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CONFERENCE ABSTRACT

"Clinical lead and manager perspectives of a co-production model for community mental health service improvement in the NHS: a case study."

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Introduction

This research undertook a detailed study of co-production in a National Health Service (NHS) trust to determine which model of co-production was being employed and how core characteristics were being implemented in practice. The setting was county-wide Community Mental Health Teams (CMHTs) who had implemented co-production in 2015. Through evaluating the drivers and challenges for co-production in addition to exploring staff knowledge, skills and attitudes, via a case study, it was hoped a greater understanding of co-production and its implications for practice would be achieved.

Aim

To evaluate the implementation of a co-production model within an NHS Trust in a community mental health setting, shaped by clinical lead and manager perspectives.

Methodology

To address the aim thematic analysis of literature identified gaps and a descriptive case study provided an understanding of participants' co-production experiences. One to one, semi-structured interviews were undertaken with senior managers (n=3), middle manager (n=5) and clinical leads (n=5). Verification interviews supported the credibility of emerging underlying themes identified via thematic analysis.

Results

Five themes emerged: corporate machine; continual revolution; power; interface and attitudes to co-production. Analysis found organisational culture impeded co-production, with significant knowledge gaps present among staff. Participants identified a skill gap hindering effective co-production, which training could enhance. Nevertheless, participants believed co-production supports service delivery.

Discussion

Mud mapping identified key areas for discussion

including knowledge, power and core characteristics. Knowledge encompassed co-production's meaning, the importance of communication and training as well as attitudes to co-production. Power covered hierarchy,

organisational disconnect and power dynamics. Core characteristics explored the requirement for all to be present, the importance of listening and culture.

Conclusion

Several barriers impeded embedding co-production in practice including organisational culture, poor communication and power imbalances.

Lessons Learnt

For co-production to be successful all six core characteristics need to be present. Additionally, a positive organisational culture needs to be in operation for co-production to be embedded in practice.

Limitations

An inability to recruit participants from North locality was significant as the sample selection was not met. However, as similar findings were noted in both East and Central localities impact was minimal. Emerging themes were validated and echoed in the CQC inspection report and staff survey. Being conducted in one NHS organisation meant results could not be transferrable, however many key findings link to similar organisational study findings. Middle managers and clinical leads did not understand co-production; therefore, information was provided prior to interviews, possibly introducing some bias. The bias was viewed to be minimal, as the interview guide supported exploration of several issues which were external to the information provided.

Future Research

Co-production research is limited concerning its application to clinical practice. What is needed is a better grasp of how a co-production model can be utilised in large organisations to improve experience and outcomes. Development of an outcome measure would be beneficial for demonstrating how successful implementation of a co-production model in practice is.