General Osteopathic Council

Council
20 July 2023
Strategic patient engagement

Classification	Public
Purpose	For decision
Issue	A key aim of our patient engagement strategy is co-production with patients, this means involving patients in decision making at strategic level. This paper shares examples of models of strategic patient engagement that exist in the wider healthcare and explores which of these models we could pilot in the General Osteopathic Council.
Recommendations	1. To consider proposed models for involving patients in governance. 2. To agree a model to pilot 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 patient 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.
Annex	A. Horizon scanning report and references
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Key messages

- This paper is exploratory in nature and allows Council space on the agenda to talk through the potential models for involving patients at strategic level, what approaches might be required for successful implementation and to agree a model to pilot in 2024.

- The focus in this paper is about how GOsC makes decisions that involve patients as opposed to the diversity of patient perspectives that inform our decision making as this is captured by engagement activity with our Patient Involvement Forum and broader stakeholder engagement.

- To scope out potential models for Council's consideration we undertook a horizon scanning exercise of strategic patient engagement in the healthcare sector (See Annex A) to identify good practice and innovation, and what factors influence success.

- Two models emerged during the horizon scanning exercise that we believe could be implemented in GOsC:

    - Patient Council Associate (two representatives)
    - Patient Advisory Panel

- Both models involve patients being involved in decision making as independent critical friends to Council, supporting GOsC in undertaking our statutory duty rather than representing a personal healthcare condition or interest.

- Both models would require a robust recruitment process - be transparently recruited to an agreed role specification, bringing significant expertise and experience, and provide strategic, impartial input to support with decision-making.

Background

1. The General Osteopathic Council (GOsC) governance structure consists of the Council, committees - that are both statutory and non-statutory - fitness to practise panels and ad hoc working groups.

2. The constitution of Council is prescribed in the GOsC (Constitution) Order 2009 as Amended in 2015, with the constitution of statutory committees prescribed in the GOsC (Constitution of Statutory Committees) Rules Order of Council 2009.

3. The constitution of non-statutory committees and ad hoc working groups falls within the authority of Council to set and amend as necessary.

4. As a statutory regulator it is essential that we put patients at the heart of what we do, this is a necessary part of our aspiration of co-production and partnership. At present we ensure there are a wide range of opportunities for patients and the public to share their views through engagement activities with

our Patient Involvement Forum. We also undertake broader stakeholder engagement, for example, liaising with patient charities to ensure diverse patient perspectives inform our work. However, we do not currently involve patients in decision making at a governance level in the same way that we involve osteopaths. It is intended that the models proposed in this paper will help us meet our aspirational goal.

5. Involving patients at governance level will allow us to foster a culture where it is seen as normal for patients to be involved as equals in decision making both at the point of care but also at the point of decision making by the regulator just like osteopaths are.

6. Elevating our engagement with patients to strategic level will also help us to meet our core objectives of protecting, promoting and maintaining the health, safety and well-being of the public. As a result, we will be able to build closer relationships with the public and the profession based on trust and transparency.

7. Reflecting on our core values, it is evident that this work will help us to live out our values in practice:

    a. **Collaborative:** Piloting a strategic engagement model will ensure that patients are at the centre of our approach to regulation by directly involving them in decision making.

    b. **Influential:** By supporting and developing patients at strategic level we will ensure that we have a robust patient voice at the most senior level of our governance structure which in turn will help to enhance public protection. This will be a first for healthcare regulation, and if successful, the learning may be of use across the health regulation sector.

    c. **Respectful:** While we already actively listen and consider the views of patients through established channels to inform decisions, having patients involved at a strategic level to make decisions demonstrates a clear commitment that we are living out our values at every level in the organisation recognising the dignity of patients to make strategic decisions about patient care in partnership with osteopaths.

    d. **Evidence-informed:** Drawing on the horizon scanning exercise (see Annex A) and listening to stakeholders we have identified factors that determine success in involving patients in governance, implementing them will guide our work and ensure the best outcomes for patients and the public.

8. This work also ties into our Strategic Goals for 2019-24, development of our next draft Strategy towards 2030, and aligns with our 2021-2024 Communications and Engagement Strategy helping us become a more inclusive and transparent organisation. By involving patients in our governance we will be leading the way in the health regulation sector.

9. Our Business Plan for 2022-23 states that we will 'Develop patient involvement in governance and strategy development beginning with the development of a Patient Council Associate Programme.' In October 2022 we put forward a proposal to the Policy and Education Committee regarding the creation of a Patient Council Associate programme.

Feedback from Policy and Education Committee

10. At the October 2022 meeting of the Policy and Education Committee (PEC), members were receptive to the concept of involving patients at strategic level but were unsure that the Patient Council Associate model (one patient) was the most appropriate model for GOsC.

11. We reflected on that feedback and undertook horizon scanning research (see Annex A) to scope out how other health organisations involve patients at a strategic level. This enabled us to identify examples of good practice and innovation, and the common factors that lead to successful strategic patient engagement.

12. We identified two potential models for involving patients at governance level:

    a. Patient Advisory Panel
    b. Patient Council Associate programme (two patient representatives).

13. Our thinking has been influenced by a variety of factors including the needs of GOsC, needs of patients, efficacy, representativeness, likely impact, budget and staff resource.

14. In June 2023, we shared our learning from the horizon scanning research with PEC to enable them to reflect on which of the two potential models would work best for GOsC and to make a recommendation to Council. There was a plurality of opinions regarding which of the two models would work best. Discussion focused on:

    a. The need for a diversity of patient voices at governance level
    b. Strategic issues such as the budget and staff resource required
    c. Governance considerations and in particular how Council itself would like the patient voice to be implemented and would effectively enable it to be heard.

15. There was recognition that the model chosen would be a pilot and that it should be an iterative process instead of an absolute process. As a result, there was a decision to seek Council's viewpoint on the matter rather than PEC make a recommendation of a model.

Horizon scanning report

16. The background research in the horizon scanning report (See Annex A) suggests the following propositions:

    a. Patients should be involved in the design and delivery of services - just like health professionals are.
    b. Recommendations from external inquiries and reports such as the Cumberledge Review (2020)[1] have identified the erasure of the patient voice in the work of health regulators and have suggested change.
    c. A range of strategic patient engagement models have been demonstrated to be appropriate in different contexts. These are outlined in further detail in Annex A.
    d. Psychologically informed engagement and a culture of power sharing are the cornerstone present in all successful strategic patient engagement models.

17. The models we are proposing for Council are the ones assessed as most suitable. The table below outlines the reasoning for the approach we have proposed.

Advantages and disadvantages

Model	Advantages	Disadvantages
Patient Council Associate programme – Two patient associates	• Similar model to Council Associate Programme so logistics already in place • Can draw on learning from Council Associate Programme in terms of the support patients might need to apply, induction, ongoing mentoring and training which could be provided both by an existing Council member and also our Patient lead. • Requirement for recruitment: lived experience of osteopathic treatment (in the last 6 months) – consideration would need to get given to exclusion criteria eg at PEC there was a point raised regards whether a patient can also be a registered health professional • Role based on partnership and not paternalism putting patients	• Lack of voting rights: a Patient Council Associate would not, and indeed could not, be considered to be a full Council member. • Lack of representativeness issue that PEC raised in October 2022 and June 2023 – concern that regional voices would not be captured (Please note: information informing patient and osteopaths views is collated separately. Osteopaths and patients involved in Council decisions inform decisions on the basis of assessing the evidence presented rather than their own opinions per se). • Potential for 'professionalisation' or corporate group think of

[1] Cumberlege J. First do no harm: the report of the Independent Medicines and Medical Devices Safety Review. July 2020

	on an equal footing with osteopathic council associates • Continuity of personnel who have opportunity to develop and enhance their knowledge • Experience and long-term involvement may make contributors more effective and efficient • Appointed by Council • Set term of appointment – two years • Removal from office by Council • Must abide by Governance Handbook • Bound by Corporate Responsibility • Remuneration in line with that given to Council Associates	patients due to extended time in post
Patient Advisory panel	• Patient Advisory panel with a chair and a deputy chair • Members would rotate attendance at council meetings and convey feedback from the group • Diversity of voices and variety of skillsets • Terms of reference • Must abide by Governance Handbook • Bound by Corporate Responsibility • Training and recruitment for all members	• Lack of continuity of patient voice and less opportunity for patients for continued development with rotating attendance will reduce ability to inform decision making based on understanding of context. • Ongoing resourcing and management required that is currently not available in GOsC eg staff administrative support for unspecified number of patients • Duplication of the work of the Patient Involvement Forum which already captures a variety of views and informs our existing work • Recruitment process likely to be much more intensive and require significantly more resourcing due to the unspecified number of posts

Piloting a model

18. Reflecting on the rich discussion at Committee has enabled us to identify a set of desired outcomes that we may wish to pilot ahead of making any substantive decisions about future governance.

19. A pilot programme could enable us to learn from the experience of patient voices informing decisions.

20. We are proposing that a pilot should be considering the following outcomes:

    a. Opportunity to understand how we can best recruit, induct, train and support a patient to contribute fully and meaningfully to Council decisions.
    b. Opportunity to seek feedback about how best to create the right Board environment to enable patients to contribute meaningfully to GOsC decision making.
    c. Opportunity to measure the impact of patient voice at the point of decision making through regular feedback from members of Council and osteopathic and patient Council Associates.

21. We welcome Council feedback on the desired outcomes from the pilot.

Patient Council Associate Programme

22. Reflecting on the balance of advantages and disadvantages we recommend that the model which is best suited to GOsC is the Patient Council Associate programme, which would involve the appointment of two Patient Council Associates for a set term.

23. Piloting this programme with two patients we believe will provide a crucial transition stage to examine how we best to facilitate full participation of a patient lay member on council.

24. Members of the Patient Involvement Forum that we consulted welcomed the idea of a pilot to enable patients the opportunity to learn about the work of GOsC at strategic level as well as enable GOsC to learn from the process. They felt this iterative approach would benefit all parties to meet the outcomes of the pilot.

25. Patient Council Associates could bring a wealth of insight, expertise and experience to the work of the GOsC and having two associates would enable different perspectives who could share learning and garner support from each other.

26. Using a robust person specification (see example below) we would seek applications from patients who have the skills, interest and experience in patient advocacy at strategic level. In turn we would provide the Patient Council Associates with mentoring to give them the best chance of participating

effectively and confidently and assign them a buddy within Council to provide support and guidance as well as dedicated support from our Patient Lead.

a. Example person specification highlighting skills and experience required:

i. Lived experience of osteopathic treatment (in the last 6 months) alongside lived experience with a range of other health professionals.
ii. Experience of working in partnership with user led groups and/or with healthcare organisations is essential.
iii. An understanding of and commitment to the statutory role of the GOsC
iv. Have an awareness of, and commitment to, equality, diversity and inclusion.
v. Ability to work creatively and collaboratively and to offer objective challenge.
vi. Ability to critically analyse and evaluate policies and plans
vii. Ability and experience of listening well to the views of people, giving priority to osteopathic patients, and representing their views.
viii. Ability to display sound judgement and objectivity.
ix. An understanding of and respect for the need for confidentiality.
x. A commitment to the 'seven principles of public life', known as the 'Nolan Principles': selflessness, integrity, objectivity, accountability, openness, honesty, leadership.

27. The programme is also an opportunity to proactively increase the diversity of Council. By identifying that we want to encourage applications from underrepresented groups and that we see diversity (of thought as well as protected characteristic) as being a strength.

28. We can introduce a contract of engagement that describes the nature of the relationship between the Patient Council Associate and the GOsC in the same way as we do with osteopath Council Associates.

29. Any appointee 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. Without such an agreement the appointment would not be made.

30. Additionally, Patient Council Associates 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.

Recommendations:

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

2. To agree to pilot a model in 2024.