Patient and Public Engagement to Support Clinical Redesign

Lancashire and South Cumbria Provider Collaborative Toolkit

1. Engagement and involvement

Meaningful engagement is a genuine two-way process which gives people an opportunity to influence decisions about the services available to them and their loved ones.

Engagement is also a duty under the NHS Act 2006 and the NHS Constitution when considering changes to health services (the way they are delivered, the range of services available, or the way services operate). These duties remain when planning and developing proposals for service change through provider collaboratives[1].

As a provider collaborative we acknowledge that:

- Engaging and involving people, communities and stakeholders in developing plans for local services is the right thing to do.
- Meaningful engagement is essential for effective service improvement and system transformation. This includes collectively identifying problems, designing solutions, and influencing delivery.
- Effective engagement ensures that plans and their implementation are robust and meet people’s needs.
- Through engagement we benefit from the knowledge, skills and experience of people who have been service users, or their carers, as well as other stakeholders.
- We will therefore seek patient and public involvement as early as possible in the redesign / transformation process to ensure maximum benefit.

2. Our process

- Typically patient engagement and involvement begins at the case for change stage, with the preceding scoping stage mainly being a clinical discussion.
- Involvement at this early stage allows for service users’ perspectives to be considered from the beginning of the service redesign process, and then as progress is made through the various stages (as shown in figure 1).

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[1] NHS England » Working in partnership with people and communities: statutory guidance

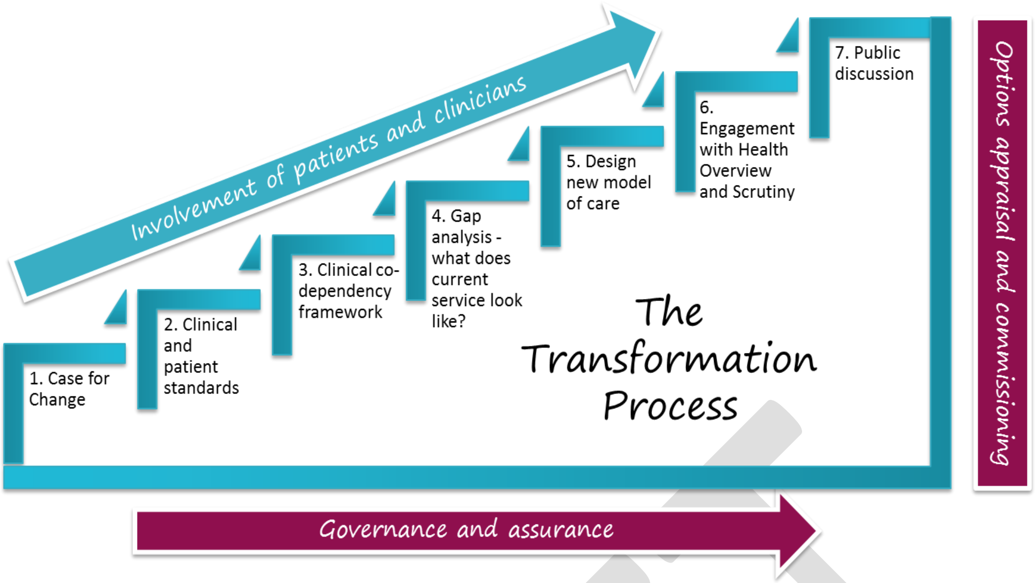

Figure 1: Engagement through the service redesign process[2]

- Where possible, projects will adopt two-way engagement methodologies. There are various ways to do this, depending on a range of factors including the intended audience, subject matter and timescales (as shown in appendix 1).

3. The 9-step guide to engagement

The following gives a step-by-step guide to planning and delivering an engagement programme[3].

- **Step 1: Plan your engagement programme**

This can relate to:

- the service areas/issues that will, or are likely to, require public engagement over the next six to 12 months or more; and/or
- the immediate area(s) of activity that will be engaged upon first (for example, specific service areas such as vascular services or MSK).

- **Step 2: Engagement objectives**

What is the purpose of the engagement exercise? For example:

- Understanding how best to improve the service, make it more accessible, reduce waste, meet unmet demand and/or enhance patient experience?
- Understanding the impact of proposals on patients and their families?

Be clear on what the engagement is expected to provide. Most importantly, identify which decisions the engagement needs to support.

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[2] Transformation Unit

[3] Adapted from NHSE guidance

- **Step 3: Decide who to engage with**

- Determine who will be impacted, directly or indirectly, by the potential service change, now or in the future.

- Ensure participants are drawn from diverse backgrounds. An equality impact assessment should be completed as part of the service redesign process to understand the impact of a service change on individuals, groups and communities; this should inform engagement planning.

- The reach should be reasonable, representative and proportionate. The greater the impact, in respect of what, how, who and where, a greater engagement reach will need to be demonstrated.

- **Step 4: When to engage and Step 5: How to engage**

Steps 4 and 5 are interchangeable and closely linked to Step 3.

The timescales for any engagement should include the planning and preparation, the promotion and delivery of the engagement, and the analysis and findings from the results.

Steps 4/5 – timescale touchstones for engagement:

a) Patient representative on decision making board

Here patients, carers or members of the public (in a limited number) are invited to join the forum where decisions are made. This allows the patient representatives to communicate and engage directly with the project team including lead clinicians, and affords them the opportunity to convey their experiences, views and opinions without an intermediary. Hearing the patient perspective, even to support preliminary thoughts and considerations, is helpful.

However, this is only effective if:

- Most board/committee/working group members, and especially the chair, agree with this approach
- The patient member(s) is supported and not made to feel intimidated
- The patient member(s) has sufficient lived experience to add value.

Duration: as soon as is practical at the start of the project

More information is in appendix 1

b) Patient advisory group

This consists of patients, carers and members of the public who are interested in being involved in the development of a particular service. The group may meet on a regular basis to input into the various aspects of the service redesign process, with the project lead and clinical lead in attendance (see section 2 above). Alternatively it may function as a virtual group which feeds in via email or online surveys. It is possible to structure the group in a way in which it meets face-to-face and also contributes virtually.

Duration: Ideally throughout the project from the case for change stage

More information about how to run a patient advisory group is in appendix 1.

c) **Pre-consultation engagement**

This involves gathering or consolidating patient experience; supporting the formulation of options; identifying gaps in service or delivery; checking understanding of the patient and/or public perspective. **Duration: minimum of 4 weeks, often much longer**

You may not need this step if:

- Your clinical/service/work to develop a case for change is already clear and supported by relevant data/evidence; and
- The patient/public perspective is already clear, up-to-date, relevant, and supported by data/evidence.

d) **Involvement/co-production**

The most intense and rewarding form of engagement, with health professionals, patients and carers working together to change, develop or design a service that provides the right clinical, social and personal outcomes for patients, carers, clinicians and staff.

This takes time (months rather than weeks) and commitment from all involved. Given the constraints and pressures on health providers this is not always practical, but with planning and foresight, can be undertaken more often than not. **Duration: 6 weeks to 6 months**

e) **Wider consultation/engagement**

Depending on the urgency, the service and the timescales, this stage of engagement can follow any or all of a-d above, or be the only engagement undertaken. After a period of co-production (d), wider consultation on the outcomes of this should still take place to get a broader consensus on what has been developed. Following a pre-consultation exercise (c), a broader consultation should take place once options or proposals have been fully formulated.

Where neither of these has been possible a consultation/engagement exercise should take place. Although this should still be reasonable, representative and proportionate, it needs to hold up to the scrutiny of health overview and scrutiny committees and, where necessary, the Secretary of State. **Duration: Minimum of 4 to 12 weeks**

Step 5: How to engage

There are various methods of engagement and you are likely to use more than one in each engagement exercise (see appendix 1). Questionnaires and surveys tend to have the widest reach and are good for quantitative information and satisfaction levels. Focus groups, workshops and deliberative events are different ways to get qualitative feedback and ideas, and to promote discussion and debate. Listening events and public meetings are useful ways of informing both local and wider audiences and to sample local opinion and reaction. Whichever engagement method is used it needs to be carefully planned.

Step 6: Planning, preparation, and promotion

Each piece of engagement needs planning (formed in part by steps 3, 4 and 5) but now includes consideration of resources available, skills, budgets, and who is doing what – a communications and engagement plan (see appendix 3). Materials (questionnaires, background papers, web page content, core scripts, FAQs, invitations, visuals, press releases etc) need to be prepared; some will need specialist support and advice. Many of these should be shared and/or tested beforehand to make sure they do what is required. Venues and other support services may need booking.

Planning, design and preparation needs to take into account the analysis and evaluation that will be required following the engagement. Qualitative/written survey responses will need theming and analysing – the more of these asked, the greater the time needed for analysis. Focus groups discussions/debates need captured, analysed and married with other feedback received.

Once all this has been done the engagement opportunities need to be promoted (via advertising, web pages, social media, partners and contacts) to give people (colleagues, patients, carers, the public and others) time to make arrangements, read materials and attend/respond accordingly. This element should not be overlooked – an event/focus group session should continue even if only one person turns up, but this rarely constitutes a successful event. **Duration: Minimum of 2 to 8 weeks or more**

During and after engagement commences:

Step 7: Doing the engagement

Engagement should not be within the sole purview of communication and engagement specialists – they can lead and advise, but others should and need to be actively involved. Some engagement activities are more resource intensive than others – focus group sessions will need, as a minimum, facilitators and scribes; workshops and events will need these and more – lead facilitator, technical support staff, presenters. The attendance of senior staff and decision-makers at many engagement events is welcomed and their absence noted.

Where there are a series of activities as part of engagement, continuous monitoring and evaluation is key; waiting until the end can be too late. Surveys too, for example, should be monitored for response rates, locality, emerging themes. Where an event is open to the public and not limited to invited attendees, thought needs to be given to the potential attendance of people with disabilities, wheelchair users, and those with hearing or sight impairments. **Duration: Minimum of 4 weeks – 12 weeks (potentially longer for co-production, collaboration, and co-design)**

Step 8: Analysis, evaluation and reporting

A record must be kept of responses and feedback received (and retained for five years).

Once a piece of engagement is complete, a report should be prepared outlining the analysis of that engagement. It should make clear:

1. Dates and timescales of the engagement
2. What engagement has taken place
3. A breakdown of the participants

4. Themes and findings of the responses, feedback and discussions held
5. Recommendations and/or issues for discussion/consideration by the organisation, and
6. Next steps.

The findings and recommendations should be reflected in a service report, where this is needed, and/or in the board/working group identifying what will or will not change because of the engagement findings. This too, should be recorded. **Duration: Minimum of 2 weeks**

Step 9: Reporting on the outcomes of engagement

It’s important to tell people what happened as a result of their participation and involvement in engagement:

- What did they influence?
- What changed as a result of engagement and involvement?
- What could not change, and why?

This often takes the form of a ‘You said, we did’ document, but there is no prescribed format for this. This not only keeps people informed and builds trust, it supports the values identified in the principles for engagement adopted by the Integrated Care Board and provider trusts. Feedback on the results of engagement should be shared on websites and, where information is known and consent given, shared with those who have contributed directly. **Duration: Depends on decision making, but unlikely to be less than 4 weeks.**

Appendix 1: The ladder of engagement[4]

	Information sharing	Involving (can be a legal requirement)	Consulting – formal, legal requirement	Co-producing / collaborating	Devolving / empowering
What?	Providing communities and individuals with balanced and objective information to help them understand problems, opportunities, alternatives, and solutions.	Working directly with communities and patients to make sure their concerns and aspirations are understood	Obtaining community and individual feedback on analysis, alternatives and/or decisions	Working with communities and patients as partners on each aspect of the decision including the identification of a preferred solution	Placing decision making into the hands of communities and individuals
When?	Eg Raising awareness of a new service/change in service/how to access existing services Changes outside of our control, eg due to new legislation	Eg Minor changes to service times, booking procedures, leaflets/information Service/pathway redesign or review Reviewing referral criteria	Eg Significant service/policy change and/or decisions which impact on what, how or where services are provided Longer term plans Issues of a contentious nature	Eg Significant service/policy change	Eg Significant change Community development
How?	Eg Information through digital platforms, the media, written materials, etc	Eg Information sharing Use of existing insight (PALs, complaints, etc) Patient advisory group Surveys Workshops/focus groups Co-production	Eg As per ‘involving’	Eg Service user reference groups Co-opting patient representatives onto planning groups	Eg Patient representative on decision making board

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[4] ppppolicy.pdf (england.nhs.uk)

Appendix 2: Patient Representatives and Patient Advisory Groups

- **Patient Representatives**

If adopting the patient representative approach, patients, carers, members of the public (in a limited number) are invited to join the forum where decisions are made. This allows the patient representatives to communicate and engage directly with the project team including lead clinicians, and affords them the opportunity to convey their experiences, views and opinions without an intermediary. As with any patient engagement and involvement approach, patient representatives have to be engaged in a non-tokenistic way. Expectations have to be managed from the outset and clarity has to be given on the role of the patient representative and what they are able to influence. The wider project group too has to be clear about the patient representative's role and value.

The patient representative approach is only effective if:

- Most board/committee/working group members, and especially the chair, agree with this approach
- The patient member(s) is supported and not made to feel intimidated
- The patient member(s) has sufficient lived experience to add value.

- **Patient Advisory Groups**

A patient advisory group (PAG) (also referred to as patient reference group, patient panel, patient participation group) consists of patients, carers and members of the public who are interested in being involved in the development of a particular service. The group may meet on a regular basis to input into the various aspects of the service redesign process with the project lead and clinical lead in attendance. Alternatively it may function as a virtual group which feeds in via email or online surveys. It is possible to structure the group in a way in which it meets face-to-face and also contributes virtually.

In order to facilitate meetings and focus the discussion, it is good practice to appoint a chair of the group – ideally this should be one of the patient members of the group as opposed to the project or clinical lead. This empowers the patients to take ownership of the group and discussions, and allows for engagement on the terms of the patients.

It is vital that a PAG does not merely become a tokenistic 'talking shop' exercise, but rather the group is able to influence the redesign process. To this end, expectations should be managed from the outset by the project and clinical lead, setting out precisely where patient input can make the most difference.

PAGs are typically not decision making forums; they provide advice and challenge where necessary. However it is important for that advice and challenge to feed in to the decision making group. For this to happen, there needs to be an agreed process by which feedback collected from the PAG can be fed in to the forum where decision are made, so that they are influenced by the patient voice.

Deciding on an approach

The approach to be adopted by the project/work stream for patient and public engagement and involvement will have to be decided by the project and/or clinical lead, with advice sought from the engagement team. Each project will work in a slightly different way and therefore the patient engagement model will vary project to project.

Appendix 3: Communications and engagement plan template

Version	Date	Contributors	Notes
V1			
V2			
V3			

Introduction:

Brief introduction around the background.

Communications and engagement objective:

What is the aim of the communications and engagement exercise?
The objectives should be SMART (specific, measurable, achievable and timed).

Strategy overview:

Summary of the key actions / approach required to deliver the plan (this section to be completed when the plan is developed).

Situation analysis:

Depending on the issue, it might be helpful to think about any background issues or risks that could impact on messaging or the wider plan, and what the mitigation would be. A PEST analysis can provide a useful framework.

Risk	Mitigation
	●
	●
	●

Audience:

Do you need to target any specific cohorts? Consider specific patient groups, staff groups, stakeholders, partners, communities. The tool below might help you to think about approaches by stakeholder group.

Key messages:

- What are the key messages?
- Are there different messages for different groups / audiences?

Tactics:

What is the best way to communicate or engage with each audience?

Timescales / key dates:

- Any key dates to consider?

Evaluation / KPIs:

- What are your desired outcomes?

Budget / costs:

Item	Cost
Total	

Project leads / governance:

- Consider who’s leading the project and which groups are involved in approvals or providing information