Co-design and co-production as integral elements to successful implementation

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**“IMPLEMENTATION SCIENCE OR ROCKET SCIENCE?
How to transfer knowledge into practice to reduce the use of coercion in mental health settings”**

**FOSTREN Training School
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Enhancing healthcare & preventing coercion through research-patient-staff collaboration

Collaboration between researchers, staff, patients and family members/significant others = crucial to improve healthcare services and outcomes, incl. the prevention of coercion

Patients & family members actively participate in /make decisions about their care, alongside healthcare professionals/staff

+

Patients, family members and staff engage in research (not just as participants) - PAR

→

Better communication, personalised treatment plans

Person-centred care

Shared responsibility & empowerment of patients to take control of their well-being, leading to more effective and tailored healthcare solutions

Co-design and co-production of research, interventions, care and outcomes

Co-production =a ‘must’ in applied healthcare research

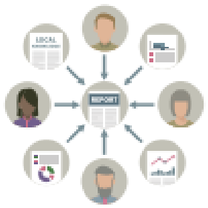
Health research used to inform policy and practice (from evidence production to knowledge mobilisation and implementation)

Services, programmes & interventions ‘co-created’, ‘co-designed’, ‘co-evaluated’ or ‘co-implemented’ (or a combination of terms), e.g., participation or involvement in any or all steps of the applied research cycle

Co-production in applied healthcare research

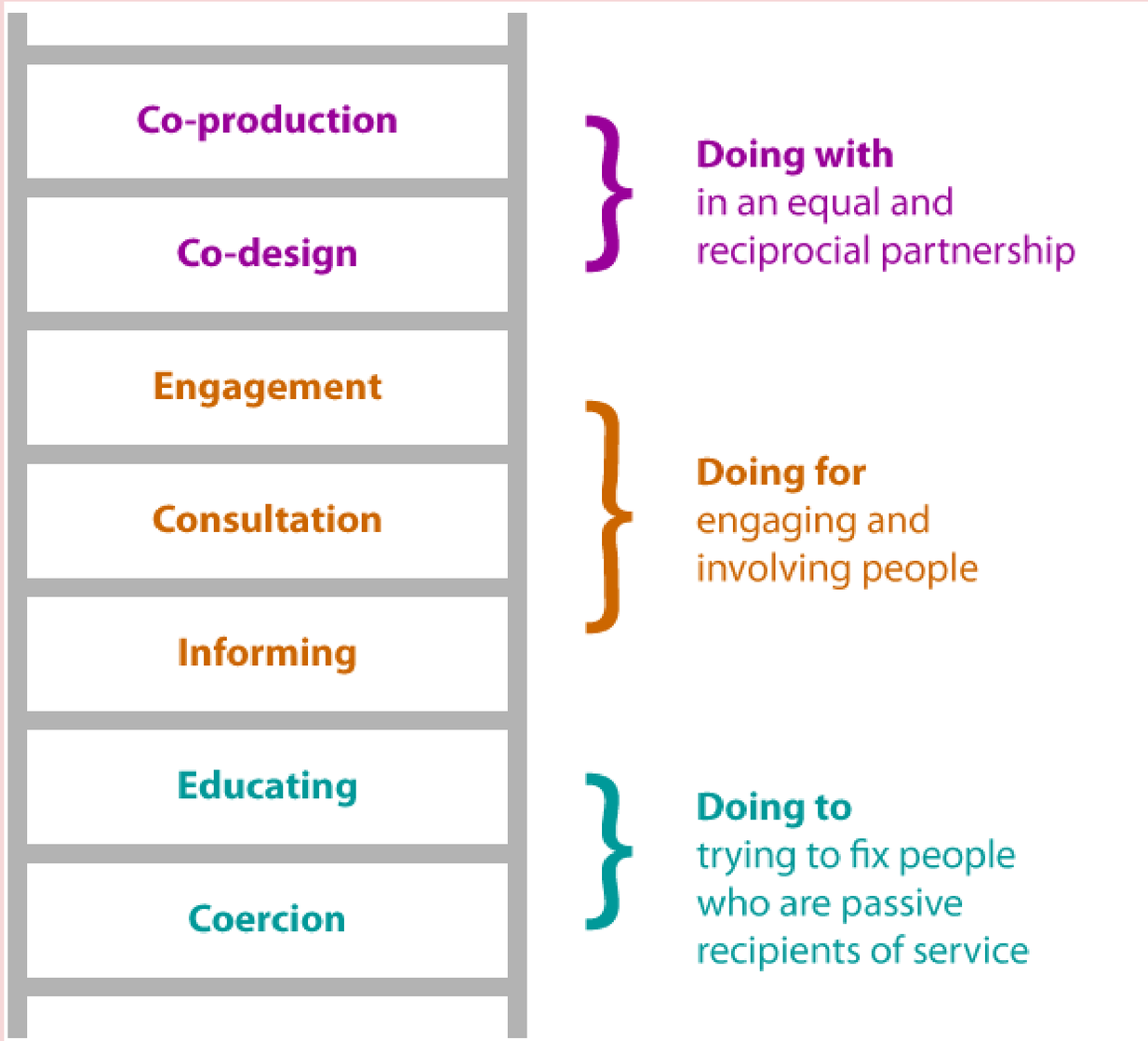
- Co-production < political economics (Ostrom, 1970's)
- Applied research: (i) research that is directed at evaluating quality and safety; (ii) developing and evaluating healthcare interventions or technologies; (iii) understanding implementation of evidence-based interventions
- Key feature: sharing of power in key decisions
- SUs working in partnership with researchers and health professionals
- Consensus - any or all research steps can be co-produced (image here showing different stages of evidence production)

Coutts (2019). The many shades of co-produced evidence. Carnegie Trust.

	TRADITIONAL RESEARCH PROCESS	CO-PRODUCTION OF EVIDENCE
Stage One: Research Project Development	 Write grant proposal	 Co-design project
Stage Two: Data Gathering	 Interviewing	 Peer researcher interviewing
Stage Three: Analysis	 Desk-based data analysis	 Data analysis workshop
Stage Four: Interpretation	 Report production	 Multi agency co-assessment
Stage Five: Research into Action	 Dissemination	 Feedback to the community

Continuum of patient influence in healthcare: from ‘passive patients’ to ‘patient voice/influence’ to ‘partnership’

- Doing things with the patients, as active participants;
- Getting insight from patients, but also ‘doing the doing’ with them;
- Designing with and keeping them involved throughout.



Co-production & co-design = different stages& focus within implementation

- **Co-design** – about the definition of a problem, then definition of a solution; important to start with it, the need for people's involvement ('experts by experience') to understand where the problems are

- **Co-production** – about the implementation of the proposed solution

- The way co-production is operationalised depends on the aim of the project, what is being co-produced and by whom

- Recognition that some people might just want to be involved in some parts of the process; others in co-producing the entire research project

Co-design in implementation science research

- Co-design = a process of collaborative design thinking or a joint inquiry and imagination where different participants associated with the design process work together to identify the problem, develop solutions, and evaluate those solutions

- Patients are viewed as ‘experts’ of their own experiences and are central to the design process. Therefore, co-design is an active collaboration process involving different people with specific knowledge and experiences, providing an equal level of power to be creative and innovative to produce outputs such as health policy, practice manuals, strategies, new services, initiatives, etc. (PAR)

- Example: Experience-based co-design (EBCD) & EBCD cycles - collaboration - ownership - iterative process of stakeholder engagement, situation analysis, selection of intervention areas, co-producing implementation strategies and pre-testing implementation tools

Bringing User Experience to Healthcare Improvement

The concepts, methods and practices of experience-based design

Paul Bate BA, PhD
Professor of Health Services Management
Royal Free & University College Medical School
University College London

and

Glenn Robert BA, MSc, PhD
Principal Research Fellow
Royal Free & University College Medical School
University College London

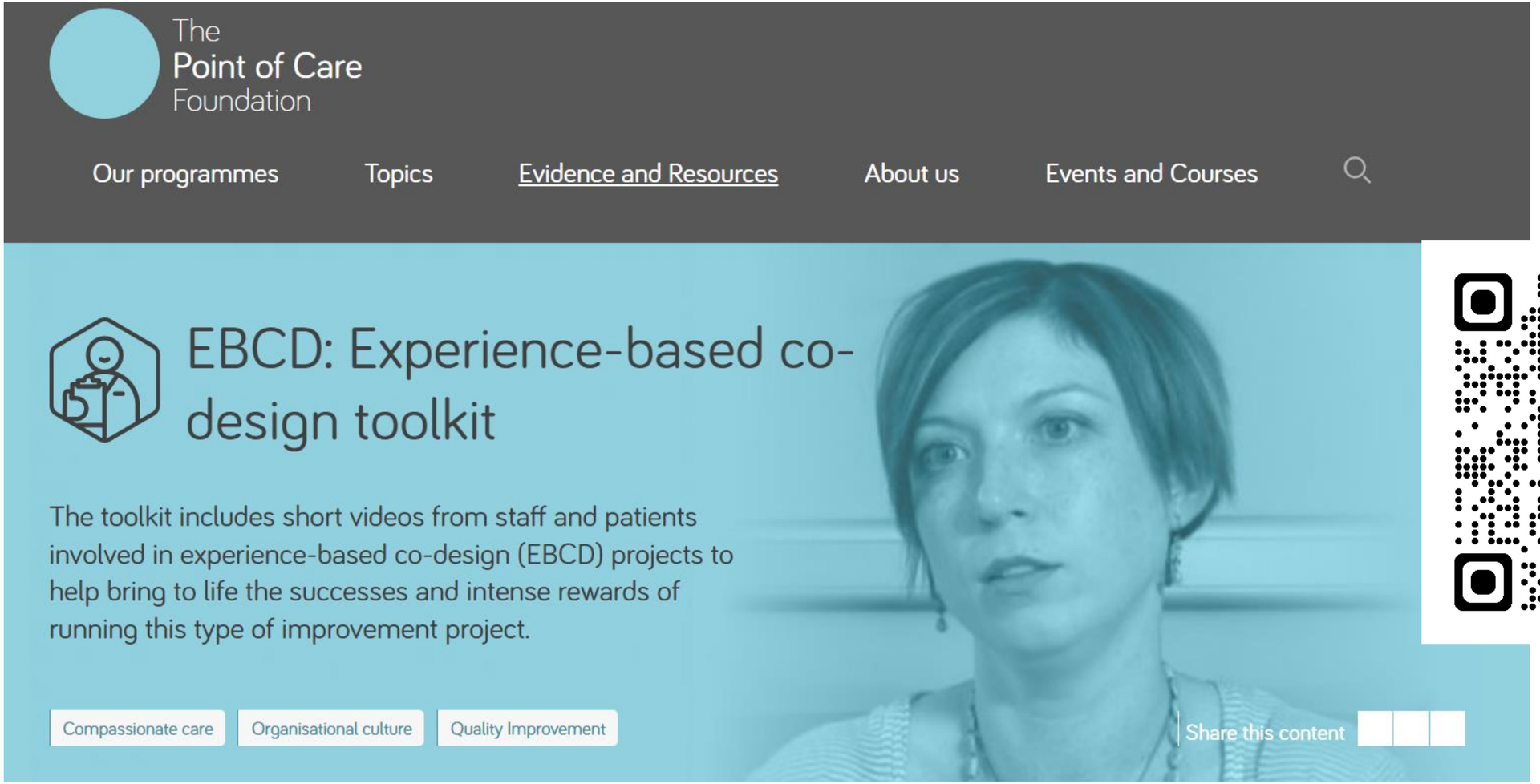
Foreword by

Lynne Maher
Head of Innovation Practice
NHS Institute for Innovation and Improvement

EBCD at the beginning

- Developed by Prof Glenn Robert, Kings College London and Prof Emeritus Paul Bate, University College London in 2007
- Quite a radical departure from the way in which people were doing improvement work → now it's 'co-everything' (take it with a pinch of salt)
- 'Co-design' in healthcare means partnership between services/those providing care and those using these services/recipients of care (e.g., patients, carers, etc.)

Point of Care Foundation: EBCD



EBCD toolkit: https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/

Also in depth courses on EBCD (for more details and support on running own projects)

EBCD vs. QI

Patients are at the heart of the quality improvement effort, but do not forget or exclude staff (start with staff's experience first

Focus on designing experiences, not just systems or processes

Staff and patients in partnership with one another

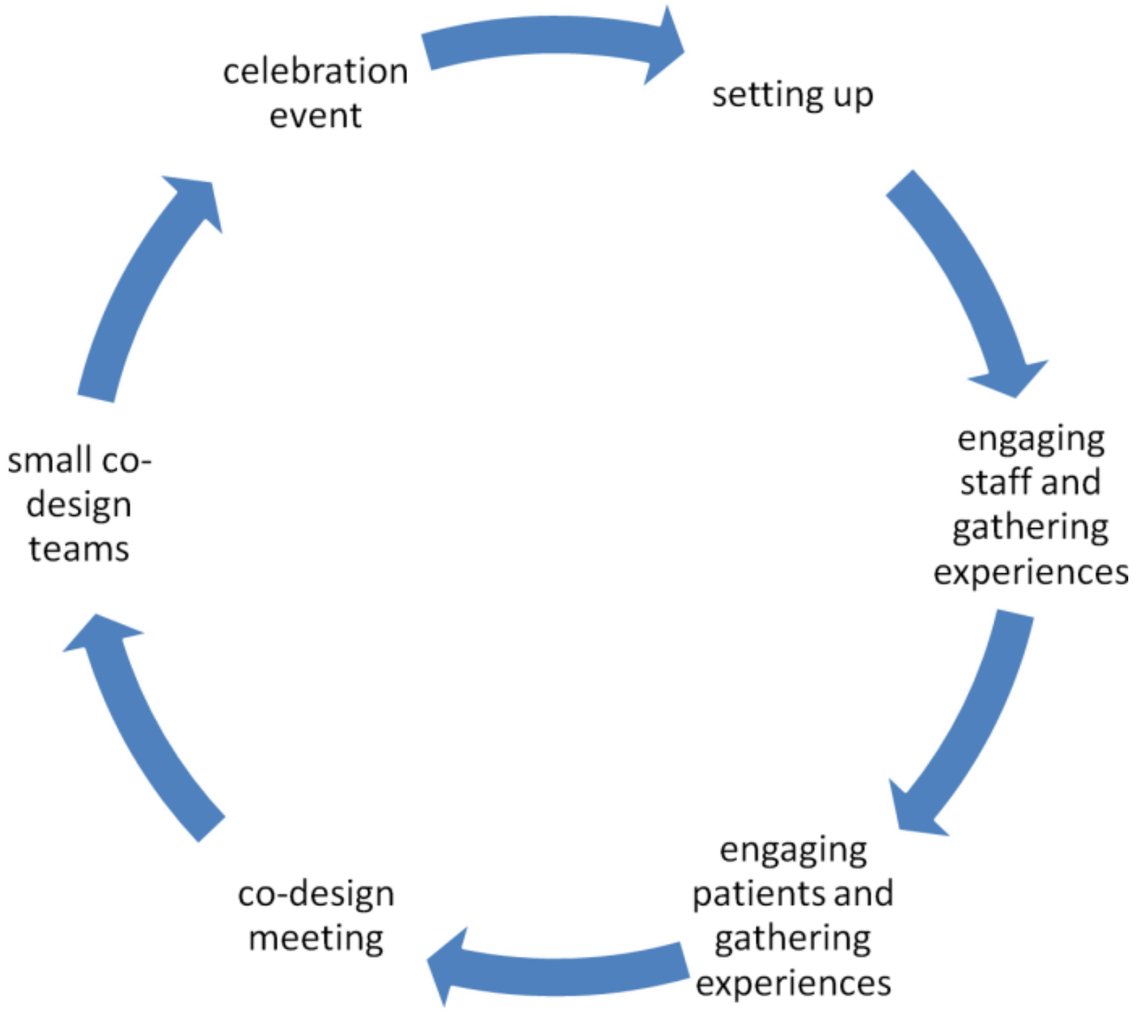
Setting up – lots of resistance

EBCD project → qualitative methods (research interviews or observation) - need for early discovery phase/not sure where the problems are

→ these come from the staff and patients' insights/may have some assumptions about key issues, but they may be challenged when we go on the discovery journey

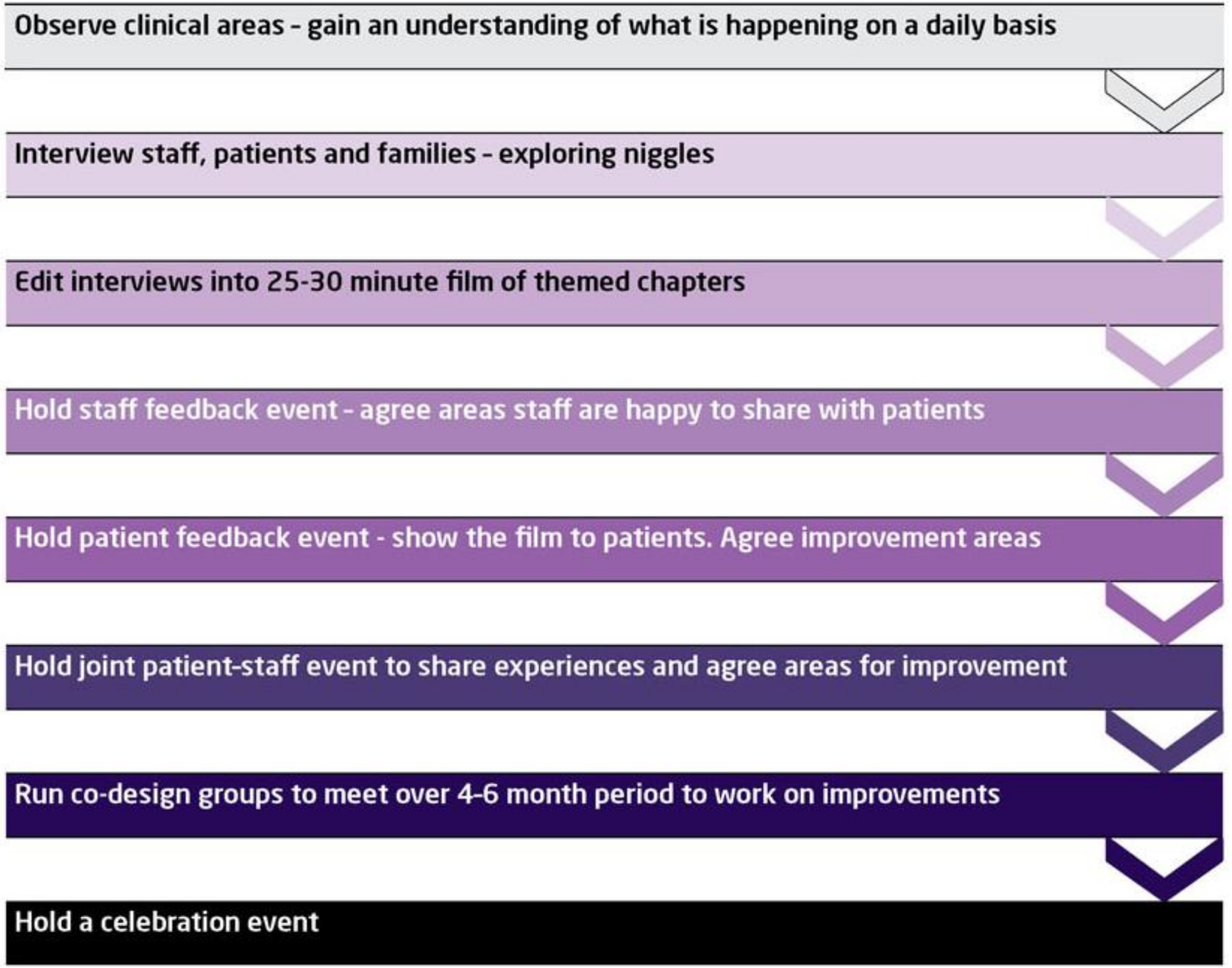
QI project – problem well defined; not experience-based

EBCD cycle(s)



Using Experience-based Co-design (EBCD) to improve the quality of healthcare: mapping where we are now and establishing future directionsS. Donetto, V. Tsianakas, G. Robert

E.g. EBCD Steps



Project steering group
meets at critical stages:

1. Before the project starts
2. Before feedback events
4. After first co-design group
5. After celebration event

The role of (trigger) films

- Easier to film nowadays (than it was years ago, when EBCD was developed) – one can uses their mobile phone and editing is much more accessible

- Films are not an essential component of EBCD, but are way more powerful – peoples' narratives/experiences are used to trigger action and do something about it; although they are sensitive and potentially distressing, they only happen once (and therefore protect the participant in sharing their experience over and over again)

- Identifying key touch points = the moments within a person's experience journey that really stood out for them → patient event – emotional mapping (process mapping) = using touch points and asking people how they felt at each time point → use this info to identify things that need prioritising

- Co-design event = key (beyond experiences), prioritising work in a collaborative way and ask people to join groups to do improvement activities within those areas

- Co-design groups of patients and staff; service improvement log & other creative data collection methods (group observation)

Feedback & Joint Events

- The film is shown to service users/family members. The interviews and observations are fed back to staff. These are separate feedback events.

- Aim is to identify issues needing improvement within both groups. Narrow this list to four or five key areas. These lists are merged to produce the final list, to be discussed at the joint patient-staff event.

- At the joint event, the trigger film is shown as a tool for structured conversations. Smaller co-design groups are formed to collaboratively design quality improvement outcomes based on co-designed and mutually agreed priorities for change.

Importance of the Facilitator

https://www.youtube.com/watch?v=3xc9HtIsUpw&feature=emb_logo

Co-Design Improvement Implementation Groups

- From the joint event, **co-design work streams** are identified and created with **different aims**, each planning to meet regularly to do the co-design work

- Made up of patients, family members and staff. Teach on shared decision making if this is new to the service

- The facilitator can run all the groups, or separate '**co-leaders'** can run each group, overseen by the central facilitator.

- Each group needs to meet often enough to maintain the momentum, but with enough time for outcomes to be achieved.

Celebration Event

- This stage involves **gathering data** and **communicating outcomes** to others to **demonstrate the value of the project**.

- Returning to the lists created in the co-design event and reporting on the improvements suggested by patients and staff, detailing what has been achieved to date.

- EBCD is an emotional investment from staff and patients. Holding a celebratory event for everyone involved **6-9 months after the joint event** is a way of thanking participants, reporting achievements, and providing a clear ending point to the project.

- Co-Design implementation groups often continue after this.

“Co-design makes vulnerable people powerful and powerful people vulnerable”

(Catherine Dale, Point of Care Foundation)

- Equalising the relationship between staff and patients
- Key distinction = vulnerability
- Shifting the balance
- Transformative

Co-production in implementation research

- Implementation science = collaboration between researchers and key stakeholders/implementers for the dual purpose of capacity building and context-adaptation

- Co-production ensures that knowledge created with inputs from various groups of stakeholders is more reflective of local contexts

- To achieve improvements in programme implementation, research findings need to be integrated into practice → need to move results from efficacy and effectiveness to scalability and sustainability in the real world of implementation.

From co-production to co-implementation

More evidence re: engaging stakeholders in earlier research stages & co-design

Gaps in evidence and practice re: co-implementation

What then, is co-implementation, and what could this concept offer for the future of implementation science in the health sciences?

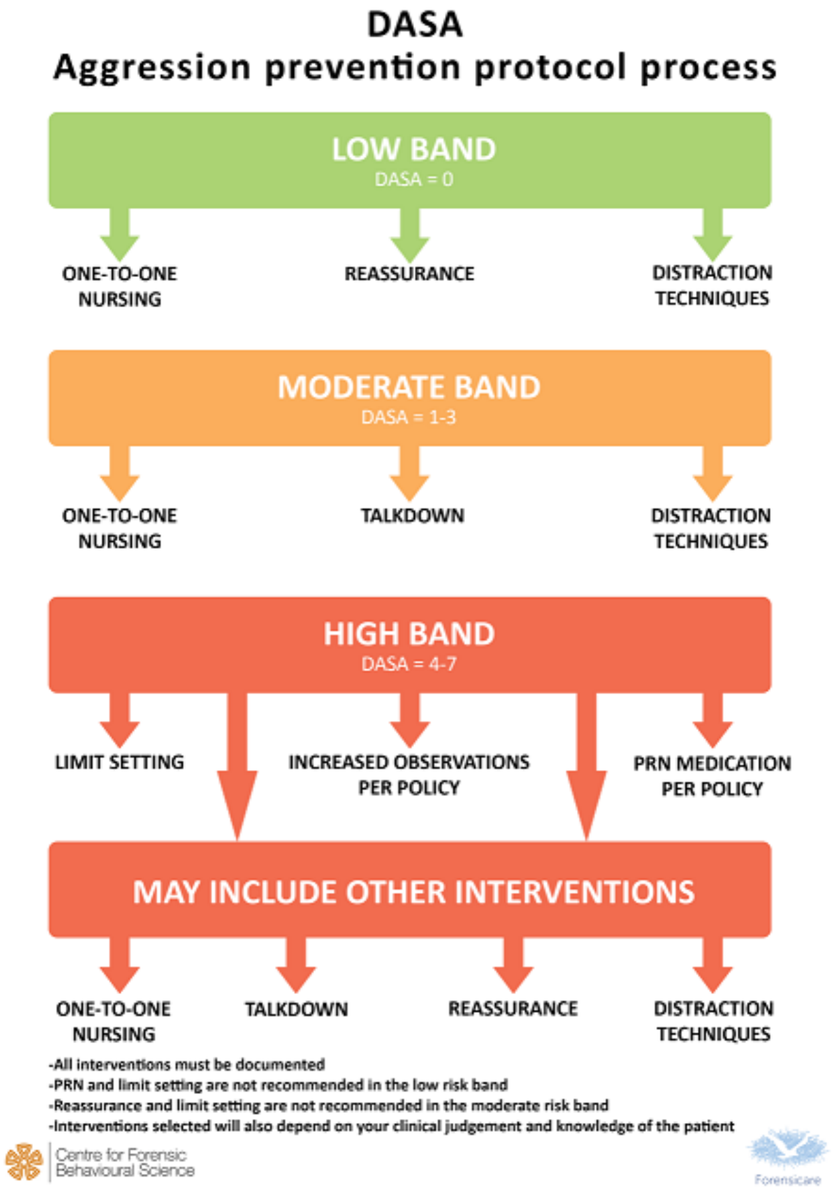
Co-implementation is embedded research, a collaborative and concurrent approach to implementation

Next: Example of good implementation in practice re staff: TELLA

Example of good practice related to co-desigining a locally adapted intervention with end-users

eDASA + APP

- Electronic DASA (Dynamic Appraisal of Situational Aggression, Ogloff & Daffern 2006)
- Aggression Prevention Protocol (APP)
- The APP offers recommendations for aggression prevention strategies or nursing interventions that correspond to the low, medium or high risk level (as measured using the eDASA)
- Based on two Australian studies the use of the eDASA+APP helps to reduce incidents of aggression and restrictive practices in mental health units



Maguire T, Daffern M, Bowe SJ, McKenna B. Evaluating the impact of an electronic application of the Dynamic Appraisal of Situational Aggression with an embedded Aggression Prevention Protocol on aggression and restrictive interventions on a forensic mental health unit. Int J Ment Health Nurs. 2019 Oct;28(5):1186-1197. ;
Griffith JJ, Meyer D, Maguire T, Ogloff JRP, Daffern M. A Clinical Decision Support System to Prevent Aggression and Reduce Restrictive Practices in a Forensic Mental Health Service. Psychiatr Serv. 2021 Aug 1;72(8):885-890.

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Developing and testing eDASA + APP FI – example of a co-design process (2022-2026)

1. Exploring nurses' attitudes towards risk assessment, management, and positive risk

2. Modifying eDASA + APP to Finnish context in workshops – co-design

3. Development of training modules

4. Integrating eDASA to Apotti (EPIC based EHR) and testing FI version in 24 inpatient mental health units(civil and forensic)

5. + ethnograph sub-study about current practices and nurses' collaborative documentation with service users

SAIRAANHOITAJIEN KOULUTUSSÄÄTIÖ
Vie hoitotyötä eteenpäin

HUS

Työsuojelurahasto
Arbetarskyddsfonden
The Finnish Work Environment Fund

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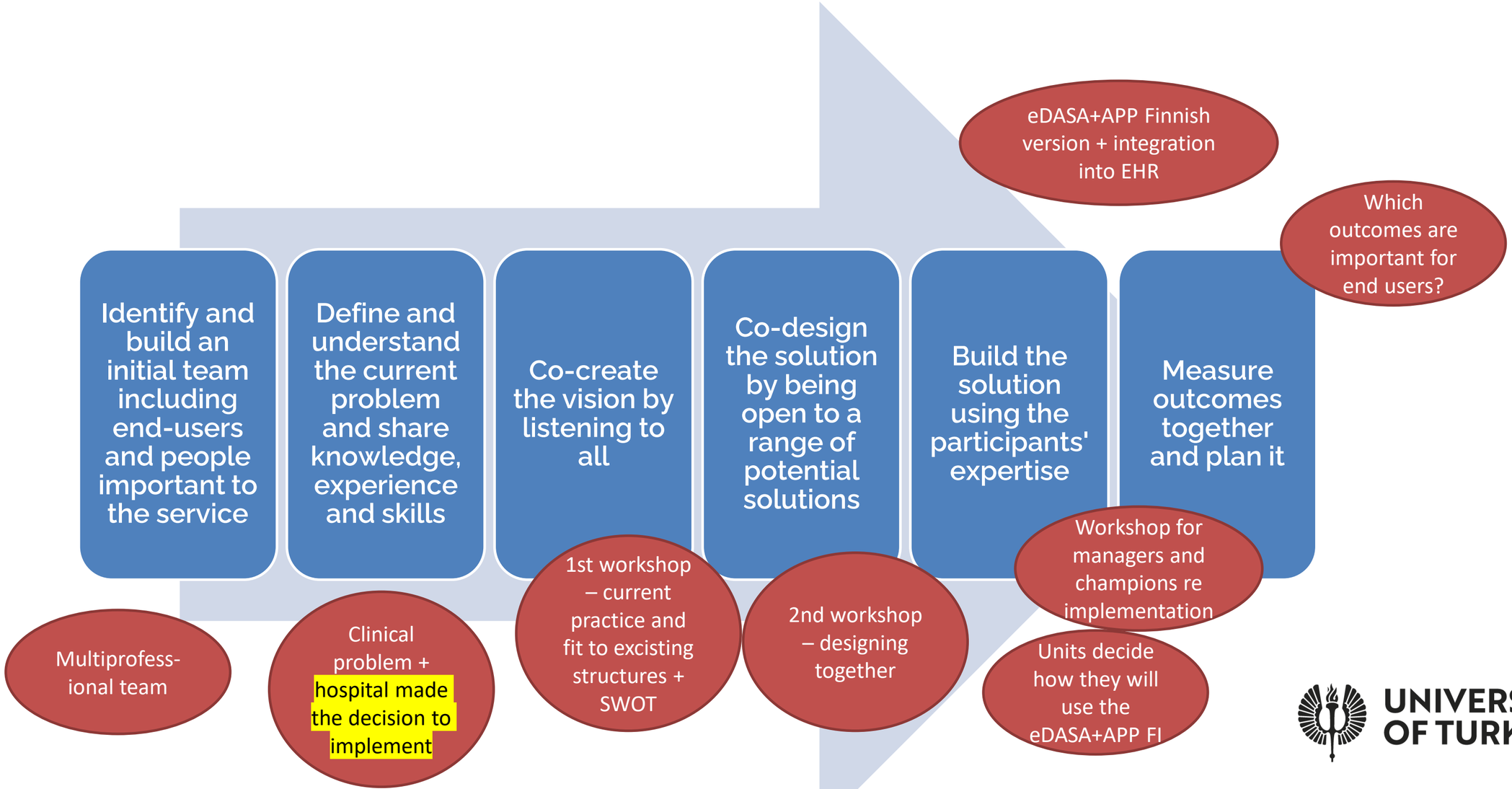
Co-design process following O'Cathain's taxonomy – 42 participants: nurses, nurse managers, a psychologist, experts-by-experience



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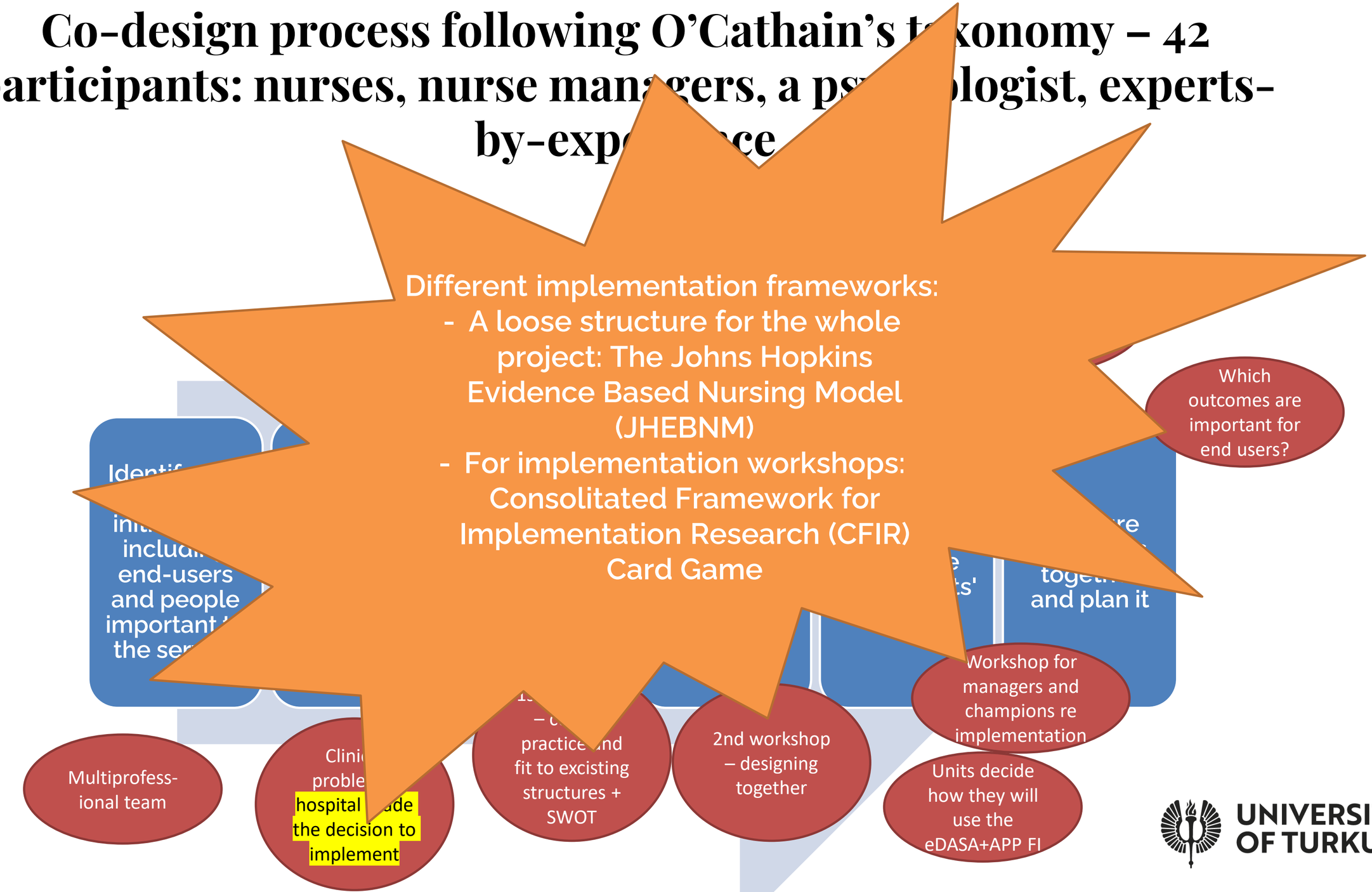

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Thank you

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