CO-PRODUCING HEALTH & CARE SERVICES TOOLKIT: LEARNING FROM COMMON AMBITION BRISTOL

IMPROVING HEALTH BY EMPOWERING AFRICAN AND CARIBBEAN COMMUNITIES

START

Common Ambition Bristol

CONTENTS
GLOSSARY
SUMMARY
WHY CHOOSE CO-PRODUCTION?
CASE STUDY
COMMON AMBITION BRISTOL TOOLKIT
Setting up & planning co-production
TOP TIPS
Doing co-production
TOP TIPS
Delivery of co-produced interventions
Sharing co-production learning
TOP TIPS
VIGNETTES
REFERENCES

CONTENTS

GLOSSARY

Common Ambition Bristol (CAB): A partnership working with African and Caribbean heritage communities in Bristol to increase HIV testing, reduce HIV stigma and improve sexual health.

Community: In this toolkit we use the term 'community' to refer to the group of people, or service users who you are co-producing services with. In Common Ambition Bristol the term refers to African and Caribbean heritage communities.

Co-production: Co-production in healthcare involves people who use health and care services and communities working in equal partnership with the people who plan and deliver services [1-3*].

HIV: HIV (human immunodeficiency virus) is a virus that damages cells in a person's immune system and weakens the ability to fight everyday infections and disease.

Intersectionality: Identities do not exist in isolation but interact and overlap such as race, class, sexuality and gender. This often compounds experiences of privilege and oppression. The concept helps to understand the complexity of discrimination and can lead to more inclusive and responsive policy making and service delivery.

Interventions: an activity that aims to change or improve something.

PrEP: Pre-Exposure Prophylaxis. A tablet taken before possible exposure to a virus that will protect against infection.

Project Advisory Group (PAG): part of the CAB model of coproduction (see pages 6-7).

Project Delivery Group (PDG): part of the CAB model of coproduction (see pages 6-7).

Stakeholders: In this toolkit we use the term 'stakeholders' to refer to all partner organizations, communities and individuals who participate in, and are affected by the process of co-production.

VCSE: Voluntary, Community and Social Enterprise.

*All numbers in superscript refer to references at the end of this document

SUMMARY

This toolkit was developed through the work of Common Ambition Bristol (CAB), a community powered co-production project.

- The toolkit shares the learning from the first three years of Common Ambition Bristol's co-production process.
- It will be of use to teams who want to co-produce health service improvement with minoritised communities.
- CAB aims to tackle HIV health inequalities and increase HIV testing in partnership.
- CAB is based on co-production, where members of the public of African and Caribbean heritage worked in equal partnership with NHS sexual healthcare staff.
- This group co-produced community outreach, community testing clinics and targeted health promotion events to tackle HIV stigma and increase HIV testing.
- An advisory group provided advice, governance, implementation support and risk management for the project. The group included community organisations, one of which represented African and Caribbean heritage groups. Another had expertise in HIV. There were also representatives from the NHS, local authority and the University.
- An evaluation was conducted by University of Bristol researchers and a team of researchers were trained in research skills as part of the project.

SUMMARY

This toolkit provides information about the key milestones in co-production based on the Common Ambition Bristol experience, suggesting ways to:

- Develop shared goals between communities and health services and negotiate core values.
- Share power and decision making throughout the process.
- Foster relationships between project partners and community members.
- Address issues of time, capacity, training and support for co-production.
- Embed evaluation and iterative feedback into the process.
- Improve patient-provider communication, collaboration and patient involvement.
- Reduce health inequities for minoritised communities.

WHY CHOOSE CO-PRODUCTION?

Co-production is an approach to working together in equal partnership and for equal benefit[1].

In healthcare settings co-production involves people who use health and care services and communities working in equal partnership with the people who plan and deliver services[1-4]. Co-production is a gold standard practice for developing equitable services.

The basics of co-production:

- Engages groups of people at the earliest stages of service design, development and evaluation.
- Requires sharing power and decision making throughout the process of service change.
- Ideally the process will also involve those who commission services from the outset.

WHY CHOOSE CO-PRODUCTION?

The value of co-production[1]

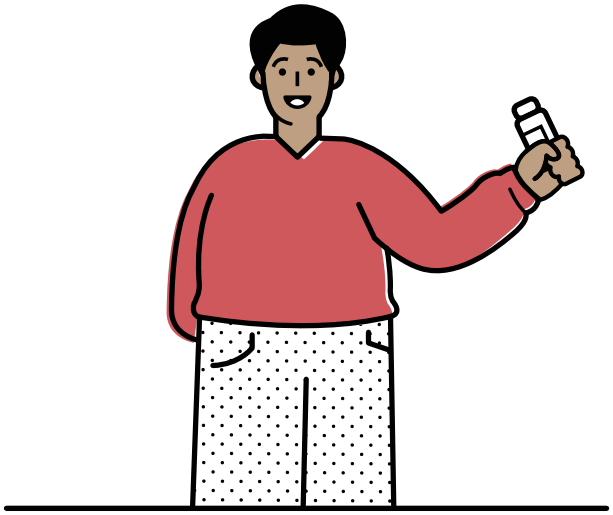
- Delivering outcomes that actually matter to people.
- Developing services that are culturally responsive and meet the needs of specific communities.
- Working towards social justice.
- Empowering people and building capacity.
- Connecting us as humans, working towards shared goals.
- Improving efficiency, in the long run.
- The value of co-production depends on the context in which it takes place and co-production is not a fix all.
- It's not always the most useful, relevant or productive approach for developing service improvement[1].
- See the ladder of co-production[5] to consider what will work best for you.

CASE STUDY: THE CONTEXT

WHY AND HOW?

People living with HIV can now lead long, healthy lives thanks to advances in treatment. A person living with HIV has a similar life expectancy to someone without the virus – if they are diagnosed early and regularly take their HIV medication.

People living with HIV and regularly taking HIV medication (reducing the amount of virus to 'undetectable' levels) cannot pass HIV on through sex. Testing is therefore vital, so that people know if they have HIV and can be given HIV medication. In addition, advances in HIV prevention mean that people who do not have HIV can protect themselves with PrEP medication. This means they will not acquire the virus, even if they have sex with someone who is living with HIV who is not on treatment.



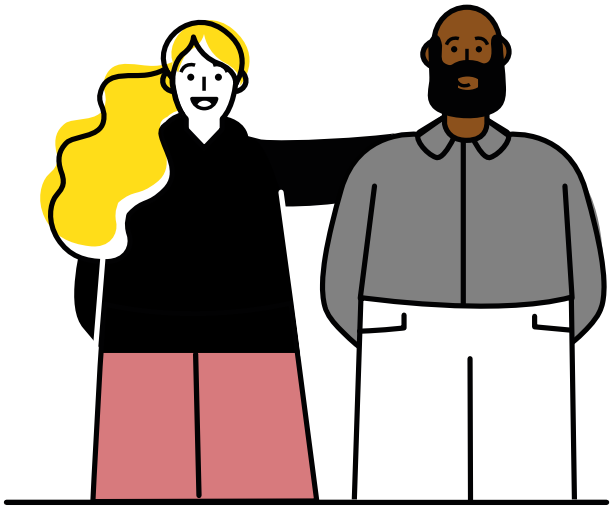
CASE STUDY: THE CONTEXT

Some groups of people are affected by HIV more than others, reflecting social, structural and economic inequities[6].

Minoritised communities make up **19%** of Bristol's population with black, African and Caribbean communities making up almost **6%.**

A local HIV Health Needs Assessment found that a disproportionate number of people of African and Caribbean heritage either have undiagnosed HIV or are diagnosed late. It also found that stigma – negative or shameful views – surrounding HIV and sexual health means that fewer people of African and Caribbean heritage access HIV testing and sexual health services generally[7].

The UK Government have set a target to end all new HIV transmissions by 2030. Bristol's HIV rates were higher than the average for England and so meeting this goal required a coordinated effort. Bristol therefore became an HIV Fast Track City in December 2019 aiming to collaborate across a number of organisations to end new HIV infections and HIV stigma in the city by 2030[8,9].



CASE STUDY: THE CONTEXT

Common Ambition Bristol was established to understand and meet the specific needs of African and Caribbean heritage communities around HIV testing and HIV stigma. It is based on intensive co-production with members of the community working in equal partnership with sexual healthcare providers. Common Ambition Bristol was initially funded by The Health Foundation for three years, from January 2021. The aim was to work together with Bristol's African and Caribbean heritage communities to address HIV inequities.

Common Ambition Bristol set up a partnership of organisations based on the existing Bristol Fast Track Cities programme. These included Brigstowe (voluntary sector organisation supporting people living with HIV), African Voices Forum (umbrella organisation for organisations representing the multiple different African and Caribbean communities in the city), University of Bristol, Bristol City Council (commissioner of sexual health services including HIV prevention), and University Hospitals Bristol and Weston NHS Foundation Trust (the NHS sexual health provider). Representatives from the African and Caribbean heritage partner organisation set up different monthly meetings to both oversee the project and plan interventions.

The 4 aims of Common Ambition Bristol

CO-PRODUCTION

From the outset Common Ambition Bristol was driven by co-production. The central mechanism for co-production was through our Project Delivery Group (PDG). This was made up of five African and Caribbean heritage community members and four sexual healthcare staff (nurses and health advisers).

The PDG was led by a project coordinator, who was based at Brigstowe. The PDG members worked in equal partnership, sharing power and responsibility from the start to the end of the project. Meeting monthly over the three years, the PDG designed and delivered a range of interventions, to meet the aims of Common Ambition Bristol These included:

- Multimedia health promotion resources (website, radio adverts, film).
- Community outreach (in black-owned businesses such as barbers, salons and shops).
- Health promotion events targeted for the African and Caribbean Heritage community events).
- African and Caribbean heritage specific HIV and sexual health testing clinics (monthly clinics in two community locations).

CASE STUDY: THE CONTEXT

- A second group called the Project Advisory Group (PAG) was formed and also met monthly. Group members were representatives from the organisations involved (CEO's of the community and voluntary sector organisations, senior researchers from University of Bristol, Sexual Health team Consultant and public health consultant/lead commissioner) and the project coordinator.
- This group held the governance responsibility for the project and held an overview of timelines and budgets. The Common Ambition Bristol evaluation was co-produced with University of Bristol researchers working with six community researchers, recruited from African and Caribbean heritage communities.

The wider Common Ambition Bristol network (PDG and PAG and community researchers) worked collaboratively at a series of workshops over the three years, sharing a valuable mix of professional skills and lived experience in sometimes unexpected, but always constructive ways. The Common Ambition Bristol co-production approach grew progressively from the small working group (PDG) to wider collaborative working between PAG and PDG.

EVALUATION

The Common Ambition Bristol team built an evaluation into the project, to explore how the co-production working model functioned in practice.

- The evaluation examined how the PDG shared responsibility, decision-making and power throughout the project. This enabled the research team to regularly provide anonymous feedback to the PDG and PAG, to inform and enhance working relationships. Evaluation data was gathered via interviews with the PDG at three time points, observations of PDG meetings and a brief online survey.
- At the end of the three years, the Common Ambition Bristol team reflected on the findings from this evaluation and together they identified key learning points. From this they developed this co-production toolkit, which will be useful for other teams and organisations when planning to use co-production with minoritised communities to address an issue of health inequality. The toolkit captures stages of the co-production journey, from set-up through to the delivery of interventions. The toolkit includes examples from the Common Ambition Bristol project, with anonymised quotes from members of the PDG to illustrate specific areas of learning.

COMMON AMBITION BRISTOL TOOLKIT

SETTING UP & PLANNING CO-PRODUCTION:

Ensure from the outset that you understand what true co-production involves (see resources on pages 1-4). Be aware of the differences between co-production and consultation or information gathering.

Ensure co-production is suitable to achieve the proposed aims of your project.

1. Establish the partnership:

Determine resources: Establish how co-production will be resourced. Consider the time commitment required and financial reimbursement needed for the partner organisations and community members.

Identify the needs of your population: Clarify the issue that needs addressing e.g. through undertaking a needs assessment, triangulating existing data and engaging with service users to hear their views and understand their lived experiences. Ensure diversity and take account for intersectionality (see glossary). Review the existing evidence base for recommendations.

SETTING UP & PLANNING CO-PRODUCTION

Identify and involve community and stakeholders:

- Aim for 'whole system' representation and identify your target community and all organisations involved in the issue and the links between them.
- Map communities, providers and commissioners of relevant health and social care services, stakeholder and third sector organisations.
- Contact representatives from community and stakeholder groups and invite their involvement and engagement as early as possible at the planning stage. If this is left until plans have been established, some organisations may not be prepared to participate.
- Sustained and honest engagement and involvement throughout a project is imperative to make work that truly resonates with a community.

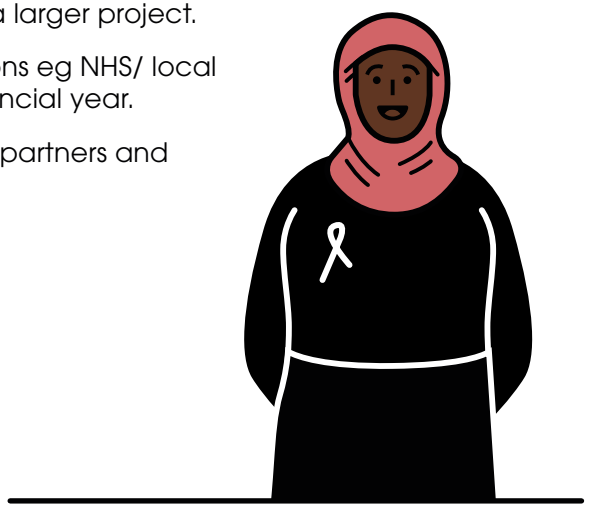
Bring stakeholders together to agree the focus:

- Ensure the stakeholder group includes[1] community representation and[2] strategic leaders (e.g. service leaders / commissioners) who can help to 'make change happen'. Ensure people involved have sufficient seniority to drive change.
- Arrange a series of meetings to discuss and clarify the issue that needs to be addressed. Ensure meetings are held at times and places convenient for all to attend. This may involve times and locations which are less usual for the NHS or commissioning teams.
- Ensure people from the community are appropriately paid for their time to participate. Ensure meetings are led by a skilled facilitator who will guarantee all voices are heard. Contact local organisations who represent the community you are working with to see if they are able to recommend a suitable facilitator.

SETTING UP & PLANNING CO-PRODUCTION

Apply for funding:

- Consider requesting advice about funding sources from: Hospital or university research and development departments, senior managers, commissioners or colleagues who have done similar projects.
- Consider larger national bodies for this such as The Health Foundation, National Institute for Health Research (NIHR), large charities, Medical Research Council, Economic and Social research Council (ESRC), Pharmaceutical companies.
  - Typically funding applications may need to be submitted several times to more than one funding source before being successful.
- Smaller funding pots could be amalgamated to fund aspects of a larger project.
  - Smaller pots of money may become available from organisations eg NHS/ local authority or other funders as above towards the end of the financial year.
- When making subsequent funding applications ensure all project partners and stakeholders are involved.



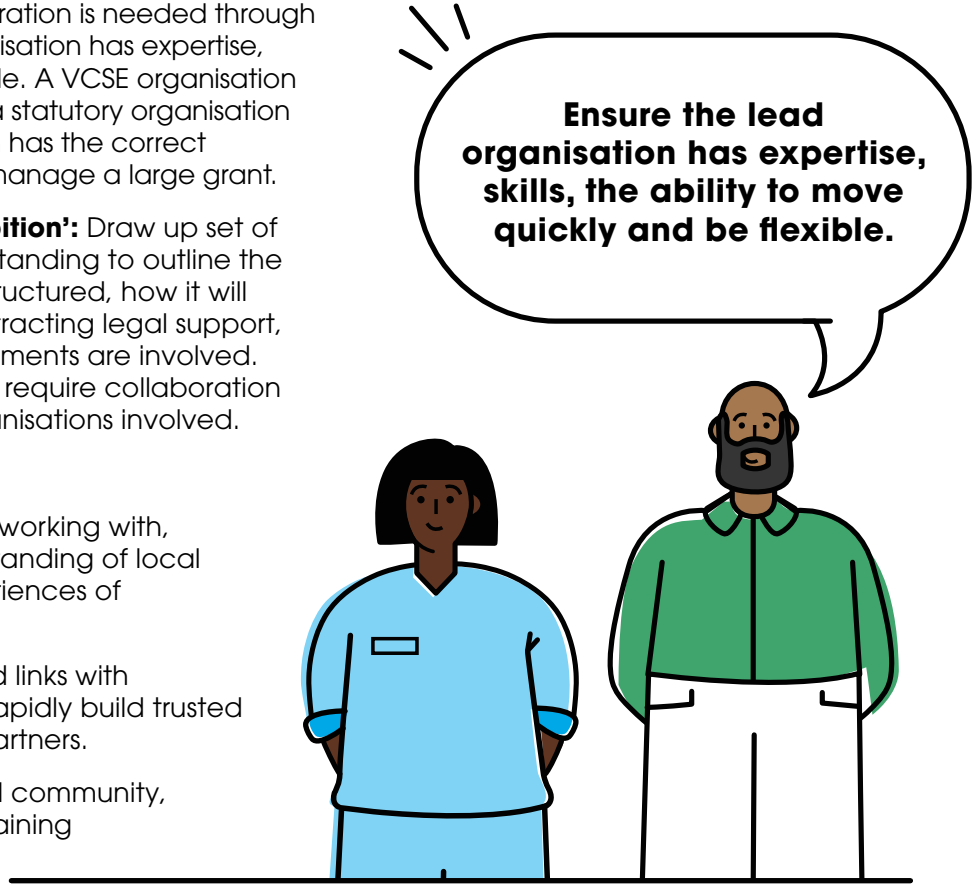
SETTING UP & PLANNING CO-PRODUCTION

Agree a lead organisation: Careful consideration is needed through stakeholder discussion. Ensure the lead organisation has expertise, skills, the ability to move quickly and be flexible. A VCSE organisation may be better placed and more agile than a statutory organisation such as the NHS. Ensure the lead organisation has the correct financial governance processes in place to manage a large grant.

Establish shared goals or a 'common ambition': Draw up set of guiding principles/ Memorandums of Understanding to outline the aims of the project, how the partnership is structured, how it will work in practice. Consider the need for contracting legal support, especially if finance and data sharing agreements are involved. Be aware this can be a lengthy process and require collaboration between legal teams from the different organisations involved.

Recruit a project co-ordinator:

- Ideally from the local community you are working with, who has empathy and a depth of understanding of local issues which affect the community's experiences of healthcare services.
- This person should ideally have established links with the community or be able and willing to rapidly build trusted relationships assisted by the community partners.
- They should preferably live within the local community, to enable relationship building and maintaining levels of trust.



COMMON AMBITION BRISTOL TOOLKIT

SETTING UP & PLANNING CO-PRODUCTION

2. Create the mechanisms for co-production:

Meaningful co-production requires partnership working and governance at both delivery level and strategic level. The Common Ambition Bristol model involved:

- A co-production working group to co-design, co-produce, and co-deliver community level interventions. In Common Ambition Bristol this group was called the PDG (Project Delivery Group) and was made up of community members, sexual healthcare staff and the project coordinator.
- A stakeholder / partner group to support and advise the co-production working group, provide strategic oversight and system change. This group will also need to oversee the governance for the project including development of a risk register and agreement about who will manage incidents. In Common Ambition Bristol this group was called the PAG (Project Advisory Group), and it included healthcare staff, university researchers, community organisation representatives and commissioners.
- Members from the two groups were encouraged to attend each other's meetings for shared learning. However, after feedback at a co-production workshop we changed the schedule to run the two meetings consecutively with an overlap where food was provided. This helped to develop relationships and break down barriers (see Vignette 1).
- Note: The CAB model of co-production was effective for our programme but there are many other ways to co-produce service change and other models may also work well.

SETTING UP & PLANNING CO-PRODUCTION

2a. What is needed to establish the co-production working group?

- **Recruit community members:**
  - Prepare a plain language role description including roles, expected time commitment and payment. Be aware that the expected time commitment is likely to be under-estimated at the start so build this in.
  - Work with influential community partners to plan how to engage individuals and groups within the community. See section 1 for how to identify community partners.
  - Advertise widely to ensure you reach people from the right community, using diverse strategies e.g. social media, word of mouth, leaflets, posters, local radio, community advocates/ influencers, community organisations. Note; advertise within the partner organisations, as there will be staff who are members of the relevant community.
  - Offer information sessions (both in person and online) for people to find out more about this opportunity and ask questions.
- **Recruit healthcare/VCSE staff:**
  - Negotiate with NHS or VCSE for protected, paid time for the ongoing involvement of their staff.
  - Have strategies in place to mitigate issues where staff and/ or volunteers leave, change or have periods of sickness. Sustainability should not be dependent on individuals. Common Ambition Bristol ensured there were at least two members of staff from each organisation to mitigate this.
- **Identify resources** for administration tasks such as co-ordinating and minuting meetings and payment for community members. Consider which IT platforms to use when sharing documents across multiple organisations. Ensure these are accessible, and include training for all to facilitate efficient cross organisational working.

COMMON AMBITION BRISTOL TOOLKIT

SETTING UP & PLANNING CO-PRODUCTION

- **Agree a structure for the co-production working group...**
  - Such as frequency of meetings, role expectations and payment for time. Consider the benefits of meeting in person versus the convenience of meeting online. Listen to the wishes of the community members as their involvement is crucial for successful co-production. Be aware of the possible technical and engagement challenges of hybrid meetings.
  - In-person meetings can be more effective for building familiarity and trust with each other. This is crucial for co-production.
- **Plan and provide induction and training...**
  - For community members and any other stakeholders: about[1] the project aims[2] background information on the subject area[3] what co-production is, what it involves[4] what the partner organisations and individuals do. New team members joining part way through the project will need this induction.
  - Show community members around the NHS or relevant services, to ensure they are familiar with these settings.
- **Establish regular support for community members...**
  - To ensure everyone understands the language used, each other's expertise and skills and can navigate power relations. Ensure they have a named person to approach (e.g. the project co-ordinator) if they have any issues with subject matter, with other team members, or if they have ideas they may not want to express in a larger group. Regular 'check-ins' or information sessions can ensure everyone feels supported and able to contribute fully to the group.
- **Negotiate and develop a set of core values...**
  - For the group to work to. Revisit these regularly as they will change over time. These will help focus the group.

SETTING UP & PLANNING CO-PRODUCTION

- **Address power relations early on**
  - Provide training and facilitation to integrate healthcare staff (who may not be members of the community) to better understand their role within the group. For example, core values and ground rules can help to ensure that all opinions are equally valid, accepted and respected. See 'Doing Co-production' Section 2: Ensure power is shared.

2b. What is needed to establish the stakeholder/partner group?

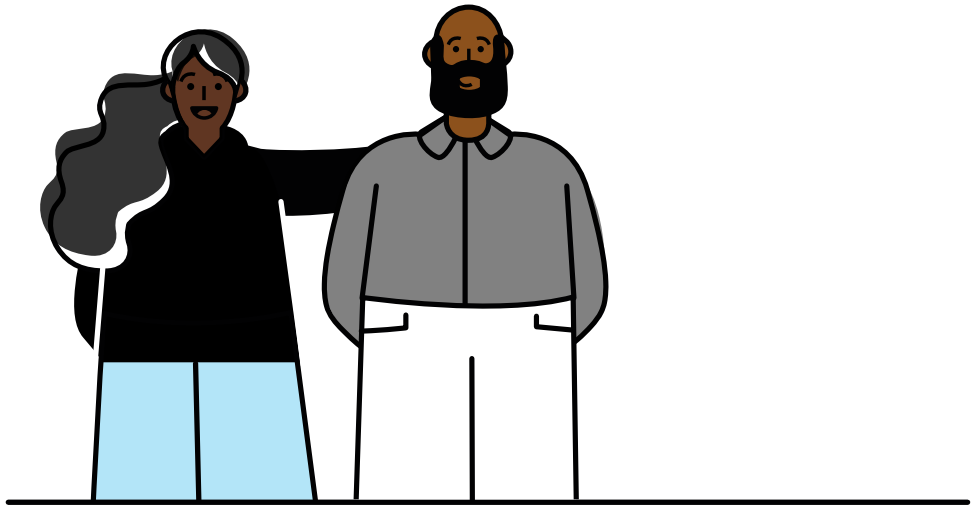
- **Establish a group** to manage timelines, budgets, risk register, governance, reporting requirements and to start to consider adoption and spread strategies as early as possible.
- **Agree a structure** for this group such as frequency of meetings, role expectations and time commitment required. Involve more than one person from each organisation, to ensure representation at every meeting.
- **Plan induction and training** to ensure understanding about the work of the co-production group and are familiar with the members' background and expertise. Ensure new members joining part way through the process all have induction.
- **Agree and plan for regular overlap and information sharing** between the co-production working group and the stakeholder/partner group.

SETTING UP & PLANNING CO-PRODUCTION

2c. What is needed for evaluation?

Start considering how you will evaluate both the co-production process and the services delivered.

- Reflect on what resources (time, funding, staffing) are being allocated to evaluation.
- Identify where existing hierarchies or power imbalances might be unintentionally replicated during the process.
- Plan how the community and/or the co-production working group will be meaningfully involved in shaping the evaluation approach and deciding what success looks like.
- You could design a simple service evaluation, collecting feedback from service users about changes made ormore formal research with academic partners if time and resources are available (see details in point 7).



Top Tips: Setting up and Planning Co-Production

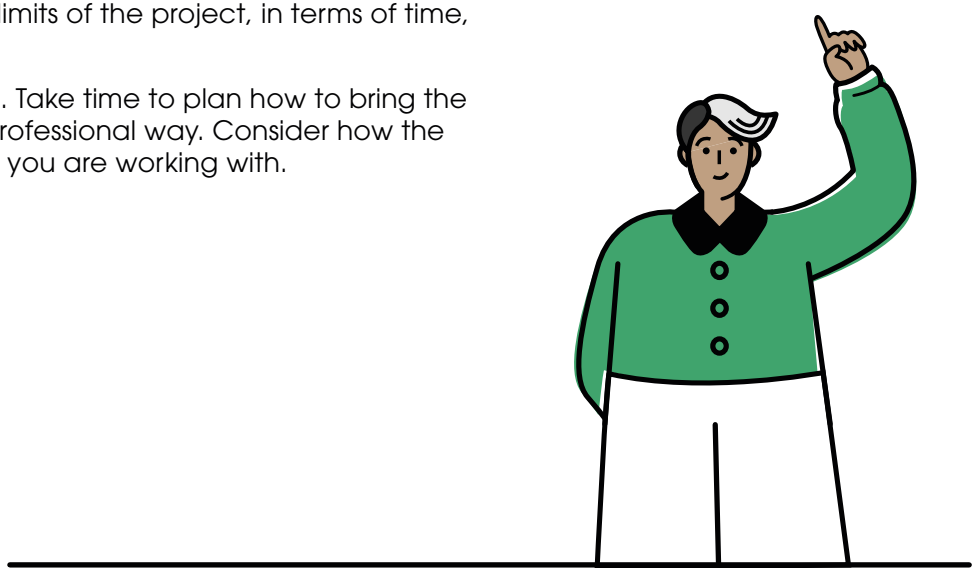
- Be prepared to be adaptive and step outside your silo.
- NHS organisations can be slow and resistant to change. Ensure the NHS staff are encouraged to 'think big' and not be constrained by fear of hierarchies and 'it's not possible'. SEE Vignette 2.
- Try to ensure people with a range of needs can participate by ensuring the location and timing meetings are accessible. Offer a range of ways to participate. For those who may nor be confident speaking up in a group offer options to contribute one-to-one or by email or message in between meetings.
- Consider how the co-production working group will work with the stakeholder/partner group. How will working relations be fostered and who will make final decisions? For our project, the community members always had the final say in decisions.
- Build in enough time and regular opportunities for trust to be built between community organisations/members and healthcare staff. SEE Vignette 1.
- Be realistic about the time and cost of coproduction. Value the expertise of lived experience by ensuring there are funds to reimburse community organisations and members for their expertise and time and resources to deliver interventions/outputs.

COMMON AMBITION BRISTOL TOOLKIT

SETTING UP & PLANNING CO-PRODUCTION

Top Tips: Setting up and Planning Co-Production

- Think outside the box for funding streams. Look for grants from trusts and foundation. Consider local funds for service improvement and national funders for research and evaluation. CAB was funded initially by The Health Foundation. A follow-on grant for service development came from Bristol City Council and the NIHR funded the second phase of evaluation.
- Ensure all stakeholders understand the limits of the project, in terms of time, capacity and resources.
- Consider how the project will be exited. Take time to plan how to bring the project to a close in a respectful and professional way. Consider how the ending may affect the community that you are working with.



DOING CO-PRODUCTION (DURING DESIGN AND DELIVERY PHASES)

1. Foster relationships between all stakeholders (eg co-production working group, the stakeholder/partner group and community researchers)

- Ensure all group members know what the key partner organisations do. Site visits can help increase understanding and familiarity.
- Ensure everyone knows each other's roles and degree of influence outside the project, via informal training and telling each other about roles.
- Members of the co-production working group and the stakeholder/partner group should attend each other's meetings and contribute where appropriate.
- Build in social time between co-production working group and the stakeholder/partner group. Sharing food can enhance social connection and allow personal relationships to develop.
- Allow time and space to share lived experience, preferably using an independent facilitator.
- Don't underestimate the value of 'icebreaker' activities to increase familiarity and to get know each other's backgrounds.
- Ensure as many meetings and events as possible are held in locations that are familiar and convenient for the community. Be aware that using rooms in clinical or official buildings may be alienating for some and impact on group power dynamics.
- When challenges arise, allow time to debrief, communicate and act on what is learnt. See Vignette 1.

DOING CO-PRODUCTION

2. Ensure power is shared

- Ensure you are aware of the perceived power imbalances faced by the community you are working with. This can only be achieved by spending time listening to the lived experiences of community members.
- Carefully explore the impact of power dynamics between community representatives, health staff and project stakeholders. Consider how everyone can be comfortable contributing to decision-making.
- Share power by acknowledging everyone's expertise: Agreeing terms and language is helpful eg; referring to Community members as 'experts with lived experience'; healthcare staff as 'experts with paid roles' and project partners as 'experts with strategic experience'.
- There is power where the budget sits, so the group need to decide where this should be held.
- Anticipate that it will take time for all members to feel comfortable to speak up in meetings.
- Offer a variety of ways for all voices to be heard both in person or via email, WhatsApp or anonymous feedback such as through an online survey.
- It is important that healthcare and commissioning team staff actively listen to the input of community members during meetings and allow them space to share their lived experience and challenge the status quo. In addition to being respectful, this allows a space for innovation and ideas to develop.
- Ensure health staff feel comfortable sharing their knowledge when it is useful. See Vignette 3.

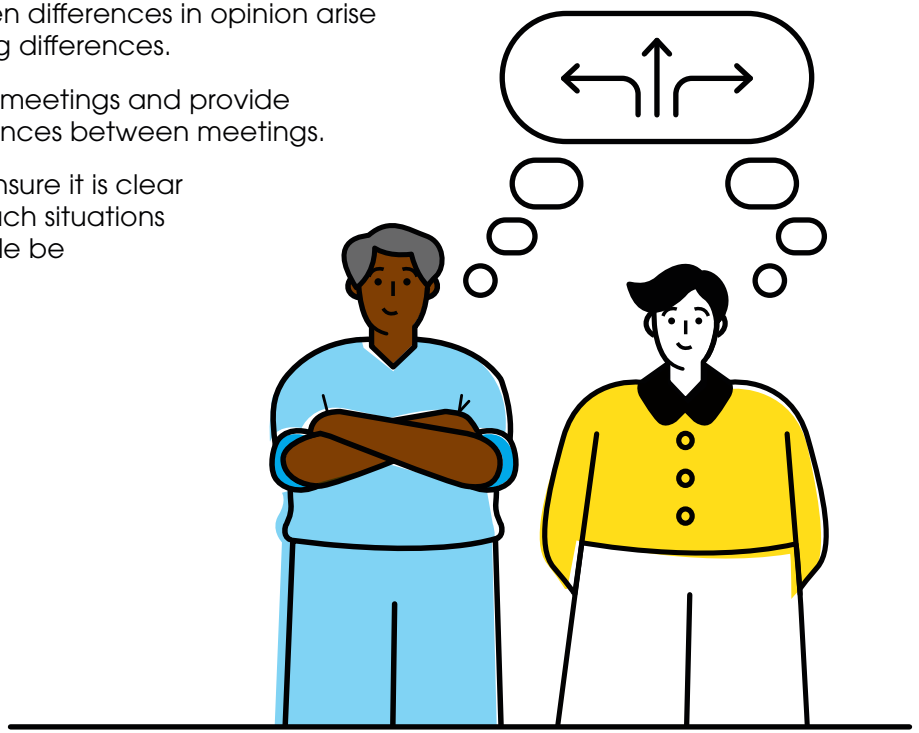
COMMON AMBITION BRISTOL TOOLKIT

DOING CO-PRODUCTION

3. Facilitate shared decision making

- Use consensus wherever appropriate to make final decisions in meetings.
- Allow time and space for discussion when differences in opinion arise and offer facilitated space for managing differences.
- Offer ways to make decisions outside of meetings and provide chances to feedback or express preferences between meetings.
- When consensus cannot be reached, ensure it is clear who makes final decisions and why. In such situations the project co-ordinator may for example be responsible for reaching a final decision.

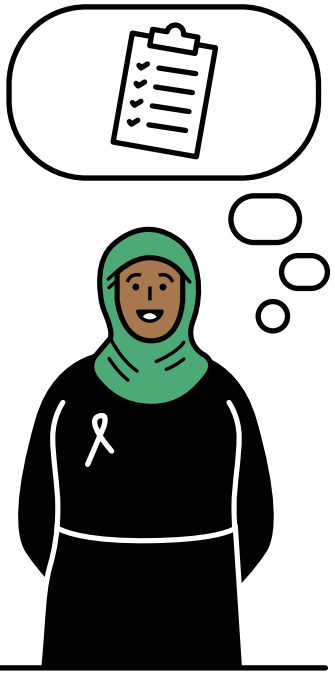
See Vignette 4



DOING CO-PRODUCTION

4. Planning the interventions

- Take time to consider all ideas for interventions, however unusual or innovative they may at first appear. Then draw on both health care staff and lived experience opinions to agree what may work within the target community to address the issue.
- Review evidence about what interventions have worked elsewhere within similar communities.
- Once a longlist of possible interventions has been developed, sort the list into groups of common themes or areas and plot what and who would be needed to deliver these, alongside potential impact.
- In CAB the interventions selected were those most likely to address the main aims of the programme (see page 10 for our aims).
- Work within available resources and consider people's capacity i.e. who will deliver the interventions.
- Consider Intersectionality and differences within communities and avoid a `one size fits all' approach when developing interventions. Consider who is missing and how to reach them.
- Engage with a range of organisations to ensure all sections of the community are included (e.g. age, sexuality, gender).



COMMON AMBITION BRISTOL TOOLKIT

DOING CO-PRODUCTION

5. Roles, training and support

- Provide clarity about roles and responsibilities e.g. who will deliver the interventions that are being planned.
- Give plenty of notice about events to the whole team (including research team) to enable people to plan their involvement.
- Work closely with community members to ensure interventions are at times and places that are possible for them to attend.
- Ensure necessary training and support for those delivering interventions e.g. community outreach.
- Check in regularly to find out whether people want more or less involvement in delivering interventions.
- Ensure new incoming group members receive the same initial training and induction.
- Support group members who are not from the community to feel confident about their contribution.

See Vignette 5

6. Time and capacity

- Ensure protected time for project partners and healthcare staff from their organisations to attend meetings and participate in intervention delivery.
- Confirm from each partner organisation that their involvement will continue, even when management and organisational structures change, or when new staff take over roles.
- Consider how time required may increase at different stages of the project and build in flexibility for this.
- Recruit volunteers and provide training to support interventions eg. outreach and events.
- Develop individuals' skills by offering chances to: chair meetings, do radio interviews, give presentations, talk to the public etc.
- Where necessary create additional paid roles for people to lead in intervention delivery.

See Vignette 5

DOING CO-PRODUCTION

7. Evaluation of the co-produced interventions

Planning & designing the evaluation

If you have capacity and resources for a formal evaluation, consider the following:

- Build in evaluation from the start by working with research teams e.g. involve research partners from the local university.
- Define the key evaluation questions and identify the data required to answer them.
- Consider evaluation design, measurement and availability of data. In Common Ambition Bristol we delivered online surveys, conducted observations and interviews and analysed routine testing data.
- Use quantitative methods such as NHS Patient record data as an important outcome measure to assess impact of changes. Be aware of potential limitations of NHS data quality, challenges of extracting data and time needed for data cleaning and analysis.
- Use qualitative methods to gain responsive insights and impactful results. The qualitative feedback collected during Common Ambition Bristol was essential to iteratively improve intervention delivery.
- The evaluation team should work with the co-production working group and the stakeholder/ partner group to co-design of the evaluation to ensure it is acceptable and promotes engagement and recruitment.

See this brief evaluation checklist for guidance:
https://nhsevaluationtoolkit.net/wp/wp-content/uploads/2024/01/Evaluation-checklist-short.pdf

COMMON AMBITION BRISTOL TOOLKIT

DOING CO-PRODUCTION

Collecting data and sharing findings

- Involve community researchers from the target community to co-deliver the evaluation. Fully cost their involvement at all stages, including data collection, analysis and dissemination. Ensure appropriate. Ensure appropriate training in research skills and ethics and provide supervision, as well as opportunities for their own professional development.
- Utilise Logic Models to focus what you doing and how you plan to deliver change .
- Common Ambition Bristol used a model of behaviour change (COM-B capability (C), opportunity (O), and motivation (M)) to help identify barriers and facilitators to HIV testing behaviour among the community and inform the invention functions to change behaviour[10].
- Regularly feedback findings to the co-production working group so adaptations can be made to improve implementation.
- Plan how you will disseminate findings to influence others and what mechanisms you will use for knowledge mobilization to create impact.

COMMON AMBITION BRISTOL TOOLKIT

DOING CO-PRODUCTION

Top tips: Doing co-production

- **Ensure a realistic timeframe:** co-production, trust, relationship building, and engagement takes time.
- **Invest in relationship building:** Take time listening and getting to know each other, being clear about roles, responsibilities, sharing lived experiences and expectations of how to work together to achieve goals.
- **Lean into the messiness:** Allow space for high emotions and difficult conversations, which are all part of the process. It is essential to offer a full debrief for all teams involved if there is a session where this occurs (See Vignette 1).
- **Acknowledge your own position and degree of privilege:** Consider how this affects your contribution to the group.
- **Tolerate discomfort:** Be open to being challenged. Important learning can come from this. Good external facilitation can support people to be more comfortable with discomfort.
- **Share learning as it emerges:** Be willing to take learning back to your organisation.
- **Stay focussed on what you can achieve:** Ensure all activities are carried out within the parameters of the original aims of the project. It is very easy for 'mission creep' to occur. Be clear about pieces of work which would be important but are beyond the capacity of the team involved. These ideas should be collated for future projects. For example, we wished to include a bespoke set of interventions for young people but this was not possible to deliver and would have diluted the quality of other interventions.

DELIVERY OF CO-PRODUCED INTERVENTIONS

The following all need to be done in close collaboration with the community:

1. Dedicated communications and engagement (website, radio adverts, resources, give-aways, etc). Ensure all partner organisations involve their comms teams to disseminate press releases, job advertisements, good news and achievements.
2. Work with existing local community groups. Create a list of any community organisations who may be able to support the project and help with dissemination of key information, or job advertisements. The commissioning teams can be very helpful with this. Reach out to these organisations to see which will be allies. Revisit this regularly. Other groups may be more willing to get involved once the project has started.
3. Engagement events should be held in local, accessible, inviting settings and, where possible be in-person with food and drinks provided.
4. Community outreach is a key way to reach into the communities you are working with. Visiting local businesses and services to share the project can work well. This is best undertaken with an existing, trusted member of the community. Building community trust requires regular, consistent visits from a team that is flexible in responding to the varying needs of local businesses and services.

COMMON AMBITION BRISTOL TOOLKIT

DELIVERY OF CO-PRODUCED INTERVENTIONS

5. If setting up community clinics, these should be located in appropriate settings, both for the community in terms of location and trusted spaces but also from a clinical aspect e.g. need for handwashing facilities and IT access.
6. Clinics and events should be staffed and/ or greeted by people from the communities where possible. Ensure that if a clinic or event is in a multi-use space, signage is appropriate and clear and that receptionists are aware of what is happening and can signpost and advocate.
7. Where there is no clinical capacity consider if your intervention or service can be delivered in a community-based venue, by trained staff from VSCE organisations.
8. Include evaluation at all stages of intervention design and delivery. Ensure iterative feedback is used to refine and improve interventions.

See Vignette 6 for an example of the development of one of Common Ambition Bristol's co-produced interventions.

SHARING CO-PRODUCTION LEARNING: Adoption and Spread – Sharing the learning from your project

Start adoption and spread work as soon as possible once the co-production is established and you have updates to share. First, as a group identify your target audiences and then map the methods you will use to reach each different audience. For example:

Community:

- If you use social media to update the community, consider:
  1. What platform will reach different demographics
  2. Which account you will post this from
  3. Which community organisations /influential people you need to work with to share your updates to the widest audience.
- You may also want to do interviews on local radio and TV stations and podcasts with local influential people from the community or conduct presentations at community events.

COMMON AMBITION BRISTOL TOOLKIT

SHARING CO-PRODUCTION LEARNING

- If you are invited to any community events or celebrations, ensure NHS staff attend and are visible.

NHS Trust:

- Ensure approval or buy in from department, division and hospital trust management and a sponsor from the executive team to champion the project.
- Ensure the project is presented to wider departmental teams so all are aware of it.
- Present the project at teaching for other departments, e.g. lunch and learn sessions or grand rounds.
- Liaise with trust's Patient Experience and Equality Diversity and Inclusion teams (or equivalents) and other teams working to tackle inequities.
- Ask to present the study to the trust board, executive meetings and departmental meetings.
- Feature the project in trust newsletters and social media.
- The sky is the limit! Think big! Be brave! Most NHS Trusts welcome new evidence based approaches for meaningful engagement and tackling health inequities.

Wider stakeholders:

Liaise with wider sector partners e.g. other community organisations and national bodies and present the project, updates and findings at local and national meetings or invite them to a webinar.

COMMON AMBITION BRISTOL TOOLKIT

SHARING CO-PRODUCTION LEARNING

Top tips: Sharing Co-production learning

- **Co-produce ways to share learning:** Use a range of methods to communicate about the project in an accessible way. Co-produce these with members of the target audience to ensure the method is appropriate.
- **Communicate your learning in a range of ways:** Utilise news stories, blogs, infographics, videos, briefings, slide decks, presentations, media interviews, webinars, reports, academic papers.
- **Provide training and support and payment** for community partners to co-present at meetings, conferences and webinars.
- **Reflect and represent your project when sharing learning:** All the above activities require person-power. We shared out dissemination activities between all project partners and tried to ensure that community members or community researchers were always part of the presenting team. This was crucial to illustrate and reflect the active co-production which drove Common Ambition Bristol.

VIGNETTES

1. COMMON AMBITION BRISTOL: FOSTERING RELATIONSHIPS BETWEEN ALL PARTNERS

Concerns about disconnect between the Common Ambition Bristol team came to a head when the wider members (PAG, PDG, community researchers) participated in a workshop to review Common Ambition Bristol's progress and agree on future goals.

Although the working day was productive, some strong opinions were shared regarding the lived experiences of community member's and feelings of deep-seated institutional racism. There was a worry (based on previous experiences) that Common Ambition Bristol would be another 'project' which would come to an end with services for African and Caribbean heritage communities being removed, leaving the community feeling let down again. The group took time to reflect on and then try to address the issues that came up in the workshop, in particular recognising the need for better transparency and personal interaction between PAG and PDG. By years two and three this had been addressed with face-to-face monthly meetings for PAG and PDG having a 30-minute cross over period, with refreshments to enable increased connection. PAG members also began visiting PDG meetings to share information about their roles and the organizations they work for. It was widely agreed that although uncomfortable, this was a very important, necessary and useful point in the process of co-production within the Common Ambition Bristol team.

VIGNETTES

"There was probably some feelings that had been underlying for some time that came to a head in that time and I think probably needed to. I felt like the response to it has also been really important and I reflected afterwards that just the space and the opportunity to have an emotive discussion about the experiences of a marginalised part of our city, in the room with people who are part of the decision making that is around that subject felt like it was really important. Really an important moment."

Sexual Health Staff, year 3 interview

"I think there was a bit of back and forth between what is beyond PDG and what's being done behind closed doors and stuff like that and I don't think that's a bad thing at all. I think we've reached a level of comfortability that as a marginalised group, it's really hard to reach. That comfortability to speak up and ask those questions. So, I think it's a good sign... I don't think there's really much that we had that PAG haven't agreed with... I know in terms of interventions and stuff like that we (PDG) get the final say and it's been really evident when we have the team meetings which are together and PAG members get stuck in with brainstorming and some interventions and stuff like that. So, yes, not only do they (PAG) say it, they show it as well."

Community Member, year 3 interview

2. COMMON AMBITION BRISTOL: SPEAKING UP AND ASKING FOR WHAT YOU NEED

Reflections from the lead Sexual Health Consultant on Common Ambition Bristol: I asked the Chief Executive of the Trust to attend the Common Ambition Bristol launch event, but thought it was unlikely he would attend.

He came along, opened the event and provided an executive team champion for the project. I learnt from this to speak up and ask for high level support for our project. When starting the interventions we thought it might be 'too big an ask' to set up a new community testing clinic, due to the demands on staffing and resources. However, we encouraged and advocated, and it happened! Common Ambition Bristol started holding monthly drop-in testing clinics for African and Caribbean heritage communities, in a community location. Following community feedback, we learnt that local issues acted as barriers to attendance for some people from other parts of the city. So ... we asked for another clinic in a different area of the city which, again, we thought was unlikely but again, we made it happen. Our second drop-in testing clinic for people of African and Caribbean heritage began and we observed attendance increasing at both clinics. From this we learnt that facing and troubleshooting the (sometimes significant) logistical issues bring results. In addition, it enabled the learning to become more embedded in our department and as a result senior managers took more ownership. Our team were invited to present to the Trust Board of Directors. As a result two things happened[1] two directors asked to join on one of our community outreach visits to black-owned businesses. (2) Learning from Common Ambition Bristol has become embedded in Trust-wide policy. Having senior level recognition and support for Common Ambition Bristol is important for our community members and for the whole team.

3. COMMON AMBITION BRISTOL: POWER SHARING WITHIN PDG

Views of sexual health staff who are members of the PDG: There was some initial discomfort from white members of the PDG about use of language and the value of their input. This was partly due to their deeper understanding about community members' experiences of structural and inherent racism within the NHS:

"We've created an environment where conflicts can lead to discussion and people can talk openly and constructively, and there hasn't been any big confrontation. All of the conversation that happens is constructive, no matter what it's about."

Community Member, year 3 interview

VIGNETTES

As the group worked together over time, the sharing of lived experiences meant that members of the PDG who were not from African and Caribbean heritage communities gained understanding, which informed the way they contributed to the group:

"I've learned lots about how the community might feel about something and therefore I feel better equipped to offer something that feels more likely to be taken up by them, because it feels like I've heard them talk about this before or something similar. So there's something about awareness of their lived experiences that I've developed through working and co-creating together. So, I feel more confident to be like 'this is probably what I think you might want but I still want to check in with you and make sure that's what you do want' and I think more often than not it would be and so ... I feel more confident now."

Sexual Health Staff, year 2 interview

4. COMMON AMBITION BRISTOL: DECISION-MAKING

The PDG sexual health staff were initially uncertain about their role in decision making and so ensured that community members had the final say in decision-making. Over time the group found ways to effectively integrate sexual health expertise with lived experience, in order to reach consensus and make key decisions about Common Ambition Bristol.

"They've always been respectful and always said that the final decision regarding interventions and stuff remains with us (CM's)... but I think they (SHS) have now become comfortable to giving their own ideas as well and are very respectful where some might not identify as African or Caribbean, but are very aware there's a disparity going on and they're very respectful in terms of that."

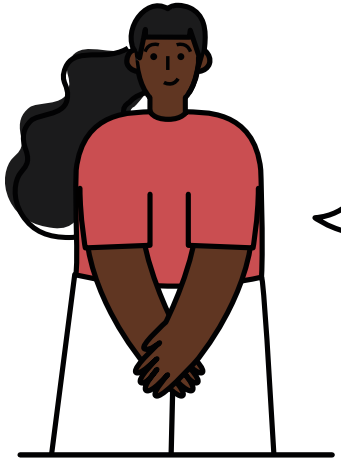
Community Member,
year 2 interview

"I think we're (SHS) still aware of it... wanting to make sure that we don't take the space but I think there's less anxiety around that and I feel like there's a comfort being able to speak from my opinion and voice, and know that actually it's going to be heard amongst other voices rather than over or above those voices as well."

Sexual Health Staff,
year 3 interview

VIGNETTES

The PDG noted that the busy meeting agendas sometimes left little time for exploring and negotiating differences in opinion. Over time, as familiarity grew, the group members felt more confident in speaking up and largely felt that decision making was equitable. They valued having the option to give feedback and express opinions outside of in-person meetings.



"We have differing views but by having a discussion, listening, questioning there is an outcome, and if it's not the one you want, accepting that it is not personal, it is a win."

Community Member, year 2 interview

"Good debate. People felt completely different about a decision, and it was discussed calmly and professionally. Decision made."

Sexual Health Staff, online survey

5. COMMON AMBITION BRISTOL: ROLE, CAPACITY AND PERSONAL DEVELOPMENT

There was a strong sense that more capacity, in terms of person power was needed to deliver the Common Ambition Bristol interventions, such as running outreach to Black-owned businesses and community events. This was addressed by the creation of two new paid posts; a community engagement worker and events co-ordinator. The team also worked to recruit volunteers and train them to support outreach and events. Some of the sexual health staff were frustrated they had not received adequate ring-fenced time from their organisations to assign to Common Ambition Bristol:

"I think if I'm going to be involved, I should be involved properly. I don't want to have half a foot in. It feels quite indicative of a lot of the culture of the structural inherent racism within the NHS ... it's not mainly deliberate but it's like, 'we're resource poor and so we're just going to give the bare minimum' So, 'if we can avoid giving out the *staff role* time for this, we'll avoid as much as we can' and I feel like actually, what this project is showing is that if you're going to do something, do it well. If you're going to invest in people, don't just do a token effort."

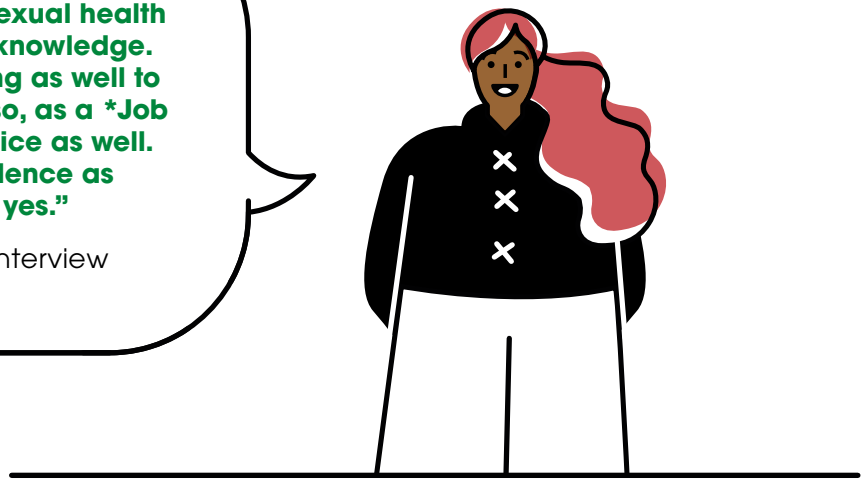
Sexual Health Staff, year 3 interview

VIGNETTES

Members of the PDG took on specific roles according to their availability and expertise. Some PDG members chaired meetings, covering when the project coordinator was away. Others became part of the outreach team and helped organize events. Some preferred to contribute by representing the PDG at PAG meetings, or by giving presentations about Common Ambition Bristol. During this process human capacities were developed, supported by initial training and ongoing support:

"I think I know a few more people in the community. I know more about sexual health and HIV so that's improved my knowledge. I like the fact that I'm contributing as well to our community if you like and also, as a *Job role*, I can use that in my practice as well. Yes, I think I've gained confidence as well and communication, yes."

Community Member, year 3 interview



6. COMMON AMBITION BRISTOL CLINICS: A JOURNEY OF TRAILING, LEARNING AND ADAPTING

The CAB Project Delivery Group chose to trial community sexual health testing clinics for people of African and Caribbean heritage. The first clinic was set up in April 2022 in an area serving these communities.

It was based in a GP surgery and run by Unity (the sexual health service provider) and CAB community members. The clinic was open once a month and offered drop-in testing. Initially the clinic was promoted via social media (Instagram and Facebook) and through the community outreach team, who visit Black -owned businesses in the city. Initial low attendance numbers were reflected on. Community engagement highlighted that many people living in another postcode area were unwilling to attend the clinic for reasons of confidentiality and safety. Once they understood the need for a second clinic in a new location, the CAB team put the wheels in motion (even though they thought it may not be possible). In July 2023 CAB launched a second clinic in another area of the city, also serving African and Caribbean heritage communities. This ensured a regular presence for CAB in two significant areas on fixed dates that the community could rely on. During CAB outreach, some business owners learnt about PrEP and asked if it could be provided in the clinics. Following this both clinics began to offer PrEP.

VIGNETTES

To increase clinic attendance and HIV testing in general, various solutions were trialled. All of these were designed through the co-production process:

- **CAB Events:** Various events helped raise the profile of the clinics. In particular a community 'cinema jam' saw clinic attendance increase by 300% the following day!
- **Radio Campaign:** The CAB team designed a radio campaign which consisted of recorded ads, played 8 times a day, 7 days a week as well as 9 live reads, on local radio stations, for a period of 3 months. The stations, Ujima and BCFM have a high listener base of people of African and Caribbean heritage. The team noted a significant increase in visits to the CAB website during this period, which provides information about multiple accessible testing options, including the CAB clinics.
- **GP Texting:** The team asked GP surgeries hosting the CAB clinics to send monthly text reminders to appropriate patients when clinic was about to happen. This was piloted for 3 months and greatly increased the number of people coming to get tested. One clinic then became concerned about bombarding the patients and put a halt on the texts. The other clinic agreed to continue but reduce their monthly texts, sending them to different patient age groups each month.

The PDG continually reviewed clinic attendance and discussed new ways to improve and maximise the number of people from African and Caribbean heritage communities coming to get tested. The evaluation has collected data from CAB clinic attendees. It shows largely positive feedback about the clinic and has highlighted things that could be improved.

Attendance numbers at the two CAB clinics have been responsible for almost a third of the extra patients being seen at UNITY (the sexual health service provider) services throughout the lifetime of CAB.

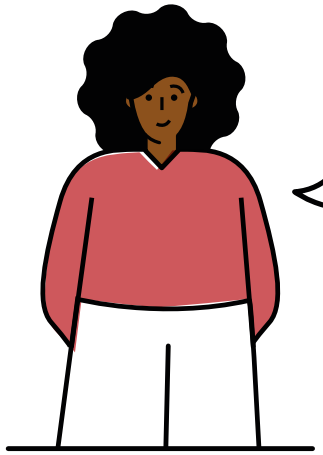
VIEWS ABOUT COMMON AMBITION BRISTOL:

"This information that Common Ambition is doing is great. Now they're coming to the people ... Lots of Black people didn't know about these PrEP or all these medications. Common Ambition is an improvement because at least they're going out and letting people know that you can access this medication. You can access this information. I've never really gone to the local doctor that much, if at all to be honest. So I like this."

Male, 41, Caribbean heritage

"You guys should please continue to do what you do. You're really helping a lot of people, and I'm just one person."

Female, 38, African heritage



"CAB your approach is a game-changer."

Trust Board Directors

REFERENCES

1. The Value of Co-Production Project (2022): https://cdn.prod.website-files.com/5ffee76a01a63b6b7213780c/63925edd5a30c19953d90fed_ValueCoPro_InteractiveSummaryFinal.pdf
2. Co-production model (2022) Coalition for personalised care: https://www.communitycatalysts.co.uk/coalitionforpersonalisedcare/resources/a-co-production-model/
3. Co-production in action (2019) NIHR INVOLVE: https://www.invo.org.uk/posttypepublication/co-production-in-action-number-one/
4. Co-production of Knowledge: The future (2021) BMJ: https://www.bmj.com/content/372/bmj.n434
5. Ladder of Co-production: https://thinklocalactpersonal.org.uk/resources/ladder-of-co-production/
6. HIV Commission. Equity (2020): https://www.hivcommission.org.uk/final-report-and-recommendations/
7. Lester J, M.V., Shah A, Chau C, et al., (2022) HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report. The annual official statistics data release. London UK Health Security Agency.
8. Altinoluk-Davis, F. (2023) Bristol HIV Health Needs Assessment. Bristol City Council Public Health
9. Fast Track Cities - Bristol One City: https://www.bristolonecity.com/fast-track-cities/
10. Michie, S., M.M. van Stralen, and R. West, (2011) The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science,. 6(1)

Authors: This Toolkit was co-produced by members of the Common Ambition Bristol Project Advisory Group and Project Delivery Group.

Funders: Common Ambition Bristol is supported by The Health Foundation, an independent charitable organisation working towards building a healthier UK.

IF YOU WOULD LIKE TO GET IN TOUCH WITH THE COMMON AMBITION BRISTOL TEAM:

Email: CAB@brigstowe.org
Phone: 0117 955 5038
Instagram: @commonambitionbristol
Facebook: @CommonAmbitionBristol
Bluesky: @commonambitionbs.bsky.social

commonambitionbristol.org.uk

SCAN ME

Common Ambition Bristol

African Voices Forum

Bristol City Council

brigstowe
Positive change together

brook

University of Bristol

The Health Foundation

NIHR | Applied Research Collaboration West

Fast-Track Cities Bristol

Terrence Higgins Trust

SHIP
Sexual Health Improvement Programme

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust