KEELE UNIVERSITY

2011

Patient and Public Involvement (PPI) Strategy Report

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Contents

1. Executive Summary

The following strategic report has been compiled in response to the Faculty of Health User and Carer Involvement Strategy and draft guidance from the GMC. It is proposed that the school's vision should be that it will be upheld as an example of best practice for its high quality and effective engagement of patients, carers and member of the public embracing them as critical friends throughout the operation and development of the Medical Curriculum and will contribute to the school's missing to graduate 'excellent clinicians'. It is proposed that PPI Partners could add value to the curriculum in 5 distinct areas:

1. Selection of students and staff
2. Teaching
3. Assessment and feedback
4. Curriculum Development
5. Quality and Governance

The report recommends the school considers and adopts some important underlying values, which will contribute to effective and high quality engagement.

1. A top down commitment regarding the importance of PPI in achieving the school's overarching mission: to graduate 'excellent clinicians'.
2. A commitment to High Quality PPI
3. Recognition of the added value to be gained from non-medical experts as 'critical friends[1]
4. Commitment to a culture, which considers the viewpoints and contributions of PPI Partners to be of equal value to academic and professional perspectives.
5. A commitment to supporting patients and members of the public appropriately before, during and after involvement.
6. A commitment that PPI will be
    a. Appropriately supported and resourced.
    b. Planned, respected and acted upon.
    c. Cross community based - where patients and the public from broad and diverse backgrounds as possible are encouraged to become involved.
7. That nobody is 'out of pocket' as a result of their invited involvement as a PPI partner

It is identified that PPI is often referred to as a collective however this report distinguishes that patients will have different needs, interest and experiences than interested members of the public. A diagrammatic model is proposed, which recognises the importance of treating partners as individuals, whilst identifying three important groups of participants.

1. Users of healthcare
2. Community Healthcare advocates
3. Interested and motivated community members.

Mapping of the school's current approach to PPI revealed that there were already examples of good practice in the areas of student selection and teaching. However, (with the exception of student selection) most of this is within the dimension of patient involvement. In relation to expert and simulated patient involvement practice is good but would benefit from the application of the pre-requisites outlined below to ensure transparency and fairness. Public involvement is mostly confined to student selection and requires some development. There is currently an over reliance on school staff to fill the gaps on panels where PPI partners have not been available. Opportunities for

the development of public involvement are identified as curriculum development, assessment and feedback and quality and governance.

In order to develop high quality PPI across the school a number of prerequisites (see model pg.12) have been recommended:

1. To establish and agree an organisational structure to support PPI:
    a. Establish a post to manage the school's PPI strategy.
    b. Champions to support the 5 identified curriculum domains.
2. Appropriate training and guidelines for chairs to facilitate PPI.
3. Consistently taking a planned approach to PPI (Annex C)
    a. Including questioning how many partners should be engaged.
4. Develop a Reimbursement, Recognition and Well being policy (RRWP) which includes:
    a. A voluntary (non-remuneration) based model of engagement
    b. A commitment that PPI should not leave partners out of pocket and to reimburse partners for expenses incurred as a result of 'invited involvement'.
    c. PPI well being charter focusing the school's attention and resources on the non-financial aspects of engagement so as to ensure a high quality experience for partners
5. Develop recruitment plans in response to clearly identified PPI roles
    a. Exploring the capacity of existing participants.
    b. Utilising well developed placement links with third sector organisations to enhance capacity.
    c. Carefully targeted recruitment activity and or a large scale open day recruitment event.

Once these pre-requisites are in place the foundations should be well established to develop PPI across the school. The development opportunities identified are summarised below:

Student and staff selection	•PPI Champion •Role Outlines •Focus Group - to explore current and future involvement •Recruit further PPI partners and reduce use of school staff • Reimburse partners
Teaching	• PPI Champion • Patient representative on professionalism and student welfare committee • Expand use of patient advocates and groups for disease specific teaching
Assessment	• PPI Champion • Simple and short mechanism to capture and document patient feedback. i..e Patient MSF and or Patent feedback diary • Involve PPI partners in standard setting
Curriculum Development	• PPI Champion • Focus group to consider curriculum development and or redesign
Quality Assurance and Governance	• Encourage recruitment of PPI partner(s) to school management committees. Each committee to complete annex c and glossary of terms • Form a PPI committee to enable partners to contribute as a group: reducing barriers to participation, increasing diversity of representation and act as a standing focus group •PPI partner involvement with SIFT QA visits • PPI partner invovlement to continue of GMC panels

It is recommended that the first phase of PPI development focuses upon the development of PPI champions, chairs training and PPI role outlines and person profiles. The second phase should consist of increasing capacity according to the identified roles an obvious place to start is with the targeted recruitment of individual committee members or pairs as will make a significant initial contribution to all areas of the curriculum. The third phase should address capacity and recruitment with the group based PPI roles i.e. admissions, PPI committee, expert patients etc. This offers the opportunity to hold a recruitment open day or combined recruitment exercise.

Ultimately, the school has the potential to develop excellent high quality PPI. Good progress has already been made in relation to patient involvement and there are exciting and significant opportunities for public involvement across the curriculum. If the school can adopt the baseline values and pre-requisites to secure a platform for future PPI there is every possibility that public engagement could thrive and add significant value to the School.

2. Introduction

This purpose of this report is to set out the strategic development of Public and Patient Involvement (PPI), within the School of Medicine. The report is in response to and incorporates factors identified by the Faculty of Health User and Carer Involvement Strategy in Education and Research (2010)[1] and the draft General Medical Council's (GMC)6 supplementary advice on Patient and public Involvement in Undergraduate Medical Education. A brief outline of the methodology deployed in researching this strategy document is contained in annex a.

3. Objectives

The following strategy will;

- Clarify the term PPI.
- Explore the importance of PPI
- Identify and map existing PPI within the school.
- Identify the key factors that can lead to high quality and effective engagement.
- Explore opportunities for development of PPI within the school.
- Propose a series of recommendations.

4. Terminology

4.1. PPI

Public and Patient Involvement are continually referred to together, however it should be noted that they are distinctly different and should not be regarded as the same. Patients, as users of healthcare services, and the public, as concerned citizens, have different perspectives on healthcare. Within the literature and in practice a broad range of headings and labels are used to refer to the same thing, the involvement of 'patients and/or the public' within healthcare who are able and willing to offer, different perspectives and or expertises based on their 'life experiences', which can be as valuable as specialist professional or academic input. Such a range of broad headings, often used interchangeably to refer to the same thing is potentially confusing, such headings include:

- Patient and Public Involvement (PPI)7[2]
- Lay participation[3]
- Lay Involvement
- User and Carer Involvement1
- Service User Involvement[4]
- User Involvement[5]

For the purpose of this report the input of patients and the public will be referred to as ***Patient and Public Involvement (PPI)***7, not least because this is the terminology chosen and used by the GMC7 and against which future QABME (Quality Assurance of Basic Medical Education) reviews may be assessed. However, it is proposed that a more suitable terminology may be Patient and Community Involvement (PCI), as this focuses the mind more toward the health economy in which the Medical School operates.

4.2.PPI Partners

Where patients and the public are referred to as a collective they will be henceforward referred to as 'PPI partners'.

5. Vision

The school will be upheld as an example of best practice for its high quality and effective engagement of patients, carers and members of the public in the operation and development of its medical curriculum.

6. Strategic Fit

UNIVERSITY STRATEGIC FIT

- 'The pursuit of truth in the company of friends'...in order to contribute positively to the local region, wider society and the national economy
- "To develop graduates who demonstrate intellectual flexibility...relevant experience...and global citizenship skills".
- "Outward facing to the local and wider communities..."
  Keele Strategic Map 2010-2015 (2011)

FACULTY STRATEGIC FIT

- "...To ensure a consistent high quality approach to user and carer involvement..."
  Faculty of Health Strategy for User and Carer Involvement in Education & Research (2010)

7. Values

It is essential the school establishes the values and beliefs it holds in relation to patient and public involvement within medical education for example:

- A commitment from the 'top' regarding the importance of PPI in achieving the school's overarching mission: to graduate 'excellent clinicians'.
- A commitment to High Quality PPI in recognition of the added value to be gained from non-medical experts as 'critical friends[6]'or partners who are willing and able to share their unique perspectives and experiences.
- Commitment to a culture which considers the viewpoints and contributions of PPI Partners to be of equal value to academic and professional perspectives.
- A commitment to supporting patients and members of the public appropriately before, during and after involvement.
- A commitment that PPI will be
  - Appropriately supported and resourced.
  - Planned, respected and acted upon – moving from feedback to partnership.

- Cross community based - where patients and the public from broad and diverse backgrounds as possible are encouraged to become involved.

- That nobody is 'out of pocket' as a result of their invited involvement as a PPI partner within the School.

8. Background

The healthcare environment is subject to a number of political, philosophical and social shifts, which are change the doctor-patient relationship[7] [8] [9]. Since 1997, there has been a departure away from market and contract focused healthcare philosophy, toward a "third way"[8], representing a shift in focus in favour of community and patient involvement and partnership. Healthcare delivery changes, such as a reduction of inpatient beds and reduced hospital admission periods in favour of care in the community, has created a shift in care "...from acute settings to chronic disease management delivered from community settings"[7]. Consequently there is an ever increasing focus on patient and public involvement (PPI) in healthcare.

Whilst PPI has been present for sometime at the policy making and Primary Care Trust (PCT) level, there is growing recognition of its benefits within medical education, particularly in relation to PPI's value and ability in influencing and determining the attributes of future newly qualified doctors. The GMC[7] recognises the importance of empowering patients and members of the public to become involved as active teachers or partners in the Medical Education process. Therefore there is a clear need and driver for the school to fully involve patients and the public and embrace them as "partners in education"[7].

9. What is the benefit PPI?

The importance of medical expert input within a medical curriculum is unquestioned and ensures the appropriate acquisition of knowledge and skills. However, it is also recognised that there is a significant role for non-medical experts because they have valuable lived experiences as consumers or future consumers of healthcare service3. To some degree this has been realised through the use of expert patients 'patients as teachers'3 "but this does not capture the wider dimension of public engagement. Unfortunately, there are few guidelines available to Medical Schools on how to manage and integrate wider community engagement into the design, development and evaluation of a medical school curriculum. This brings us to ask the question why should the school invest resources to develop PPI? What is the added value? The following individual and organisational benefits are proposed.

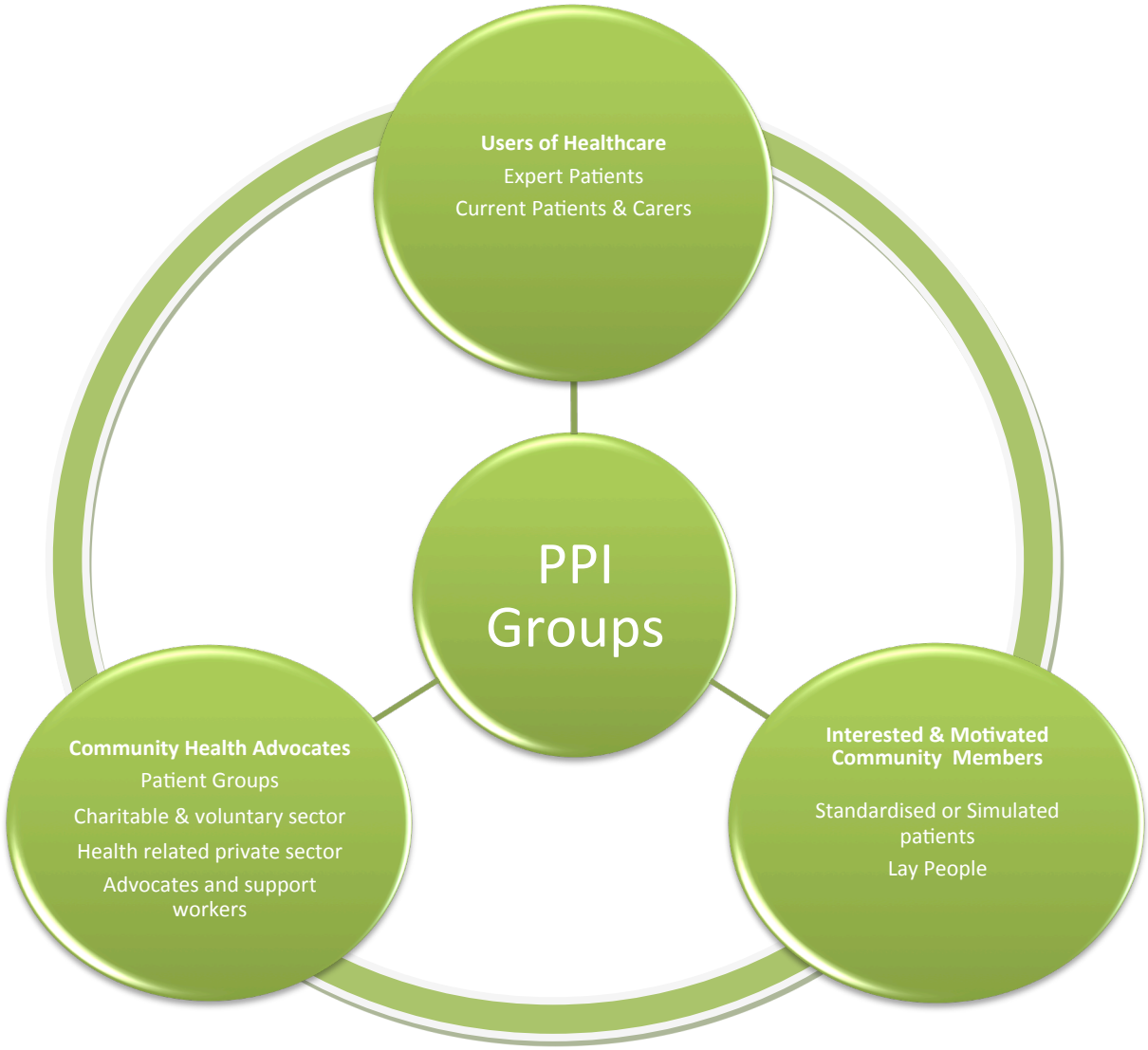
Individual / Group (PPI Partner)	Organisation (School)
Therapeutic - Enhanced confidence and self-esteem	Reduced or removed blind sports.
Increased satisfaction with health services and medical education	Ensure decisions do not go off at tangents.
Utilitarianism – 'sense of achieving greater good'	Graduating excellent clinicians matched to the needs of the community.
Facilitates acquisition of skills and knowledge	New insights, challenge and perspectives – potential to Inject new life into course content[7]
Stepping stone to ongoing employment[10]	Increased diversity of opinion.

Sense of empowerment from involvement[7]	Raised awareness and profile of the school

10. Who are PPI partners?

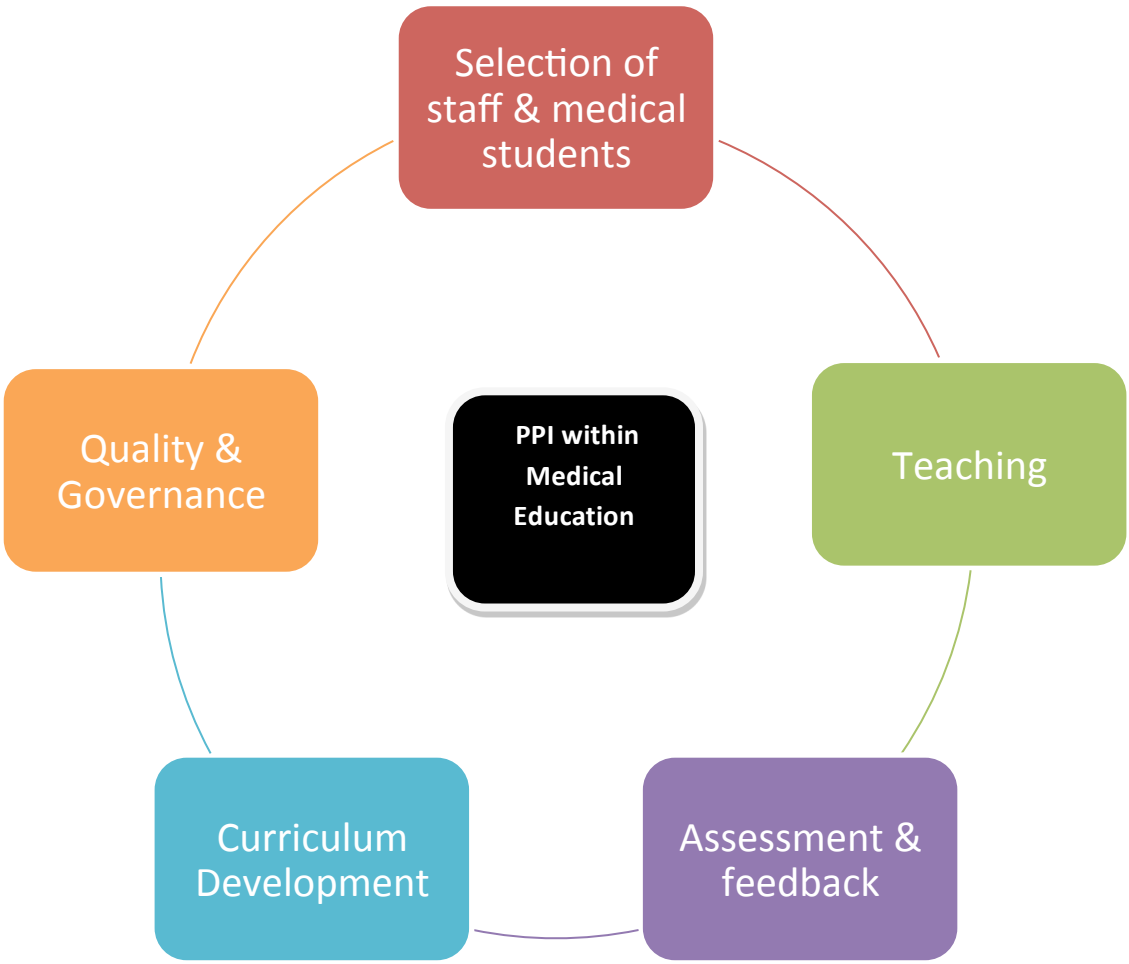
The following model proposes three areas of potential patient and public involvement. This is an adaptation and amalgamation of the work of Litva et al[5] and GMC[7] and identifies three categories firstly, users (consumers) of healthcare, interested and motivated community members (citizens) and community healthcare advocates. Whilst this helps to establish the various dimensions from which PPI can be sourced it does not intend to imply distinct categorisation or preference. In fact it is quite possible than an individual will fit into two or all three of the categories.

The types of patient and public involvement groups described within the model are described in more detail in Annex B.



11. Opportunities for Patient and Public involvement within Medical Education?

Having established that there are a range of groups who could be involved within an Undergraduate Medical curriculum, where can PPI partners make a contribution to medical education? The model below identifies five key areas. This model will be used throughout this strategy report to map the schools current PPI and to identify areas for development.



Model amended from ideas presented by GMC 2011 p.18

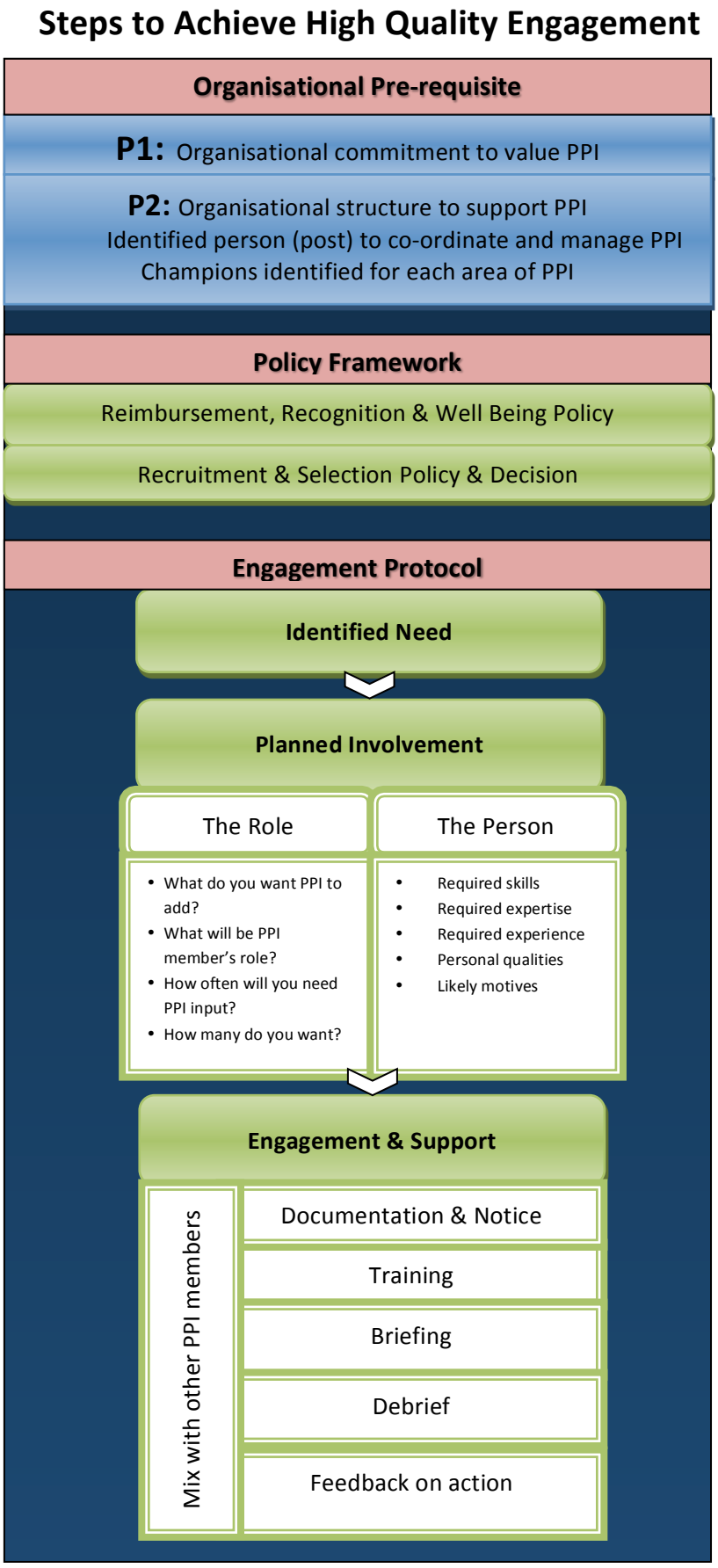
12. Current PPI within the School

The following Table maps PPI activity within the School of Medicine as at end of March 2011 against the headings identified above.

School of Medicine: Current PPI Map		
Curriculum Area / Module	**Patient Involvement**	**Public Involvement**
STUDENT & STAFF SELECTION	• Bank of nearly 40 lay people (25 used in 2010-11 cycle) involved in the recruitment of students. There were 117 interview panels in 2010-2011	
TEACHING		
ASSESSMENT & FEEDBACK		
MODULE 1	**Expert Patients** • Experiential learning(EL) i.e. alcohol misuse **'Real patients'** • Placements in hospitals & community	**Patient Groups, Third Sector, Advocates & Private Sector** • EL half day placements i.e. care homes, gyms, advocacy groups, charities etc. **Simulated Patients** • OSEE exams • Communications skills
MODULE 2	**Real & expert patients** • Half Day placements in hospitals and the community	**Patient Groups, Third Sector, Advocates & Private Sector** • SSC provider feedback • Non specific & unit specific half day placements & feedback **Simulated Patients** • OSEE exams
MODULE 3	**Real & expert patients** • Placements in hospitals & community • Longitudinal Patient • OSCE	**Simulated Patients** • OSCE
MODULE 4	**Real & expert patients** • Placements in hospitals & community • OSCE	**Simulated Patients** • OSCE
MODULE 5	**Real & expert patients** • Assistantships in hospital & community • OSCE	**Simulated Patients** • OSCE **Patient Groups, Third Sector, Advocates & Private Sector** • Cluster Projects
Curriculum Development	None	
Quality & Governance		**Lay members** • GMC Panels • Informal patient feedback

13. Effective and sustained engagement

This leads us to perhaps the most challenging question, how can effective engagement be achieved? and what are the key processes that the School must consider to support high quality and effective engagement? The following diagram identifies the key processes and considerations:



To enable to school to achieve effective and sustained engagement also first important to consider what poor engagement may look like. The table below summaries the likely indicative behavioural outcomes in relation to the effectiveness of the engagement process deployed.

Characteristics of less than adequate engagement.		**Characteristics of Effective Engagement**
Angry and Subversive	V	Passionate and Direct
Timorous and Passive	V	Open and Courageous
Uninvolved and Absent	V	Committed and Present[6]

13.1. P1 – Commitment to value PPI

The first prerequisite is that the school must; formally acknowledge the value of PPI and the contributions they may offer and have a clear commitment to change as a result of their input3.

Recommendation

- School commitment to engage with PPI and to change as a result of PPI partners input

13.2. P2 – An organisational structure to support PPI

The second prerequisite requires the School to have an organisational structure that supports and values PPI. The structure must be rational and must manage and value, but not control PPI[6]. It will also be a deonstration of the schools commitment to PPI. A central post to support and mange PPI is essential to ensure that patients and the public are appropriately supported and to manage and direct the school's strategy ensuring that PPI partners experiences are organised and professional, thus making effective and sustained participation more likely.

However, a commitment to PPI can not be the domain of one person in a similar vain to health and safety, it needs to be the school's expectation that excelletn patient and public involvement is everyones concern not just the domain of the PPI Manager or champions. To support this wherever PPI is utilised a named PPI Champion should be identified. This enables targeted development of school staff working with PPI partners and clear lines of communication for PPI partners.

Recommendations

- Create a post within the School's structure to oversee the Schools'strategic development of PPI and ensure the wellbeing of PPI partners.
- Identify PPI champions for each discipline where PPI input will be sought i.e. admissions, assessment etc..

13.3. Reimbursement, Recognition & Wellbeing Policy

Getting the terms of involvement right from the start is an essential[11] platform. The GMC7 recommend schools adopt a "fair, considerate and accessible system of rewarding patients" (p.17) and members of the publics' contribution.

Recommendation

- A School Reimbursement, Recognition, and Wellbeing (RRW) policy is recommended.

A RRW policy should ensure consistent and equitable treatment across the school in relation to financial and non-financial reward and recognition.

Initially, in August 20101, a faculty wide strategy was proposed, however due to the significant difference between the resources available to support PPI reward between the Research Institutes and Schools, it has not been considered feasible. However, some correlation is possible in the non-financial, well-being and support focused activities.

There has been growing support within research related PPI for wide spread financial reward for PPI partners to compensate them for the time given. Special HMRC guidance and exceptions have been developed and applied to any payments made to PPI participants involved in research. However, due to specific link to research related PPI the exceptions cannot be transferred to PPI participants involved in non-research based involvement activities. Reward and recognition therefore becomes a complex matter, not least because consideration needs to be given to:

- Available budget resources.
- Tax and National insurance deductions from payments.
- Protection of PPI partners' benefit conditions.
- Diversity of participation.
- Whether employment law applies.[12]

13.3.1. Reimbursement of expenses

The school should make a commitment to ensuring that nobody is out of pocket as a result of their involvement as a PPI partner within the School.

HM Revenue and Customs and the benefits system views expenses that are *'wholly, or exclusively and necessarily incurred in the course of the work*'[11] as generally not considered to be earnings. Therefore it is important that the School's RRW policy covers out of pocket expenses incurred as a direct consequence of "invited" involvement.

Research regarding current practice within the School revealed, rather surprisingly that reimbursement of travel expenses was not commonplace. This practice is not acceptable for the future and the school must look to reimburse PPI partners for the direct travel costs (in addition to facilitating paid parking arrangement) incurred by participating in 'invited PPI activities' and this should be incorporated within the School's RRW policy. The School does fund and facilitate the availability of car parking (through the provision of parking scratch cards and reservation of spaces) and this should continue.

Any reimbursement process should preferably ensure that PPI partners are out of pocket for as little time as possible7 [11]. Best practice would suggest that wherever possible costs are reimbursed on the day incurred in cash incurred or by the School directly i.e. on account for taxi's, refreshments and subsistence etc. The later approach ensures where PPI partners are in receipt of benefits, there is no likely impact on their entitlement to benefits because those involved "...on a voluntary basis can be reimbursed travel expenses from home to work and the benefits system does not treat these as expenses on income (provided they are actual and not rounded amounts)... However, reimbursed travel expenses from home to work are treated as earnings by the benefits system for those in paid involvement"[11].

The impact of any payment to a PPI partner should be carefully considered and planned because even an inadvertent breach could result in their benefit income being stopped pending enquiry and in some instances, it has been the case that through misunderstandings and errors benefits have be lost permanently**Error! Bookmark not defined.**,[11]. Clearly the School has a moral and social obligation to ensure it gets this right and time spent now planning reimbursement will be rewarded later.

One of the challenges for PPI partners who are on benefits as a result of disability or ill health, is that involvement may be interpreted as "readiness for work"[12] irrespective of whether a payment for time is made or not. The school can avoid this by providing partners with a standard letter explaining why involvement is different from work, and should not be used to measure capacity for work[12].

To ensure that partners are not of pocket the School's Reimbursement Policy should address the following;

- Travel – Car, taxi, rail etc.
- Subsistence – Provision of refreshments, lunch, accommodation etc.
- Administration – i.e. photocopying costs, telephone expenses, postage etc...
- Individual Support – Support worker, facilitator, interpreter and or communicator[12]
- Benefit impact

13.3.2. RECOGNITION & WELLBEING:

There are a number of options available to the school in relation to recognition and an important strategic decision is required:

OPTION A –Nominal (pepper corn) Payment Model

Offer a nominal payment (£20 per engagement) to all PPI partners to compensate them for their time and contribution, whilst giving individuals the option to accept or refuse the payment.

Such involvement is not usually equated to paid employment covered by a contract of employment. However, employment rights are afforded to those involved in regular paid activity (without having the status of employee). Those rights include; The National Minimum Wage, terms and conditions of engagement and annual leave. This may make this model unsustainable

Advantages	Disadvantages
Gives participants the freedom to choose whether to accept payment.	Budget require Budgeting may be complex not knowing who will/will not claim Could be costly as NMW laws likely to apply making £20 option unlikely.
The option to reject payment protects participants who are on benefit.	Administration costs and time associated with processing payments could be high.
Financial recognition acknowledges their contribution as partners.	Potential to offend some participants due to the checks required by University regulations to process the payment.
May encourage sustained engagement.	Potential to offend some participants as the remuneration level could only feasibly be a token amount. Is this indicative of tokenistic

	engagement?
	Disparity between Schools and RI's could affect ability to recruit. i.e. primary care currently offers £70/half day involvement.
	There is a substantial question mark regarding whether a nominal payment i.e. £20 per half day is considered employment. A substantial amount of time would be required to explore and facilitate this disproportionate to the likely benefits.

OPTION B – Willing Volunteer Model

Adopt a principle of voluntary involvement, offering no financial payment to PPI partners, but to pledge to appropriately support and resource their wellbeing, throughout their involvement with the school. This based on the premise as detailed INVOLVE (experts in public participation) that to most PPI partners non-financial incentives which more important than financial rewards. *"...Many people choose to become involved...for the opportunity to learn new skills, make a contribution and to meet new people. Working conditions within a group can be just as important to members of the public...as payments. It is important to support people in ways which optimise their capacity to contribute."*[12]

The School could consider adopting a 'PPI Wellbeing Charter' and could include the following commitments:

School Medicine PPI Well Being Charter

When engaged in invited activities within the school we you can expect the following treatment:

a) You will always be greeted, briefed and debriefed.
b) You will not be out of pocket as a result of your 'invited' involvement.
c) You will be sent documentation before meetings /involvement activities.
d) You will always be thanked for your involvement and contribution.
e) You will be provided refreshments and lunch, or a voucher to exchange at the school cafe for food and/or refreshments
f) When joining the school as a PPI partner you will receive an induction regarding; medical school, curriculum overview, your role and health and safety information relevant to the primary location
g) You will have access to dedicated and identified support to during your involvement. You will be offered support at meetings if you are particularly nervous, area new partner or are involved in complex or senior level activities.
h) The school will resource support for participants who require assistance to fully engage i.e. interpreters, support workers etc.
i) We will facilitate opportunities for partners to meet each other and share ideas and experiences: PPI Partner Committee every semester.
j) Where you are new to the role we will offer you the opportunity of support from an existing partner through a 'buddy' scheme facilitated by the school and existing experienced PPI volunteers.
k) Identifying and supporting skills training7 in response to generically identified needs. i.e. contributing assertively to meetings, equality and diversity etc.
l) Arrange and fund an annual recognition / social opportunity for PPI partners.

In addition to the charter non-financial reward options could be explored such as:

1. Opportunities for volunteers to benefit from being part of the wider University community i.e. discounts for cfm events etc...
2. Explore training opportunities for partners, **c**urrently the University will not allow volunteers to access relevant professional staff development courses such as contributing assertively to meetings, equality and diversity training etc. In fact admissions had to pay £400 for training for their lay panel members. This does not represent an efficient use of University resources
3. A one-off gift or payment. "...providing it is a genuine "one off" arrangement", and there is no paid involvement relationship "...it is possible to provide a cash gift in appreciation. This is similar to the practice employed by small consumer research companies when engaging members of the public in a service. "When making a payment for a one-off involvement activity, which takes place on one day only, the payment is viewed as a thank you gift. The payment should be reasonable for the activity and there should be no prior paid involvement within the same financial year"[12] the payment must come with an accompanying letter explaining its purpose (p.9).

Advantages	Disadvantages
• Focuses the school's attention and resources on high quality, best practice and supported engagement based on the premise of treating participants well throughout their involvement with the school.	• Potential inequality compared with other schools and RI's within the faculty offering high levels of payment, which could affect recruitment, retention and ability to share participants.
• Budgeting may be easier as there is less uncertainty regarding the costs involved compared with option a.	• A budget will still need to be identified to resource much of the activities.
• May encourage more truly altruistically motivated participation.	• Could be considered to be morally unacceptable not to offer payment particularly where input is lengthy, complex and or requires a high level of expertise, but this could be monitored.
• Avoids the potential to offend.	• May limit the degree to which people can afford to participate. Which could result in less diverse and proportionate representation i.e. may be only those retired could afford to participate.
• Avoids potentially complex, morally and socially unacceptable consequences regarding benefit interactions. Voluntary involvement allows for safe reimbursement of actual expenses.	• Heavily reliant on goodwill and could be considered by some to be an exploitative model.
• Gives the school the opportunity to be innovative and creative in its non-financial support activities.	

OPTION C: Employment Model

Pay all PPI partners who are working on invited involvement projects on a casual contract on a minimum wage basis.

- £5.93 per hours (over 21 rate)
- £4.92 per hours (18-21 rate)

Advantages	Disadvantages
• Offers fair pay for fair contribution	• Very costly option. Current involvement in student recruitment interviews alone could cost over £2,400 per annum before on costs and annual leave (12%).
• May encourage sustained engagement	• Financially and resource intensive i.e. administration time to raise and process the contracts required.
• May make recruitment easier	• Potential that as involvement increases, casual contract is inappropriate for the level of engagement.
• Would allow access to wider university resources through employment status.	• Overly formalises involvement processes. Moving from altruistic motivation to financial motivation.
• May force engagers to consider the value sought from engaging PPI partners due to the costs involved.	• Could prevent the school truly involving and learning from PPI partners as the cost implication could be prohibitive.
	• Could detract resources away from ensuring non-financial aspects are addressed properly.
	• Disadvantageous in participation terms. As those on benefits may choose not to engage as payment is likely to be insufficient to substitute benefit income, but significant enough to be deducted from benefits. A current lay member said to me "if I wanted to earn money I could earn a lot more elsewhere... that's not why I do it."

OPTION D: Combination Approach i.e. B & C

There is the option of combining the approaches i.e. adopting both option C and B. This could be looked on as a 'gold standard' or long-term aim where financial resources are not constrained. However it is likely to be too ambitious to consider at the moment given the substantial amount of PPI development required within the School. It is also unlikely that any payment model would be chosen as a standard due to the potentially negative consequences in widening participation terms to ensure diversity of representation of the local health care economy.

Recommendations

- Write and agree a RRWP based on the premise that
  - "...paperwork must not impose a penalty on participation. "[6]
  - Uniform and prompt approach to pre-payment or reimbursement of expenses incurred through all PPI participation.
- Develop a PPI Partner Wellbeing Charter, which will ensure that non financial reward and recognition and wellbeing of partners is consistent and considered. This charter should be known and referred to by all engagers of PPI partners and committee chairpersons.
- That the school continues to adopt a voluntary (non-payment) model of PPI. This will ensure obstacles to involvement in benefit terms and propensity to offend are avoided. The option of reviewing the situation should remain where certain partners become more intensively involved, at which point a formal employment relationship may be a more suitable arrangement.
- Explore potential for one off gift / recognition perhaps to coincide with annual social event.
- Canvas central university to open up central training courses to volunteers inc. PPI partners.

13.4. Recruitment and Selection

"There is no ideal or easy approach to recruitment. Evaluations show that a broad and balanced approach to reflecting the community is needed". However, this brings its own challenges in relation to access and ability levels. There is little point in holding huge events that attract hundreds of people, but fail to attract hard to reach / under accessed groups and hence they remain just that. There is also no getting away from the fact that certain roles will require certain people and hence targeted recruitment. The following identifies ways in which the school could recruit further PPI partners.

Capture our knowledge

A central database of school of lay participants would be valuable, which could track their current involvement and detail their skills, expertise and interests. As the pool of interested partners grows so too can the database.

Fully utilise our existing participants.

Currently recruitment takes place in silos across the school according to need and there is little or no sharing of lay participants between these silos. This is a missed opportunity as there is no reason why a simulated patient could not contribute in the student interview process or school committee. An important and low cost recruitment tool would be to explore with PPI partners already involved in other areas of the curriculum, whether they are being fully utilised or whether they are willing and have the capacity to be involved further.

Word of Mouth

It is worth considering if those already participating within the curriculum could or indeed would recommend involvement to a friend.

Define the School requirement

It is difficult to plan in detail a recruitment strategy until the number and nature of potential PPI roles required within the school is established. The School needs to be in a position where it has a

number of clearly defined PPI roles it wishes to recruit to. Then a decision will be need as to whether the school wishes to adopt a targeted recruitment strategy or whether it wants an open and broad approach to recruitment and develop a PPI pool. Once this is clarified there are numerous recruitment methods, which could be deployed;

Advertise in community education newsletter.
This would represent a relatively low cost advertising option and would reach all of our existing placement providers across the third sector and general practice. This may encourage hard to access groups to become involved with the school. There is also potential for PPI in the generation of this newsletter so that it better reflects the community.
Advertise via third sector placement providers & Community voluntary services (CVS).
This would capture all third sector providers, patient groups, advocacy organisations and interest groups across the local health economies whether they are currently engaged in placement learning or not.
Create a flier for
Advertise in local surgeries & Hospital clinics via our hospital teaching links.
A flier sent to local surgeries about the opportunity to engage with the medical school could be hugely successful in recruiting new PPI partners. In researching this strategy a number of GP's said they knew a number of patients who would enjoy the role and could even benefit therapeutically from participation.
Create a web page for PPI partners.
Engage with PPI partners in its creation, one function it could have is to act as a recruitment tool for further recruitment of PPI members. It could also contain all the important question and answer material partners may require.
Open Event
An open day style event has the potential to have multiple benefits it will raise the profile of the Medical School in the local health economy and attract potential future PPI partners. A number of different PPI roles from Interview participants through to simulated patients could be recruited on the day.

- Overview of the curriculum
- Overview of the various roles
- Opportunity to meet and ask questions of existing PPI partners
- Students could be involved in the event
- Opportunity to apply on the day

Radio Stoke
Primary Care Sciences had a great degree of success recruiting PPI partners when they started. They held an open day event and advertised it on the local radio in addition to other advertising media.
Continue to target current recruitment sources

- Amateur dramatic societies approached for simulated patient recruitment
- Stoke College
- Staffordshire University
- Keele Alumni
- Word of mouth

Selection

The work involved in selecting PPI partners should not be underestimated and should be a consideration in the recruitment method chosen. There is limited value attracting 100 interested participants where there are only 20 roles/opportunities for involvement available.

Selection activity could form a hybrid interview/scenario based activity. Where a panel is convened of say:

- Engaging group representative / chairperson
- PPI Manager
- Student representative
- 2 Existing PPI partners

The panel will need to explore through interview and a structured scenario based discussion:

- Motivation for applying
- Skills
- Expertise
- Experience
- Communication skills
- Ability and willingness to contribute effectively to a discussion
- What they feel they can bring to the undergraduate curriculum

The Interview need only be short and should not be an obstacle to participation, but should ensure that the correct person is selected for the role required there by achieving sustained involvement after the initial excitement and enthusiasm has faded.

Recommendations

- Adopt a mixture of the two targeted and siloed recruitment for some PPI partners and a more generic approach for other roles. Siloed and targeted for individual PPI roles and Generic and broad i.e. open day for group roles i.e. forums.
- Develop a central database of all school PPI partners, which can document their current involvement.
- Utilise existing base of PPI partners to explore potential for word of mouth recommendations.
- Utilise the capacity and expertise of current curriculum placement providers to recruit willing and able PPI partners.
- Selection process should involve an interview of potential partners as well as a scenario or situation based example.
- Create web portal to express PPI interest and to share PPI work / roles with the community.

13.5. Engagement Protocol

13.5.1. Identifying the need

The GMC7 highlight that engagement should take place for a specific and clearly identified purpose and that this purpose will vary according to circumstances and need. As such the PPI partners required will change accordingly. The School must commit to identify the existing and anticipated

benefits6 to be gained from PPI before progressing to recruitment and indeed engagement. This results in a clear commitment by the individual(s) or group(s) wishing to utilise PPI to plan the involvement of PPI partners and then to listen, engage, support and act upon their input.

13.5.2. Planned Involvement

Annex C is a PPI planned involvement framework, which could be utilised within the school during the early contemplation of PPI. It is anticipated that Annex C will prompt individual and groups within the school to consider and answer the key planning steps required for high quality and successful engagement. It will also act as a vital tool to recruit and select PPI partners against. It could also be used by individuals or groups within the school when evaluating and revising their existing PPI activities. It is an important step to ensuring that the reason and nature of "involvement" is clearly understood by the engager / engaging group and provides an appropriate defence to any accusation of tokenistic involvement.

Two versus One?
Another important element for consideration and important in the planning and facilitation stage is how many PPI partners do you need? Experience within Primary Care Sciences has revealed that PPI partners work better and contribute more effectively in pairs or small groups where:

A. Partners are new to their role(s).
B. Where the information or tasks involved are complex
C. Where involvement is particularly institutionally specific
D. Where emotional involvement and anxiety is potentially high

Being in pairs gives PPI partners the opportunity to temper each other if one becomes too vocal or agenda driven and also enables them to support each other if they feel intimidated by the topic or situation.

Recommendation

- Use of Annex C prior to PPI engagement
- Always consider the number of PPI Partners to be engaged

13.5.3. Engagement & Support Guidelines

Documentation
Without over formalising or creating paperwork barriers to participation, there is value in the School having a document which stipulates the role the PPI partner has agreed to undertake which needs to include:

- Brief overview of the role.
- Clarification regarding payment or non payment dependent upon the school's decision.
- Their right to reimbursement.
- Support required on an ongoing basis to facilitate involvement.
- Length, duration and frequency of the engagement.
- A date at which engagement will be reviewed.

Guidelines for chairs

It is the Chairs responsibility to create an environment which is safe and conducive to effective engagement. Each engager must have access to guidelines on Patient and Public involvement within meetings as minimum. Ideally, each chair should receive an introductory briefing to PPI and their responsibilities. A useful document, which the School's guidelines could be based upon is produced by twocan Associates (2010) focuses on PPI in research groups- guidance for chairs. With some minor modification it represents a potentially very helpful guide to facilitating PPI and group work generally. It is available using the following link: *Patient and public involvement (PPI) in research groups – Guidance for Chairs.* It will also be important for Chairs to understand the barriers to participation in relation to themselves and PPI partners. Annex D outlines some of the potential barriers.

Recommendations:

1. Ensure documentation is provided to PPI partners detailing the nature of their commitment.
2. Develop an amended version of twocan associates (2010) guide for chairs to be made available to all those responsible for facilitating lay involvement.
3. Develop short training workshop for chairs and PPI champions.

14. Opportunities for PPI Development

Student and Staff Selection

The GMC7 have identified student selection as an emerging area and that with careful selection there is great potential for patients and the public to contribute. The active involvement of PPI Partners in interviews, alongside academics and clinicians, can significantly enhance the assessment of how a potential recruit relates to other people[10].This is an area in which the School of Medicine has already made great advances, which was acknowledged by its inclusion the draft GMC7 document this year.

The School of medicine for the 2010-2011 student recruitment process

- 117 interview panels interviewing.
- 6 students per panel, totalling 702 student interviews.
- 25 Lay people were actively involved throughout the period.
- An average of 4-5 interview panels each.
- Participants typically comprise councillors, retired professionals, educationalists (including non-medical academics) and others seeking voluntary activity.
- Non-academic members of School staff are also called upon.
- Participants receive parking spaces reserved and parking scratch cards.
- Lunch is always available either at the beginning or end of the interviews.
- All Participants are trained although access to this training has historically been expensive to access.
- There is no reimbursement of expenses travel or other expenses.

Recommendations

There is scope for the following developments to enhance and maximise engagement although the precise basis depends on the admissions process used to select students.

1. Ensure reimbursement in accordance with school RRW policy. Thereby ensuring partners are not out of pocket.
2. Identify PPI Admissions Champion.
3. Develop a written role outline and person description of PPI partner role.
4. Convene a focus group of PPI partners to explore selection and discuss topics such as:
    a. The role of PPI Partners currently on interview panels
    b. How PPI partners contribution could be maximised.
    c. Alternative selection methods.
    d. How to encourage participation of current registered but inactive partners.
    e. Development of a role description and person specification for future lay recruiters dependent upon the preferred selection model.
5. Review the value gained from engaging school lay participants. It is debatable whether these are truly the best lay participants. Whilst, they are non-medical experts, they are at the far end of the knowledge and specialism continuum. Their employment relationship may limit their ability to effectively challenge other panel members. It is possible that there could be greater value to be gained from engaging non-medical school Keele staff.
6. Consider engaging partners on a defined time-scale giving the opportunity to review participation and giving a time frame to participants to commit to rather than an open ended commitment.
7. Increase the pool of PPI Partners available through recruitment exercise i.e. open day.

8. Explore potential involvement of lay members in recruitment of school staff. In the same way as there are benefits from lay involvement in student recruitment they could be mirrored in staff recruitment.

Teaching

Can Simulated Patients take on the role of PPI Partner?

The school engages patients particularly well across the curriculum in teaching. There is a well establish simulated patients programme. Although for the purposes of this strategy simulated patients (SP's) have not been considered as lay members. This is a possibly contentious decision, but it recognises that SP's tend to fall under more of an employment model, where the school dictate and control what they are asked to do and how they do it (often down to having a detailed script) and in return the School pays them on casual employment contracts at fixed rates. Consequently, the scope for SP's to input their own experiences, expertise and skills as a lay person is heavily constrained by their role. If it were possible for them to detach from their SP role it could be argued they may be able to contribute as a PPI Partner. However, they are also somewhat constrained by a degree of 'institutionalisation' and 'professionalisation' as a direct result of the degree of training and continual engagement they receive as an SP.

Annex D illustrates this continuum by placing the different PPI roles on an axis plotting increasing levels of knowledge, engagement and training against motivation to participate. It is therefore unlikely that they are unable to contribute on truly lay terms and could therefore not add the degree of value the School could gain from a truly external perspective.

Expert Patients as PPI Partners?

The school utilises expert patients in teaching across the curriculum from communication skills in module 1 through to OSCE examinations in year 5. Expert patients have been incorporated within this strategy as they are current users of healthcare, who currently receive no training other than that they may have rehearsed their story on a number of occasions (Annex E). They are unpaid, although it is commonplace for them to be provided with return taxi and refreshments and lunch on examination days. There is scope for current expert patients to engagement as PPI partners. It is recognised that patients play an important motivational role in terms of adding relevance and context to learning and helps students development of:

- Clinical reasoning
- Communication skills
- Professional attitudes
- Empathy[17]

They can be involved with facilitating seminars, demonstrating to small groups and giving presentations. However, it requires a recurrent and ongoing commitment.

Real Patients

The School currently offers students a vast array of opportunities to interact with a broad array of patients both on an ad-hoc and planned basis. However, there is a continuum upon which patients fall in relation to their degree of professionalization. This is highlighted in Annex F, which illustrates the transition that takes place from real patient to expert patient. It is worth considering when patient involvement is required as a different level of competence and confidence will be evident at each stage, which will influence the patient's ability to engage. There is great potential to capture

student encounters with real and expert patients which could add value in terms of feedback to students and to the school on quality. To avoid repetition this is addressed later in the report under recommendations for development of assessment, feedback and quality.

Recommendations

1. Identify a PPI teaching champion.
2. Ensure that expert patients are reimbursed according to RRW policy.
3. Recruit a patient representative to student professionalism and welfare committee.
4. Understand Patient continuum when planning and recruiting patients.
5. Explore potential to expand the pool of available expert patients by engaging with our third sector placement organisations, carers and support groups / advocates. They could enable access too hard to reach groups.
6. Consider involving third sector organisations in the development to specialist teaching topics or where user or carer lived experience would enrich student learning i.e. module 1 alcohol abuse; currently AA bring expert patient volunteers to speak to students about alcoholism. However, there is scope to utilise other providers and offer a more enriched and balanced experience i.e. Adsis, BAC O'connor centre, Re-Solve etc..

Assessment & feedback

The GMC (2009 p.111), states that "...all patients and carers who come into contact with the student should have the opportunity to provide constructive feedback on their performance." However, this should be achieved in a constructive and proportionate way[7]. There is minimal formal evidence of PPI in the school's current assessment and feedback processes. However, there are vast arrays of informal patient feedback opportunities within the curriculum and the challenge and opportunity is to attempt to capture and document this feedback.

Recommendations

- Identify an assessment and feedback PPI champion.
- Develop a short and simple mechanism that could enable formalisation of patient feedback to students without excess bureaucracy, enabling patients and the public to comment of their perception of a student encounter. Feedback could be immediately valuable to the student and could feed forward into their future years as students and ultimately as future doctors i.e.
    - Explore the potential for Patients to complete an MSF (Multi-Source Feedback) on long term placements i.e. mod 5 apprenticeships or for earlier feedback MSF to SSC provider in module 2.
    - Continue to utilise SP's and expert patients in OSCE and OSEE examination.
    - Explore the potential for a patient feedback diary, which students could ask patients to complete following their encounters with the student. This could be used in the following settings
        - After modules 1 and 2 half day placements.
        - After encounters with SP's
        - After PBL groups have worked with expert patients or simulated patients in experiential learning and communication skills sessions (Module 1). Expert patients commonly feedback after sessions in the tutor debriefs and statement how well the students' performed, but unless you are that group's PBL tutor feeding forward is difficult.
        - Student selected component (module 2)
        - Longitudinal patient component (module 3)
    - Consider involving PPI partners with particular specialist skills in standard setting processes. i.e. statisticians, mathematicians, data specialists etc.

Curriculum Development

The GMC recognise that Curriculum Development is arguably one of the most difficult areas to achieve effective PPI, likely because of the technical and broad nature of undergraduate medical curricula. Annex D & E help us to understand this conundrum. Asking generally, non-expert and inexperienced participants to explore highly complex, institutionally specific, technical and challenging material could be potentially daunting and handled incorrectly could leave PPI partners feeling intimidated. However, a clear school commitment to facilitate PPI together with targeted recruitment to a clear role outline and person profile could assist. It is also important to consider the value that a non-expert could add in terms of challenging the school's curriculum design in terms of its content and processes. Sometimes the simple and obvious questions like why do you do x? Or why don't you do y?. Engaging PPI partners as critical friend[6 13] could add value in terms of reducing or even removing blind spots[14].

The specific and specialist nature of the level of ability likely to be required does present a challenge in relation to achieving a diversity of representation. However this could be overcome by ensuring that loan PPI is not common place and the PPI input is sought in group situations.

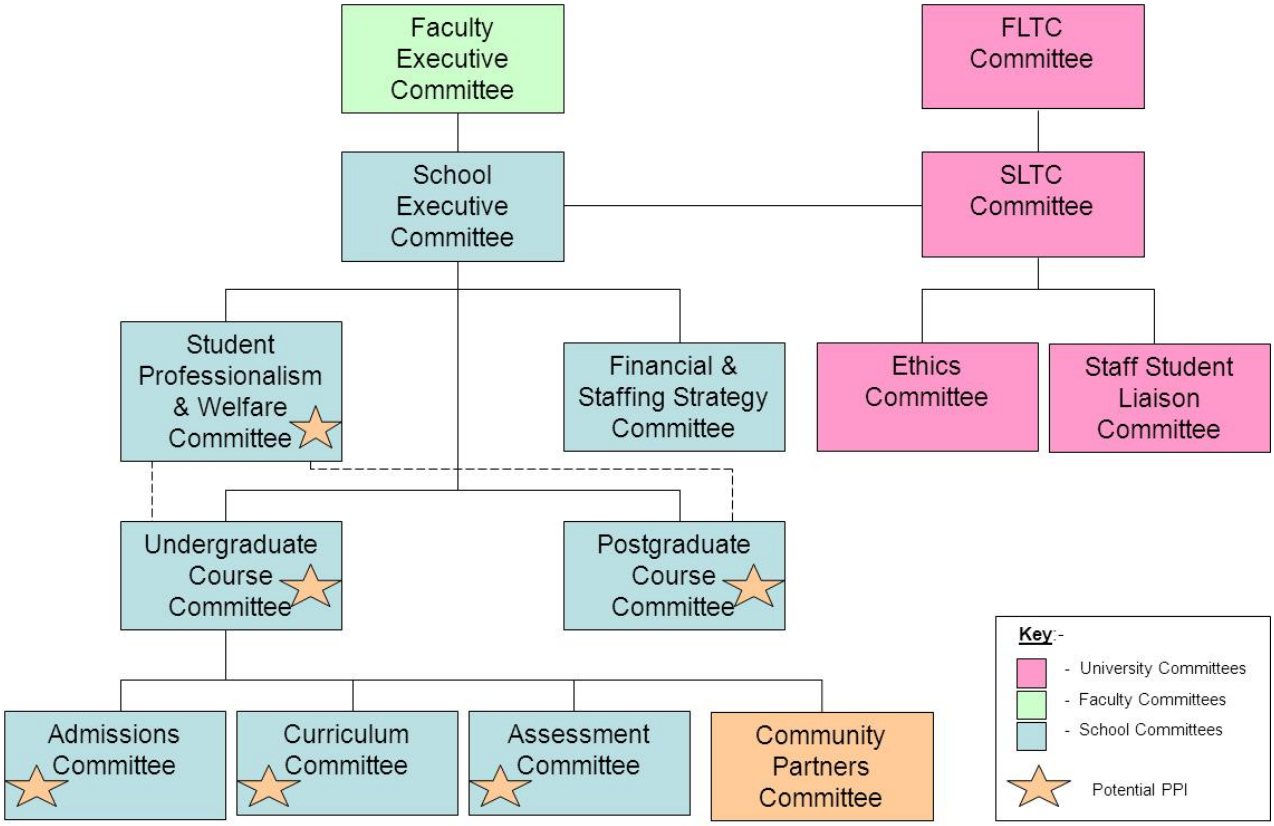
Recommendations

1. Identify a PPI Champion for Curriculum Development
2. Involve PPI partners on the School Curriculum Committee. This is a prime example of where two PPI partners should be invited, rather than one due to the complexity of the role.
3. Consider holding PPI focus groups where specialist knowledge is less of a concern, but where the engagement of a broad group of critical friends is desired. Focus group topics could explore:
    a. Assessing specific topics or curriculum initiatives - guidance suggests that perhaps specific chunked down areas may be easier to achieve effective involvement than broad discussions around curriculum development and content.
    b. Developing new curriculum areas, ideas or specialist module i.e. portfolio learning.
    c. Exploring major curriculum changes.

Quality and Governance

PPI within the school in this area is currently under developed. The GMC[7](p.32) acknowledge that PPI in quality and governance "...is a broad and challenging area, with the greatest area for effective, constructive input, which could influence strategic and long term decisions, and at the same time the greatest threat of tokenism...." Tomorrow's Doctors (2009 p.43) also states that "quality data... will include feedback from patients." And that they should have defined roles within quality management and control processes, but it is somewhat silent on wider community engagement and their role.

School of Medicine Management Structure



As identified above the school has an interesting and real opportunity to involve PPI partners within its newly revised management structure. However, this is the area where the great risk of tokenism presents. It is not as simple as putting one PPI partner on each committee. In order to avoid a tokenistic approach the following recommendations are proposed.

Student Professionalism and Welfare

There would appear a significant opportunity for PPI in relation to welfare and professionalism. An external patient perspective, could add extra value in terms of procedural integrity, from both a school and student perspective, by arguably adding a degree of natural justice. PPI partners could contribute in relation to;

- Perceived and or actual severity in relation to conduct issues
- Proportionality of sanctions

- Impact in terms of professionalism
- Societal view – what as a patient do I think...

PPI partners would require support and reassurance from the rest of the committee particularly where decision about student progression and continued participation are considered. Professionals such as head teachers, retired police officers, legal professionals could be a good fit here.

Recommendations:

- Each committee must carefully consider and plan the input a PPI partner would make and the committee should jointly complete a planned involvement framework. Considering the level of required PPI:
    - Knowledge
    - Confidence
    - General academic
    - Previous work or life experience
    - Commitment
- Targeted recruitment exercise to attract and recruit appropriately skilled and competent PPI partners for each committee.
- Each committee should consider and decide how many partners would be most effective taking into account the level of complexity and experience required.
- Each committee should develop a glossary of terminology for PPI partners or others external to the committee to refer to. This will aid understanding and help PPI partners to fit in. Management meetings can, to an outsider, seem lengthy, boring and impenetrable. Moves to make processes more transparent and easy to understand may actually be of benefit to all involved[10]
- In addition to PPI partners on various committees the School consider establishing a PPI committee composed of a broad range of participants from the following groups:
    - Users of healthcare
    - Interested and motivated community members
    - Community Health Advocates
- The committee could also act as a pre-formed and available focus group, which could explore topical issues of concern to the school. Also where relevant and appropriate.
- Chairs could refer topics to the PPI committee for discussion or borrow members of the committee for particular projects.
- The committee would provide opportunities for less confident PPI partner participation and wide engagement of representative views.
- The School could consider involving two PPI partners on SIFT quality assurance visits.
- Continue to involve PPI partners in GMC panels**.**

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15. Conclusion

It is evident that important progress has already taken place to include patients as critical friends within the undergraduate curriculum. There are significant opportunities to expand upon this and to develop the involvement of the public as partners within the School. There are some important pre-requisites that need to be agreed as a School in order to secure effective and high quality PPI and to avoid tokenistic engagement. However, with the correct structure and resources the scope to

develop PPI across the school is vast with the potential to deliver benefits to the school, students, University and the community.

ANNEX A

Strategy Research Methodology

1. **One to one interviews and discussions**

   School staff

   Julia Molyneux – admissions

   Dr Janet Lefroy – regarding simulated and expert patients

   Gemma proctor – simulated patients and expert patients & email correspondence

   Primary Care Sciences

   Carol Rhodes – Primary Care Sciences

   Pam Carter – Primary Care Sciences

   Central University

   Louise Plant – HR Officer

2. **Telephone Interview**

   Existing Lay People - Mr Andrew Worrall admissions lay participant

3. **Literature Search**

ANNEX B

TYPES OF PPI INVOLVEMENT

Users of healthcare

Current patients and carers

Patients include individuals attending a clinic or a user (with or without a carer) of a particular health or social care service.7 **Carers** or more appropriately, Informal carers[15], are those who provide unpaid care to another (partner, child, other family member or friend) who has an illness or disability and would not manage without their support. Carers , have regular and lived experience of health and social care services and have valuable experiences to share and shape future services. The GMC recommend that wherever possible input from both patients and carers be sought as they offer "distinct and complimentary perspectives". For this reason they have been grouped with patients in the model above and it is recommended that they be considered together when engaging of patients within the Medical curriculum.

Expert patient s

Patients, usually with a long-term condition, who attend clinics or access services on regular basis, have extensive knowledge of their condition and are willing to share this with students in a teaching or assessment environment.

The GMC (2011) also included an additional category ' the virtual patient', this has been excluded from this model as it is difficult to appreciate the physical contribution and interaction possible however it is quite possible that current, simulated and or expert patients, could have a valuable role in the development of virtual patient characters and their sub routines in the same way as they would for simulated activities.

Interested and Motivated Community Members

Standardised or Simulated Patients (SP's)

Typically, trained actors or role players7, who adopt a particular set of patient characteristics and scenarios and who have been trained and rehearsed prior to a session, giving the students an opportunity to learn or be evaluated in a standardised and therefore easily replicable manner, an important consideration in student assessments. SP's allow a "safe introduction to reality"[16], thereby protecting real patients from harm and allowing the opportunity for students to rewind and pausing learning without embarrassment. Carers, lay people or expert patients may volunteer to take on such a role.

Lay People

A member of the community who is not medically qualified a "non-expert", but who poses important transferable skills, abilities and expertise which enable them to bring a valuable alternative perspective to a discussion or decision making process. Examples include non-medical healthcare professionals, teachers, bio-scientists, social scientists, legal professionals, educationalists etc... However, people from many other areas of the community may be equally appropriate.

Community Health Advocates

Patient groups

Representatives who are specialists regarding a particular service, community location of particular interest group.

Voluntary and Charitable Sector "Third Sector"

Representatives from community organisations (national or local), who work closely with and, support the needs and interests of their community. Such groups typically are not medical experts but possess transferable specialist skills and interests and are able to help reinforce a bio-psychosocial approach to medicine. Such groups can play an important role across the Medical Curriculum enhancing student learning through real observable interventions and experiences i.e. There is scope for benefits to be maximised through a partnership approach, where groups with similar specialist interests, including medical experts who support the same or similar community groups, can contribute to the development and or delivery of curricula programmes i.e. Alcohol and substance misuse has been supported within the medical school through a partnership approach with Alcoholics Anonymous, Adsis and University Hospital North Staffordshire (UHNS).

Health and Social Care related private sector

This is an area omitted from the GMC's recent report; however it is an area rich in potential for student learning. For example there are private sector companies delivering commissioned projects for the NHS such as the MEND (Mind, Exercise, Nutrition, Do-it) programme. Privately run elderly care settings are also rich learning environments for students in relation to their awareness of the health and social care needs of this group. Private Allied Health (PAH) partners are also significant resource i.e. Private hospitals, Physiotherapists, Podiatrists, Chiropractors, Speech Therapists, Life style coaches, personal trainers etc...

Advocates and support workers

Advocacy groups are often incorporated within the third sector, however they are an important group to consider. Advocates support particularly community groups to ensure that their voice and concerns are heard. Again such groups are able to offer lived experiences of current health and social care users.

Each patient or member of the public is an individual.

It is valuable to understand the various groups of participants, but it is essential to treat each member as individuals as their membership of a certain group may be misleading and has the potential to stereotype and discriminate[17]. An important consideration is that students encounter a diverse array of people representative of the health economy

ANNEX C

Planned Involvement Framework

PLANNED INVOLVEMENT FRAMEWORK

Requesters' Name:	**Engaging Group:**	
Primary Location for Involvement:	**Name of PPI Champion:**	
Anticipated duration of involvement:	**Anticipated frequency:**	**Number of Partners needed:**
Hours/ Days /Weeks / Months *(Delete as appropriate)*		

Nature of Planned Participation
(*Please tick the most relevant)*

☐ **Information Giving** Mostly transferring information to PPI partners regarding what is planned or is already decided	☐ **Consultation** Consulting on a decision; offering opinions, listening to feedback.
☐ **Participation** Encouraging different ideas, thoughts, solutions; deciding together and seeking joint decisions.	☐ **Partnership** Not only deciding jointly but actually doing it together in partnership

Role Outline (In plain English)

General role overview

Anticipated benefits of PPI

Description of ideally suited PPI partner:

Please provider a brief description and indicate which group(s) would be suitable:

☐ **Users of healthcare**
☐ **Interested and motivated community members**
☐ **Community Healthcare Advocates**

Role Specifics	
☐ Ambiguous problem / task	☐ Defined problem / task
☐ General	☐ Specific
☐ Simple	☐ Complex
☐ Low Emotional Impact	☐ High Emotional Impact
☐ Low Importance	☐ High Importance
☐ Generic Tasks	☐ Specific Tasks
Person Specification	
☐ Passive	☐ Active
☐ Trained	☐ Untrained
☐ Inexperienced	☐ Experienced
☐ Simulated situation	☐ Real Situation
☐ Novice	☐ Expert
☐ General level of confidence	☐ Highly Confident
☐ Clear communicator	☐ Excellent communicator

ANNEX D

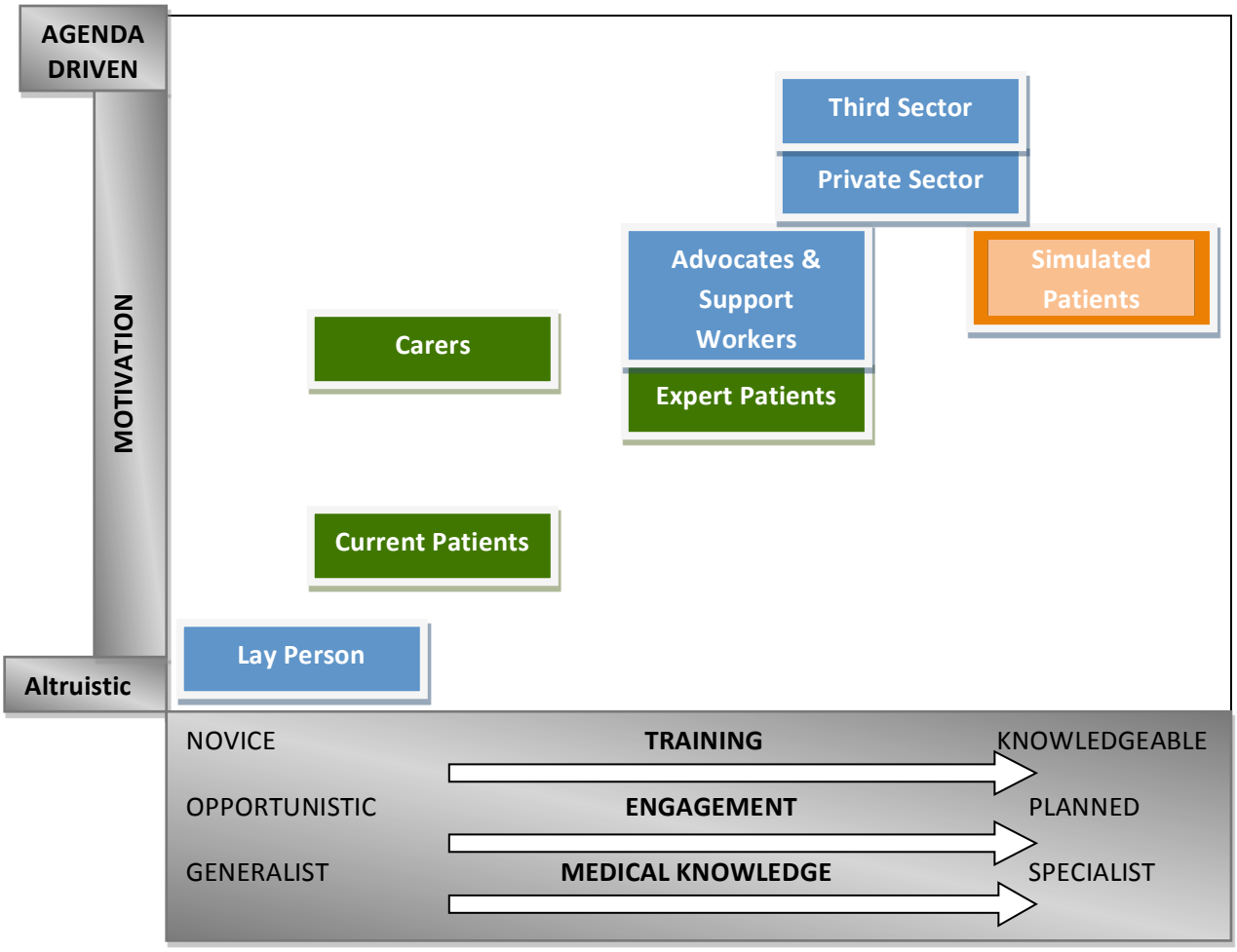
BARRIERS TO EFFECTIVE PPI

PPI Partners	Organisations
Time – Competing Priorities	Inertia – content with current and familiar ways
Isolation	Lack of resources to structure and support PPI.
Lack of confidence / self belief	Competing demands
Feeling blitzed by jargon	Lack of experience and or confidence working with PPI Partners.
Lack of understanding of learning and teaching strategies and or medical education principles	

ANNEX E

Novice-Expert and Motivation Continuum

From a patient and community perspective the figure below illustrates similar characteristics for each type of community involvement group and sub group.



It is important to consider the fluidity of movement of individuals dependant on life events for example a lay person may start out as truly opportunist, non-specialist and altruistic and then due to a change in their or their families or friends health or could through lived become increasingly knowledgeable, specialist and agenda driven. This can also occur as a natural progress to pro-longed involvement as a lay participant resulting in semi-professionalism or instutionalisation. It is also quite possible for a lay person to have an agenda in their involvement with the Medical school whilst still remaining a novice and generalist that is true of all the other roles. The model above is intended to demonstrate the breadth of areas to consider in relation the contribution possible from various groups.

ANNEX F

Patient Continuum

It is worth considering that at this stage that there is a continuum to consider when recruiting Patient members between the novice, untrained and opportunistic and the extensively trained, highly knowledgeable, planned involvement. The table below illustrates the characteristics for this continuum. It is important to consider this when recruiting a patient and therefore understand the best fit given the type of involvement required.

	Real Patients  Simulated					
Types	**Spontaneous 'real' patient**	**Rehearsed 'real patient'**	**Expert 'real patient'**	**Briefed 'simulated patients'**	**Scenario based 'simulated patient'**	**Standardised 'simulated patient'**
Application	Clinical setting	Clinical setting	Clinical setting Assessment	Classroom Assessments	Classroom Assessments	Assessments
Spontaneity	Spontaneous Unrehearsed	Somewhat rehearsed / recited	Substantially rehearsed or recited	Somewhat rehearsed Short brief	Somewhat rehearsed Short brief of scenario	Highly rehearsed and scripted
Planning	Real-time opportunistic	Real-time opportunistic	Planned	Planned	Planned	Highly Planned
Training	Untrained	Short brief	Coached	Minimal Coaching	Coached	Highly coached
History presentation alteration	Unaltered	Some alteration to history or examination performance	Substantial alteration with a simulated abnormality or complaint	Improvisation encouraged	Improvisation encouraged	Highly planned minimal improvisation
Patient Student interaction	Verbal	Verbal Clinical Examination	Verbal Clinical Examination	Verbal	Verbal Minimal clinical examination	Verbal Clinical Examination

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