Involving Rural Communities in Health and Care Services Co-Production

Promoters and Barriers as Reported in the Academic Literature

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Executive Summary

Health and Care Services Co-Production

This report is about what helps and hinders the involvement of remote and rural communities in the co-production of health and care services. Co-production is about health service professionals, such as doctors, nurses and managers, working in partnership with individuals and communities. This partnership approach pays attention to the opinions of patients, family members, carers and the wider community and aims to include them in health and care services planning and provision.

Co-Production in Remote and Rural Areas

The context of remote and rural areas can bring challenges to the co-production approach to health and care services with, for example, large drive times between communities. This report tells you what helps and hinders the involvement of remote and rural communities in co-production. It does so by reviewing the academic literature on this topic.

Academic literature on health and care services co-production was searched in order to identify studies of remote and rural areas. Ten papers were identified as relating specifically to this topic. Each of these papers contained research on co-production in a remote and rural context and identified things that helped co-production (promoters), as well as barriers to co-production. This report presents the common barriers and promoters to co-production that were identified.

Promoting Remote and Rural Co-Production

The papers included in this literature review suggest several ways to promote co-production in remote and rural areas including the following.

- Use of engagement methods that have been shown in other case studies to be inclusive and successful in promoting participation. This can include planning with communities; involving communities actively in service delivery; facilitating engagement through existing community organisations and having a flexible and adaptable approach to engagement.
- Ensuring that the community feel the engagement process is a positive experience for them. This includes feeling supported, and listened to by health and care professionals and managers who have a positive attitude towards the community and the engagement process.

- Ensuring that the community feel they are appropriately represented in any design and delivery processes.
- Ensuring that the community are involved in ways that generate feelings of ownership and empowerment. This can be achieved by ensuring that community members are at the heart of all activities.
- Ensuring that appropriate resources are identified and in place to enable the co-production to happen.
- Paying attention to the characteristics of a rural community and how these could affect the engagement process, e.g. population size, demography and past experiences of co-production within the community.

The evidence reviewed in this report allows us, therefore, to suggest that successful co-production in remote and rural areas is related to the following.

- Engagement that is appropriate to the context of rural communities.
- Engagement that equips and supports rural residents to 'get involved'. This includes empowering communities to engage with health services providers and enhancing their skills to self-manage and promote health within their own localities.

Introduction: Co-Production in Health and Social Care

Defining Co-Production

Current health and social care policy within the United Kingdom (UK), and the devolved nation of Scotland, promotes service user and wider community engagement in the planning and provision of health and care services. Healthcare planners and clinicians are encouraged to open up decision-making processes in order to give a greater voice to, and valuing of, patients, family, carer and wider community views (Royal College of General Practitioners Commissioning Group, 2011). Increasingly, the role of the individual in managing their own health and care is seen as a key part of both preventing disease and managing chronic conditions. At the same time, within the UK and across other countries, public health services have come under strain as our populations age and the economic crisis of 2008 takes effect.

Within this context, a discourse has emerged around the 'co-production' of health and care services. Co-production is promoted in policy as a way to achieve goals such as facilitating a greater patient voice and autonomy within the health and care system. It is suggested as a positive 'reform' that will empower patients and help deal with the issues of population aging and public sector services pressure. Although a long-standing term, that dates back to the work of Eleanor Ostrom in the 1970s, the phrase has gained prominence more recently through the work of the think-tank New Economics Foundation (NEF) and others. Ostrom and other early adopters of the term co-production used it to highlight how consumers or service users are a central part of any public service. In recent times the term has been used to argue for a shift in ethos within public sector service delivery:

"An assets approach…built on equal relationships…where services 'do with, not to' the people who use them and who act as their own catalyst for change"

Loeffler et. al. (2013) p.14

One of the most commonly-quoted definitions of co-production is that given by the innovation charity Nesta:

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."

Boyle and Harris (2009), p. 11

Overall, therefore, co-production is seen as a positive way to achieve greater equity and efficiency within health and social care services. Many positive experiences of, and outcomes from, co-production have been reported – for example see the work of the Joint Improvement Team (JIT) and Co-Production Network in Scotland. Some work has, however, challenged the assumption that co-production will always produce positive outcomes (e.g. Glynos and Speed, 2011).

Remote and Rural Co-Production

Despite the generally positive portrayal of co-production, there is recognition that as a service design and delivery mechanism, it can bring challenges, especially in particular geographical or cultural contexts (Stewart and MacIntyre, 2013). Academic studies have considered, for example, the impacts of co-production for the management and delivery of care (Stewart and MacIntyre, 2013). Other work, such as De Witte and Geys (2013) considers co-production outside the health and care context. However, there is little research or evaluation that considers health and social care co-production within remote and rural geographical, social, cultural and economic contexts.

Yet, previous research suggests that the remote and rural context can bring particular challenges to co-production (Munoz, 2013). Often cited are factors such as low population densities; high travel times and costs and existing high burdens of informal volunteering (Farmer et. al., 2012).

This report details the results of a systematic literature review carried out in order to review, synthesize and interpret the current evidence base on services co-production in remote and rural areas. It aims to strengthen our understanding of the contextual influences on remote and rural services co-production. It is the first systematic review to consider both context and barriers to co-production within remote and rural areas.

The review takes a meta-ethnography approach – this is a type of interpretive synthesis that considers the findings of different research projects in order to identify shared themes. Thus, by identifying findings that span different case studies reported in the literature, as well as differences, this review helps to inform the development of theory around the successful involvement of remote and rural communities in co-production. This has the potential to inform the development of co-production across remote and rural contexts as well as highlight issues which may require further research and evaluation.

The methodology of the literature review is outlined in the next section of this report. It is followed by the results of the meta-ethnography that detail the themes around promoters and barriers to remote and rural co-production. These themes are

discussed further in the following section that looks at how they can inform theory development. Areas of further research and consideration are highlighted in the concluding section.

Method

The objective of the literature review was to review, synthesize and interpret the current academic evidence base on services co-production in remote and rural areas.

Research Question:

What are the promoters and barriers to engaging remote and rural communities in health and care services co-production as reported in the literature and what can they tell us about how to support successful engagement?

The characteristics of a co-produced service as defined by New Economics Foundation (in 'Public Services Inside Out') were used to define co-production within the review. Engagement and service delivery processes were deemed to be co-production if they met the following criteria.

- Recognise people as assets.
- Build on people's existing capabilities.
- Promote mutuality and reciprocity.
- Develop peer support networks.
- Break down the barriers between professionals and recipients.
- Facilitate rather than deliver.

A systematic literature review was carried out using a meta-ethnography approach (Victor, 2008). This allowed us to identify, synthesise and interpret the existing evidence base (Dixon-Wood et. al., 2006). As most of the work in this area is within the social sciences, often using mixed methods, the meta-ethnography approach allowed us to consider the breadth of studies, their similarities and differences and search for both commonalities and outliers (Petticrew and Roberts, 2006).

The review was carried out using the steps listed below.

1. Develop data extraction template and search terms.
2. Literature search using the online Scopus database.
3. Exclusion of papers not related to core theme and/or research question.
4. Completion of data extraction template for each remaining paper.
5. Meta-ethnography to identify common and unusual themes.
6. Researcher interpretation of thematic results.

Geography	Co-Production	Sector
Remote	Co-Production	Health AND design
Rural	Co-Produce	Health AND delivery
	Coproduction	Care AND design
	Coproduce	Care AND delivery
	Community engagement	
	Community participation	

Table 1: Search terms use in literature search

The search terms produced an initial selection of papers totalling 1,454. After the removal of duplicate papers this left a group of 806 papers. These 806 papers were reviewed using a data extraction template; with any papers not meeting the following criteria being removed:

- Paper is in English.
- Paper discusses primary data and is not a literature review.
- Activities met the New Economics Foundation co-production criteria.
- Paper was written after 1973.
- Paper does not focus solely on a developing world context.

This left a group of 10 papers; each of which was read in full and data extracted on the following.

- Author.
- Year of publication.
- Country of case study.
- Type of communities involved.
- Methods of engagement used.
- Promoters identified.
- Barriers identified.

Overview of the Papers Included in the Review

1. Angell, K.L., Kreshka, M.A., McCoy, R., Donnelly, P., Turner-Cobb, J.M., Graddy, K., Kraemer, H.C. & Koopman, C. (2003) 'Psychosocial intervention for rural women with breast cancer: The Sierra Stanford partnership'. Journal of General Internal Medicine 18 (7), 499-507
2. Anton, S., McKee, L., Harrison, S. & Farrar, S. (2007) 'Involving the public in NHS service planning'. Journal of Health, Organisation and Management 21 (4-5), 470-483
3. Broussard, M., Blackwell, R., Caillouet, L.P., Nichols, K.H. & Shipman, M. (2003) 'Connecting our resources: Louisiana's approach to community health network development'. Journal of Rural Health 19 (SUPPL.), 372-383
4. Brumby, S.A., Willder, S.J. & Martin, J. (2009) 'The sustainable farm families project: changing attitudes to health.'. Rural and remote health 9 (1), 1012
5. Coady, M. (2009) 'Enabling volunteer health planning capacity: A rural Canadian case study'. Journal of Enterprising Communities 3 (4), 393-404
6. Eyre, R. & Gauld, R. (2003) 'Community participation in a rural community health trust: The case of Lawrence, New Zealand'. Health promotion international 18 (3), 189-197
7. Fries, E.A., Ripley, J.S., Figueiredo, M.I. & Thompson, B. (1999) 'Can community organization strategies be used to implement smoking and dietary changes in a rural manufacturing work site?'. Journal of Rural Health 15 (4), 413-420
8. Lee, K.S.K., Conigrave, K.M., Clough, A.R., Wallace, C., Silins, E. & Rawles, J. (2008) 'Evaluation of a community-driven preventive youth initiative in Arnhem Land, Northern Territory, Australia'. Drug and Alcohol Review 27 (1), 75-82
9. Munoz, S., (2013) 'Co-Producing Care in Rural Communities', Journal of Integrated Care
10. Nimegeer, A., Farmer, J., West, C. & Currie, M. (2011) 'Addressing the problem of rural community engagement in healthcare service design'. Health and Place 17 (4), 1004-1006

Of the papers included in the review, three of the case studies are Scottish; three are from the United States of America; two are Australian and there is one Canadian and one New Zealand case study.
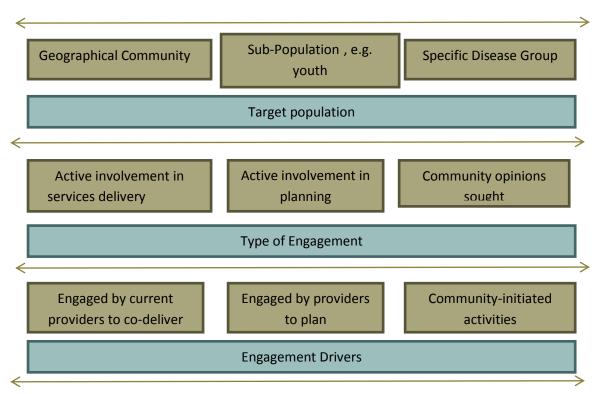
Figure 1: the spectrum of characteristics of the activities discussed within the papers

The Scottish papers focus on engagement with the rural 'community' at large, i.e. engagement that targets anyone residing within a particular rural geographical community. The Australian papers look specifically at two population subgroups that may be considered 'hard-to-reach': Aboriginal youth and farmers/farming families. The United States of America papers are more mixed, covering: a manufacturing workplace; a rural community in general and a breast cancer survivor community. The New Zealand, paper considers governance of a health trust and the paper from Canada considers formal volunteering of community members within health services delivery.

There is a spectrum of co-production considered within the papers from engaging with people to 'opinion seek', through to co-designing and co-producing services. Engagement in design/planning is more prominent within the Scottish-based literature. The New Zealand paper is a formal example of community engagement in health services governance, whereas the Canadian example is more about voluntary involvement in delivery as a provider. The Australian and United States of America examples speak more to facilitation of community organisation for preventative health initiatives. Some papers speak of 'official', state or current provider initiated/endorsed engagement, whilst many report on participatory action research projects that have been funded, at least partly, by research monies.

The methods used to evaluate the co-production activities within the papers were: interviews (Munoz, 2013; Lee et. al., 2008; Eyre, 2003; Anton et. al., 2007; Angell et.

al., 2011); surveys (Fries et. al., 1999; Brumby et. al., 2008); health measurements (Fries et. al., 1999; Brumby et. al., 2008; Angell et. al., 2011); thematic content analysis (Munoz, 2013); observational studies (Lee et. al., 2008); participants' narrative accounts (Coady, 2009).

Promoters and Barriers: Themes

This section of the report details the commonalities and differences between the papers as observed when their findings were compared. The comparison produced the following themes.

i. Methods of Engagement
ii. Ethos of Engagement
iii. Community Characteristics
iv. Resources

i.   Methods of Engagement

A variety of methods to engage remote and rural communities in health and care services co-production are discussed within the papers. Unsurprisingly, the authors state that the methods used within their case studies were selected because they were believed to facilitate access to, engagement with, and information gathering from, the service users or communities involved. There is an explicitly reported effort to use methods that will be participatory and welcomed by the community as well as producing positive data collection and service provision/health status improvements.

The role of service users and communities at the heart of the process is a consistent theme throughout the papers. Different methods are, however, used to achieve this – all of these methods are presented by the authors as being effective ways to involve remote and rural communities in the design or delivery of health services:

Common Methods:

- **Planning and/or discussion of scenarios with community members (co-design):** involving community members in scenario or other types of service planning are discussed by Anton et. al. (2007); Broussard et. al. (2003); Fries et. al. (1999); Nimegeer et. al., (2011) and Munoz (2013), i.e. the three Scottish case studies and two case studies from the United States of America.

- **Interventions that involve communities in planning *and* delivery (co-delivery):** involving communities beyond the planning stage and into taking an active part in services delivery itself is discussed by Angell et. al. (2011); Brumby et. al. (2008); Coady (2009); Fries et. al. (1999) and Lee et. al. (2008). Angell et. al.'s (2011) work talks of the role, for example, of breast cancer survivors in designing, developing and the using a tool for self-management and peer support.

- **Engaging with existing organisations:** both Brumby et. al. (2008) and Fries et. al. (1999) attribute some of the success of the activities reported in their case studies to the fact that engagement was facilitated by approaching and then involving existing organisations. In the case of Fries et. al. (2008) the use of a rural worksite is described as enabling the activities to "reach under-served minority populations". Brumby et. al.'s (2008) engagement is also an "industrial collaboration" designed in order to engage farmers and farming families.

- **Having a flexible and adaptable methodology and approach**: both Lee et. al. (2008) and Angell et. al. (2011) comment on the importance to their case studies of having an open and adaptable approach to community engagement. Angell et. al. (2011) advocates for having personal contact at the heart of the engagement process and, rather than a consistent protocol, one that is open to interpretation and can be adjusted to suit the particular situation and individuals involved. This is reported to foster personal contact and trust – something that is quite challenging to existing systems that assume standardisation of approach. Lee et. al. (2008) highlight that the staff involved in the co-production also need to be adaptable as it goes along. Whilst, Lee et. al. (2008), Eyre and Gould (2003) and Broussard et. al. (2003) all highlight the positives to come from the use of methods that are open to community innovation and have open-ended, flexible natures, challenges are recognised in terms of community representativeness – use of representatives/existing organisations may not represent the views of all and throughout many of these situations, open processes will include those who *self-select* to be involved.

- **Recognising and utilising assets:** Many papers advocate the use of methods that may be termed 'asset based' and look to draw on the value of "local expertise" (Fries et. al., 1999) and "community resources" (Eyre and Gould, 2003) to achieve their desired outcomes. Eyre and Gould (2003) attributes success to recognising and using a range of community resources (labour, material, finances).

Different Methods:

- **Involve community members in formal governance:** the paper by Eyre and Gould (2003) stands out in its discussion of the formal engagement of community members in health services governance as it considers Rural Community Health Trusts in New Zealand.

- **Integrating use of popular activities**: in the paper discussing an Aboriginal youth programme in Australia – designed with this sub-population with the aims to "prevent substance misuse and increase respect for culture and their elders among young people" – Lee et. al. (2008) highlight the "enthusiasm" for "training and recreation" activities that were integrated into the programme. Examples include activities such as film-making; youth and community festivals and a mural programme.

- **Dialogue for community readiness**: the paper by Coady (2009) suggests the approach of having a dialogue with community members before engagement starts in order to test levels of 'readiness' to take part in such activities:

  "The study finds that dialogue is a key mechanism for assessing community and system readiness, and for building trust and mutual understanding in such health partnerships… early dialogue is critical to developing community health planning capacity…"

ii. Ethos of Engagement

As outlined above, the authors of the papers included in this review each attribute some of the success of the reported case studies to the use of methods that are considered to be inclusive, empowering, participatory and community focused. The success comes down to, at least in part, therefore, how the community members/participants *feel* about, or perceive, the process. Three ways in which the community feels positively about the engagement in co-production are reported across several papers:

1. Community feel supported and listened to.
2. Community feel ownership/empowered.
3. Community feel appropriately represented.

Community feel supported and listened to

Throughout the papers, the authors report that in successful co-production communities need to feel that they are supported and listened to within the health and care arena, e.g. as co-designers of services or active agents in their delivery. The community participants need to be sure that their contributions are being valued by health professionals and planners; that their contributions will be considered and have the potential to make a difference. They also need to feel that they are not being overburdened by a retreating public sector.

The generation of feelings of support and valuing of knowledge/opinions is played out in several ways within the papers:

- **Health service staff or other 'leaders' genuinely listen to and consider community views:** several case studies highlight the importance of the community feeling that they are listened to. Brumby et. al. (2009) and Angell et. al. (2011) both highlight the personal element of this through the use of supported learning that is "personally engaging" (Brumby et. al., 2009) and the use of community partners to contact and recruit participants (Angell et. al., 2011). Coady (2009) points out that the approach of the health professional is key, e.g. that they "[have] a positive image of the community…[are] liked and working well with community… [and] assume an enabling role…"; we can see that this goes beyond the health professional using the right methods and speaks to their attitude and approach to engagement. Anton (2007) and Munoz (2013) also highlight the benefits of the community feeling that they have been listened to, trusted, and that the process they are engaged in is not political.

- **Background of health service staff:** Lee et. al. (2008) discusses the importance of having a co-ordinator from an Aboriginal background within the Aboriginal Youth Project. This could speak to the potential importance of using locally-based activists or staff that have an awareness of local context. Aton (2011), however, points out that remote and rural health service staff may also live within the communities that are being engaged – leaving them in a difficult 'in-between' position.

Community feel ownership/empowered

All the papers suggest that successful co-production is grounded in the community feeling a sense of empowerment or ownership over the process, decisions being

made and future direction of travel. Again, the authors advocate for placing the remote and rural community members at the heart of all activities.

Several papers use participatory action research with Munoz (2013) and Broussard et. al. (2003) both attributing the participatory action research being "community-initiated" to the generation of feelings of ownership and empowerment. Coady (2009) reports similar findings when leadership is shared. Agnell (2011) reports that if these feelings are not achieved, the community can remain suspicious and retain feelings of being a "guinea pig". Lee et. al. (2008) highlights the need for successful engagement to generate feelings of ownership by the community.

Service providers being an active part of the process is also suggested as a promoter for co-production (Munoz, 2013; Lee et. al., 2008; Broussard et. al. , 2003) with their presence at events facilitated by and held within the community signalling to the community that they are valued (Munoz, 2013; Nimegeer et. al., 2012).

Community feel appropriately represented

Across several case studies, the community feeling that it is appropriately represented is given as a promoter of successful co-production. Whilst all the papers advocate for engaging community members within co-production; this was carried out in various ways within the case studies – from open public meetings to the use of community researchers and representatives from existing community organisations. There is no one answer to what works best – each of these methods is described as offering community representation; success is linked, therefore, to the community members also feeling that it is appropriate.

Anton et. al. (2007) highlights public sector staff opinions on the appropriate type of public representative for a 'formal' role, such as on a committee:

"…interested in public involvement", who are "charismatic"; "have knowledge and experience in local community matters"… are "trustworthy" and "confident at discussing and presenting difficult issues"

Fries et. al. (1999) and Eyre and Gould (2003) both highlight potential barriers to communities feeling appropriately represented. Representatives, for example, may not have ideas that link to wider views or interests within the community (Fries et. al., 1999). This can occur if leaders emerge through self-selection (Eyre and Gould, 2003) and are limited to the "usual suspects" (Anton et. al., 2007).

iii. Resources

Resources are often reported as being "needed" in order to facilitate co-production or the Participatory Action Research described within the papers. An absence or lack of resources is often seen as a barrier therefore to achieving successful health or care services co-production in rural areas. Coady (2009), for example, explicitly names "resources" as a promoter of successful co-production. There are subtle differences between the papers in the ways in which 'resources' are discussed:

- **Financial Resources:** some access to financial resources is highlighted as a promoter to, or barrier for, rural community engagement in community-driven co-production (Coady, 2009; Munoz, 2013).

- **Human Resources:** the availability and willingness of community members to get involved is discussed within several papers. Coady (2009), for example, states that local knowledge and skills are resources that "can be used to complement" health services delivery. Munoz (2013), however, identifies that co-production can challenge the capacity of rural communities who are already involved in formal and informal volunteering. Both Fries et. al. (1999) and Broussard et. al. (2003) identify the time needed and travel that rural community members will potentially need to undertake as barriers. Broussard et. al. (2003) also identifies capacity issues for remote and rural health professionals to get involved in engagement and co-production.

- Eyre and Gould (2003) attribute some of the success of their engagement to that fact that they feel they draw on multiple local resources: labour; materials and finances.

iv. Community Characteristics

The impact of the characteristics of a rural community, e.g. population size; demography, on the engagement process, as well as the experience and or success of co-production, is a finding that spans several of the papers:

- **Population:** remote and rural populations are often ageing, small in size and dispersed in terms of settlement patters. Coady (2009) highlights that demographics such as "depopulation" can act as barriers to participation in co-production; as does Munoz (2013) who highlights the increased burden of effort; bureaucracy and a lack of leaders/participants that can be associated with the characteristics of rural populations.

- **Community Dynamics:** Munoz (2013) and Coady (2009) both refer to community "factions" that may act as a barrier to successful co-production. It may be difficult to achieve consensus across a geographical community and Munoz (2013) highlights that decision-making processes within a co-production framework can stir up existing community tensions. Coady (2009) case study notes organisations such as Community Health Boards in Canada[1] (CHBs) as a potential "bridge" that can span and "mitigate factions".

- **Opinions and Understandings:** although discussed in different ways in different papers, a theme can be seen across several of the case studies that relates to the impact of the opinions and understanding of the players involved in the co-production on the success of the process. Munoz (2103) highlights how 'traditional' expectations of the public sector's role in delivering services can be hard to shift and, therefore, stifle co-production. Similarly, Coady (2009) and Broussard et. al. (2003) highlight the need for clarity on the process and knowledge of health and services within the community in order to promote co-production. Coady (2009), for example, cites the use of "medicalised context and language" as a barrier to community engagement. Such lack of clarity and 'unfriendly' language may contribute to what Anton et. al. (2011) cites a lack of confidence among community members to be able to get involved as a barrier. Coady (2009) suggests having a dialogue with the community in order to ensure (or build) readiness for co-production can, therefore, act as a promoter. Eyre and Gould (2003) also cite that a community with a history of good engagement with the health sector in the past is more likely to experience successful development of co-production.

- **The Rural Economy:** this theme relates to that of 'population' in Munoz (2013) as the demands of rural working life are seen to leave little capacity for any 'extra' effort within services co-production. Both Munoz (2013) and Eyre (2003), however, do point towards a rural community's fear of sustainability as a motivating factor to get involved.

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1. As Coady (2009) explains "…health in Canada's provinces and territories is generally governed by regional health authorities, and district health authorities (DHAs). Corresponding community level structures – often referred to as community health councils or community health boards (CHBs), are legislated to facilitate community input in the identification of health needs and priorities."

Discussion: Co-Production with Remote and Rural Communities

Following the thematic synthesis describe above, a further higher order interpretation was undertaken to draw out a conceptual framework of co-production in remote and rural communities. This was done by re-reading and re-coding each paper – grouping the initial codes outlined above in relation to their underlying drivers (see figure 2).

Underlying the themes in the thematic synthesis is the conceptualisation of co-production as both appropriate to, and understanding of, rural context. In addition, an underlying driver is equipping and supporting rural residents to get engaged. Our conceptual framework (figure 2) suggests that when/where these two come together it facilitates co-production in remote and rural communities.

This speaks to the theories of change highlighted by O'Mara-Eves et. al. (2013) in relation to public health. The remote and rural co-production described within the papers included in this literature review appears to draw on elements of each of the theories of change discussed by O'Mara-Eves et. al. (2013). Those parts which particularly apply to the remote and rural co-production conceptual framework are underlined in the following excerpt:

"1. Theories of change for patient/consumer involvement. This is engagement with communities or members of communities in strategies for service development, in which empowering individuals enhances their engagement with service professionals to effect sustainable changes in services. The need for on-going investment will depend on the nature of the changes made; on-going partnership is not necessary for sustaining changes, but can benefit subsequent changes.

2. Theories of change for peer-lay-delivered interventions. Services engage communities, or individuals within communities to deliver interventions. The aim of empowering people by enhancing their skills is to effect sustainable change amongst themselves and their peers. Although the individual behaviour changes sought may be sustainable, the intervention needs on-going investment from services for subsequent generations.

3. Theories of empowerment to reduce health inequalities. When people are engaged in a programme of community development, an empowered community is the outcome sought by enhancing their mutual support and their collective action to mobilise resources of their own and from elsewhere to make changes within the community. An empowered community can do much to sustain its own efforts."
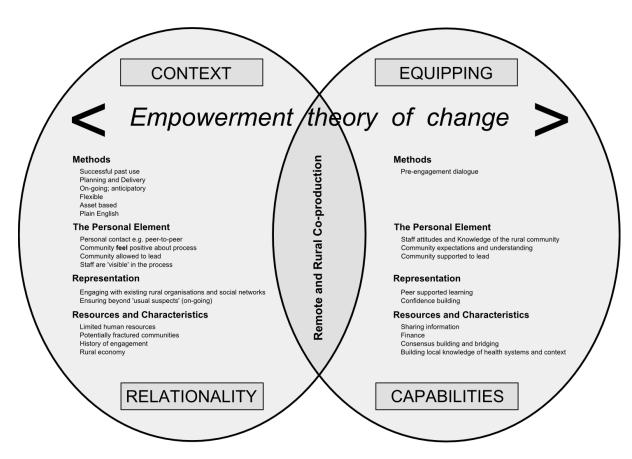
Figure 2: Remote and Rural Co-Production Conceptual Framework

Thus, a theory of change for remote and rural community co-production, drawing on this thinking and the conceptual framework derived from our systematic review can be suggested:

Remote and rural health and care services co-production engages individuals and communities in strategies for services design, development and delivery, in ways that empower participants and enhance their engagement with health and care services and the promotion/maintenance of their own health. By being sensitive to community context and capabilities, remote and rural health and care services co-production can empower people in ways that effect peer-to-peer learning and mutual support. It empowers individuals and communities to take action, mobilise resources of their own and from elsewhere to make changes to the ways in which health is promoted/maintained and health and care services are designed and delivered.

It can be seen that empowerment sits at the heart of this theory of change. Across all the papers reviewed, underlying drivers of successful co-production were related to participants feeling that they could speak up, contribute meaningfully and drive forward change. This is a collaborative relationship, based in an empowerment theory of change. As shown in figure 2, therefore, remote and rural co-production can be conceptualised as a delicate balance between supporting and facilitating engagement, as well as space and freedom for community action and leadership.

Recognising, and being sensitive to, rural context, and equipping residents for co-production, are related to our thematic areas of: methods used; personal element; representation; resources and characteristics. The second round of coding and higher level analysis of the papers included in this review highlighted many connected underlying drivers between these themes. Their inter-relatedness speaks to the theory-building of Entwhistle and Cribb (2013, p.8) that includes relational and capabilities thinking that encourages us to consider:

 "…the deeper and more subtle aspects of clinician-patient relationships…and that clinicians' commitments and practical contributions to an ethos of healthcare as a cooperative enabling endeavour might sometimes be more important than questions of who does what in terms of identifying problems, setting goals and implementing tasks".

"…the material and social circumstances of people's lives can shape their knowledge, confidence, skills and motivation as well as their self-management behaviours."

Entwhislte and Cribb (2013) highlight the importance of the health services-professional-patient relationship. Combining this with relational thinking from health geography (e.g. Cummins et. al., 2007) suggests that the context of remote and rural co-production includes other actors, networks and flows (for example, the 'place' of rural communities within economic systems and a relationship with the health services that is temporally as well as geographically bounded).

The themes from the literature synthesis also point to the need to equip communities for co-production; rather than assume that conditions are ripe for co-production. This can be related to capabilities thinking (Entwhistle and Cribb, 2013) – the recognition, for example, of community understandings of health; staff attitudes towards communities; individual's confidence; all speak to a need to equip rural communities and proffessionals with the resources needed to engage successfully in co-production in ways that are sensitive to rurality as well as individual circumstances.

Looking across the papers, the case studies suggest that successful co-production is related as much to creating a positive and supportive environment as to the mechanics of the methods of community engagement employed. A theory of change for remote and rural communities spans both relational and capabilities thinking, is situated within theories of empowerment, and includes recognition of geographical, temporal, cultural and other contextual influences.

Conclusions and Future Directions

The studies included in this review are academic papers, most of which report findings of time-limited participatory action research. Within this review, we have not

identified many papers that consider the barriers and promoters of rural co-production from the perspective of ongoing, 'real-life' delivery situations.

Also notable, is that there is little discussion of whether, and if so how, the promoters and barriers identified in the papers are specific to a remote and rural context; or effected by such a context. The key dimensions of rurality mentioned in these papers are: rural economy; blurring of staff/resident roles; and time related to travel requirements. Other promoters and barriers have aspects that may well be shared with urban areas but played out /experienced in different ways within rural areas, e.g. community tensions; lack of resources; demographics etc.

Future work is needed to examine 'real-life' health and social care co-production in remote and rural areas. In particular, longitudinal work would help move beyond the 'snap-shot' that results from time-limited studies such as those reviewed in this report. This review was limited to the academic literature accessed through the Scopus search engine – widening the search criteria to non-academic and other search engines would also be useful.

The review has provided a starting point for the conceptualisation of successful remote and rural co-production within health and social care. The conceptualisation highlights the importance to such co-production of feelings of community empowerment, as well as applying relational and capabilities thinking to the consideration of how local context and community skills promotion can affect engagement. In turn, this suggests the need for future evaluations and research to capture more than the mechanics of engagement methods and to consider aspects such as ethos, emotion and community satisfaction that are harder to measure.

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