	31.3	37.1	23.9	12.8	9.3	18.0	4.4
Phobia								
Ever had	16.1	15.6	22.6	23.6	27.8	15.5	16.8	8.4
Ever diagnosed	4.3	5.9	7.2	6.0	-	2.9	3.6	1.1
Had in last 12 months (diagnosed)	3.7	5.2	6.7	5.2	-	2.4	3.1	0.8
Any of eight types of CMD^c								
Ever had	87.5	89.8	91.2	90.3	83.7	77.4	82.1	43.4
Ever diagnosed	75.1	78.6	83.5	88.1	47.8	55.0	64.4	27.4
Had in last 12 months (diagnosed)	61.0	70.1	72.9	77.7	40.0	35.8	48.5	13.7
Men	151	93	59	31	12	176	405	3,057
Women	319	191	142	72	31	428	932	4,485
All	470	284	201	103	43	604	1,337	7,542

An individual can have more than one CMD. NOS CMD stands for CMD not otherwise specified.

Table 4: Common Mental Health Disorder Reporting. (Information from NHS Digital, licensed under the current version of the Open Government License)

Key to the above table is that findings were collated from people living in private housing in England do not constitute individuals in hospitals, prisons, and sheltered housing, nor the homeless. This suggests that the report is conservative and that in

reality, mental health needs are much greater (McManus et al., 2016). In addition, these statistics do not consider individuals with a diagnosis of personality disorder (PD) who also accessed mental health services. Nevertheless, it is evident that mental health is a significant issue within the UK, with a reported one in eight adults receiving treatment for their illness (McManus, et al., 2016; Welsh Health Survey, 2015). With this level of demand for addressing mental health issues and stretched resources, utilising a model that will effectively deliver services is crucial.

1.5.2. Local Prevalence

The NHS Trust in this study covered three council areas: Lancashire County Council (LCC), Blackburn with Darwen (BWD) Council, and Blackpool Council (BC). In LCC, 114,397 adults had a diagnosis of depression, accounting for 11.8% of the total registered adult population – significantly higher than the England prevalence of 9.9%. 12,398 people were diagnosed with severe mental illness (including schizophrenia and bipolar affective disorder), accounting for 1.02% of the population – higher than the 0.94% England prevalence. In BWD (16,016 or 11.7%) and BC (22,289 or 15.4%), the prevalence of depression was also significantly above the England average, as was the prevalence of severe mental illness – BWD (2,276 or 1.26%) and BC (2,733 or 1.54%) (LCC (a), 2019). Table 5 (LCC (a), 2019) below illustrates the increasing demand for mental health services within the Trust's catchment area, highlighting a need to consider how services could be delivered to a large population with increasing need, in a cost-effective manner (Lancashire County Council (a), 2019; Lancashire County Council (b), 2019).

Indicator	Period	Recent Trend	Lancashire Percentage	England Percentage
Depression recorded incidence (18+)	2017/18	Increasing	9.3%	9.4% (11% the worst and 7% the best)
Depression recorded prevalence (18+)	2017/18	Increasing	11.8%	9.9% (5.4% the worst and 15.6% the best)
Severe mental illness recorded prevalence (all ages)	2017/18	Increasing	1.02%	0.94% (0.57% the worst and 1.54% the best)
ESA claimants for mental and behavioural disorders (rate per 1000 working age population)	2016	Increasing	31.9%	27.1% (10.1% the worst and 66.8% the best)

Table 5: Local Versus National Service Requirement adapted from Lancashire County Council (a & b) (2019)

A further consideration is continued housing development schemes – because of a sharp population rise – unmatched by government funding and stretching resources further. This has immense implications for the service provision of CMHTs, meaning that consideration of efficient service delivery was crucial. Figure 1 illustrates the increases in population between 1986 and 2010 (the latest published table from LCC), and Table 6 illustrates actual population sizes in Lancashire from 2002 to 2018.

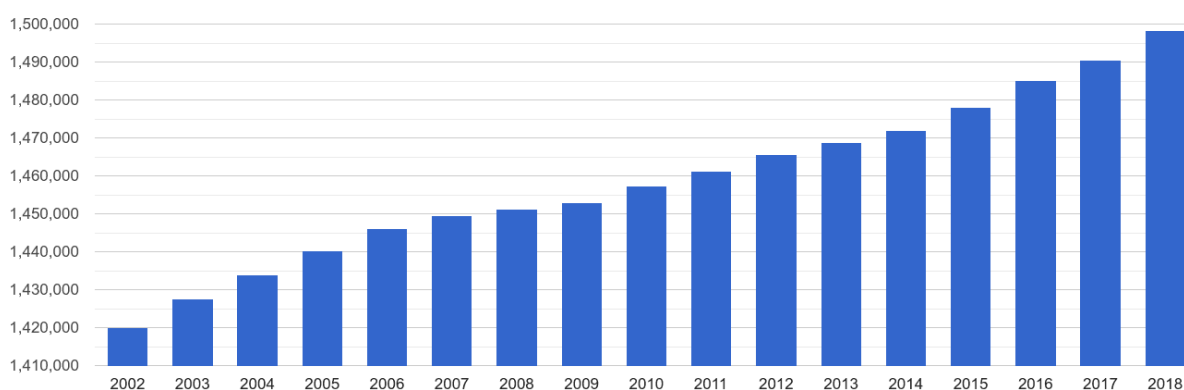


Figure 1: Lancashire's population increase 2002-2018 taken from <https://www.plumplot.co.uk/Lancashire-population.html>

Year	Number	Intercensal Change	
		No	% per year
1981	889,736	-	-
1901	1,025,417	135,682	1.4%
1911	1,115,323	89,906	0.8%
1921	1,160,967	4,643	0.4%
1931	1,170,865	9,898	0.1%
1941	1,171,133	268	0.0%
1951	1,238,241	67,518	0.5%
1961	1,261,241	22,589	0.2%
1971	1,344,816	83,575	0.6%
1981	1,372,300	27,500	0.2%
1991	1,370,331	-1,969	-0.0%
2001	1,44,731	44,400	0.3%
2011	1,460,900	46,100	0.3%

Table 6: Lancashire's population numbers 1981–2011 adapted from <https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population-and-households-2011-census/lancashires-population/>

Based on the mental health prevalence and increasing population figures, increased demand and reduced resources, it is evident that rethinking service provision is necessary. However, it is unclear whether co-production is the solution. While the NHS England supports co-production's usage in practice, the interpretation of what co-production is remains ambiguous and requires clarification (Osbourne, Radnor & Strokosch, 2016).

1.6 Co-production's Development

1.6.1. Situation of Co-production

Introducing co-production signalled a directional change for the NHS (NHS England (a), 2015). However, while several authors have conceded that co-production is essential for service improvement, Bevan (2006) noted that 75% of change initiatives failed because of leaders' differing expectations (NHS England, 2017).

Understanding staff attitudes towards co-production would enable leaders to better engage people in the model, making this study relevant and timely.

1.6.2. A Community Historical Timeline

Community-based approaches to treatment, as opposed to hospital admission, have been a long-standing NHS goal (Edwards, 2014) with limited success. Over the past 30 years, transformation occurred in three distinct stages: rapid de-institutionalisation, development of community systems, and diversification of services to meet local needs (National Institute for Health and Care Excellence, (NICE), 2015).

Changes to community led-care arose from a growing evidence base (The Health Foundation & The Kings Fund, 2015), with discussions about mental illness peaking in the 1950s and 60s. Scandals in the 1970s highlighted the ill-treatment of service users, stressing the requirement for further change (NICE, 2015). Services were delivered at home, with access to specialist hospitals for longer-term needs (Naylor, Alderwick & Honeyman, 2015). Whilst institutional closures were successful, community services' functions continuously revolutionised (Gilbert Peck, Ashton, Edwards & Naylor, 2014). However, they struggled to meet demand, and the focus shifted to person-centred care (Gilbert et al., 2014).

While mental health provision differs between counties in England, core services include supported housing, psychological interventions, medication reviews, and self-help groups. As a result of care coordination and self-referral, earlier interventions are delivered to patients (Foot, Gilbert, Dunn, Jabbal, Seale, Goodrich, Buck & Taylor, 2014). Services are provided by different healthcare professionals such as nurses, social workers, psychologists, OTs, and consultant psychiatrists. The World Health Organization (2007) highlighted that CMHTs can make mental health care more accessible whilst reducing social exclusion. However, the decommissioning of inpatient beds has not resulted in further investment in community services, which means sparse provision, as is evident in the North West of England.

1.6.3. The Western World View of Co-production

In addition to wider political movements, over the last 7 years (prior to the commencement of this study), the NHS has experienced immense pressure because of budget cuts and reduced resources (Farmer, 2011). The potential implication of the UK's decision to leave the European Union (McKenna, 2016) has called for a reconsideration of service delivery through asset utilisation (Kings Fund, 2019), thereby remedying resource issues by facilitating care (Turner, Realpe, Wallace & Kosmala-Anderson, 2015). Service provision can be delivered through various means, ensuring that needs are met, and resources retained. Co-production has been adopted as a critical approach to public policy (Needham, 2009; Department of Health, 2010) but has remained a western construct and not a globally recognised approach.

In 1968, Fuchs argued that the new service economy (banking and healthcare) differed from the old industrial economy (agriculture and manufacturing) within the United States (US). A different relationship between producer and consumer was required. In subsequent decades, sociologists and political scientists considered using co-production in police and educational services. Communities co-produced through initiatives such as neighbourhood watch and parent–teacher associations. In the 1970s, Ostrom used co-production to explain increased crime rates when officers were not patrolling Chicago's streets (Ostrom, 1996), illustrating that community input was required (Stephens & Ryan-Collins, 2008). Ostrom (1996) argued that citizens had motivations to co-produce; however, economics was not considered. In 1980, Toffler coupled co-production with economics to illustrate links between previously separated functions of production and consumption. He argued that through co-production, companies could maximise convenience whilst minimising cost (Toffler, 1980). Early co-production development demonstrated positive impacts on organisations through developing a community of practice with a shared human endeavour for mutual benefit.

UK co-production evolved during the 1980s, when mental health services were criticised for poor asset utilisation (Think Local Act Personal, 2018) and the focus was on reciprocal relationships between doctors and service users to improve outcomes (Coote, 2002). However, during the 1990s, co-production became obsolete, with market-driven public service improvements prioritised (Centre for Market and Public Organisation, 2011). Health and social care were viewed similarly to other goods, and service users were determined to need things done 'for' them. The mid-2000s saw co-production resurface (being implemented across public and voluntary organisations because of the disability movement and the mental health user movement (MerseyCare, 2013). The disability movement suggested that society disabled individuals through environmental barriers, and people should independently decide how to live their lives. Similarly, the mental health user movement promoted recovery and empowerment through equal partnerships with professionals. Both these movements called for a co-production approach to ensure that service users were actively involved in their care.

Considering the above, it was noted that the Trust's model operates at odds with relevant literature, through exclusion of service users who are central to NHS advancements (Langergaard & Scheuer, 2009). In the UK, NHS England championed co-production (McShane, 2015) to transition from a medical to a social model, adhering to the five-year forward view to enhance service user experience and stabilise organisational finances (NHS England, 2014). The National Audit of Schizophrenia (2014) highlighted that more collaborative relationships are needed via co-production with service users. Whilst the inclusion of service users would have added value to the study, the Trust's co-production model did not include service users; hence service user involvement was excluded to reflect the Trust's co-production model.

The Trust's implemented co-production model was based on professional experience crucial for the organisational story, and it included emergent topics from policy documents and a review of secondary sources, framing co-production

knowledge (assets, networks, capacity, catalyst, equality, and reciprocity). Some authors have asserted that no real definition of co-production exists (Osborne, Radnor, and Strokosch, 2016). However, this thesis takes a different view, arguing that if the term was so diluted, its potential to support change and empowerment would be compromised. I constructed the definition below following an extensive concept analysis of key characteristics (see Chapter 3, pg 61):

‘Co-production is the collaboration and equal distribution of power to maximise asset utilisation among stakeholders to work towards an agreed, shared outcome. It requires the employment of reciprocal relationships to facilitate capacity development’.

1.6.4. The Local View for Lancashire

The Trust was established as a specialist mental health provider in 2002, offering inpatient, community, and forensic services (Lancashire Care NHS Foundation Trust (LCFT), 2019). Figure 2 displays the original service provision, including adult mental health, OT, older people’s mental health, learning disabilities, children’s mental health, safeguarding, eating disorders, and drug and alcohol services.



Figure 2: Overview of Original Service Provision adapted from LCFT (2020) <https://directory.lscft.nhs.uk/index.php>

The Trust was awarded foundation status in 2007, becoming a provider of health and wellbeing services in 2013, meaning that it became an independent, not-for-profit,

public benefit corporation with accountability to the local community as opposed to central government (Wrightington, Wigan and Leigh NHS Foundation Trust, 2019). The Trust seized the opportunity to provide holistic services to meet both physical and mental health needs (LCFT, 2019). Figure 3 illustrates the new diversified structure.

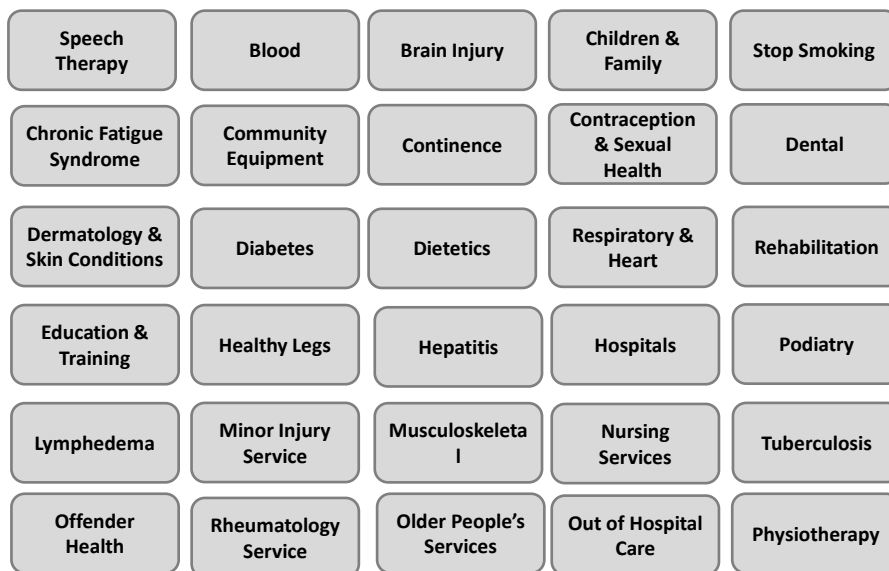


Figure 3: Overview of Current Service Provision adapted from LCFT (2020) <https://directory.lscft.nhs.uk/index.php>

The Trust offers services to approximately 1.5 million people (LCFT, 2019), covering a large geographical area comprising of eight clinical commissioning groups (CCGs) across three local authorities (Figure 4).



Figure 4: The Trust's Geographical Footprint adapted from LCFT (2020)
<https://directory.lscft.nhs.uk/index.php>

The Trust's core workforce comprised of approximately 6,400 people, although it provided more than 1.5 million contracts to people per year, with an annual turnover of £345 million, illustrating the sizable nature of the organisation. The Trust more recently expanded to include South Cumbria in its portfolio; however, Lancashire remains the study's focus as this was the core service provision area at the time of commencement. Three clinical care streams were in operation, including a mental health network, a community and wellbeing network, and a children and families' wellbeing network (LCFT, 2019). The mental health network is the focus of both this study and my clinical, management, and research involvement.

The Trust implemented the co-production model between 2015 and 2018, following abandonment of the previous model of 'stepped care' (NICE, (2011)). Stepped care developed local care pathways to promote service access (NICE, 2011). However, the Trust's size required a broader approach to strategic management for compliance with Government policies on individualised care (Public Sector Research Centre, 2007). Communicating the newly acquired services was challenging for the Trust, as they were distinctive from core services (Figures 3 and 4). Whilst co-

production was a desired direction, there was no clear strategy for implementation. The Trust's annual review mentioned the use of co-production as a means of enhancing services (LCFT, 2019); however, no policy document or strategic plan existed for implementation. The size of the Trust required the introduction of three care streams to support specified service delivery. Within the mental health network, where the study was situated there were inpatient, forensic, and community teams, as depicted in Figure 5.

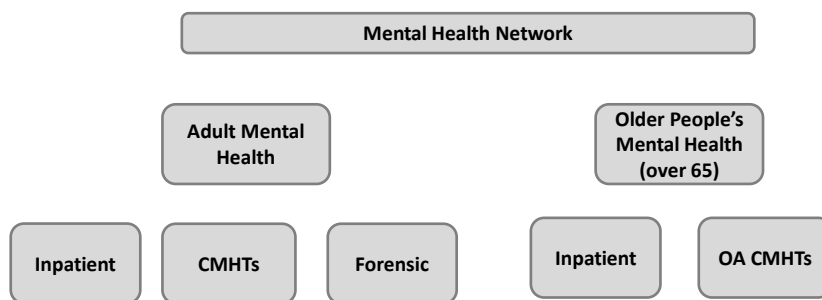


Figure 5: Overview of Mental Health Network

Within the Trust, there were 13 CMHTs across Lancashire, as depicted in Figure 6.

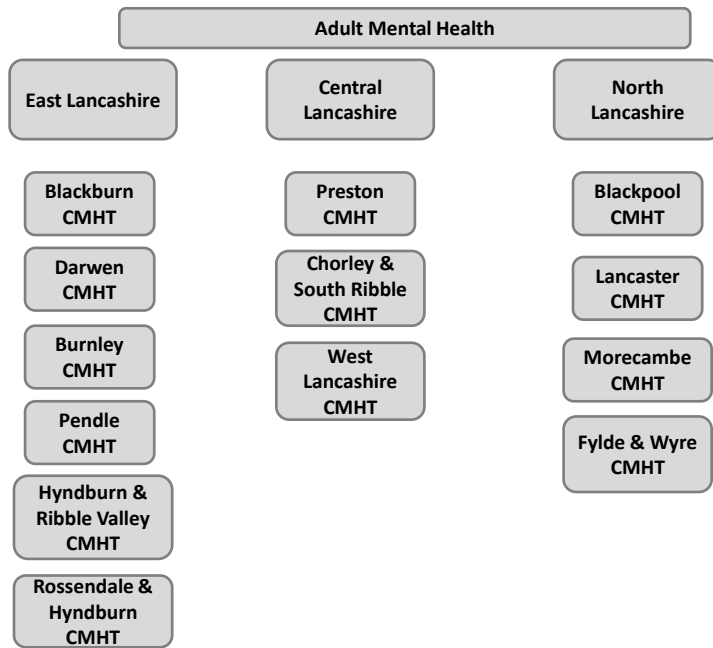


Figure 6: Overview of Adult Mental Health Services

Finally, team construction for the CMHTs provided insight into team leaders and clinical lead’s responsibilities (see Figure 7).

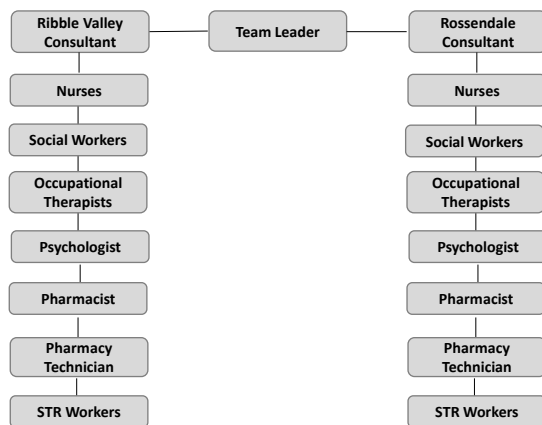


Figure 7: Overview of CMHT Structure

1.6.5. The Trust’s Co-production Model

My knowledge of the structure of the Trust’s co-production model came from conducting this study, where senior managers provided a brief history of intent. The Trust envisaged that managers and clinical leads would co-produce services for

increasing service quality and cost effectiveness. Prior to the commencement of this project, co-production was briefly mentioned in the context of managerial and clinical lead reports; however, it was not always evident or obvious. This study revealed that the Trust's model did not include service users. Senior managers reported that co-production was in operation higher up in the hierarchical chain, with network directors co-working with clinical network directors to manage their care stream. The organisational diagram in Figure 8 depicts the Trust's managerial hierarchy, displaying the co-production relationship between network directors and clinical network directors.

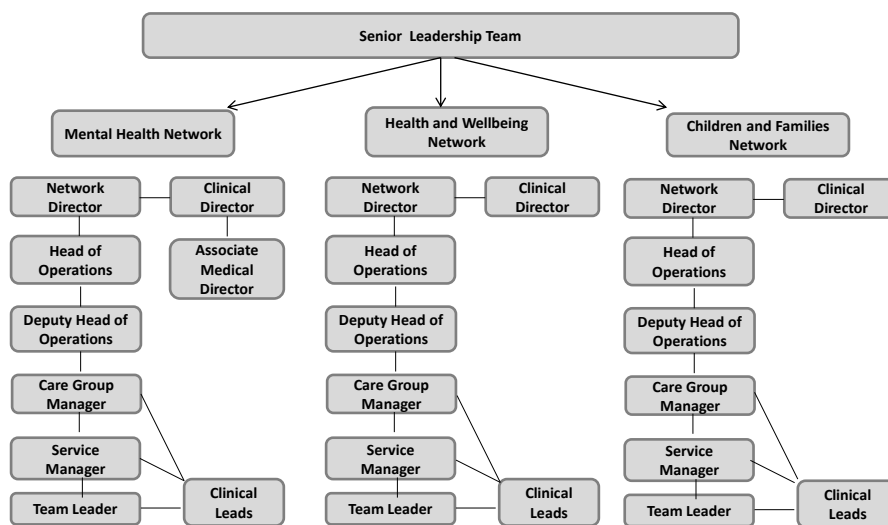


Figure 8: Organisational Structure

An organisational restructure negatively impacted on co-production's success by reducing frontline managers and hence increasing workload pressures. Subsequent impacts were highlighted in the Care Quality Commission (CQC) report (CQC, 2018) that identified problem areas regarding the provision of a safe and effective service with strong leadership (CQC, 2018). Whilst mental health services for adults of a working age were rated high, it was highlighted that issues existed with access to inpatient beds, the use of the community treatment order, service users' awareness of their rights, and dissemination of information throughout community teams (CQC, 2018). Trust leaders continued to consider how their co-production model could remedy issues; however, they made minimal progress by the time the CQC revisited them in 2019, where regulation breaches were noted for person-centred care, safe

care and treatment, safeguarding, governance, and staffing, thus illustrating that challenges had existed with embedding the co-production model (CQC, 2019). Poor staff wellbeing was evidenced in the Cultural Assessment Tool (CAT) completed by Professor Michael West from the Kings Fund and the staff survey (Kings Fund, 2015; CQC, 2018), with evaluation tools indicating that a better understanding of co-production's impact was required. In addition, co-production literature on healthcare was newly developing (Pinfold, Szymczynska, Hamilton, Peacocke, Dean, Clewett, Manthorpe & Larsen, 2015), and further research into practical application was thus needed.

Implementing co-production in the Trust occurred in conjunction with significant service shifts. For example, neighbourhood working emerged with a focus on preventative healthcare, meaning more collaborative working relationships with general practitioners (GPs). CMHTs were split into smaller areas to improve communication. Whilst neighbourhood working was aligned with co-production's ethos, the staff perceived this as additional work. This highlights the leaders' importance in the illustration of how co-production complements the move. The organisational expectations must subsequently be communicated to allow managers to effectively convey co-production's ethos which may improve service delivery, thus proving to be cost effective for the Trust and the wider NHS.

1.7 Context review of policy documents and the challenge of defining co-production

A review of policy documents and secondary literature was conducted to provide guidance where the topic of interest was vague. There was not sufficient literature and co-production was vaguely defined and not understood clearly. The dissection of the policy documentation into simpler elements helped promote clarity whilst providing a mutual understanding of co-production and a working definition for the purpose of this thesis.

Some of the challenges in implementing the correct type of co-production model or its effective implementation, or even interpretation, arise because of the various

definitions existing within literature. Osborne et al. (2016) have argued that co-production is not well defined, asserting that definitions are poorly formulated, with Clarke (2015) stressing the requirement of a definition in mental health. Although academic evidence was lacking, Osborne et al.'s (2016) view has been echoed by the New Economics Foundation (2010), which asserts that no singular, agreed definition for co-production exists (Boyle & Harris, 2009). A poor definition presents problems for practice when the pace of change advocated by policymakers' risks distorting meaning further (Stephens & Ryan-Collins, 2008). Concerns exist as co-production implementers could respond to criticism and implement too quickly (Department of Health, 2010). Instances have occurred in practice where practitioners interpreted the meaning differently, resulting in differences in functioning (Bhalla, Caye, Dyre, Dymond, Morieux, & Orlander, 2011). Co-production must be defined to ensure effective communication, thereby enabling a shared understanding and producing better outcomes.

While some authors provide a guide that offers flexibility in the application of co-production (Clarke, 2015), others like Needham and Carr (2009) stress that flexibility results in confusion. Organisational clarity on required involvement and desired outcomes is consequently needed (Clarke, 2015). Whilst flexibility and adaptability are key for implementation of the model, I would argue that for the reliability of future research, an agreed definition would prevent implementation barriers and dilution of the term itself. Even though common elements of co-production emerged from the policy review (shared decision-making, distribution of power, and reciprocal relationships), the benefits of a concept analysis within this thesis became apparent, as the nomenclature was comprehensive.

1.8 Relevant Policy Documents

Key policy documents have influenced the evolution of co-production in the UK. Those documents have mainly been produced by leading think tanks, including the Kings Fund and SCIE. Policy documents and secondary data sources were reviewed and considered for inclusion (see Figure 9).

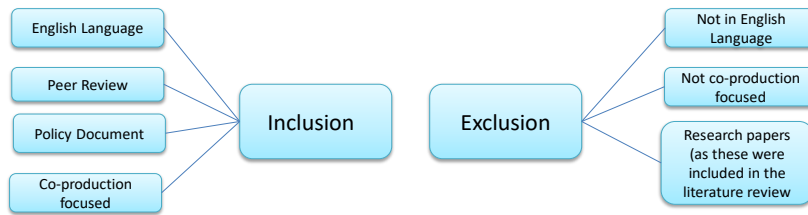


Figure 9: Inclusion and Exclusion Criteria

Papers were selected from various sources: the Trust, internet searches for drivers of co-production, and websites for leading think tanks including the Kings Fund (www.kingsfund.org.uk and www.scie.org.uk) . Selected papers were analysed thematically through data extraction, highlighting major themes, identifying common terms and phrases, and checking and rechecking the findings for accuracy. A thematic analysis was deemed to be appropriate because it was also used for the literature review and data analysis, thus providing some consistency to the management of data. Table 7 illustrates the papers selected for the policy review and the emerging themes.

Document	Author	Year	Key Point	Matches Themes
Claiming the health dividend: unlocking the benefits of NHS spending	Kings Fund	2002	The document demonstrates how the NHS could use assets better to sustain long-term health.	Assets Power Information sharing Collaboration Leadership
Co-production in Public Services: a new partnership with citizens	Horne and Shirley	2009	Rather than simply replicating specific 'co-production practices', accelerating co-production requires more structural changes to <i>budgets</i> , support for civic society, and mutual help; performance regimes; and professional training and culture.	Assets
SCIE Research Briefing 31: Co-production: An emerging evidence base for adult social care transformation	Needham and Carr	2009	People who use services have assets that can help to improve services.	Assets Reciprocity
Practical approaches to co-production	Department of Health	2010	Organisations need to consider how to engage 'hard-to-reach' groups to ensure inclusion in co-production.	Assets Collaboration Reciprocity
What is co-production?	The Health Foundation. Inspiring Improvement	2010	The recognition that service users can contribute their assets to service improvement and an agreed outcome is critical.	Collaboration Power Assets Reciprocity
Doing with, not to: community resilience and co-production	Scottish Community Development Centre	2011	Building capacity and confidence within the community is vital to co-production's success.	Assets Information sharing Collaboration Power
Leadership and engagement for improvement in the NHS. Together we can	Kings Fund	2012	NHS leadership appears to be focused on meeting targets rather than engaging service users.	Leadership Assets
Varieties of co-production in public services: time banks in a UK health policy context.	Glynos and Speed	2012	The document identified discrepancies in the way co-production principles can be defined, interpreted, and linked to broader notions of social justice: recognition-based interpretations with a transformative accent and choice-based interpretations with an additive accent.	Collaboration
Co-production in social care: what it is and how to do it.	SCIE	2013	The Care Act focuses on co-production to ensure that service users are involved in the development of services to make them better.	Power Leadership Collaboration Reciprocity Assets
Co-producing services – co-creating health	Public Health Wales	2013	Co-production can support the delivery of person-centered care, which prioritises putting patients and their families in equal relationships with professionals, thus providing choice and control.	Power Collaboration Leadership
Co-production of health and wellbeing in Scotland.	Loeffler, Power, Bovaird, and Hine-Hughes	2013	Reciprocity and collaboration are key to the development of sound partnerships, which can increase asset usage, meaning better outcomes.	Collaboration Assets Reciprocity
Co-production of health and wellbeing outcomes: the new paradigm for effective health and social care	Alakeson, Bunnin, and Miller	2013	This document recommends trailblazing sites to be developed to implement co-production approaches together.	Collaboration
People in control of their own health and social care. The state of involvement	Kings Fund (a)	2014	Despite everyone professing to 'put the patient first', it still appears that this is an aspiration as opposed to everyday practice.	Assets Reciprocity Power Leadership
Reforming the NHS from within. Beyond hierarchy, inspection and markets	Kings Fund (b)	2014	Leadership within the NHS needs to be collective and distributed.	Leadership Power
Co-production for personal health budgets and integrated personal commissioning	NHS England	2015	There are six phases of co-production.	Power Reciprocity Leadership Collaboration

Document	Author	Year	Key Point	Matches Themes
Co-production and the co-creation of value in public services: a suitable case for treatment?	Osborne, Radnore, and Strokosch	2016	The document is a robust starting point for the evolution of new research and knowledge about co-production and for the development of evidence-based public policymaking and implementation.	Assets Information Sharing
Reimagining community services: making the most of our assets	Kings Fund	2018	Growing demands are impacting on practitioners' ability to meet people's needs, and while useful work is ongoing in the NHS, radical transformation through asset utilisation is needed.	Assets Collaboration

Table 7: Policy Document and Secondary Data Table

Thematic analysis identified six core elements: power, collaboration, assets, reciprocity, information sharing, and leadership. They are elucidated below – each in relation to co-production and illustrating that co-production does not operate in a silo but alongside core elements. The following sections illustrate how the presence of each key theme is needed for co-production's success. In addition to the core reviewed papers, references are utilised from the topic area's literature to support key arguments. A practical example from my clinical practice is utilised to illustrate the use of the key themes in practice.

1.8.1. Power (Equality or Blurring of Roles)

Power was identified as a customary co-production topic within the secondary data, with equality and effective relationships between organisations and service users being key (SCIE, 2013). The purchasing power of the NHS was greater than ever over the last decades; however, more could be done to utilise power to challenge corporate behaviours and create sustainable developments through distribution (Kings Fund, 2002). Considerations of hierarchical power in everyday practices were key to successful distribution (Baxter & Brumfitt, 2008). What transpired thematically, however, was that if power equality was not achieved, individual disempowerment occurred (Toomey 2009), resulting in disengagement from the organisation's vision (Kotter, 1997). Without subscription to changes or 'buy-in', success is unlikely, and this impacts on staff and management relations, thus impeding enhancement of service delivery. The way in which power is shared in a hierarchical structure should be a critical organisational consideration (Anderson & Brown, 2010). Individuals' desires to relinquish power may be challenging, as people often seek to maintain their power (Akella, 2003). The following clear thematic conclusion was subsequently

drawn: honest conversations must take place about the benefits of sharing power (Williams, Dwyer, Eddy, Fink, Jaber, Linas, Michael, O'Hare, Schaefer, Shaffer, Trachtman, Weiner, Falk, American Society of Nephrology Quality & Patient Safety Task Force, 2012). Supporting engagement in collaborative co-production processes enables empowerment to achieve shared outcomes.

The way in which professional discourse perpetuates hierarchical power and increases separation between organisations and service users (Fenwick & Nerland, 2014) (as well as between staff and managers) (Ham, 2014) was noted thematically. Findings indicate that without a shared discourse (or language), there is no 'buy-in' for positive co-production activity (Public Health Wales, 2013). For example, if a common language is not established, then not all parties are equally included in discussions, leading to disengagement and withdrawal from activities, which impacts on successful co-production. Conversely, a shared discourse inculcates opportunity to distribute power and thus service improvement through collaboration (Coen & Kerns, 2012). Those involved in co-production within the Trust recognised its challenges but sought ways to manage or even mitigate them. The above theme of power discourse and distribution becomes an opportunity to strengthen co-production in a critical application of theory to practice when there is active collaboration. For example, within my local CMHT, co-production has been adopted as an approach to multi-disciplinary care, with all team members as active participants of discourse development. Power is evenly distributed, with decisions made as a team, thus allowing for outcomes to be achieved. As previously stated, co-production operates alongside other components. With collaboration at its core, it is no surprise that a theme emerged.

1.8.2. Collaboration (Networks)

Co-working, which involves respecting different approaches to care, is an essential element of supporting power distribution and co-production in practice. In my team, their acceptance of professional expertise was critical for successful agreement of joint action plans. Collaboration, however, is a complex process of information sharing to support joint working to ultimately improve care (O'Daniel & Rosenstein,

2008; Lindeke & Sleckert, 2005). Collaborative co-production also challenges existing relationships between professionals and service users (The Health Foundation, 2010). A review of literature indicates that without collaborative networks, co-production is unsuccessful (Realpe & Wallace, 2010). Consideration of whether effective networking is operational is critical to its success. If collaboration is not coupled with distributed power, then the achievement of outcomes will be impacted, as individuals may approach tasks differently. Thus, agreed outcomes endeavour to unify all parties, placing greater focus on achievement (Kings Fund, 2002). What has not been contested is that joint decision-making is a core principle – even if co-production is viewed in discrete additive terms rather than relationally (Glynos & Speed, 2012).

When individual decision-making occurs, issues subsequently arise for co-production's success (Alakeson, Bunnin & Miller, 2013). Participatory decision-making is integral to supporting healthcare improvements (Seitanidi, Koufopoulos & Palmer 2010; Loeffler et al., 2013). A strengths-based approach is key to effective collaboration and equal distribution of power, where individuals' assets are utilised to maximise the opportunities for outcome achievement. As previously stated, co-production operates alongside other components. With individuals' strengths central to the concept an asset-based approach to co-production is critical to its success.

1.8.3. Assets

Strengths-based approaches empower individuals through role provision, supporting team camaraderie and development. Asset utilisation, coupled with collaboration and distributed power, maximises individuals' strengths, thereby increasing their levels of empowerment and engagement in achieving outcomes (Ham & the Kings Fund, 2014). However, whilst asset utilisation improves efficiency (Needham & Carr, 2009), the Kings Fund (2018) has suggested that to avoid silo working, a complete community redesign is needed because of fragmented services. As stipulated, the Trust's model did not include service users; however, the Department of Health (2010) asserted that this was essential for co-production's success, as community resilience would be strengthened, meaning motivated staff and successful co-

production (Scottish Community Development Centre, 2011). It would be beneficial to consider the need for service user involvement in co-production.

Debates have been held over whether people need to actively engage for co-production to occur (Horne & Shirley, 2009). Whilst a choice to not engage in a collaborative process is still considered to be co-production (Osborne et al., 2016), evidence has indicated that a relational approach produces better results (Horne and Shirley, 2009). Effective engagement of leadership in co-production should support the desired outcomes of service efficiency. Evidence has also suggested that asset utilisation is useful in managing service challenges, such as resource management, access to third sector agencies, and the maintenance of staff and service users' wellbeing. The utilisation of assets supports all parties collaboratively working to achieve predetermined goals, and it can thus increase satisfaction. The above theme demonstrates opportunities to strengthen co-production through the application of theory to practice. For example, within my CMHT, team members identified one another's strengths and utilised these to support outcome achievement. They became adept at using one another's skill base as opposed to working in silos, thus improving both working relations and care. To create a cohesive co-production environment, facilitative leadership is key; it was hence not surprising that this theme emerged.

1.8.4. Leadership (Catalysts)

A leader's ability to facilitate strengths-based, equality-driven collaborative working is essential to any change endeavour. The Kings Fund (2014) has suggested that leadership style is vital for successful co-production engagement. Leaders should moderate their approach, distributing power and moving from their position as experts towards facilitation (Bradley, 2015). Literature has suggested that leaders should be enthusiastic and inclusive to enable co-production. Such catalysts, in addition to co-production's roots of shared power and respectful relationships, have suggested that transformational leadership could complement a co-production model (Krummaker & Vogel, 2010). This type of leadership works on the premise that leaders collaborate with people to identify required change, thereby creating a

shared vision (Seltzer & Bass, 1990). Co-production, however, involves more than working with people; it requires fundamental culture changes, where all parties are equal participants. Literature has also stressed that challenges occur for transformational leaders affecting change when predetermined targets exist (Currie & Lockett, 2007), as with my Trust. The current leadership provision should be reviewed, encouraging managers to collaborate meaningfully (Amanchukwu, Stanley & Oloolube, 2015) to maximise workforce engagement and hence to improve organisational and service user outcomes. Success in this regard is more likely through facilitating rather than directing co-production. For example, when implementing co-production at a local level, I facilitated power distribution and collaboration. Although initially challenging, through a review of individual assets and positive reinforcement, co-production became a staple approach of the team. They saw me less as a decision-making manager and more as an integral team member because of the development of reciprocal relationships. It was expected that reciprocity would emerge as a theme.

1.8.5. Reciprocity

For co-production to be successful, relationship development is critical, since desired outcomes are unlikely to succeed without healthy working relations. Literature argues that reciprocal relationships are fundamental to successful co-production (SCIE, 2013). Reciprocity is a process whereby individuals contribute to service delivery (McCourt & Stevens, 2009) for mutual benefit and through equal relationships. Thematically evident is the idea that co-production provides enhanced stakeholder understanding, increasing insights into others' perspectives and thus improving effectiveness (Davies, et al., 2014). The Trust could foster an environment in which professionals can equally contribute and gain knowledge from others' experiences as well as recognise the local benefits and invest more fully in the process.

Reciprocal relationships require co-operation and willingness to embrace interdependence. Findings have suggested that without equally distributed power, reciprocity can never be achieved, confirming that all parties need to be willing to

share power (Peterson, 1993). The organisation could encourage staff to share personal values to enhance the development of co-created ideas. Evidence indicates that honest conversations about respect and individual meaning are vital to successful reciprocal relationships (Straus, Johnson, Marquez & Feldman, 2014). The organisation can foster mutual respect with staff and encourage personal growth, thus improving wellbeing and retention, resulting in better service delivery outcomes.

Evidence has also suggested that relationships are key to co-production's success and that staff recognise the value of working with others to increase knowledge and understanding (Scottish Community Development Centre, 2011). However, evidence has also alluded to power's influence on reciprocal relationships (Kings Fund, 2014). Reciprocity offers the organisation opportunities to challenge power dynamics and translate theory into practice. For example, within my CMHT, reciprocal relationships have been developed through education and insight into other professional approaches, and respect has been established. The team have made joint decisions, sharing risk equally, meaning that they felt supported to undertake actions; this has increased positive attitudes to the benefits of co-production. Part of this process was capacity development, which also emerged as a theme in the literature.

1.8.6 Information Sharing (Capacity)

Capacity development among all stakeholders and the community is at the heart of co-production. Through effective communication, capacity development engages individuals to work towards a common goal. For example, when implementing co-production within my CMHT, I made certain that all parties had access to relevant information, which ensured distributed power and collaboration, and plans subsequently developed based on skills. Thematically evident was that an unclear co-production definition provided scope for confusion, which could impact on the capacity of organisations to co-produce (Osborne et al., 2016). The Trust could outline its model to increase capacity. By communicating intent, confusion is eliminated, and clarity about how to proceed with co-production is attained, thereby

increasing success (Clarke, 2015). In addition, by communicating intent, errors and risks in practice are minimised.

NHS organisations such as the Winterbourne and Mid-Staffordshire NHS Trust have historically had publicly reported issues with communication (Radford & Johnson, 2015). Serious incident reviews have evidenced the continuation of poor communication (Hafford-Letchfield, Lambley, Spolander, & Cocker, 2014). The development of a co-production communication strategy and a training schedule to develop skills would be beneficial; managers could disseminate these to their staff to enhance teamwork. Evidence has indicated that information distribution is essential for co-production's implementation: staff recognise effective communication (Kings Fund, 2002). The theme of sharing information offers opportunities for co-production to be enhanced and strengthened through empowerment and knowledge.

1.8.7. Identified Core Characteristics of the Policy Document Review

Through a thematic analysis, the review identified that successful co-production requires six core characteristics: power/equality, collaboration of networks, asset utilisation, leaders as catalysts, reciprocity, and information sharing to create capacity. Findings indicate that power can be equally distributed despite the challenges presented by a hierarchical organisation. Through equality, collaboration between networks can be enhanced – this is critical for co-production's success. Findings also reveal that joint decision-making enhances co-production and increased staff wellbeing and retention. The review highlights that asset utilisation can improve service outcomes and support the development of reciprocal relationships within organisations. The review indicates that active engagement in co-production yields better outcomes and that leaders must facilitate engagement. Evidence suggests that the development of a communication strategy, which includes outlining dissemination methods and training schedules, can support implementation and create capacity for a co-production environment. Finally, the development of co-production knowledge supports the development of the scope of the research.

Conclusion to Chapter 1

This chapter provided information on the development of co-production within the UK and its application to healthcare settings. It also presented and contextualised the selected case (with the local prevalence of the need for and application of co-production) evidencing co-production key themes. Throughout this chapter, it was determined that mental health-related needs within the UK are high, and the demand for services has hence increased. Co-production was determined to be a model that could address this need if the six core characteristics work in unison, illustrating the need for this study. The six characteristics of co-production were then compared with the thematic analysis of empirical literature within the theoretical literature review to determine patterns (see Chapter 2).

Chapter 2 – Literature Review

2. Introduction to Literature Review

This chapter offers a theoretical review of current co-production literature in relation to the study objectives. First, the review's search strategy is described, outlining the systematic approach taken, along with research articles and the associated inclusion and exclusion criteria. A critical review of the included articles was conducted, and gaps in literature identified, which inform the methodological approach to the study.

2.1 Background

As illustrated in the previous chapter, co-production is a developing term within healthcare, and it has been evident as a practice within the NHS over the past 5 years. Given the challenges experienced with the Trust's co-production model in practice, a review of current literature was required to identify gaps for further study.

2.1.1 Search Strategy

The following electronic databases were accessed to capture relevant research articles:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL): This database provided access to a breadth of relevant nursing and allied health professional literature linking directly to the subject group of interest, as most managers within the Trust are either nurses or allied health professionals.
- Medical Literature On-Line (MEDLINE): This is the largest US medical database. It was utilised because co-production was founded in the US, and it was important to include related articles. In addition to US articles any relevant articles pertaining to co-production were also considered.
- Academic Search Premier: This is a renowned database spanning multiple disciplines, and, as an OT, it was essential to consider evidence from across professions to understand the scope of co-production in practice.

The review comprised three search phases, as outlined in Table 8.

Review Phase	Dates
Initial review	February 2016 to August 2016
Second review	November 2016 to March 2017
Final review	August 2018 to present

Table 8: Review Phases

Three phases ensured a continuous review of new literature. Databases were searched initially in 2016, and update searches were conducted between August 2018 and January 2019, where all available databases were used. Keywords were used to attain relevant literature (see Table 9 and appendix 3a, b, and c), and Boolean operators were employed in all instances.

Keywords	Reason for Selection
Co-production	This was the focus of the study.
Healthcare	Co-production was introduced into healthcare, and it was pertinent.
Mental health / Psychiatry	The study was conducted in a mental health service setting.
Collaboration / joint working	Given the minimal availability of co-production literature, collaboration literature was reviewed; however, the term was not used in subsequent searches, because of a greater co-production literature yield.
Assets/strengths	Assets were highlighted as a core characteristic of co-production.
Capacity	Capacity was highlighted as a core characteristic of co-production.
Equality/power	Equality was highlighted as a core characteristic of co-production.
Reciprocity/mutuality	Reciprocity was highlighted as a core characteristic of co-production.
Networks	Networks were highlighted as a core characteristic of co-production.
Catalysts/facilitation	Catalysts were highlighted as a core characteristic of co-production.

Table 9: Keywords and Reason for Selection

Websites, including those of the King’s Fund and SCIE, were accessed because of independent work on co-production (included in Chapter 1).

2.1.2. Aims and Objectives

The aim of the literature review was to develop a full understanding of co-production in healthcare. The objectives were to determine a definition, identify current working models, explore the history of implementation and to locate gaps within the literature.

2.1.3. Study Selection and Screening Process

Snowballing supported the database search, as outlined in Figure 10, which is an adapted version of Wholin's (2014) snowballing diagram. It was felt that snowballing could add to the review process and maximise the yield of relevant articles. Forward (review from cited articles) and backward (use of reference list) snowballing was completed, and database searches were carried out for additional articles.

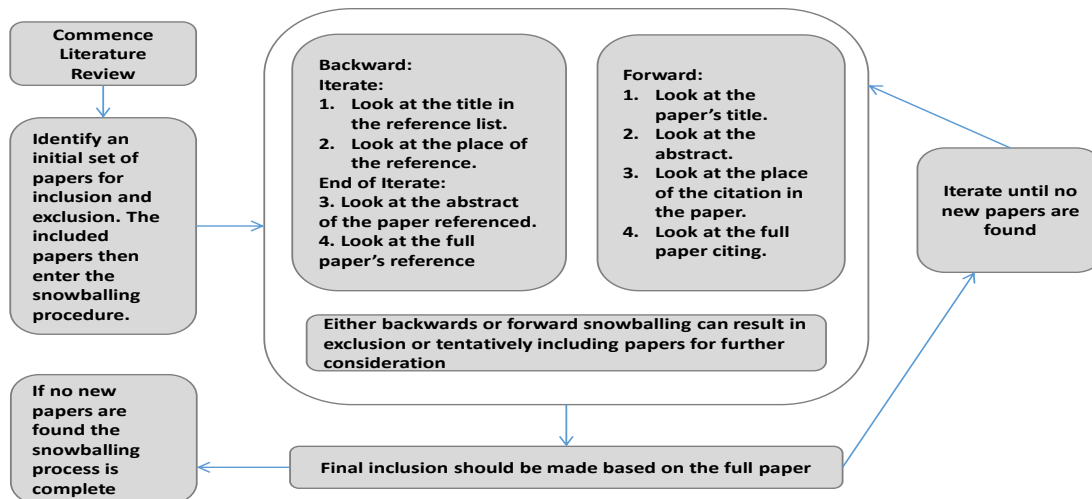


Figure 10: Snowballing Process

Once articles were attained any duplicates were removed, abstract reviewing occurred to determine relevance to co-production which significantly reduced the number of articles as can be seen in Figure 12 – Prisma Flow Diagram. Full texts were then reviewed for relevance to co-production and further omissions were made.

2.1.4. Inclusion and Exclusion Criteria

Studies available in English were included, and those not in English were excluded. In addition, articles not related to theory testing co-production were excluded. Given the newness of the subject matter, no time limit was applied. Articles were considered in relation to population and included for children, adult mental health, physical health, learning disabilities to provide a comprehensive overview of co-production in healthcare. Area of interest was a further consideration and was based on the implementation of co-production and the desire to determine if the implementation of co-production could be realised and if it was going to improve

service user care and staff wellbeing. Both UK and international studies were considered and whilst co-production in mental health was the study focus understanding if the literature supported the model implemented by the Trust was also required. Local and international peer reviewed articles, with a mixture of qualitative, quantitative, mixed methods and systematic reviews were considered. To support the review’s theoretical nature, all relevant information about the concept required consideration; see Figure 11.

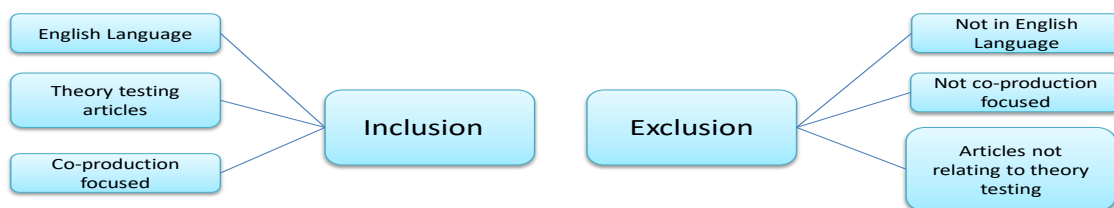


Figure 11: Inclusion/Exclusion Criteria

2.1.5. Critical Appraisal and Risk of Bias

For methodological rigour, Critical Appraisal Skills Programme (CASP) (2017) were used (see Table 10). However, as CASP has no tool for reviewing mixed-methods studies, the Mixed Methods Appraisal Tool (Crowe, Sheppard & Campbell, 2011) ensured that the rigor of all studies was tested.

Tool Used	Reason for Selection
CASP Systematic Review Checklist	<i>N</i> = 2 literature reviews were included in the review; the systematic review checklist was utilised.
CASP Qualitative Checklist	<i>N</i> = 11 studies were qualitative; this tool was appropriate to determine the rigor of the reviewed studies.
The Mixed Methods Appraisal Tool	A mixed methods study was reviewed; however, CASP did not have an appropriate tool available to accurately review this article. It is noted that no critical appraisal tools were available for mixed methods, which led to the development of this tool.

Table 10: Checklists and Reason for Selection

2.1.5. Extraction

Determining abstract inclusion was challenging (because of the lack of set methods); however, key concepts were utilised for consideration. These were determined based on common themes that emerged through the work undertaken in Chapter 1. The use of CASP and Crowe supported the review of the articles for appropriateness, as illustrated in appendix 2.

2.1.6. Analysis/Synthesis

A thematic analysis was used to synthesise qualitative data and to explore key themes and current co-production literature. The analysis occurred in three stages, which supported the organisation of data for synthesis: line-by-line coding of findings, organisation of codes into descriptive themes, and development of analytical themes.

2.1.8. Results

Searches yielded 819 papers; however, following the selection process, 15 significant papers were attained. A PRISMA flow diagram was then developed (Figure 12) to help improve the reporting of this systematic review (Maticic, Maticic & Puljak, 2019).

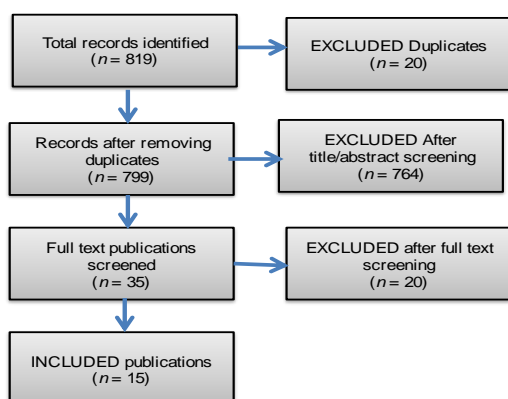


Figure 12: Prisma Flow Diagram

Fifteen articles were included in the review. Their areas of practice are outlined in Table 11; it was deemed necessary to highlight current research in varying clinical settings to determine the focus of co-production.

Area to which Articles Apply	Quantitative	Qualitative	Mixed Methods	Systematic Review	Number of Articles
Mental Health	0	6	1	1	9
Physical Health	0	3	0	0	3
Children's Services	0	2	0	0	2
Learning Disabilities	0	2	0	0	2

Table 11: Articles by Area and Methodology

Critical appraisal of the selected 15 articles illustrated that 7 studies were conducted in the UK and the rest were international studies. Quality of the studies varied as did their contribution to the co-production discussion. There were issues with the generalisability and transferability of findings due to the variety of research settings and the lack of clarity surrounding co-production's meaning. A critical appraisal table summarises the discussion on quality (see appendix 1 – Systematic Literature Review Protocol).

Thematic development via thematic analysis enabled categorisation of articles, and seven clear themes emerged: meaning, leadership, knowledge, power, collaboration, assets, and communication. These themes provided the review's structure. Whilst reciprocity was used as a key search term, it did not emerge as a theme during the thematic analysis of primary data (see Table 12).

Emerging Themes	Number of Applicable Articles
Meaning	3
Leadership	3
Power Distribution	5
Collaboration	3
Assets	2
Co-production Knowledge	6
Communication	3

Table 12: Number of Articles Organised by Theme

Following article identification, a synthesis table was constructed to gain insight into the topic as a whole (see Table 13).

Author & Location (UK/International)	Methods	Sample Size	Co-Pro defined	Summary of Findings	Synthesis
Bradley (2015) UK	Review of study outcomes		√	<ol style="list-style-type: none"> 1. Carers are fundamental to the development of mental health services. 2. A need exists for co-produced services and care. 3. To support understanding, co-production requires a definition. 4. Having clear guidance on how co-production can operate in practice could be beneficial. 	Bradley identified similar findings to those of Heaton, Day, and Britten, all of whom suggest that collaboration between stakeholders is key to co-production's success.
Gillard, Simons, Turner, Lucock, and Edwards (2012) UK	Mixed methods cohort study	120 new users of a range of adult mental health services	X	<ol style="list-style-type: none"> 1. Maintaining methodological flexibility is crucial to the co-production of knowledge. 2. Reflection is integral to the process. 3. A review of co-production knowledge can act as a tool for reflecting on the success of service user involvement. 	Gillard et al., similarly to Mayer and McKenzie (2012) and Davies et al. (2014), focused on stakeholders' involvement in co-production with a focus on service users, and they agreed that service user involvement can lead to greater outcomes and added value. All these studies were conducted in the UK, suggesting a local appetite to utilise service user assets.
Heaton, Day, and Britten (2016) UK	Case study	54 semi-structured interviews with programme stakeholders and 28 members of four case study projects.	X	<ol style="list-style-type: none"> 1. There is a close fit between the nine mechanisms of closer collaboration and co-production theory. 2. Collaborative working exemplifies a project consistent with strong co-production. 	Here, the authors focused on the benefits of collaboration and had similar findings to Robert's et al.'s (2012) study. Coen and Kearns' (2012) study (also UK based) produced different findings on collaboration in co-production (suggesting that true collaboration could not be achieved as power imbalances exist), compared to Væggemose, Vedel Ankersen, Aaggard, and Burau's (2017) study, which was based in Europe and seemed to offer a solution to some of the challenges of co-production through the promotion of staff involvement to improve organisational co-production.

Author & Location (UK/International)	Methods	Sample Size	Co-Pro defined	Summary of Findings	Synthesis
Horgan, Manning, Bocking, Happell, Latiti, Doody, Griffin, Bradley, Russell, Bjornsson, O'Donovan, MacGabhann, Savage, Puli, Goodwin, van der Vaart, O'Sullivan, Dorrity, Ellila, Allon, Sitvast, Granerud, and Biering (2018) International (Finland, Norway, Ireland, Iceland, and Australia)	Qualitative descriptive design	50 participants over eight focus groups	√	<ol style="list-style-type: none"> 1. Co-production enriches the data collection process. 2. Experts-by-experience (EBEs) can enhance students' understanding of recovery. 3. Communication and self-reflection are important personal values. 	This was the only study across multiple countries, and it offers insight into the similarities between countries. The authors also used EBEs and noted the value they added to the study, as did Mayer and McKenzie (2012).
Dalgarno and Oates (2017) UK	Thematic analysis of interviews	Eight semi-structured interviews with mental health practitioners	√	<ol style="list-style-type: none"> 1. The meaning of co-production had four themes. 2. Clinicians' use of co-production means a reassessment of their own power. 3. Co-production alters clinical practice. 	Clarke and Bradley commented on the need for a definition of co-production, and Dalgarno and Oates concurred. However, they furthered this within their study to identify the four themes participants attached to the meaning of co-production. In addition, this study mirrored results from Mayer and McKenzie and from Realpe et al., who identified that co-production can directly impact on stakeholders' experiences in practice.
Mayer and McKenzie (2012) UK	Interpretative Phenomenological Analysis (IPA)	Convenience sample of five males who were experts by experience	√	<ol style="list-style-type: none"> 1. Participants preferred an organisation that encouraged empowerment, agency, and equality. 2. Co-production impacts on the identity structure. 	Similarities exist between the work of these authors and that of Dalgarno and Oates (2017) regarding the identification of the direct impact of co-production on professionals in practice. Given the time frame between both studies, their findings are strengthened.
Davies, Sampson, Beesley, Smith, and Baldwin (2014) UK	Mixed methods	204 participants in the training and 162 questionnaires completed with staff who accessed training	X	<ol style="list-style-type: none"> 1. Training can be effectively delivered. 2. Immediate results suggested an improvement in knowledge post training. 3. A follow-up suggested that capability efficacy was reduced. 4. Consistency is critical to co-production's success. 	A similar approach exists here to that of Mayer and McKenzie (2012), who also utilised EBEs in their study. However, these studies had a different focus. Mayer and McKenzie (2012) focused on the self-identification of service users as professionals, whereas Davies et al. (2014) focused on the importance of service user involvement in changing professionals' perspectives on PD. Both, however, recognise the importance of service user involvement to improve outcomes.

Author & Location (UK/International)	Methods	Sample Size	Co-Pro defined	Summary of Findings	Synthesis
Væggemose, Vedel, Ankersen, Aaggard, and Burau (2017) International (Denmark)	Case study	Interviews with six co-ordinators and two managers	√	<ol style="list-style-type: none"> 1. Staff play a central role. 2. A close interplay occurs between public services and civil society, which are essential to co-production. 3. Collaborative relationships between provider and organisation are key to co-production. 	Væggemose, Vedel Ankersen, Aaggard, and Burau's (2017) study, which was based in Europe and seemed to offer a solution to some of the challenges of co-production through the promotion of staff involvement to improve organisational co-production not addressed in UK studies such as Roberts et al. (2015)
Edgren (1998) International (Norway)	Case study	12 individual interviews (with eight staff members and four service users)	X	<ol style="list-style-type: none"> 1. Short and long periods of inpatient admission can be advantageous for considering a patient as a member of the healthcare team. 2. Patients have a deep understanding of their own bodies and health. 3. Power can be equally distributed by considering patients as professionals in their own care. 	Edgren's (1998) study was stand alone in the approach to joint care planning during inpatient stay. Some of the findings have been challenged by other studies. For example, the idea that including service users in care planning can equally distribute power was contested by Coen and Kearns (2015), who suggested that power can never be truly distributed between professionals and service users.
Realpe, Wallace, Adams, and Kidd (2015) UK	Mixed methods	11 expert views were gathered to develop a tool (excluding service users). This tool was applied to 50 video-recorded consultations with service users	√	<ol style="list-style-type: none"> 1. Twenty-two co-production behaviours were identified. 2. Higher frequencies of co-production behaviours were identified in the consultations where person-centeredness and more patient communication were involved. 3. Further testing of the tool is needed. 	The design here was different from the other papers: the authors developed a measure for co-production behaviours. They did not include service users as experts when designing the measure introducing a power dynamic. Despite the positive outcomes from consultations, this is an issue with the design.
Tuurnas, Stenvall, Rannisto, Harisalo, and Hakari (2015) International (Finland)	Case Study	19 workers from 12 organisations were interviewed	√	<ol style="list-style-type: none"> 1. Outcomes of the service user process are dependent on service user needs as well as organisational and professional interests. 2. Complex relationships within co-production must be considered. 	Tuurnas et al. (2015) were the main researchers to highlight issues with communication and co-production,
Coen and Kearns (2012) Republic of Ireland	Case study	Seven non-resident parents were interviewed	X	<ol style="list-style-type: none"> 1. Involving service users in the operation and refinement of the project was crucial. 2. The role of centre staff was initially critical to establish the project. 3. Staff were making decisions on when to step back from involvement with service users; however, this was not a co-produced decision. 	Here, it was suggested that power distribution cannot be achieved between professionals and service users. However, Roberts et al. (2012) disagreed with this point and suggested that service users are empowered to actively engage in co-production.

Author & Location (UK/International)	Methods	Sample Size	Co-Pro defined	Summary of Findings	Synthesis
Roberts, Greenhill, Talbot, and Cuzak (2012) UK	Action research	Six service users receiving input from the community learning disability team.	√	<ol style="list-style-type: none"> 1. People with learning disabilities have their own stories to tell. 2. Group members created a character called (fairness, respect, equality, dignity, and autonomy) FREDA to illustrate how human rights laws affect them. 3. The original plan was not followed; instead, it developed based on the groups agreed outcomes. 	Here, it was suggested that power distribution can be achieved between professionals and service users. However, Coen and Kearns (2012) disagreed with this point, reasoning that professionals hold the power and even covertly lead decision-making.
Lecluijze, Penders, Fernon, and Hortsman (2015) International (Netherlands)	Longitudinal qualitative study	58 semi-structured interviews, including professionals and policy makers.	X	<ol style="list-style-type: none"> 1. Interaction between local and national differences as well as between disciplinary and organisational differences produced various constructions of risk. 2. The Child Index did not fit well with professionals' daily practices. 	Lecluijze et al.'s study was not similar to any other study reviewed. The outcomes were not positive or wholly applicable to this study; however, the project critically identified that collaboration is a core element of successful co-production, which was a finding echoed by Heaton, Day, and Britten as well as Bradley.
Olsen and Carter (2016) UK	Action learning methods	Eight women who were service users	X	<ol style="list-style-type: none"> 1. The process allowed organisations to explore issues from a range of perspectives. 2. Co-production, whilst highlighting competing priorities, can also provide a means of managing these tensions. 	The action research methodology was employed here, unlike all other studies, and consideration of organisational influence on the success of co-production was standalone too. In addition, no other study openly discussed barriers to co-production.
Lwembe, Green, Chigwende, Ojwang, and Dennis (2016) UK	Qualitative research methods	Semi-structured interviews and focus groups; 11 service users completed treatment and were included in the study	X	<ol style="list-style-type: none"> 1. A 75% retention rate was noted (which is higher than usual for BME groups). 2. The project helped to overcome barriers to accessing mental health services 3. Co-production could lead to the delivery of patient-centred services to improve access and experience within mental health services for BME groups. 	Lwembe et al.'s study, although similar to other methodological selections, differed in the service user group it focused on. No other studies focused on BME groups and their engagement in co-production. This study highlighted that a co-production approach can engage service users who have been historically challenging to engage.

Table 13: Summary Table

In summary the above table coalesced in four areas. All papers established that involving stakeholder in co-production is essential; that communication critical and that collaboration and power distribution is needed for co-production to be successful. One paper (Coen & Kearns, 2012) illustrated a contradictory finding suggesting that power can never be truly equally distributed due to pre-existing power dynamics.

2.2 Review of Literature

2.2.1. Power Distribution

Power was the most common emerging theme ($n = 5$), with many authors discussing the challenges of power distribution in practice. The policy review also highlighted how, without power distribution, co-production would not be successful. Edgren (1998) concluded that power distribution influenced role definition and co-production's success. The study indicated that power can be distributed to others and positively influence outcomes, suggesting that co-production could be a positive model (in the right clinical setting).

Findings identified how, when stakeholders relinquished power, successful co-production and improved care occurred. Despite these positive findings, Coen and Kearns (2012) have argued that even when attempts to distribute power are made, equality is not achieved, which raises issues regarding whether co-production is a viable approach; this suggests that the consideration of power dynamics and potential for distribution to occur in my study is crucial.

Coen and Kearns' (2012) study demonstrated that encouraging service user involvement and staff withdrawal was determined by professionals and not as joint decision making. Power was still prevalent, with a need for increased collaboration to achieve a truly co-produced centre. Findings questioned if power can be distributed between professionals and service users within a hierarchical environment with pre-existing authorities at play. In healthcare, imbalances exist within binary opposites such as doctor and service user or professional and service user, and they affect the development of this study. Coen and Kearns' (2012) asserted that challenges exist when distributing power; however, Dalgarno and Oates (2017) showed progression could be made and an equilibrium achieved through joint working, evidencing that co-production could be a useful model for healthcare services. These findings illustrate conflicts about whether power can be distributed in practice, which highlighted why this was a necessary consideration when constructing my study. They concluded that co-working shifts power dynamics suggesting that minimising

clinical conversations promotes the re-evaluation of roles. Although findings highlighted equality opportunities, consideration of the need for clinical conversations was overlooked, suggesting further exploration of power distribution in clinical environments is required. However, the capacity to co-create was gradual suggesting co-production's implementation would be lengthy, highlighting why a review of existing progress was needed.

Dalgarno and Oates' findings showed participants re-evaluating their expert role illustrating power distribution within groups via reciprocity (suggesting that reciprocity is key to co-production). Regardless of criticisms, the findings provided a baseline, supported by Mayer and McKenzie's (2017) study, which offers insight into power distribution from service users' perspectives.

Mayer and McKenzie (2017) support the redefining of service user identity using interpretive phenomenological analysis (IPA) to review the psychological impacts of co-production on experts-by-experience (EBEs) working in mental health. Three themes emerged: 'the co-production approach', 'I'm a professional', and 'identities in transition'. Co-production enabled participants to develop a professional identity, illustrating that role identity which was key to wellbeing, self-esteem, and autonomy (La Guardia, 2009). Determinedly, if individuals feel empowered, then greater equilibrium is achievable, and better outcomes are attained.

Despite suggestions that equality could be achieved, Olsen and Carter (2016) highlighted that even when intent is positive, organisational culture can be a barrier. The diversity of the learning set sample provided a variety of experiences and opinions, illustrating that multi-agency co-production is challenging. Reflection on the drivers and challenges of multi-agency co-production is crucial. Despite barriers, the authors stressed that the challenge was worthwhile, as participants were integral to ensuring the aim was always in focus. The study also found that co-production could be a useful vehicle for creating knowledge, as participants were sharing skills and knowledge, highlighting the benefits of asset utilisation. However, organisational culture and tensions arising from business approaches were significant barriers.

These external influences impeded co-production's success, suggesting that consideration of these factors is needed when implementing co-production in practice. The study demonstrated co-production's potential value for healthcare.

2.2.2. Co-production Knowledge

Gillard, Simons, Turner, Lucock, and Edwards (2012) studied the co-production of knowledge to aid communication improvement. The authors demonstrated flexibility in their approach (allowing non-research participants to question academic conventions), leading to the discovery of complex findings that could otherwise have been missed and highlighting co-production's potential to discover new knowledge. The study also found that service users and carers are integral to decision-making when coding interview data through the production of analytical categories for discussion. Findings support Olsen and Carter (2016) that service users are integral to co-production and knowledge development.

Heaton, Day, and Britten's (2016) study further supports these findings. They considered four core elements of co-production mirrored in the policy review (Chapter 1): active agents (assets), equality of partners (blurring roles), reciprocity, and facilitation (catalyst). They located an additional element, 'transformative in approach' showing that participants were cognisant of the role of frontline professionals who were critical to the pathway's success, this development occurred. When change occurs, consideration of staff views is necessary to support the development of co-production knowledge. In doing so, opportunities to support power distribution occur, as the inclusion of various stakeholders encourages the uptake of active roles, resulting in equality in the research process. This finding is significant because it highlights that utilisation of assets and skills could result in power distribution, with the development of knowledge being applicable to all healthcare settings, as engagement is not an isolated concept. Most people within the project had previously worked together, meaning there was pre-existing trust, which supported power distribution, increased the knowledge creation and better co-production outcomes. Importantly, service users entered co-production groups that

were well established when commencing treatment, and reflection on how to support knowledge among staff to encourage dissemination was thus deemed essential.

Horgan et al. (2018) have extended the scope of co-production knowledge to include EBEs in the co-production of nursing education. Two key findings emerged: the first being valuing the strengths of EBEs to see beyond diagnostic labels which had positive impacts on students' knowledge, their understanding of recovery, and their ability to develop rapport, and has the potential to improve future nursing practice. The finding is significant because it demonstrates the benefits of a strengths-based approach. Co-production could enhance involvement whilst improving the nursing curriculum and reducing stigma. The second finding highlighted the potential to increase knowledge, compassion, collaboration, and respect, via self-reflection and conversations with EBEs. Whilst applicable to students, transferability to staff inductions could promote co-production behaviours. These findings magnify the benefits of increasing EBEs' involvement, which could support professionals to remain focused on a strengths-based approach, supporting knowledge creation within teams through a focus on assets. The findings from the above studies indicate that the generation of co-production knowledge is essential to the collaboration process.

2.2.3. Collaboration

Collaboration was an emerging theme in the policy review (Chapter 1) and this finding was mirrored within the literature review. Collaboration is essential to successful co-production during the development of co-production knowledge. Roberts, Greenhill, Talbot, and Cuzak (2012) demonstrated that collaboration can enhance co-production through inclusion and empowerment. Findings showed that co-production led to participants feeling empowered to utilise assets and collaborate to achieve a joint outcome supporting their knowledge creation. More importantly may have been participants' confidence to develop knowledge and collaboration within the group through the creation of fairness, respect, equality, dignity, and autonomy (FREDA) as a vehicle for constructing views on human rights. Participants

described the 'empowering process', thus highlighting co-production's value in practice.

Coen and Kearns (2012), however, suggested that not everyone co-produces to the same extent, highlighting a limitation with Roberts et al.'s (2012) study, as consideration of whether all individuals engaged equally did not occur, suggesting that the drivers for engagement in co-production should be considered. In addition, Coen and Kearns (2012) found that co-production benefitted the play centre development; however, levels of engagement differed from family to family based upon their needs. This supports the view that collaboration is essential for co-production if we concur with the assertion that people only co-produce to meet their own needs and do not consider the needs of other group members as important – they thus partially collaborate. Væggemose, Vedel Ankersen, Aaggard, and Burau (2017), however, have asserted that staff are key to successful collaboration and co-production. While stakeholders may strive for an equal investment in co-production, achievability is questionable given the varying reasons for co-producing. For example, for service users, the reason could be to recover; for carers, it could be respite; for professionals, it could be to deliver effective care; and for the organisations, the reason could be to meet predetermined targets.

Væggemose et al.'s (2017) study considered organisational challenges, investigating how providers and staff operated within the two logics of public service and civil society in Denmark. Both Roberts et al. (2012) and Coen and Kearns' (2012) studies were UK based and produced different findings compared to Væggemose et al. (2017), whose study was based in Europe and seemed to offer a solution to some of the challenges of co-production through the promotion of staff involvement to improve organisational co-production. However, its transferability to UK services requires thought on how staff engagement differs between countries and how the different healthcare systems impact on working lives, wellbeing and motivation to engage. As the focus of the study was on staff, it is possible to consider how applicable the findings are to the Trust's co-production model. Væggemose et al.

(2017) did not consider service users' views on collaboration or the part they played in the process, suggesting that co-production was not fully achieved.

Similarly, Lecluijze, Penders, Feron, and Horstman's (2015) study – also European – identified the need for collaboration in order to co-produce. Their study differed from Roberts et al. (2012) and Coen and Kearns' (2012) studies, since much like the research by Væggemose et al. (2017), the focus was on staff not service users, and this makes comparability challenging. Lecluijze et al. (2015) aimed to improve understanding of socio-technical processes in child welfare and how risk was constructed within the process. Findings demonstrated the rigidity of technology for professionals to construct their perception of risk, hindering their ability to co-produce. The study highlighted that co-production was fallible if the system did not support the needs of the stakeholders. Despite the lack of success, findings have indicated that successful service delivery depends on professional collaboration, meaning effective leadership is required to engineer the appropriate environment for success.

2.2.4. Leadership

Leadership was identified in the scoping and literature review as pivotal for co-production's success, which Turnnas, Stenvall, Rannisto, and Hakari (2015) have highlighted. Participants utilised words such as fragmented, scattered, overlapping, and specialised to describe their working environments, thus highlighting challenges. These terms are used frequently in mental health services in relation to organisational change, suggesting that these experiences are not silos, but institutionally require addressing such as professional demands (attaining knowledge of providers and developing a clear managerial structure) which hinder co-production. As leadership is essential in all healthcare settings, consideration of how to manage these challenges is needed.

Hierarchical structures can lead to confusion, especially when high turnover of managerial staff occurs, which can impact on services' fragmentation and staff wellbeing. Effective leaders must circumvent challenges to ensure that staff feel

secure and supported. Fragmentation with poor communication negatively impacts on co-production opportunities for service users, highlighting staff concerns surrounding service user involvement. Leaders could ensure effective communication, and opportunities for co-production exist within their local service to increase productivity. This was notable, as the Trust's model excludes service users, and Turnnas et al. (2015) have stressed the importance of those users' engagement in the process for staff, meaning that establishing how essential their involvement is to the Trust's staff is a crucial consideration.

Despite these findings, Davies, Sampson, Beesley, Smith, and Baldwin (2014) have highlighted the benefits of co-producing with EBEs to improve leadership and engagement with service users. Their study reviewed the implementation of PD training for NHS staff. Staff deemed the training to be a powerful experience, viewing service users in a positive role and thus gaining an understanding of their condition. Whilst initial results were positive, three months post intervention, evidence revealed that experiences in practice had not significantly improved, suggesting a greater need for consistent co-production. This finding is essential, as services must consider how to embed co-production and maintain input from EBEs to sustain the initial findings. Results were positive, suggesting that co-production can influence staff experiences with consistent involvement in co-production behaviours; this supports the view that a long-term plan to embed co-production is needed, as opposed to isolated use. Davies et al. (2014) have stressed that co-production can benefit service users, staff, and the organisation. Previous studies have explored co-production with staff and service users; however, there was also a need to focus on the organisation. In addition to service user involvement, the way in which leaders within the organisation support co-production is key.

2.2.5. Meaning

There is an absence of meaning around co-production (reflected in the policy review). Meaning is a relative term identified during the policy review and confirmed within the literature. Of the 16 articles reviewed, only $n = 8$ attempted to define co-production, and there was no one agreed definition; variation exists, suggesting a need for further clarity. Bradley (2015) presented key findings from seminal work that

attempted to introduce co-production in mental health services. Studies have illustrated carer contribution, and the results revealed that professionals do not always recognise assets, suggesting a need to co-produce further. She noted that clearer guidance was needed on co-production implementation to avoid acting in isolation. The recognition of a need for guidance and understanding is noted as a challenge within this study, yet it is noteworthy that Bradley (2015) conducted his review with the inclusion of UK studies, suggesting that further review of seminal work is required as co-production literature develops.

Whilst Bradley (2015) identified the need to clarify the meaning of co-production, attempts to provide clarity were missed. Dalgarno and Oates (2017), however, endeavoured to provide some context. Their results have demonstrated that the meaning of co-production has four themes: definition, power dynamic, negotiating roles, and influence on practice. All these identified themes are highlighted and considered within the thesis. In addition to these themes, the concept analysis identified further areas for consideration, including asset utilisation.

2.2.6. Asset Utilisation

Through the policy review, assets were determined to be an essential element of co-production because of service pressures and the contribution of the skills that individuals possess. Davies et al. (2014) have noted the importance of co-producing with EBEs. Their study utilised individuals' assets, which resulted in a powerful response from participants. Findings indicated that positive responses faded over time, suggesting that asset utilisation throughout the co-production process should be common practice. Edgren (1998) concurred, stating that greater outcomes occur when service users engage in their own care. The study noted improvements to identity, which, with the move towards preventative care, is important, as service users will be shaping healthcare services, and a strong identity will support them. Roberts et al. (2012) furthered the concept of asset utilisation, demonstrating that co-production can be truly transformative, with service users taking ownership of the co-production group identifying and their own understandings of human rights. Lwembe et al. (2016) extended this concept to consider the inclusion of minority service

users. Their study examined the use of co-production in improving healthcare services for black and minority mental health service users. The authors found that through asset utilisation, participants were likely to engage with services, supporting the above-mentioned findings. The study, however, was small and requires more rigorous analysis on a larger scale. The above studies were conducted in different healthcare settings within the UK and Europe, suggesting that skill utilisation can support the improvement of service delivery. To ascertain individuals' skills, effective communication is critical.

2.2.7. Communication in Co-production

Communication is a repeated challenge experienced within the NHS and, it is unsurprising that it emerged as a theme. For asset utilisation to be maximised, effective communication is required, as stressed by Turnnas et al. (2015), who have identified a need to focus on communication within co-production. Their case study highlighted that fragmented services with poor communication negatively affect co-production opportunities, thus impacting on outcomes being achieved. However, Reape, Wallace, Adams, and Kidd (2015) have suggested that improvement in communication through clarity of co-production behaviours could improve experiences. Their study designed a prototype measure of co-production to review consultations with individuals with long-term conditions. An agreed map was produced that defined behaviours influencing co-production. The inclusion of EBEs could have ensured that the measure was more robust, as it would have been a truly co-produced list of behaviours.

Following the checklist development, 50 videoed consultations were observed to correlate the use of the identified behaviours with service users to test reliability and credibility. Findings were positive and noted an increase in the use of co-production behaviours, suggesting that the measure could be implemented in practice to improve professionals' interactions with service users who have long-term conditions (which would encompass mental health). Despite the credibility of Reape et al.'s (2015) measure, the scope to hold consultations within the NHS is challenging because of the described work pressures, meaning that consultations could be

perceived as additional work, and this would be a barrier to engagement. Consideration about staff 'buy-in' to co-production is noted as critical. In addition, these results may not be transferrable to service users with short-term conditions, such as anxiety and depression; this is important and suggestive that further research is required.

2.3. Impact and Measurement

Based on the review, certain concepts are essential to successful co-production. However, gaps in evidence exist around measuring the success of co-production. Consideration of how to measure co-production's impact is critical for this study and wider research settings. Realpe et al. (2015) have identified that by engaging service users in consultations, co-production could be monitored. Their study had a small sample size, which makes transferability an issue and demonstrates the lack of involvement of service users in the development of co-production behaviours, thus introducing a power dynamic. Whether this measure alone would be sufficient to measure co-production's impact is questionable. Consideration of alternative measures is consequently critical. The 'co-production self-assessment framework', in which six questions are scored by an individual or group to assess implementation (Think Local Act Personal, 2018), was the only available measure, and while some identified measures existed for co-production, no testing or validation was done.

2.4 Conclusion for Literature Review

Six themes emerged from the review to support the understanding of co-production: one, the distribution of power and how it is circulated within a hierarchical environment, with pre-existing imbalances (Edgren, 1998); in addition to co-working shifting group dynamics (Coen & Kearns, 2012). Two, collaboration enhancing co-production through inclusion and empowerment (Roberts et al, 2005); albeit, not everyone co-produces equally, thus impacting on collaboration levels (Coen & Kearns, 2012). Third, consistent leadership and the use of co-production behaviour are needed for embedding to occur; determining community leaders' understanding and perceptions of co-production is critical to ascertain whether co-production can be successful in practice (Davies et al, 2014).

Fourth, the focus on communication within co-production, with a requirement for clear guidance on how co-production is implemented (Turnnas et al., 2015), fifth was the need for asset utilisation, with all studies illustrating the potential strengths of this approach for improving service delivery (Davies et al, 2014). To comprehend co-production and its uses, appreciating the operational setting was vital (see Chapter 1 – Background), was present in all the papers.

Sixth was reciprocity, which whilst no studies have specifically focused on reciprocity and co-production, the importance of relationships between service users and those who deliver services was important. Through active engagement, participants are likely to develop their own sense of identity (Edgren, 1998) and engage more fully (Lwembe et al., 2016). In addition, for reciprocal relationships to develop, power distribution (Coen & Kearns, 2012) and recognition of the role that service users can have in developing their own care and treatment are required (Davies et al., 2014).

Gaps identified: a lack of clarity surrounding the meaning of co-production, how all core characteristics of co-production can be utilised in practice, how different stakeholders engage based on their understanding and perception of co-production, a lack of evidence of co-production's success within community mental health settings. The literature review provides a useful springboard to design this study, with findings identifying clear gaps for exploration to add to the current knowledge base. Considering the key findings, the research problem is as follows.

Conclusion to Chapter 2

This chapter outlined the search strategy, presented available co-production literature, and offered a summary of gaps in evidence. The original contribution to the research field was explored, with the identification of the research problem and study objectives. By completing the theoretical review, which supports the policy review's finding that a lack of a clear definition of co-production exists, the need for a concept analysis to remedy this is highlighted. It is worth noting that while the scoping and literature review provided some clarification on co-production's core

characteristics, new challenges arose because of the conceptual nature of the term, thus reaffirming the requirement for a concept analysis. The core characteristics identified were used to frame the concept analysis' model case.

Chapter 3 – Concept Analysis

3.1 Introduction

Following the completion of the theoretical literature review a lack of clarity remained surrounding how I would communication co-production's meaning following completion of the thesis, prompting the need for further exploration via a concept analysis. Co-production must be handled with care: on the one hand it needs to be valued for its flexibility, performing to the varying needs of those engaging in its processes. On the other hand, definition is necessary for efficiency and practice. Many papers oscillated between both camps and co-production was difficult to anchor given the looseness of terms with which the theory is both defined and applied. From a methodological perspective, a concept analysis was undertaken to ensure clarity and that any ambiguity around its meaning was reduced. What started out as a simple definition of terms, grew into a chapter offering an original contribution to the field.

3.1.1. Concept Analysis

Several models are available to undertake a concept analysis, including an evolutionary concept analysis (Rodgers, 1989), the utility method (Morse, 2000), and the principle-based method (Penrod & Hupke, 2005), all of which offer guidance. Walker and Avant (1995) offer a guided framework and their model is a development of Wilson's framework (1963), providing a concept derivation by concept synthesis. Walker and Avant's (1995) model was selected because of its utilisation within healthcare settings and its ability to provide structure to the research.

There is no agreed definition of a concept among scholars, and varying philosophical standpoints exist for how to approach further exploration. Concepts, viewed as constituents of thought (Machery, 2009), are undisputed. However, what concepts are, still creates a debate among researchers. It is suggested that a concept is an

abstract idea (Ratanasiripong & Chi, 2013); however, this idea needs to be broken down into its simplest parts to allow for a common understanding (Foley and Davis, 2017). Meanwhile, Bousso, Poles and Cruz (2014) extend the definition further, stating that a concept is a mental formulation, where words are used to describe an image. However, it is generally agreed that concepts are the basic building blocks of scientific knowledge; hence, the strength of the guiding theories for any discipline depends on the quality of the concept analysis (Botes, 2002).

Concept analysis is linked to a philosophical inquiry research design, aiming to clarify meaning through intellectual analysis (Burns & Grove, 1993). Whilst differing in their standpoints regarding what concepts are, all above-cited authors concur that concepts convey meaning. Thus, not defining co-production would promote misinterpretation, and examination of the co-production concept in relation to other concepts would consequently hold little meaning. In addition, concept analysis fits well with the OT ethos of breaking tasks down into their basic parts and then reconstructing them to create meaning (Brown & Hollis, 2013).

3.1.2. Methodological Approach to the Concept Analysis

The aims of the concept analysis were to identify and name co-production with some truth based upon an evidence base; to understand any codicils or surrogate terms which related to co-production and determine a working definition for going forward. The inclusion and exclusion criteria was the same as that outlined in chapter 2, page 49. For the search strategy, data collection was supported by policy documentation, followed by a literature review. Walker and Avant's (1995) model was used to conduct a methodological enquiry by exploring the aim, the uses of the concept, defining attributes, a case model, a borderline model, antecedents and challenges, and the empirical referents.

3.1.3. Defining Attributes

To explore the definitions of co-production, its etymology is a good place to start. The Oxford English Dictionary (2010) defines co-production as *'the production of ...*

work ... jointly with another or others'. Many definitions relate to the production of plays (Collins Dictionary, 1994). An analysis of the verb 'to produce' could further enhance the meaning of co-production. The Oxford English Dictionary (Simpson, Weiner & Oxford University Press, 1989) defines 'produce' as follows: *'to bring into existence, give rise to, cause'*. In addition, an etymological investigation of the derivation of co-production leads to the words 'co' and 'produce'. The prefix 'co' comes from the Latin word 'com' – meaning 'with and together' – and 'produce' is from the Latin word 'producere', meaning 'to bring forth' (Hoad, 1996). No existing synonyms for co-production were located in Roget's Thesaurus (1982).

Several definitions were observed, with the TLPA National Co-production Advisory Group from Think Local Act Personal (2018) (<https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-is-co-production/>) stating that *'co-production is not just a word, it's not just a concept; it is a meeting of minds coming together to find a shared solution'*. Since the introduction of co-production into healthcare, key policy papers have suggested that the NHS utilises the definition by the New Economics Foundation (2010 pg.3), which defines co-production as *'...delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours'*. The King's Fund also favours the new Economics' definition and utilises it in their co-design toolkit (Murray, 2013). However, the National Occupational Standards (2014 pg.1) expanded on the idea, suggesting that co-production is *'A way of working whereby citizens and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it'*.

Bringing together the above ideas, co-production is multi-faceted, with several actions required for successful implementation, including collaborating, sharing power, working together, and practicing reciprocity. Those definitions suggest that a radical approach is required, with service users driving service delivery instead of

Government-imposed practice. However, current literature suggests that co-production is poorly formulated (Osborne et al., 2016), thus initiating problems for implementation, as demonstrated through the different discourse used among the varying definitions.

A shared discourse would support greater understanding, in addition to clarifying meaning to enhance communication (Kemp, 1985), and it would enable the term to be used correctly (Slee, Slee & Schmidt, 2008). A clear understanding is required for co-production's success because workforces utilise different approaches, values and beliefs.

From reviewing available co-production definitions, several defining attributes were noted (New Economics Foundation, 2012). They are as follows: identifying people with assets, breaking down barriers between service users and professionals, building on existing capabilities, including reciprocity and mutuality, using peer and personal networks alongside professional networks, and facilitating them becoming agents of change as opposed to simply being service providers.

3.1.4. Core Characteristics

Throughout exploration of policy documents and the theoretical literature review, six core characteristics were identified and discussed in Chapters 1 and 2. These characteristics were deemed appropriate for use within this concept analysis was supported by the Coalition for Collaborative Care who developed a co-production model focusing on the values needed for successful co-production (Coalition for Collaborative Care, 2016). The model outlined a need for ownership and acceptance of co-production by all, a culture of openness and honesty, a commitment to sharing power, clear communication, and a culture of valuing and respecting people to maximise the model's potential (see Figure 13).



Figure 13: Coalition for Collaborative Care (2016) (reproduced with permission from the Coalition for Collaborative Care)

In addition, they presented a seven-stage plan for *'how to do it'* (see Figure 14) by gaining senior management support, recruiting a variety of individuals through open and fair methods, implementing systems, identifying areas where co-production could impact the greatest, training, and constantly evaluating progress (Coalition for Collaborative Care, 2016). This model, however, was not adopted within the Trust, as it was noted no pre-existing model was adopted for implementation.

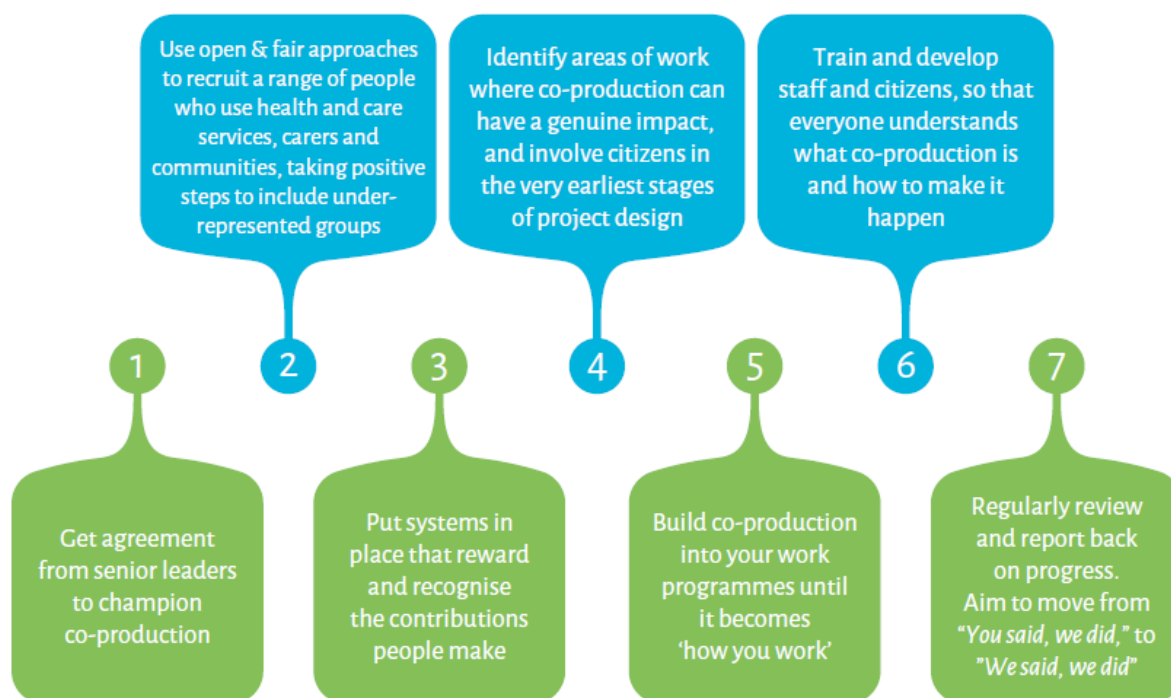


Figure 14: Coalition for Collaborative Care (2016) Seven-Stage Plan (reproduced with permission from the Coalition for Collaborative)

Figure 16 presents the suggested model; however, it is noteworthy that this principle is newly developed and has not undergone rigorous testing to support its success or validity. While the Coalition for Collaborative Care is developing a diagnostic tool to support organisations with identifying strengths and areas for improvement (Coalition for Collaborative Care, 2016), no current robust measurement guide can be utilised, leaving this model flawed. As a result, no agreed model for co-production currently exists. However, there are six agreed characteristics and principles (confirmed in previous chapters): (1) assets, (2) equality/blurring roles, (3) capacity, (4) networks, (5) catalysts, and (6) reciprocity/mutuality which many authors agree upon. Each of these are explored below.

(1) Assets

McGeechan et al. (2016) have suggested that asset utilisation – when the skills and attributes of all involved are acknowledged – is key to co-production. Assets are qualities such as time, skills, and abilities (Scottish Community Development Centre,

2011). This means that all parties involved in co-production, including service users, need to transform from passive recipients to active participants of care, where they are equal partners in the delivery of services (National Empowerment for Science, Technology and Arts, 2012). Through asset-based approaches, individuals are empowered to make decisions, thus increasing the likelihood of achieving desired outcomes (McLean, McNeice & Mitchell, 2017). Acknowledging skills could revolutionise the relationship between professionals and service users, thereby encouraging individuals to assume responsibility for their own wellbeing (Mental Health Foundation, 2013). Independent thinking about wellbeing can also support a move towards preventative healthcare, minimising service demand and thus saving money (Curry, 2006). Asset utilisation is integral to co-production's success by positioning individuals to blur professional boundaries.

(2) Equality or Blurring roles

Equality is an essential part of co-production and enables relationship building (Pestoff, Brandsen & Verschuere, 2012). However, co-production can be inhibited by existing power imbalances between professionals and service users. Equality in this context refers to the acknowledgement that no one individual's views are more important than another's (Horton & Patapan, 2004). Concerted efforts are required to shift the balance of power to enable even distribution amongst all involved (Fugini, Bracci & Sicilia, 2016), thereby blurring the roles to remove the defined boundaries (NESTA, 2012). Balance is vital to ensure that greater expertise does not equate to greater power. Recognition of individual skills should consequently be central to maintain a balanced approach (Loeffler, Power, Bovaird & Hine-Hughes, 2013). Ensuring that diversity and inclusion are addressed, is crucial because of service users being under-represented in the local mental health population (Sclater, 2009). Various issues, such as diagnosis, are factors because, for example, people with severe depression are less likely to engage in active co-production than people with PD, which can impact on capacity development.

(3) Capacity

Co-production seeks to enhance strengths such as networks, social capital, and motivation (Scottish Community Development Centre, 2011). Filipe, Renedo, and Marston (2017) have suggested that co-production involves altering the delivery model from a deficit approach to one that supports asset utilisation (NESTA, 2012). Both models require consideration to ensure effective co-production, as a deficit model identifies development areas, whilst an asset-based model utilises strengths to effect change. Adoption of an asset-based approach, with capacity building at its heart, would support the engagement of all parties, thus promoting a cohesive, resilient community.

(4) Networks

Networks are the foundation on which activities are based. Without the right networks in place, community-led programmes are unlikely to succeed, and health improvement strategies will likely flounder (Scottish Community Development Centre, 2011). The most advantageous method for transferring knowledge is by engaging peer and personal networks alongside professionals (NESTA, 2012). Solid network development and power distribution between service providers and service users is essential and could lead to reciprocal relationships, thus increasing viability for success. To enable these, development leaders must become facilitators, not directors.

(5) Catalysts

Being a catalyst involves engaging public service agencies to become facilitators (Sanderson & Lewis, 2012). To enable facilitation, accessibility must be considered to address power imbalances. For example, many service user forums occur at NHS buildings, and this strengthens power imbalances and affects engagement levels because of the stigma. Thus, consideration of meeting locations is key. It could be argued that meetings held away from Trust sites can equally stigmatise service users' mental health; however, evidence suggests that normalising mental health is beneficial to recovery and acceptance within society (Repper & Carter, 2011).

Agreement about information sharing should be determined, as issues such as confidentiality may restrict provision. Professional discourse will impact accessibility, since not everyone will understand different languages. As such, a shared language should be developed for all members to feel involved, which may aid the redistribution of power and the development of reciprocal relationships.

(6) Mutuality or Reciprocity

Put simply, reciprocity means someone receiving something in return for what they have invested (Silverstein et al., 2002), and it is a key component of co-production. Mutuality offers a range of incentives to promote engagement with co-production. Thus, mutuality should enable individuals to develop and work in reciprocal relationships with professionals with shared expectations. When commencing co-production, mutuality must be considered and can range from reward schemes to developing positive relationships.

3.1.5. Advantages and Disadvantages of Co-production

The success of co-production is promoted when the above six characteristics are present. Whilst co-production is a relatively new healthcare concept, many authors highlight its potential advantages, including increased quality of care, better outcomes, and the development of a more cohesive community (Osbourne, Radnor & Strokosch, 2016; Needham, 2009; Loeffler et al., 2013; Kettunen, 2010).

Even though no evidence for co-production's outcomes exist in practice, Boviard and Downe (2008) have reported from their survey that engagement in co-production results in more accessible services, better 'joined up' services, more responsive services, higher quality services, and better value for council taxpayers. Despite the potential benefits, the main disadvantages include the lack of a clear definition; the lack of an agreed model of implementation; a resistance to relinquish power; and unwillingness to perform the required tasks (finding that co-production makes the employee's role more demanding).

3.1.5. Example Cases

3.1.6.1. Model case

Walker and Avant (2005) argue for a model case packed with all the defining attributes (and a pure example). One example for the model case is KeyRing Living Support, a supported living service for vulnerable adults. The concept was that a series of local networks would be established, whereby mutual support was offered (using members' skills and talents), linking people in with the local community. It comprised nine adult members (service users) and one volunteer, who resided within a 10 to 15-minute walk from one another, acting as a support network. KeyRing's support was based on people living independently within their own homes but sharing their skills with one another and the community (assets). The study drew on the community through a development philosophy that highlighted the need for social networks to promote good living (mutuality/reciprocity). Volunteers were considered to act as good neighbours, supporting people when challenges arose and enabling networking within the community (capacity).

Over time, the process led to a mutual support network (network), where all members of the community were valued for their contributions. All six core characteristics for co-production were present within the study. Members were involved in recruiting staff, and they were trustees on the Board, helping to blur the boundaries between recipients and providers of the service. Essentially, the developed networks were not only for vulnerable adults, but they also included a wide range of community residents, where individual assets were nurtured and maximised (equality/blurring roles). The key finding was that peer support networks not only improve outcomes for people but also increase the scope for effectiveness of services (catalysts) (NESTA, 2012).

3.1.6.2. Borderline case

Borderline cases provide justification for the defining attributes and are examples containing most, but not all the defining attributes of a concept (Walker & Avant, 2005). In relation to co-production, one example of a borderline case is Essex

Coalition of Disabled People (ECDP) solutions, which had four core characteristics (NESTA, 2012), making this an appropriate borderline case. As a user-led organisation, ECDP solutions supported the delivery and influence of local authority policies around support planning. The service sought to blur the perceived boundary between service users and professionals to improve the overall experience of support planning. It had been stated that the process increased service users' confidence in conveying their lived experiences. When the programme was evaluated, support planners explained that the approach was efficient, active, knowledgeable, and available, leaving participants feeling that their lives really mattered.

3.1.7. Antecedents and Consequences

3.1.7.1. Antecedents

Antecedents are events that must take place prior to a concept's occurrence (Walker & Avant, 2005). Hence, prior to co-production occurring, all parties need to be motivated to engage in the process. Without 'buy-in', implementation attempts would likely falter. Outlining potential benefits would increase the desire to engage (Kings Fund, 2012), but opportunities must be available for all parties to engage through power distribution and consideration of who is needed to effectively co-produce (SCIE, 2013). Effective communication to provide an understanding of the vision is also required (The National Archives, 2013), as without clarity, people struggle to 'buy-in' to the model. Additionally, a clear understanding of organisational expectations is essential, as without it, fluid use of the co-production model would not occur (Chartered Institute of Personnel and Development, 2014). Perhaps the most important antecedent, however, is the ability to engage in the co-production process (Hsu, et al., 2013) as without engagement, co-production will not be successful.

3.1.7.2. Consequences

By engaging in co-production, the desired consequence is that service users' goals are achieved, resulting in improved quality of life and recovery from illness (or equipped to manage relapse). Co-production could lead to fewer complaints

because of ownership of care and more satisfaction in plan formulation (NHS England, 2015). From a staff perspective, co-production could improve wellbeing and job satisfaction (New Economics Foundation, 2013). It was expected that co-production would support the development of an inclusive culture, where staff take on local team ownership (SCIE, 2013). From an organisational perspective, it was anticipated that targets would be achieved in a cost-productive manner as a result of co-production's implementation (Clark, Jones, Harris & Robert, 2017). Co-production could also lead to staff feeling invested and engaged, and recruitment and retention rates could thus improve, thereby reducing staff turnover and producing better outcomes (Kings Fund, 2012).

3.1.8. Empirical Referents

Empirical referents are measures available to evidence co-production's success (Walker & Avant, 2005), however no measurement tools were found (SCIE, 2013). From an OT perspective, the Canadian Occupational Performance Measure (COPM) could evaluate goal achievement, focusing on satisfaction and the performance element of tasks (Enemark Larsen, Rasmussen & Christensen, 2018). The tool encourages individuals to identify their own goals for the focus of intervention, acting as a guide for professionals to follow. At regular intervals, plans are reviewed, and progression is noted. The tool encourages co-produced conversations and could be used to review group outcomes. In addition, the Quality of Life Scale (QOLS) could be utilised to determine whether quality of life improves throughout the co-production process (Burckhardt & Anderson, 2003). The tool is a 15-item instrument, measuring five conceptual domains: mental and physical wellbeing; relationships with other people; social, community, and civic activities; personal development and fulfilment; and recreation. The tool is a prominent means of measuring an intervention's success in healthcare, and it could review service users' experiences when co-producing; however, no evidence has been found to review its current use.

3.1.9. Working Definition

The term co-production migrated from the United States to UK healthcare systems in the 1980s when a critique of mental health services acknowledged that service user

experience could support service delivery (Clarke, 2015). In response, the King's Fund acknowledged that doctors required service users' input and claimed that nobody would benefit without nurturing the relationship between doctors and service users (Coote, 2002).

Co-production's popularity within the NHS has increased in recent years, yet debate remains around the understanding of the term and its practical application (SCIE, 2015). Further exploration of co-production's benefits is thus needed, especially when targets are high, resources are stretched, and service user expectations are raised. Opportunities exist for organisations utilising co-production, promising rewards for both the organisation and the service user. Quality care, where individuals are empowered, is at the core of the OT ethos, making the model attractive as a concept because of the reciprocal benefits. Co-production subsequently aims to provide an understanding of the complex relationships that exist in healthcare (Turner, Realpe, Wallace & Kosmala-Anderson, 2015).

More recently, the NHS has experienced financial pressures, resulting in stretched resources and overworked staff (Farmer, 2011). Brexit has sparked consideration of revolutionising service delivery via social prescribing and preventative healthcare (McKenna, 2016; Loeffler et al., 2013; Needham, 2009). Co-production could address these challenges through the delivery of individualised care (Turner et al., 2015), but only if there is agreement between all parties.

Co-production utilises service users, communities, and third-sector agencies to shape developments (Langergaard & Scheuer, 2009); however, an unclear definition could hinder success through inconsistent implementation. The model recognises that all individuals can contribute, thereby allowing service users and professionals to unite equally to reform service delivery (Slay & Stephens, 2013). Hence, from completion of the concept analysis, and as mentioned in Chapter 1, I have devised the following working definition, which is adopted for this research study:

'Co-production is the collaboration and equal distribution of power to maximise asset utilisation among stakeholders, to work towards an agreed, shared outcome. It requires the employment of reciprocal relationships to facilitate capacity development'.

Conclusion to Chapter 3

Bringing together so many competing ideas, concepts and definitions was lengthy, but key evidence-based characteristics were found to support defining co-production. These characteristics could also support co-production's implementation, aiding organisations with improving outcomes whilst providing high-quality care. For successful co-production, the development of asset utilisation by empowering people to co-produce their own care must take place more progressively than EBE groups (which often pay lip service to service user involvement, but only include minimal numbers of service users). Service users tend to believe that professionals 'know best' and thus allow those professionals to direct their treatment, thereby demonstrating a power imbalance; all parties must commit to distributing power. In addition, organisations should look to the wider community for service delivery support, since it offers a wider support network, whereby NHS organisations become facilitators of care as opposed to the main directors. At a time of financial pressure, facilitation could alleviate stress and provide roles, such as peer support workers, to service users and professionals, likely leading to better outcomes.

Chapter 3 outlined the need for a concept analysis of co-production to clarify meaning and develop a shared understanding. The epistemology of the term was explored, along with current attempted definitions. The core characteristics were identified; they are crucial to the methodological selection, development of the interview guides, and consideration of implications for policy and practice. Undertaking and completing the concept analysis has provided clarity and has informed a focused study. It has also afforded the opportunity to develop a conceptual framework to visualise co-production and its components. The conceptual framework was developed over the course of the study (see appendix 6 a, b, c). Completion of the concept analysis has provided a stronger position to

critique the Trust's approach to co-production. The subsequent chapter presents the methodological approach to the study.

Chapter 4 – Methodology

4.1 Introduction

Following the identification of gaps within the literature review, consideration of the methodological approach needed to address the study aims was required.

Therefore, this chapter considers my involvement as the researcher and ethical considerations, exploring how bias was minimised. Also presented, is a justification for the study's research design, and guides the reader through the process of data collection via semi structured, one-to-one interviews and through the process of data analysis which comprised of thematic analysis (utilised for the policy review and literature review) to ensure data management was consistent. Finally, a reflexive account of the research journey is provided to allow transparency.

4.2. Researcher Involvement

My motivation for undertaking this research arose from anecdotal evidence observed around a senior management and frontline staff divide and disquiet about continual organisational change. As co-production was being implemented, I was keen to ascertain an understanding of the term and queried whether its application in practice mirrored information attained from the literature review. It was anticipated that a clearer picture of co-production's drivers and challenges could be achieved to support enhancing model delivery. Given my position within the Trust, my 'insider status' (and the strengths and limitations thereof) was considered (Adler & Adler, 1987, p.33).

Being perceived as an insider was a benefit to the study, enabling access to the sample (Heath, Williamson, Williams & Harcourt, 2018). However, working in the Trust could have led some to view me as a biased advocate rather than a researcher (Heath et al., 2018). Conducting research within a work environment made the study economical because of cultural understanding, resulting in swift commencement of data collection (Ganga & Scott, 2006), which supported completion within the timeframe. A further benefit was gaining participants' trust (Bonner & Tolhurst, 2002), which added depth to the findings because they felt comfortable conversing honestly about their current experiences. However, this insider position initially resulted in a

desire to stick with known participants, which had the potential to introduce bias if unchecked (Bonner & Tolhurst, 2002). Such issues were checked in academic supervision, and reflexivity was employed. Role conflict was also a challenge (Bonner & Tolhurst, 2002), meaning that integrity and bravery were required to report unfavourable findings (though this was never warranted). Despite challenges, Frost and Stablein (1992) argue that being immersed in the subject helps to address personal biases, thereby providing authenticity.

My impact on the study was an essential consideration. I was acutely aware of potential personal bias because of academic advancement and the possibility of confirmation bias because of my personal experiences with co-production within the organisation. A comprehensive interview guide was developed (and then amended on evaluation following the pilot interview) to ensure that questions did not lead participants' responses and that a neutral approach was adopted. Study supervisors supported this process, as they were more objective, and bias was thus discussed, if needed, to minimise its impact on the study.

It was considered that pre-existing relationships could impact on my interactions because of familiarity and result in sharing my thoughts and beliefs. Following exploration in supervision, it was determined that with a tight interview guide, these relationships would not be a barrier, as accessibility to the research setting would be attained. The researcher is the instrument of analysis (Starks and Trinidad, 2007), and a subjective endeavour necessitates the inevitable spread of preconceptions. These preconceptions influenced how data is gathered, interpreted, and presented. The impacts of the role of the researcher are discussed in Chapter 7.

4.3. Ethics

This thesis is the culmination of a 5-year study of co-production in community mental health settings. Ethical consideration was critical to advancing the study and ensuring participants' protection. Ethical approval from the University of Salford Ethics Committee (see appendix 7 – Ethics Form) was attained in December 2017 (see appendix 8 – Study Approval). A National Research Ethics Service application

(NRES) was considered, but not required (see appendix 9 – NRES form). In November 2018, the Research and Development team for the Trust agreed to the study for the purpose of the thesis (See appendix 10 – Trust Approval Letter and appendix 11 – Service Evaluation Form).

Clinical leads, middle managers, and senior managers were invited to engage in a one-on-one, semi-structured interview (lasting up to one hour). For participants to make an informed choice, they had to be free to decide upon their engagement (Marshall & Rossman, 2016) following receipt of the invitation letter (see appendix 12 – Invitation Letter) and participant information sheet (See appendix 13 – Participant Information Sheet). Consent to participate was gained in principle; and then formally, which included the information sheet, an invitation letter, a consent form for completion, and information about co-production (see appendix 12 – Interview Letter, appendix 13 – Participant Information Sheet, and appendix 14 – Consent Form). An email reply was requested, with a signed consent form attached.

Confidentiality and anonymity were addressed at the time of submission for ethical approval. Measures were utilised to ensure participants' protection, including locking paperwork in secure NHS sites, not utilising phrases that could identify the participants, informing them of their right to withdrawal, and assigning codes to protect their identity when administrators transcribed interviews. Conflicts of interest were minimised through regular supervision meetings with my Trust supervisor. These sessions involved discussion of the study aims and benefits to the Trust, as well as issues with accessing participants and minimising bias. Any bias I had towards the Trust was reduced by the research design, Trust supervision, and academic supervision. Most of the data analysis was conducted in my own time and for no personal gain.

Interviews were recorded digitally to allow verbatim transcription, so that no information was lost through note taking and so that participants' views could be accurately represented (Tressier, 2012). Electronic data was stored on a password-

protected, encrypted computer, and paper transcripts were stored in a locked cupboard in a locked office in an NHS building. Codes were used to ensure the anonymity of participants and to allow for the referencing of quotes (Crow & Wiles, 2008).

4.4. Epistemological Position

My epistemology and ontology were integral to understanding my axiology and value system. As a logical and independent thinker, trained to increase independence and personal autonomy, I believe that people could be empowered to construct meaning through exploration of their reality. Experiences and the environment also heavily contribute to construction, as do interactions with external influences. My experience of supporting people to develop new meaning after illness strongly influences this viewpoint. Epistemologically, I lean towards the view that reality is a co-constructed concept shaped by individuals' experiences, which perhaps explains my interest in co-production. I also feel that practical experience, texts and interactions enhance understanding of the world. My axiological position is that every individual's values are important and valid, and when they differ from my own views, I am open to those individuals' opinions. It was important to ensure that participants' views were represented accurately and that findings were validated to ensure participant's realities. Given my ontological and epistemological positions, a case study was a good fit, as it offers the opportunity to represent participants' views and experiences through the illustration of the organisational story. Interviews were used for their inductive approach to attain emerging ideas.

4.5. Rationale for Selection of Research Methodology and Method

1. The case sought to identify the knowledge, skills, attitudes, and processes required to determine what constitutes successful co-production.
2. Whilst qualitative research has practical issues, including access to the desired setting, availability of resources, and ethical concerns (Parahoo, 1997), the chief executive officer (CEO) offered support, and issues were thus easily remedied.

Qualitative methods can be time consuming (Morse & Field, 1995); however, strong time management supported completion within the timeframe.

3. The CEO expressed commitment to make time for participant engagement, which addressed concerns surrounding availability.

4. Most participants were healthcare professionals; language, comprehension, and cultural barriers were considered to be minimal (Morse & Field, 1995).

5. As an OT, the meaning and purpose that people attribute to occupations is important, lending itself well to qualitative inquiry. Reflection skills were employed to address researcher bias.

6. Co-production's infancy in healthcare requires consideration. When a topic is well developed, it can be researched more easily with quantitative methods (Morse & Field, 1995). However, because of minimal knowledge regarding co-production, an exploratory qualitative design was considered beneficial to better understand the concept.

Methodology rationale

A descriptive case study investigates specific phenomena with limited preliminary research (Yin, 2014), as with co-production. It was pivotal that the case study's focus was linked to the research problem (Yin, 2014). To meet the objectives, a single embedded case study design was adopted with sub-divisions of participant groups. A purposeful sampling approach gathered participants, allowing for the selection of people who could provide the greatest insight into co-production. Case study was used because it is an exploratory study where people can comment upon my outcomes; hence, the methodological selection was appropriate. It was hoped that participant insights would enable the development of recommendations to enhance the current model, improving outcomes for all parties.

Experience and a literature review revealed that group work was key to co-production. However, understanding individual participants' knowledge bases was necessary, with differing parties of co-production being involved.

Interview rationale

One-on-one, semi-structured interviews were conducted to ensure accessibility within a busy workplace (Edwards & Holland, 2013) and interviews offer an interpretive approach to data collection (Qu & Dumay, 2011). Whilst case studies support the use of multiple methods to enable discoveries within the social world (Coffey & Atkinson, 1996), which can provide a holistic picture (Morse, 1994; Webb, 1989), Johnson and Onwuegbuzie (2004) caution that multiple methods should only be used if they fit the study. Observations in conjunction with interviews were considered; however, with no clear co-production definition, participants' knowledge base was queried, suggesting that observations would not add significant value to the study. The singular method of interviews was consequently selected.

Qualitative inquiry evolves as data is collected and simultaneously analysed, thus providing opportunities for revision as the study progresses. Whilst unstructured methods would permit participants to express views with minimal researcher influence, they encourage lengthy discussions about irrelevant topics. A further consideration was whether to interview people singularly or in groups, and it was determined that individual interviews would avoid conversation steering by the group (Guadarrama, 2002). People may be more prepared to divulge sensitive or confidential issues in a one-on-one setting (David & Sutton, 2004).

4.6. Data Collection – Sampling

Purposeful sampling was adopted using 'key informant sampling'. According to O'Leary (2006 pg.83), the aim of the approach is to '... gather some insider or expert knowledge that goes beyond the private experiences, beliefs and knowledge base of the individual you are talking to'. By 'hand picking' participants based on their expertise, it was anticipated that the realities of co-production's implementation within the Trust would be gained (O'Leary, 2006). The sampling approach offers many opportunities, including the following: providing access to a potentially inaccessible world, providing key information that shapes data collection, being useful as primary data, being instrumental in the early stages of the research process, and helping to develop interview questions (O'Leary, 2006).

O'Leary (2006) also noted four challenges when employing key informant sampling: identifying informants, confirming their statuses, considering their subjectivities, and considering ethical dilemmas such as power positions. In this study, these challenges were addressed during the selection of sub-cases and through reflexivity. Potential bias of purposeful sampling was considered; however, given the need to include co-producers, the approach was deemed appropriate.

Selection of Professional Role – Senior Managers

Sub-cases from three managerial hierarchical groups were selected: senior managers, middle managers, and clinical leads. The first group, discussed in this section, was selected because of the identified gap in literature. It was deemed appropriate to determine what their knowledge, skills, and attitudes towards co-production were. As the initial co-production decision makers, their involvement added value to the case. It was hoped that an understanding and context could be achieved regarding the rationale for implementing co-production. Gaining insight into senior managers' views of facilitators and barriers to implementation was valued. Finally, including those in power and who are able to action changes from recommendations was essential.

Selection of Professional Roles – Middle Managers and Clinical Leads

The selection of middle managers and clinical leads was appropriate because of the nature of the co-production model that the Trust had implemented (outlined in Chapter 1). As these groups are responsible for grassroots implementation, they are ideally situated to provide feedback on how the model is working in practice. Interviewing them also presented an opportunity to view whether their attitudes towards co-production aligned with the reality of implementation.

As Chapter 1 illustrated, the organisation is large, offering both mental health and general community services. However, the case focuses on mental health, as this is pertinent to my clinical field – a requirement for the professional doctorate. Had the whole organisation been sampled, impact would have been diluted. Within mental health services, there are inpatient and community sectors with multiple teams in

operation, all of whom have been directed to implement co-production. The aim of this case study is to offer recommendations that could have a direct impact on that specific clinical environment.

Sampling and Data Collection Summary

Table 14 details the initial sampling. In this table EL represents East Lancashire, CeL Central Lancashire, and NL North Lancashire. SM denotes a senior manager, MM a middle manager, and CL a clinical lead.

Action	Target number
Interviews of Senior Leadership Team	Approx. 4-6 participants from a total membership of 13 were considered for the sample. The final number of interviews was 3. SM1's interview lasted 70 minutes, SM2 lasted 60 minutes and SM3 lasted 75 minutes.
Interviews of CMHT managers/ team leaders	Approx. 10-13 from a total membership of 17 (including the researcher) were considered for the sample. The final number of interviews was 4 (EL – 3, CeL – 1, NL – 0). MM1's interview lasted 12 minutes and was a pilot interview. MM2's interview lasted 50 minutes, MM3 lasted 40 minutes and MM4 lasted 45 minutes.
Interviews of CMHT clinical leads	Approx. 6-8 from a total membership 11 were considered for the sample. The final number of interviews was 5 (EL – 4, CeL – 2 and NL – 0). CL1's interview lasted 90 minutes, CL2's interview lasted 60 minutes, CL3 lasted 86 minutes, CL4 lasted 65 minutes and CL5 lasted 63 minutes.

Table 14: Initial Sampling Table

Interviews

The initial interview guide was trialled and amended as the case progressed (see appendix 15a, b, c, and d). The final guide compiled information attained via the literature review, the concept analysis, and experience (see appendix 15c). For senior manager interviews, a further interview guide was developed (see appendix 15d). As interviews with middle managers and clinical leads were completed prior to those with senior managers, and since data analysis must occur as a continuous process in case study research, initial themes were identified. These themes were then added to the initial interview guide so that when interviews with the senior managers occurred, the views of the middle managers and clinical leads were expressed, and responses were attained.

A pilot interview determined the quality of the interview guide. As an insider researcher, it was deemed appropriate to conduct the pilot interview with a known colleague because of our pre-existing relationship. The purpose of the descriptive case study was provided, and an appointment date and location were identified. The location was a place of participant's choosing. Participant 1 was emailed (who engaged in the pilot) a participant information sheet, invitation letter, and consent form, providing further details for consideration prior to formal consent for the interview (the process was repeated for subsequent participants).

In the pilot interview, the interview room was constructed to ensure comfort with consideration for potential interruptions which were minimised. A case overview was provided, and the consent form was completed (see appendix 14 – Consent Form). It was explained that an interview guide would be utilised alongside a Dictaphone (See appendix 15 – Interview Guide). An outline of the process was provided, with initial questions focusing on demographics and the remaining questions on co-production to ensure the participant was fully aware of the process.

The initial demographic questions contextualised the research in terms of the participant's experience and were key to gaining insight into participant's views. No questions were misunderstood; however, further information could have been extrapolated through probing. The interview lasted 12 minutes, suggesting that opportunities were missed to gain further information; the interview guide was hence amended. Further amendments were made following completion of the concept analysis to include core characteristics, and this guide was utilised for the remaining interviews. The pilot interview transcript is included in the main case study.

Following the pilot interview, it was apparent that an understanding co-production was absent, so information was provided at the time of recruitment. The information outlined in Figures 13 and 14 was disseminated with the invitation letters. Presentations were also conducted in senior management meetings and at local governance meetings to encourage engagement (see appendix 5) and maximise data collection.

Some participants were known because they are colleagues; however, some were unknown, and this is reflected upon in Chapter 5. Irrespective of relationships, a professional approach was adopted, and smart casual attire was worn. It was explained that the interviews would be informal; participants were given time to respond. Prompts were utilised, and additional questions were asked to prompt fuller answers or clarify points made.

The interviews lasted between 30 and 90 minutes, although the expected range had been 45–60 minutes. At the end of the interviews, participants were afforded the opportunity to add any further comments. Finally, participants were thanked for their time and advised them that feedback on the findings would be provided at a later date.

4.7. Data Management, Preparation, and Storage

The objective of data preparation is to ensure that data is well organised to facilitate easier retrieval and preparation for the next stages of the process. Interviews were personally transcribed, apart from senior management interviews, which were completed by a confidentiality-trained administrative worker because of time pressures. The use of a transcriber did not impact on the data analysis process. Transcribing was completed within a week of each interview; however, an interview log was completed, usually between 24 and 48 hours of the interview occurring to facilitate the write ups to maintain focus on emergent main themes (See appendix 18 – Interview Log). These notes acted as prompts (Given, 2008) and were referred to regularly and then compared with the emerging data (Hammersley & Atkinson, 1995). Transcribing took between 5 and 13 hours to complete, depending on the length of each recording (a section of a coded transcript is included in appendix 16 – Transcript Exert). A participant table evidenced the recruitment, interview, and feedback process (see appendix 17 – Participant Table).

Interviews were anonymised at commencement of data collection, stating a code on tape pertaining to each individual, so transcripts were anonymised (offering additional anonymity when transcribed by the administrative worker). Participants

were then assigned a number and these codes were kept separate from the consent forms.

4.8. Data Analysis

Thematic analysis allows for organisation and interpretation of data (Nowell, Norris, White & Moules, 2017; Boyatzis, 1998), and it fits well with the social constructivist. Codes and themes were developed to ensure that a construct for participants' experiences was attained. The process of checking the reality of findings for individual participants during feedback sessions fitted well with my ontological, epistemological, and axiological positions. Validations discussions occurred where participants confirmed findings. The thematic analysis protocol recommended by Miles and Huberman (1994) was adopted and was a useful guide to ensure that all appropriate steps were completed, increasing the authenticity and trustworthiness of my findings. The three-stage process outlined in Figure 15 was followed.

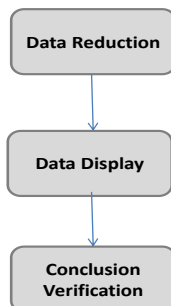


Figure 15: Thematic Analysis Protocol as Recommended by Miles and Huberman (1994)

In step 1, data was reduced and organised via reading and re-reading transcripts to facilitate immersion in the data, which supported the ascertaining of persistent themes (Morse & Field, 1995). A coding protocol was considered recommended by Miles and Huberman (1994), as depicted in Figure 16.

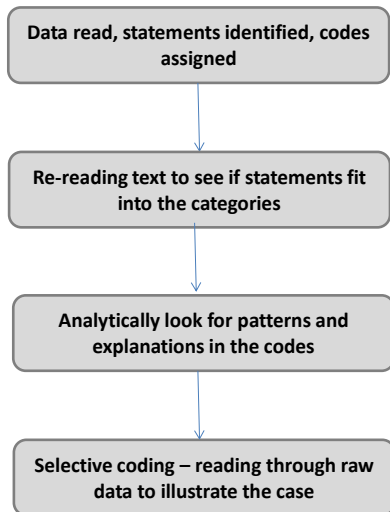


Figure 16: Coding Protocol as Recommended by Miles and Huberman (1994)

Codes were valid and reflective of research aims, and they were mutually exclusive, not overlapping, and exhaustive, meaning that all data fit into a category. Open coding was completed, where hard copies of the transcripts were examined, analysing each line for significant phrases. Key phrases were highlighted, and these were copied onto post-it notes. Manual sorting of data then occurred and any analytical notes pertaining to large amounts of text were attached to the reverse of the post-it notes to highlight their significance. Thereafter, a written tracer was allocated to the front of each post-it note to facilitate identification of the interview from which it came and the location within the transcript.

The content of each post-it note was given a specific label and sorted into conceptual categories relating to broad categories. Some phrases initially fitted more than one category, and duplicate post-it notes were created to allow the phrase to be allocated to each relevant category. An additional note was made to highlight that the code was in multiple categories. Finally, as the analysis progressed, Continual reflection occurred allowing the sorting and fine tuning of the process of developing major categories, sub-categories and labels. Reflection also facilitated decision making about which category multiple codes remained in. All coding and theming was discussed with academic supervisors to increase trustworthiness (Nowell, Norris, White & Moules, 2017).

Stage 2 of the coding process identified statements that could fit into the identified categories. During this process, axial coding occurred to identify new codes, adopting a more analytical approach to exploring patterns and explanations within the data. Questions were asked such as “can codes be linked together under a more general code?” For example, ‘being heard’ and ‘being done to’ were initially separate categories; however, following the initial coding process, sufficient explanatory evidence for them to remain independent categories was lacking, and they were subsequently merged. Questioning also occurred as to whether codes had a sequential pattern, noting that some codes occurred before others. Finally, selective coding was completed whereby data was revisited to identify cases that illustrated the analysis. Confirmation bias was avoided by discussing findings and themes with academic supervisors, and the seeking of contradictory evidence as well as confirmatory evidence.

To support the coding process, a provisional start list was developed from the conceptual framework, interview questions, and literature review. For example, the master code of CPI was used to illustrate co-production interpretation with the following sub-codes of: CPI-SM (interpretation of senior managers), CPI-MM (interpretation of middle managers), and CPI-CL (interpretation of clinical leads). The full start list is depicted below in Table 15:

Co-production interpretation	CPI
CPI: Senior Managers	CPI-SM
CPI: Middle Managers	CPI-MM
CPI: Clinical Leads	CPI-CL
External Context	EC
EC: Demographics	EC-DEM
Power	P
P: Senior Managers	P-SM
P: Middle Managers	P-MM
P: Clinical Leads	P-CL
Reciprocity	R
R: Senior Managers	R-SM
R: Middle Managers	R-MM
R: Clinical Leads	R-CL
Co-production behaviours	CPB
CPB: Senior Managers	CPB-SM
CPB: Middle Managers	CPB-MM
CPB: Clinical Leads	CPB-CL

Table 15: Initial Coding

This list was revised, noting that the initial codes did not cover the main points and were too complex. At regular intervals, codes were revisited as new themes emerged (see appendix 19a and b), and when codes became saturated with information, new sub-themes were identified and relabelled. Pattern codes helped to provide explanatory codes, which identified emergent themes, thereby pulling together data in a more meaningful manner. Saturation occurred when no new themes emerged (Lincoln & Guba, 2000). Two validation interviews were conducted (after analysis was completed and prior to the senior managers' interviews) to determine whether the themes and sub-themes were representative of middle managers and clinical leads' views.

Miles and Huberman (1994) suggests that to draw conclusions from mass data, an optimal display of data, in the form of tables or charts, is essential. This was a continual process of developing labels and categories, which informed decisions around data presentation methods, facilitating the development of data display tools and supporting greater analysis (see appendix 21). Labels and categories were organised via codes into sub-themes and then grouped further into themes. The coding process changed from the initial stages (see appendix 20a and b). Themes were reviewed for merit and detail, which provided the structure for the findings chapter (see Chapter 6).

Following data reduction, coded data was organised as suggested by Biddle et al. (2001): the data units, such as statements and sentences, were clustered into common themes, so that similar units were grouped together into first-order themes and separated from units with different meaning. The process was then repeated with the first-order themes, which were then grouped into second-order themes, as depicted in Figure 17.

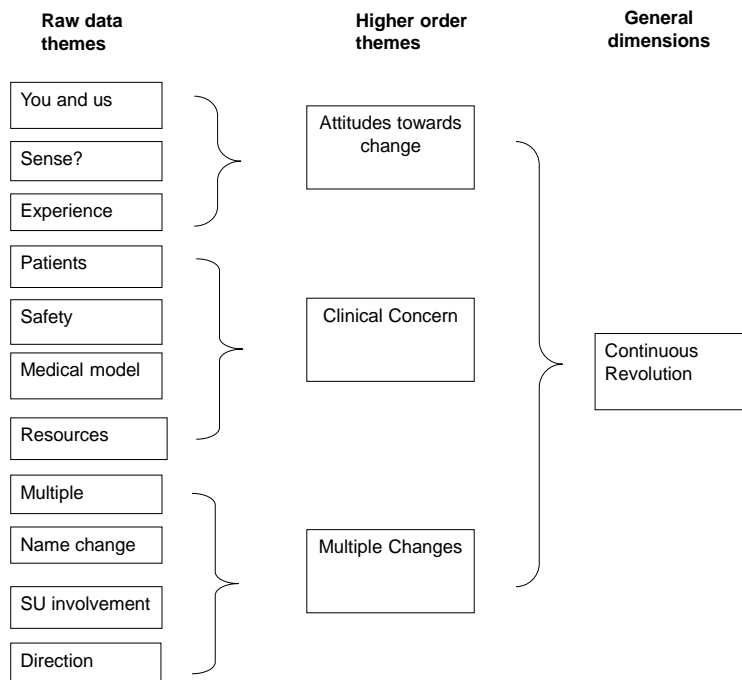


Figure 17: Data Display of First- and Second-Order Themes

Numbers tallied the frequency of codes; however, allocating numbers did not provide value to the process and detracted from the emphasis that participants used when discussing issues. Krane, Greenleaf, and Snow (1997, page 24) support this view, stating that ‘Placing a frequency count after a category of experiences is tantamount to saying how important it is; thus, value is derived by number. In many cases, rare experiences are no less meaningful, useful, or important than common ones. In some cases, the rare experience may be the most enlightening one’. Numbers were discarded, and to support the theming process, tapes were reviewed to search for the weight and passion participants attributed to the categories during their interviews.

Completion of the analysis allowed for conclusions to develop. These initial conclusions were then verified and examined against existing transcripts, through identifying occurring patterns (as discussed on page 116). Within each code, data units illustrating the situation being studied were searched for. Keywords were examined such as ‘done to’ and ‘disconnect’ to make sense of the data, and

statements were reviewed that not only supported initial thinking, but also refuted them, whilst trying to build a comprehensive picture of the research area.

4.9. Ensuring Trustworthiness and Authenticity of my Findings

Member validation was used for trustworthiness and authenticity of findings (Holloway and Wheeler, 2013). By meeting with participants prior to the completion of data analysis, testing of interpretations and checking of accuracy could occur. Participants were provided with a summary of the complete findings, and they were asked to critically comment on the adequacy. Another method employed was searching for negative cases and alternative explanations in the data. This occurred so that interpretation did not focus on identifying only cases to support ideas, but to also identify and explain cases that contradict them. Through this approach, true integration with the data happened through challenging thinking.

An audit trail to ensure reliability is necessary for the authenticity of the findings, and it is a requirement of the professional doctorate. Through the development of this thesis, an audit trail was presented whereby others can judge the process and key decision-making. Reflexivity was also employed, which ensured that criticality was considered in relation to the researcher role within the data collection process as well as demonstrating to the reader awareness of this and how it may have influenced findings.

4.10. Conceptual Framework

To support thinking surrounding the methodology, a diagrammatic conceptual framework was devised to illustrate theoretical thinking explicitly (Miles & Huberman, 1994). The purpose of the framework was to establish the promotional and inhibiting factors of co-production (Robson, 2002), which supported the selection of the research objectives and case construction, thus adding credibility to the methodological development. The framework was amended over the course of the study to reflect new insights gained, specifically participants' experience, which was deemed critical to the framework. As key variables included the Trust's context and process methods, a case study was an applicable methodological selection to present the Trust's unique approach to co-production. It became apparent that to

address the existence of core characteristics within the Trust, interviews with participants would produce the most effective data.

Figure 18 requires explanation and should be read from left to right. The left column of the diagram highlights three key case influences. First, the 'researcher's perspective' was based on my experience and interest; second, co-production 'literature' and third, (following data collection) 'participant's experiences' were added. The lines display likely connections with the next set of variables. Variables were determined through experience, the policy review (which identified six core characteristics of co-production), and the concept analysis (which confirmed these characteristics). Hence, it was determined that any one of the nine areas could impact on co-production's successfulness or unsuccessfulness. The inclusion of 'other factors' acknowledged additional factors that may not have been considered, but that could be significant to the conceptual framework. Finally, successful and unsuccessful co-production outcomes were considered.

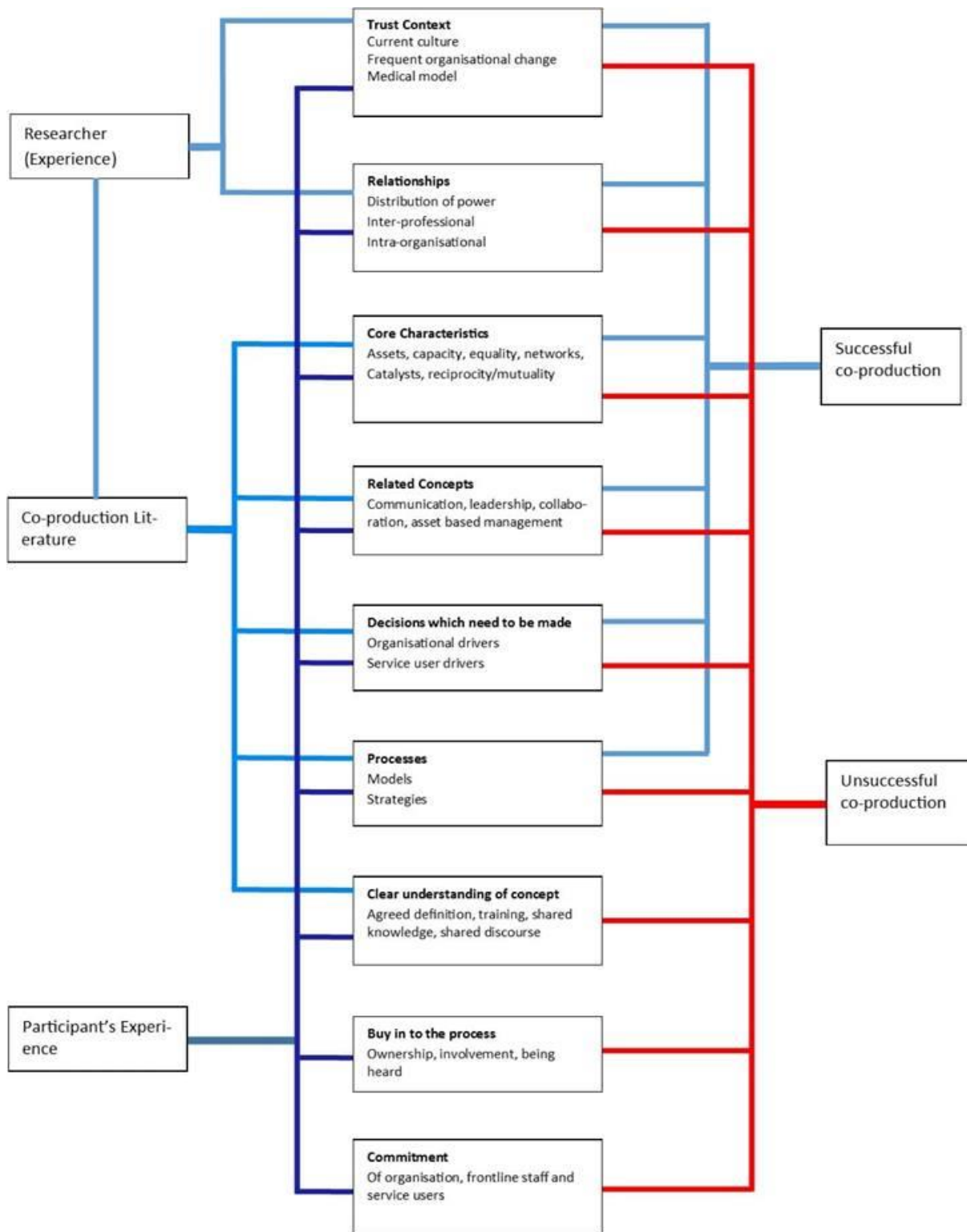


Figure 18: Conceptual Framework

4.11. Reflexivity and Reflection

Reflexivity was key to the project because it allowed for reflection on situations with a clear plan for intended future actions (Fook, 2007). It provided opportunities for the development of self-awareness and enabled me to evaluate each stage of the research project and my impact on the process. Reflexive accounts enhanced trustworthiness through illumination of my judgements (Cutcliffe, 2003) and examination of my privilege within the field to challenge my positionality, thus ensuring that my power was checked (Reid & Russell, 2017). Gibbs' (1988) reflective cycle (as depicted in the adapted diagram in Figure 19) was adopted for this thesis.

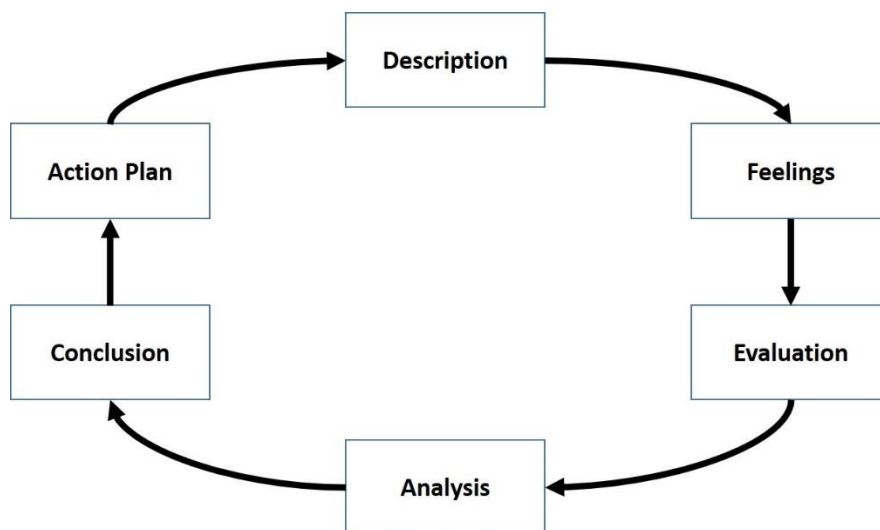


Figure 19: Adaptation of Gibbs' (1988) Reflective Cycle

Reflexivity supports the credibility, dependability, and confirmability of the research (Houghton, Casey, Shaw and Murphy, 2013). Reflexive tools utilised in the research included maintaining a reflective journal, academic supervision, and reflection using Gibbs' (1998). As a model used in clinical practice, it fitted well with my ontological and epistemological positions, and it thus complimented a case study methodology. The model acknowledges how personal feelings influence situations (Helyer, 2015), and it provides a link between learning from what has happened and future practice (Boud, Keogh & Walker, 1994). The model prompted me to action plan allowing consideration of future changes and enabled me to reflect in depth on my professional doctorate experience. The model has been used successfully

throughout OT training and practice, producing marked learning; therefore, it was considered appropriate for the thesis.

4.11.1. Reflective Journey

Each reflective encounter is labelled from A to E to provide clarity of experiences. These encounters include: the need for reflection as part of the doctoral journey, determining what to study when questions about co-production focus were raised, research relationships and how these impacted me as a researcher, promoting involvement of participants and the importance of advertising, and sharing findings to ensure participants receive feedback.

Reflections

4.11.1.1. A. *The Need for Reflection*

Conducting reflection from the outset of the study was evident; however, ensuring meaningful reflection presented challenges. I believed that, as a core element of OT, reflection would be easy. However, not maintaining a reflective diary made recalling events problematic, highlighting the need for a recording system because of the length of the doctorate. On commencement of maintaining a diary, it felt arduous; nevertheless, the process allowed for clarity, resulting in it becoming more natural over time. Whilst possible alternative methods could have enhanced the process (such as working with a research team and dictating reflections, the method adopted served the purpose for the study. For future studies, reflective diaries will be maintained from the outset.

4.11.1.2. B. *Determining what to Study*

Co-production is the research topic; however, during the interim assessment, questions arose around the cases' true focus, as the Trust's model did not mirror literatures' view on co-production. Whilst challenging, the process clarified thinking and improved my confidence. Specific challenges arose, including questions on how to proceed with the study, impact on confidence, and disappointment at struggling to defend points. However, the experience supported the development of skills to articulate why co-production is the cases' focus, the identification of a clear rationale, and confirmation that people's critique does not mean my work is wrong. The

challenges experienced were essential for my development, and they shaped the remainder of the doctoral journey. When in the situation again at the internal evaluation stage, I was able to effectively defend my decisions, as I was prepared for how the viva would be structured. I had also spent time gaining confidence in my work to allow articulation to occur more naturally.

4.11.1.3. C. Research Relationships

I was concerned about developing and maintaining relationships with participants, especially those with whom I worked. An additional concern was interviewing senior managers and being confident enough to ask probing questions. Initial thoughts were that engaging work colleagues would be more comfortable because of existing relationships; however, the reality had not been fully considered. I wished to ensure that participants did not view me as inadequate, and I wanted to maintain the persona I had established within the team. On reflection, these feelings were a form of imposter syndrome, which initially impacted on me being open. I also recognised the presence of anxiety about interviewing my employers and challenging them, because of my preconceptions about authority. A focused interview guide ensured that probing questions were asked, alleviating some stress.

To manage anxieties surrounding interviewing colleagues, I ensured that I was prepared and honest, which supported progressing to engaging in co-production conversations as I held clinical conversations with them. As an agent of change, awareness of the reluctance to shift power and the need to frame change favourably was considered and acted upon. The case was presented to the senior leadership team and framed around the benefits of co-production for the organisation, which aided with access to the participants and gaining support for the case study. I had a duty to my employer; however, I recognised that conflict could occur with my responsibilities to the participants to truly represent findings and that it should thus be constantly considered. Whilst it could be argued that a conflict of interest had occurred, I was mindful of this. I recognised that my integrity as a researcher was my focus and resultantly maintained a desire to provide an honest account of the organisational story.

Failure to recruit impacted on the initial planned timescales for data collection and added additional stress to the process. It was evident that my anxieties had impacted on the progress of the case study – something to be mindful of in future endeavours. In addition, the initial anxieties experienced were misplaced, as no issues arose during interviews. For future research, I would plan more efficiently, developing a checklist of tasks to address prior to data collection. I will have confidence in my abilities and be comfortable with being uncomfortable. Conducting research with participants who I know was a learning curve (as I had underestimated the challenges), and it not only increased confidence in my academic ability, but also prompted reflection on future sampling strategies.

4.11.1.4. D. Promoting Involvement

Promoting the case study and recruiting participants were considerations. A difficulty arose when aiming to promote maximum involvement of participants, especially in localities with no personal ties (central and north localities). I had underestimated the challenge of engaging people in research. Not having awareness left me frustrated at my lack of insight, which led to me consider how to address issues quickly; this was stressful and not wholly successful. As a result, no participants from the north locality engaged in the case study, which impacted on the organisational representation of findings. I had over-estimated people's desires to engage in research. I did not consider the impact of sending an email invitation to participants who receive high volumes of email communication. My lack of awareness resulted in delays with data collection, and the challenge led to the consideration of multiple communication methods when recruiting participants, to avoid delays and poor response rates. Hence, I would use posters prior to recruitment, network to identify key players, and follow up with phone calls post email.

4.11.1.5. E. Sharing of Findings

Findings were shared with participants on an individual basis to senior management, who openly accepted the feedback and agreed with the main themes. Presenting findings was exciting, as it was a culmination of years of hard work. Even with the added workload to fit in and around people's schedules, it was worthwhile. Given

some undesirable findings, I was concerned about how senior management would react; however, they responded fairly considering the findings. Disseminating was essential to inform participants of the outcome of their contributions to the case development. The experience of sharing findings was positive. For future studies, I would consider the appropriateness of group feedback to minimise time and enable group dynamics to validate the findings. Findings were fed back to clinical leads and middle managers prior to completion of the thesis to validate those findings and confirm my interpretation of the data. I would book feedback dates at the earliest opportunity and develop a clear feedback plan.

4.12 Impact on the Researcher

4.12.1. Knowledge

Development of research knowledge took on different forms throughout the research journey, including taught mechanisms, self-directed learning, and practical application. Understanding of research design, methods, and their application was enhanced through modules, reading, online resources, and supervision. The process was challenging because of previous research struggles and concerns about completing the process, which impacted on the progression of learning as I adapted to the 'new language'. At times, imposter syndrome made me question my knowledge and skills; however, as time progressed, achievements boosted my confidence, and I even conducted teaching sessions to share my knowledge with students. The doctorate increased my understanding of the research process and helped me structure, focus, and formulate the case study. It made teaching as a career more accessible, since imparting knowledge around my research topic made me realise that I have an affinity for teaching. However, the process was challenging, and the fact that insufficient background reading can impede progress became evident. Acknowledgement of knowledge gaps led to managing time more effectively. Should I engage in a future research study, I would ensure that background reading is a primary focus.

4.12.2. Mastery of Qualitative Approaches

For future endeavours, I would not dismiss quantitative approaches; however, I would still lean towards qualitative approaches because of my ontological and epistemological positions. I would also consider the time and mental strength required, determining more realistic timeframes to promote better preparedness and enhance my confidence.

4.12.3. Critical Thinking

Developing critical thinking skills benefited my research as well as my clinical and managerial practice. Completing the doctorate supported this process, expanding my scope for critical questioning as well as my flexibility in approach.

4.12.4. Reflexive Summary

I believed that participants were a fundamental resource for the case study, but they impacted personally on me also. In one interview, current challenges for middle managers were discussed. I initially felt negatively when discussing how societal issues make change difficult. I was questioning the point of my study, which saddened me because of the volume of work I had already completed. I spent 13 hours transcribing the interview, and my viewpoint shifted. I heard the positive things the participant conveyed about making team decisions where no support is given. I realised that people wanted to help and support me, and I was not solely responsible for everything. Time spent with the data felt revolutionary; it alleviated stress and helped me focus on the participants' voices and not my own viewpoint. The interviews highlighted that, despite developing co-production knowledge, I was not employing it in practice. Co-produced leadership meetings consequently occurred that effected local change. In addition, I remained aware of my bias, allowing me to encourage participants to express their views.

Developing co-production knowledge was challenging; however, completion of the concept analysis supported this process. I initially felt frustrated when thinking outside the box, which is not natural for a logical thinker; however, the challenge empowered me. I expanded my co-production and case study methodology

knowledge and combining the two developed my appreciation for how the implementation of co-production varies in different contexts.

Senior management's requests for my participation in co-production groups demonstrated the development of subject knowledge, with the presentation of my research to OT students evidencing this further. My subject knowledge and understanding of being critical positioned me to advise others wishing to implement co-production appropriately; however, remaining aware of the limits of my knowledge was essential. Should I repeat the process, I would feel more confident with completing a concept analysis, but likely do it at an earlier stage.

Conclusion to Chapter 4

The exact steps to address the aims are outlined, along with a justification for the methods chosen. A thematic analysis organised data to generate data broad enough to explicate findings in relation to this setting (and hopefully replicate externally). Throughout the process, a reflexive approach was adopted to ensure trustworthiness, as discussed in the next chapter. This chapter provided an appropriate methodological approach to meet the research objectives, from which data collection and analysis could follow.

Chapter 5 – Findings

5.1 Introduction

Questions embedded in the case raised from the review of co-production literature, and emerging themes are explored and a summary of findings from data analysis are presented. A summary of findings from two validation interviews and the senior manager interviews is presented.

Data were re-themed and categorised: (1) corporate machine, (2) continuous revolution, (3) power imbalances, (4) interface, and (5) attitudes to co-production. Findings presented all professional views within the themes. No separation of views occurred, so all voices were represented. However, notably, some sections contained fewer comments from senior managers when compared with middle managers and clinical leads. Viewpoints on organisational challenges also differed slightly between senior managers on the one hand and middle managers and clinical leads on the other hand. For example, the corporate machine and the ‘disconnect’ described by middle managers and clinical leads was not recognised in the same way by senior managers, who had a clearer understanding of the two distinct roles; hence fewer conversations were held about these issues. Also notable was the limited specific discussions of co-production within mental health services, which appeared to be secondary to wider organisational challenges and their impact on co-production in practice. Reference was made to several extracts from the transcribed interviews, which had interview tags attached, for instance MM4/6, to identify their exact location within stored data. Figure 20 identifies the main themes which emerged through data analysis.

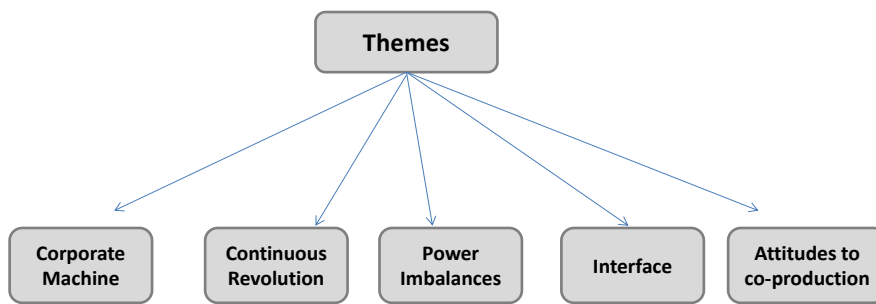


Figure 20: Themes

5.2. Themes

5.2.1 Theme 1 – Corporate Machine

The corporate machine, (outlining a ‘disconnect’ between corporate and frontline services) presented as a prominent finding. A participant used the term corporate machine to describe their perception of the Trust’s priority, which captured the views and opinions expressed by all middle managers and clinical leads, and it was hence adopted as the theme title. Participants expressed that the ‘disconnect’ was inherent within the organisation’s culture, impacting on interface, power relationships, and their involvement with change processes. The themes were further divided into sub-themes to encapsulate participants’ views, including (1) corporate versus clinical, (2) perceived management attitudes, (3) commitment, and (4) politics (see Figure 21), all of which are explored next.

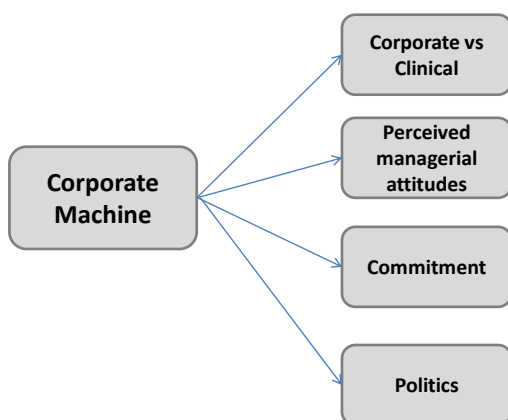


Figure 21: Theme One Corporate Machine

5.2.2. Corporate versus Clinical

All participants identified a 'disconnect' between corporate and clinical services and described the subsequent impact on organisational drivers, communication, and role understanding. Financial stability, whilst being a key driver for the NHS (Department of Health and Social Care, 2019), resulted in external demands, including remaining cost effective, which conflicted with co-production because of competing demands. This point was illustrated in the following quote:

'I think that it is very financially driven, and I think it is very much about pleasing the clinical commissioning groups (CCGs) and meeting what their expectations are, and I think we are moving away from co-production' (MM2/2).

An isolated view was expressed that to maintain financial stability, the Trust attracts new business, yet delivery of these services is often impeded by a lack of resources, as summarised below:

'We take on business that we don't know how to operate' (CL2/7).

Common among middle managers and clinical leads was the notion that the 'disconnect' affects communication, as illustrated by the following participants:

'I think the top and the bottom just lose, completely lose sight of each other' (CL1/4).

'We have just had an 'always event' about communication, but it is always hard to get people to come' (MM4/6).

'Communicating that at a team level does not really happen' (MM2/2).

Another feature of the 'disconnect' was a 'tick box' mentality, which many participants felt was organisationally prevalent. Perceived endorsement of 'tick box' tasks was reported to increase workloads, thus furthering the divide, as noted by a senior manager:

'And I would recognise the corporate versus clinical, as I think that's driving the senior management versus frontline staff issue, and that would be the order I would put that in, and I will be really honest, I will put that firmly in the camp of nursing and quality, less of an issue I think personally in finance and human

resources (HR), but the marking homework mentality, serious untoward incident, investigations, the computer says no, I think firmly sits in that portfolio' (SM2/10).

A possible solution suggested by one clinical lead was to promote staff into managerial positions to share staff views:

'I sincerely hope that there is a bit more connect between senior management and colleagues, and I feel actually we need to step up to the management position, people who are on the frontline' (CL5/8).

Role confusion seemed to increase frustrations, thus increasing the 'disconnect' between senior management and middle management and potentially reducing the scope for co-production (a mutually held concept among all middle managers and clinical leads), as outlined below:

'It never ceases to amaze me now, in this day and age, that there seems to be a lot of people, what I call corporate services, that we never had when I started out, and I am not saying that is a bad thing, but I do sometimes wonder what actually everybody does' (MM4/6).

However, senior managers had clear role definitions within corporate services, suggesting that a shared understanding among staff could support co-production's facilitation:

'It's interesting when we talk about corporate services, because we have tried to reframe that so support services who are actually there to support the frontline' (SM1/9).

Middle manager and clinical lead participants expressed frustration about the perceived lack of clinical knowledge, as disparity in knowledge has the potential to affect engagement in co-production, as the following participant stated:

'...the advert that went out for the senior nursing posts, they didn't even need to have a nursing qualification. It's ok if they had a business qualification so I don't know if people higher up the hierarchy that are being employed have actually got the skills and went into the care field in the same way as people further down did' (MM3/3).

However, some participants felt that the 'disconnect' could be Trust-specific, as one person noted:

'...having an operational management that have no links to clinically led services in my opinion is something that is very unusual' (CL4/7).

This described management system hinders co-production and impacts on service users when clinical decisions are not made by frontline clinicians. One participant summarised this problem as follows:

'...is such a ludicrous way to run something where the people who are really qualified managerially to be involved in things and respond in certain ways when in that clinical way they are not the right person to be making that call' (CL1/4).

One participant also considered the 'disconnect' to extend to service users, not just staff, and reflected the importance of their involvement in co-production:

'if you just stick to the consultant and the team manager and not including the service users, then you might miss the needs of the service users' (CL2/5).

Despite some concerns, participants felt the Trust has existing methods through which co-production could be communicated:

'I recently attended the ENGAGE day, and that was nice so have similar events when you talk about different directions that the Trust is going with co-production' (CL5/8).

All participants agreed that parties need to work to address the 'disconnect' to ultimately improve co-production. The findings of the scoping and literature review stressed the importance of collaboration and agreed shared outcomes for co-production to be successful, which is supported by this finding. Addressing perceived managerial attitudes within current culture could bridge the divide, as explored below.

5.2.3. Perceived Management Attitudes

Management attitudes formed a strong theme, with many participants expressing that organisational culture impacts on staff wellbeing; therefore, a positive co-

production culture requires nurturing. The Social Care Institute for Excellence describes co-production as 'people who use services and carers working in equal partnerships with professionals toward shared goals'. The disconnect or organisational culture means that co-production would struggle to thrive in an environment that does not foster shared goals. Some participants suggested that management approaches undervalue staff through dismissing concerns, as highlighted in the following quote:

'I think there is a general dismissiveness of concerns that I see happening to people' (CL1/4).

Feeling dismissed can result in staff feeling unheard, as outlined in the example below:

'We have whistleblowing at the XXXX (inpatient ward), we have got staff who are saying very clearly that it is an unpleasant environment, yet the Trust chooses to ignore all of these things' (CL4/7).

One clinical lead said their clinical decisions were questioned, which they believed is now part of the organisational culture:

'I think that the Trust has probably unconsciously allowed that culture to be there' (CL1/4).

Whilst evident that some managerial behaviours impacted on staff wellbeing, impact on the delivery of care was also identified:

'I don't think they give too much thing about service user's either, you know? If they involve service users in these decisions, which service user would support the fact that they want to travel across the country to see their relatives?' (CL2/5).

Although challenges with staff management and engagement are clear, most acknowledged that the Trust is well-meaning, endeavouring to provide effective change, as summarised below:

'I think they try their best, and they are basically well-meaning in terms of respect and delivering the service' (CL2/5).

One participant also recognised the challenges that senior managers face:

'...people at the very top have to make some very difficult decisions' (MM4/6).

Nevertheless, despite the overall positive view of care provision, occasions occur where the impacts are negative. The Trust's vision of doing more, for the better, for less negatively impacted the workforce:

'you know this getting away from this amazing and quite amusing notion in a concrete way where you do more, for better, for less...it is sort of well-meaning...but those three things combined, well they can only either say that people are unrealistic, or if it is realistic it's because people have been doing things less well with more, so whichever way you look at it, it is a really invalidating thing to do' (CL1/4).

Despite participants' recognition that efforts are made to address the organisational 'disconnect', they felt more action is needed to make co-production successful. A move towards the Trust becoming catalytic and facilitative in their approach was identified as a requirement. Literature has also suggested that for outcomes to be successful, all parties should feel equal in the co-production process, highlighting the importance of participants' calls for further attempts to bridge the divide.

5.2.4. Commitment

As noted, a reason for this divide is the organisational culture of the Trust, which impedes co-production. A core element of the current culture is the tick-box response to demands. A participant illustrated their desire to achieve targets, but noted that this adds pressure to workloads, which could reduce the appetite for co-production:

'Documentation is one thing that I am keen about, but it just takes so much time in terms of ensuring that the clinic letters are thorough and address all the areas and they are typed on time and communicated' (CL5/8).

Another clinical lead noted the merit of tick boxes, yet felt that local level flexibility, with the provision of latitude for decision-making, would be beneficial:

'our tick box documentation, I mean I don't want us to get rid of that because it is really important, but if it allowed you to be more flexible with that in the greater good then that could be a real benefit' (CL1/4).

Despite consensus that targets are important, at times, there was minimal organisational follow through, causing frustration:

'we are very focused on, as I said, hundreds and hundreds of politically correct tick boxes to feed the beast from upstairs that nobody knows, and then you find out that these things have not been done for years' (CL4/7).

In addition, there was agreement that tick boxes hinder clinical practice when delivered as directives, as a senior manager reported:

'there is no doubt that certain parts of the support services have got into a tick-box mentality, who have got into demanding of as oppose, to 'how can I get alongside and help you'' (SM1/10).

The sample acknowledged the potential benefits of co-production. However, one viewed implementation as a tick-box exercise for reputational prestige, as summarised below:

'...it was quite clear no co-production was taking place; it was just a tick-box exercise' (MM1/1).

They went on to question the organisation's commitment:

'I also question if the organisation is fully committed to it or not, because I haven't seen enough evidence of co-production in action' (MM1/1).

This highlighted that practical application of co-production was absent in some areas of the Trust. All middle managers and four clinical leads strongly expressed ambiguity around what co-production is, as illustrated in the following quote:

'I think the Trust perspective is very ambiguous in what they believe co-production is' (MM2/2).

Despite the ambiguity, the sample believe that senior managers are not modelling co-production, as articulated in the following quote:

'They talk about it but it is often not demonstrated from a senior level, and as we know, if things are not demonstrated from above, then it is very difficult for us to then feed that back up' (MM2/2).

This participant felt these issues linked with deterioration in managerial approaches:

'I think what was identified within the last care quality commission (CQC) inspection was issues with the board to floor, and I think that has actually got worse, not better' (MM2/2).

Senior managers, however, concurred that remaining committed to co-production is vital to sustainability, as summarised by the following participant statement:

'Well I personally think if we are going to be both sustainable and resilient, we have got to put more emphasis on co-production' (SM2/11).

However, issues arose when all board members were not fully committed to co-production:

'I think that it is partly about the individuals, partly about the maturity of the relationships, and some of it about people just understanding that, because quite paradoxically, despite the board signing up to that and supporting it, there are individuals around the board table who I think have a more traditional view of how you achieve performance and accountability' (SM1/10).

Findings from the literature review support the sub-theme of commitment, strengthening the view that all parties need to engage for successful co-production. The Trust's commitment to co-production is critical, but participants viewed the NHS' political nature to be a significant barrier, as explored next.

5.2.5. Politics

Clinical leads noted that politics impact on clinical practice and effective co-production. Differing views were held, with some perceiving the Trust as behaving 'politically correctly' for competitive advantage, while others thought political correctness impeded the organisation's ability to effectively deliver services.

The following quote illuminated the common view that political portrayal does not represent the reality experienced by service staff:

'I think the Trust is very good, like big organisations are, at a bit of public relations (PR) sort of model where it is around saying the right thing and the right buzz word, advertising promotions, to just protect their reputation or enhance their reputation, but when you actually go deeper into it, none of that is actually there' (CL2/5).

One participant identified reluctance from Trust managers to share power, believing that co-production would limit their sense of control. They believed reputation to acquire business superseded distributing power:

'There is a big risk in terms of the agenda, which is controlled at the moment by the Trust, in terms of controlling the finances and managing resources and trying to give reputationally, give out a really strong, positive message to people who want to buy our service. I am aware that this is a real challenge in terms of losing services, which is where reputation is important' (CL1/4).

Many factors influence the 'disconnect', including the split between corporate and clinical services, perceived managerial attitudes, and the political landscape, all mirroring literature's findings. It was also evident that the sample questioned the authenticity of co-production, which has impacted on 'buy-in'. Continuous service revolution consequently became a theme, being a major contributor to the 'disconnect' and the incentives for engaging with co-production.

5.3 Theme 2 – Continuous Revolution

Continuous revolution was a term coined by one participant to describe their experience of change within the NHS, and it succinctly describes the change mentioned by all participants. The sub-themes identified under this theme were (1) attitudes to change, (2) clinical concerns, and (3) multiple change (see Figure 22).

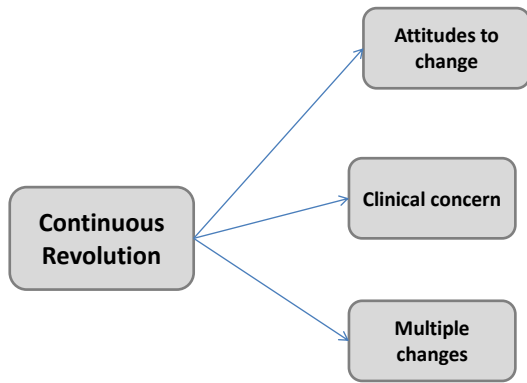


Figure 22: Theme Two Continuous Revolution

5.3.1. Attitudes to Change

Participant views on change were divided into two sub-themes: personal experiences and organisational approach. First, there was consensus that change was difficult, and that co-production was not actively occurring:

'I haven't had a great experience to be honest in terms of changes put forward and how they are managed' (CL1/4).

The participant continued:

'it tends to be difficult and I guess as with a lot of people. I think that changes to services are often quite personally difficult' (CL1/4).

However, a clinical lead reflected on positive change experiences, where support was received by co-production colleagues, suggesting that when support is available, change is manageable:

'I have been able to initiate change within my team, and I think I feel pretty much supported by my team leader whenever I have come up with any suggestions' (CL5/8).

Participants collectively expressed scepticism about the motives for change, which included the implementation of co-production:

'...nobody understands it, and nobody believes it' (CL4/7).

They continued to express that top-down organisations often minimise their own deficits, contrary to co-production's ethos:

'something that is very common in top-down approaches, that you highlight the successes and try to hide the deficits' (CL4/7).

Additional to mistrust, all parties stressed that cultural change was needed, with one person exploring the concept of resistance to change:

'...how people think that we should manage our own sort of services and that resistance to change' (CL1/4).

The empowerment and engagement of staff were significantly attested by another clinical lead:

'I think culture is hugely, hugely important because I think as a clinical lead, I need to be empowered, and I need to be part of the change rather than being told that this thing is happening to your team' (CL5/8).

This participant suggested that empowerment could support change management and a co-production culture:

'I think there is some inconsistent practices across the Trust, so I think we could definitely do better, and I think it needs to come from the change in culture where we normalise it that it has to be co-production' (CL5/8).

Another shared view was the requirement to embed organisational change whilst ensuring adequate training to possess co-production skills, as highlighted below:

'...any change needs to be firmly embedded, and there needs to be training and support' (MM3/3).

'So I guess if there was some training and it clearly identified what co-production is or co-production isn't I guess, suppose maybe for me I quite like when an example is given where someone did something and the benefits of using a co-production model' (MM4/6).

'Training will enable me to identify those areas that need improvement or need modifying or whatever' (MM1/1).

Despite negative experiences of change, there was a sense of optimism that if the change were to be truly transformational, they could 'buy into' the process, as summarised by the following quote:

'...there is a potential benefit of greater change too, by pushing things to something which is genuinely different' (CL1/4).

If change is continual and organisational attitudes are not transformational, then service delivery is impacted, thus minimising co-production's success in practice. All clinical leads collectively considered this to be a clinical concern; it is explored in the following sub-theme.

5.3.2. Clinical Concern

Clinical concerns can lead to negative attitudes, impacting on recruitment and retention. An example was provided by a clinical lead where a previous employee publicised their views in public arenas:

'So, one of the most anti-advocates against the Trust...he left the Trust...he is known to be a world class leader in his field, but in his lectures...he calls us an organisation that is very top down, does not know what it is doing' (CL4/7).

Participants felt there was a lack of clarity, coupled with a perceived inability to maintain a safe working environment, which heightened concerns and led some participants to take decisive action:

'they are withdrawing services from areas where they don't feel it is safe' (CL4/7).

A collectively expressed belief was that service users were not at the heart of decision-making (a key element of co-production):

'we are known as an organisation that has no regard for its patients. With all your goodwill but your political stance is like this' (CL4/7).

A common-held perception was that management of service user complaints was counterproductive, as honest responses were not provided:

'the NHS is terrified of upsetting people and being straight with people' (CL1/4).

'people higher up have got a sense of what type of work is done in mental health services which is so far from reality that it is untrue' (CL1/4).

They furthered their point:

'So I think a position has been put where the Trust is sort of striving for "oh look isn't everything great", and that kind of response from people who feel affected by that is well that is just nonsense and it doesn't make sense and it isn't real' (CL1/4).

Middle managers and clinical leads felt that senior managers do not openly discuss the truth about the implications of change, as outlined below:

'I think in some cases, sometimes you feel that there is a bit of cheekiness, there is a cost saving sold as a, "right we are doing a service transformation, we are changing the service", but essentially when you look at it, you have a reduction in your care coordinators' (CL5/8).

However, if frontline reality was acknowledged, then the opportunity to address the 'disconnect' and strengthen co-production could be provided:

'I think more straightforwardness and honesty about things doesn't make things okay, but it might bring people a little closer to a real position' (CL1/4).

In addition to strong feelings surrounding attitudes and clinical concerns, the sample referred to the volume of organisational change and its impact on clinical practice. Literature has highlighted that change is challenging and that staff involvement and co-production are thus critical for success. This is supported by the sub-case selection of middle managers and clinical leads, as discussed below.

5.3.3. Multiple Change

The concept of change occurred commonly throughout literature and was mirrored in the data, with all participants highlighting a culture of multiple organisational changes impacting effective co-production and staff wellbeing:

'it's just one change after another. It doesn't seem that there has been a period of stability to try and really see what is going on. At the minute, it is so chaotic, that everyone is really confused' (CL2/5).

A further cultural element that compounded confusion was the repeated name changes of local teams, as expressed below:

'The CMHT changed its name to complex care and treatment team (CCTT); we had red, amber, and green labels; we had single point of access, and then that became the assessment and treatment team, and then that became START' (CL2/5).

Many participants believed that frequent management changes results in shifts in focus because of individual motivations:

'that short termism whereby most managerial posts similar to political posts seem to run often procedurally on a two- to three-year kind of term' (CL1/4).

Senior management participants acknowledged the constant change; however, one participant noted that the organisation has little control:

'I think there is something about how do we do change implementation, because the changes are going to stay there, and that's not necessarily in our gift to control; what is in our gift to control is how we develop the models in the first place' (SM2/11).

Many drivers dictate the need for change. The Trust cannot control these drivers, such as the current economic climate, which cannot be prevented, because of austerity, as stressed below:

'I would like to be able to give people assurances that it's going to stop, but it isn't. I think the problem is, things that are fixed, we have to drive efficiency between 2% and 4% every year. There is nothing to cut now, so we have to do that through transformation and find different ways of doing it' (SM1/10).

Change was challenging for participants, and the success of any change depends on 'buy-in' from staff; therefore, incentivising co-production is critical. It was also essential that staff's clinical concerns were considered, and a closer understanding of each other's reality established. Power, which was highlighted as another challenge, has a further impact on change, particularly on the success of the implementation of co-production.

5.4 Theme 3 – Power

The theme was divided into the following sub-themes: (1) imbalance, (2) not being heard and done to, (3) emotional response, and (4) what needs to happen to address the power imbalances (see Figure 23). Power was divided into several sub-themes as power functions on so many levels within an infrastructure and it was essential to evidence how this presented within the data collected.

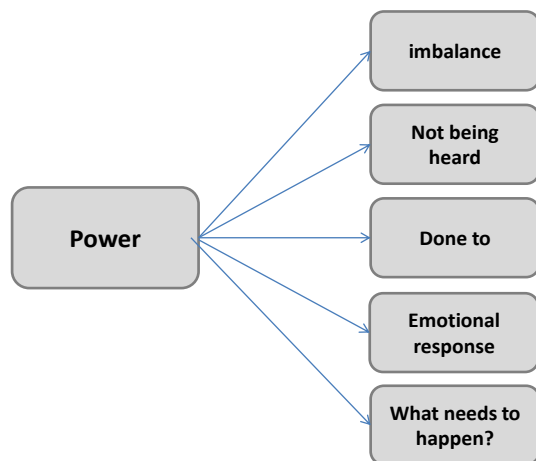


Figure 23: Theme Three Power

5.4.1. Imbalance

Power was a major theme within the literature review, identifying that challenges exist with encouraging equal power distribution, which is critical for co-production, and this was confirmed by participant interviews. Co-production furthers previous power discussions, suggesting that without equality, outcomes are unlikely to be achieved. The middle managers and clinical leads in the sub-case strongly assert that imbalances existed, hence the inclusion of imbalance as a sub-theme.

Participants, however, reflected that even senior managers can feel powerless:

‘I suspect most people within the Trust feel that they don’t have very much of it, even people who are perceived to have significant amounts of it by people who think that they have less than that person. I suspect that if you ask the people higher up in the Trust, they think about the power that people have over them in terms of commissioners or the Department of Health’ (CL1/4).

Individual views differed regarding where power lies, with middle managers and clinical leads all believing that power is weighted towards senior management:

'I think there is a bit more balance towards management. Perhaps I saw it more because I came from a Trust which was more primarily clinically led. I am not saying that it needs to be driven by the clinicians, but I think it needs to be a little more balanced, and sometimes you are being told this is happening' (CL5/8).

Conversely, senior managers believed that this view was, in some respects, a misconception, as stressed by the following participant:

'I think people make assumptions of positional power without question' (SM2/11).

One evident finding was the perceived disempowerment of clinical leads with participants stressing that they experienced a distinct move away from doctors exercising power:

'there was a move away from doctors having a certain amount of power within those relationships' (CL1/4).

Clinical leads felt this left them deskilled:

'So, in a way you are sort of deskilled, to be honest with you' (CL2/5).

This deskilling resulted in the medical workforce avoiding involvement in systemic changes, as noted by one participant:

'We are focused too much on offering the clinical care and leaving other systematic issues to someone else; who is that someone else?' (CL5/8).

One senior manager noted the clinical lead inaction, expressing a need to strengthen the medical voice in mental health services to improve co-production:

'something about mental health particularly in relation to Medics that is really paradoxical because if you were in an acute trust, often the Medics are the most powerful voice, and they exercise it and as a variance depending on what specialty they are in – arthropods, cardiac surgeons, and neuro surgeons who again are the loudest. Actually, I think one of the challenges we have is that the medical voice is not powerful enough in this organisation' (SM1/10).

Power imbalances, perceived or actual, can impact on engagement in decision-making around change and hence co-production. The sample expressed having little choice in the decisions made:

'I think we got bullied into it, into this new model' (CL2/5).

This participant's use of the word 'bullied' was concerning and highlighted the level of disempowerment being experienced by some within the Trust, illustrating the challenges with gaining continued commitment to co-produce. The point was extended to emphasis the perceived lack of control:

'sometimes you feel that whatever order comes from the top, we will implement like God will command you to do this, then we do it' (CL2/5).

Middle managers also confirmed the imbalance of power within the organisation, as outlined below:

'I think there can be power imbalances' (MM3/3).

With co-production, equally distributed power was a key concept, and consideration was thus essential. All participants agreed that power should be distributed, yet some expressed that achieving even distribution would be challenging:

'I don't see that being feasible or practical in this Trust' (CL2/5).

The same participant illustrated how challenging power distribution would be:

'because you can't even have a microwave or a kettle in your office now, never mind make major changes to the way your organisation works' (CL2/5).

One discussed challenge was being heard, which all middle managers and clinical leads expressed:

'I tried to argue my case, but it wasn't really taken on – we do that in another team, why can't we do it here' (CL5/8).

A senior manager, however, argued that change is required in terms of in how people perceive power within the Trust, so that self-empowerment can occur:

'so x number of people are considered the senior team; actually, the team are the people who you need to get together to do the job, and it shouldn't matter

where or what you are within the organisation, you get the right people together, but that is not in a dominant form as yet' (SM2/11).

Despite the lone view of frontline staff empowering themselves, another senior manager noted enforcement to complete tasks they were not in agreement with, suggesting that self-empowerment alone is not sufficient:

'I think that a lot of the things that I end up doing are not of my choosing in the sense that there is a decision at a strategic level' (SM3/13).

The power imbalance was described by the sample, who believed that this was organisationally systemic. Middle managers and clinical leads expressed how these imbalances have manifested in their voices 'not being heard' and feeling 'done to', which was something literature noted as a barrier to effective co-production.

5.4.2. Not Being Heard and Being Done to

Not being heard was a core reason for people feeling disempowered within the workplace (TUC, 2015) as articulated:

'the other part of the culture that has become really clear to me in the time that I have worked here is that the top don't hear what the reality is, and that is just a recurring theme' (CL1/4).

A middle manager summed this up as the Trust paying lip service to staff:

'The decisions have already been made, and we might have meetings and consultations, but it is only really paying lip service' (MM4/6).

A further frustration was the perceived label of being resistant to change, which compounds feelings of not being heard and results in relational difficulties:

'It's really difficult for people planning changes to hear concerns about changes without dismissing them as people being resistant to change' (CL1/4).

Some participants stated that the warnings they expressed tended to be dismissed, as strongly emphasised by one member:

'it was very demoralising. We went ahead with the changes, and soon all of those problems became a reality' (CL2/5).

One clinical lead asserted that if staff persisted in expressing concerns, they were subjected to the culture of being side-lined. This discourages people from speaking out because of fear, and affects the implementation of co-production:

'although they don't get side-lined for being a villain, you get side-lined because you are out of the equation and out of the plan' (CL4/7).

The Trust has attempted to improve culture through feedback from external agencies to inform organisational improvement and enhance co-production. However, one participant expressed that feedback is not always acted on:

'we keep bringing in someone to tell us that we are doing it right, and each time they tell us that we are doing it wrong. So, what we do is commission other services' (CL4/7).

Many emphasised that the service user's voice often also goes unheard because of service demands, however hearing service users' views is vital to delivering an effective service:

'it is not acceptable that people are waiting a week to two weeks in the community for a bed and hear their stories (service users)' (CL5/8).

For successful co-production, all agreed that listening is key and believed that this is relevant to all members of the Trust, not just management:

'I think it would be about listening to people and particularly not just at a managerial level but listening to people across the Trust' (MM2/2).

While there was a managerial desire to enact 'the right sort of changes', a perceived 'disconnect' exists between what is actioned and what manifests in real terms:

'What I see as the patient facing bit just feel done to and don't feel involved in that, and people who are making the changes think that they are doing the right sort of changes in a sensitive way, but something is missing between the two' (CL1/4).

The same participant suggested that staff can feel a loss of autonomy:

'really inhibiting of teams in terms of how they can feel relatively autonomous clinically because that pervades everything, and it is that you have got to run it by the team leader and you have got to run it by the manager' (CL1/4).

It appeared that despite managerial efforts to support staff, exclusion from decision-making continues to occur, leading to strengthening of the 'disconnect':

'it is very clear it is you and us' (CL4/7).

Indeed, reflecting on their experience of a management restructure, one middle manager found themselves in a more senior role, with no extra pay, despite expressing no desire to progress higher, resulting in powerlessness:

'I suppose I felt that it was something more done to me really' (MM4/6).

Despite frustration, all participants were keen to address challenges. One senior manager articulated a scenario in which people's voices could be heard:

'if you take something that cuts across the whole of CMHT, you could actually say we would like six reps from CMHT to form a little group as a bit of a think time and work with you, and we want you to connect with different teams and connecting with your teams and asking different teams to be looking at different bits of it and trying to bring it together and synthesising. It would all be more complicated and messy, but when you got the outcome, you can play it back and people will go "oh well, at least they listen"; that's the other thing, co-production doesn't mean you get your own way, but you do get chance to say your piece' (SM1/10).

Through a lack of organisational power distribution, participants expressed feeling powerless, invalidated, and disengaged, which literature asserts inhibits co-production. It was noted that these feelings led to emotional responses, highlighting a negative organisational culture that impacts on co-production in practice.

5.4.3. Emotional Response

The combination of a challenging work environment, a negative culture, and feelings of being undervalued can lead to emotional responses that hinder co-production efforts. One key issue that all participants raised was increasing stress levels:

'it became a very stressed and stressful job' (CL4/14).

'Well it was really stressful' (MM4/6).

'I'm just going to do my job and I am happy with that – I don't want to take the stress now of getting involved and not being heard' (CL2/5).

Stressors can take on many forms, yet one of the greatest challenges for staff is providing high-quality care within unhelpful systems:

'it always feels like you are trying to do the right thing in spite of some processes which are supposed [to] support that' (CL1/4).

Participants believed that their core function is to care and provide an effective service. However, systems hinder this function, and increasing workloads result in a lack of work-life balance, with many participants taking work home to meet demands:

'I sit at the weekends looking at my computer and doing my letters, and my wife asks me when is it going to finish; you know, it is really exhausting and never ending' (CL5/8).

This pressure has impacted on work-life balance and thus staff wellbeing. It has also subsequently affected their ability to remain in work, as summarised below:

'we see it day in and day out, staff leaving because they can't cope, and it is too sharp at the front end and you are being told to do yet another thing, and they may not say anything, but they vote with their feet, so I think we need to focus on that' (CL5/8).

Despite noted efforts to support frontline staff, this was not enough to negate high expressed emotions:

'the XXXX (inpatient ward) was about to close down because every single LCFT consultant in the XXXX left and resigned' (CL4/7).

All participants acknowledged the challenges with retaining staff because of current issues, and they recognised the impact this could have on co-production:

‘So, it is easy sometimes to recruit but sometimes harder to retain our staff, which is hugely disruptive for our patients and co-production’ (CL5/8).

An inability to retain staff means a loss of skills, as experienced staff are replaced with newer staff at a faster rate because of burnout:

‘you train someone to the highest level and then they leave, so I think we need to focus on retaining staff and ensuring that they don’t burn out, because it is a huge stress’ (CL5/8).

One participant stressed that improved co-production would be a reasonable response to retention issues through empowerment:

‘If you think about the staff survey, all of the things that were really identified was that we are not effectively co-producing, and the reason that’s important fundamentally is if we have a high turnover rate or we are not attractive to recruit, then we actually don’t have services, and we don’t attract the best people either; we get the people that might have had behaviours that we want to see less of in other organisations coming to us as a result of that, so I think that’s the fundamental’ (SM2/11).

The emotional responses clearly express levels of stress and pressure, which impedes co-production’s success. It was evident that power imbalances and the perceived treatment are impeding staff efforts to co-produce and maintain their own mental health. It was also evident that these dynamics are significant and could be potentially damaging for the Trust. Participants, however, were keen to remain solution-focused and to consider how power could be redistributed.

5.4.4. What Needs to Happen to Distribute Power

There are three key areas in which participants felt that a power imbalance could be addressed. First, the happiness of staff:

‘The things that aren’t considered co-production are...the happiness of staff’ (MM2/2).

For staff to be happy, they need to be heard, involved, and validated. However, there were instances where the sample expressed that managerial actions were invalidating, thus impacting on staff contentment:

'there is an expectation that people want to be treated in a really quite childish way, where the people in authority protect people from the reality' (CL1/4).

A change in the conversational dynamic between senior management and staff could result in people feeling more valued, empowered, and engaged, as outlined below, and this would reduce frustration:

'it is very much about if people feel empowered and valued – sadly the things that lacking within this Trust' (MM2/2.).

Second, middle managers and clinical leads desire a clear understanding of what staff roles and functions are in co-production, as summarised:

'I think there was some mention, thinking back there was some mention of this coming, but it wasn't like, "oh, this is starting now, and this is what the expectations are"' (CL2/5).

To clarify staff roles, there was a need to explore what it is, how it may work, and what the organisation expects:

'how if our Trust was doing it, that introduction of what the thing is, why the thing is, and what their sense of what it might be and how it might work, with some dialogue and development of that idea to get to a point where the people who there was an expectation to operate that way, had a similar expectation' (CL1/4).

Finally, it was proposed that giving staff ownership of their team and decision-making could rebalance the power, validate staff, and increase happiness, thereby fitting in with co-production's aims:

'I think if you give the actual team leader and consultant the message that, "you own this, and we would not interfere with it", I think that would be more acceptable than well effectively what happens here is that the reality being, where the Trust is telling you what to do' (CL2/5).

Power was the strongest theme, illustrating the challenging cultural climate which is a barrier to successful co-production. All case participants illustrated how misuse of power is impacting on individuals as well as service provision and how damaging the consequences could be. Consideration of how to manage power within a hierarchical setting to move to the core characteristics of co-production identified earlier in this thesis is hence critical. Suggestions for how to combat this were openly explored, and the sample believed that co-production needs an effective interface, which they felt is lacking within the Trust. This is explored below.

5.5 Theme 4 – Interface

All case participants described interface issues in relation to communication within the Trust. It was deemed to be an appropriate title for this theme, and it was broken down into the following sub-themes: (1) discussion, (2) communication methods, and (3) relationships (see Figure 24).

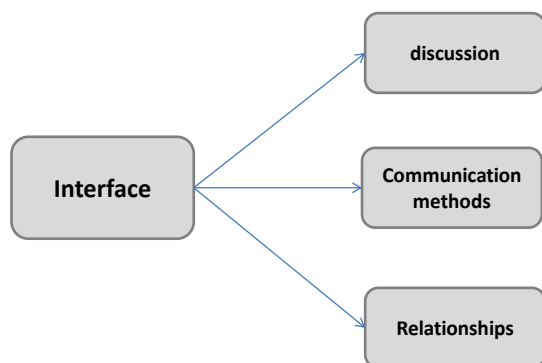


Figure 24: Theme Four Interface

5.5.1. Discussion

A sense of not being heard illustrated the need for greater involvement in process development, as a lack of clinical engagement can often result in barriers to service delivery:

‘something which often seems like an intuitively good idea, but the process itself often dilutes the idea to such a degree that people feel the need to make some sort of change, but the bits that might have been most useful get lost along the way’ (CL1/4).

Engaging in these conversations, however, is difficult because of a lack of communication from both senior managers and frontline staff:

'there isn't really a way of there being a two-way discussion, I think on either side actually' (CL1/4).

All participants agreed that further communication on co-production must occur to avoid the model becoming obsolete:

'The initial communication was fine, but I guess the fact that it then just disappeared' (CL1/4).

'Could do more with understanding' (CL5/8).

'I would advise that they do the groundwork first, then the process or model they want to use is communicated thoroughly' (MM1/1).

Participants had varying information on co-production: senior managers had accessed specific training, while others had heard the term, but had no context, and some had received minimal information. All, however, agreed that a need for greater communication exists:

'there should be communication and there should be agreement' (MM3/3).

All senior managers recognised that attempts to communicate co-production had not been successful, resulting in varied implementation throughout the Trust:

'If you believe that communication is about ensuring that people understand, then we have probably been pretty dismal. If communication is about telling people, I think we had a go at telling people, but that is different' (SM1/10).

An understanding of the drivers of change was needed to be able to engage with it:

'we weren't sure what the driving force was, whether it was to save money, whether it was an answer to the fact that they couldn't recruit' (CL2/5).

All participants felt that communication about the origins and expectations of co-production is needed for consideration of local implementation and engagement in a two-way discourse would be beneficial:

'there are things we think, "oh well that might not apply or may be unhelpful or detrimental or wasteful"; then you would make the decision not to go along with those things, and ideally share that with people as to your feedback' (CL1/4).

It was clear that discussion is important for participants and that the methods employed could have been more robust. Literature findings have indicated that a lack of clear communication can impede co-production in practice, which supporting this case study's finding.

5.5.2. Communication Methods

Communication and thus delivery methods are essential to successful co-production. The sample expressed that the main communication method is email, which was felt to be ineffective because of the high volume received:

'you get emails at least once a month saying you have to start doing this as well, you have to start doing this, and you know the system is already stretched as it is, and I really feel that it is time that we as a Trust and we as clinicians think about actually putting our focus on areas that would benefit patients in co-production most without adding more bureaucratic layer to our work' (CL5/8).

Email can target large groups of people (Baggot, 2007), however they can be ineffective for discussing major change, since information gets lost:

'the number of emails and number of correspondences you get, you don't get chance to do justice and read everything in detail. I could more with understanding better what is the Trust's vision of co-production? I am sure that the Trust would have other ways of engaging their clinical leads and team leaders to make them better informed?' (CL5/8).

The sample heard about co-production via different forums, with middle managers being informed at a governance meeting, clinical leads via a discussion paper, and senior managers through training. All communication was ineffective, and participants considered that alternative methods of communication could have been successfully employed:

'maybe it could be mentioned at an ENGAGE event' (MM4/6).

'maybe there could have been something in the communications bulletin, with a link you could click on' (MM4/6).

'they maybe could have used a screensaver' (MM4/6).

Further practical methods that could have been utilised for communicating about co-production are visibility and conversations:

'if there is co-production, we need to be informed that this is what the Trust is intending to do, and we need you to come here and sit down with us, like with Appreciative Leadership, appreciative kind of dialogue and thinking about how best we could take this forward really, and contributing to the policy and suchlike' (CL5/8).

One participant stated that staff and management must make time for communication to effect change:

'it's about giving people time, isn't it, and I guess unless you have got time, you cannot go out and have those conversations with people, can you?' (MM4/6).

Whilst participant views differed on the best method of communication, all agreed that training sessions could result in successful deployment of co-production:

'if there was some training and it clearly identified what co-production is or co-production isn't' (MM4/6).

For successful communication, an awareness of the learning style is needed, and some senior managers outlined their denial about how well they communicate:

'I'm sure it's probably not been communicated as well as it could have been, and I'm not sure it's been communicated well enough, and again it's the classic dilemma of a leader, like, "am I not being clear enough or are they just not listening?" and it's so easy to go, "oh they're not listening; I've told them 15 times and they still aren't hearing it". Particularly very senior people, you live in a very verified world, and if all of the people you speak to know about it or wouldn't dare admit that they didn't, you can kid yourself that the rest of the organisation knows about it and understands' (SM1/10).

It was evident from the data that the method of communication is vital to successful change and the development of co-production knowledge, and participants highlighted healthy working relationships as key.

5.5.3. Relationships

Relationships are vital to co-production's success, as equitable relationships at all levels are needed to co-work. This view was shared by both middle managers and clinical leads:

'I think relationships are the key, if you have good relationships with your colleagues, with your consultants, with your senior managers, with your team leaders, they will go above and beyond, and they will do anything' (CL5/8).

'I guess a lot for me is about your relationships with people. It is probably fundamental' (MM4/6).

'I think that has happened just because of relationships with individual people and that that has sort have been allowed to happen in spite of the structures which exist really' (CL1/4).

The sample emphasised that developing and maintaining positive relationships would increase chances of addressing the 'disconnect':

'I think the top and bottom completely lose sight of each other. I think that is a real risk' (CL1/4.3.23-24).

Reality was a re-emerging concept, and it was evident that two separate realities exist within the organisation: the reality of frontline staff versus the reality of the senior managers:

'there are possibly just two quite distinct cultures within the organisation whereby we just don't communicate well with each other and have a differed sense of things' (CL1/4).

In addition to strong relationships, considering the challenges of maintaining them is critical, especially when differing personalities compete:

'I think that sometimes, certain personality traits might affect as well. There are different people modelling different ego states, where they think they are superior to someone else or better than someone else, so consequently not give the other partner the respect they deserve' (MM1/1).

It was evident that reciprocal relationships are essential to addressing interface issues and are vital for co-production's success. Interface was a significant theme identified, as was participant's attitudes towards co-production.

5.6. Theme 5 – Attitudes Towards Co-production

All participants discussed their attitudes towards co-production. These were divided into three sub-themes: (1) knowledge, (2) beliefs, and (3) incentives (see Figure 25).

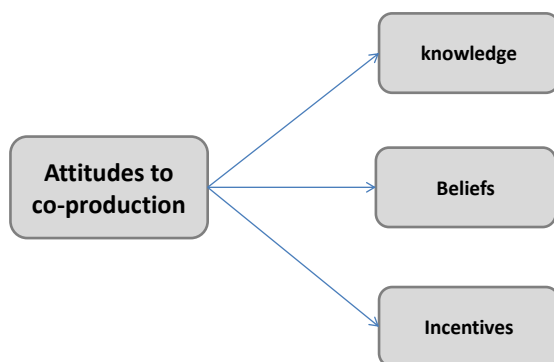


Figure 25: Theme Five Attitudes Towards Co-production

5.6.1. Knowledge

Knowledge of co-production was a prominent sub-theme and essential to co-production's success in practice. Participants who are responsible for implementing co-production in practice, expressed a lack of co-production knowledge, as summarised below:

'I have not had a great deal of knowledge or experience of co-production' (MM1/1).

Clarity around what co-production entails is also needed. However, there remained ambiguity around the concept:

'I think the Trust perspective is very ambiguous in what they believe co-production is' (MM2/3).

Ambiguity has led to a lack of understanding around co-production:

'I'm not entirely certain of an absolute definition of co-production, but my understanding would be an integrated approach between professionals in the delivery of service' (MM3/3).

Whilst all middle managers and clinical leads had limited knowledge, senior managers had a sound understanding:

'But for me, co-production is about getting the right people together to come up with the most effective solution and have that the debate about how you get to that point. Co-production isn't just doctors and nurses and a manager; it could be a team of service users, it could be two organisations jointly looking at how, so I think we get quite caught up on its got to be a very stereotypical head of operations, clinical director, lead nurse, lead manager, that perhaps co-production at its most naive, I think it can cover a whole range of spheres. I think we shy away from having those conversations; what I think we tend to do is we developed what I describe as unconscious compromise from either one party or the other, as we get caught up in not having a straightforward dialogue and I think we need to support people to do that' (SM2/11).

An effective communication strategy would be beneficial. Despite the challenges, all participants believe that co-production is about enhancing service user care:

'it's about how we can come to a decision around what disciplines believe, obviously in the best interests of that service user and how we can effectively move that person's care forward' (MM2/2).

One participant cautioned that a lack of co-production knowledge leads to inappropriate use of the term:

'I have heard people use the term co-production occasionally without often knowing what they mean, quite often to make a point' (CL1/4).

While the varying levels of co-production knowledge was surprising, the sample illustrated that a common understanding of co-production is required for successful

implementation of the model. A lack of a clear understanding leads to patchy co-production, which clearly indicates that knowledge impacts outcomes. Findings from literature support this finding, highlighting that co-production knowledge is critical and that without a clear meaning, implementation is likely to be challenging. A further attitude towards co-production and an equally important sub-theme was participant's beliefs regarding co-production.

5.6.2. Beliefs

Beliefs about co-production determine engagement and influence whether the principles are 'lived'. One participant clearly expressed that co-production is not occurring:

'in my opinion, co-production exists in our Trust by name, and to be honest with you, that makes me angry' (CL4/7).

The following view explored whether co-production organisationally exists, whereas other views focused more on the viability of co-production, expressing that there are many potential benefits of co-production if implemented properly:

'I think co-production, if implemented properly and extensively, it is probably the better model because ultimately the type of work we do in the healthcare component. I think co-production fits in very nicely with that because you have a multi-disciplinary team (MDT) approach; you will have a management approach and a clinical approach, which has the potential to be very very good' (MM1/1).

One participant strongly emphasised that there is no better model and supported co-production:

'I think you have to co-produce, and not one model or one discipline of staff will have the answer, so it is really important that we all work together and have our own distinct professions and identities but come together to discuss issues. So, I don't think there is a better model' (MM2/2).

Whilst co-production was viewed as a positive model, embedding it within the culture is needed:

'I don't think co-production should always be about when there is an issue, but I sometimes think that because we are so busy, and we work in the NHS, that sometimes that is how it constantly feels' (MM4/6).

Despite the general positive regard for co-production, participants felt that senior managers should model co-production behaviours to demonstrate commitment. They noted that prime examples of co-production could be seen within local teams:

'there are some very good examples within team, and I think higher up needs to view this so that they can take this back and reflect on that and how they could embed that higher up' (MM2/2).

Some participants expressed that co-production as per the literature is the only way for the organisation to proceed:

'I think personally that is the only way to move forward, if you had the service users on board' (CL2/5).

'I think the thing which opening things up might allow people to do much better is to have a much more straightforward relationship with some of the patients that we have contact with' (CL1/4).

Beliefs about the relevance and applicability of co-production were deemed to be central to engagement, which clearly illustrates that staff beliefs can impact on implementation. However, also pertinent is that these findings go further and suggest that motives for engagement are also key to successful co-production, as when staff perceived dishonesty, their engagement decreases. Another essential element is managing the organisational 'disconnect' so co-production is not just used to resolve issues but is a more embedded culture. Perhaps most pertinent were the participants' strong view that co-production cannot occur if service users are not fully involved. They believed that a vital perspective is overlooked, impacting on the achievement of successful outcomes, suggesting staff's desire for the model to be reviewed to consider this inclusion. All case participants noted that a further key element of co-production in practice is the incentives provided to each party, as highlighted within the policy review.

5.6.3. Incentives

'Buy-in' to co-production is needed for success, as a lack of belief in the process would then make encouraging power distribution challenging. All case participants noted several incentives to engage with co-production and strengthen the model. It was believed that a shared leadership approach, with increased collaboration and reduced directiveness, would help meet co-production's aims and support the rebuilding of relationships. One participant suggested a few options for this:

'...two heads are better than one' (MM4/6).

'sometimes someone might come up with an idea that you hadn't even thought about' (MM4/6).

'it's that being more of a collaboration than one person saying what we are going to do and everyone thinking that they are being dictated to' (MM4/6).

'yeah about people taking responsibility and ownership' (MM4/6).

Many incentives were proposed for engaging with co-production. One participant strongly felt that the main incentive was staff happiness:

'the happiness of staff. They feel invested in it, and they can go home and feel like they have done a good job' (MM2/2).

Having happy staff can result in reduced workplace stress, and if effective co-production were to occur, then a further reduction in anxiety and stress levels could be experienced:

'Ultimately, it makes things easier for people, so the incentive will be that it will leave people feeling less anxious in terms of their personal accountability for everything; it's a sense of shared and collective' (SM1/10).

In relation to people's personal accountability, a major element was decision-ownership. Most clinical leads indicated that this was pivotal for buying into the model:

'I think if you give the actual team leader and consultant the message that, "you own this, and we would not interfere with it"' (CL2/5).

In addition to staff wellbeing and stress reduction, improved co-production could facilitate strategic opportunities to review and change long standing practices, which would introduce flexibility into how staff work:

'What we really want is a broad understanding across the Trust of people functioning in a particular way with an allowance for local variation of service variation because the Trust is big and disparate, so you are always going to have some things that work in different ways because of the services. It might be that even within a small location, they have ended up with quite different services if they were much more in the gift of that being a shared decision in terms of direction' (CL1/4).

Allowing for a review of working practices can ensure a focus on how service users can benefit from a co-production approach. Literature has identified that co-production requires service user involvement to harness assets, build capacity, and produce effective outcomes. This is supported and furthered by the following quote:

'You would hope that there might be some particular benefits in terms of the experience people had coming into services. I think the thing which opening things up might allow people to do much better is to have more straightforward relationships with some of the patients that we have' (CL1/4).

CL1 identified an important point: that service user involvement would benefit both staff and the service user. Another participant concurred that co-production could potentially decrease risks associated with some mental health settings:

'I think reduced risk – whether it is the risk of poor mental health, risk to other, risk to self – so if you have got patients on the same page as you, I think it works much better that way. I think it is definitely worth it in terms of the long-term benefit, the recovery of the patient, better patient satisfaction, if you invest that time in co-production' (CL5/8).

All case participants agreed that incentives are vital for co-production's success, as the absence of reciprocal relationships and a lack of transparency about motives for engagement reinforce their belief that co-production is no more than a political position.

Conclusion for Chapter 5

The data analysis identified five main themes (with 17 sub-themes) amongst the participants, four of which appear to be embedded as part of the Trust culture, resulting in a 'disconnect' between clinical and corporate services, frustration at frequent changes, feelings of dissatisfaction because of power imbalances, and frustration surrounding ineffective communication. Nonetheless, the final theme shone a light of hope that reassessment of the current co-production model to include service users in the process and the provision of a more effective communication strategy could result in co-production positively influencing Trust culture. All participants believed that commitment and investment should be made to maximise the potential benefits of the model. The next chapter presents a discussion of the above findings, and their links to relevant literature.

Chapter 6 – Discussion

6.1 Introduction

This chapter illustrates some interpretations of the findings discussed in the previous chapter. An overview of the methodological selection provided followed by discussions of the three key areas of interpretation which included the development of co-production knowledge, power and co-production, core characteristics of co-production. Application to practice is considered in relation to previous change endeavours and the strengths and limitations of the study are considered.

6.2. Review of Methodology and Methods

A descriptive case methodology developed an in-depth understanding of co-production within the Trust and provided opportunities to consider participants' knowledge, skills, and attitudes towards co-production. A focus on evaluating implementation provided a forum for honest feedback about co-production's drivers and challenges in practice. Sufficient descriptions were displayed to enable adequate interpretation of the meaning and context of what was researched (Popay, Rogers & Williams, 1998).

In addition to local relevance, there was potential for findings to have some transferability and credibility to wider settings, as a case within a precise context. The case authentically represented the purposive sample's data, from which insight and a desire to affect change emerged. Should the study be repeated, action research to effect change, as a co-production endeavour in practice, would be considered.

6.3. Interpretation of Findings

6.3.1. Development of Co-production Knowledge

From a review of relevant literature and exploration of the case's findings, it was apparent that several strands of knowledge are needed to embed co-production

within mental health services: knowledge development, communication, training, and attitudes.

6.3.1.1. Knowledge Development

The literature review and this case identified poor definition which presents implementation challenges as without an agreed understanding, co-production is open to interpretation (Clarke, 2015; Bradley, 2015). It was evidenced that ineffectual knowledge distribution negatively impacts on co-production indicating that clarity is crucial as supported by Dalgarno and Oates (2017). However, this case study went further, identifying that co-production knowledge is critical to successful implementation, as concurred by Gillard et al. (2012). OTs work to determine purposeful and meaningful activities that improve wellbeing, thus producing better outcomes (Goldberg, Brintnell & Goldberg, 2002). Extending this principle to co-production, service user involvement enhances meaning; demonstrating criticality for change endeavours, to promote 'buy in'. With co-production's nebulous nature, implementation without a knowledge base presented challenges, posing issues for practice as differing understandings will lead to variations in implementation across an organisation, meaning a lack of standardisation.

A lack of clarity within the Trust led to the design of a model that did not align with the literature review's findings of what co-production entails. Exclusion of service users led to knowledge gaps which could have been enhanced via inclusion as supported by Gillard et al. (2012). The decision to exclude service users demonstrates co-production's ambiguity, which is mirrored in Bradley's (2015) findings, highlighting further issues for consistent implementation in practice, diluting co-production's impact. This case study identified a requirement for a clearer definition, which was provided via a concept analysis (see Chapter 3). This finding presents clear evidence of the need to engage service users in co-production to enhance meaning; however, this requires effective communication, particularly when pertaining to a nebulous concept.

Hence, co-production was defined within this thesis for clarity in practice, and it was constructed using academic literature, reflective in the language utilised. Whilst encompassing co-production's core elements, the use of the definition within an education setting highlighted that the terminology was not as accessible as initially thought. Whilst academics and people familiar with co-production could understand the definition, it became apparent that this may not be the case for all parties engaging in co-production. Discussions outlined the importance of shared discourse and accessible language for co-production's successful implementation, and this discovery was hence critical. Future consideration of how to modify the definition to ensure accessibility for patients, students, the community, and people who are new to the concept of co-production, whilst maintaining its essence, is required. It is evident that co-producing a definition with key parties is likely to move more towards a universally accessible understanding, standardised implementation and better co-production outcomes. Crucial to the development of a comprehensive definition is how co-production's principles are communicated.

6.3.1.2. Communicating Co-production

Communication was evidenced as sporadic, presenting challenges to achieving total board 'buy-in' evident, meaning effective role out of the model was hindered. Interestingly, following an interview with one senior manager, they advised that for effective organisational change, all board members need to subscribe to actions, which had not occurred with co-production; communication was thus patchy, and implementation was impacted. Turnnas et al. (2015) asserted that poor communication can minimise service user opportunities to co-produce; this case study identified that it also inhibits staff opportunities. Co-production models should ensure that opportunities exist for all to engage equally. Massive implications exist for practice when communication is unclear as evidenced through most serious incident reviews, hence co-production communication needs to be consistent, accurate and disseminated via a strategy. This case study suggests that a targeted strategy, including all relevant parties, is needed when implementing co-production. This was

important because whilst a plethora of research is available regarding communication in healthcare, there is limited consideration within co-production literature, suggesting that further exploration is required.

Maintaining corporate awareness is challenging as organisations grow and communication channels escalate (Adams, Blandford, Budd & Bailey, 2005), posing implications for practice as communication strategies need to be bolstered to ensure effective communication, as where gaps exist 'disconnect' occurs. This thesis identified that co-production is a complex phenomenon, suggesting that email communication would only convey basic co-production information. Hence, a multifaceted approach to communication is required to consolidate co-production knowledge. Designing a targeted communication strategy would be beneficial in this regard. It was evident that the most effective communication strategy is the display of co-production behaviours, which is supported by Realpe et al. (2015). By displaying co-production behaviours, mirroring can occur, thereby creating a co-production culture. A starting point to address this could be the delivery of co-production training to key parties.

6.3.1.3. Training

Knowledge development extends beyond communication, and training to enhance skills would result in better co-production outcomes. Findings illustrated that disparity in training provision resulted in a power imbalance and communication flaw – a likely cause of inconsistent implementation. Unequal training has significant ramifications for practice as it results in differing knowledge and skills levels meaning unequal provision of intervention, which is likely to impact on outcomes. This case study furthers that relationships and integration are key when designing a communication strategy, and a greater appreciation and understanding of each parties' role could occur if joint training is completed, ensuring open channels for co-production conversations and thus an increased likelihood of the model's success. Conversely, findings evidenced that when poor relationships exist, communication was ineffective

and co-production fails. Fostering a culture of open communication could result in adherence to the model (Richter, Mazurenko, Kazely & Ford, 2017). The relationships forged, as well as the knowledge, 'buy-in', and attitudes of staff, are key to successful co-production and successful service delivery in practice.

6.3.1.4. Attitudes

Findings demonstrated that benefits of co-production consisted of: team ownership, staff wellbeing, and retention, which encouraged 'buy-in' to the model. The main driver, however, was a better service for patients. My case study goes further, asserting that service users have unique co-production knowledge that is integral to success and that they should be equal partners in the development of co-production strategies from the start. This is significant for practice as person-centred care is integral to mental health provision and is a core element of OT practice. Without service user inclusion outcomes are unlikely to succeed. Whilst it was recognised that user engagement can be challenging within mental health settings, it is still essential to support service users to engage in co-production activities because of the associated benefits. Whilst attitudes were positive, the demands placed on professionals could hinder co-production opportunities (Turnnas et al., 2015), suggesting that organisations should consider managing this through embedding co-production as a cultural norm. This descriptive case study proved to be promising for co-production's success because by addressing participant issues, 'buy-in' to co-production could occur. However, a major barrier identified was the distribution of power and power dynamics, which derailed the Trust's co-production efforts.

6.3.2.1. Power and Co-production

Much has been written about power in literature; however, its application within co-production presents a specific challenge. While people who hold power are encouraged to distribute it among the co-production team, those people tend to maintain it and exhibit anxieties around others making decisions for which they are ultimately responsible. The main issues noted in relation to power are hierarchy, disconnect, and dynamics.

6.3.2.2. Hierarchy

Within any large organisation, a hierarchy exists to provide a sense of structure to increase performance (Cataldo & Ehrlich, 2012), however, hierarchies can be ineffective when a top-down approach is adopted (West, Barron, Dowsett & Newton, 1999) as employees feel a lack of power and control (Osabiya, 2015). Avoiding hierarchal structures within the NHS is impossible, as they are needed for operational purposes; however, this presents organisational challenges when implementing co-production. How the hierarchy functions is critical for practice and adopting a 'flatter' approach could be beneficial and allow staff to experience more freedom to innovate. In the absence of this option, consideration of how concerns can be escalated and truly listened to so that staff feel validated is needed.

I argue that top down hierarchies lead to job dissatisfaction, leaving the organisation, and even becoming mentally unwell, impacting co-production's success. These responses have significant implications for organisations, as they result in a loss of revenue through sick leave, resource gaps (through a lack of ability to recruit), and underperforming staff, resulting in an inability to deliver core services effectively. The right people need to be in the right positions within an organisation for co-production to be successful. Innovative, forward thinkers who lead as opposed to manage would ensure that a co-production culture can be developed, the 'disconnect' overcome, and the model effectively implemented.

6.3.2.3. Disconnects in Co-production

None of the studies in the literature review focused on organisational co-production, the issue of 'disconnect' was not evident in their findings. However, this descriptive case study noted that 'disconnect' can negatively impact on co-production efforts as communication suffers, making active engagement troublesome. This was evidenced in a lack of mental health discussions surrounding co-production and a larger focus on organisational challenges. 'Disconnect' can result in staff disengagement and disempowerment which can have huge ramifications for retaining staff. However, through addressing the challenge of engagement self-identity development can occur,

which has potential for encouraging honest conversations (Edgren, 1995). Employing reciprocity could commence the process of engaging staff to overcome the 'disconnect' so that co-production can be engaged in more fully (Lwembe et al., 2016).

The case study indicated that emotional responses stem from the 'disconnect'; therefore, a redistribution of power and empowerment are critical to staff wellbeing and service user outcomes (Roberts et al., 2011). Poor understanding of pressures can impede co-production activity, enhancing 'disconnect'. In practice all parties need to share their pressures to develop compassion and respect so that power can be distributed evenly, meaning that all parties feel valued and recognised.

6.3.2.4. Dynamics

A power imbalance between doctors and staff was expected as a result of my experience in practice, with nursing literature littered with articles about this dynamic (Nelson, King & Brodine, 2008). However, in this descriptive case study, this was not the case, as the imbalance was between frontline staff and senior managers. Interestingly, consultants' discussions on disempowerment, highlighted an inactive workforce. When disengagement occurs, other outlets are sourced to maintain wellbeing, such as a private practice. This is concerning, as co-production cannot occur when imbalances exist. In practice a disempowered workforce can lead to a loss of staff and ineffectual care so heeding this finding is significant for all large organisations.

Local co-production groups in practice have seen consultants shift to active participants in team leadership and local service development, evidencing the positive impact of co-production. The finding furthers that power is not being effectively utilised by anyone and that the use of co-production to cultivate individual power could benefit implementation. By re-establishing relationships and implementing co-production's core characteristics, emotional responses to

disempowerment could be resolved, thereby improving recruitment and retention challenges.

6.3.3.1. Core Characteristics of Co-production

This descriptive case study of co-production could not have been completed without conducting a policy review, literature review, and concept analysis because of the nebulous nature of the term. Clarity surrounding what co-production entailed was attained, and this case study has evidenced that for co-production to be successful, all the core characteristics are needed, namely, assets, equality, networks, capacity, catalysts, and reciprocity.

Asset utilisation is ineffective when strengths are not being utilised, which if harnessed, could transform the organisations (Roberts et al., 2012). As outlined the inclusion of service users in co-production would enhance the current practice, since these users have assets such as time, experience and skills that could improve service delivery (Davies et al., 2014).

Reciprocity could allow for the exploration of incentives, highlighting what is important to individuals, which could support the development of co-produced organisational values to which all parties subscribe. Incentivising the process maximises 'buy-in', thus increasing the chances of success. Addressing desires for ownership of the local co-production process could improve relationships and engagement in co-production, thereby building scope for collaboration. Networks are critical for successful co-production, as highlighted through the scoping and literature review and the concept analysis, which identified that collaboration results in greater outcomes (Lecluijze et al., 2015). The findings of the case study strengthened this assertion, illustrating that without effective networks, co-production will falter. Findings noted that fundamental issues with collaboration exist within the organisation that require addressing prior to consideration of engaging service users and the community. Much collaboration research exists that indicates that if co-working is ineffective, then job satisfaction and wellbeing decrease (Hall, Johnson,

Watt, Tsipa & O'Connor, 2016; Shier & Graham, 2013), as the findings illustrate. This has significance for all organisations looking to implement co-production; a co-produced implementation process should be ensured, where key people are involved in the collaboration process to increase chances of success.

The need for co-production knowledge and skills is critical for successful implementation of co-production. Where knowledge and skills were absent, co-production did not occur (Heaton et al., 2016). The lack of community and service user involvement in the model resulted in co-production's downfall, as the focus was on internal delivery – an ethos that is diametrically opposed to the co-production ethos. This impacted on staff willingness to 'buy in' to the model and evidenced the importance of considering who key parties in the co-production process are. This case study indicates that without service user involvement, meaning for the model does not exist, suggesting a need for further work to progress to facilitators (Davies et al., 2014).

6.3.3.2. Listening

All core characteristics are critical to co-production's success; however, I would assert that listening is central to co-production, impacting on interactions with service users and the community (Brett et al., 2014). If organisationally, communication is poor, by proxy communication with service users will suffer. However, listening is a useful tool for gaining information, developing and building trust, maintaining reputations, motivating employees, and minimising conflict, and it is essential for organisational success. Without active listening, assets went unnoticed, power imbalances strengthened, and collaboration ceased. A lack of reciprocity was consequently embedded in the culture, and directive approaches minimised opportunities for service user involvement. Through the absence of listening, co-production's implementation was thus unsuccessful, with staff involvement in the expression of ideas diminished. Several examples were highlighted within the case study: apathy to act, fear of recrimination, poor mental wellbeing, and inability to recruit and retain staff. This was important as it highlighted a need to evidence

commitment to co-production, strengthening the viewpoint that listening was an essential component of successful co-production.

This descriptive case study identified that listening to staff within a disparate organisation is challenging, begging the question of how co-production could be utilised within large organisations. Communication on large scales is not a simple process; however, it is well worth the investment (Kotter, 1997) to promote appreciation amongst the workforce. Listening is not just about spending time within teams but is evidenced in how an organisation treats staff with respect and dignity (Schmidt, 2000) which impacts on engagement in organisational changes. An identified barrier was the use of technology for communication where unstructured data does not equate to greater understanding. This case study recommends a multifaceted communication approach incorporating both technological mediums and open dialogue to ensure effective listening in practice.

6.3.3.3. Culture and Co-production

As identified in Chapter 1 culture is the lynchpin for co-production's success, existing in every organisation, and it is developed based on a set of shared attitudes, beliefs, and rules established over time. Culture can positively or negatively impact on staff wellbeing and organisational success. Handy (1999) has identified four types of organisational culture: power culture, role culture, task culture, and person/support culture. Findings from this descriptive case study suggest that the current culture within the Trust is a power culture, where performance is judged by results. In part, this results-driven culture is government-imposed, with senior managers stressing that they have little influence, as generating revenue is critical to the success of the business. Power culture is illustrated by the high staff turnover and low morale, which was clearly described throughout this case. The evident lack of any professional group utilising their power added a strange dynamic to the culture, which could be a reason for the challenges experienced when implementing co-production. In practice, all individuals need to recognise and act on their own power base to effect change and embed co-production.

Findings confirmed that where a blame culture exists a demoralised, dissatisfied workforce with increased mental health issues occurs. This culture, whilst concerning, is not exclusive to the Trust, with many NHS doctors feeling that they work in a 'dangerous and toxic environment with a blame culture which jeopardises patient safety and discourages learning and reflection' (Wise, 2018, pg1). The presence of this culture is a barrier to co-production, as imbalances result in disempowerment and fear affecting delivery of care. Blaming staff for mistakes in practice harms the positive risks professionals are prepared to take in practice, directly impacting on successful outcomes for service users. Hence, a move away from this culture would allow staff to confidently conduct their duties making implementing co-production an easier process.

6.4. Summary of Findings and Application to Practice

The case study findings identified drivers and challenges for implementing co-production in practice. A major challenge identified was inequitable distribution of power within a hierarchical setting, which negatively affects relationships, thus increasing the 'disconnect' between senior managers and frontline staff. This finding is significant for application to practice as all NHS organisations are hierarchical, meaning that power equality is likely to be a challenge for all organisations employing co-production. However, a driver for co-production and a possible remedy to the power issues is giving leaders ownership of the model. Middle managers and clinical leads expressed that taking ownership of co-production within their local teams would improve both their wellbeing and that of the team. They also believed that it could reduce staff sickness and increase retention and that it would demonstrate trust in their ability to lead effectively, responding to local needs. This move to more autonomous and shared leadership could be a positive step to redistributing power in practice, thus improving working conditions and service outcomes.

Whilst varying reasons for reluctance to share power were outlined and a possible solution identified, a further potential challenge noted was the lack of an agreed meaning. Participants highlighted that a lack of understanding about co-production led to confusion with how to apply the concept to practice, impacting their ability to distribute knowledge amongst the team. Because of the absence of a clear, accessible definition of co-production, a mismatch of information was articulated at different hierarchical levels of the Trust. This descriptive case study highlighted that varying levels of knowledge can impede successful implementation of co-production. In practice, parity of information sharing is essential to ensure that there is equity of co-production knowledge developed to create consistency in delivery.

Service user involvement within the co-production model was a further driver identified. Whilst this involvement was absent within the Trust's model, all participants agreed with the literature's assertion that the inclusion would enhance the model, increase meaning, and promote reciprocity and engagement of staff. Literature also strongly asserts that service users are integral to co-production, and this case study not only supports that assertion but also goes further to identify that their involvement is critical to gaining 'buy-in' from frontline staff. Through engaging service users, assets can be maximised and outcomes improved, and implementation is likely to be more successful. The findings highlight the drivers and challenges to implementing co-production within the NHS and suggest that all core characteristics must be operational for success in practice.

6.5. Is Co-production Different to Previous Change Efforts?

Previous literature has demonstrated that systemic challenges of communication (Foot, Sonola, Bennett, Fitzsimons, Raleigh & Gregory, 2014), power imbalance (Ochocka, Janzen & Nelson, 2002), and continual change (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2001) within CMHTs have persisted over several years. However, the findings of this case study demonstrate an appetite to address these issues through the application of co-production, although this is likely to be a complex process (because of the hierarchical nature and size of the organisation). However, co-production resonated with all participants as a potential solution, as

opposed to being viewed as another change process. Participants believed that a co-production culture could address systemic challenges whilst improving wellbeing and service user care, thereby offering the opportunity to reinvent relationships with service users and the community. However, consideration of previous change attempts was pertinent to determine how co-production might differ. This case could not fully answer these questions; however, it deduced that co-production is a concept that draws together the best elements of previous efforts and comprises a set of principles to which all could subscribe. By focusing on what works well, the potential for success improves. Co-production offers new hope in the potential for service improvement in a cost-effective manner (especially if service user and community assets are considered). It is also noteworthy that since the commissioning of this descriptive case study, interest in co-production has expanded; more research is being published with more concerted efforts to define the concept, which is promising for the model becoming more widely utilised to improve service delivery.

6.6. Limitations of the study

As with the majority of studies, the design of the current case study is subject to limitations. Sample selection caused some conflict for me. Having read relevant literature, the importance of service user inclusion was evident, and inclusion may have increased the credibility of the findings. However, as the Trust's model did not include service users the decision was made to also exclude them from the sampling process to accurately present the case. I believe however that their inclusion could have provided weight to the discussion and subsequent recommendations, which may have enacted more change in practice. In future studies inclusion of service users in both the development of the project and the sampling would address this limitation.

Whilst the sample size was sufficient, time constraints meant that further confirmation of findings was not possible. Whilst two verification interviews were completed more would have been beneficial for increasing the authenticity of the case. To address this

in future studies, I will be aware of the timeframe and resource demands to ensure that the methodological selection can be fully achieved.

Implementation of the data collection method was a limitation of the case study. Due to inexperience with primary data collection I was unable to recruit participants from the north locality, as was initially planned, therefore the participant selection was not met. However, since similar findings were noted in both east and central localities, impact was minimal. To overcome this issue in future studies, a more robust recruitment plan will be devised to ensure that a wider range of participants can be effectively enlisted.

Lack of previous evidence in the research field meant that the literature review was completed with sparse information, making it challenging to provide a clear theoretical foundation for my research question. Hence, determining the scope for the research project challenging and this has likely impacted on the quality of the literature review and subsequent discussion. As co-production literature develops this should reduce the above described challenges.

Scope of the discussion was a limitation of the case study due to this being my first research project. This resulted in the scope and depth of the discussion being compromised in comparison to experienced scholars. Through continuing to complete research projects, I will become more adept at interpreting and discussing research findings which should increase the trustworthiness of my studies.

Conclusion for Chapter 6

This chapter has outlined that the findings have implications for practice that require consideration when implementing co-production. Equal knowledge distribution, effective communication, training and positive attitudes are needed to commence a co-production process. Power issues including hierarchy, disconnect and dynamics need addressing to maximise the potential for co-production's success. Core

characteristics and listening need to be present to sustain co-production. Essentially, culture needs to be optimum for co-production to be embedded. Overall, literature confirms the descriptive case study findings; however, unexpected findings occurred, and new knowledge was developed.

Chapter 7 – Conclusion and Recommendations

7.1 Introduction

This chapter concludes the research journey providing recommendations for the Trust and implications for practice and policy. Future research requirements are identified and reflection on the impact of the professional doctorate experience is made.

7.2. What the Case Study Demonstrates

A negative organisational culture within the Trust was noted, impacting on staff wellbeing, recruitment, and retention. This presented itself through ineffective communication, staff not being listened to, an imbalance of power, a lack of staff involvement in decision-making, no staff ownership of local co-production, poor interface, lack of senior management visibility, and constant change. Organisational culture appears to be the main barrier to successful co-production, as staff voices are not heard. This appeared to impact on discussions around co-production in mental health as participants focused on the organisational culture impeding co-production. In addition, clinical leads and middle managers expressed a lack of clarity surrounding how the Trust implemented its model, and they stressed having minimal knowledge, which directly impacts on co-production's success. Co-production requires embedding in practice via a cultural shift and effective communication. The case study does demonstrate that a co-production model could improve the delivery of mental healthcare both locally and nationally, with the inclusion of service users and the community in the design.

7.3. Meeting the Research Objectives

Objective 1: To determine and define what co-production is and which model of co-production was used in the Trust. A concept analysis formulated a working definition of co-production, allowing for the identification of core characteristics and their need to operationally function together for co-production's success. This definition offers NHS organisations and the research community clarity on what co-production is and

what it is not. The provision of a definition offers the opportunity to guide mental health practice to improve outcomes for the organisation, staff, the service user and the community.

Objective 2: To identify how core the characteristics of co-production were implemented within the organisation. Findings identified that many challenges were experienced when implementing co-production, including an unequal distribution of power, a lack of asset utilisation, and poor capacity development. The case study found that where core characteristics were absent, ineffective organisational cultures existed, impeding co-production's success. The case asserts that when all core characteristics are operational mental healthcare can be improved and outcomes are more likely to be achieved.

Objective 3: To gain an understanding of clinical leads and managers' knowledge, skills, and attitudes towards co-production within CMHTs and how this has affected implementation. Findings illustrated varying levels of knowledge among participants, with senior managers having the greatest knowledge base. Provision of training to mixed groups of corporate and clinical services could readdress the 'disconnect' and enhance the provision of mental health services, not only in the community, but in inpatient settings too. Findings demonstrated that inequality in co-production knowledge was significant highlighting the need for a consistent, equitable approach to implementation to maximise the potential for success in all settings including CMHTs.

Objective 4: To offer recommendations to the organisation and the wider research community to enhance co-production in practice and impact on mental health service provision. Recommendations for the Trust were outlined to enhance co-production. In addition, a descriptive co-production model was devised to illustrate the key requirements. With identifying some significant findings, it was essential that this information was distributed to organisations and researcher looking to further co-production in practice.

7.4. Strengths of the Study

Whilst no two case studies would be identical due to the uniqueness of the Trust's case, because the methodological design for the study was sound, the approach could be replicated; with enough detail provided within discussions about data collection and analysis to guide researchers wishing to adopt a similar approach.

A strength of the study was the reduction of researcher impact through including regular academic supervision, maintaining a reflective journal and a structured interview guide which ensured that the research study was trustworthy.

The completion of a concept analysis provided a working definition adding to the evidence base, ensuring an effective review of the Trust's co-production model.

7.5. Achieved Original Contributions

The case study provides a focused evaluation of a specific co-production model used in CMHT settings in a Mental Health Trust in England. A concept analysis of co-production and a working definition have been formulated. Unique insight is offered into how organisational culture can impact the implementation of a co-production model. Challenges with implementing co-production within community mental health settings, which has not previously been a focus of research, are highlighted, although these findings could be extrapolated across the organisation. Core characteristics of equality, assets, capacity, catalysts, networks, and reciprocity are outlined, with findings demonstrating the need for an outcome measure to be developed in the future. The challenges and drivers of co-production demonstrate the model's feasibility to benefit the NHS, highlighting the requirement to address systemic challenges to enhance success. Provision of a descriptive model provides a practical guide to employing core characteristics during implementation.

7.6. Recommendations

The recommendations are split into two categories. It was deemed to be pertinent to offer recommendations to the LCFT for supporting its co-production model to improve its outcomes. In addition, it is relevant to present recommendations for other organisations that are considering co-production implementation through a descriptive model.

7.6.1. Recommendations for the Organisation

1. Organisational culture should be addressed, and a co-production culture adopted, blending work-based learning for frontline staff and management.
2. Minimising the effects of hierarchical structure on the implementation of co-production needs to occur with all board members subscribing to the model.
3. A clear communication strategy should be devised, utilising multiple communication methods to target a wider range of staff.
4. That the co-production model implemented should be reviewed, considering the case study findings that inclusion of service users and the wider community could bring the model more in line with co-production literature.
5. Future research to evaluate changes which could include action research to develop co-production in practice, and an ethnographic study where organisational culture can be explored more thoroughly.

7.6.2. Recommendations for Organisations Seeking to Implement Co-production

The outlined implications present a descriptive model of co-production, displaying the components needed for its successful implementation. The key elements of the model are as follows: Inclusion of service users in a co-production model; positive organisational culture; equal distribution of power; effective communication; effective change management strategies and identification of incentives to engage staff.

There were lessons to learn from LCFT's co-production model as a major challenge was due to service user exclusion. Organisations should commit to reviewing their

culture by attaining feedback from staff, CQC reports, and staff surveys, thus maximising a co-production environment. Organisations must consider how power can be distributed where hierarchical structures exist. Organisations implementing co-production should consider how to convey their co-production vision through an effective communication strategy. Senior managers must make efforts to inform frontline staff about the realities of change to support a reduction in resentment. Through open and honest conversations, staff can embrace change by possessing a clear rationale. The promise of improved service user care was a main driver for adopting the model.

The knowledge developed from the descriptive case study adds a new dimension to existing co-production theory, which has not focused on evaluating the success of implementation in an NHS organisation. It provides a much-needed addition to the small co-production evidence base. The understanding of the ideal components of co-production is a welcome contribution to what was already known.

7.7. Further Research

As a UK study, considering senior management rather than just frontline staff and service users, the case is valuable in terms of the extent to which it has investigated co-production. Nevertheless, it remains a study of a single case. To determine the wider application of these findings to other organisations, healthcare colleagues should consider these findings in relation to their own contexts and determine their applicability. Until the findings are tested, their wider merits will not be known. Several areas have been identified for future research.

The primary area in need of further research is the definition, refinement, and application of co-production in one or more forms to other UK NHS organisations. If sufficient numbers are available, a multi-site case study would ideally allow valuable comparisons to be made. Nevertheless, testing these findings in a single site remains valuable, and others may well adapt the model to their own situations, prompting even further research to test those refinements.

Additional understanding is required about how co-production models can be designed and evolved to be most effective as a framework to support staff and service users and to promote community engagement in service design and decision-making.

Co-production research is limited concerning its application to clinical practice. Whilst attention to the use of co-production as a tool for research is valuable, a better grasp of how a co-production model can be utilised in large organisations to improve service user experiences and outcomes is required.

The development of an outcome measure would be beneficial, since at present, no method exists for demonstrating how successful the implementation of a co-production model is in practice. Testing of any outcome developed would then be required, as would investigation of the sustainability of any model.

7.8. The Professional Doctorate Process

Completing the professional doctorate has encouraged me to question information and have a voice to ensure good practice and quality is maintained, even at times of pressure and low resources. The professional doctorate strengthened my integrity and helped me to realign myself with clinical practice whilst reaffirming my professional identity. In addition, completing the case study has afforded me the opportunity to utilise co-production in the workplace, thereby improving relationships and empowering people both to share their views and to support one another during stressful and challenging times and to remain an agent of change where possible.

References

- Adams, A., Blandford, A., Budd, D. & Bailey, N. (2005). Organisational communication and awareness: a novel solution for health informatics. *Health Informatics Journal*. 11(3), pp. 163-178.
- Adler, P. A., & Adler, P. (1987). *Qualitative research methods series, Vol. 6. Membership roles in field research*. Thousand Oaks: Sage Publications.
- Akella, D. (2003). *A question of power: how does management maintain it?* *Research*, 28(3), pp. 45-56.
- Alakeson, V., Bunnin, A. & Miller, C. (2013). *Co-production of health and wellbeing outcomes: the new paradigm for effective health and social care*. London: Office for Public Management.
- Amanchukwu, R. N., Stanley, G. J. & Ololube, N. P. (2015). A review of leadership theories, principles and styles and their relevance to educational management. *Management*, 5(1), pp. 6-14.
- Anderson, C. & Brown, C. E. (2010). The functions and dysfunctions of hierarchy. *Research in Organizational Behaviour*, 30, pp. 55-89.
- Baggot, C. (2007). *Email marketing by the numbers: how to use the world's greatest marketing tool to take any organisation to the next level*. New Jersey: John Wiley & Sons.
- Baxter, S. K & Brumfitt, S. M. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care*, 22(3), pp. 239-251.
- Bevan, H. (2006). *Helen Bevan on change management*. London: NHS Institute for Innovation and Improvement.

- Bhalla, V., Caye, J., Dyre, A., Dymond, L., Morieux, Y. & Orlander, P. (2011). *High-performance organizations. The secrets of their success*. Boston: The Boston Consulting Group.
- Biddle, S. J. H., Markland, D., Gilbourne, D., Chatzisarantis, N. L. D. & Sparkes, A. C. (2001). Research methods in sport and exercise psychology: quantitative and qualitative issues. *Journal of Sport Science*, 19, pp. 777-809.
- Bonner, A., & Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher*, 9(4), 7-19.
- Botes, A. (2002). Concept analysis: some limitations and possible solutions. *Pubmed*, 25(3), pp. 23-27.
- Boud, D., Keogh, R. & Walker, D. (1994). 3rd Ed. *Reflection: turning experience into learning*. New York: Routledge Falmer.
- Bouso, R. S., Poles, K. & Cruz, D. (2014). Nursing concepts and theories. *Revista da Escola de Enfermagem da USP*, 48(1), pp. 141-145.
- Bovaird, T. & Downe, J. D. (2008). *Innovation in public engagement and co-production of services*. Cardiff: Cardiff University.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Boyle, D. and Harris, M. (2009). The challenge of co-production: How equal partnerships between professionals and the public are crucial to improving public services, London: National Endowment for Science, Technology and the Arts.
- Bradley, E. (2015). Carers and co-production: enabling expertise through experience. *Mental Health Review Journal*, 20(4), pp. 232-241.
- Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C. & Suleman, R. (2014). A systematic review of the impact on patient and public involvement on service users, researchers and communities. *The Patient-Patient-Centred Outcomes Research*, 7(4), pp. 387-395.

Brown, H. V. & Hollis, V. (2013). The meaning of occupation, occupational need and occupational therapy in a military context. *Physical Therapy*, 93(9), pp. 1244-1253.

Burckhardt, C. S. & Anderson, K. L. The Quality of Life Scale (QOLS): reliability, validity and utilization. *Health Quality Life Outcomes*, 1(60).
<https://doi.org/10.1186/1477-7525-1-60>

Burns, N. & Groves, S. K. (1993). *The practice of nursing research*. London: WB Saunders.

Care Quality Commission. (2018). *CQC inspection for Lancashire Care NHS Foundation Trust*. Accessed via <https://www.cqc.org.uk/provider/RW5> on 9/1/19.

Care Quality Commission. (2019). *CQC inspection for Lancashire Care NHS Foundation Trust*. Accessed via <https://www.cqc.org.uk/provider/RW5> on 9/9/19.

Cataldo, M. & Ehrlich, K. (2012). The impact of communication structure on new product development outcomes. *Proceedings of the SIGCHI Conference on Human Factors in Computing Systems*, pp. 3081-3090.

Centre for Market and Public Organisation. (2011). *Research in public policy*. Bristol: Bristol University.

Chartered Institute of Personnel and Development. (2014). *Developing managers to manage sustainable employee engagement, health and wellbeing*. London: CIPD.

Clarke, M. (2015). Co-production in mental health. *Mental Health Review Journal*, 20(4), pp. 213-219.

Clark, D., Jones, F., Harris, R. & Robert, G. (2017). What outcomes are associated with developing and implementing co-produced interventions in acute healthcare settings? A rapid evidence synthesis. *British Medical Journal Open*.
<https://bmjopen.bmj.com/content/7/7/e014650.citation-tools> accessed on 8/9/18.

Coalition for Collaborative Care (2016). *A co-production model*. London: Coalition for Collaborative Care

Coen, L. & Kearns, N. (2012). Co-producing innovation or innovating co-production? Responding to the contact needs of no-resident parents in the Republic of Ireland. *Child and Family Social Work*, 18, pp. 207-216.

Coffey, A. & Atkinson, P. (1996). 6th Ed. *Making sense of qualitative data: complementary research strategies*. London: Sage Publications.

Collins Dictionary. (1994). 18th Ed. *Collins English Dictionary*, Glasgow: HarperCollins Publishers.

Coote, A. (2002). *Claiming the health dividend: unlocking the benefits of NHS spending*. London: Kings Fund.

Critical Appraisal Skills Programme. (2018). CASP qualitative research checklist. (Online) <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist.pdf>. Accessed on 8/9/18 at 11.38.

Crow, G. & Wiles, R. (2008). *Managing anonymity and confidentiality in social research: the case of visual data in community research*. Economic and Social Research Council. Accessed via <https://eprints.soton.ac.uk/80291/>

Crowe, M., Sheppard, L. & Campbell, A. (2011). Comparison of the effects of using the Crowe Critical Appraisal Tool versus informal appraisal in assessing health research: a randomised control trial. *International Journal of Evidence-based Healthcare*, 9(4), pp. 444-449.

Currie, G. & Lockett, A. (2007). A critique of transformational leadership: moral, professional and contingent dimensions of leadership within public services organization. *Human Relations*, 60(2), pp. 341-370.

Curry, N. (2006). *Preventive social care. Is it cost effective?* London: Kings Fund.

Cutcliffe, J. R. (2003). Reconsidering reflexivity: introducing the case for intellectual entrepreneurship. *Qualitative Health Research*, 13(1), pp. 136-148.

Dalgarno, M. & Oates, J. (2017). The meaning of co-production for clinicians: an exploratory case study of practitioner trainers in one Recovery College. *Journal of Psychiatric Mental Health Nursing*. 25, pp. 349-357.

David, M. & Sutton, C. D. (2004). *Social research. The basics*. London: Sage Publications.

Davies, J., Sampson, M., Beesley, F., Smith, D. & Baldwin, V. (2014). An evaluation of knowledge and understanding framework personality disorder awareness training: can a co-production model be effective in a local NHS mental health Trust? *Personality and Mental Health*, 8, pp. 161-168.

Department of Health, (2010). *Practical approaches to co-production: Building effective partnerships with people using services, carers, families and citizens*, Department of Health: London.

Department of Health and Social Care. (2019). *NHS financial stability*. London: National Audit Office.

Edgren, L. (1998). Co-production – an approach to cardiac rehabilitation from a service management perspective. *Journal of Nursing Management*, 6(2), pp. 77-85.

Edwards, R. & Holland, J. (2013). 1st Ed. *What is qualitative interviewing?* London: Bloomsbury Publishing Inc.

Edwards, N. (2014). *Community services. How they can transform care*. London: Kings Fund.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A. & Hannigan, B. (2001). Stress and burnout in community mental health nursing a review of literature. *Journal of Psychiatric and Mental Health Nursing*, 7(1), pp. 7-14.

Enemark Larsen, A., Rasmussen, B. & Christensen, J. R. (2018). Enhancing client-centred practice with the Canadian Occupational Performance Measure. *Occupational Therapy International*, ecollection accessed via <https://pubmed.ncbi.nlm.nih.gov/30050391/>

Farmer, M. (2011). 1st Ed. *Cold tea and tears. It did happen to a dietician*. Beauchamp: Matador.

- Fenwick, T. & Nerland, M. (2014). 1st Ed. *Reconceptualising professional learning. Sociomaterial knowledges, practices and responsibilities*. London: Routledge.
- Filipe, A., Renedo, A. & Marston, C. (2017). The co-production of what? Knowledge, values and social relations in health care. *PLoS Biol* 15(5): e2001403. <https://doi.org/10.1371/journal.pbio.2001403>
- Foley, A. S. & Davis, A. H. (2017). A guide to concept analysis. *Clinical Nurse Specialist: The Journal of Advanced Nursing Practice*, 31(2), pp. 70-73.
- Fook, J. (2007). Reflective Practice and Critical Reflection. in Lishman, J. (1st Ed), *Handbook for Practice Learning in Social Work and Social Care, Second Edition: Knowledge and Theory*. London: Jessica Kingsley, pp. 363-75.
- Foot, C., Gilbert, H., Dunn, P., Jabbal, J., Seale, B., Goodrich, J., Buck, D. & Taylor, J. (2014). *People in control of their own health and social care. The state of involvement*. London: Kings Fund.
- Foot, C., Sonola, L., Bennett, L., Fitzsimons, B., Raleigh, V. & Gregory, S. (2014). *Managing quality in community health services*. London: Kings Fund.
- Fuchs, V. R. (1968). *Front matter, the service economy*. National Bureau of Economic Research.
- Frost, P. J. & Stablein, R. E. (1992). *Doing exemplary research*. UK: SAGE.
- Fugini, M., Bracci, E. & Sicillia, M. (2016). 1st Ed. *Co-production in the public sector*. London: Springer International Publishing.
- Ganga, D. & Scott, S. (2006). Cultural “insiders” and the issue of positionality in qualitative research: moving “across” and moving “along” researcher-participant divides. *Forum: Qualitative Social Research*, 7(3). Accessed via <http://www.qualitative-research.net/index.php/fqs/article/view/134/289>
- Gibbs, G. (1988). 1st Ed. *Learning by doing: a guide to teaching and learning methods*. Oxford: Oxford Polytechnic.

- Gilburt, H., Peck, E., Ashton, B., Edwards, N. & Naylor, C. (2014). *Service transformation. Lessons from mental health*. London: Kings Fund.
- Gillard, S., Simons, L., Turner, K., Lucock, M. & Edwards, C. (2012). Patient and public involvement in the coproduction of knowledge: reflection of the analysis of qualitative data in a mental health study. *Qualitative Health Research*, 22(8), pp. 1126-1137.
- Given, L. (2008). *The SAGE encyclopaedia of qualitative research methods*. London: SAGE Publications Inc.
- Glynos, J. & Speed, E. (2012). Varieties of co-production in public services: time banks in a UK health policy context. *Critical Policy Studies*, 6(4), pp. 402-433.
- Goldberg, B., Brintnell, E. S. & Goldberg, J. (2002). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. *Occupational Therapy in Mental Health*, 18(2), pp. 17-44.
- Guadarrama, I. N. (2002). 1st Ed. *Forging alliances in community and thought*. London: IAP.
- Hafford-Letchfield, T., Lambley, S., Spolander, G. & Cocker, C. (2014). *Inclusive Leadership in social work and social care*. Bristol: Policy Press.
- Hall, L.H., Johnson, J., Watt, I., Tsipa, A. & O'Connor, D. B. (2016). *Healthcare staff wellbeing, burnout and patient safety: a systematic review*. PliS ONE 11(7) e0159015 doi:10.1371/journal.pone.0159015.
- Ham, C. (2014). *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. London: Kings Fund.
- Hammersley, M. & Atkinson, P. (1995). 2nd Ed. *Ethnography: Principles in Practice*. London: Routledge.
- Handy, C. (1999). 4th Ed. *Understanding organizations*. London: Penguin Books.
- Hart, F. & Bond, M. (1995). 1st Ed. *Action research for health and social care. A guide to practice*. Buckingham: Open University Press.

Heath, J., Williamson, H., Williams, L. & Harcourt, D. (2018). "It's just more personal": using multiple methods of qualitative data collection to facilitate participation in research focusing on sensitive subjects. *Applied Nursing Research*, 43, pp. 30-35.

Heaton, J., Day, J. & Britten, N. (2016). Collaborative research and the co-production of knowledge for practice: an illustrative case study. *Implementation Science*, 11(20). Accessed via <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-016-0383-9>

Heyler, R. (2015). Learning through reflection: the critical role of reflection in work-based learning. *Journal of Work Applied Management*, 7(1), pp. 15-27.

Hoad, T. F. (1996). *The concise Oxford dictionary of English Etymology*. Oxford: Oxford Press.

Holloway, I. & Wheeler, S. (2013). *Qualitative research in health care*. New York: John Wiley & Sons.

Horgan, A., Manning, F., Bocking, J., Happell, B., Lahti, M., Doody, R., Griffin, M., Bradley, S. K., Russell, S., Bjornsson, E., O'Donovan, M., MacGabhann, L., Savage, E., Pulli, J., Goodwin, J., van der Vaart, K. J., O'Sullivan, H., Dorrity, C., Ellila, H., Allon, J., Hals, E., Stivast, J., Granerud, A. & Biering, P. (2018). 'To be treated as a human': using co-production to explore experts by experience involvement in mental health nursing education – the COMMUNE project. *International Journal of Mental Health Nursing*, 27, pp. 1282-1291.

Horne, M. and Shirley, T. (2009) *Co-production in Public Services: a new partnership with citizens*. London: Prime Minister's Strategy Unit.

Horton, K. & Patapan, H. (2004). 1st Ed. *Globalisation and equality*. London: Routledge Taylor Francis Group. Kettunen, P. (2010) "Co-production: A New Concept in Evaluation", paper presented at the Centre for Financial & Management Studies, SOAS, University of London 25 9th European Evaluation Society International Conference, 6-8 October 2010, Prague, Czech Republic. In

Asquer, A. (2012). *Co-investment in the co-production of public services: are clients willing to do it?* London: Centre for Financial and Management Studies.

Houghton, C., Casey, D., Shaw, D. & Murphy, K. (2013). Rigor in qualitative case-study research. *Nurse Researcher*, 20, pp. 12-7.

Hsu, J. S., Hung, Y. W., Chen, Y. H. & Huang, H. H. (2013). Antecedents and consequences of user coproduction in information system development projects. *Project Management Journal*, 44(2), pp. 67-87.

Johnson, R. B. & Onwuegbuzie, A. J. (2004). Mixed methods for research: a research paradigm whose time has come. *American Educational Research Association*. 33(7), pp. 14-26.

Kemp, V. (1985). Concept analysis as a strategy for promoting critical thinking. *Journal of Nursing Education*. 24(9), pp. 282-284.

Kettunen, P. (2010) "Co-production: A New Concept in Evaluation", paper presented at the Centre for Financial & Management Studies, SOAS, University of London 25 9th European Evaluation Society International Conference, 6-8 October 2010, Prague, Czech Republic. In Asquer, A. (2012). *Co-investment in the co-production of public services: are clients willing to do it?* London: Centre for Financial and Management Studies.

Kings Fund. (2002). *Claiming the health dividend: unlocking the benefits of NHS spending*. London: Kings Fund.

Kings Fund. (2012). *Leadership and engagement for improvement in the NHS. Together we can*. London: Kings Fund.

Kings Fund (a). (2014). *People in control of their own health and social care. The state of involvement*. London: Kings Fund.

Kings Fund (b). (2014). *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. London: Kings Fund.

Kings Fund. (2015). *Understanding organisational culture*. London: Kings Fund Insight Magazine (Autumn).

Kings Fund. (2018). *Reimagining community services making the most of our assets*. London: Kings Fund.

Kings Fund. (2019). *Brexit: implications for health and social care*. London: Kings Fund. <https://www.kingsfund.org.uk/publications/articles/brexit-implications-health-social-care> Accessed on 9/9/19.

Kotter, J. P. (1997). *Leading change*. Harvard: Harvard Business School Press.

Krane, V., Greenleaf, C. A. & Snow, J. (1997). Reaching for gold and the price of glory. A motivational case study of an elite gymnast. *The Sport Psychologist*, 11, pp. 53-71.

Krummaker, S. & Vogel, B. (2012). An in-depth view of the facets, antecedents and effects of leaders' change competency: lessons from a case study. *The Journal of Applied Behavioral Science*, 49(3), pp. 279-307.

La Guardia, J. G. (2009). Developing who I am. A self-determination theory approach to the establishment of health identities. *Educational Psychologist*, 44(2), pp. 90-104.

Lancashire Care Foundation Trust. (2019). *Lancashire Care NHS Foundation Trust*. Accessed via <https://www.lancashirecare.nhs.uk/media/Publications/Annual%20Plans-Accounts-Reports/Annual-Report-2018-19/Annual-Report-2018-19-Final.pdf> on 9/9/19.

Lancashire County Council (a). (2019). *Common and severe mental illness*. Accessed via <https://www.lancashire.gov.uk/lancashire-insight/health-and-care/health/mental-health-and-wellbeing/common-and-severe-mental-illness/> on 9/9/19.

Lancashire County Council (b). (2019). *Population history*. Accessed via <https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population/population-history-1891-2011/> on 9/9/19.

Lancashire's population increase 2002-2018 Accessed on 27/6/20 at <https://www.plumplot.co.uk/Lancashire-population.html>

Lancashire's population numbers 1981–2011 adapted from <https://www.lancashire.gov.uk/lancashire-insight/population-and-households/population-and-households-2011-census/lancashires-population/>
Accessed on 27/6/2020.

Langergaard, L. L. & Scheuer, J. D. (2009). Specificities of public sector service innovation. Roskilde: Roskilde University.

Lecluijze, I., Penders, B., Feron, F. J. M. & Horstman, K. (2015). Co-production of ICT and children at risk: the introduction of the Child Index in Dutch child welfare. *Children and Health Services Review*, 31(7), pp. 715-721.

Lincoln, Y. S. & Guba, E. G. (2000). *Paradigmatic controversies, contradictions, and emerging confluences*. In Denzin, N. K. & Lincoln, Y. S. 2nd Ed. *The handbook of qualitative research*. London: Sage.

Lindeke, L. L. & Sieckert, A. M. (2005). Nurse-physician workplace collaboration. *Online Journal Issues Nursing*, 10(1), pp. 5.

Loeffler, E., Power, G., Boviard, T. & Hine-Hughes, F. (2013). *Co-production of health and wellbeing in Scotland*. Edinburgh: Governance International.

Lwembe, S., Green, S. A., Chigwende, J., Ojwang, T. & Dennis, R. (2016). Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: an evaluation of a pilot service. *PubMed*, 18(1), pp. 14-23.

Machery, E. (2009). 1st Ed. *Doing without concepts*. Oxford: Oxford University Press.

Marshall, C. & Rossman, G. B. (2016). 1st Ed. *Designing qualitative research*. Singapore: SAGE Publications Inc.

Maticic, K., Maticic, M. K. & Puljak, L. (2019). Assessment of reporting quality of abstracts of systematic reviews with meta-analysis using PRISMA-A and

discordance in assessments between raters without prior experience. *BMC Medical Research Methodology*, 19(32), accessed via <https://doi.org/10.1186/s12874-019-0675-2>

Mayer, C. & McKenzie, K. (2017). '...it shows that there's no limits': the psychological impact of co-production for experts by experience working in youth mental health. *Health and Social Care in the Community*. 25(3), pp. 1181-1189.

McCourt, C. & Stevens, T. (2009). Relationship and reciprocity in caseload midwifery. *Emotions in Midwifery and Reproduction*, 17(35), pp. 1-20.

McKenna, H. (2016). *Five big issues for health and social care after the Brexit vote*. London: Kings Fund.

McLean, J., McNeice, V. & Mitchell, C. (2017). *Asset-based approaches in service settings: striking a balance. An illustration of asset-based approaches in services, and an exploration of their potential for the future*. Glasgow: Glasgow Centre for Population Health.

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: results of a household survey*. The NHS Information Centre for health and social care.

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). *Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014*. Leeds: NHS digital.

McGeechan, G. J., Woodall, D., Anderson, L., Wilson, L., O'Neill, G. & Newbury-Birch, D. (2016). A co-production community-based approach to reducing smoking prevalence in local community settings. *Journal of Environmental and Public Health*, 2016. Accessed on 27/6/2020.

McShane, M. (2015). *Good care needs to be co-production*. London: NHS England.

Mental Health Foundation. (2013). *Starting today. The future of mental health services*. London: Mental Health Foundation.

Merseycare. (2013). *A disability history timeline. The struggle for equal rights through the ages*. Liverpool: Merseycare.

Miles, M. B. & Huberman, A. M. (1994). 2nd Ed. *An expanded sourcebook. Qualitative data analysis*. London: Sage Publications.

Morse, J.M. (2000) Exploring pragmatic utility: concept analysis by critically appraising the literature. In: *Concept Development in Nursing: Foundations, Techniques, and Applications*, 2nd ed., 333–352. Eds. B.L. Rodgers and K.A. Knafl. Philadelphia: Saunders.

Morse, J. M. & Field, P. A. (1995). *Qualitative research methods for health professionals*. London: Sage Publications.

Murray, C. (2013). *Experienced-based co-design toolkit*. London: The Kings Fund.

National Audit of Schizophrenia. (2014). *Report of the second round of the National Audit of Schizophrenia (NAS2) 2014*. College Centre for Quality Improvement.

National Empowerment for Science, Technology & Arts. (2012). *UK innovation index: measuring the contribution of innovation to economic growth, and how this varies across sectors*. London: NESTA.

National Institute for Health and Care Excellence. (2011). *Common mental health problems: identification and pathways to care*. London: National Institute for Health and Care Excellence.

National Institute for Health and Social Care Excellence. (2015). *Transition between inpatient hospital settings and community or care home settings for adults with social care needs*. London: NICE.

National Occupational Standards (2013) SFHMH63: Work with people and significant others to develop services to improve their mental health.

<http://www.govint.org/>

Naylor, C., Alderwick, H. & Honeyman, M. (2015). *Acute hospitals and integrated care. From hospitals to health systems*. London: Kings fund.

Needham, C. (2009). *SCIE research briefing 31: Co-production: an emerging evidence base for adult social care transformation*. Accessed via <https://www.scie.org.uk/publications/briefings/briefing31/> on 9/9/19.

Needham, C. & Carr, S. (2009). *SCIE Research Briefing 31: Co-production: An emerging evidence base for adult social care transformation*, London: Social Care Institute for Excellence.

Nelson, G. A., King, M. L. & Brodine, S. (2008). Nurse-physician collaboration on medical-surgical units. *Medsurg Nursing*, 17(1), pp. 35-40.

NESTA. (2012). *People powered health co-production catalogue*. London: NESTA.

New Economics Foundation. (2010). *Right here, right now. Taking co-production into the mainstream*. London: NESTA.

New Economics Foundation. (2012). *Co-production. A manifesto for growing the core economy*. London: New Economics Foundation.

NHS England. (2014). *Five-year forward view*. London: NHS England.

NHS England (a). (2015). *Good care needs to be a co-production*. London: NHS England.

NHS England (b). (2015). *Co-production for personal health budgets and integrated personal commissioning*. London: NHS England.

NHS England. (2017). *Co-production for personal health budgets and integrated personal commissioning. Summary guide*. London: NHS England.

Nowell, L. S., Norris, J. M., White, D. E. & Moules, N. J. (2017). Thematic analysis: striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), pp. 1-13.

- O'Daniel, M. & Rosenstein, A. H. (2008). *Chapter 33: Professional communication and team collaboration*. In Hughes, R. G. (2008). *Patient safety and quality: and evidence-based handbook for nurses*. Rockville: Agency for Healthcare and Research Quality.
- Ochocka, J., Janzen, R., & Nelson, G. (2002). Sharing power and knowledge: Professional and mental health consumer/survivor researchers working together in a participatory action research project. *Psychiatric Rehabilitation Journal*, 25(4), pp. 379-387.
- O'Leary, Z. (2006). 1st Ed. *Researching real-world problems: a guide to methods of inquiry*. London: Sage Publications.
- Olsen, A. M. & Carter, C. (2016). *Responding to the needs of people who have learning disabilities and have been raped: co-production in action*. Salford: University of Salford. Accessible at <http://usir.salford.ac.uk/37157/>
- Osabiya, B. J. (2015). The effect of employee's motivation on organizational performance. *Journal of Public Administration and Policy Research*, 7(4), pp. 62-75.
- Osborne, S. P., Radnor, Z. & Strokosch, K. (2016). Co-production and the co-creation of value in public services: a suitable case for treatment? *Public Management Review*. 18(5), pp. 639-653.
- Ostrom, E. (1996). Crossing the great divide: Coproduction, synergy, and development. *World Development*, 24(6), pp. 1073-1087.
- Parahoo, K. 1997. *Nursing research: Principles, process and issues*. London: MacMillan Press.
- Penrod J. & Hupcey J. (2005). Enhancing methodological clarity: principle-based concept analysis. *Journal of Advanced Nursing* 50(4), pp. 403–409.
- Pestoff, V., Brandsen, T. & Verschuere, B. (2012). 1st Ed. *New public governance, the third-sector and co-production*. New York: Taylor Francis Group.

Peterson, N. (1993). Demand sharing: reciprocity and the pressure of generosity among foragers. *American Anthropologist*, 95(4), pp. 860-874.

Pinfold, V., Szymczynska, P., Hamilton, S., Peacocke, R., Dean, S., Clewett, N., Manthorpe, J. & Larsen, J. (2015). Co-production in mental health research: reflections from the people study. *Mental Health Review Journal*, 20(4), pp. 220-231.

Popay, J., Rogers, A. & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8(3), pp. 341-351.

Public Health Wales. (2013). *Co-producing services – co-creating health*. Wales: Public Health Wales.

Public Sector Research Centre. (2007). *The road ahead for public service delivery. Delivering on the customer promise*. UK: Pricewaterhousecoopers.

Qu, S. Q. & Dumay, J. (2011). The qualitative research interview. *Qualitative Research in Accounting & Management*, 8(3), pp. 238-264.

Radford, R. & Johnson, S. (2015). *NHS please don't kill me!: your survival guide to NHS care*. Leicestershire: Matador.

Ratanasiripong, N. T. & Chi, K. T. (2013). A concept analysis of attitude towards getting vaccinated against human papillomavirus. *Nursing Research and Practice*, Volume 2013, Article ID 373805. Accessed via <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3679858/>

Realpe, A. & Wallace, L. M. (2010). *What is co-production?* London: The Health Foundation.

Realpe, A., Wallace, L. M., Adams, A. E. & Kidd, J. M. (2015). The development of a prototype measure of the co-production of health in routine consultations for people with long-term conditions. *Patient Education Council*, 12;91(12), pp. 1608-1616.

Reid, J. & Russell, L. (2017). *Reflexivity and praxis: the redress of 'I' poems in revealing standpoint*. London: Emerald Group Publishing Ltd.

Repper, J. & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), pp. 392-411.

Richter, J., Mazurenko, O., Kazely, A. S. & Ford, E. W. (2017). How differences between manager and clinician perceptions of safety culture impact hospital processes of care. *Journal of Patient Safety*.

Roberts, A., Greenhill, B., Talbot, A. & Cuzak, M. (2012). 'Standing up for human rights': a group's journey beyond consultation towards co-production. *British Journal of Learning Disabilities*, 40, pp. 292-301.

Robson, C. (2002). *The role of personal learning orientations and goals in students' application of information skills in Malaysia*. Oxford: Blackwell Publishers Ltd.

Rodgers, B. K. (1989). Concepts, analysis and the development of nursing knowledge, the evolutionary cycle. *Journal of Advanced Nursing*, 14(4), pp. 330-335.

Roget's Thesaurus. (1982). *Roget's thesaurus of English words and phrases*. London: Penguin Reference.

Sanderson, H. & Lewis, J. (2012). *A practical guide to delivering personalisation: person-centred practice in health and social care*. London: Jessica Kingsley Publishing.

Schmidt, L. (2000). Respecting others: The hermeneutic virtue. *Continental Philosophy Review*, 33(3), pp. 359-379.

Sclater, E. (2009). *Practitioner's views on the most effective specific equality duties*. London: Equality and Human Rights Committee.

Scottish Community Development Centre. (2011). *Community development and co-production*. Glasgow: Scottish Community Development Centre.

- Seitanidi, M. M., Koufopoulos, D. N. & Palmer, P. (2010). Partnership formation for change: indicators for transformative potential in cross sector social partnerships. *Journal of Business Ethics*, 94(1), pp. 139-161.
- Seltzer, J. & Bass, B. M. (1990). Transformational Leadership: beyond initiation and consideration. *Journal of Management*, 16(4), pp. 693-703.
- Shier, M. L. & Graham, J. R. (2013). Organizations and social worker well-being: the intra-organizational context of practice and its impact on a practitioner's subjective well-being. *Journal of Health and Human Services Administration*, 36(1), pp. 61-105.
- Silverstein, M., Conroy, S. J., Wang, H., Giarrusso, R. & Bengtson, V. L. (2002). Reciprocity in parent-child relations over the adult life course. *The Journal of Gerontology*. 57(1), pp. 3-13.
- Simpson, J., Weiner, E. S. C. & Oxford University Press. (1989). 2nd Ed. *The Oxford English Dictionary*. Oxford: Oxford University Press.
- Slay, J. & Stephens, L. (2013). *Co-production in mental health*. New Economics Foundation: London.
- Slee, D. A., Slee, V. N. & Schmidt, H. J. (2008). 5th Ed. *Slee's health care terms*. Boston: Jones and Bartlett Publishers.
- Social Care Institute for Excellence. (2013). *Co-production in social care. What it is and how to do it*. London: SCIE.
- Social Care Institute for Excellence. (2015). *Co-production in social care: what it is and how to do it*. London: SCIE. Social Care Institute for Excellence (2018). *IMCA involvement in accommodation decisions and care reviews*. London: SCIE. Accessed via www.scie.org.uk/publications/guides/guide39/challenges. On 11/12/18.
- Starks, H. & Trinidad, S. B. (2007). Choose your method: a comparison of phenomenology, discourse analysis and grounded theory. *Quality Health Research*, 17(10), pp. 1372-80.

Stephens, L. & Ryan-Collins, J. (2008). *Co-production. A manifesto for growing the core economy*. London: New Economics Foundation.

Straus, S. E., Johnson, M. O., Marquez, C. & Feldman, M. D. (2014). Characteristics of successful and failed mentoring relationships: a qualitative study across two academic health centres. *Academic Medicine*, 88(1), pp. 82-89.

The Health Foundation. Inspiring Involvement (2010). *What is co-production?* London: The Health Foundation.

The Health Foundation & The Kings Fund. (2015). *Making change possible: a transformation fund for the NHS*. London: The Health Foundation & The Kings Fund.

The National Archives. (2013). *Annual report and accounts 2012-2013*. London: The Stationary Office.

The Oxford English Dictionary. (2010). 3rd Ed. *The Oxford English Dictionary*. Oxford: Oxford University Press.

The World Health Organisation. (2007). *Expert opinion on barriers and facilitating factors for the implementation of existing mental health knowledge in mental health services*. Oxford: The World Health Organisation.

Think Local Act Personal. (2018). *Where did co-production come from?* London: Think Local Act Personal. Accessed via www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/in-more-detail/where-did-co-production-come-from. On 11/12/18.

Toffler, A. (1980). 1st Ed. *The Third Wave*. United States: Bantam Books.

Toomey, A. H. (2009). Empowerment and disempowerment in community development practice: eight roles practitioners play. *Community Development Journal*, 46(2), pp. 181-195.

Tressier, S. (2012). From field notes, to transcripts, to tape recordings: evolution and combination. *International Institute for Qualitative Methodology*. 11(4), pp. 446-460.

TUC. (2015). *Mental health and the workplace. A TUC education workbook*. London: TUC.

Turner, A., Realpe, A. X., Wallace, L. M & Koamala-Anderson, J. (2015). A co-produced self-management programme improves psychosocial outcomes for people living with depression. *Mental Health Review Journal*, 20(4), pp. 242-255.

Tuurnas, S., Stenvall, M., Rannisto, J., Harisalo, R. & Hakari, M. (2015). Coordinating co-production in complex network settings. *European Journal of Social Work*, 18(3), pp. 370-382.

Væggemose, U., Vedel Ankersen, P., Aaggard, J. & Burau, V. (2017). Co-production of community mental health services: organising the interplay between public services and civil society in Denmark. *Health and Social Care in the Community*. 26, pp. 122-130.

Walker, L. O. & Avant, K. C. (1995). 4th Ed. *Strategies for theory construction in nursing*. New Jersey: Pearson Prentice Hall.

Walker, L. O. & Avant, K. C. (2005). *Strategies for theory construction in nursing*. USA: Pearson/Prentice Hall.

Webb, C. (1986). Action research: philosophy, methods and personal experiences. *Journal of Advanced Nursing*. 14(5), pp. 403-410.

Welsh Health Survey 2015: *Health status, illness, and other conditions*.

West, E., Barron, D. N., Dowsett, J. & Newton, J. N. (1999). Hierarchies and cliques in the social networks of health care professionals: implications for the design of dissemination strategies. *Social Science and Medicine*, 48(5), pp. 633-646.

Wholin, C. (2014). *Guidelines for snowballing in systematic literature studies and a replication in software engineering*. Accessed via <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.709.9164&rep=rep1&type=pdf> on 9/9/19.

Williams, A. W., Dwyer, A. C., Eddy, A. A., Fink, J. C., Jaber, B. L., Linas, S. L., Michael, B., O'Hare, A. M., Schaefer, H. M., Shaffer, R. N., Trachtman, H., Weiner, D. E., Falk, A. R., American Society of Nephrology Quality & Patient Safety Task Force. (2012). Critical and honest conversations: the evidence behind the "choosing wisely" campaign recommendations by the American Society of Nephrology. *Clinical Journal of American Society Nephrology*, 7(10), pp. 1664-1672.

Wilson, J. (1969). *Thinking with concepts*. Cambridge: University Press. (Original work published in 1963).

Wrightington, Wigan and Leigh NHS Foundation Trust. (2019). *What are the benefits of foundation trust status?* Accessed via http://www.wwl.nhs.uk/foundation_trust/foundation_trust_app.aspx on 9/9/19.

Wise, J. (2018). Survey of UK doctors' highlights blame culture within the NHS. *British Medical Journal*, 362. Accessed via <https://www.medicalprotection.org/uk/articles/two-in-three-doctors-believe-there-is-still-a-blame-and-shame-culture-in-the-nhs-mps-survey-reveals>

Yin, R. K. (2014). 5th Ed. *Case study research. Design and methods*. Thousand Oaks, CA: Sage.

Appendices

Appendix 1 - Systematic Literature Review Protocol

1. Change Record

Updates/changes	Version	Reasons for change
Change to search terms	2	Completion of concept analysis
Change to review plan/ research questions	3	Change in focus following development of research questions
Update on research strategy and synthesis table	4	Third literature review completed and new articles identified.

2. Background

a) The problem in practice

Pressure on the NHS is resulting in increased stress levels, poor job satisfaction and increased sickness rates. Subsequently, this has resulted in an inability to recruit and retain staff. Significant 'disconnect' between senior management and frontline staff is present which appears to be worsening. The organisation was implementing a co-production model, but there was little knowledge or evidence of this in practice and therefore it was pertinent to review how this model was implemented, how effective it was in practice and how well it was communicated to staff.

b) The main research question being addressed by this study

This study aims to evaluate the implementation of a co-production model within an NHS Trust in a community mental health setting, shaped by management and clinical leads' perspectives. The objectives of this research are as follows: 1) to determine and define what co-production is and which model of co-production was used the Trust; 2) to identify how core characteristics of co-production were implemented within the organisation; 3) to gain an understanding of clinical leads

and managers' knowledge, skills, and attitudes towards co-production within community mental health teams (CMHTs) and how this has affected implementation; 4) to offer recommendations to the organisation and the wider research community to enhance co-production in practice.

3. Search Strategy

a) Policy review

An initial policy review was completed to provide a background picture to co-production within the NHS. It was hoped that conducting this preliminary search would provide a historical context and understanding of the development of co-production as a concept. The review focused on the key emerging notions arising from secondary data sources, focusing on drivers and barriers to successful co-production. Focus was afforded to areas specifically associated with service transformation and co-production including, change, power, collaboration, information sharing, assets and NHS leadership. A full search strategy for the policy review is available in Chapter 1.

b) Review of relevant articles

Following on from the policy review a theoretical literature review was conducted utilising forward and backward snowballing (as noted in Chapter 2). The aim of the review was to focus on the available co-production literature and highlight gaps which required addressing and provide a focus for the research study. An automated search utilising the databases available through SOLAR at the University of Salford was determined as the most appropriate approach to increase yield following the snowballing, due to the scope of access to articles and the time which this takes in comparison to manual searching.

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
Bradley (2015) UK	To provide a brief overview of co-production literature to date within mental health in the UK. The aim was clear and stated early on.	Review of studies, there was no clear system for reviewing the articles and no systematic approach adopted. A systematic literature review would have increased the credibility/ reliability of the paper's findings.	Not addressed as not a research study which is appropriate.	No clear outline of articles sampled or method of selection. This impacts on the credibility/ reliability of the paper.	No clear approach to analysis of the papers reducing reliability. The article presents a summary of studies.	results found professionals do not always recognise these assets and there is no guide for implementation	No clear synthesis process meant rigor was not attained within this paper. This has implications for application of findings.
Gillard, Simons, Turner, Luccock, and Edwards (2012) UK	Provided a clear aim - the co-production of knowledge to aid communication improvement	Mixed methods cohort study	No discussion of whether research approval was attained, no mention of potential issues and no outline of the research framework utilised.	120 new users of a range of adult mental health services. Increasing the sample size could have increased the reliability of the findings.	Interviews were conducted at commencement with the service, and again nine-months later. Baseline data was acquired, comparable to later findings which added to the reliability and authenticity of results.	co-production knowledge influenced areas of practice, such as positive risk taking	The approach was appropriate and well described which increased the rigor.
Heaton, Day, and Britten (2016) UK	Aimed to address the question: what does the theory of co-production add to our understanding of the process of knowledge creation and translation in PenCLAHRC? The aim is clear however could have been presented more prominently in the abstract.	Illustrative case study which was an appropriate methodological selection	No ethical approval was required – this was confirmed by the chair of a NHS local research ethics committee. Information was given to participants and consent gained. Could have been strengthened by identifying which research framework	54 semi-structured interviews with programme stakeholders (some of whom were interviewed twice) and 28 members of four case study projects. The sample size was appropriate increasing the study's credibility.	Semi-structured interviews were an appropriate data collection method allowing the aims of the study to be met. To strengthen the trustworthiness of the study they carried out further analysis of one of the research projects.	They found that participants were cognisant of the role of frontline professionals who were perceived to be the users of the pathway and thus they were critical to the development of pathway changes	There was no clarification as to why some people were interviewed twice or why these were counted as separate within the sampling. More explanation would have increased rigor and the ability to replicate the study.

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
			they were following.				
Horgan, Manning, Bocking, Happell, Latiti, Doody, Griffin, Bradley, Russell, Bjornsson, O'Donovan, MacGabhan n, Savage, Puli, Goodwin, van der Vaart, O'Sullivan, Dorrity, Ellila, Allon, Sitvast, Granerud, and Biering (2018) International (Finland, Norway, Ireland, Iceland, and Australia)	develop an understanding of the contribution of EBE to mental health nursing.	Qualitative descriptive design.	Ethical approval was gained from every university ethics committee . Consideration of risks and benefits occurred, and informed consent was gained.	50 participants over eight focus groups.	Focus group interviews were conducted in seven sites, Finland, Norway, Iceland, the Netherlands, Ireland (two universities), and Australia with a convenience sample.	the value of EBE on enhancing student' understanding of recovery and the importance of self-reflection to inform future nursing practice.	Conducted across multiple international sites meant results were comparable and thus transferrable. The use of multiple sites and multiple researchers increased the study's trustworthines s.
Dalgarno and Oates (2017) UK	To explore the meaning of co-production for clinicians based on their experience of co-production in recovery colleges.	Qualitative approach, although there is no clear link to a methodological approach such as IPA, ethnography.	Approval from NRES and university ethics. There was a research protocol in place to ensure participant safety. Main ethical concerns were identified and addressed .	Eight participants who volunteered. This would suggest ... sampling, however this was not specified within the paper. There was no clear rationale for the recovery colleges selected which decreases the authenticity.	They used thematic analysis of eight semi-structured interviews with clinicians who co-delivered recovery college workshops. Data analysis was rigorous, with authenticity ensured via initial coding being ratified by a second researcher, providing assurance to the study's value	the meaning of co-production had four themes: definition, power dynamic, negotiating roles and influence on practice. Participants re-evaluated their expert role within relationships with service users, consequently improving their interactions in practice.	did consult with participants about their interview guides, fitting with a co-production ethos increasing credibility.
Mayer and McKenzie (2012)	review the psychological impacts of co-production on	Phenomenological study using IPA which was an appropriate	Ethical approval was attained,	Convenience sample of five males. This is a relatively	face to face, semi-structured interviews	Three master themes were yielded including: the	The study did aim to prevent identifying participants,

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
UK	EBE working in mental health. The aim was clearly stated within the abstract.	methodology to meet the study aims.	however there was no discussion of the research framework which was utilised. There was no mention of potential ethical issues.	small sample and the lack of recruitment of females means the sample is not representative, impacting on credibility.	focusing on what co-production meant. Method selection was appropriate to address the study aim. IPA was used to conduct the analysis.	co-production approach, I'm a professional and identities in transition	although they could have addressed the small sample size to improve rigor.
Davies, Sampson, Beesley, Smith, and Baldwin (2014) UK	Their study reviewed the implementation of personality disorder training for NHS staff.	A repeated measures within participants design was used.	There was no discussion of ethical implications or approval being gained.	204 participants in the training and 162 questionnaires completed. This was a reasonable representative sample.	Self-report questionnaire data was compared at three point in time which allowed them to review the training impact at separate stages increasing credibility and reliability. Whilst the study design was comprehensive it would be challenging to replicate without information on course content.	staff found training to be a powerful experience, viewing service users in a positive role, gaining an understanding into their condition.	Sessions focused on service user involvement and co-production to engage professionals in personality disorder training. EBE were integral to the delivery and researchers provided training to volunteers presenting the programme - a positive of the study.
Væggemose, Vedel, Ankersen, Aaggard, and Burau (2017) International (Denmark)	investigating how providers and staff operated within the two logics of public service and civil society in Denmark. The aim was clearly stated within the abstract.	Case Study which was an appropriate methodological selection to meet the study's aim. The case study consisted of two cases municipalities.	Danish legislation did not require ethical approval, however a research framework was adopted to guide the project ensuring participant safety.	Interviews with six co-ordinators and two managers. Selection of the municipalities used deviant case sampling which increased authenticity.	participant observations and semi-structured interviews in two municipalities, with rationale for the selection of sub-cases well-presented although, the complex nature of the selection could make replication challenging	Results confirmed the central role played by staff and the interplay between civil society logic (what users and families find meaningful) and public services. Collaborative relationships are key for facilitating co-productive practice.	had no consideration for service user's views on collaboration or the part they played in the process which reduced credibility. consideration of transferability to UK services required thought on how staff engagement differed

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
					participant observations and semi-structured interviews in two municipalities, with rationale for the selection of sub-cases well-presented although, the complex nature of the selection could make replication challenging		between countries and how the different healthcare systems impacted on working lives.
Edgren (1998) International (Norway)	The aim was clearly stated – to describe and analyse the hospital delivery system for patients recovering from myocardial infarction, applying the offering and values concept from service management theory.	Case study methodology which was appropriate for addressing the aim. Author also provided a clear rationale for selection of this approach.	Ethical approval was gained and ethical consideration in the design of the study was noted.	12 individual interviews with eight staff members and four service users). Participant selection methods were unclear impacting on credibility although sample size was not considered an issue due to the methodological selection.	Interviews were conducted which was an appropriate data collection method to meet the study aim.	Results suggested that inpatient admissions can provide advantageous environments to co-produce with service users, by asset utilisation and distribution of power.	study findings cannot be extrapolated fully to all settings impacting on transferability.
Realpe, Wallace, Adams, and Kidd (2015) UK	to review consultations with individuals with long term conditions	a sequential mixed method design utilising eleven experts to develop the measure	No discussion of ethical approval, research framework or potential issues.	11 expert views were gathered to develop a tool. This tool was applied to 50 video-recorded consultations. The tool was only designed by professionals and did not include service users reducing the credibility due to incomplete co-production.	observed 50 videoed consultations, to correlate the use of the identified behaviours with service users to test reliability and credibility. The study design was thorough highlighting that the measure could be used to guide professionals through	the guide was beneficial and noted an increase in the use of co-production behaviours	this could be a guide which could be implemented in practice to improve professionals' interactions with long term conditions service users

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
					consultation s.		
Tuurnas, Stenvall, Rannisto, Harisalo, and Hakari (2015) International (Finland)	to find out how complex network structures meet the co-production process in the context of social and health care services. The aim was clearly stated.	Case study was used which was an appropriate methodological selection to meet the study aims.	Ethical approval was not discussed, nor was a research framework .	19 workers from 12 organisations were interviewed. Service users were not interviewed, despite the potential benefits of their experiences, suggesting co-production was not fully attained.	semi-structured interviews. Analysis of data was via content analysis which is an appropriate analysis technique. Analysis was completed in three sections	the need for effective leadership to encourage service user co-production	There was little instruction from researchers during the interviews which meant that findings were direct responses from participants which had not been influenced by potential bias, increasing the credibility.
Coen and Kearns (2012) Republic of Ireland	co-production's impact when opening a play centre, allowing non-resident parents contact with their children. The study aimed to gain insight into participants' experiences and findings demonstrated that encouraging service user involvement and staff withdrawal was determined by professionals and not a joint decision	Case Study was utilised and qualitative data collection which was clearly justified.	No discussion of ethical approval or research framework .	Seven non-resident parents were interviewed. The sample was all males; however, this is representative of the fact non-resident parents are usually male meaning the sample was representative.	evaluated a 12-month pilot scheme utilising qualitative data for analysis. 48 non-resident parents were invited to complete a questionnaire and self-select for an interview. Documentary research and field analysis were also conducted.	challenges existed when distributing power. Involving service users in the operation and refinement of the project was crucial. The role of centre staff was initially critical to establish the project. Staff were making decisions on when to step back from involvement with service users; however, this was not a co-produced decision.	The study was rigorous however there was not consideration about how power had not been equally distributed through staff advising participants when to withdraw.
Roberts, Greenhill, Talbot, and Cuzak (2012) UK	how co-production can empower thinking and how rights can be upheld to ensure equal treatment	Action research which was an appropriate selection due to the desire to enact change. A clear rationale was provided for the selection of methodological approach.	No discussion of ethical approval, research framework or potential issues.	Six service users. The sample size was relatively small, which could reflect challenges with engaging individuals with learning disabilities in co-produced activities, however due to the methodological selection credibility was	All participants were active members of community learning disability teams and attended groups over 24 weeks (90-minute sessions over 6 months)	People with learning disabilities have their own stories to tell. Group members created a character called FREDA to illustrate how human rights laws affect them. The original plan was not followed; instead, it developed based on the	Service users were not interviewed which could have increased the credibility of the study.

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
				not negatively impacted		groups agreed outcomes.	
Lecluijze, Penders, Fernon, and Hortsman (2015) International (Netherlands)	aimed to improve understanding of socio-technical processes in child welfare and how risk was constructed within the process.	Longitudinal qualitative study - A four-year, ethnographic study	No discussion on ethical approval or research framework	58 semi-structured interviews, including professionals and policy makers. This was a large sample	Semi-structured interviews for data collection and systematic process of coding for analysis.	Interaction between local and national differences as well as between disciplinary and organisational differences produced various constructions of risk. The Child Index did not fit well with professionals' daily practices.	Whilst rigor was attained, the study did not link specifically to the area of research and was only included as it was felt one point was transferrable.
Olsen and Carter (2016) UK	examined co-production's influence through action learning methods to discuss the experiences of women with learning disabilities who were raped	Action Learning which was an appropriate co-production approach to the research.	No discussion on ethical approval or research framework .	Eight women. Diversity of the learning set sample provided a variety of experiences and opinions, supporting a multifaceted approach	Learning sets were completed. Group discussions and escalating of concerns allowed the group to address and resolve issues. Not clear how data was analysed which impacts on the credibility.	The process allowed organisations to explore issues from a range of perspectives. Co-production, whilst highlighting competing priorities, can also provide a means of managing these tensions.	The study methodology could have been clear in terms of how data was collected and analysed which would have increased the rigor.
Lwembe, Green, Chigwende, Ojwang, and Dennis (2016) UK	examine the use of co-production in improving healthcare services for black and minority mental health service users	Qualitative research methods	No discussion of ethical approval or a research framework .	25 participants were enrolled, however 10 were signposted to more intensive services for support. The study had a 75% retention rate which was significantly higher than studies with black and minority ethnic service users, suggesting that the research approach was engaging 11 service users completed treatment and	Semi-structured interviews and focus groups. Handwritten field notes and audio recordings were made. Validation occurred increasing authenticity.	A 75% retention rate was noted (which is higher than usual for BME groups). The project helped to overcome barriers to accessing mental health services. Co-production could lead to the delivery of patient-centred services to improve access and experience within mental health services for BME groups.	The study however was small and therefore their findings required more rigorous analysis on a larger scale.

Article	Question, Aim, Objectives	Research Method	Ethical issues	Sample/ Recruitment	Data collection/ analysis	Findings	Rigor
				were included in the study.			

c) Concept Analysis

A concept analysis determined appropriate in response to a review of several journal articles identifying a lack of clarity about what co-production means in both the scoping and the literature review. It was therefore deemed essential to review the concept and seek some understanding of what the concept means and what defining attributes are required to be in place for co-production to be a success. Walker and Avant's (1995) model of concept analysis was adopted for the analysis as it provided a step by step guide to the process and was clear in what information was required to successfully clarify the concept.

d) Resources to be used (digital libraries and search engines)

The following Electronic databases were accessed to capture relevant research articles:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL): provided access to a breadth of relevant nursing literature linking directly to the subject group of interest, as most managers within the Trust are nurses.
- Medical Literature On-Line (MEDLINE): the largest United States (US) medical database and was utilised as co-production was founded in the US; it was important to include related articles.
- Academic Search Premier: a renowned database, spanning multiple disciplines and, as an OT, it was essential to consider evidence from across professions to gain scope of co-production in practice.

The review comprised three search phases as outlined in table 8.

Review Phase	Dates
Initial review	February 2016-August 2016
Second review	November 2016-March 2017
Final review	August 2018 – present

Table 8 – Review Phases

Three phases ensured continuous review of new literature. Databases were searched initially in 2016, but update searches were conducted between August 2018 and January 2019, where all available databases were used. Key words were used to attain relevant literature

Key word: co-production, healthcare, mental health, assets, equality, capacity, networks, catalysts, reciprocity

e) time-period to be covered by the review and rationale

A time limit of the last 10 years was utilised for all searches. This was to ensure that information collated is current and applicable. Additionally, as co-production is newly developing it was deemed unlikely that a wider search would produce any additional yield.

f) Ancillary search procedures

Websites including the King's Fund, and Social Care Institute for Excellence (SCIE) were accessed as they are independent bodies to the NHS who had been focusing work on co-production. Most of their information can generally be found in journal articles and website reports into co-production studies which had been undertaken.

Also, searching of the reference lists of the primary search articles occurred as it was anticipated that this could lead to similarly relevant studies which could enhance the literature review.

4. Selection Criteria

a) The aims of this theoretical review were considered. Studies available in English were included and those not in English were excluded. Articles not related to theory testing co-production were excluded. No time limit was applied due to the newness of the subject matter. To support the review's theoretical nature, all relevant information about the concept required consideration.

b) How the selection will be undertaken

As described snowballing (both forward and backwards) was utilised to support article selection.

5. Study Quality Assessment

a) Quality checklists

The Critical Appraisal Skills Programme (2017) (CASP) tools were utilised for guidance. As most articles were qualitative, the qualitative tool was used most frequently. CASP was selected due to the structured process and it is also considered as suitable with a wide audience in healthcare settings (Public Health Resource Unit, 2006). As CASP had no tool for reviewing mixed methods studies, the Mixed Methods Appraisal Tool (Crowe, Sheppard & Campbell, 2011) ensured rigor of all studies was tested. Additionally, through utilising the tools judgement was able to be made about which evidence to consider trustworthy. Most articles reviewed were theory-generating; mainly due to co-production being used as a model to conduct the research. These reviews focused on theory-testing articles where co-production directly related to practice; however, some theory-generating papers were still pertinent and were included.

6. Data Extraction

a) design data extraction form (and check via a dry run)

Question	Review findings
Clear statement of aims?	
Appropriate methodology?	
Appropriate design to meet aims?	
Appropriate recruitment strategy?	
Appropriate data collection to address research issue?	
Researcher/participant relationship considered?	
Ethical issues considered?	
Data analysis sufficiently rigorous?	
Clear statement of findings?	
How valuable is the research?	

b) The strategy for extracting the data

The plan was to switch between reading primary papers, data extraction and synthesis/interpretation in several cycles as key themes and questions emerged from the synthesis. These themes would then be cross-checked against the primary papers. Each article will be scrutinised against the CASP qualitative research tool. Once the data extraction form is completed, articles will be revisited to answer other questions such as if they are theory generating or theory testing.

Literature Summary Table

Can be located on page 58 in Chapter 2

7. Synthesis

A table was devised to support the synthesis of information reviewed. The main ideas were constructed and then author's views on this point were documented to allow development of arguments with a view to establishing of new ideas.

8. Reporting

The report writing was aimed at healthcare professionals who work within the NHS and any healthcare setting looking to implement a co-production model. The report is also part of the professional doctorate course and therefore written with the academic standards expected in mind. It is hoped that the report will be published in academic journals to support the development of practice for healthcare professionals.

9. The need for a study on this topic

In a bid to introduce innovation, using the existing resources, co-production is being adopted as a critical approach to public policy in healthcare (Needham, 2009; Department of Health, 2010) and is considered a cornerstone of policy reform around the world (Horne & Shirley, 2009). Within the Trust this model is currently being implemented alongside a new collaborative leadership strategy, which is expected to impact on how all professionals work. Therefore, it is important that the impact of this implementation is considered and explored.

Whilst many concede that co-production is an essential framework for improvement to service, it is suggested that 75% of change initiatives are unsuccessful because of leaders having a different set of expectations and ideas (Bevan 2006). Therefore, it is imperative that the understanding of staff within the organisation be considered and studied further. Additionally, Evans-Blacko, Jarrett, McCrone & Thornicroft (2010) identify the importance of finding the facilitators and barriers to implementing change, and with co-production literature still in its infancy, there is a need for this work to be considered and explored - the driver for the proposed research.

10. Schedule

Supervisions were held regularly to support the process of the above (see Appendix 22) and timeframes are outlined in the GANTT chart (see Appendix 23).

Appendix 2: CASP Critique Example

Nadeau, L., Jaimes, A., Rousseau, C., Papazian-Zohrabian, G., Germain, K., Battaglini, A. & Measham, T. (2012). Partnerships at the forefront of change: documenting the transformation of child and youth mental health services in quebec. <i>PubMed</i> , 21(2), pp. 91-97.	
CASP Questions	Review
1. Was there a clear statement of the aims of the research?	The aims didn't feel clear within the abstract. Within the study there is a subheading for goals of the study, which does however outline the main three aims of the study. The aims were felt to be valid as three CSSSs that had recently put in place YMH teams, with on site or visiting psychiatrist to review outcomes.
2. Is a qualitative methodology appropriate?	Yes, as the study aims to highlight the subjective experiences of the participants and looks at the dynamics of collaboration in CYMH services. (Whilst this study was mixed methodology the write up was focused on the qualitative data acquired).
3. Is it worth continuing? Was the research design appropriate to address the aims of the research?	Not much research was reviewed to identify the need for the study. Just a background history of the service was provided, which whilst it sets the scene does not explore whether similar methods implemented in other institutes/countries could have been applied. The study is reported to as a mixed method but there is no mention of the quantitative data collection. Also, no consideration of alternative methodological approaches or justification for their selections.
4. Was the recruitment strategy appropriate to the aims of the research?	They identified participant by purposeful sampling to ensure representation of the different teams' diversity of training and experience. It did not describe how recruitment occurred practically, however. They noted child psychiatrists were not interviewed but they did not quantify why. They stated that they wanted representation of diversity yet chose not to include a profession who could have contributed. No mention of if informed consent was obtained. Although it could be assumed that be attending the interviews consent was assumed, this is not specified.
5. Was the data collected in a way that addressed the research issue?	It was clear how data was collected and discussed clearly. No justification was given to two of the chosen methods. They discuss a joint meeting with workers to enrich the preliminary findings (however 45 people were involved suggesting the findings were discussed outside of the participants originally selected). This was no clear. They conducted participant observations to contextualise results, but it is not clear how many people were observed or if these were involved in the interviews. No discussion about how the interviews were conducted or if a topic guide was used. Not clear if interviews were tape recorded and had written, but thematic analysis was completed separately by the two researchers then compared finally being validated by the research team.
6. Has the relationship between researcher and participants been adequately considered?	There was no exploration of the relationship. Assistants were used to conduct the interviews, which could remove some of the researcher bias. They mentioned how prospective qualitative data is useful in complex systems but there was no discussion about why the sample size was selected.
7. Have ethical issues been considered?	Ethical approval was sought but no discussion about informed consent was had. CSSS de la Montagne ensures that research subjects, including adults and minor's incapable of giving consent are protected. They have a regulatory framework.
8. Was the data analysis sufficiently rigorous?	(+) two researchers analysed data separately to increase accuracy of interpretation. (+) The whole research team validated findings. (-) not clear how information was collected (i.e. taped, hand written) (-) no discussion at how themes were derived – they are merely presented. (-) no in-depth discussion about data analysis. (-) lack of direct information from participants displayed. (-) no consideration about their own influence on the study.
9. Is there a clear statement of findings?	(-) no discussion about credibility.

	<p>(-) no one clear statement of findings</p> <p>(+) throughout reading the findings did become clearer.</p> <p>(+) the findings to link to the original question.</p>
<p>10. How valuable is the research?</p>	<p>(-) no previous discussion of existing knowledge</p> <p>(-) no comparison to other HCS in other countries</p> <p>(+) they identified the other areas of research to explore evolving partnerships.</p> <p>(-) no discussion about how the research could be applied to other areas.</p> <p>(-) no clear direct link with co-production in current healthcare settings.</p> <p>Therefore, the study was deemed not appropriate for inclusion within the literature review.</p>

Appendix 3a: Initial Search – February 2016 to August 2016

Key words: co-production, healthcare, mental health, collaboration

Search Engine Used	Search Terms	Publication Date	Number of results		
			Any content Type	Relevant Articles	Duplicates
CINAHL	co-production AND mental health	Any	14	4	0
CINAHL	co-production AND healthcare	Any	19	8	2
Academic Search Premier	co-production AND mental health	Any	26	7	0
Academic Search Premier	co-production AND healthcare	Any	91	13	2
MEDLINE	co-production AND mental health	Any	8	3	0
MEDLINE	co-production AND healthcare	Any	38	7	3
CINAHL and MEDLINE	collaboration AND mental health	Any	4543	30	0

Table 1 – Initial Search (February - August 2016)

Appendix 3b: Second Search – November 2016 to January 2017

Key words: co-production, healthcare, mental health, collaboration

Search Engine Used	Search Terms	Publication Date	Number of results			New relevant articles
			Any content Type	Relevant Articles	Duplicates	
CINAHL	co-production AND mental health	Any	15	4	0	0
CINAHL	co-production AND healthcare	Any	21	9	2	1
Academic Search Premier	co-production AND mental health	Any	32	13	0	6
Academic Search Premier	co-production AND healthcare	Any	106	17	4	4
MEDLINE	co-production AND mental health	Any	12	7	0	4
MEDLINE	co-production AND healthcare	Any	45	7	4	1

Table 2 – Second Search (November 2016 – January 2017)

Appendix 3c: Final Search – August 2018

Key words: co-production, healthcare, mental health, assets, capacity, networks, equality, catalysts, reciprocity


Search Engine Used	Search Terms	Publication Date	Number of results			New relevant articles
			Any content Type	Relevant Articles	Duplicates	
CINAHL/MEDLINE/ Academic Search Premier	co-production AND mental health AND healthcare	Any	67	16	10	6
CINAHL/MEDLINE/ Academic Search Premier	co-production AND assets	Any	39	4	2	2
CINAHL/MEDLINE/ Academic Search Premier	co-production AND capacity	Any	156	6	3	3
CINAHL/MEDLINE/ Academic Search Premier	co-production AND equality	Any	24	5	3	2
CINAHL/MEDLINE/ Academic Search Premier	co-production AND reciprocity	Any	8	0	0	0
CINAHL/MEDLINE/ Academic Search Premier	co-production AND networks	Any	241	4	2	2
CINAHL/MEDLINE/ Academic Search Premier	Co-production AND catalysts	Any	284	0	0	0

Table 3 – Final Search (August 2018)

Appendix 3d – Theory Generating Articles from Searches

Search Engine Used	Theme	Number of Theory Generating Articles
CINAHL/MEDLINE/ Academic Search Premier	Co-production and mental health	10
CINAHL/MEDLINE/ Academic Search Premier	co-production and physical health	3
CINAHL/MEDLINE/ Academic Search Premier	co-production and children's services	2
CINAHL/MEDLINE/ Academic Search Premier	co-production learning disabilities	2


Appendix 4: Organisational Letter

Lancashire Care 
NHS Foundation Trust

Lancashire Care NHS Foundation Trust
Sceptre Point
Sceptre Way
Walton Summit
Preston
PR5 6AW

Tel: 01772 695311

16th August 2016



Team Leader
Pendle CMHT
Pendle House
Leeds Road
Nelson
BB9 9TG


Dear 

I hereby give consent for you to undertake your research project on "What co-production means within mental health" within Lancashire Care NHS Foundation Trust as part of your professional doctorate at the University of Salford.

Yours faithfully




Chief Executive

 Supporting Health and Wellbeing

Chair: David Eva Chief Executive: Professor Heather Tierney-Moore OBE



Appendix 5: Presentation for the board

Doctoral Research

Hayley Bamber MSc
Professional Doctorate Student
University of Salford

About the researcher

Professional work:

- Qualified as an OT in 2006 and started working in a forensic hospital (2 years)
- Moved to LCFT in 2008 to work as an OT in the CMHT
- In 2010 set up a recovery service as the clinical lead OT
- In 2013 moved over into management of the CMHTs.

Academic work:

- BSc (Hons) Occupational Therapy
- MSc Advanced Occupational Therapy - dissertation – "What leadership style is likely to promote the best outcomes when Occupational Therapists work with Support Time and Recovery Workers?"
- Currently on the professional doctorate course focusing research on co-production.

What is co-production?

- Not a well defined term – completed a concept analysis.
- Core characteristics include:
 - Equality/blurring roles
 - Assets
 - Capacity
 - Catalysts
 - Networks
 - Reciprocity/mutuality



The issue

- Decreased government funding for NHS Trusts
- Increased pressure on frontline services
- Lack of resources
- Aging population
- Possible implications of Brexit ...
- ...all lead to needing to think about how services are provided, hence the introduction of co-production...
- ...as we can use SU's direct knowledge and skills as well as their lived experience to support the design and delivery of a "best fit" service which will provide a more cost effective service, in turn having a quicker and more efficient throughput of service users.

Research topic

- 'An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental health care setting.'

Project Summary

- The overall purpose of this project is to examine how a co-production model is implemented in an NHS mental health Trust. This case study will identify three staff groups' understanding of what co-production is. It will also compare the model being implemented to the relevant literature to identify evidence that can be used to inform a guide to optimise implementation which can be adopted by other agencies. I propose to conduct interviews with senior managers, middle managers and clinical leads within a mental health service to ascertain their understanding of the co-production model which is in operation within the Health Trust where I work.

Project Objectives

- To examine knowledge, skills and beliefs of a range of senior managers, middle managers and clinical leads who work in an NHS mental health setting that is implementing co-production.
- To identify drivers and challenges to delivering co-production as a means of improving services within an NHS mental health setting in the NW of England.

Rationale

The literature review highlighted that:

- limited co-production research within mental health settings.
- For co-production to be successful the negative impacts of practice must be addressed and practice itself must be willing to adapt to accommodate this process.
- All parties involved must be open to collaboration and power needs to be shared equally regardless of capacity.
- Challenges such as capacity and preconceived ideas should not mute the voice of service users and involvement of the wider community can support achieving this. Evidence suggests however, that there are many barriers to co-production and gaps in understanding within this area.
- More theory-testing research is required to measure the impact of implementation of the model in practice and senior management involvement in this process also requires exploration.
- A need to consider how effective communication from a top down approach is implemented within a large organisation and the impact that this has on the successful implementation of a co-production model.

How is the study being conducted?

- **Methodology:** Case Study – to illustrate the Trust's story.
- **Sampling:** purposeful sampling to include the relevant people.
- **Participants:** Senior Managers (SLT), middle manager (band 8a/7 in CMHTs) and clinical leaders (consultant psychiatrists in CMHTs) across the whole of LCFT to provide a Trust wide view and increase anonymity..
- **Exclusions:** BWD and Blackpool as they are unitary authorities and do not function in the same way as the rest of the Trust.
- **Data Collection:** Interviews.
- **Data Analysis:** Thematic/Narrative analysis.

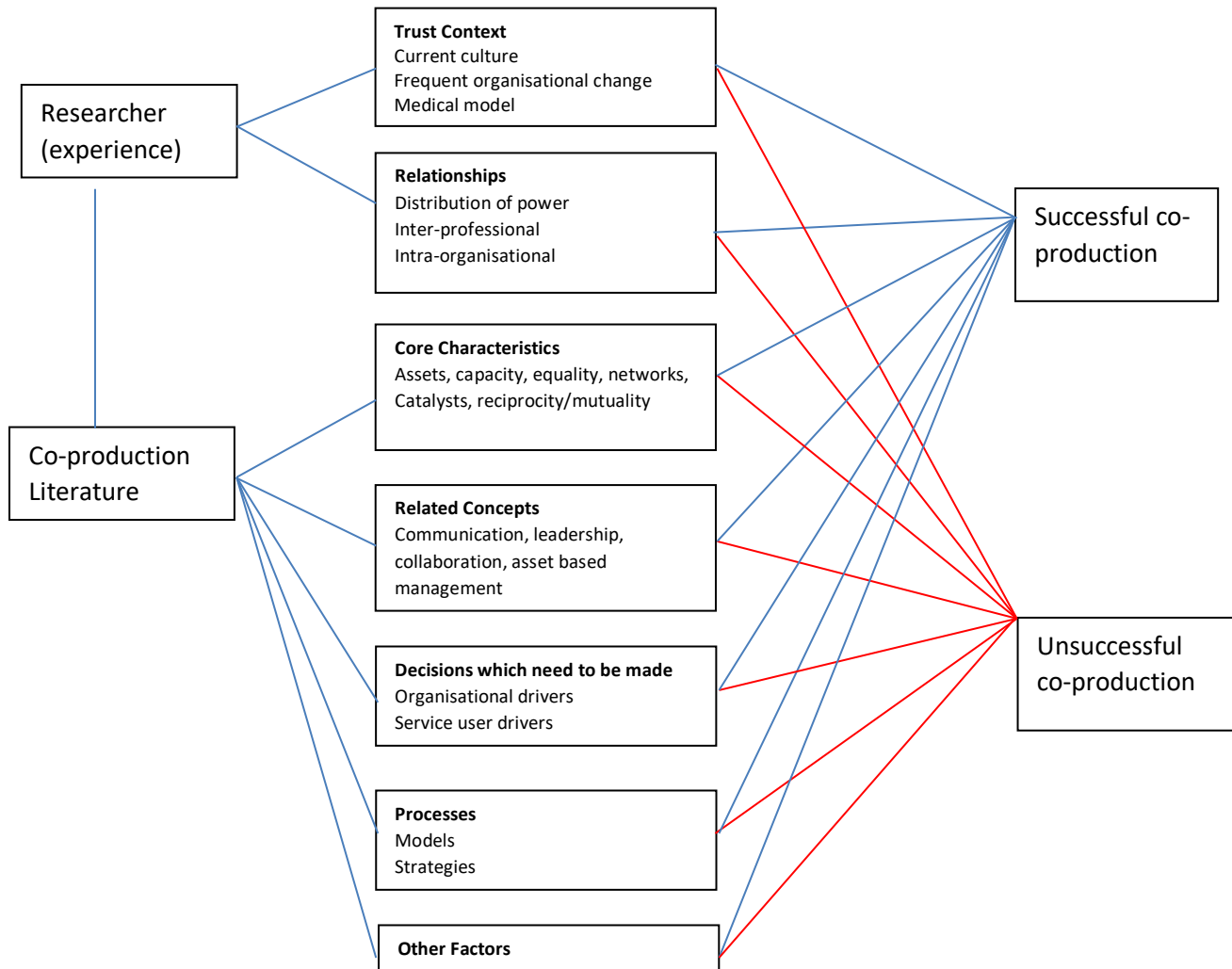
Benefits for the Trust

Literature suggests that:

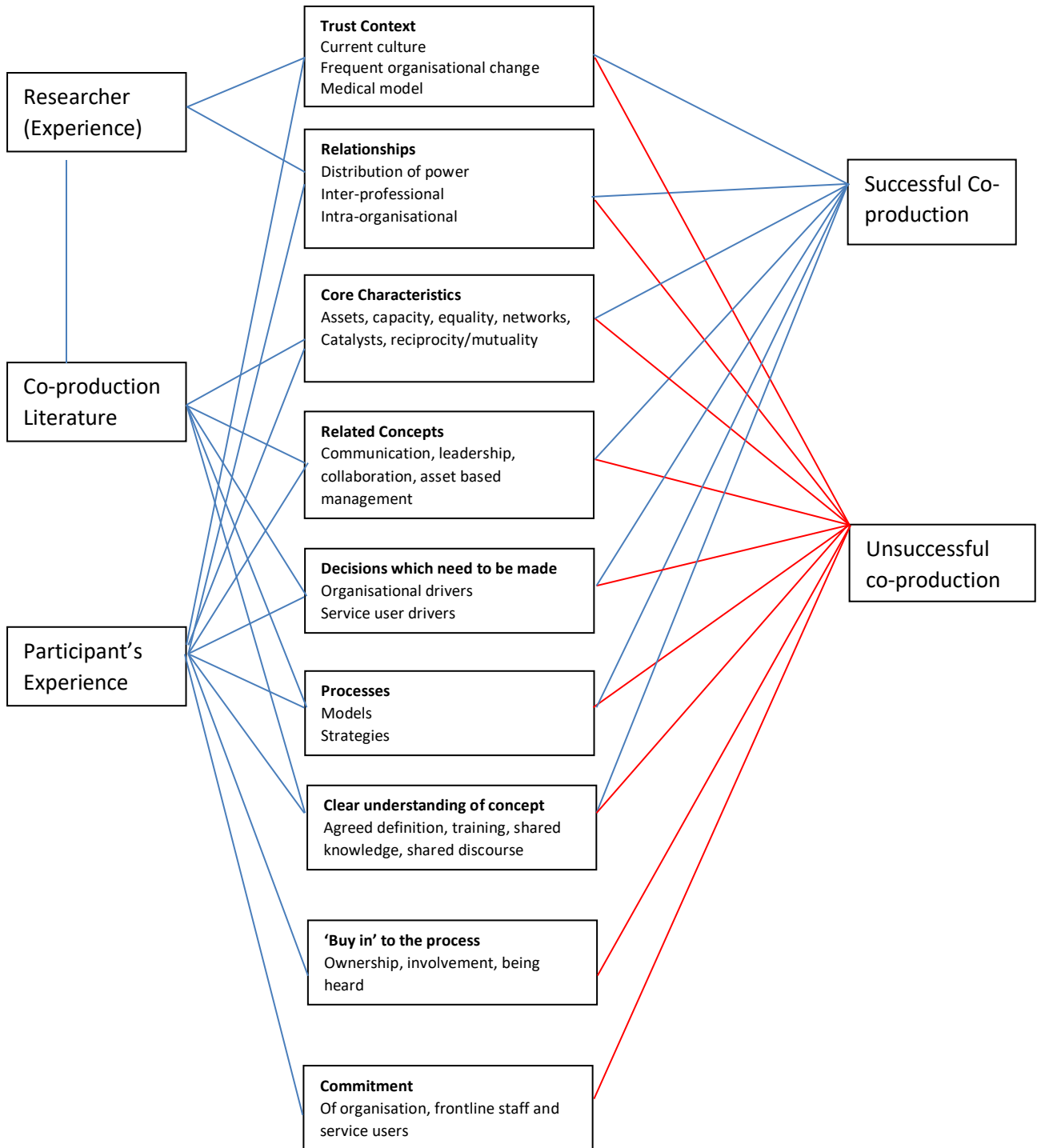
- Co-production will improve outcomes for both service users and organisations.
- Co-production will improve service user satisfaction.
- Co-production can improve efficiency of service provision.
- Co-production can support a reduction in spending as it focuses on the use of community and service user assets to deliver care and treatment.

The study will aim to support the provision of recommendations to enhance the current co-production model for the Trust.

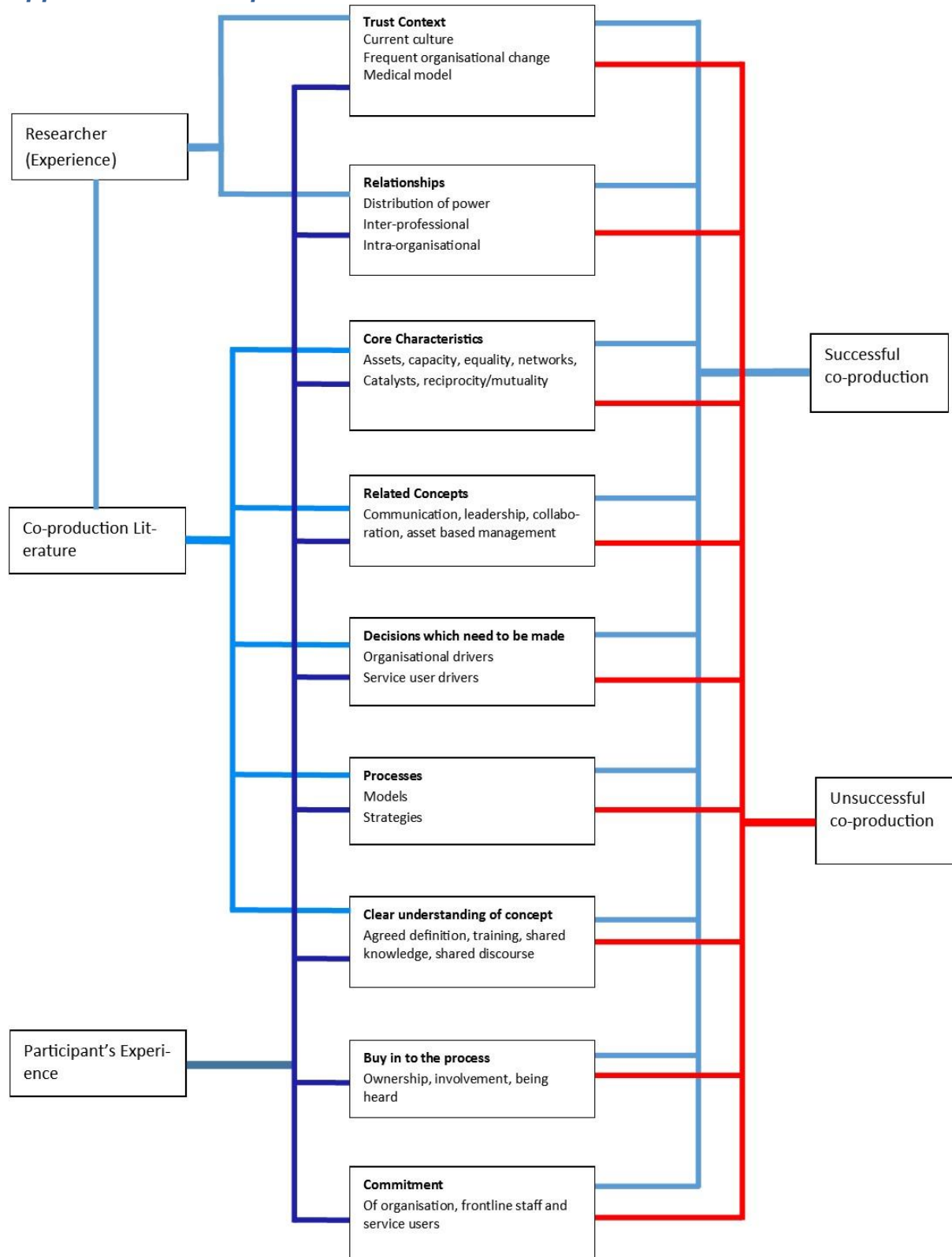
Appendix 6a: Conceptual Framework Version One



Appendix 6b: Conceptual Framework Version Two



Appendix 6c: Conceptual Framework Version III



Appendix 7: Ethics Form



Health Research Ethics Application Form

This form should **only** completed by staff and PGRs from the **School of Health Sciences** and the **School of Nursing, Midwifery, Social Work and Social Sciences**. For queries please contact Health-ResearchEthics@salford.ac.uk

For all other schools, please visit <http://www.salford.ac.uk/ethics>

School Research Ethics Approval FILTER Form

No research can be started without full, unconditional ethical approval. There are a number of routes for obtaining ethical approval depending on the potential participants and type of study involved – please complete the checklists below to determine which is the most appropriate route for your research study.

A. Teaching & Learning Research (STAFF ONLY)

- | | | |
|----|--|--------|
| 1. | Is the proposed study being undertaken by a member of UoS staff? | Select |
| 2. | Is the purpose of the study to evaluate the effectiveness of UoS teaching and learning practices by identifying areas for improvement, piloting changes and improvements to current practices or helping students identify and work on areas for improvement in their own study practices? | Select |
| 3. | Will the study be explained to staff and students and their informed consent obtained? | Select |
| 4. | Will participants have the right to refuse to participate and to withdraw from the study? | Select |
| 5. | Will the findings from the study be used solely for internal purposes?
<i>e.g. there is no intention to publish or disseminate the findings in journal articles or external presentations</i> | Select |

If you have answered **YES to all Qs1-5** your study does not require UoS ethics approval as the work sits under enhancing quality of teaching and learning.

If you have answered **NO to any of Qs1-5** you should complete the checklists below to determine which route you should use to apply for ethics approval of your study.

To find out if your study requires ethics approval through NRES answer the questions below.

A. National Research Ethics Service (NRES)

- | | | |
|----|--|----|
| 1. | Does your study involve access to NHS patients or their data, or involve participants identified from, or because of, their past or present use of NHS services? | NO |
| 2. | Does your study include adults who lack capacity to consent as research participants and/or those under 18 years of age? | NO |
| 3. | Does your study involve the collection and/or use of human tissue as defined by the Human Tissue Act 2004?* | NO |

If you have answered **YES to any of Qs1-3** you should complete this application form, for University of Salford ethics review, you will normally have a response within 4-6 weeks of submission. Once you have UoS approval you can then complete and submit the relevant NHS National Research Ethics Service (NRES) form (the information from the UoS forms can be transferred onto the NRES forms). For further information and details of how to apply to NRES can be found at <http://www.nres.nhs.uk/>

** For more information, please discuss with your supervisor or Research Lead*

If you have answered **NO to Qs1-3** complete the checklist below to determine whether your application is eligible for Fast Track (proportionate) review or full review.

A. Full versus 'Fast Track' (Proportionate Review)

1. Expose participants to high levels of risk, or levels of risks beyond those which the participant is likely to encounter in their everyday activities? These risks may be psychological, physical, social, economic, cause legal harm or devalue a person's self-worth. *E.g. untrained volunteers exposed to high levels of physical exertion; participants purposefully exposed to stressful situations; research where participants are persuaded to reveal information which they would not otherwise disclose in the course of everyday life.* NO
2. Involve the administration of drugs, medicines or nutritional supplements as part of the research design? NO
3. Include adults who may be classed as vulnerable? *E.g. adults with learning disabilities or mental illness; drug/substance users; young offenders; prisoners/probationers; those in a dependent relationship with the researcher* NO
4. Include children or young adults (below 18 years of age)? NO
5. Involve the discussion or disclosure of topics which participants might find sensitive or distressing? *E.g. sexual activity; criminal activity; drug use; mental health; previous traumatic experiences; illness; bereavement* NO
6. Use questionnaires which focus on highly sensitive areas? NO
e.g. illegal activity; criminal activity; disclosure and analysis of findings based on sensitive personal information as defined by Data Protection Act e.g. racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health; sexual life
7. Incorporate interviews or focus groups which involve the discussion of highly sensitive areas? NO
e.g. illegal activity; criminal activity; disclosure and analysis of findings based on sensitive personal information as defined by Data Protection Act e.g. racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health; sexual life
8. For research accessing and analysing existing datasets. Will the dataset include information which would allow the identification of individual participants? NO
9. Involve deliberately misleading participants in any way? NO
10. Involve recruiting participants who have not been provided with a participant information sheet and asked to sign a consent form? NO
*Please note that for questionnaire based studies where the questionnaire is completed by the participant, a consent form is generally not required as consent is implied by the completion of the questionnaire. Applicants conducting **questionnaire-only** studies should answer NO*
11. Involve the collection and/or use of human tissue from healthy volunteers? NO
Under these circumstances human tissue is as defined by the Human Tissue Act 2004 - "Any, and all, constituent part/s of the human body formed by cells." Research studies involving the use of plasma or serum are not covered by the HTA.
12. Involve high levels of risks to the researcher? NO
e.g. lone working at night; interviewing in your own or participants homes, observation in potentially volatile or sensitive situations

If you have answered **'NO' to all Qs1-12** your study is eligible for 'fast track' review. You should complete the application form that follows and submit it electronically with any supporting documentation e.g. participant information sheets, recruitment material, consent forms to **Health-ResearchEthics@salford.ac.uk**. Please ensure that your electronic submission is anonymised (all names removed) and that versions and dates are completed on the checklist with the same included on corresponding documents.

Staff – please submit from your email address including your name and email in the body of the email only

Students – please ensure your application is submitted by your supervisor

Supervisors – please submit the fully anonymised version of your student's application from your email account. This serves as your approval for the application to be sent for review. Please ensure in the body of the email only you include the full name of your student, and cc them in.

Your application will be reviewed by the University Ethics Panel for Research, Enterprise and Engagement, and you will normally be informed of the outcome within 4 weeks.

Please note that if the allocated reviewer finds that your application has been wrongly submitted for 'fast track' review you will be notified and your application will be forwarded for full review, which can take up to 6 weeks.

If you have answered **YES to any of Qs1-12** your study is not eligible for 'fast track' review and will be considered for full review. You should complete the following application form and submit it electronically with any supporting documentation e.g. participant information sheets, recruitment letters, consent forms to **Health-ResearchEthics@salford.ac.uk**. Please ensure that your electronic submission is anonymised (all names removed) and that versions and dates are completed on the checklist with the same included on corresponding documents.

Staff – please submit from your email address including your name and email in the body of the email

Students – please ensure your application is submitted by your supervisor

Supervisors – please submit the fully anonymised version of your students application from your email account as way of approving the application to be sent for review, please ensure in the body of the email you include the full name of your student (and cc them in)

School Research Ethics Approval Application Form CHECKLIST

School	School of Health & Society
Course of Study	Professional Doctorate
Title of proposed research project	An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model within an NHS mental healthcare setting.
Has this project received external funding?	NO If YES , please provide name of Research Council or other funding organisation: Click here to enter text.
Do you use non-human genetic materials from outside UK for your research?	NO If YES , has this been collected since the 12 th October 2014? Select

Please select which type of review is required:
(Proportionate Review)

Fast Track

The checklist **MUST BE COMPLETED**. It is designed to help you to ensure that you have all the supporting documents submitted with your ethics application form. This information is necessary for the committee to be able to review and approve your application. Please complete the relevant boxes indicating whether a document is enclosed and where appropriate identifying the **date and version** number allocated to the specific document (*in the header/footer*). Additional documents can be recorded in the boxes provided or extra boxes added to the list if necessary.

Document	Enclosed?	Date	Version No.
Application form	<u>Mandatory</u>		
Protocol	NO		
Risk Assessment Form	YES	06/11/17	2
DBS Check	NO		
Participant Invitation Letter	YES	06/11/2017	2
Participant Information Sheet	YES	06/11/2017	2
Participant Consent Form	YES	06/11/2017	2
Participant Recruitment Material – e.g. copies of Posters, newspaper adverts, website, emails.	NO		

Organisation Management Consent/Agreement Letter	YES	16/08/2016	1
Research Instrument, non-validated questionnaire	NO		
Draft interview guide/Topic guides for participants	YES	06/11/2017	2

NOTE: If the appropriate documents are not submitted with the application from then the application will be returned directly to the applicant and will need to be re-submitted at a later date, thus delaying the approval process.

Ethics approval must be obtained by all applicants prior to starting research with human subjects, animals or human tissue.

Postgraduate students **must** discuss the content of this form with their PhD supervisor(s). A final copy of this application form should be agreed between the student and supervisor(s).

Staff must submit a fully anonymised version to Research Centres Support Team (Health-ResearchEthics@salford.ac.uk). Students must have their fully anonymised application submitted by their supervisor (from the supervisors email account) to Research Centres Support Team (Health-ResearchEthics@salford.ac.uk)

Is this application a resubmission?

Yes No

If YES, please indicate Ref Number (if known) [Click here to enter text.](#)

Is this an amended version of the original application?

(Please ensure that the changes are highlighted within the documents)

Yes No

Staff/PGR Student

experience/qualifications:

MSc Advanced Occupational Therapy

BSc (Hons) Occupational Therapy

School

University of Salford, School of Nursing, Midwifery, Social Work and Social Sciences

Course of study:

Professional Doctorate

(PGR use only)

Start date of project:

1/12/17

End date of project:

1/4/19

Proposed start date for participant recruitment:

1/12/17

Will this project take place on University premises?

Yes No

*If you answer 'yes' to any of the above questions, a risk assessment of the project is required and **MUST** be submitted with the application.*

Is a DBS check required?

Yes No N/A

Have you read the Lone Worker Policy?

Yes No

The form must be completed electronically; the sections can be expanded to the size required. To assist you with the completion of this form there are [Guidance Notes for Completing the School Research Ethics Approval Form](#), which indicate what is required for each section.

1. Title of proposed research project:

(refer to guidelines in section 1)

An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental healthcare setting.

2. Project Summary

The overall purpose of this project is to examine how a co-production model is implemented in an NHS mental health Trust. This case study will identify three staff groups' understanding of what co-production is. It will also compare the model being implemented to the relevant literature to identify evidence that can be used to inform a guide to optimise implementation which can be adopted by other agencies. I propose to conduct interviews with senior managers, middle managers and clinical leads within a mental health service to ascertain their understanding of the co-production model which is in operation within the Health Trust where I work.

3. Project Objectives *(refer to guidelines section 3)*

To examine knowledge, skills and beliefs of a range of senior managers, middle managers and clinical leads who work in an NHS mental health setting that is implementing co-production.

To identify drivers and challenges to delivering co-production as a means of improving services within an NHS mental health setting in the NW of England.

4. What is the rationale which led to this project? *(refer to guidelines section 4)*

In a bid to introduce innovation, using the existing resources, co-production is being adopted as a critical approach to public policy in healthcare (Needham, 2009; Department of Health, 2010) and is considered a cornerstone of policy reform around the world (Horne & Shirley, 2009). Within Lancashire Care Foundation Trust (LCFT) this model is currently being implemented alongside a new collaborative leadership strategy, which is expected to impact on how all professionals work. Therefore, it is important that the impact of this implementation is considered and explored.

While many concede, that co-production is an essential framework for improvement to service, it is suggested that 75% of change initiatives are unsuccessful because of leaders having a different set of expectations and ideas (Bevan 2006). Therefore, it is imperative that the understanding of staff within the organisation be considered and studied further. Additionally, Evans-Blacko, Jarrett, McCrone & Thornicroft (2010) identify the importance of finding the facilitators and barriers to implementing change, and with co-production literature still in its infancy, there is a need for this work to be considered and explored - the driver for the proposed research.

The literature review I have undertaken has highlighted that there is limited co-production research within mental health settings hence this will be the focus of the study. The review has also highlighted that there are many potential facilitators of co-production to help any model to be implemented well. For co-production to be successful it is apparent that the negative impacts of practice must be addressed and practice itself must be willing to adapt to accommodate this

process. All parties involved must be open to collaboration and power needs to be shared equally regardless of capacity. Challenges such as mental ability should not mute the voice of service users and involvement of the wider community can support achieving this. Evidence suggests however, that there are many barriers to co-production and gaps in understanding within this area. More theory-testing research is required to measure the impact of implementation of the model in practice and senior management involvement in this process also requires exploration. There is a need to consider how effective communication from a top down approach is implemented within a large organisation and the impact that this has on the successful implementation of a co-production model.

5. Research Methodology *(refer to guidelines section 6)*

This study focuses on the implementation of a 'co-production model' within an NHS mental health service and the lived experiences of the senior managers, middle managers and clinical leads who are involved in co-production implementation. It seeks to gain staff views of the implementation process, their knowledge, skills and attitudes to co-production and their experiences of it. These findings will then be compared to the evidence base for co-production in the literature. A primarily qualitative case study approach is to be used.

Qualitative research is used here as an iterative process facilitating understanding of the perspective of the person who is affected by the problem (Creswell, 2007) affording under heard groups the opportunity to have their voice heard (Creswell, 2007). It can uncover new data which could enhance further understanding and highlight patterns within the topic area (Creswell, 2007; Gerrish & Lacey, 2010; Saks & Allsop, 2013).

A reflexive process will be included, through analysis of the researcher role within the study, via self-critique of values and beliefs, and would lend itself well to the study aims.

More specifically, a case study approach will be utilised as it enables the opportunity to increase knowledge about the organisation whilst maintaining the real-life experiences of the people it encompasses (Yin, 2014). This methodology will also allow a focus on the decision-making of implementing a co-production model, how implementation occurred, and review the facilitators and barriers in this process (Schramm, 1971).

More specifically, a case study approach will enable the opportunity to increase knowledge about the organisation under study whilst maintaining the real-life experiences of the people it encompasses (Yin, 2014). The primarily qualitative case study will focus on the trajectory of implementing a co-production model, how implementation occurred, and review the facilitators and barriers in this process (Schramm, 1971).

A case study is an empirical inquiry allowing investigation of the organisation/" the case" in great depth which will highlight the numerous contextual issues which are pertinent to the case. However, the researcher will not be approaching this study from a realist epistemological

standpoint, due to the fundamental belief that there are multiple realities and meaning depending on the individual and the external factors around them (Yin, 2014).

Methods

Qualitative methods

Firstly, individual face-to-face interviews will be conducted with middle managers (n=10-13) and clinical leads. (n=6-8). Secondly interviews will be conducted with members of the Executive Management Team (EMT) (n=4-6) to gain senior management perspective. The EMT interviews have been identified to be conducted following the other interviews as there will be some levity to pose questions to them based upon data which has been collated. Interviews will last for approximately 60 minutes and interview guide has developed from information from the literature review and practical experience to support the interview process. All interviews will take place on Trust premises and will be transcribed by a single administrative staff trained in confidentiality.

Secondary data

Secondary data in the form of mostly meeting minutes and strategy documents will also be collated for thematic analysis and contextual information to underpin the case study.

Analysis

A major challenge with data analysis is managing the volume of data collected and determining what information is valuable and therefore at this point the conceptual framework will be revisited, to support focusing on the predetermined goals to prevent overload (Miles & Huberman, 1999). A coding system will be developed and initially, descriptive codes will be utilised, entailing generic subjects with minimal interpretation. Patterns will then begin to emerge as more interviews are conducted. It may be necessary to revisit earlier analysed documents to apply inferential codes as codes become salient. A process of pattern coding will be use (Miles & Huberman, 1999). It is possible that some codes will become too saturated with information and require new sub themes being identified and relabelled. Therefore, it will be essential to look for recurring phrases or terms used which demonstrate a common thread and equally important to look for internal differences as this will present a higher form of commonality helping to avoid fitting data into poorly formulated codes. Pattern codes or categories will support the provision of explanatory codes that identify emergent themes and pull together plentiful data in a more meaningful manner. Coding and recoding will be complete when categories are saturated and sufficient regularities occur (Strauss, 1987; Lincoln & Guba, 2000) although it can be difficult to decide when to cease analysis and this is often determined by time constraints. If saturation does not occur the sample size will be expanded.

6. How many participants will be recruited and/or involved in the study, and give the rationale for this number? (refer to guidelines section 7)

Sampling Strategy –

Participants will be recruited based on the diverse insight that they will be able to provide about co-production. An information pack will be sent via internal mail outlining the remit of the study and advising how people can sign up to participate (through email, or via phone contact on a works mobile phone). A written consent form will be sent out with the information pack for completing, with a request that this is posted back to the researchers work address.

An approach of stratified purposeful sampling was adopted to enable the facilitation of comparisons to relevant literature. The basic idea was to conduct interviews with relevant senior managers, middle managers and clinical leads within one mental health NHS Trust within the North West of England. It was decided to focus specifically on community mental health as this is the area where the author works and therefore has relevant knowledge which ties in well with the ethos of the professional doctorate.

The management structure of a Community Mental Health Teams (CMHT) is one Band 8 manager over two CMHTs and two Band 7 Team Leaders (one per team). Each individual CMHT has a consultant. To safeguard participants identity and provide depth to the case, all Band 8s across the Trust (which covers Pennine, Central and North locality (which comprise of 11 CMHTs) will be interviewed along with one team leader for each team (apart from the researcher who is team leaders for one of the teams). These interviews will be conducted first followed by the interviews for the clinical leads who within LCFT are identified as the consultant psychiatrists for the CMHT. Interviews will finally be conducted with 4 members of the Executive Management Team to gain senior management perspective. The EMT interviews have been identified to be conducted following the other interviews as there will be some levity to pose questions to them based upon data which has been collated. All interviews will be audio recorded and transcribed by an administrative staff member trained in confidentiality and field notes will also be maintained by the interviewer.

Sampling and data collection summary

Action	Location	Approximate number	Data Collection Period
Interviews of Executive Team	Trust Headquarters	Approx. 4-6, Total membership 13	Approx. 2 days Approximately 45-60 minutes per interview
Interviews of Community Mental Health Team (CMHT) managers/ team leaders	Trust site where the CMHT's is based	Approx. 10-13 Total membership 17(including the researcher)	Approx. 10 days Approximately 45-60 minutes per interview
Interviews of CMHT clinical leads	Trust site where the CMHT's are based	Approx. 6-8, Total membership 11	Approx. 7 days Approximately 45-60 minutes per interview

7. Please describe how you plan to obtain organisational agreement for your project (if required). (Refer to guidelines section 8)

A meeting has been held with the Chief Executive of the Trust to outline the research vision. As co-production is a model that has been being implemented within the Trust over the last 12 months, benefits of looking at the facilitators and barriers to its implementation were identified. The Chief Executive provided her agreement to completing the study within Lancashire Care Foundation Trust and has provided an organisational letter to confirm which is in the attached appendix. She is happy now for the Trust to be identified during the write up of the thesis however she did advise that should finding be extremely critical the thesis may need to be anonymised. Discussions were held with her to express that the intent is to publish the findings from the study which she agreed with. She has also assured that she will inform the Board how important it is for the organisation to engage with this study and agreed to support them taking time out to be interviewed, which should make accessing participants a simpler process.

Once approval has been attained from the University an NRES application will be submitted and this approval provided to the R&D Department at the Trust.

8. Please identify which Code of Conduct and/or Governance Framework you will be adhering to? (Refer to guidelines section 9)

The College of Occupational Therapist's 'Research Governance Policy' was initially considered, however when reviewing the Royal College of Nursing's 'Research ethics: RCN guidance for nurses' it was found to be far more in depth and therefore has been selected as the policy for the research project.

9. Please describe the data protection issues that you need to address? (Refer to guidelines section 10)

Informed consent – an information sheet will be provided, covering the reason for the study, potential risks and how to withdraw; to ensure participants are fully informed (Smith, 2010). Consent forms will be signed (Buchanan, 2004) and information provided about use of data on withdrawal from the study as this will be retained if it is felt integral to the case. If participants wish to withdraw, the information collated to the point of withdrawal will be maintained for the benefit of the study.

As data will be collected from the Trust how this is stored will be paramount in protecting people's identity and right to data protection. Therefore, below are the steps which will be taken to address this concern.

- Only the researcher and the research supervisor will have access to transcripts and field work notes (Strawbridge 2007).
- All confidential information such as tape recordings, written transcripts, consent forms and field notes will be secured in a locked drawer in a locked office, which will be on an NHS site - with the only key being held always by the researcher (Wollack & Fremer, 2013). Identifiable information will be kept in a separate locked drawer to the coded

transcripts to ensure additional security of people's identity. Interviews will be recorded on a Dictaphone and then transcribed by one member of the administration team (who will transcribe for all the interviews onto a password protected document. Names will not be used in the transcribing process and codes will be substituted for these to protect participants' anonymity. The administration staff will sign a confidentiality agreement to ensure that they are aware of the importance of maintaining participants' confidentiality. When data analysis has been completed all data will be deleted.

- On completion of the research study, all information will be destroyed (Liu & Davis, 2011) after a period of 5 years.
- Anonymisation of all data will occur (Hennink, 2007), and mindfulness of identifiable phrases/information will be carefully managed (Duncan, Jabine & de Wolf, 1993). To further protect anonymity participants will be sent a copy of quotes from their interviews which are to be used within the thesis to allow the opportunity to feedback if they feel that they may be identifiable from them.

10. Please describe how other ethical issues will be considered (Refer to guidelines Section 12)

Consideration has been given about risk to the researcher considering utilisation of senior managers in the sample and the potential that the research could uncover issues around the success of the model's implementation and potential negative feedback from frontline staff. The researcher will utilise supervision to discuss potentially delicate findings to allow discussion about how to best present these within the thesis.

Additionally, consideration has been given to the lone working of the researcher and to address this all interviews will take place at a Trust site. I will also follow the lone working procedure of my team and highlight my study days and location in my outlook calendar and call in safe when the interviews have been completed.

Whilst it is unlikely that an adverse event would occur, should this happen the researcher supervisor would be contacted for advice and an incident report form (datix) completed for the Trust.

Poor practice – Participants will be informed that should poor practice be observed that the researcher has an obligation (as a researcher and as a member of a professional body) to report this incident. Should this happen, I will raise an incident report form (datix) (incident report form) and report the concerns to the individual's manager. Although unlikely, should there be safeguarding concerns a safeguarding alert will be raised. Any such incidents will also be discussed with my supervisor for support

11. Please identify if reimbursements and/or incentives will be provided to participants. (Refer to guidelines Section 13)

No reimbursements will be provided however all interviews will be conducted during working hours (at the agreement of the Chief Executive) to avoid use of their own time. Additionally, this will allow staff to claim back mileage via the Trust for their travel (although the researcher will aim to meet where is most convenient for the participants).

12. Please describe the dissemination strategies for your project findings. (Refer to guidelines Section 13)

A summary event will be held at the Trust (with the participants invited) to share the findings of the study and a written summary will also be provided should the participants want this (this is covered within the consent form. Additionally, presentation of findings will be made at staff meetings and there will be a view to publication. Also, findings will be presented within the professional doctorate theses which will be available via the University of Salford library.

13. References – provide full list of all references used.

- Bevan, H. (2006). Helen Bevan on change management. London: NHS Institute for Innovation and Improvement.
- Buchanan, E. A. (2004). *Readings in virtual research ethics: issues and controversies*. London: Information Science Publishing.
- Creswell, J.W. (2007). *Qualitative inquiry & research design choosing among five approaches*. (2nd Ed). SAGE.
- Department of Health, (2010). *Practical approaches to co-production: Building effective partnerships with people using services, carers, families and citizens*, London.
- Duncan, G. T., Jabine, T. B. & de Wolf, V. (1993). Panel on confidentiality and data access committee on national statistics. Commission on behavioural and social sciences and education. National research council and the social science research council. Washington: National Academy Press.
- Evans-Lacko, S., Jarrett, M., McCrone, P. & Thornicroft, G. (2010). Facilitators and barriers to implementing clinical care pathways. *BMC Health Services Research*, 10(182).
- Gerrish, K., Lacey, A. (Eds). (2010). 6th Ed. *The Research Process in Nursing*. London Blackwell.
- Hennink, M. M. (2007). *International focus group research. A handbook for the health and social sciences*. Cambridge: Cambridge University Press.
- Horne. M. and Shirley, T. (2009) *Co-production in Public Services: a new partnership with citizens*. London: Prime Minister's Strategy Unit.
- Lincoln, Y. S. & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In Denzin, N. K. & Lincoln, Y. S. 2nd Ed. *The handbook of qualitative research*. London: Sage.
- Liu, M. & Davis, K. (2011). 2nd Ed. *A clinical trials manual from the Duke Clinical Research Institute: lessons from a horse named Jim*. John Wiley & Sons.
- Needham, C. (2009). *Co-production: An emerging evidence base for adult social care transformation*. London: SCIE.
- Miles, M. B. & Huberman, A. M. (1994), *An extended sourcebook. Qualitative data analysis*. London: Sage Publications.

- Saks, M., Allsop, J. (2007). *Researching Health Qualitative, Quantitative and mixed methods*. Sage Publishing.
- Schramm, W. (1971). *Notes on case studies for instructional media projects*. Working Paper for Academy of Educational Development. Washington DC.
- Smith M. J. (2010). *Program evaluation for social work and health professionals*. Oxford: Oxford University, Press.
- Strauss, A. L. (1987). 1st Ed. *Qualitative analysis for social scientists*. New York: Cambridge University Press.
- Strawbridge, J. M. (2007). *The experience of long-term sobriety for men ages 55 through 65 who are currently members of alcoholics anonymous*. Florida: Boca Raton.
- Wollack, J. A & Fremer, J. J. (2013). 1st Ed. *Handbook for test security*. New York: Routledge Taylor Francis Group.
- Yin, R. K., (2014). *Case study research. Design and methods*. Los Angeles: SAGE.

NB: *Projects that involve NHS patients, patients' records or NHS staff, will require ethics approval by the appropriate NRES. The School Research Ethics Panel will require written confirmation that such approval has been granted. Where a project forms part of a larger, already approved, project, the Ethics Approval Panel for Research, Enterprise and Engagement should be informed about, and approve, the use of an additional co-researcher.*

NB: The ethical and efficient conduct of research by PGR students is the direct responsibility of the supervisor.

I certify that the above information is, to the best of my knowledge, accurate and correct. I understand the need to ensure I undertake my research in a manner that reflects good principles of ethical research practice.*

***By submitting your application via email you are confirming you will comply with the above**

*Please note that whilst the School indemnifies PGR student research projects, the supervisor is signing that they are satisfied that the student has considered the ethical implications of their work and to confirm for the PGR student's project to proceed subject to approval by the ethics panel.***

****By submitting your students' application you are confirming you will comply with the above**

PRIOR TO SUBMITTING THE APPLICATION FORM:

Please refer to the 'Application Checklist' and ensure appropriate supporting documentation is submitted complete with version and date, with the application form. Failure to complete the necessary documents will result in the application being returned to the applicant without being reviewed thus delaying the approval process.

Appendix 8: Study Approval Letter



Research, Enterprise and Engagement
Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

1 December 2017

Dear Hayley,

RE: ETHICS APPLICATION HSR1718-027 – ‘An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental health care setting.’

Based on the information that you have provided, I am pleased to inform you that your application HSR1718-027 has been approved to go forward to NRES.

Once you have received it, please submit a copy of the NRES approval letter to Health-ResearchEthics@salford.ac.uk so that it can be placed on your application file.


If there are any changes to the project and/or its methodology, then please inform the Health Research Ethics Support team as soon as possible.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Sue McAndrew', written over a light grey rectangular background.

Sue McAndrew

Appendix 9: NRES Approval


Health Research Authority

MRC

Medical
Research
Council

Is my study research?

i To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

'An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-

IRAS Project ID (if available):

You selected:

- 'No' - Are the participants in your study randomised to different groups?
- 'No' - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- 'No' - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision (s) that you need further advice on to the HRA Queries Line at HRA.Queries@nhs.net.

For more information please visit the Defining Research table.

Appendix 10 – Trust Approval Letter

Lancashire Care 
NHS Foundation Trust

Lancashire Care NHS Foundation Trust
Research and Development
The Lantern Centre
Vicarage Lane
Fulwood
Preston
PR2 8DW
Tel: 01772 773498
Research.office@lancashirecare.nhs.uk

Trust Project ID: 99

14th November 2018

To Whom It May Concern:

Dear Sir/Madam,

Researcher: Hayley Bamber

Project Title: A case study analysis of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within a Community Mental Health care setting

I am writing to confirm that the above named project has been reviewed in the R&D department and has been classified as a service evaluation and not a research project.

Therefore the project does not require Health Research Authority (HRA) Approval, Research Ethics Committee (REC) Approval nor Lancashire Care NHS Trust R&D permission of Capacity and Capacity to be carried out in the Trust.

The project does however need to be registered with the Trust as a Service Evaluation being undertaken within the organisation. Please contact R&D for information how to do this.

I hope that the above information is satisfactory, but if you require further information please do not hesitate to contact me.

Yours faithfully



Beverley Lowe
R&D Senior Officer

 Supporting Health and Wellbeing
Medical Directorate

Chair: Mr Derek Brown

Chief Executive: Professor Heather Tierney-Moore CBE



Appendix 11 – Service Evaluation Form

Service Evaluation Registration

Project ID

Project Title

An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental health care setting.

Start Date End Date

Network:
Cluster:
Service:

Details of Supervisor:

This is a permanent member of staff who has agreed to act as senior responsible officer for the project. They will have overall responsibility for the project and designing and taking actions forward. This person should sit on or deputise for the Senior Management Team

Name Contact Number
E-mail
Job Role

Details of Project Lead:

This is the member of staff with responsibility for carrying out the audit and should not be the same person as the Supervisor

Name Contact Number
E-mail
Job Role

Please state the names and roles of any other professionals involved in the audit:

Name Contact Number
E-mail Role in project

Background/Rationale

(This is the reason for selecting the topic, e.g. a specific guideline, incident, complaint, etc.)
Please note this field has a character limit of 1000

In a bid to introduce innovation, using the existing resources, co-production is being adopted as a critical approach to public policy in healthcare (Needham, 2009; Department of Health, 2010) and is considered a cornerstone of policy reform around the world (Horne & Shirley, 2009). Within Lancashire Care Foundation Trust (LCFT) this model is currently being implemented alongside a new collaborative leadership strategy.

Project Aims

To examine knowledge, skills and beliefs of a range of senior managers, middle managers and clinical leads who work in an NHS mental health setting that is implementing co-production.

To identify drivers and challenges to delivering co-production as a means of improving services within an NHS mental health setting in the NW of England.

Protocol

Will you be collecting new data?

Yes


Does your study protocol demand changing treatment/patient care for accepted standards for any of the patients involved?


No


Are your findings going to be generalisable?

No

Please upload any relevant documentation

 Ethics Form 2017V2.docm
122.66 KB

 CONSENT FORM V2.docx
175.27 KB

 Information sheet V2.docx
178.82 KB

Are service users involved in feedback for the project?

No

(E.g. filling out questionnaires)

Method

Cohort

please give details of which patient group would be used and the size of this group
i.e. all patients who are admitted to service in May 2014 with a diagnosis of depression

Senior managers (from the executive management team), middle managers (from CMHTs) and clinical leads (consultant psychiatrists from the CMHTs)

Sample Size

Please give details of the number of patients that will be reviewed and the percentage of the cohort that this equals

i.e. randomly select 10% of identified cohort

senior managers n=4-6 (approx. 50%)

Middle managers n=10-13 (approx. 75%)

Clinical Leaders n=6-8 (approx. 60%)

Method of data collection

Method of data analysis

Project Delivery Responsibilities:

(Please give details of the predicted date that each stage will be completed)

Project plan

Data collection

Data analysis

Report writing

For any issues or queries please contact:

Research@lancashirecare.nhs.uk

This section is to be filled out on completion of your project

Project Status

Please upload completed reports here:

Date completed

Appendix 12: Invitation to interview letter



Lancashire Care 
NHS Foundation Trust

Participant Invitation letter

Name:

Address:

Date:

Study Title: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental healthcare setting.

Dear {name},

I am writing to invite you to participate in a piece of research, which will be conducted within Lancashire Care Foundation Trust focusing on the recent implementation of a co-production model. Whilst I currently work within the Trust as a Team Leader within Hyndurn and Ribble Valley Community Mental Health Team, this is a student study and forms part of a professional doctorate in the School of Health and Society at the University of Salford.

The study aims to explore the experiences of senior managers, middle managers and clinical leaders who have implemented the model, to ascertain their knowledge, skills and beliefs about co-production.

As a leader within the Trust, your experiences are important to this study. Your involvement will support the development of an understanding of the facilitators and challenges to implementing the model and support the development of recommendations, if needed, to strengthen the current model in place.

I understand that you might have questions about this study and your involvement. Please read all the enclosed documents, which are aimed at answering any questions which you may have. If you find that you still have questions or concerns following reading the enclosed documents, then please do not hesitate to contact me on the details provided in the information document.
Thank you.

Yours sincerely,

xxxxxxxxx

Student – Professional Doctorate in the School of Health and Society
University of Salford

Appendix 13: Participant information sheet



PARTICIPANT INFORMATION SHEET

Title of study:

An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental healthcare setting.

Name of Researcher: xxx

I would like to invite you to participate in a research study, which is forming part of a professional doctorate at University of Salford. Prior to you agreeing to take part in the study, it is essential that I provide you with relevant information so you can understand the reasoning for the research and what your involvement will be. Please take the time to read the following information carefully, discuss the study with others if you wish, and feel free to ask questions if you are unclear on any aspect of the study or require any more information. My contact details and my supervisors' details are located at the end of the form.

What is the purpose of the study?

The study will explore the experiences of senior managers, middle managers and clinical leads who have engaged in the implementation of a co-production model within Lancashire Care Foundation Trust. The purpose of this study is to gain a greater understanding of stakeholders' knowledge, skills and beliefs on co-production and to review the facilitators and challenges which have occurred during implementation and provide recommendations for strengthening the current operational model in the Trust.

Why have I been invited to take part?

You have been invited to participate in this study because you are believed to have first-hand experience of working with the Trusts' co-production model.

Do I have to take part?

No, participation is completely voluntary and there is no obligation to take part. Additionally, you can withdraw your consent to participate at any point during the study.

If you wish to withdraw from the study you can do so by emailing me at xxxxxxx

What will happen to me if I take part?

As part of the study and you will be asked to participate in an interview. You will be asked to complete the attached consent form to signal your wish to engage in the study and confirm your understanding of this information sheet.

The study employs interviews as the data collection method. You are invited to participate a one to one interview lasting approximately 45-60 minutes. This interview will be conducted at your place of work to minimise your inconvenience at a time that is convenient to you – when interest in the study has been attained I will contact you to arrange an appropriate time for the interview. Interviews will be recorded on a Dictaphone and then transcribed and maintained confidentially.

Expenses and payments?

There is no payment for involvement within the study however I will ensure that interviews are conducted at a location that is convenient for you.

What are the possible disadvantages and risks of taking part?

You may not feel comfortable discussing issues relating to your working environment and experiences. You can ask to stop the interview at any point or decline to answer individual questions that you do not feel comfortable answering.

What are the possible benefits of taking part?

You may find the project interesting and it may give you an opportunity to reflect on your experiences during the integration journey. The information gained in the study will be used to inform the Trust of the facilitators and challenges which have been experienced with implementing the model and it is hoped that recommendations can be provided on how to strengthen the current model in place based on information attained from this study.

What if there is a problem?

If you have any concerns please contact my supervisors, whose details at the end of this form

If you wish to make a complaint please contact

Professor Sue McAndrew
Chair of the Ethics Panel,
Joule House Acton Square,
University of Salford, M5 4WT.
Email: xxxxxxxxxx
Tel: 0161 295 6355

Will my taking part in the study be kept confidential?

Yes, if you consent to take part in the study all information and your identity will be kept confidential and will not be disclosed to anyone.

All electronic data including recordings and transcripts will be maintained and stored on a password protected computer.

All paper data collected such as field notes, will be anonymised and coded. Hard paper copies of data, including consent forms will be stored in a locked draw within a locked room, accessed only by the researcher.

Should poor practice be observed this will be raised with your line manager and an incident report form (datix) will be completed. Additionally, if there are any safeguarding concerns a safeguarding alert will be raised.

It is important for you to understand that if you reveal anything which is related to criminal activity and/or something that is harmful to yourself or others, the researcher will have an obligation to share that information with the appropriate authorities in including relevant professional bodies.

What will happen if I don't carry on with the study?

Your involvement in the study is voluntary and therefore you are not required to be involved. A choice not to participate will not be documented or reported. If you consent and to engage and then change your mind, you can withdraw from the study at any point. Should you choose to withdraw, any information which has been collected up until this point will be retained and used within the findings.

What will happen to the results of the research study?

The study will be reported in a number of ways:

- As a doctoral thesis at the University of Salford
- Publication within academic journals
- Possible presentation at conferences
- Reported to the Trust to inform future learning and development opportunities

Who is organising or sponsoring the research?

The Study is being conducted as part of the Professional Doctoral programme, by a student at the University of Salford.

Further information and contact details:

Researcher:

XXXXXXXXXX

Supervisors:

XXXXXXXXXXXX

XXXXXXXXXXXX

Appendix 14: Participant consent form



CONSENT FORM – Interview

Title of study: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within an NHS mental healthcare setting.

Name of Researcher: xxxxxxxx

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and write your initials in the Yes or No column to indicate your response.

- | | | | |
|------------|--|------------|-----------|
| 1 | I confirm I have read and understand the participant information sheet (V2 06/11/17) for the study. I have had an opportunity to consider the information and ask questions. | YES | NO |
| 2 | I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, and without my rights being affected. | YES | NO |
| 3 | I am aware that if I decide to withdraw from the study, information you have provided, up to the point of withdrawal, will still be used in the research. The timeframe for withdrawal is immediate. | YES | NO |
| 4 | I agree to participate in an individual interview which will be recorded on a Dictaphone. | YES | NO |
| 5 | I understand that my personal details will remain confidential and not be shared with people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to myself or others, the researcher must share that information with appropriate personnel. I also understand that should poor practice be observe that the researcher has an obligation to report this to my line manager and complete an incident report form (datix). | YES | NO |
| 6 | I understand that my anonymised data will be used in the researcher’s thesis and will also be used in academic publications, teaching and conference presentations. | YES | NO |
| 8 | I agree to participate in the study. | YES | NO |
| 9 | I would like to receive a summary of the findings from this study. | YES | NO |
| 10. | I agree that my anonymised direct quotes will be used when reporting study findings | YES | NO |

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

Appendix 14a: Interview guide version One



Researcher: Hayley Bamber

Title: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model within a mental healthcare setting?

Proposed Interview Questions: *This is an interview guide and questions may be altered following completion of a concept analysis.*

1. How long have you been in your current position?
2. What is your profession? <i>Consultant/OT/nurse</i>
3. How long have you been working for the Trust?
4. Can you tell me how you first found out about co-production?
5. Can you tell me about the co-production model which the Trust is utilising?
6. How was the model communicated to you and do you feel that this was done effectively?
7. Can you tell me about your experiences of co-production in practice?
8. What is working well with the model?
9. Can you give me some examples of this?
10. What have been the challenges of implementing the model?
11. Can you give me some examples of this?
12. Do you feel that anything could be done differently to improve the implementation of the model?
13. The core principles of co-production are power sharing, using people's assets and reciprocity. Can you give an example of how each of these areas has impacted on the implementation of the model?

Appendix 15b: Interview guide version Two



Researcher: xxxxxxxx

Title: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within a mental healthcare setting.

Proposed Interview Questions: *This is an interview guide and questions may be altered following completion of a concept analysis.*

1. How long have you been in your current position?
2. What is your profession? <i>Consultant/OT/nurse</i>
3. How long have you been working for the Trust?
4. Can you tell me about your knowledge and experience of co-production?
5. Do you work in a co-production environment? <i>What are your current experiences?</i> <i>How is the model being implemented?</i> <i>What are the facilitators/barriers?</i>
6. Have you worked in a co-production environment in any of your previous roles? <i>How did the approach used compare with the LCFT model?</i> <i>What was different?</i>
7. How well were you informed about the Trust's decision to implement a co-production model?
8. How do your beliefs about co-production compare with the reality of its implementation within LCFT? <i>If not, then how does this differ?</i>
9. Have you undertaken any training or development sessions to support your role with implementing co-production? <i>What skills do you feel are required to implement co-production within your work place?</i> <i>Do you feel that you have all the necessary skills to implement the model effectively?</i>
10. What advice would you give another organisation looking to implement co-production?
11. Is there an alternative model or approach which you feel would be more beneficial than co-production to improve services?

Appendix 15c: Final Interview guide – Middle managers and Clinical leads



Researcher: xxxxxxxx

Title: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within a mental healthcare setting.

Proposed Interview Questions: *This is an interview guide and questions may be altered following completion of a concept analysis.*

1. Can you tell me about your current position?
2. What is your profession? <i>Consultant/OT/nurse</i>
3. How long have you been working for the Trust?
4. Can you tell me about the previous positions that you have had?
5. Can you tell me about your knowledge of co-production?
6. Can you tell me about your experiences of co-production?
7. Do you believe that you work in a co-production environment? <i>What are your current experiences?</i> <i>How is the model being implemented?</i>
8. Can you tell me about some of the challenges which you are experiencing with implementing co-production?
9. Can you tell me about some of the benefits of using a co-production model?
10. Have you worked in a co-production environment in any of your previous roles? <i>How did the approach used compare with the LCFT model?</i> <i>What was different?</i>
11. Do you feel that you well were you informed about the Trust's decision to implement a co-production model? <i>How was it communicated to you?</i> <i>Do you feel that there could have been a better way to communicate the implementation to you?</i>

<p>12. Do you feel that the Trust maximises the use of service user and community assets? <i>If yes, how do you do this?</i> <i>If no, what could be done to increase the use of service user and community assets?</i></p>
<p>13. Can you tell me your experience of power within the Trust? <i>Do you feel that power is evenly distributed within the Trust/team?</i> <i>If no, how do you feel that this could be addressed?</i></p>
<p>14. Can you tell me about your experience of moving from a deficit approach model (medical model) towards a co-production/recovery model?</p>
<p>15. Do you feel that LCFT has sufficient networks within the community to meet the needs of service users? <i>If yes, does the Trust utilise these effectively? What works well?</i> <i>If no, what could be done differently to increase community involvement?</i></p>
<p>16. What do you feel the incentives are for people to engage with a co-production model? <i>How do you feel that the Trust could incentivise the process?</i></p>
<p>17. How do your beliefs about co-production compare with the reality of its implementation within LCFT? <i>If not, then how does this differ?</i></p>
<p>18. Have you undertaken any training or development sessions to support your role with implementing co-production? <i>What skills do you feel are required to implement co-production within your work place?</i> <i>Do you feel that you have all the necessary skills to implement the model effectively?</i></p>
<p>19. What advice would you give another organisation looking to implement co-production?</p>
<p>20. Is there an alternative model or approach which you feel would be more beneficial than co-production to improve services?</p>

Appendix 15d: Final interview guide for senior managers



Researcher: xxxxxxxx

Title: An exploration of the knowledge, skills and beliefs of senior managers, middle managers and clinical leads who are implementing a co-production model for improving services within a mental healthcare setting.

Proposed Interview Questions: *This is an interview guide and questions may be altered following completion of a concept analysis.*

1. Can you tell me about your current position?
2. What is your profession? <i>Consultant/OT/nurse</i>
3. How long have you been working for the Trust?
4. Can you tell me about your knowledge of co-production?
5. Can you tell me about the Trusts' vision for co-production within its services?
6. Can you tell me about the drivers for implementing co-production within the organisation?
7. Can you tell me about your experiences of co-production?
8. Do you believe that co-production is working effectively in practice? <i>What are your current experiences?</i>
9. Can you tell me about some of the challenges which you are experiencing with implementing co-production?
10. Can you tell me about some of the benefits of using a co-production model?
11. How well do you feel that the Trust's decision to implement a co-production model was communicated to staff? <i>How was it communicated?</i> <i>Do you feel that there could have been a better way to communicate the implementation?</i>
12. Can you tell me your experience of power within the Trust?

<p><i>Do you feel that power is evenly distributed within the Trust/team? If no, how do you feel that this could be addressed?</i></p>
<p>13. What do you feel the incentives are for people to engage with a co-production model? <i>How do you feel that the Trust could incentivise the process?</i></p>
<p>14. How do your beliefs about co-production compare with the reality of its implementation within LCFT? <i>If not, then how does this differ?</i></p>
<p>15. Have the organisation provided any training or development sessions to support people with understanding their role with implementing co-production?</p>
<p>16. What advice would you give another organisation looking to implement co-production?</p>
<p>17. Is there an alternative model or approach which you feel would be more beneficial than co-production to improve services?</p>
<p>18. One of the themes which came out of the initial data analysis was that view that there is a distinct divide between corporate and clinical services. What are your thoughts on this?</p>
<p>19. Another theme was about constant revolution of services and a lack of embedding of models in practice. What are your thoughts on this?</p>
<p>20. Another theme was about power within the organisation and how staff feeling done to and not heard within the organisation. What are your views on this?</p>
<p>21. Staff also advised that they feel that there is a lack of interface from the top of the organisation to the bottom and vice versa. What are your thoughts on this?</p>
<p>22. The final theme which emerged was about people's attitudes towards co-production which reflects that people feel that the model if implemented as the literature indicates would be a good thing for the organisation, its staff and service users. In light of this do you feel that co-production could be successful within the organisation?</p>

Appendix 16: Transcript Excerpt

1	patient will be discharged, this patient is not appropriate for this, without the	
2	involvement of clinicians at all, which sometimes then makes you wonder how much	
3	is it really joint working?How much say do you have?Similarly resource allocation, I	Comment [BH(98)]: decision making, collaboration, commitment
4	think it would be nice to have clinicians involved. I think the Trust is striving toward	Comment [BH(99)]: involvement
5	working towards both of us working together but I think there is still some way to go	Comment [BH(100)]: resources, involvement
6	unfortunately.	Comment [BH(101)]: collaboration, well meaning
7		
8	Can you tell me about your experience of moving away from a deficit/medical model	
9	towards a co-production/recovery model?	
10		
11	Yes so my experience, well I have been very fortunate, I have always worked	
12	throughout my training with some really great clinicians and we have always taken a	
13	more holistic biosocial approach really. Medical model you could go into my clinic	Comment [BH(102)]: experience (beliefs)
14	letters right from the first day I started working - I have never just been focused on	
15	medications and medical model and physical health I have been very keen to ensure	
16	that I take the patient as a unique, whole person who has their own needs, got his	Comment [BH(103)]: experience (beliefs)
17	children, got his job, got his depression, got his medication, got his weight gain and	
18	all the rest of it and I need to address it all as like a unique patient. So I think that is	Comment [BH(104)]: experience (beliefs)
19	really important because if you just focus on one, so called medical model, you might	
20	miss wider issues. There might be other psychosocial stressors contributing to	Comment [BH(105)]: good thing
21	someone's current mental health problems, why they aren't going to work, so I think	
22	they will be missing out on high quality care if you are not using a co-production	
23	model.	
24		
25	What do you feel the incentives are for people to engage with co-production?	
26		
27	Incentives are, I think we covered it earlier as well, it is hard work in the clinic	
28	because you have to really sit down and talk to the patient, with the wider team as	
29	well, looking at when you have conversations with the care coordinator about	
30	offering them everything, to be holist and it is quite easy to say prescribe Zopiclone	
31	for sleep. However I think it is definitely worth it in terms of the long term benefit, the	Comment [BH(106)]: SU benefits
32	recovery of the patient, better patient satisfaction, if you invest that time in co-	
33	production. And again I think reduced risk, whether it is the risk of poor mental	Comment [BH(107)]: SU benefits
34	health, risk to other, risk to self so if you have got patients on the same page as you I	
35	think it works much better that way.	
36		
37	How do your beliefs about co-production compare with the reality about how it is	
38	being implemented within the Trust?	
39		
40	I think we could do better. So for example, I would want a quick access to a care	Comment [BH(108)]: Experience (beliefs)
41	coordinator to a consultant when we are in the community. When an inpatient I will	Comment [BH(109)]: resources
42	have quick access to a consultant if a patient comes in and have a bit of a holist	
43	approach working with the patient. Similarly if a patient is with the home treatment	
44	team then I would want them to be seen promptly, regularly and appropriately, with	
45	the resources if that is OT, psychological therapy, medical nursing care - I would	
46	want them to have it available for the patient. I think there is some inconsistent	

1 practices across the Trust so I think we could definitely do better and I think it needs
2 to come from the change in culture where we normalise it that it has to be co-
3 production, we have to work with the patient and this is the patient's right to see a
4 consultant, get psychological therapy and have a care coordinator so I think if our
5 culture is changed and we strive towards giving that excellence that may actually
6 help, but like I said there are inconsistencies and I know that in some of the teams,
7 people are unallocated, some teams don't have access to a pharmacist,
8 psychological access is limited so I think there are inconsistencies about how people
9 can be fully involved in their care.

Comment [BH(110): Need for something different

Comment [BH(111): Need for something different

Comment [BH(112): Resources, collaboration

10
11 What advice would you give to another organisation looking to implement co-
12 production?
13

14 I think it comes right to, well at different levels really, right from the teaching and
15 training level, so if we have got nursing students, medical students, how do they
16 learn how to work very closely with the patient and empower them and offer this
17 holistic care and see the role model of senior nurses and doctors implementing that.
18 So it starts right from there. What we are currently offering so again learning from our
19 mistakes and complaints, having this culture of openness and so having policies that
20 support us to empower our patients and work together and support clinicians to do
21 what they want to do at a local level, if they think it works quite well for their particular
22 team— so I think that is particularly important. I think there is a bit of a thing about
23 recruitment and retention and unfortunately there is a bit of a crisis in the Trust, but
24 also nationally, so it is easy sometimes to recruit but sometimes harder to retain our
25 staff which is hugely disruptive for our patients and co-production. So you
26 train someone to the highest level and then they leave, so I think we need to focus
27 on retaining staff and ensuring that they don't burn out because it is a huge stress.
28 Again we see it day in and day out, staff leaving because they can't cope and it is too
29 sharp at the front end and you are being told to do yet another thing and they may
30 not say anything, but they vote with their feet so I think we need to focus on that. And
31 I think at more at the Trust board and higher management level to ensure that there
32 are appropriate resources available to offer what we are meant to offer, to ensure
33 that the staff are well looked after and to look at if there are any particular areas of
34 high sickness and high risk and proactively going there and solving the problem,
35 rather than things come up to crisis.

Comment [BH(113): SU benefits

Comment [BH(114): Su involvement, support

Comment [BH(115): recruitment

Comment [BH(116): recruitment, stress

Comment [BH(117): stress, recruitment

Comment [BH(118): resources, support

36
37 I only laugh because that is my team at the minute, we have three vacancies which
38 we cannot recruit to and I have 92 service users on my caseload.
39

40 It does have a bit of an impact doesn't it, on you for example. You will be very keen,
41 well say if I go to do my mandatory training I will be very stressed about what is
42 happening with my team...

43
44 ...yeah don't have a day off...
45

Appendix 17: Participant table

Participant Code	Locality	Email Sent	Email/Verbal Response received	Consent received	Interview Date	Feedback Provided
MM1	East	18/1/18	18/1/18	23/1/18	23/1/18	23/5/18
MM2	Central	18/1/18	18/1/18	22/1/18	7/2/18	22/5/18
MM3	East	6/2/18	6/2/18	8/2/18	14/2/18	6/8/18
MM4	East	17/2/18	17/2/18	19/2/18	22/3/18	6/8/18
MM5	Central	15/3/18	n/a	n/a	n/a	n/a
CL1	East	18/1/18	18/1/18	16/3/18	16/3/18	24/5/18
CL2	East	6/2/18	6/3/18	21/3/18	21/3/18	3/8/18
CL3	East	15/3/18	23/3/18	5/6/18	5/6/18	5/6/18
CL4	East	15/3/18	15/3/18	23/3/18	23/3/18	23/7/18
CL5	Central	30/4/18	30/4/18	24/5/18	24/5/18	23/7/18
SM1	All	24/5/18	24/5/18	5/6/18	5/6/18	5/6/18
SM2	All	24/5/18	n/a	n/a	n/a	n/a
SM3	All	24/5/18	24/5/18	21/6/18	21/6/18	21/6/18
SM4	All	24/5/18	24/5/18	24/5/18	14/6/18	14/6/18

Appendix 18: Interview log summary example

Contact Type: Interview

Site: CMHT

Contact Date: 16/3/18

Today's date: 16/3/18

Written by: Hayley Bamber

1. What were the main themes which were highlighted during this contact?

Power – consultants feel they don't have it. Staff feel they don't have it.

Reality – senior management don't seem to understand the reality for frontline workers.

Communication – no real communication about co-production and expectations.

Disconnect – the two ends of the hierarchy don't interact well.

Attitude – co-production could be good and a real change.

Change – always continuous revolution which is unsettling for staff.

Involvement – consultants are not involved in service development.

2. Summarize the information from each question posed during this contact.

Question

Demographics

Co-production model

Model communication

Experience in practice

Core characteristics

Working well?

Benefits?

Challenges?

Examples

Do differently?

Information

Clinical lead, all CMHT experience

Could be a good thing/real change/promotes involvement

Discussion paper/email/no further follow up

Not observed it in practice

Agreed with characteristics/not observed in practice.

Not working in practice due to poor communication.

SU involvement/empowerment/logic decisions

'Buy in'/culture/blame/organisational relationship with service users

None

Invest/demonstrate from top/be clear on expectations/ownership

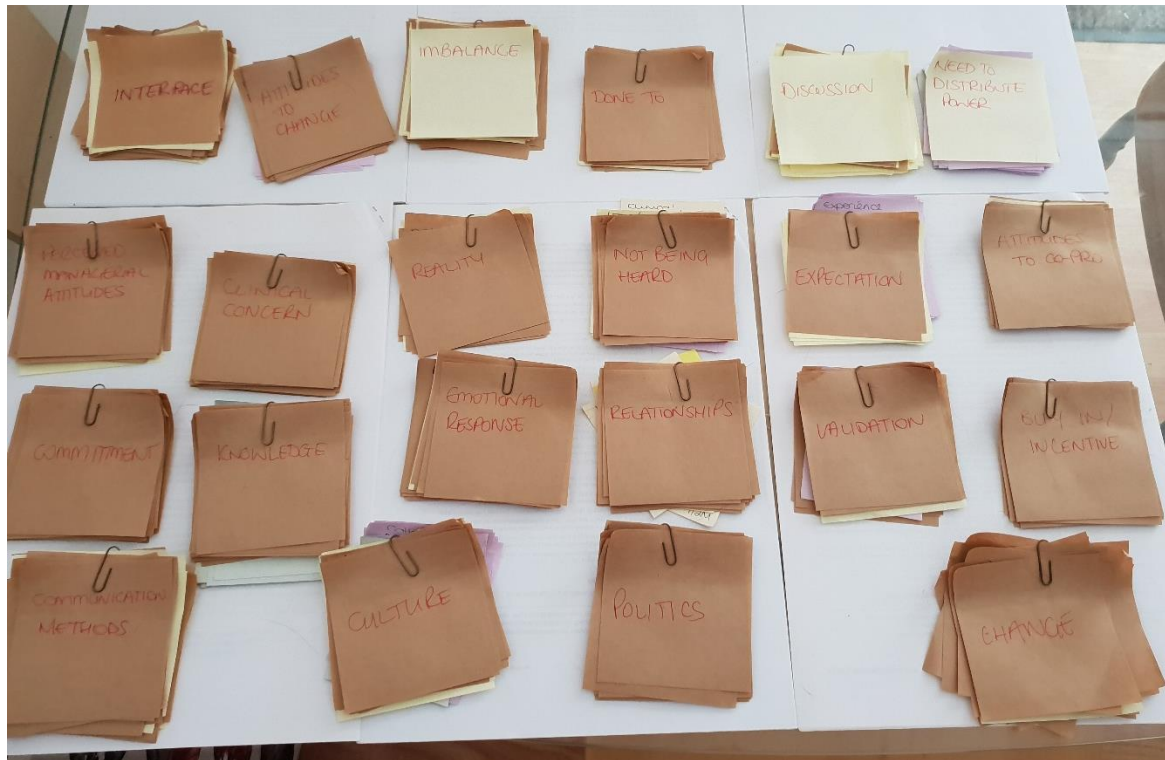
3. Anything else which was striking/important during the contact?

Participant wanted involvement in decision-making and organisational development but noted that consultants are often excluded as they assert clinical thinking which is often at odds with managerial ideas. Noted that power was forcibly taken from consultants. This made me consider how I practice as a manager and whether I include my consultants enough in decision-making.

4. Any new questions forming during contact?

No

Appendix 19a: Initial manual coding picture



Appendix 19b: Final manual coding photograph



Appendix 20a: Themes version One

Theme	Subthemes	Codes	
Corporate Machine	Commitment	Money	
		Demonstration of co-production	
		Tick box	
			Lack of learning
		Politics	Clinical v corporate
			Reputation
			Disconnect
			Tick box
			Business
			Top down
		Perceived managerial attitudes	Well meaning
			Tick box
			Lack of clinical understanding
			Lip service
	Top down		
		Blame	
Continuous Revolution	Change	Multiple	
		Direction	
		Name changes	
			SU involvement
		Attitudes towards change	You and us
			Sense?
			Experience
		Clinical Concern	Patients
			Safety
			Medical model
		Resources	
Power	Done to	Involvement	
		Not connected	
			Validated
			Ownership
			Expectation
			Top down
		Not being heard	Listening
			Lip service
			Tick box
			Power imbalance
			Top down
		Reality and Reaction	Realistic?
			Disconnect
			Honesty
	Staff retention		
		Stress	
		Decision-making	
Interface	Discussion	Meaning	
		Expectations	

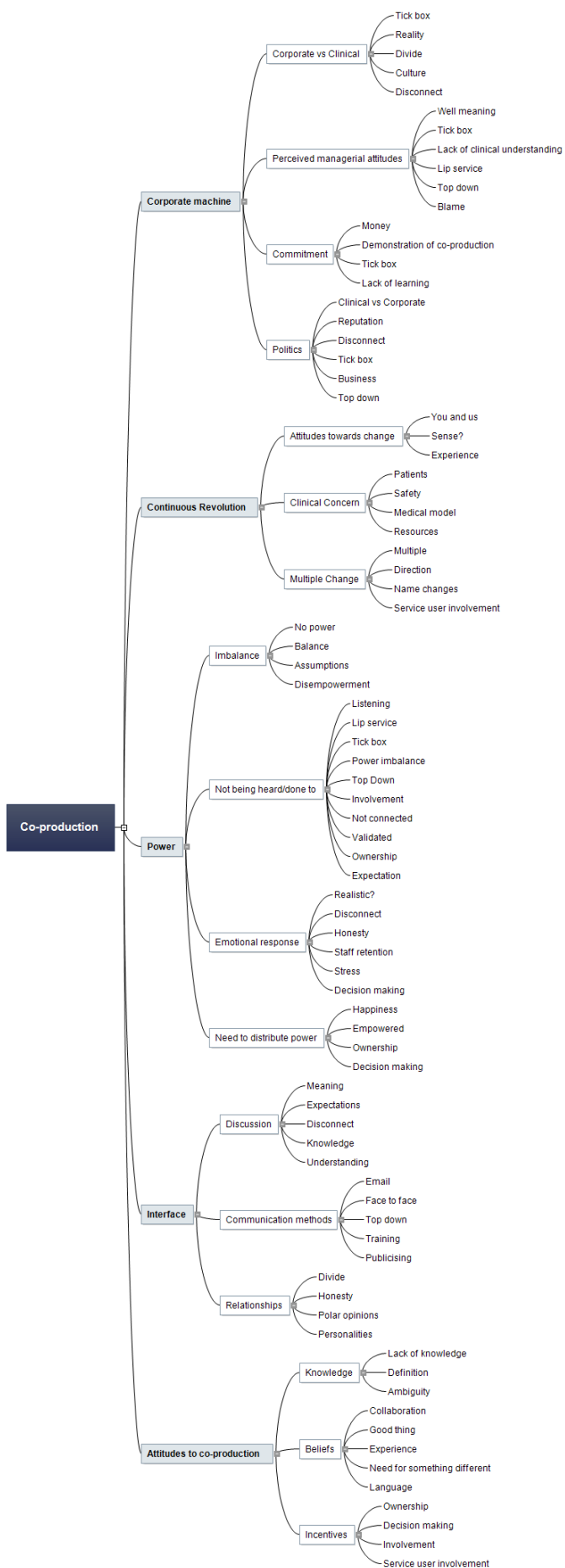
		Disconnect
		Knowledge
		Understanding
	Communication Methods	Email
		Face to face
		Top down
		Training
		Publicising
	Relationships	Divide
		Honesty
		Polar opinions
		Personalities
Attitudes to co-production	Beliefs	Collaboration
		Good thing
		Experience
		Need for something different
		Language
	Incentives	Ownership
		Decision-making
		Involvement
		Service user involvement

Appendix 20b: Themes version Two

Theme	Subthemes	Codes	
Corporate Machine	Corporate versus Clinical	Tick box	
		Reality	
		Divide	
		Culture	
		disconnect	
	Perceived managerial attitudes	Well meaning	
		Tick box	
		Lack of clinical understanding	
		Lip service	
		Top down	
		Blame	
		Commitment	Money
	Demonstration of co-production		
	Tick box		
	Lack of learning		
	Politics		Clinical v corporate
			Reputation
			Disconnect
		Tick box	
Business			
Top down			
Continuous Revolution	Attitudes towards change	You and us	
		Sense?	
		Experience	
	Clinical Concern	Patients	
		Safety	
		Medical model	
		Resources	
	Multiple Change	Multiple	
		Direction	
		Name changes	
		SU involvement	
		Power	Imbalance
	Balance		
Assumptions			
Disempowerment			
Not being heard/Done to	Listening		
	Lip service		
	Tick box		
	Power imbalance		
	Top down		
	Involvement		
	Not connected		
Validated			
Ownership			
Expectation			

	Emotional Response	Realistic?
		Disconnect
		Honesty
		Staff retention
		Stress
		Decision-making
	Need to distribute power	Happiness
		Empowered
		Ownership
		Decision-making
Interface	Discussion	Meaning
		Expectations
		Disconnect
		Knowledge
		Understanding
	Communication Methods	Email
		Face to face
		Top down
		Training
		Publicising
	Relationships	Divide
		Honesty
		Polar opinions
		Personalities
Attitudes to co-production	Knowledge	Lack of knowledge
		Definition
		Ambiguity
	Beliefs	Collaboration
		Good thing
		Experience
		Need for something different
		Language
	Incentives	Ownership
		Decision-making
		Involvement
		Service user involvement

Appendix 21: A diagrammatical representation of themes



Appendix 22: Supervision and Training

Supervision

Date	Supervisor	Outcomes
22/9/16	Tracey Williamson	<p>Further reading on ethnography and case studies</p> <p>Email PGR about anonymity on the ethics form and about earliest date for completing IA and IE assessments.</p> <p>Contact Chief Executive about anonymity of the Trust in my writing and about any admin support available for interviews.</p> <p>Redraft ethics form.</p>
9/12/16	Tracey Williamson	<p>Draft of Literature Review</p> <p>Draft for Methodology Chapter</p>
23/1/17	Tracey Williamson	<p>Complete Learning Agreement</p> <p>Complete second draft of Literature Review.</p>
25/5/17	Tracey Williamson and Elaine Ball	<p>Complete works on literature review – synthesis table/linking themes/signposting.</p> <p>Complete a draft for the IA report.</p> <p>Begin work on methodology – background reading.</p> <p>Continue work on ethics approval form.</p>
13/7/17	Tracey Williamson and Elaine Ball	<p>Prep for tomorrow's IA.</p>
18/8/17	Tracey Williamson and Elaine Ball	<p>Spend time reflecting on IA process.</p> <p>Try to determine focus of the research.</p>
14/9/17	Tracey Williamson and Elaine Ball	<p>Focus on completing ethics form for submission.</p> <p>Work on clarifying if the study is looking at co-production.</p>
10/10/17	Tracey Williamson	<p>Complete and proof read ethics approval form and the required attachments.</p> <p>Complete a draft of the concept analysis</p>
15/11/17	Tracey Williamson and Elaine Ball	<p>Revisit ethics paperwork and make minor changes and send to Tracey and Elaine today.</p>

		<p>Revisit concept analysis and read more around what a concept is.</p> <p>Complete a second draft of the concept analysis, trying to insert my own voice.</p> <p>Update GANNT chart to outline planned actions.</p>
5/12/17	Tracey Williamson and Elaine Ball	<p>Wait until the New Year to send out invites for interviews.</p> <p>Complete another draft of concept analysis.</p>
16/1/18	Tracey Williamson	<p>Redraft concept analysis.</p> <p>Complete conceptual framework</p> <p>Complete new literature review protocol.</p> <p>Commence data collection – send first 2 transcripts to Tracey and Elaine</p>
15/2/18	Tracey Williamson	<p>Concept analysis completed for now – aim to publish in the summer.</p> <p>Conceptual framework – put into the methodology chapter.</p> <p>Interviewing – redraft interview guide following completion of concept analysis.</p> <p>Methodology – start work on this chapter and do the background reading.</p>
15/3/18	Tracey Williamson and Elaine Ball	<p>Complete further interviews.</p> <p>Attend governance meetings.</p> <p>Write research questions and send to Tracey and Elaine.</p> <p>Redo literature review protocol in light of today's discussion.</p> <p>Tweak methodology with the amendments suggested.</p>
26/4/18	Tracey Williamson	<p>Complete data collection by completing validation interviews to determine if saturation has been completed.</p> <p>Complete interviews with Senior Leadership Team.</p> <p>Complete coding and theming.</p>
21/5/18	Tracey Williamson (phone)	<p>Coding is completed.</p> <p>Themes have been established but will require development.</p> <p>Complete draft of findings chapter</p>
29/6/18	Tracey Williamson (phone)	<p>Second draft of findings to be completed.</p>

		To address how I am going to structure and interlink the themes.
24/7/18	Tracey Williamson (phone)	Link the quotes more to the story in the findings. Commence the discussion chapter.
6/8/18	Tracey Williamson and Elaine Ball	To edit currently completed chapters ready for IE. To redo literature review to update with current literature. To bring the structure of the thesis together. To submit IE document on 17/9/18. To look at who could act as the external examiner for the viva voce.
26/9/18	Tracey Williamson and Elaine Ball	To prepare for IE next month.
17/10/18	Elaine Ball	Debrief after IE Take away feedback to process ready to meet and plan.
13/12/18	Elaine Ball and Mariyana Scholtz	Send Mariyana copy of the thesis so she can comment. Start working on recommendations from the IE ready for resubmission.
8/2/19	Mariyana Scholtz	Work on feedback on the literature review Read some other literature reviews and consider how these have been structured.
26/2/19	Elaine Ball and Mariyana Scholtz	Continue working on the edits for resubmission.
29/5/19	Elaine Ball	Work on getting a full draft of the thesis complete ready for editing.
Between May 2019 and January 2020	Elaine Ball – various phone conversations to polish thesis	Work on final edits Work on use of language Work on signposting. Send to editors. Complete final draft ready for submission.

Training

Date	Training accessed	Outcomes
11/8/16	Literature Searching Part 1: Getting started with a literature search. E-learning.	Supported starting the literature review
12/4/17	Literature Searching Part 2: Choosing which databases to search. E-learning.	Supported justification of database selection

1/6/17	Literature Searching Part 6: Advanced Searching. E-learning.	Supported with using limiters to reduce the volume of articles.
15/6/17	Watched the 'Get up and running with NVivo 10 for Windows' video as recommended on the PGR website	Helped me decide to utilise this software to support the data analysis process.
30/7/17	Reviewing literature and paraphrasing (YouTube training from University website)	Felt more confident with literature searching
23/11/18	Get ready for Viva workshop	Readiness for viva, increased knowledge of process, increased confidence
20/12/19	Enhancing Research Impact (online learning)	To support dissemination of findings from the study.

Appendix 23: Gantt chart

April 2017				May 2017				June 2017				
3	10	17	24	1	8	15	22	29	5	12	19	26
Literature Review								IA report Prep				
July 2017				August 2017				September 2017				
3	10	17	24	31	7	14	21	27	4	11	18	25
	Interim Assessment	Methodology chapter					Ethics Form		Submit Ethics	Background chapter	Learning agreement	
October 2017				November 2017				December 2017				
2	9	16	23	30	6	13	20	27	4	11	18	25
Annual review/PDP	Concept Analysis chapter					Concept analysis/methodology						
January 2018				February 2018				March 2018				
1	8	15	22	29	5	12	19	26	5	12	19	26
Data Collection – MM & CL						Data Analysis						Validation meetings
April 2018				May 2018				June 2018				
2	9	16	23	30	7	14	21	28	4	11	18	26
Begin to write up findings					Data Collection - SLT			Results chapter	Reflection chapter			
July 2018				August 2018				September 2018				
2	9	16	23	30	6	13	20	27	3	10	17	24
Prepare draft for IE – Literature Review					Prep for IE							Learning Agreement
October 2018				November 2018				December 2018				
2	9	16	23	30	6	13	20	27	3	10	17	24
Annual review/PDP	Internal Evaluation				Discussion chapter					Conclusion		
January 2019				February 2019				March 2019				
2	9	16	23	30	6	13	20	27	3	10	17	24
Contents table and list of tables			References	First full draft	Internal Evaluation Resit							
April 2019												
3	10	17	24									
Work on feedback from IE												

May 2019				June 2019				July 2019				
3	10	17	24	1	8	15	22	29	5	12	19	26
Work on feedback from IE								Complete 2 nd Draft thesis				
August 2019				September 2019				October 2019				
3	10	17	24	31	7	14	21	27	4	11	18	25
Work on editing all chapters								Hand in final draft for comment		Learning agreement		
November 2019				December 2019				January 2020				
2	9	16	23	30	6	13	20	27	4	11	18	25
Annual review/PDP	Send off for editing											Submit thesis
February 2020				March 2020				April 2020				
2	9	16	23	30	6	13	20	27	4	11	18	25
Annual review/PDP	Send off for editing											Viva Voce