Patient and Public Involvement (PPI) Strategy

June 2019

1. Introduction

1.1 In April 2019, University Hospitals of Leicester NHS Trust approved a new and comprehensive Quality Strategy: "Becoming the Best". The involvement of patients, their families and carers is a central component of the Quality Strategy. Indeed, in the diagram illustrating the scope of the Quality Strategy, patient and public involvement is depicted as a chain, running through and driving activity around our core priorities (see *appendix 1*). This updated PPI Strategy focuses on how the Trust will engage and involve patients, carers and the wider public on its quality improvement journey.

1.2 The CQC, in their report "Quality Improvement in Hospital Trusts" (2018), have identified that one of the hallmarks of high performing Trusts is that they put patients at the very heart of their quality improvement activity. They note, in particular, the journey these Trusts have undertaken from simply *consulting* with patients on service developments and improvement work to "*building true partnership* for QI with meaningful patient and public involvement" (CQC, 2018, p29). In short, Trusts that do well on Quality Improvement do so with a clear commitment to collaborating with users of their services.

1.3 This updated PPI Strategy, mindful of the evidence identified by the CQC, seeks to support our "Becoming the Best" journey by describing how we will undertake a complementary journey towards "co-producing" our Quality Improvement priority areas. Such an approach recognises that the vital "business intelligence" and partnership our patients can provide will positively influence our Quality Improvement journey and support us to provide the best hospital services for our local population.

2. Aims of the Strategy

2.1 This PPI strategy seeks to ensure that;

- Patient & Public Involvement is an integral and valued element of our quality improvement activity
- Users of our services have meaningful ways in which they can influence how those services are designed and run.
- The Trust meets its statutory obligations to involve and consult with service users and the wider public.
- The Trust meets Care Quality Commission standards on patient and public involvement
- The Trust's services and facilities are mindful of, and shaped through engagement with our diverse population.
- Community and patient engagement purposefully seeks the input of underrepresented and "Seldom Heard" groups.

- Staff have access to guidance, training and development to enable them to actively co-produce services with the patients, carers and families who use them.
- The Trust is committed to developing a culture in which "Co-Production" is a routine means by which its services are designed and developed.

3. Statutory Duties

3.1 In addition to the many and obvious benefits of patient and public involvement, the Trust also has a statutory duty to consult and involve patients and the wider public. This legal requirement is set out in the Health and Social Care Act (2012), which reinforces Section 242 of the NHS Act (2006), stating that we are obliged to ensure that users of our services are involved / consulted in –

a) The planning and provision of services
b) The development and consideration of proposals for changes in the way those services are provided and
c) Decisions we make which affect the operation of those services.

4. Co-Production: Climbing the Ladder

4.1 It has become increasingly common to understand patient and public involvement via the metaphor of a ladder, with each rung representing a greater level of involvement, partnership and influence. First introduced in 1969 by Sherry Arnstein, the "Ladder of Participation" was developed in the American Department of Housing, Education, and Welfare to describe levels of citizen participation.

4.2 Arnstein's "Ladder" has been adapted and reinterpreted on numerous occasions to focus more specifically on patient and public involvement in the commissioning and provision of health services. The top rung on these health - focused ladder diagrams, echoing Arnstein, usually refers to circumstances in which decision-making power is shared equally among professionals and patients. This is usually referred to as "Co-Production". Some models go further, describing a situation in which power is actually devolved and budgets and decision making are placed directly in to the hands of patient and public groups (as described in NHS England's current "Ladder of Engagement and Participation").

4.3 This PPI Strategy adopts "Co-Production" as the aspirational top rung of a "ladder" adapted to fit the needs of the Trust and its Quality Improvement journey. At this point it is important to note that there is no single, agreed definition of Co-Production and emphases differ across organisations and sectors. However, most, if not all definitions share in common the principles of equality and reciprocity between professionals and people using services, their families and carers.

4.4 Patient participation charity Involve offer the following useful explanation of the Co-Production approach;

> "Co-production rejects the traditional understanding of service users as dependents of public services, and instead redefines the service/ user relationship as one of co-dependency and collaboration. Just like users need the support from public services, so service providers need the insights and expertise of its users in order to make the right decisions and build effective services. In practice, it means that those who are affected by a service are not only consulted, but are part of the conception, design, steering, and management of services".

4.5 There are many advantages to adopting a Co-Production model of participation. Chief among these are the opportunities it brings to work with people with genuine "lived experience" of conditions and extensive experience of being the recipients of our services. People with long term conditions, for example, often use multiple hospital services. If we seek to provide integrated and person-centred care, their experience of traversing these services is an invaluable source of information and insight which can shape future service design. Adopting a Co – Production approach not only places patients around the table as we design and develop services, it engages them as equal partners, recognising the value they bring as the "customer" and ultimate judge of the quality of a service.

4.6 This strategy encourages an understanding of Co-Production as an *approach* to decision making and service design rather than a discrete and specific methodology. It takes as a starting point, the principle that people who use a service are best placed to inform its improvement. If we are serious about putting patients at the heart of our Quality Improvement activity, then Co-Production will be the principle means of achieving this. For the purpose of this strategy the following working definition of Co-Production will be adopted;

"Staff work in equal partnership with patients, their carers and families. They are involved at the initiation phase and throughout the life of projects and share decision making with staff in the design, development, management and evaluation of services that they use".

4.7 Using the definition of "Co-Production" above, the Trust's PPI team have adapted a "Ladder of Engagement" to guide the direction of travel outlined in this strategy. The model ranges from one – way communication with patients and the wider public, through to the equal partnership with patients described above.

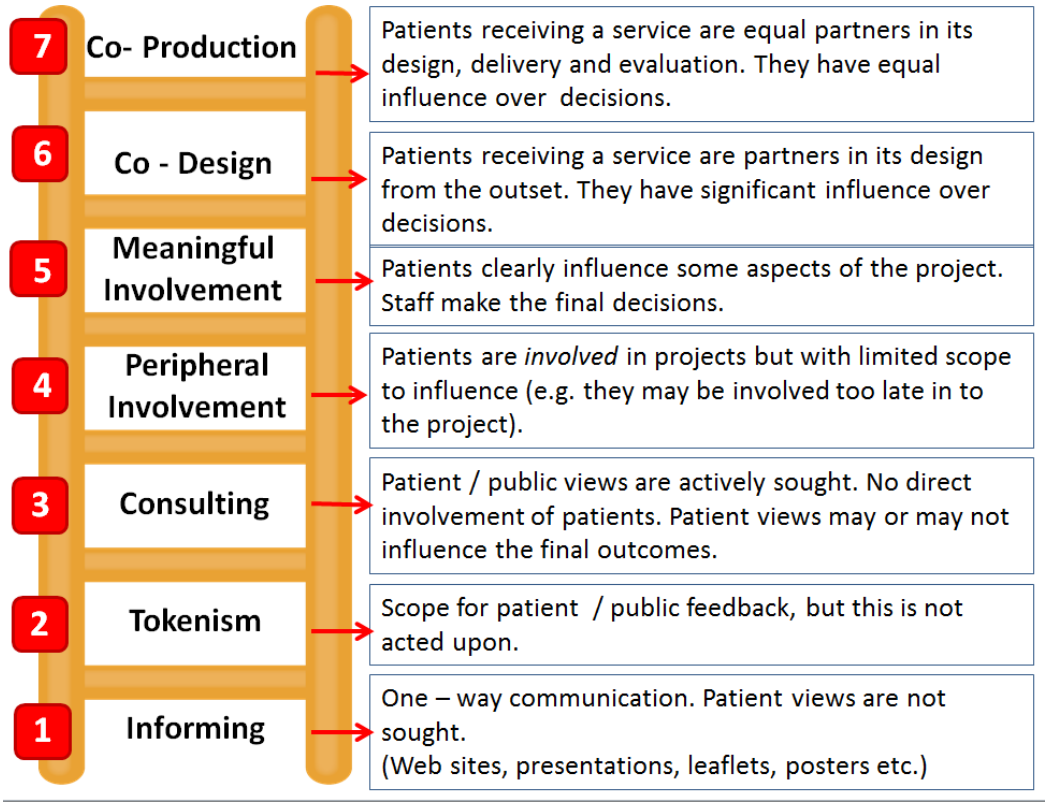


Fig 1. "Ladder of Engagement" diagram

4.8 Although arranged in ascending order, there is, of course, a value to each of these modes of engagement and depending upon the circumstances, any one of them may be considered an appropriate course of action. The recommended level of engagement with patients and the public will depend upon the scope they may have to influence decisions and the extent to which they may be affected. Patient and public involvement becomes more meaningful and influential, however, on the upper rungs of the ladder.

4.9 Through the implementation of this strategy it is anticipated that patient involvement in our quality improvement activity (and beyond) will be increasingly pitched in the upper three rungs of the ladder diagram; ensuring that it is meaningful and genuinely shapes the services that patients receive. Although it will take time and commitment on the part of our staff, the aspiration is that our "Becoming the Best" journey is also a journey towards genuine Co-Production.

5. Seven Steps to Make Co-Production Happen

5.1 Nationally, the Coalition for Collaborative Care (C4CC), in association with NHS England, have developed a useful Co-Production model (2016; see *Appendix 2* of this document). The Coalition is an alliance of people with long term conditions and organisations committed to achieving person-centred, collaborative care to their lives and work. They advocate "seven practical steps to make Co-Production happen in reality". It is suggested here that the Trust follow this guidance to support its journey towards a culture of Co-Production.

5.2 The C4CC's seven steps to making Co-Production happen are;

1. **Get agreement from senior leaders to champion Co-Production**

2. **Use open & fair approaches to recruit a range of people who use health and care services, carers and communities, taking positive steps to include underrepresented groups.**

3. **Put systems in place that reward and recognise the contributions people make**

4. **Identify areas of work where co-production can have a genuine impact, and involve citizens in the very earliest stages of project design**

5. **Build co-production into your work programmes until it becomes 'how you work'**

6. **Train and develop staff and citizens, so that everyone understands what co-production is and how to make it happen**

7. **Regularly review and report back on progress. Aim to move from "You said, we did," to" We said, we did".**

5.3 The remainder of this strategy will be organised around the above seven steps (adapted to fit the needs of our acute hospital); setting out how the Trust will take its Co-Production aspirations forward.

5. STEP ONE: Gaining agreement from senior leaders to champion Co-Production

5.1 Following discussions at the Trust Board in May 2019 it is clear that senior leaders in the organisation are very supportive of Co-Production as the aspiration for its programme of patient and public involvement activity. This support is an important first step to ensuring that we put patients at the heart of our quality improvement journey as described in "Becoming the Best".

5.2 In approving this strategy the Trust Board are asked to actively champion Co-Production in the organisation, encouraging other senior clinicians and managers to explore how they might meaningfully involve patients in the development and design of services. Ideally, some Board members will participate in internal communications and marketing to promote Co-Production, sending a clear message of endorsement to the wider organisation.

5.3 The Board are further encouraged to demonstrate commitment and leadership on patient and public involvement by actively monitoring the Board paper cover sheets submitted with Board papers and not accepting submissions that have not involved or engaged (where relevant) with patient representatives and groups. It is proposed that the expectations outlined in the Board cover sheet template be strengthened to place more specific expectations on authors.

6. STEP TWO: Use open & fair approaches to recruit a range of people who use hospital services, carers and communities, taking positive steps to include underrepresented groups.

6.1 The following section sets out our plans to recruit and manage patients and patient representatives to participate in a range of PPI activity across the Trust. Specifically, it outlines the role of the Trust's Patient Partner group, proposes new and more accessible opportunities to get involved and sets out the Trust's programme of community engagement.

Working with Patient Partners

6.2 The Trust has supported a group of Patient Partners (formerly Patient Advisors) for almost 20 years. Patient Partners are members of the public who provide a patient or carer's perspective on various groups, projects, Boards and Committees within the organisation. Following an evaluation of the Patient Partner role in 2018 and the introduction of the Trust's new Quality Strategy in 2019, a new model of working with Patient Partners has now been agreed. The changes will bring Patient Partner activity closer to the priorities set out in the Quality Strategy and support the Trust to meet the Co-Production aspirations set out in this strategy. In short, Patient Partners will;

- Be regularly involved in service development and quality improvement activity
- Be primarily focused on the priorities outlined in the Quality Strategy
- Provide challenge on patient and public involvement
- Support and facilitate PPI in the projects they are involved in
- Provide some assurance on PPI progress in the projects they are involved in
- Act as a consultation group for staff in the Trust

- Actively engage with users of our services

6.3 Where previously, Patient Partners were allocated to Clinical Management Groups (CMGs) and coordinated by "PPI Leads" (usually CMG Matrons and Heads of Nursing), Patient Partner coordination and allocation will now be managed centrally by the PPI team. Patient Partner activity will be focused on the priorities identified through our "Becoming the Best" Quality Strategy. This will not preclude Patient Partners from undertaking work in the CMGs, particularly where that activity relates to the Quality Strategy objectives. Opportunities to get involved in CMG projects will be open to all Patient Partners and managed through direct requests to the Trust's PPI team. This process will, effectively, create a "pool" of patient representatives, facilitating better involvement of patients with first-hand experience or an interest in specific service development projects. It will also assist the Trust to identify activities that are in or out of scope of the new role.

6.4 While the core priority for Patient Partner allocation will be to support the Quality Strategy, and to become involved in the priority areas identified in it, there will naturally be other areas of work in which Patient Partners may be influential and meaningfully involved; particularly where they have first-hand experience of a service. In order not to lose these important opportunities, the PPI team will apply the following criteria when considering future requests for Patient Partner involvement;

a) The project's relevance to the Quality Strategy
b) The proposed level of involvement measured against the ladder of Engagement tool
c) The extent to which the project is patient focused.

6.5 The Patient Partner role will evolve to see Patient Partners acting as advocates or "ambassadors" for patient and public involvement. As such, their participation on Boards and project groups will include them challenging on wider patient engagement, reporting progress and signposting to the PPI team and the Trust's PPI resources.

6.6 Patient Partners will take up a more active PPI assurance role, evaluating patient and public involvement in the Quality Strategy projects they are attached to. This will contribute to the quarterly PPI update paper taken to Trust Board (see below).

6.7 A programme of training and development will be established to support Patient Partners to facilitate at patient engagement events and to engage with service users and represent these views to UHL staff. Patient Partner meetings will change to accommodate this training and development activity.

6.8 Following the Trust Board meeting in May 2019, a tenure of a maximum of six years has been introduced for Patient Partners. The tenure will be reviewed by the PPI team after three years and, pending satisfactory review, Patient Partners will be offered the opportunity to serve a further three years. One of the key advantages of tenure implementation is the opportunity it provides to increase the participation of a wider and more diverse range of patient representatives in the group. It also allows the Trust to regularly introduce "fresh eyes" in to its priority projects and initiatives. A phased implementation of tenure for existing Patient Partners is being introduced, based on the length of time they have already served in the role.

6.9 Given the investment the Trust is making in its Patient Partners; the expectation of this strategy is that their involvement will not be tokenistic and will be situated across the top three "rungs" of the Ladder of Engagement model. As such, activities such as audits of uniform policy, replenishing stocks of patient literature and supporting routine surveys will fall outside of the new Patient Partner remit. In short, we wish our Patient Partners to be *meaningfully* involved and influential in the development of UHL services and in our quality improvement journey.

6.11 A new role outline will be created to reflect the changes outlined in this paper. This will be supported by clear guidance on the role for both Patient Partners themselves, and for members of staff working with Patient Partners.

"Hospital Improvers": A new opportunity for patients, their carers and families.

6.12 Co-Production in quality improvement and service development projects will require the participation of patients who are current and recent users of our services. With over 90 services operating within the Trust, we cannot expect our Patient Partner group alone to fulfil this function. As the Trust's quality improvement programme grows, we will see an increasing need to engage directly with users of specific services who have first hand, "lived" experience of what it is like to be a patient in that service. Given the ambitions of the Quality Strategy, it is increasingly clear that the Trust would benefit from an additional means of involving patients in its projects.

6.13 It is proposed, therefore, that the Trust establish a new means of inviting patients to become involved in quality improvement projects and service developments. The "Hospital Improvers" scheme would be open to current and recent patients and would seek to involve them in projects they have direct experience of. The scheme would be of particular value to patients who would like to get involved but may not wish to commit to the regular, long term requirements of the Patient Partner role, or do not wish to participate on Boards and committees etc. Instead, Hospital improvers would be offered opportunities to get involved which they may take up as and when they wish.

6.14 Hospital Improver involvement would primarily focus on projects relating to the Quality Strategy and would encompass both online interaction (via surveys, online voting etc.) and face to face involvement at events. Individuals signing up to become a Hospital Improver would be asked to identify the services they have experience of and the issues on which they would like to have some input (e.g. discharge, hospital catering, Diabetes, accommodating religious needs etc.).

6.15 Permission will be sought from individuals for their details to be held on the Trust's existing membership database, which will facilitate targeted invitations to get involved in relevant projects and events. Thus, Hospital Improvers would represent a growing patient resource with which staff in the Trust may engage to improve the quality of services.

6.16 Clear branding will be developed for the Hospital Improver scheme which reflects the branding of the Quality strategy, emphasising its connection and focus. The branding will be used on postcards and leaflets explaining the purpose of the scheme and its opportunities. Promotional items (badges, pens, lanyards etc) would help to raise awareness and visibility of the programme as well as fostering a sense of shared purpose among participants. Regular targeted communications to Hospital Improvers would further build a sense of belonging to a "Co-Production community" among the group.

6.17 Recruitment will be undertaken on a rolling basis with a year one target of at least 40 Hospital Improvers. Opportunities to get involved will be promoted in a variety of ways and recruitment undertaken with the Trust's public membership, through ongoing community engagement and internally via UHL staff. Internal and external communications will support a growing awareness of the scheme and its opportunities. Although recruits will not be interviewed, they will be subject to some simple recruitment criteria. As such, Hospital Improvers will be expected to;

- Have experience of a UHL service / services within the last 18 months
- Agree to abide by a code of conduct

- Agree for the Trust to hold basic data on its membership database
- Agree to receive invitations to involvement events and opportunities to get involved online
- Complete an equality monitoring form to allow the Trust to ensure Hospital Improver participation is representative

There is, in some respects, a "family resemblance" between Hospital Improvers and our recently formed internal Improvement Agents. These two roles should be seen as complementary, both providing wider engagement on our quality improvement activity.

6.18 It is anticipated that the Hospital Improver scheme will significantly improve opportunities for involvement for underrepresented groups. Monitoring of participants' ethnicity, disability status, gender, age etc will also allow the PPI team to identify gaps in representation and target recruitment among specific groups and communities.

6.19 Distinct from the limited and higher – commitment Patient Partner role, the Hospital Improver scheme would provide accessible and flexible opportunities for any patient to get involved and influence the shape of services. It is likely, of course, that some Hospital Improvers may seek more substantial engagement with the Trust and apply for a position as a Patient Partner. The visibility of this programme will also represent a clear message to patients and the wider public that we are a "listening organisation", putting patients at the heart of what we do.

Community Engagement

6.20 Moving forward, it is proposed that the Trust's community engagement programme adopt four specific areas of focus;

a) To better understand the experience and needs of particular groups and communities
b) To promote the Hospital Improver scheme and other opportunities for groups and communities to influence the shape of hospital services
c) To undertake more targeted engagement on the priorities outlined in the Quality Strategy
d) To increase the Trust's visibility outside the perimeters of our three hospital sites

6.21 In year one of this strategy the PPI team will continue with its quarterly "Community Conversations" events; inviting Trust Board members to engage with local communities and groups to learn more about their experience of our services. Depending on capacity, the aim would be to increase the frequency of these events in subsequent years.

6.22 In addition to the more formal Community Conversation events, the PPI team will also undertake smaller scale "relationship building" engagement with a range of local community and patient groups. The Hospital Improver programme will act as an excellent vehicle for this smaller scale engagement; providing the PPI team with a genuine "offer" for individuals to get involved with the Trust beyond the significant and ongoing commitment of the Patient Partner role.

6.23 The PPI team will purposefully seek to build relationships with communities and groups the Trust has historically had little engagement with as well as groups that have experience of the issues prioritised by the Quality Strategy. The team will also continue to ensure that they maintain relationships with groups with whom the Trust has previously engaged. As such, they will return to groups to promote opportunities to get involved, our public membership, the Marvellous Medicine talks and other events.

6.24 Patient Partners will be invited and encouraged to participate in the PPI team's public engagement programme. This will not only allow them to broaden their understanding of the experience of patients, it will provide an alternative to engaging with patients while they are receiving acute clinical care. To support this engagement, community representatives will be invited to present at Patient Partner meetings to discuss their experience of hospital care. Again, this will allow Patient Partners to broaden their understanding of the wider patient experience as well as supporting the Trust's equality and diversity programme.

6.25 Over the year there are a number of key community festivals and events across LLR which offer opportunities for public sector bodies to have a presence and engage with participants. For example, the Belgrave and Loughborough Melas, Leicester Pride, the African Caribbean Carnival, county shows, food festivals, Riverside Festival etc. Such events have not been prioritised in the past as the quality of engagement is not always good and cost and capacity issues can also preclude the Trust's involvement. Having said this, it could be argued that the Trust is conspicuous in its absence, as other NHS and public sector organisations do routinely participate in such events. Going forward, the PPI team would like the Trust to commit to a presence at some of these events; particularly if the Hospital Improver scheme is approved. While attendees at festivals may not be minded to share in depth accounts of their hospital experience, they may well be happy to hear about the Hospital Improver scheme and take away some information to consider their involvement. In short, it is advantageous to the Trust from a public relations perspective to have a visible presence at community events, particularly where there is a straightforward call to action such as the Hospital Improver scheme. The PPI team will explore with the communications team, the extent to which they would be able to support this engagement.

6.26 In order to facilitate more focused engagement on the Quality Strategy, it is proposed that a new programme of patient and public engagement events be established which will each concentrate on a specific area of the Quality Strategy. Under a working title of "Hospital Improvement" workshops, project leads and relevant clinical and managerial staff will be invited to lead sessions which engage with Hospital Improvers, Patient Partners, Healthwatch representatives and other relevant patient groups (For example, the Trust's Patient & Carer Cancer Partnership Group). The workshops will share the ambitions of projects and seek the input of participants to shape future work. Such events will also provide opportunities for UHL teams to identify participants who may wish to get involved in sub – projects etc. Frequency of these events will depend, in part, on the timescales of each quality strategy initiative but it is anticipated that at least four events could take place in year one.

6.27 In addition to the Hospital Improvement workshops, project teams will be invited to participate in relevant public engagement sessions as part of their wider PPI activity.

Working with Healthwatch

6.28 As the Trust focuses its PPI activity on the priorities identified in the Quality Strategy, it will continue to seek input from local Healthwatch colleagues. A Healthwatch representative already sits on the Trust Board and Healthwatch representatives meet regularly with our Chief Executive. In addition to this, the PPI team will work with Healthwatch Leicester / Leicestershire and Healthwatch Rutland to identify how they can best input in to the Trust's quality improvement journey. In particular we will ensure that relevant learning from Healthwatch engagement is fed in to the Trust's quality strategy priorities.

7. **<u>STEP THREE</u>: Put systems in place that reward and recognise the contributions people make.**

7.1 There are a number of steps that could be taken to reward and recognise the contributions that participants have made. The provision of simple refreshments at engagement events, for example, is a small gesture of thanks for people's time and effort. The PPI team would also like to explore the feasibility of providing free car parking for participants at PPI events. This reflects a core principle that no one should be out of pocket by getting involved with Leicester's Hospitals.

7.2 The provision of timely feedback should be a routine commitment from the Trust to all participants in its PPI programme. Hospital Improvers, for example, could be sent a regular e – newsletter which identifies where their input has made a difference. Good examples of engagement will also be featured on the Trust's web site and across Social Media.

7.3 In recognition of the commitment and sustained input from Patient Partners, the Trust will continue to offer a sessional payment of £20 per session (up to a maximum of six sessions per month) as well as out of pocket expenses. This payment both recognises the time and effort Patient Partners put in, but also offer some recompense for sundry costs (printing etc.) associated with their involvement.

7.4 The PPI team will explore other opportunities to reward and recognise both staff and patients for good practice in involvement.

8. STEP FOUR: Identify areas of work where co-production can have a genuine impact, and involve patients in the very earliest stages of project design

8.1 If the Trust wishes to see a step change in the commitment to meaningful PPI across projects associated with the new Quality Strategy, early consideration of PPI requirements and obligations should be mandated at the very beginning of a project.

8.2 It is proposed, therefore, that all project teams connected to the Quality Strategy priorities be required to complete a "Patient Involvement Request" at the initiation phase of their project. The request form will prompt a consideration of questions such as;

- What intelligence have you captured from patients about what is happening in the service?
- Which patient / carer groups will be affected by the project?
- How will you involve patients, their families and carers in this work?
- What will be the scope for patient input to influence the outcome of the project?
- Will any patient group be disproportionately affected by the project?
- If so, what are your plans to engage with this group?

These considerations will be built in to the Driver Diagram and process that all quality strategy projects will follow. Quality Improvement leads will be expected to play their part in ensuring that a Patient Involvement Request and PPI plan is completed at the early stage of all QI projects.

8.3 Patient Involvement Requests will be submitted to the PPI team, who will provide support and guidance to project leads. Patient involvement / engagement expectations will be determined by this initial assessment and progress will be monitored via a quarterly PPI update report to Trust Board. This process will provide an excellent opportunity to identify projects which lend themselves to Co-Production and in which it might be trialled.

8.4 The introduction of such an assessment at the initiation phase will mitigate against a common complaint by patient representatives that they are involved too late in to the life of a project to have any meaningful influence. In such circumstances, their involvement is seen as tokenistic.

8.5 The PPI team's assessment of project needs will incorporate elements of Equality Impact Assessment. Project teams will therefore be asked to consider the potential impact of their project on "protected characteristic" groups and be encouraged to undertake targeted engagement with any affected groups. As such, any service equality requirements will be identified at the beginning of projects and more readily built in to service developments. The PPI team will undertake to feed relevant feedback from community engagement in to quality improvement projects via the project lead.

9. STEP FIVE: Build co-production into your work programmes until it becomes 'how you work'

9.1 The increased profile of PPI in our quality improvement journey has presented a real opportunity to develop a culture of Co-Production within the Trust. While it will take some time to develop, the process outlined above will allow us to identify Co-Production opportunities, promote what has worked well and encourage a more routine adoption of the approach. The aspiration is that all quality improvement projects, on completion, will confidently be able to claim that they have put patients at the heart of the project. The PPI team will provide quality assurance support to the QI leads in reviewing the quality of PPI within specific projects.

9.2 With Co-Production as an integral element of the unified approach outlined in Becoming the Best, the Trust has probably not had a better opportunity to create a pervasive culture of patient involvement. This is in no small part due to the support it will receive from our Trust Board as an integral element of the Quality Strategy.

10. STEP SIX: Train and develop staff and patients, so that everyone understands what co-production is and how to make it happen

10.1 Training and development is essential to making Co-Production happen in the Trust. Although the principles are not academically difficult to grasp, PPI is still far from routine and there is still a degree of uncertainty and anxiety around the agenda.

10.2 The PPI team have already committed to delivering a programme of training and development for Patient Partners, to equip them to fulfil the requirements of the revised role. Their role as partners in Co-Production will form a key element of this training, alongside skilling Patient Partners up to facilitate at patient engagement events etc.

10.3 If we are aiming for a culture of routine Co-Production activity then appropriate training will need to be readily available to staff; particularly, in the first instance, staff involved in quality improvement projects. The frequency of training will reflect the growing demand as the quality improvement journey picks up pace. It is anticipated that the PPI team will run a staff workshop every two months initially in addition to providing on demand training for project teams.

10.4 Training will be supported with other resources including a PPI Toolkit, guidance and information on Co-Production and other web resources such as accounts of examples where patient engagement has worked well. The PPI Team will also explore the feasibility of developing an e-learning package to support staff in their PPI activity.

10.5 The PPI team will work closely with the communications team to ensure a programme of internal communications provides regular information and raises awareness of the Trust's PPI aspirations. This will include the promotion of opportunities for staff to engage with communities and other patient groups.

11. STEP SEVEN: Regularly review and report back on progress. Aim to move from "You said, we did," to" We said, we did".

11.1 PPI progress on quality strategy projects and other projects across the CMGs will be reported as part of the quarterly PPI update paper to Trust Board. PPI will also form part of the assessment and tracking process applied to the Trust's quality strategy initiatives.

11.2 Our Patient Partners will also be asked to contribute to the assurance process around PPI performance by evaluating the projects they are involved in. Patient Partners will evaluate both their own involvement and the involvement of wider patient groups. This evaluation will contribute to the Board reporting outlined above.

11.3 Feedback on PPI performance will also be taken regularly to the Trust's Patient Involvement and Patient Experience Assurance Committee (PIPEAC). This will provide opportunities to both share success and good practice, and also to provide insight in to the learning from external community and patient engagement.

11.4 The importance of providing feedback to participants in PPI has already been noted above. This should be a condition of any patient engagement and seen as part of the "Co-Production contract" between staff and patients.

12. Risks

12.1 As with success in Quality Improvement, success in Patient and Public Involvement depends ultimately on the "Culture and Leadership" within an organisation. The C4CC Co - Production Model cited above identifies certain organisational preconditions for Co – Production. It emphasises;

- The agreement from senior leaders to act as champions
- A culture of openness and honesty
- A commitment to sharing power and decisions with citizens
- Clear communication in plain English
- A culture in which people are valued and respected

12.2 Alongside this cultural shift, it will be necessary to address the opportunities staff have to "opt out" of PPI activity. Historically, there have been few sanctions or consequences for those who do not involve patients in their service developments and quality improvement initiatives. It is hoped that better monitoring and clear reporting to Trust Board will both incentivise performance around PPI and provide the Trust Board with better information on PPI performance and opportunities to challenge where involvement is not taking place.

12.3 The workload generated by the changes outlined above is, to an extent, unpredictable and will vary depending on the speed of adoption of the Quality Strategy methodology, demand for Patient Partners and demand for Hospital Improvers. It is proposed, therefore, that the strategy be subject to a first year review. Some modest resource is identified below but capacity will be reviewed after one year to evaluate what can sustainably be delivered.

13. Resource

13.1 Implementation of this strategy will represent significant resource implications for the PPI Team. This will come, in particular, with the team's more direct involvement in Patient Partner allocation, adopting a more central function supporting PPI across the Quality Strategy priorities and CMGs, launching and managing the Hospital Improver programme increasing monitoring and reporting activity and increasing the Trust's public engagement programme. In order to meet the expectations set out above, it is requested that the PPI team expand to include at least a PPI Support Officer role, which is likely to be banded at around a Band 4. The Board are asked to support this.

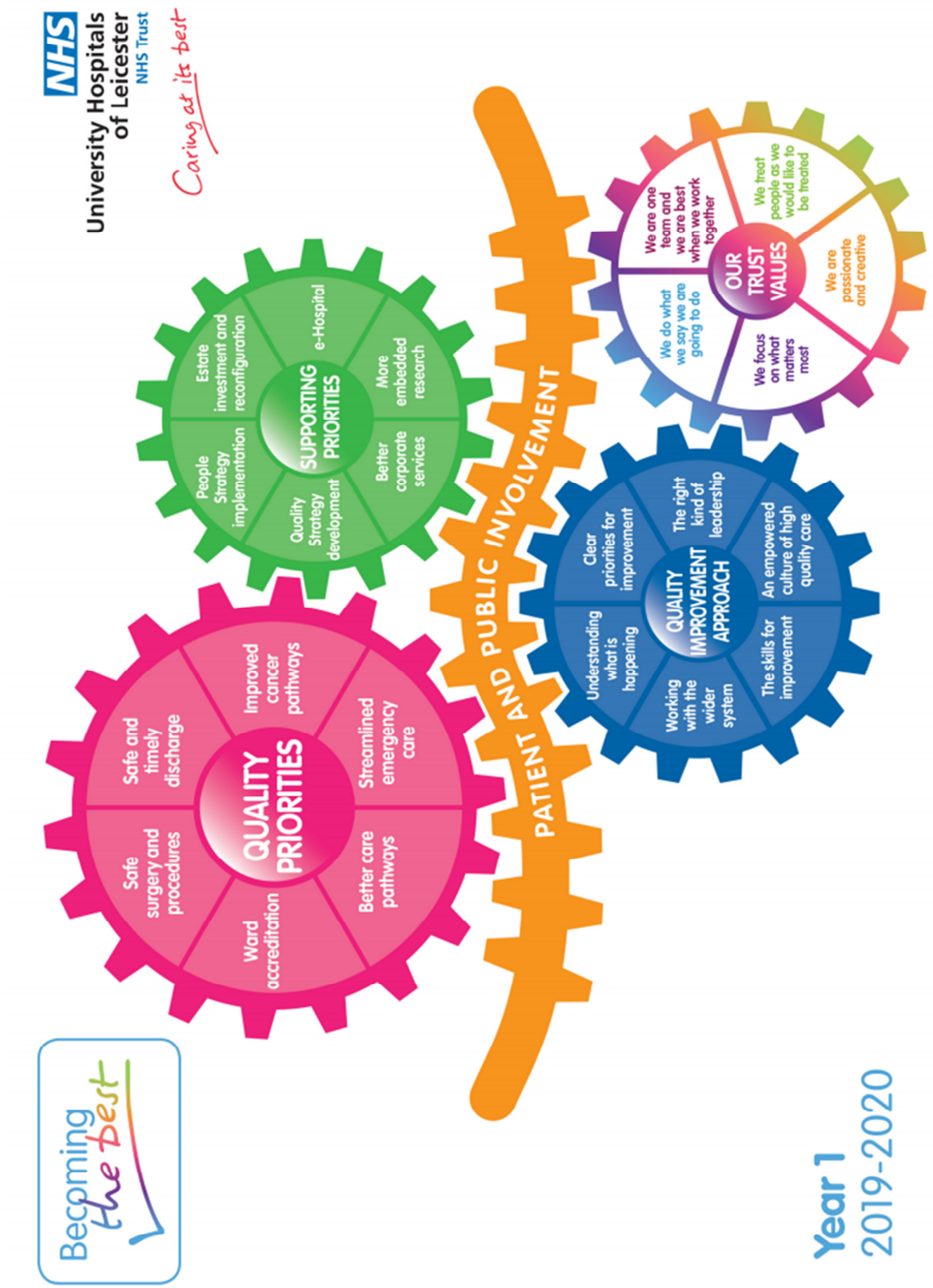
13.2 Although every effort is made to identify low cost external venues, there will be ongoing costs associated with the expanded programme of public engagement outlined above. There will also be modest costs associated with promotion of the PPI team's role, the new ways of working with Patient Partners, promoting the Hospital Improver role and encouraging PPI across the Quality Strategy initiatives. In order to raise their profile, the PPI team will explore re-branding and internal marketing to raise awareness among UHL staff of their role and function. Modest funding for promotional materials will ensure that the Hospital Improver programme is visible in communities and appears well supported by the Trust. The following costs are anticipated.

Item	Indicative costs (£s)
UHL Annual Public Meeting	2000.00
4 X Community Conversations events	1400.00
Community outreach sessions (room hire, sundry expenditure)	1000.00
Stall hire at festivals / events	1000.00
Interpreting / accessibility	800.00
Refreshments (Hospital Improvement events X 4)	160.00
Pull up promotional banners	200.00
Promotional leaflets / business cards	600.00
Promotional items (badges, pens etc.)	1500.00
Total	**£8660.00**

14. Conclusion

14.1 The changes outlined in this strategy represent a significant step change in patient and public involvement and community engagement. Its implementation presupposes a degree of "culture shift" in the organisation, demanding a higher level of commitment and "buy in" for PPI than has previously been the case in UHL. A closer integration of PPI to the quality improvement journey described in "Becoming the Best" will support the implementation of this strategy and provide a clear focus for our patient involvement moving forward. Clearly this will take some time to become established in the Trust. To that end, a phased implementation is outlined in the action plan in appendix 3 of this document.

Appendix 1. Quality Strategy diagram



Appendix 2: Coalition for Collaborative Care Co-Production Model

A Co-production Model

Five values and seven steps to make this happen in reality

What is co-production?

Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.
Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches.

Values and behaviours

For co-production to become part of the way we work, we will create a culture where the following values and behaviours are the norm:

How to do it?

Seven practical steps to make co-production happen in reality: