Keywords Patient collaboration/ Person-centred care/Secure care

This article has been double-blind peer reviewed

In this article...

- The benefits of and barriers to coproduction of patient care
- A survey examining mental health staff members' perceptions of coproduction
- Recommendations for organisations to implement coproduction and engage staff

Exploring coproduction of patient care in a secure mental health setting

Key points

Coproduction is key to person-centred care, but there is much misconception among health staff

A mental health charity conducted a survey exploring its staff members' experiences of coproduction

It revealed staff had an implicit understanding of the concept and saw it as relevant to their role

Opportunities for improvement included interpersonal and environmental barriers to the implementation of coproduction

Organisations should provide staff with a clear definition of coproduction that emphasises the cooperative element, including good practice examples

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Abstract Coproduction is an important mechanism in the delivery of person-centred care and can contribute substantially to a patient's recovery pathway. However, secure care presents a number of challenges, which may prevent the embedding of coproduction as standard practice. This article reports on the development and findings of a charity-wide survey exploring the knowledge of and attitudes towards coproduction among staff working in secure mental health care. The survey's findings will inform an educational campaign to improve awareness of coproduction and drive its implementation as standard practice.

Citation Webb E, Girardi A, Stewart I (2021) Exploring coproduction of patient care in a secure mental health setting. *Nursing Times* [online]; 117: 4, 34-38.

Coproduction is now considered the gold standard in healthcare and is listed as a key principle in the delivery of person-centred care in clinical guidelines (National Institute for Health and Care Excellence, 2016). At its core, coproduction can be defined as a process of multidisciplinary collaboration between patients, staff and stakeholders as equal partners with complementing knowledge. Nonetheless, there is no standardised definition and coproduction is currently used as an umbrella term (Boyle and Harris, 2009). There is much misunderstanding among health professionals about what coproduction looks like and this can act as a barrier to its implementation (Bee et al, 2015).

A limited but growing evidence base shows positive patient outcomes are achieved through coproduction, including improved sense of self and quality of care (Bosco et al, 2019), as well as reduced use of medication and health services (Slay and Stephens, 2013). The involvement of people with lived experience in the education and training of nurses has also been highlighted as important in driving the effective implementation of coproduction into practice (Horgan et al, 2020). Nonetheless, the delivery of person-centred care can present a particular challenge in mental health services due to potential limitations in patient capacity (Pilgrim, 2018). As a result, coproduction is not always embedded as standard practice and staff may lack comprehensive knowledge of it, both as a concept and in practice. Consequently, patients can be treated as passive recipients of care (Marklund et al, 2020), which can have a negative impact on their recovery pathway (Alguera-Lara et al, 2017).

Coproduction is not only about patient involvement. Clinical care guidance highlights the importance of a 'whole-systems' approach that embeds staff participation at all organisational levels (Social Care Institute for Excellence, 2007). Endorsement at leadership level is key to cultural change, but frontline staff have an equally essential role in translating coproduction

into care, including those working in non-clinical areas.

Developing an educational campaign

This article describes a staff survey conducted at St Andrew's Healthcare, a charity providing specialist mental health care for patients with complex clinical needs through a range of services. The charity already recognises the importance of coproduction. This is evident in a multitude of its practices, including patient involvement in corporate events and staff training, as well as representation on interview panels. A commitment to patient and carer engagement is also reflected in the charity's patient experience and involvement strategy, which outlines a number of priorities grounded in coproduction. These include the need to listen and respond to feedback, to coproduce plans and services, and to involve patients and carers in research opportunities.

Part of the charity's overarching approach is the psychology profession strategy, which was developed to ensure that the charity is psychologically minded, putting the patients' health and wellbeing at the centre. From this, a patient experience and coproduction working group was formed. Although this was initially a psychology-led group, membership has since expanded to include wider experience, perspectives and skills. The group currently comprises psychology and nursing staff, as well as patients. A key initiative of this group was to develop an educational campaign to encourage staff to implement coproduction.

The first step was to explore knowledge and experiences of coproduction within the charity, to inform the key campaign messages and determine where resources could be deployed to the greatest benefit. A charity-wide staff survey was launched, in which coproduction was defined as "the collaboration between the individual with lived experience of mental illness, their family, friends and carers, service providers, and professionals as equal partners in the commissioning, planning, and delivery of support". This was adapted from the definition of coproduction used by Rethink Mental Illness (2017).

Alongside the staff survey, information was pooled from two other sources to inform the campaign. The internal clinical audit and assurance team conducted monthly audits of care plans during 2019-20, which reviewed whether:

- Patients and their carers had been involved in writing their care plans;
- The patient's voice was conveyed;
- A copy had been given to the patient.

The patient engagement team also conducted an annual patient survey about patients' perceptions of their own involvement in their care. A multimodal approach was used to develop the campaign, triangulating findings from all three data sources; however, this article's focus is the staff survey.

Box 1. Care coproduction staff survey

1. Which integrated practice unit or department do you currently work in?	
2. What is your job title?	
3. How long have you been working at St Andrew's? _____ years _____ months	
4. Have you ever heard of care coproduction with patients?	
☐ Yes – go to 4a	☐ No – go to 4b
4a. If YES, please describe what you know or your experience of care coproduction with patients	**4b. If NO, please explain what you think care coproduction with patients is**
5. This is what we believe care coproduction is: The collaboration between the individual with lived experience of mental illness, their family, friends and carers, service providers and professionals as equal partners in the commissioning, planning, and delivery of support	
6. How relevant do you think care coproduction with patients is to your role?	
☐ Very irrelevant	☐ Slightly irrelevant
☐ Neither relevant nor irrelevant	☐ Slightly relevant
☐ Very relevant	
7. Please explain your choice.	
8. How relevant do you think care coproduction is for patients at St Andrew's?	
☐ Very irrelevant	☐ Slightly irrelevant
☐ Neither relevant nor irrelevant	☐ Slightly relevant
☐ Very relevant	
9. Please explain your choice.	
10. Do you feel you could coproduce care with patients?	
☐ Yes	☐ No
☐ Don't know	☐ Not applicable
11. How confident do you feel coproducing care with patients?	
☐ Not at all confident	☐ Slightly confident
☐ Neither confident nor unconfident	☐ Moderately confident
☐ Very confident	☐ Not applicable
12. Do you think patients at St Andrew's are currently involved in producing their care plan?	
☐ Yes – go to Q12a	☐ No – go to Q12b
☐ Don't know – go to Q13	☐ Not applicable – go to Q13
12a. If YES, please describe how patients are involved (for example, how often, what they do etc)	**12b. If NO, please explain the reasons or barriers that you believe prevents care coproduction from being implemented at St Andrew's Healthcare**
13. What are we doing well at St Andrew's to facilitate care coproduction with patients?	
14. What do we need to improve to facilitate care coproduction with patients?	

Survey development and distribution

Multidisciplinary staff and patients developed the survey, which comprised 10 questions (Box 1) relating to seven domains (Table 1). Patient membership of the coproduction working group was encouraged, but not always achieved, due to difficulties in patients accessing the meetings. Nonetheless, patient consultation was embedded into the survey development to ensure items were relevant to patient care. Patients were approached by a member of the multidisciplinary team to discuss the domains and questions, which were then revised based on the feedback given.

The survey was advertised on the charity's intranet for four weeks, distributed internally via email, and advertised through a computer lock screen. Paper copies were also distributed at various locations around the Northampton site. To understand different staff members' perspectives, the survey was made available to all clinical and non-clinical staff. Prior to completing the survey online, participants read a brief introduction that outlined who had developed the survey and its purpose and informed them their responses would be used to build an anonymous database. Staff members who agreed to proceed had to give their consent and could terminate their participation at any point. Those who completed a paper survey posted them in a response box; because the survey was anonymous, it was not possible to withdraw an individual's response once posted.

There was no need to seek ethical approval, as the survey was a service evaluation rather than research, but the internal clinical audit and assurance team approved the project on its first submission. Participants were required to provide information about their job role. To minimise the risk of them being identified, the number of respondents within the total sample and length of time in role were stratified by job role and department.

Survey results

We stratified the frequency and percentage of survey responses by job role and department. Quantitative responses were explored as percentages across the overall sample and stratified by role type (clinical versus non-clinical). We analysed qualitative responses manually, using reflexive thematic analysis to identify patterns. Themes were then identified at a semantic level, focusing on the explicit meanings within the data. An essentialist epistemological position was adopted to guide analysis, assuming a unidirectional relationship between language and meaning, and a six-step approach was used (Braun and Clarke, 2006). Analysis began by focusing on the key idea expressed and summarising this into a code. We then refined these codes and grouped together those sharing similar meanings. We then encompassed the themes generated from this process into broader overarching themes within the seven domains (Table 1).

Table 1. **Domains explored in the staff survey**

Domain	Meaning
Knowledge	Conceptual understanding of coproduction
Experience	Current and previous experiences of engaging in coproduction practices
Relevance	Perceived relevance of coproduction to staff and for patients
Skills and confidence	Perceived ability of and confidence in coproduction
Engagement	Perceptions of patients' involvement in care
Barriers and opportunities for improvement	Factors preventing engagement and areas requiring further progress
Strengths	Areas where the charity is evidencing good practice

The survey elicited 108 responses from 21 departments across the charity's Northampton site. Eighty participants (74.8%) were in a clinical role, with the majority working as healthcare assistants (26.2%), assistant and trainee psychologists (18.8%) and nurses (11.3%). The remainder mostly worked in child and adolescent mental health services (15.8%) and in dementia and Huntington's disease care units (11.6%). Staff working non-clinically comprised a quarter (25.2%) of the sample and commonly worked in academia (11.6%) and administration (10.3%).

We identified 19 themes across the seven domains (Fig 1), which we discuss below.

Knowledge

Just under half of participants said they had heard of coproduction; this was higher among clinical (48.8%) than non-clinical staff (40.7%). Nonetheless, when asked what they thought coproduction was, most staff (67.2%) could define it accurately; this included those who said they had not heard of it, suggesting a level of implicit understanding. Most participants described coproduction as an equitable, multidisciplinary collaboration between staff, patients and others (for example, family) for the primary purpose of facilitating recovery. This was in line with the definition developed by our working group to gauge understanding, which appeared later in the survey. When the level of implicit understanding was taken into account, knowledge of coproduction within the charity rose to over 80%.

Experience

The participants' direct experiences of coproducing care mostly involved working alongside patients to produce care plans, but also extended to service-wide care, and developing patient activities and educational resources. Indirect experiences that helped coproduction included staff interactions with others, including carers and external partners. Organisational experiences included attending patient-led meetings and engaging with patients in research and audits.

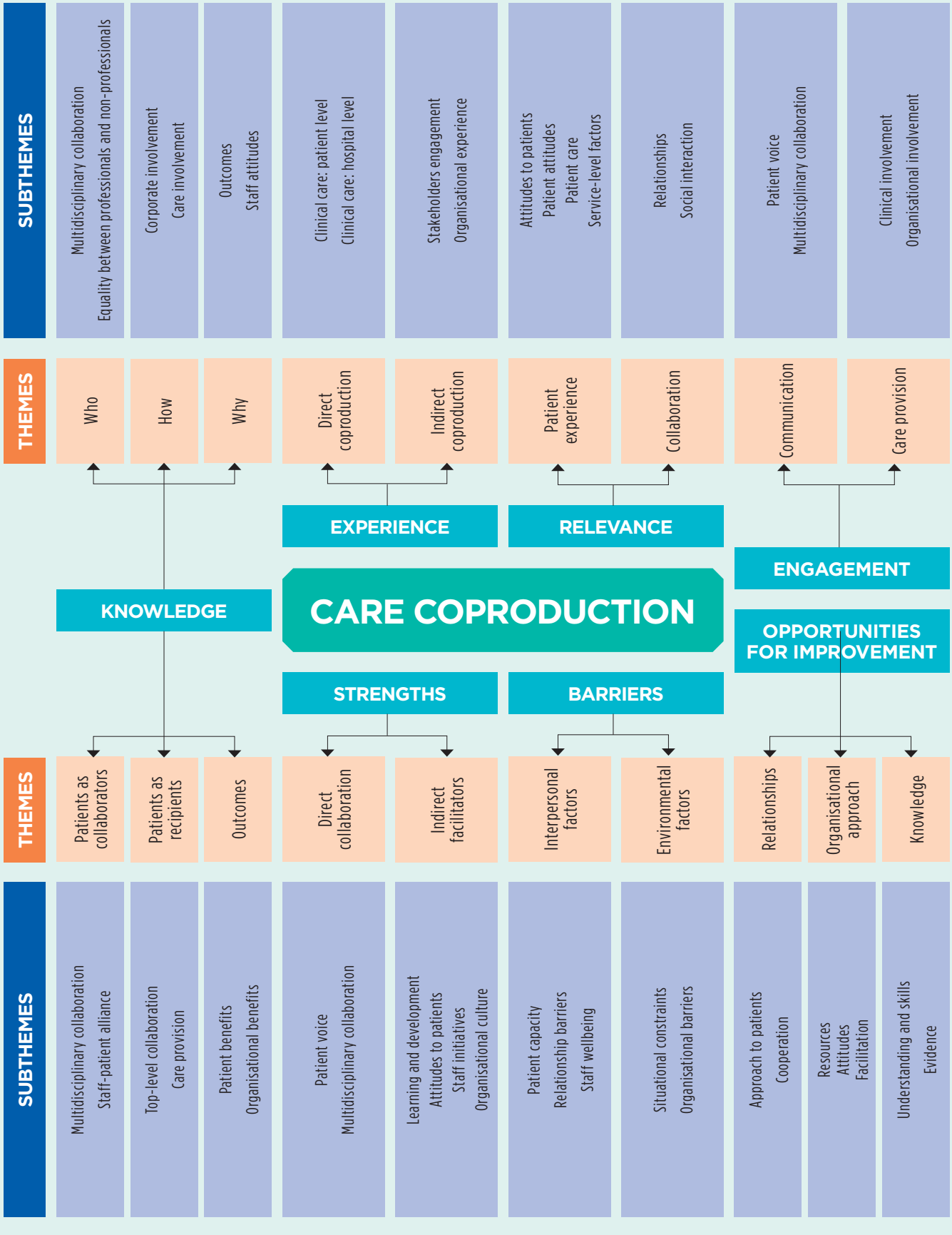
Relevance

We asked staff members to rate the extent to which they felt coproduction to be relevant on a Likert scale, ranging from 1 (very irrelevant) to 5 (very relevant). The majority of clinical and non-clinical staff perceived coproduction to be relevant both to their role (96.3%) and to patients (100%). Participants reported perceiving coproduction as meeting a need for collaboration and having a positive impact on patient experience. While no participant thought coproduction was neither 'very irrelevant' nor 'slightly irrelevant' to their role, some highlighted factors they felt limited its relevance. Specifically, these were limitations of the role itself – such as a lack of patient contact – and a need for further collaboration through opportunities to engage with stakeholders.

Skills and confidence

Across the sample, self-reported ability to coproduce care was high (79%).

Fig 1. **Thematic map of the themes and subthemes of each domain**



Understandably, a greater percentage of those in clinical roles felt able to coproduce care (85%) than those working non-clinically (55%). Confidence in coproducing care was rated on a Likert scale ranging from 1 (not at all confident) to 5 (very confident). Almost three quarters of participants (74.5%) indicated confidence in their ability to coproduce care. The mean rating of 3.92 suggested that, generally, staff felt 'quite confident', although those in clinical roles tended to give higher confidence ratings (m=4.09) than those working non-clinically (m=3.3). Over three quarters of clinical staff (80.8%) indicated confidence in their ability to coproduce care, whereas half of non-clinical staff (50%) reported some degree of confidence.

Engagement

Over half of participants (58.3%) perceived patients to be involved in the coproduction of their care, with perceived patient involvement greater among clinical staff (63.2%) than non-clinical staff (42.3%). However, the percentage of staff members who perceived patients to be absent in the production of their care was also greater in the clinical (11.8%) than non-clinical sample (7.7%). Almost a third of staff were unsure about the level of patients' involvement, with higher uncertainty among non-clinical staff (50%) than clinical staff (25%).

When discussing what patient involvement looked like, participants recognised coproduction was a multidimensional practice that varied between individual patients. Participants frequently referred to coproduction in terms of communication, as a way of ensuring the patient's voice is heard. They also highlighted patients' more immediate involvement in the provision of care, such as participating in events and meetings, and in the delivery of staff training.

We considered the potential impact of individual staff members' experience on awareness, skills and perceptions of patient involvement. However, in our sample, experience was not synonymous with an awareness of coproduction, self-perceived ability to coproduce, nor insight into current coproduction practices.

Barriers and areas for improvement

We further explored staff members' perspectives on current practice in terms of factors preventing or aiding the coproduction of care. The barriers highlighted were largely environmental, including constraints on staff time and resources and geographical distance between patients and stakeholders. Interpersonal barriers were also frequently referenced, such as limitations in patients' capacity.

Recognising these barriers, many staff registered the need to optimise relationships, namely in the way patients, staff and stakeholders collaborated. They also highlighted a number of areas requiring organisational improvement, including increased availability of resources and coproduction opportunities. Participants placed importance on improving staff knowledge through promoting coproduction and opportunities for training. They also emphasised the need to evidence the benefits of coproduction, including improved outcomes, as well as communicating to patients how their inputs had been actioned.

Strengths

Based on their experience of coproduction across the charity, staff highlighted two key strengths when discussing examples of direct collaboration: the opportunity for patients to make their thoughts heard and co-operative relationships between staff, patients and stakeholders. They also mentioned indirect facilitators of coproduction, including:

- Educational opportunities and resources for patients;
- Good-quality staffing and positive employee experience;
- Positive staff attitudes towards patients;
- An organisational emphasis on coproduction.

Implications and future directions

The findings of the staff survey have prompted several considerations for the development of our educational campaign. First, it is essential to provide a clear definition of coproduction that emphasises the cooperative element; this ensures shared understanding of the concept. The campaign should also include examples of how staff can use coproduction within clinical and non-clinical settings, because uncertainty around patient involvement in care could reflect a limited understanding of what coproduction looks like in practice. Such examples need to be practical and realistic, particularly because barriers perceived by staff included constraints relating to the secure setting and pressure on resources.

Second, the campaign needs to consider its target audience. Although responses varied across job roles and departments, both clinical and non-clinical staff saw coproduction as relevant to their role and to patients, showing the importance of addressing both groups of staff within the campaign. Where possible, the campaign also needs to address the perceived barriers to patient involvement. For example, providing evidence of positive outcomes could encourage implementation where a lack of staff confidence is a barrier. Promoting good-practice examples could provide further encouragement to staff and would also be important in the campaign.

The survey explored staff knowledge, attitudes and experiences, but the campaign will also address patients. Active collaboration is the core principle of coproduction, and we recognise the need to educate all stakeholders. We will encourage patient involvement in developing the campaign by consulting patients at virtual working group meetings and patient involvement networks. While we cannot yet provide a definite description of what this collaboration will look like, we will seek patient involvement in the coproduction of key messages and their subsequent dissemination through different mediums, such as arts and poetry. **NT**

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