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Title	Using co-production in the implementation of community integrated care: a scoping review
Type	Article
URL	https://clock.uclan.ac.uk/id/eprint/40900/
DOI	https://doi.org/10.7748/phc.2022.e1753
Date	2022
Citation	Marshall, Kirsty and Bamber, Hayley (2022) Using co-production in the implementation of community integrated care: a scoping review. Primary Health Care. ISSN 0264-5033
Creators	Marshall, Kirsty and Bamber, Hayley

It is advisable to refer to the publisher's version if you intend to cite from the work.
<https://doi.org/10.7748/phc.2022.e1753>

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Why you should read this article:

- To recognise co-production as an essential component of community integrated care
- To be aware of the benefits and challenges of implementation of co-production in integrated care service design
- To understand that practitioners need to address power dynamics among organisations, practitioners and citizens, patients and service users when commencing co-production in integrated care

Using co-production in the implementation of community integrated care: a scoping review

Kirsty Marshall, Hayley Bamber

Key points

- *Co-production is a core element of community integrated care development*
- *Power dynamics among organisations, practitioners and citizens, patients and service users affect how co-production is implemented*
- *Nurses need to develop skills in co-production when managing change*

Citation

Marshall K, Bamber H (2022) Using co-production in the implementation of community integrated care: a scoping review. Primary Health Care. doi: 10.7748/phc.2022.e1753

Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

Correspondence

k.a.marshall@salford.ac.uk

Conflict of interest

None declared

Accepted

4 October 2021

Published online

xxx 2022

Abstract

The 2020 update of the Marmot report into health inequalities stated that life expectancy in England has stalled, ill health has increased and inequalities in health have widened, especially in the north of the country. Co-produced integrated care is a potential solution to fragmentation in health and social care. This scoping review considers how co-production has been used in the implementation of integrated care and how it can inform future practice and research. The review identified three main themes covering co-production to improve community integrated care for organisations, practitioners and patients/service users. The review concludes that co-production is desirable and potentially beneficial. When commencing co-production in integrated care, practitioners need to consider power dynamics among organisations, practitioners and citizens, patients and service users.

Author details

Kirsty Marshall, senior lecturer, Integrated Care, School of Health and Society, University of Salford, Salford, England; Hayley Bamber, lecturer, Occupational Therapy, University of Central Lancashire, Preston, England

Keywords

best practice, community, community care, management, practice development, professional, professional issues, service development, service redesign

Background

Life expectancy in England has stalled, ill health has increased and inequalities in health have widened, especially in the north of the country (Marmot et al 2010, 2020). Inequalities in health and access to healthcare have been magnified [Q1 ok as rephrased?] by the coronavirus disease 2019 pandemic, which has exposed fragility in healthcare systems worldwide (Lewis et al 2020), leading to renewed calls for stronger and more resilient care systems able to respond to and adapt to challenges and crises (Lewis and Ehrenberg 2020). Approaches include the development of integrated care systems, outlined in a government white paper (Department of Health and Social Care (DHSC) 2021).

Health inequalities result from multiple factors many of which fall outside the remit of healthcare systems, including social, economic, environmental, cultural and political factors (Allen et al 2018). Allen et al (2018) identify opportunities to improve population health and reduce inequalities through the design of more effective healthcare models, such as supporting the implementation of integrated services through co-production (Realpe and Wallace 2010). Co-production forms one of the principles of integrated care identified by the World Health Organization (WHO) (2016) and should be considered an essential component of the development of integrated services.

This article presents a review of literature exploring how co-production can support the development of integrated services, identifying research and areas that may require further research (Goodwin 2016a).

Defining integration

The white paper, Integration and Innovation: Working Together to Improve Health and Social Care for All (DHSC 2021), outlines a substantial shift in the structure and management of the health and social care system. It is imperative that nurses and other practitioners have a strong understanding of what integrated care is and how its expansion will affect their future practice and patient outcomes. Approaching the concepts of integrated care can be daunting, with 175 definitions in operation many of which are context dependent and distinctly different across the world (Billings et al 2003, Armitage et al 2009, Goodwin et al 2014). Ham and Curry (2011) stated that there is no single best way of delivering integrated care and Goodwin (2016b) argued that the variance in definitions has been driven by the many legitimate purposes, stakeholders and requirements involved.

Shaw et al (2011) define integrated care as reflecting:

‘.... a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.’

National Voices (2013) developed an alternative definition of integrated care from the patient’s perspective:

‘I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.’

A more appropriate way to understand integrated care is as an overarching approach with a set of guiding principles rather than a stringent definition. The WHO’s core principles of integrated care (Box 1) provide one such set of overarching principles (Goodwin 2016b, WHO 2016).

Box 1. World Health Organization core principles of integrated care

- » Collaborative
- » Comprehensive
- » Continuous
- » Coordinated
- » Co-produced
- » Empowering
- » Equitable
- » Ethical
- » Evidence-informed
- » Governed through shared accountability
- » Holistic
- » Preventive
- » Respectful
- » Sustainable
- » Whole-systems thinking

(World Health Organization 2016)

Reflecting on the WHO's principles, integrated care cannot be seen just as a purely structural change, but one that requires a cultural shift (Ham and Curry 2011, WHO 2016). For integrated care to be truly transformative and deliver improved outcomes for people, clinicians need to work differently at service and practice level (Goodwin 2016a). Through changing the way they work with people and communities, services can target their community's needs resulting in cost-effective delivery, improved care experience and outcomes and service user well-being (Goodwin 2016a). Co-production is an important factor in the successful development of integrated care as it links the process of care with the people who receive the care (Realpe and Wallace 2010).

Defining co-production

Challenges exist with defining co-production for practical application in healthcare services (Bamber 2020). The New Economics Foundation (Boyle and Harris 2009) defines co-production as:

'...delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.'

Bamber (2020) puts forward an alternative definition:

'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.'

Core characteristics of co-production

Bamber (2020) identifies six core characteristics of co-production (Table 1).

Table 1. Core characteristics of co-production (Bamber 2020)	
Core characteristic	Meaning in practice
Assets	Recognition of the skills and attributes of all involved (McGeechan et al 2016)
Equality	Concerted efforts to shift the balance of power through blurring boundaries to enable even distribution among all involved (Fugini et al 2016)
Capacity	Altering the delivery model from a deficit approach to one that supports asset use (Filipe et al 2017)
Networks	Transferring knowledge by engaging peer and personal networks alongside professionals (Nesta 2012)
Catalysts	Engaging public service agencies to become facilitators (Sanderson and Lewis 2012)
Reciprocity	Someone receiving something in return for what they have invested (Silverstein et al 2002)

As integrated care is adopted across health and social care services it is vital that nurses gain knowledge on the provision of meaningful service-user involvement in all stages of service design, implementation and evaluation to place those who use services at the centre of their care and improve outcomes (Kaehne et al 2018).

Aim

The aim of the scoping review was to explore how co-production has been used in integrated care implementation. A scoping review is suitable when there is a requirement to review and map available literature for critical ideas comprehensively (Anderson et al 2008, Levac et al 2010).

Method

A population, interventions, comparators, outcomes and study design (PICOS) framework (Methley et al 2014) was used to formulate the review question: 'How has co-production been used in integrated care implementation in the UK adult health and social care sector?'

Multiple resources were used to select relevant qualitative and quantitative studies, including electronic databases, internet searches and research registers. Journals and reference lists were also checked by hand for relevant studies. A University of Salford library search included MEDLINE and the Cumulative Index to Nursing and Allied Health Literature databases. Scholar and individual journal websites, such as the Journal of Community Nursing and the International Journal of Integrated Care, were searched separately. All articles had to be published after 2008 and the Darzi review of the NHS (Darzi 2008) as this point was identified as a significant shift in policy towards the inception of integration. Search terms are outlined in Box 2.

Box 2. Search terms

- » Integrated care
- » Co-production
- » Patient/service user
- » Integrated care and co-production
- » Integrated care/patient/service user
- » Integrated care/co-production/patient/service user

Inclusion and exclusion criteria were developed to enable the final selection of literature (Box 3). PICOS ensured a robust and systematic approach was followed in selection and refinement (Methley et al 2014). A total of 87 articles were identified from the resources searched. All abstracts were screened against the inclusion and exclusion criteria and duplicates were removed. Abstracts that met the inclusion criteria were included in the next stage ($n=67$). Identified articles were reviewed in full against the inclusion and exclusion criteria ($n=7$). Citation tracking (manual search) was then used to identify other relevant articles ($n=4$) (Methley et al 2014). A final set of 11 articles was included in the scoping review.

Box 3. Population, interventions, comparators, outcomes and study design (PICOS) inclusion and exclusion criteria

Inclusion criteria

- » Population: research that focused on adult care (aged 16 and above) and on community services. International and national studies were included where relevant
- » Interventions, comparators: integration and partnership, inter- and multisector, including public, private and voluntary sector, neighbourhood team development where co-production formed part of the design
- » Outcomes: research that demonstrated success or failure of integrated care and integration (including service delivery, patient outcomes and financial outcomes) were included where co-production formed part of the design
- » Study design: multiple study designs were included in line with scoping review methodology (Anderson et al 2008). All studies were required to be in English

Exclusion criteria

- » Population: research that focused on children's services
- » Interventions, comparators: public-private sector partnerships and corporate responsibility partnerships. Studies on accountable care development and integrated care systems from a commissioning perspective. Government and/or think-tank documents with no direct reference to the UK health and social care system
- » Outcomes: research that focused on one aspect of structural transformation (for example information technology, clinical pathways or electronic health records) and did not include a co-production element. Research that only applied to performance measures was excluded as it did not relate to the research question
- » Study design: non-peer reviewed articles, comment pieces and foreign-language articles without translation

Extraction of data

To extract the relevant data from the included articles ($n=11$) and provide a standardised approach, a range of Critical Appraisal Skills Programme (2019) checklists were used.

Charting of data: evaluation, analysis and interpretation

The use of a framework enabled the theming of the literature to be standardised, which added to the dependability of the findings (Nowell et al 2017). Braun and Clarke's (2006) six-phase thematic analysis was used:

- Familiarising yourself with the data.
- Generating initial codes.
- Searching for themes.
- Reviewing themes.
- Defining and naming themes.
- Producing the report.

Each article was reviewed, relevant information and data were assigned a code or multiple codes with a total of $n=89$ codes developed, including repeated codes. The codes ($n=89$) were analysed to identify three main themes and sub-themes (Figure 1). Table 2 summarises the identified articles.

Figure 1. Themes and sub-themes

Table 2. Summary of the articles included in the scoping review

Article title	Author(s)	Method of data collection	Findings
Everyday and unavoidable co-production: exploring patient participation in the delivery of healthcare services	Baim-Lance et al (2019)	15-month ethnography of 45 patients in three HIV clinics in New York, US	Co-production is developed by making and relying on clinic-based relationships, and for patients also with a wider human community [Q2: not quite clear what this means This is the wording in the article '...the paper shows how coproduction is forged by making and relying upon clinic-based relationships, and for patients also with a broader human community' I'm not sure what that means – What about 'Co-production is developed through everyday and unavoidable dimensions of co-produced human connections and relationships.'?]
Carers and co-production: enabling expertise through experience?	Bradley (2015)	Literature review	Informal carers (family and friends) are a fundamental resource for mental health service provision, but their views are rarely sought by health professionals or considered during decision-making
Patient and public involvement in priority-setting decisions in England's transforming NHS: an interview study with clinical commissioning groups in south London sustainability transformation partnerships (STPs)	Coultas et al (2019)	Thematic analysis of 18 semi-structured interviews with clinical commissioning group (CCG) governing body voting members, non-voting governing body members and CCG staff with roles focused on patient and public involvement (PPI)	Contestations among CCG members not only about what PPI is, but also the role that it plays and could play in STP commissioning decision-making
Community participation to design rural primary healthcare services	Farmer and Nimegeer (2014)	Community-based participatory action research	Communities differ in their receptiveness to innovative service design, but can develop new models
Citizens as active participants in integrated care: challenging the field's dominant paradigms	Glimmerveen et al (2019)	Critical reflection	Care users and citizens are treated as passive recipients of services
Towards people-centred integrated care: from passive recognition to active co-production?	Goodwin (2016a)	Editorial	There must be active participation, empowerment and leadership from people in the co-production of their health
Co-production in integrated health and social care programmes: a pragmatic model	Kaehne et al (2018)	Discussion paper	There must be a pragmatic approach to co-production in integrated care programmes
Co-production at the strategic level: co-designing an integrated care system with lay partners in North West London, England	Morton and Paice (2016)	Perspective paper on co-produced integrated care system	Including lay partners in co-design from the start and at every level was important
Developing, delivering and evaluating primary mental health care: the co-production of a new complex intervention	Reeve et al (2016)	Integrated process evaluation	Normalisation process theory supported successful implementation and development of a new model of primary mental healthcare in six GP practices

Contextualizing co-production of health care: a systematic literature review	Palumbo (2016)	Systematic literature review	The importance of co-creating partnerships between healthcare professionals and patients to mobilise the resources of patients
Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care	Valentijn et al (2013)	Literature review	The conceptual framework combines the functions of primary care with the dimensions of integrated care

Results

Co-production to improve community integrated care: organisations

Organisational structure as a barrier

Integrated care requires fundamental changes in models of health and social care at system (macro), professional and organisational (meso) and clinical (micro) level (Valentijn et al 2013). Increased attention is given to upstream participation and co-production activities are seen as a vital component in the delivery of integration. For example, the engagement of patients, service users and citizens in the co-design of services as partners with professionals, managers or policy-makers (Glimmerveen et al 2019). Citizens as co-production partners is supported by the WHO (2016), which states that integrated care services should be respectful, collaborative and co-produced. Bradley (2015) states that carers and family members are a valuable resource. However, evidence demonstrates that these ideals are not always met.

Kaehne et al (2018) identify a fundamental challenge in the conceptualisation of co-production in health and social care, asserting that there appears to be tension between the organisational structures that control the planning and commissioning of services and the aspirations and interests of patients and service users. Goodwin (2016a) notes that integrated models remain dominated by institutional and professional paradigms rather than being co-produced and, as a result, service change has not reached a point of equal and reciprocal relationships. Morton and Paice (2016) assert the need to include service users at a strategic level, outlining that for co-production to be meaningful there is a need to recruit lay representatives who have the time, ability and commitment to engage in the process.

An alternative method of co-production in integrated care is seen in Farmer and Nimegeer's (2014) community-based participatory action research study, in which findings demonstrated that community participation can lead to designing new service models that fit within existing budgets and meet local aspirations and healthcare priorities. The authors reflect that there are challenges in continuous community involvement and maintaining commitment.

Structural change versus cultural change

Challenges as a result of organisational structures can act as barriers to co-production in integrated care and can be exacerbated further by organisational culture (Kaehne et al 2018, Coultas et al 2019, Glimmerveen et al 2019). These challenges were observed by Morton and Paice (2016) who found that in the early stages of their project some professionals were uncomfortable with the concepts of co-production, feeling lay representatives may not be able to grasp the complexity of the strategic process. This view was echoed by Coultas et al (2019) who found that there were complexities in co-producing, priority setting and maintaining commitment to an authentic patient and public voice in commissioning. They concluded that there is a strong desire to change traditional institutionally led models.

Kaehne et al (2018) present a further challenge stating that there remains a lack of robust evidence on the effect of co-production on service outcomes, improved service satisfaction or quality of care for patients or service users. They explain that lack of evidence is not a sign that co-production is not beneficial but is related to the challenges of defining co-production and the use of service evaluation methods that are often non-comparative, making it challenging to draw wider conclusions on effect.

Commitment

Despite challenges, there appears to be enthusiasm for co-production in the development, delivery and evaluation of integrated care services. The challenge sits in transferring organisations' enthusiasm into a commitment to transformation that allows for a wider diversity of voices in how care is designed and delivered (Farmer and Nimegeer 2014, Morton and Paice 2016, Kaehne et al 2018). Reeve et al (2016) advocate the use of a complex intervention framework to support co-production in integration. They assert that the use of this framework is important as there is overarching distrust in the system and this stifles the aims and activities of those attempting to develop integrated care using a co-production approach.

Co-production to improve community integrated care: practitioners

Power imbalance and communication

Organisational structures and culture are vital to the implementation of co-produced integrated care (Goodwin 2016a, Morton and Paice 2016). Baim-Lance et al (2019) identify the importance of understanding power dynamics when attempting to explain how practitioners and service users interact when using a co-production approach. They state there is a need to understand that service users often view themselves as having lesser power and this can lead to them being confined to a subservient 'patient' role in the constraints of the medical model, which acts as a barrier to co-production.

Glimmerveen et al (2019) argue that while organisations and practitioners often describe the imperative to place individuals at the centre of integration efforts, this does not always lead to a redistribution of power. In many cases citizens remain passive recipients of professional and managerial efforts rather than partners in the co-production of services and their own care.

A systematic literature review by Palumbo (2016) on the co-production of healthcare services found that there remains a need to recognise that professional expertise is complemented by the skills and knowledge of patients who can play a significant role in service design and delivery and their own care. The review recommends that patients and service users should be engaged and encouraged as active partners.

Challenges professionals to think differently

Glimmerveen et al (2019), who presented the paradox between policy rhetoric and the reality and experience of participation in integrated care design by service users and patients, identified that professionals often fail to appreciate users' perspectives and treat patients/service users and their families as opponents or a nuisance instead of partners.

Kaehne et al (2018) explain that part of the challenge for patients and service users when engaging in co-production is understanding their role. Professionals should adopt a pragmatic model of co-production and articulate what the role and purpose of co-production activities are in the change process, drawing on realistic notions of patient capacity and the user's ability to influence complex and highly structured organisations (Kaehne et al 2018).

Co-production to improve community integrated care: patients/service users

Defining the role

The reviewed articles identified the potential benefits and challenges for patients, service users and citizens when engaging in co-produced service redesign. Kaehne et al (2018) explain that the ideal version of co-production is one that advocates full accountability and meaningful involvement of patients and service users in the decision-making process. However, they warn that this approach requires allocating sufficient resources to patient representatives, assigning them decision-making power and supporting them through discussions with unfamiliar terminology and organisational vernacular.

Power challenge and authentic involvement

The need to invest time and resources in co-production was also stipulated by Farmer and Nimegeer (2014) who found that one of their communities withdrew from the project. They explained that there was evidence of community leaders advocating non-participation so that they were not viewed as complicit with health service change. In contrast, Coultas et al (2019) found that patients and citizens were often seen as disruptive powers and clinicians regarded citizen involvement as an effective counterbalance to managerial control.

Discussion

This review demonstrated a mixed picture of co-production in integrated care design. Overall, the articles were positive about the intention and desire to co-produce integrated care at all levels, however there are challenges that require consideration when contemplating the implementation of a co-production model in integrated care design.

To achieve integrated services that are true to the WHO's (2016) overarching principles, organisations are required to shift their traditional power bases at strategic, organisational, professional and service-user level. Power dynamics remain at the centre of the opportunities and challenges of integrated care and co-production. While service users may view themselves as in a position of lesser power (Baim-Lance et al 2019), clinicians regard them as having the power to disrupt hierarchical structures (Coultas et al 2019). Power dynamics may be detrimental to the delivery of integrated care and there is a need to address these imbalances and to move to more authentic active participation (Goodwin 2016a, Glimmerveen et al 2019). Co-production could challenge traditional power structures that confound passive behaviours and support the development of services. However, co-production requires resources, time, space and investment to support engagement in these activities (Kaehne et al 2018). As seen in Farmer and Nimegeer (2014), the desire for co-production from service users, patients and citizens should not be assumed and efforts must be made to understand the

wishes of the people with whom organisations want to engage. This is important when considering co-production in integrated care, which requires a transformational shift in service approach and delivery.

This transformational shift requires consideration of two important points: professionals thinking differently and organisations constructing services differently. Evidence in this review suggests that professionals view co-production positively and recognise the value of service-user and citizen involvement in service development. However, as Glimmerveen et al (2019) note, often this does not lead to desired changes. It is critical that professionals reflect on their own power in organisations and harness their voice to use their knowledge and expertise to participate actively in the co-production process. Organisations need to consider the structure of services to enable co-production with professionals, service users, patients and citizens.

To redress the power imbalance there is a requirement for relinquishing power and empowering the active participation and ownership of all participants (Baim-Lance et al 2019, Coultas et al 2019). The identification of clear and well-defined roles developed in conjunction with service users and citizens enables individuals to consider their own power and positionality, which is beneficial for co-production in practice. Engaging with individuals could lead to more successful integration, improved outcomes for patients and opportunities to reduce the health inequalities experienced by many communities.

Recommendations and further research

This review begins to explore the possible links between co-production in service development and the aim of co-produced healthcare, which places professionals and citizens as equal partners. Further research is needed to understand how co-production in service design can influence and change wider service delivery models. There is also a need to expand the role of co-production in integrated care to ensure that as services develop they reflect the communities they serve.

Conclusion

While there is a strong rhetoric to support the implementation of co-production in integrated care service design, more work is needed to explore how traditional power structures can be challenged and subverted to enable authentic implementation. As the introduction of integrated services moves forward, it is important that nurses and other clinicians embrace the need to co-produce services with those who will be using them to meet the principles set out by the WHO (2016).

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