Meaningful ENGAGEMENT

Evidence from ENGAGEMENT is more important than evidence of ENGAGEMENT
LIFE IS IN THEIR HANDS—DEATH IS ON THEIR MINDS!

IT EXPLODES LIKE 12 STICKS OF DYNAMITE!

HENRY FONDA

12 ANGRY MEN

LEE J. COBB • ED BRAGG • E.G. MARSHALL • JACK WADDELL • JOHN MANKIN

Directed by SIDNEY LUMET • Produced by HENRY FONDA and REGINALD ROSE • Associate Producer GEORGE JACOBS

© 1957 U.S. ROBOTICS CORPORATION. ALL RIGHTS RESERVED.
“I’m involved in delivering a service and I need to know how to get people to use it”

“I’m planning a new service and I need to know how to use it so I can make it effective”
1. “I want to set up a new service or change an existing one which I want to co-produce with users”

2. “I undertake robust research and co-design so I can build in users’ experience to my design”

3. “I analyse the data thoroughly to ensure that my findings reflect users’ experience”

4. “I make changes to the service based on the experiential that I have gathered”

5. “I consult with stakeholders on the new service / changes to the service”

6. “I make changes based on the consultation results or I respond explaining why I have decided not to make changes”

7. “I use evidence from my research and co-design to design an effective communications campaign that I know will resonate with the audience”

8. “I officially launch the service and communicate with the population about it”
By the summer of 2017, the Planned Care (PC) workstream expressed an interest in gathering information on the reasons behind the diagnosis gap in SH for specific CVD related conditions such as Hypertension (HT) and Atrial Fibrillation (AF). The workstream wanted to understand more on how people moved through the different clinical pathways, in order to be able to feed this information into the redesign of pathways and so improve diagnosis rates for these conditions.

In the Autumn of 2016 Surrey Heartlands (SH) commissioned M.E.L. Research to help understand the population’s health and care priorities. We spoke to 129 citizens in seven workshops and allowed them to talk in their own words about what was important to them rather than asking them which of our priorities was most important. GPs, nurses, carers and many other healthcare professionals were extensively involved in feeding their experiences and knowledge into these discussions so citizens could develop an informed opinion. This data was fed into a survey administered to a randomly drawn sample of 1,500 people who were broadly representative of our population and brought statistical rigor to the findings from the workshops.

The SH research team ran a series of qualitative interviews with patients and clinicians to better understand the ‘lived experience’ of the HT, AF, Heart Failure and Angina pathways and mapped out the patients’ journey and common issues. Patient journey maps were developed following these interviews. This work was underpinned by the findings from the Foundation Research.

Following the Sept. workshop, the research team wrote a report on the findings and presented it at the workstream delivery board. The board used the findings along with other desk research had shown that a community pharmacy based check, similar to the Healthcheck, but shorter, less invasive and with immediate results could be useful for driving up diagnosis rates among groups that typically did not take up the offer of a Healthcheck. The working title of this service was BP Plus. The research team undertook ten hour long interviews with GPs and Community Pharmacists and nine 30 minute interviews with citizens who had been diagnosed with or who were at risk of HT or AF on this proposed new service provisionally entitled BP Plus. The research team undertook ten hour long interviews with GPs and Community Pharmacists and nine 30 minute interviews with citizens who had been diagnosed with or who were at risk of HT or AF on this proposed new service provisionally entitled BP Plus. The research team undertook ten hour long interviews with GPs and Community Pharmacists and nine 30 minute interviews with citizens who had been diagnosed with or who were at risk of HT or AF on this proposed new service provisionally entitled BP Plus. The interviews introduced BP Plus to participants and gathered evidence on the potential concerns, disadvantages and benefits for these groups. This helped establish the local antecedents of success for BP Plus and topics for discussion in the next stage of the research (Stage 9).

Running alongside the qualitative interviews the research team used the Citizens Panel to understand our whole population’s attitudes and propensity towards accessing a diagnostic type check like BP Plus in a community setting like a pharmacy, leisure centre or library (et al.). In total 695 people aged 18+ who live in Surrey Heartlands completed this survey in June 2018. The data was weighted to ensure it was reflective of the population’s demography. The Citizens Panel is a demographically representative, non-self selecting online panel of 3,000 Surrey Heartlands residents.

In June 2018, the research team ran a co-design workshop with GPs, Pharmacists, system leaders, stakeholders from the voluntary sector and Citizens diagnosed with or at risk of HT / AF to ‘fine tune’ BP Plus so that it met the needs of the local area. The workshop was deliberative in style introducing findings in plain-English from stages 1, 3, 4, 6 & 7 of this project to inform discussions. The findings from the interviews in stage 6 were used to set a meaningful context for BP Plus and helped the team develop a discussion that was known to resonate with delegates concerns and issues. Delegates were encouraged to challenge the proposal and aim to reach a consensus.

Surrey Heartlands recognises citizens’ experiential knowledge is really useful in bringing in new perspectives during service transformation. The PC work stream has a dedicated Citizen Ambassador (CA) who has experiential knowledge of CVD services in SH but is not an ‘expert patient’. They do their own independent engagement work with citizens and clinicians to support (or contradict) the research team’s engagement findings. On this project the CA had input into the design of the Citizens Panel survey and was an observer during workshops.

The project culminated in a final brainstorm event involving the project team and a wide array of stakeholders where findings and actions were broadly agreed. This ensured consensus on the findings and maximum buy in for BP Plus from the local system.

One of the areas which the engagement process had helped to identify as a priority for the workstream was the underdiagnoses of HT and AF. The workshop and subsequent desk research had shown that a community pharmacy based check, similar to the Healthcheck, but shorter, less invasive and with immediate results could be useful for driving up diagnosis rates among groups that typically did not take up the offer of a Healthcheck. The working title of this service was BP Plus. The research team undertook ten hour long interviews with GPs andCommunity Pharmacists and nine 30 minute interviews with citizens who had been diagnosed with or who were at risk of HT or AF on this proposed new service provisionally entitled BP Plus. The interviews introduced BP Plus to participants and gathered evidence on the potential concerns, disadvantages and benefits for these groups. This helped establish the local antecedents of success for BP Plus and topics for discussion in the next stage of the research (Stage 9).

In June 2018, the research team ran a co-design workshop with GPs, Pharmacists, system leaders, stakeholders from the voluntary sector and Citizens diagnosed with or at risk of HT / AF to ‘fine tune’ BP Plus so that it met the needs of the local area. The workshop was deliberative in style introducing findings in plain-English from stages 1, 3, 4, 6 & 7 of this project to inform discussions. The findings from the interviews in stage 6 were used to set a meaningful context for BP Plus and helped the team develop a discussion that was known to resonate with delegates concerns and issues. Delegates were encouraged to challenge the proposal and aim to reach a consensus.
## Hypertension patient pathway journey mapping

<table>
<thead>
<tr>
<th>Pre-diagnosis</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solutions</strong></td>
<td><strong>Solutions</strong></td>
<td><strong>Solutions</strong></td>
<td><strong>Solutions</strong></td>
</tr>
<tr>
<td>• Educate citizens: Campaigns – has your BP been checked? It could be high and you don’t know – it can cause... / online resources / apps&lt;br&gt;→ Berkshire doing a public awareness campaign ‘know your numbers’&lt;br&gt;• Clinical pharmacists do screening, prescribing, opportunistic testing, counselling around medication, opportunity here but need to communicate/let people know.&lt;br&gt;• Educate professionals so they know where to support patients&lt;br&gt;• Workplace just as not going anywhere it feels uncomfortable.&lt;br&gt;• Gymnas / dentist / hairdresser / community groups (e.g. singing / church) / waiting rooms / supermarkets / shopping centres / leisure centres can have a BP monitor to detect high blood pressure.&lt;br&gt;→ Local pharmacies – 1st site in every village, diagnosis&lt;br&gt;• Department of health and some pharmacists in GP practices but there is a lack of awareness that this is available.&lt;br&gt;• Get a letter for health check to raise more awareness and have the health check with pharmacists&lt;br&gt;• Test in travel clinic&lt;br&gt;• Wisscart – GP case finding blood pressure check on everyone who comes in. Automated machines so no to produce less ‘white coat’ syndrome.&lt;br&gt;• Prevention – link with the BHS (aging programme) on IBH 1 at the moment – shock people into changing their lifestyle.</td>
<td>• Make sure all GPs are following NICE guidelines – clear on what the diagnostics are – link to this.&lt;br&gt;• Systematic audit / patient data systems – registered as ‘hypertensive’ but coded wrong – in East Berkshire did a systematic audit and found 5,000 patients who had been coded wrong and needed a check with their GP.&lt;br&gt;• Engage GPs and Incentive Financially – QUAN shift&lt;br&gt;• Need more shared decision making&lt;br&gt;• Diagnosis – practice nurses – train them so they are capable of diagnosing high blood pressure to take the pressure of GPs.</td>
<td>• Make sure all GPs are following NICE guidelines&lt;br&gt;• Pharmacists understand and have great knowledge of medication – could adjust or change patients medication rather than GP&lt;br&gt;• Nurses and Pharmacists potentially be involved – multiple points of call.&lt;br&gt;• Government to reduce salt content in ready made meals or could think more locally – in work places – more healthy options for food in canteens as for some people this is the only option for people to eat somewhere.&lt;br&gt;• Lifestyle management – improve referral / signposting and increase opportunity to access it&lt;br&gt;• Decision aids opportunity – culture change</td>
<td>• Berkshire&lt;br&gt;• Group clinics&lt;br&gt;• Care navigators&lt;br&gt;• It can be managed in the community in the future – use more virtual monitoring e.g. enter blood pressure readings online.&lt;br&gt;• Encourage self-management&lt;br&gt;• Opportunity for nurses and pharmacists to become prescribers and manage the condition</td>
</tr>
<tr>
<td><strong>Barriers to change</strong></td>
<td><strong>Barriers to change</strong></td>
<td><strong>Barriers to change</strong></td>
<td><strong>Barriers to change</strong></td>
</tr>
<tr>
<td>• Funding&lt;br&gt;• Priorities&lt;br&gt;• How do we link up with each other with the captured data from different places&lt;br&gt;• Community champions – suffers from condition and goes out into the community to raise awareness</td>
<td>• Government unlikely to support change</td>
<td>• Government unlikely to support change</td>
<td>• Government unlikely to support change</td>
</tr>
</tbody>
</table>

---

*Note: The table contains suggestions and strategies for improving hypertension patient pathways, focusing on pre-diagnosis, diagnosis, treatment, and management solutions. Each section lists potential barriers to change and solutions to mitigate them.*
You Are Not Like the Consumer

% claim to have used in last 3 months

- LinkedIn: Ad people 93%, Normal people 14%
- Facebook: Ad people 92%, Normal people 60%
- Instagram: Ad people 90%, Normal people 62%
- Netflix: Ad people 83%, Normal people 37%
- BuzzFeed: Ad people 81%, Normal people 22%
- Amazon: Ad people 63%, Normal people 18%
- Pinterest: Ad people 47%, Normal people 30%
- Twitter: Ad people 43%, Normal people 16%
- Reddit: Ad people 38%, Normal people 12%

Source: TVAAdNation, 2016, Ipsos Connect/Thinkbox, adults 15+
Question: Which of the following websites, apps or services have you visited or used in the last 3 months?
Developing an animation to highlight the problems offenders face in accessing healthcare - a clinical engagement tool

BACKGROUND
People in prison tend to have poorer health and poorer access to health services than the wider population. To address these inequalities, community services need to be designed to include patients in prison.

Clinicians and other healthcare professionals are often unaware of the problems faced by people in prison in accessing health and care services, and therefore may not consider them when developing services which could improve their access or quality of care.

OUR PROJECT
We are making a 5-minute animated film based on patient experiences, co-produced with ex-offenders. The film will highlight some of the issues experienced by people in prison when accessing community health care services. This tool will be used to engage community clinicians in the need for improved service development for prisons and as an awareness raising tool.

This project brings together a range of professionals to help solve the problem. It is a unique collaboration between local authority, charity, academics and the NHS as well as Passion Pictures, an award winning animation production company.

SCREENING
We will screen the film with community clinicians and hold open discussions about the film’s effectiveness. We will also hold celebratory events in participating prisons alongside a panel of professionals. After screening, all parties will participate in a dialogue about involving people in prison in research.

METHODS

1. FOCUS GROUPS
User Voice charity will organise and run five workshops in different prisons, collecting diverse opinions on health and wellbeing in prison from men and women including foreign nationals.

2. ONE TO ONE INTERVIEWS
Themes emerging from workshops will inform in-depth interviews with offenders in prisons (n=15).

Interviews will be conducted with participants who need time to explore a particular healthcare experience in depth or to explore a particular theme.

3. AUDIO INTERVIEWS
Following qualitative analysis five audio interviews will be conducted with current offenders. The topics under discussion will be informed by the findings from the focus groups and in-depth interviews and record high quality audio data which will be used in the animation. This audio will provide the narrative for the final film.

4. FILM PRODUCTION
The research team will work with animators and producers at Passion Pictures to turn the themes and recorded audio into a cohesive story to form a 5 minute animated film. People with lived experience of prison will be able to input into the final animation development via a community forum convened by User Voice.