Appointing ‘critical friends’ helped a cardiac unit gain practice development unit status

Using the skills of public volunteers to steer services

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- How to get the public involved in improving care
- Benefits of involving lay people in practice development
- Integrating lay members into teams with professionals
- Lessons learnt from public-patient involvement

Keywords: Public-patient involvement/Practice development/Cardiac care

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Nursing Practice

Discussion

Public involvement

The Health and Social Care Act (Department of Health, 2001) placed statutory duties on NHS organisations to consult patients and the public at an early stage about planning and organising services. The Welsh Assembly Government has said it is committed to patients and the public being involved in decisions about healthcare at a strategic and individual levels.

At the outset, public-patient involvement in the steering group for the PDU project raised several questions, including:

- How would candidates be identified?
- Would they have a minor, largely passive role as sources or recipients of information, or be more active as “critical friends” who, without being obstructive, would not be frightened to ask challenging questions?
- How would the lay representatives integrate socially into a steering group comprising healthcare professionals?

Clinical practice. PDU status recognises quality care and allows units to share knowledge, skills and ideas with other PDUs in the UK, Ireland and the US, raising care standards internationally.

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5 key points

1. By law, NHS organisations have to involve patients and the public in organising services.

2. Lay people who have not used services can be more objective than former patients.

3. Lay people can bring a broad range of skills and experience.

4. Professionals and lay people need to trust each other so lay people can take on more responsibilities.

5. Staff must be open to being challenged and lay people need to act as critical friends.

### BOX 1. ACCREDITATION CRITERIA

Units applying for practice development unit accreditation must meet these 15 criteria:
- A clear client group focus, reflected in the membership of the team
- An accreditation approach chosen by the team
- A shared vision for the practice development unit among the team
- Leadership that facilitates development, evaluation and dissemination of its work
- A framework for developing evidence and best practice
- All team members involved in self-development related to care and unit development
- A development plan identifying resources needed to achieve accreditation
- A process for disseminating evaluated practices
- Partnership with a centre of education to support practice and theory development
- A rigorous, evidence-based approach to practice
- Active engagement of the whole team in reflection and learning from practice experience
- Evidence of creativity and innovation in relation to patient care and unit development
- Evaluation of the impact of unit developments on patients, organisation and staff
- Acceptance of the role of agent of change within the organisation, region and nationally, publicising success to promote best practice
- A steering group to focus and coordinate strategic direction

Representatives would have to consider how involved they wished to become, their level commitment, the degree of influence they were seeking and what they expected to get out of it on a personal level.

Cardiac ITU/HDU is a highly technical and skilled area. Another issue to be addressed was the degree to which lay representatives needed to understand the technicalities to be able to make a worthwhile contribution to steering group discussions.

Wersch and Eccles (2001) studied four ways in which patients had been involved in a guideline development group in the north of England:
- Incorporating individual patients in guideline development groups;
- A one-off meeting with patients;
- A series of workshops with patients;
- Incorporating a single consumer advocate in guideline development groups tasked with seeking views and representing the interests of consumers.

They concluded that consumer involvement was not straightforward and each method presented difficulties. In the first scenario – similar to that envisaged for the cardiac PDU steering group – patients contributed infrequently to discussions, had problems with technical language and their contributions were not acted upon.

None of the other methods would have been appropriate to the PDU, which needed continuing public-patient involvement.

### Early challenges

Staff initially avoided the challenge from CDHPP to involve patient representatives on the steering group, feeling unsure who to ask and unclear what the patient representative would be asked to "steer".

The first representative chosen was someone the professionals felt would gladly be involved but, at the same time, would not challenge the professional group. They invited a former patient who had undergone emergency surgery and survived beyond all expectations. He was articulate and educated, but the group had not imagined that he would challenge their approaches to practice development.

What emerged was a challenging relationship in the form of his partner, who accompanied him to steering group meetings. It was this public-patient input that made the team realise they could rise to the challenge of lay involvement. Further invitations went out to patient representatives, including a retired professor in surgery. The health professionals were still cautious, however, and selected people they had given care to whose critical approach was likely to be tempered by a perceived “debt of gratitude” to the unit.

At the time, these patient representatives had limited knowledge of the organisational, economic, environmental, social and technical setting in which the unit operated, and their role was unclear.

Several authors have modelled volunteer involvement in planning processes using the “ladder of participation” concept, first proposed by Arnstein (1969). Participation is seen as a number of discrete steps like the rungs of a ladder. At the lowest rung, volunteers are kept informed but have no decision-making powers. Successive rungs allow volunteers to have increasing levels of input until, on the highest rungs, they lead, initiate action and share decisions with staff. Using this model, these first patient representatives were confined to the lowest rungs of the ladder.

Steering group meetings were held bimonthly to discuss progress towards accreditation. First stage accreditation was achieved on schedule in September 2003 and full accreditation in July 2004. The patient representatives acted largely in a support role as sources and recipients of information. Influencing practice development policies and procedures still remained out of their reach, but this was about to change.

### The PDU matures

By 2006, the steering group had become comfortable with patient representatives sitting with the health professionals in PDU discussions. It was felt that a wider lay representation might offer benefits.

The lay representatives on the steering group were all former patients; what was needed were public representatives interested in cardiac services. The health board’s clinical governance team and the patient experience manager invited interested members of the public to join the group. Several lay members were recruited who had no former links with the cardiac ITU/HDU. It was hoped these new members, who had all served or were serving on other lay bodies in the health board, might bring fresh insights and have access to useful contacts within and outside the board.

The presence of lay members brought such benefits as recognising that practice development should be concerned with the needs of not only patients but also families and carers. Issues like information leaflets, visiting arrangements, furnishings, facilities and state of decoration of the visitors’ room were given a higher priority. Keeping families informed about the progress of their loved ones and helping them through
the grieving process when patients died were seen as vital elements of care.

In 2007, the PDU was required to undergo a reaccreditation exercise – a procedure that normally takes place every two years. This proved to be a major turning point for public involvement. The reaccreditation procedure involved the steering group preparing a new submission document giving evidence of progress made against the 15 criteria. The submission is passed to CDHPP before members of the awarding authority visit.

Assembling the evidence and writing the submission document is not a trivial task but, in 2007, only the primary PDU leader had the information to do it. Due to time constraints, the steering group did not have an opportunity to read and comment on the document before it was submitted.

Although the CDHPP team recommended reaccreditation, this event made it clear to the steering group and public representatives that it was unfair and potentially risky to rely so heavily on the efforts of one individual. This was an area where the public-patient representatives believed they could make a real contribution.

Public-patient group empowerment
An early initiative was for one of the public representatives, a retired project manager, to meet with PDU leaders to help establish objectives for the next 12 months.

The guiding principle was these had to be SMART (Specific, Measurable, Achievable, Resourced and Timetabled) to allow the steering group to determine whether the project was running to schedule and what actions were needed to bring it back on track if not.

One important objective was to secure the long-term viability of the PDU by having a succession plan, and ensuring that others received the training and experience needed to understudy the primary PDU leader. Another change was that a public representative undertook to implement a recording system so anything discussed in steering group meetings was logged as a single-line entry in a document under one of the 15 PDU criteria. It was thought this would simplify the task of assembling evidence for the next submission and allow several people to work simultaneously on producing the document.

The steering group recognised the needs of both patients and their families, carers and friends. Consequently, it approved expenditure for specialised patient handling and physiotherapy equipment and for facility improvement in the visitors’ room.

Public representation had now matured to the point where one lay member felt confident enough to act as “devil’s advocate” to try and tease out what the long-term aims should be for a mature PDU where practice development had become an integral part of day-to-day activities. He posed the question: “What do we lose if we now sever our connection with CDHPP and rely on the culture of practice development being maintained by the present cohort?”

The responses were interesting. One senior nurse wrote: “I certainly think it will be good for us (and indeed patient care) to keep going with future reaccreditations. It’s an excellent reminder of why we do what we do, and why we want to put patients at the forefront of care.”

This powerful statement encouraged all steering group members to continue to focus and coordinate the strategic direction of care. It also showed how much volunteer participation had moved forward.

Moving on
In 2009, a second reaccreditation exercise was successfully completed. As planned, when the submission document was prepared, different sections were assigned to different authors – including one of the public representatives.

The PDU leader acted as editor, pulling together the separate sections and adding her introduction and conclusions. There was time for steering group members to review the completed document before the submission deadline.

Inevitably, the final document contained different writing styles, but the CDHPP inspectors saw this as evidence that the whole team – including public representatives – had been involved in its production and it therefore truly represented a consensus view. Patient representatives also helped by recording patient stories that formed part of the presentation to the CDHPP visiting team.

All six lay members were present on accreditation day and took an active part in discussions with the visitors.

The reaccreditation visit report contained a number of suggestions about how the PDU might identify its future directions. Again, it was the public representatives who had the time and skills to carry out this work on behalf of the steering group. They analysed the external political, economic, environmental, social and technical drivers to identify the opportunities and threats they might present. Project framework documents used by other PDUs were examined and a new design for the cardiac PDU proposed and approved for a trial run.

Although their involvement had changed radically from the early days, there was still no formal statement about what the lay representatives were being asked to steer. We held a facilitated session to draw up formal terms of reference then agreed a 12-month rolling programme highlighting who was responsible for what and by when, which also identifies any activity running behind schedule.

Lessons learnt
Achieving a situation where health professionals and public representatives share decisions does not happen overnight, nor is change achieved at a constant rate. Initially health professionals may be nervous of being challenged and volunteers unsure of what contributions they can make.

The breakthrough comes when both sides recognise they are not competing – that the professionals’ skills, experience and knowledge is complemented by the public volunteers. One measure of success is how comfortable the professionals are with volunteers acting as critical friends. The volunteer pool has the potential to offer an almost boundless set of skills, experience and enthusiasm that health professionals can tap into at little cost – the trick is to match volunteers’ skills to opportunities.

This initiative suggests a lack of detailed technical knowledge need not be an impediment – indeed, in some respects, it can be an advantage. For example, in the vetting of patient information, people with limited technical knowledge may be better positioned to judge whether such documents can be understood by non-professionals.

Conclusion
The cardiac PDU steering group has developed into a close-knit body where professionals have been able to use the skills offered by public representatives. They in turn have derived a great deal of satisfaction from their involvement – an arrangement that looks set to continue to everybody’s advantage. NT

References
