General Osteopathic Council

11

Council
22 November 2023
Strategic patient engagement

Classification	Public
Purpose	For decision
Issue	This paper outlines two possible approaches to a pilot to assess the impact of patient partnership in decision making in GOsC.
Recommendations	1. To consider proposed models for involving patients in GOsC governance. 2. To agree to pilot a model in 2024.
Financial and resourcing implications	Promotion, recruitment and participation fees are incorporated into the budget.
Equality and diversity implications	We know that there is an underrepresentation of individuals from ethnic minorities within governance generally, not just at the General Osteopathic Council. Ensuring that we use a wide range of mechanisms to encourage people from ethnic minorities and other minority backgrounds to be involved will need to be an integral part of our process. We intend to seek specific advice on this point.
Communications implications	Our commitment to co-production is an important part of our strategy and communications and we will develop a communications plan around the preferred model to raise awareness of our work, the benefits arising and to encourage involvement from others.
Annexes	A. Lay Council Member draft person specification B. C. Patient Advocate Partnership Programme – draft person specification
Author	Rachel Heatley and Fiona Browne

General Osteopathic Council

11

Key messages

- This paper outlines two options for Council to consider piloting which would enable GOsC to include the patient voice at strategic level:

    - A patient appointed in 2024 as a lay member of Council with a specific focus on patient issues, who is recruited to an agreed person specification (see Annex A for example/draft person specification).

    - A two-phased pilot with ultimate aim of recruitment of a patient as a full lay member (see Annex B for example/draft person specification):

        - Phase 1 (2024-26): Two patient representatives informing decisions but without decision making rights.
        - Phase 2 (2026 onwards): Recruitment of patient as full Council Lay member with decision making rights.

- Reflecting on feedback from Council we believe the title 'Patient Council Associate' has inadvertently conflated the purpose of Council Associate programme with the rationale for involving patients at strategic level. We have suggested alternative titles for Council's consideration (see paragraph 11) including: Patient Advocate programme, Patient Partnership programme or Patient Voice programme.

- Before any substantive decisions are made about future governance, we would ask Council to consider the following points:

    - GOsC's current organisational culture
    - The needs of patients and how to create a safe environment
    - The needs of Council and how to include the patient voice in short and long term
    - Equality, diversity and inclusion
    - Recruitment and training
    - Remuneration/Budget
    - Staff resource

Background

1. Patient partnership is a critical part of our approach to regulation and a crucial part of our draft Strategic Plan towards 2030.

2. In July 2023, Council members considered options for inclusion of the patient voice at strategic level and the following points were discussed:

a. Members were supportive of the patient voice at strategic level but did not consider the Patient Associate model would be viable as it was suggested there is no clear progression or development pathway.

b. The purpose of the Patient Advisory Panel was questioned - what would the panel be advising on? It was not considered that giving advice could be viewed as being the same as having a voice and being part of discussions and decision making.

c. There was support for a third option for a patient representative as a Council Lay Member with recognition that the role's primary focus, namely advocating for patients, should be stipulated when recruiting for a new lay member of Council.

3. In summary the Chair concluded:

a. That Council was not in a position to make a definitive decision on based on the recommendation to agree a model for strategic patient engagement.

b. That the Executive provide more detail on the options for:

i. a Patient Advocate as a lay member of Council to fully participate in the decision-making process, and

ii. a Patient Associate, able to participate in discussions but not be part of the decision-making process.

iii. the Executive were asked to consider and reflect on the issues which have been raised by Council and also what might best meet the aims of the project for the meeting in November 2023.

iv. the significant amount of work which has been undertaken to date was acknowledged but to ensure that the outcomes would properly address the requirements of the Executive, Council and future patient representatives it was important to ensure the next steps could be taken with confidence.

Horizon scanning exercise: benefits and barriers to strategic patient engagement

4. We have revisited the findings from horizon scanning exercise that we undertook earlier this year to consider benefits and barriers to including patients at governance levels in organisations. From this learning we have developed a pilot specification to translate this learning into desired outcomes for Council, the executive and patients along with different methods to testing these outcomes.

Benefits

5. Benefits that other health organisations have gained:

    a. Further legitimise the decisions taken by their boards and councils.

    b. Enhance their strategies by incorporating insight, perspectives, expertise and experience from patient leaders.

    c. Identify and address knowledge gaps and concerns/expectations of patients and the public.

    d. Assess policy development and processes at the outset to ascertain patient priorities and involvement requirements.

    e. Promote among healthcare professionals an enhanced appreciation of patient-centred care.

    f. Demonstrate to stakeholders that they are committed to valuing the patient voice/perspective as an equal partner.

    g. Proactively increase the diversity of their organisations.

6. Quotes from research when patients are involved in co-production and decision making in a supportive and effective manner.

    "Existing evidence regarding PPI in macro-level health policy decisions suggests that it improves the quality of and access to health care. Furthermore, it increases user responsiveness and satisfaction with the provided health care services."[1]

    "Public and patient involvement is expected to result in more democratic decision making and thus better accountability. Furthermore, they (patients and the public) are assumed to make health-care services more responsive and thus contribute to improving individual and community health."[2]

Barriers

7. Common barriers to success that health organisations have experienced include:

    - Power imbalances and dynamics
    - Inflexible culture and processes
    - Unconscious bias towards patients

[1] Lisa Ann Baumann, Anna Katharina Reinhold, Anna Levke Brütt,
[2] Souliotis K. Public and patient involvement in health policy: A continuously growing field. Health Expect. 2016 Dec;19(6):1171-1172. doi: 10.1111/hex.12523. PMID: 27878935; PMCID: PMC5139060.

- Inadequate time scheduled for learning and support, focused on developing confidence and capability
- Lack of openness to feedback by both parties
- Lack of clarity around the objectives of roles resulting in confusion which risks alienating the people involved if expectations are not managed.

8. Quotes from the research highlighting the outcomes when the right conditions are absent for co-production and decision making.

   'Poorly conducted participation can lead to a lack of trust among patients and a loss of reputation for an organization.[3]

   'PPI often appears to be trapped in a vicious cycle…The reality of implementation is complex…This fuels the cycle of predictable and disappointing results and exposes PPI to criticisms of exclusivity and tokenism.[4]

Alternative title to Patient Council Associate

9. Reflecting on feedback from Council we believe the name 'Patient Council Associate' has inadvertently conflated the purpose of Council Associate programme with the rationale for involving patients at strategic level informing decisions but without voting rights.

10. The purpose of Council Associate programme is to help identify future governance leaders, provide a development pathway for osteopaths and encourage high quality registrant applications for future governance positions. In contrast, involving patients at Council level, would demonstrate our commitment to patient engagement, bring new insights to enrich our decision making and ultimately include patients in the same way we do osteopaths.

11. To provide greater clarity of purpose, we suggest the alternative titles for Council's consideration:

    a. Patient advocate programme
    b. Patient partnership programme
    c. Patient voice programme

[3] Pizzo E, Doyle C, Matthews R, Barlow J. Patient and public involvement: how much do we spend and what are the benefits? Health Expect. 2015 Dec;18(6):1918-26. doi: 10.1111/hex.12204. Epub 2014 May 12. PMID: 24813243; PMCID: PMC5810684.
[4] Ocloo J, Matthews R. From tokenism to empowerment: progressing patient and public involvement in healthcare improvement *BMJ Quality & Safety* 2016;**25:**626-632.

Options for Council to consider

12. Council rightly observed that without clarity about the outcomes of involvement of patient partnership in decision making, it would be difficult to determine how best to involve patients.

13. Reflecting on discussions at July 2023 Council meeting, the desired outcomes for both options are:

    a. To understand how to effectively include the patient voice at Council level in decisions.

    b. To understand how to enhance the quality of the perspectives available to Council to inform high quality decision making ensuring that decisions involve patient and osteopath voices.

    c. To understand how better the executive team might support patient advocates/members at Council level and other Council members.

    d. To understand the knowledge, skills and experience necessary for a patient voice at Council.

14. We have outlined details for both options to begin to articulate the desired outcomes to enable us to make better quality, more effective decisions which realise the benefits of involving patients in decision making but which also minimise the barriers to effective involvement too.

15. We ask Council to consider this information and agree the best option for delivery of those outcomes.

Option 1: Patient as full Lay Council Member

16. The appointment of a Lay Council Member representing the voice of patients to fully participate in the decision-making process.

17. We would seek to recruit candidates with non-executive director experience in patient engagement/patient advocacy roles in the NHS, patient charities, health charities and the voluntary sector.

18. A contract of engagement would be required to describe the nature of the relationship between the patients and the GOsC.

19. The role would be based on partnership and not paternalism putting a patient on an equal footing with osteopaths and other Council Lay members as it would include full voting rights.

Recruitment

20. **Timeline:** Unless there is a lay resignation of a Council member, the next lay vacancy could theoretically arise in 2025. But this would depend on People Committee agreement to open rather than closed competition at that point to enable new applicants to apply. If People Committee provide an option for closed re-appointment for all current and newly recruited lay members, a vacancy may not arise naturally until 2029. Alternatively, we could explore amendment to the constitution rules which would require Department of Health approval, but would be unlikely in the current climate.

21. Taking this approach would allow us to achieve our ultimate goal for patient partnership in due course meaning we will have gone from 3 patients in 2020 to a Patient Involvement Forum with 45 members and a patient at Council level.

22. **Person specification:** To help inform your decision we have created a draft person specification based on the findings from the horizon scanning exercise earlier this year. The draft specification can be found in Annex A.

23. **Remuneration:** Parity with Council members.

Induction and evaluation

24. **Induction:** An 'introduction to the GOsC' meeting with Chair of Council and GOsC Executive, as well as committee specific induction meetings.

    a. Online training courses to complete on Equality, Diversity and Inclusion, GDPR and cyber-security.

    b. The patient will need a degree of ongoing support following their appointment so a system of buddying is required to support patient to become established in post.

    c. One lay member of Council to buddy with the patient but also a close working relationship between our patient lay member and our Senior Policy and Research Officer who leads our patient engagement work.

25. **Evaluation:**

What might success look like?	**What steps might we take to achieve success?**	**How might we measure that success?**
Patients remain engaged in the work of the Council.	Regular communication, buddying and support.	Attendance at, and participation in, meetings.

What might success look like?	What steps might we take to achieve success?	How might we measure that success?
		Patients complete their term and do not leave post early. Positive feedback from 'buddy' as to patient engagement.
Patients develop their understanding of how GOsC governance works in practice.	Induction arrangements and ongoing support mechanisms in place.	Patients asked to complete a reflective self-evaluation towards end of their term. Success being identification of new skills which can be evidenced based on feedback from Council colleagues over their term of office.
Patients work collaboratively with colleagues and develop their scrutiny, evaluation and influencing skills.	Chair of meeting to ensure that patients have an equal voice in discussions.	Patients asked to complete a reflective self-evaluation towards end of their term. Success being identification of new skills which can be evidenced based on feedback from Council colleagues over their term of office.
The patient voice is evident in decision making	See steps 1 to 3 above	Evaluation and audit of the patient voice in decision making through review of Minutes of discussions and decisions of Committees and Council Qualitative feedback from Council members and staff about whether the patient voice influenced decision making.

Option 2: Patient partnership programme pilot 2024-2026 (two osteopaths)

26. A two-phased pilot with ultimate aim of recruitment of a patient as a full lay member in 2026:

    a. Phase 1 (2024-26): Two patient representatives informing decisions but without decision making rights.

    b. Phase 2 (2026/27 onwards): Following a comprehensive evaluation of the two-year pilot we would recruit a patient as full Council Lay member with decision making rights.

27. As this would be a new initiative for GOsC, we believe an 18-month pilot would allow us time to identify what barriers and enablers to success, and then to use that learning to create a permanent Lay Council Member post for a patient representative with recruitment in 2026/27.

Recruitment

28. **Timeline:** We could begin recruitment in late summer 2024, which would allow new Council members to inform the recruitment process and would tie in to our next Council member recruitment.

29. A recommendation for this option is to have an application form and selection criteria adapted so that the gateway to access is not as high as it would be, if there was an application to be a full member of Council. However, we would still seek to recruit candidates with non-executive director experience in patient engagement/patient advocacy roles in the NHS, patient charities, health charities and the voluntary sector.

30. A contract of engagement would be required to describe the nature of the relationship between the patients and the GOsC.

31. **Person specification:** To help inform your decision we have created a draft person specification based on the findings from the horizon scanning exercise earlier this year. The draft specification can be found in Annex B.

32. Appointees would need to sign up to the Governance Handbook and be bound by the same confidentiality and collective responsibility arrangements which exist for full members of Council.

33. The patients would be expected to commit to the role as if they were a full member. This would include preparation for meetings, attendance at meetings, undertaking appropriate training and participating in any appraisal or learning/development review.

34. **Remuneration:** Parity with osteopaths who are part of the Council Associate Programme.

Induction and evaluation

35. **Induction:** As paragraph 24 above.

36. **Evaluation:** As paragraph 25 above.

Recommendation: Option 2

37. Considering the desired outcomes outlined in paragraph 13 and the barriers to success that other organisations have experienced when trialling strategic patient engagement, (see paragraph 7), a two-phased pilot will provide a necessary transition period to help us to get to the outcomes and to inform a subsequent recruitment.

38. In particular, a two-phased pilot will enable us to:

    a. Explore the knowledge, skills and experience required for including an effective patient voice involved in decision making.

    b. Identify how best we can develop a board environment that will best support a patient to make effective contributions is one the is built on psychological safety.

        i. Psychological safety is a precursor to adaptive, innovative performance. The four quadrants of psychological safety that will be required are inclusion safety, learner safety, contributor safety, and challenger safety.

    c. The best mechanisms for evaluating the programme

    d. Refine the recruitment, induction, training processes and explore the support provision needed.

    e. Measure the impact of patient voice at the point of decision making through regular feedback from members of Council.

    f. Importantly it would also provide the evidence for the process of ensuring that a lay Council vacancy arose to give effect to the policy decision in a timely manner.

The benefits of an iterative approach

39. We believe that a lay member role with a focus on patient needs should be the ultimate goal to ensure we can successfully embed the patient voice at strategic level we need to take an iterative approach.

40. We have an opportunity to co-design our own model with patients over the next 2 years. Having an initial pilot of an associate position will provide a crucial transition stage to examine how we best to facilitate full participation of a patient lay member on council.

41. Over the last three years it has been evident that engaging patient partners requires more time and resource, and it is not a simple process. With every new activity we trialed we had to adapt our approach – EDI issues, changes to

language, changes to font, further consideration to the type of activities we can reimburse.

Recommendations:

1. To consider proposed models for involving patients in GOsC governance.

2. To agree to pilot a model in 2024.