London Leadership Academy

Developing Effective Lay Partners

Written by:

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1. Executive Summary:

Co-production and collaboration in the health and care sector are increasingly recognised as important and challenging. While efforts have been made to prepare staff for these new ways of working, less has been done to develop patients and carers to play their part as lay partners. With this need in mind, the London Leadership Academy and Lis Paice designed 'The Effective Lay Partner' programme which gave forty participants three days of development. The programme was extensively evaluated before, during, and after (immediate, 1 month and 3 months) the intervention. Impacts included participants starting new roles, getting involved in new sectors, spreading their learning, changing organisational guidelines, and gaining more confidence. Lessons learned and next steps are also summarised at the end of this paper.

2. Introduction

One of the major changes in healthcare over the last 20 years has been the growing emphasis to involve patients and the public. The NHS Constitution requires that healthcare professionals, clinicians and managers will engage with patients and the public when they plan changes to services. Similarly, the National Framework 'Developing People - Improving Care', refers to collaboration between leaders in organisations and patients as one of the key conditions to high quality health and care systems[1]. Some of this engagement will be at the individual level, through involving people in decisions about their own care. Some will be at the level of service users, co-designing services they use. Some will be at a strategic level, co-producing strategies and policies that extend across the system. Coproduction at strategic level is less commonly achieved and it can be challenging to find enough patients or carers who are willing to work as lay partners at this level and who are effective in the role.

This need to equip effective lay partners led the London leadership academy to commission a leadership programme for patients and carers with lay partner roles in CCGs or other healthcare organisations, designed to inspire their commitment, develop their collaborative skills and improve their effectiveness in the role.

3. Patients and Carers as Lay Partners

The importance of patients and carer involvement in co-production of healthcare is now commonly recognised as imperative to improving health service, ensuring sustainability, and increasing patient responsiveness[2], but there is little published guidance on how to develop people to undertake these 'lay partner' roles.

[1] Developing People – Improving Care. A national framework for action on improvement and leadership development in NHS funded services. London: NHS Improvement. *September 2017.*

[2] Dunston, R., Boud, D., Brodie, P. & Chiarella, M. (2009). Co-production and health system reform – From re-imagining to re-making. *Australian Journal of Public Administration,* **68(1),** 39-52.

The challenges are probably greatest for patients and carers working at a strategic level, where they are necessarily working outside their personal lived experience. It may prove difficult to recruit and retain people, especially as it is usually a voluntary unpaid role. Previous published work in North-West London[i] concluded that the most effective lay partners had the following characteristics:

1. Lived experience as a patient and/or carer;
2. Experience of working at a strategic level, in any field;
3. Commitment to a shared vision - not single issue champions;
4. Willingness to challenge professionals;
5. Ability to listen, weigh arguments and help reach a consensus;
6. Diverse connections within the community;
7. Time to read papers, attend meetings and communicate.[3]

These core characteristics fed into the design of a leadership programme targeted specifically at this group.

4. Developing the Programme

The London Leadership Academy Commissioned Professor Lis Paice OBE FRCP to develop and deliver the programme. Lis is a retired doctor with a strong background in medical education and an active interest in executive coaching. She is a passionate advocate of co-production and led the establishment of the North West London Lay Partner Advisory Group (LPAG), which won the 2015 LLA Patient Champion of the Year Award. She has also established lay partner advisory groups in The Hillingdon Hospitals NHS Foundation Trust and Epsom Health and Care.

As a first step in developing the programme, Lis and a colleague carried out interviews with several new and well-established patient leaders, seeking their views on what should be covered and how the programme should be delivered. The following principles were developed from these interviews:

1. The course should focus on people who had already shown commitment by taking on roles;
2. It should be highly interactive;
3. It should seek to develop skills and attitudes rather than impart knowledge;
4. It should support the development of collaborative behaviours;
5. It should encourage the individual's self-awareness and self-confidence;
6. It should use a coaching approach, recognising the experience and resourcefulness of participants;
7. It should offer experience of working with healthcare professionals as equals;
8. It should be co-delivered with experienced lay partners and patient leaders.

Recruitment was targeted at patients and carers who already had some experience of the lay partner role as lay members of healthcare groups, boards or committees in London. The programme was advertised through a newsletter to London CCGs, more widely to a variety of London-based healthcare organisations and also patient participation groups. Forty applicants meeting those criteria were accepted onto the programme.

[3] Morton, M and Paice, E 2016 Co-Production at the Strategic Level: Co-Designing an Integrated Care System with Lay Partners in North West London, England. International Journal of Integrated Care, 16(2): 2, pp. 1–4, DOI: http://dx.doi.org/10.5334/ijic.2470

Taking into account the previous discussions, we came up with the following learning objectives:
By the end of the programme, participants should

1. Understand the range of ways patients, carers and the public can be involved;
2. Understand the principles of coproduction and have experienced it in action;
3. Have learned and practised the skills needed for effective lay partnership including negotiation, influencing, committee work, teamwork, representing the views of others, acting as critical friend and supporting shared values and vision;
4. Have developed their understanding of the NHS challenges ahead;
5. Be confident in the provisions of the Human Rights Act and the relevance of that legislation to the work of the NHS;
6. Have forged supportive new relationships and networks;

5. The Programme

The programme was delivered over three days, the first two close together and the final day after a few weeks, to allow participants to put their learning into practice and report back on their experiences.
Each day was facilitated by Lis Paice, supported by a patient engagement expert who ensured that individual needs were met and suitable adjustments made to address disabilities.

Table coaches facilitated groups of 5-6 participants. These were healthcare professionals, mainly doctors, with coaching qualifications and experience. The reason behind using doctors was that they would be experienced in talking with patients with a variety of disabilities, they would be familiar with the context in which the participants were working and they would provide an opportunity for participants to get to know senior healthcare professionals in a non-clinical environment.

Day 1: Co-production
This day was the most information-heavy, focusing mainly on how the NHS works and co-production. As mentioned previously, this is important because co-production is being increasingly encouraged in the NHS as it can contribute to the long term sustainability and high quality service. Feedback at the end of the day was largely positive, along with recommendations for 5-6 participants per table and more discussion time.

Day 2: Collaboration
This day focused on collaborative behaviour. Participants generated a list of behaviours they appreciated in others at meetings which was then refined to a list of collaborative behaviours they aspired to themselves. Participants also had the chance to hear short presentations about a service improvement project from two of a group of 8 Darzi Fellows (junior healthcare professionals on a leadership programme) and to questions or make comments about their project, followed by feedback from the table coaches.

This is all significant because with co-production, comes a power shift that appreciates the knowledge of the patient as well as the healthcare professional. These deeply rooted power dynamics could be difficult to shift,

and therefore, effective collaboration is of utmost importance. Once effective collaboration exists, the dialogue is also considered beneficial as it helps to generate knowledge and promote learning for both groups[4].
At the end of the day, participants offered positive feedback to each other on collaborative behaviours they had observed. The Darzi Fellow spokesman also fed back that the session and suggestions from the patient representatives were really beneficial for them, because it helped them see their project from a different perspective, and enable them to consider aspects that they had not considered before.

Day 3: Continuing Development
This day focused on continuing the development of the first two days. Participants began by sharing their experiences that occurred since the last session. Then they had the opportunity to hear from two of six healthcare managers about a service improvement project and ask questions or comment. Participants were encouraged by their coaches to challenge and practice collaborative behaviours and obtained feedback from the managers and from their coaches . In the afternoon there were talks on the Human Rights Act and on Inclusive Language, followed by reflection on the programme and creating an action plan for using and developing the learning. Participants and table coaches gave each other positive feedback on collaborative behaviours they had observed. They were also offered a follow-up telephone session with one of the coaches or facilitators.

6. Evaluation

Immediate
At the end of Day 3, participants were asked to fill out evaluation forms. We received 32 completed forms. Not every participant answered every question. The table below summarises the participant's ratings on different aspects of the course.

How helpful did you find the following elements of the course? (Marks out of 5)		
	Number	Average
Working in small groups	32	4.7
Table coaches	29	4.6
Talks from patient leaders	29	4.2
Other guest speakers	32	4.2
Darzi Fellow exercise	25	4.1
Manager case studies	32	4.3
Learning how I impact on others	31	4.3
How likely are you to recommend this course to a friend in the same sort of position as you?	32	4.6

Some areas that participants found most useful included "links to inclusive language", "knowledge on how the NHS works", "networking", "coproduction", "the coaching element" and "learning from each other".
The table coaches were also asked for their reflections. The consensus was that over the three days they observed participants developing more collaborative behaviours and more insight into how they impacted on

[4] Bleakley, A. & Bligh, J. (2006). Students learning from patients: Let's get real in medical education. *Advances in health Sciences Education.* **13,** 89-107.

others. They commented that on the final day the atmosphere in the room was calmer, people worked together more as a team and people had learned to share the airtime and listen as well as wait for their turn to speak. The quiet ones were more confident in speaking out and the vociferous ones had learned to make space for other views.

Twenty-three participants opted to have follow up phone calls, but only 19 followed through. The coaches reported useful conversations, mainly about how to take the learning forward and seek out new lay partner roles. Some wanted to discuss their personal effectiveness in the light of the feedback they had received from peers on the programme.

1-month Follow-up

Participants were contacted one month after the programme had finished and asked how it had impacted on their effectiveness as lay partners. The following are representative quotes:

> "I have begun to initiate positive improvements in Access issues for cancer patients and carers in the hospital"
>
> "The setting up of a patient awareness group at the local GP"
>
> "I have spoken up on behalf of patients and the public so many times in meetings already since the course… it was the course, and meeting the other lay partners, that empowered me to feel able to do so"

All the participants also agreed that the programme met their expectations and that they would recommend it to a friend.

3-months follow up

Three months after the programme, participants had the opportunity to meet up again. Seven participants attended this session. Interviews with these participants revealed that some of them had made considerable progress since the end of the programme:

One participant is now involved with a charity where they participate in projects helping to evaluate patient services, and partake in patient forums. This participant is also now part of the recruitment panel and patient reference group for a foundation trust. They have also gone on to run workshops, and recently co-delivered a masterclass on mental health.

Another participant has gone on to join a large charity, where they passed through a challenging application process. They believe that the programme helped them to secure this position. Through their work with this charity, they were approached by a professor at a leading university to assist with research. They have also spoken with an end of life steering group at an NHS foundation trust, and contributed to a change in their guidelines to give emotional support to other patients when there has been a death on the ward.

A further participant has joined a patient safety culture working group in a trust. They meet monthly and help the trust engage patients in safety. This participant has also since ventured into two completely new fields of work – research and education, and has also joined the primary care council of a national medical organisation, becoming the first patient representative on this council.

Other delegates have also gone on to take on new roles – like joining a clinical research group, joining a leadership academy's reference group, and helping other patients through home visits.

7. Lessons Learned:

The lessons learned and to consider for next time have been grouped into lessons learned before, during and after the intervention.

Before:

1. Participants who had not yet had much experience as lay partners were a little lost and had difficulty contributing to the group discussions on the first day. The two case study exercises helped them get involved.

During:

2. The majority of participants wanted the programme to be more interactive, although a few wanted more talks. In retrospect, perhaps attempting to cover topics like How the NHS Works, The NHS Constitution and The Human Rights Act was overambitious.
3. There needed to be more time for people to practise their collaborative skills and get feedback from peers and coaches.
4. Using a coaching approach, with trained coaches as table facilitators, was highly successful. Using doctor/coaches in this role was costly however. It is worth seeing whether the same impact could be achieved with table coaches who are not doctors.
5. The experience of working with healthcare professionals in the case studies was very empowering and enlightening, especially as the participants outnumbered the professionals so the balance of power was skewed in the patient's favour. We found no difficulty in identifying willing volunteers as the opportunity to present their project to a group of patients seemed to be attractive and the feedback was that it had been useful.
6. The co-delivery with experienced patient leaders and lay partners was important, and they were excellent at taking topics and presenting them from a patient perspective, but in retrospect all new topics should probably be delivered on the first two days and the number of topics should be strictly limited in order to leave more time for interactive skills and attitude development.

After:

7. Follow-up phone calls may be useful, but require telephone coaching skills and the coaches need remuneration, so a cost that could be cut.
8. A follow-up meeting was not well-attended although those who participated gave useful feedback and appreciated the event.
9. Follow up evaluation with facilitators and guest speakers would have been useful

8. Next steps:

With the evaluation and lessons learned in mind, Lis redesigned the programme so that it took into consideration the feedback from the participants and the lessons learned. As a result, the cost of the programme was reduced, and the London Leadership Academy has commissioned this programme again for both London and Kent, Surrey and Sussex.

For the next London Programme, the dates have been set for the 23 & 24 of November 2017, and 16 of January 2018.The next stage for us is to start advertising and recruiting delegates

[i] Int J Integr Care. 2016 Apr-Jun; 16(2): 2.
Co-Production at the Strategic Level: Co-Designing an Integrated Care System with Lay Partners in North West London, England
Michael Morton and Elisabeth Paice