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Expert Patient Programme Toolkit

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Foreword from Centre for Mental Health

Foreword by Marsha McAdam (Ambassador and Peer Consultant, Centre for Mental Health) and **Andy Bell** (Chief Executive, Centre for Mental Health)

> **"The Expert Patient Programme exemplifies something profoundly important about the future of mental health services both in the UK and globally. It's time for a shift in the balance of power, with a more even and equal relationship between professionals and patients in mental health services.**

So much starts with the training that mental health professionals get. It instils not merely knowledge and skill but values and understanding. Ensuring that experts by experience are both co-designing and co-delivering training alongside professionals may help to educate a new generation of mental health workers with a deep appreciation for what it means to experience mental illness and to be treated for it.

Life with a mental illness is made difficult in so many ways. Discrimination may not always be as overt as it was, but it's still there in people's lives. Life with a mental illness is made too short because services neglect people's physical health. Too many people are left without enough money to live on or a secure roof over their head. And for many people, traumatic experiences are made worse when they are in contact with mental health services.

Training may not change that overnight. But it is an essential part of making a sustained and meaningful change, in creating an ethos for equality and respect. This report demonstrates how embracing the expert patient role in training psychiatrists can be a part of the solution.

We know that co-design and co-delivery aren't easy. They take work. They mean that professionals have to 'give up' some of their power. They can bring up difficult issues for participants. But the work brings you to something different on the other side. And that has lasting benefits for both professionals and patients, now and in the future.

Foreword from Doubleday Collaboration

Foreword by
Professor Dame Robina Shah
Chair, Doubleday Medical Schools Collaboration for Patient Partnership

> **"I am humbled to contribute to this vital and transformative initiative. As someone who has dedicated my career to ensuring that the voices of patients and communities are embedded within health and social care, the Expert Patient Programme (EPP) represents an exciting step forward. The EPP is more than just a toolkit—it is a commitment to patient-centred healthcare that places the lived experiences of patients at the heart of medical education.**

As healthcare professionals, we are taught to treat conditions, but we must never forget that behind every diagnosis is a person with a unique story and set of challenges.

The EPP Toolkit bridges the gap between clinical knowledge and patient-centred care, offering healthcare students and professionals alike the invaluable opportunity to learn directly from those who have experienced mental health challenges. This level of involvement not only enhances the clinical skills of future doctors but also nurtures empathy, compassion, and understanding, qualities that are just as essential as technical proficiency.

The COVID-19 pandemic has highlighted the importance of community, solidarity, and resilience. Many people faced heightened mental health challenges, and for those with pre-existing conditions, the impact was even more profound. The EPP shines a light on the strength of these individuals, empowering them to transform their experiences into learning opportunities for others. This allows patients and their families to regain a sense of agency and purpose, contributing to the education of the next generation of healthcare providers.

For too long, the voices of lived experience have been marginalised in healthcare. The EPP addresses this imbalance, ensuring that people with mental health conditions actively shape how medical students are taught. This co-production model enriches medical education while also challenging societal stigma to co-create a more inclusive and compassionate healthcare system.

As you explore this toolkit, I encourage you to reflect on the lessons it offers. Each story shared by an expert patient serves as a reminder that healthcare must always prioritise the person, not just the condition. The tools, frameworks, and insights within this document will inspire you, as they have inspired me, to continue advocating for a healthcare system where patient voices are at the forefront of care.

Through genuine partnership, we are shaping a future grounded in empathy, inclusion, and mutual respect. By working hand in hand, we can ensure that lived experiences become an integral part of medical education, creating a healthcare system where every voice is valued, and every patient is seen as more than their condition.

EPP Toolkit Preface

The aim of this Toolkit is to provide those involved in developing and delivering healthcare professional (HCP) education the resources they need to embed lived experience in their teaching.

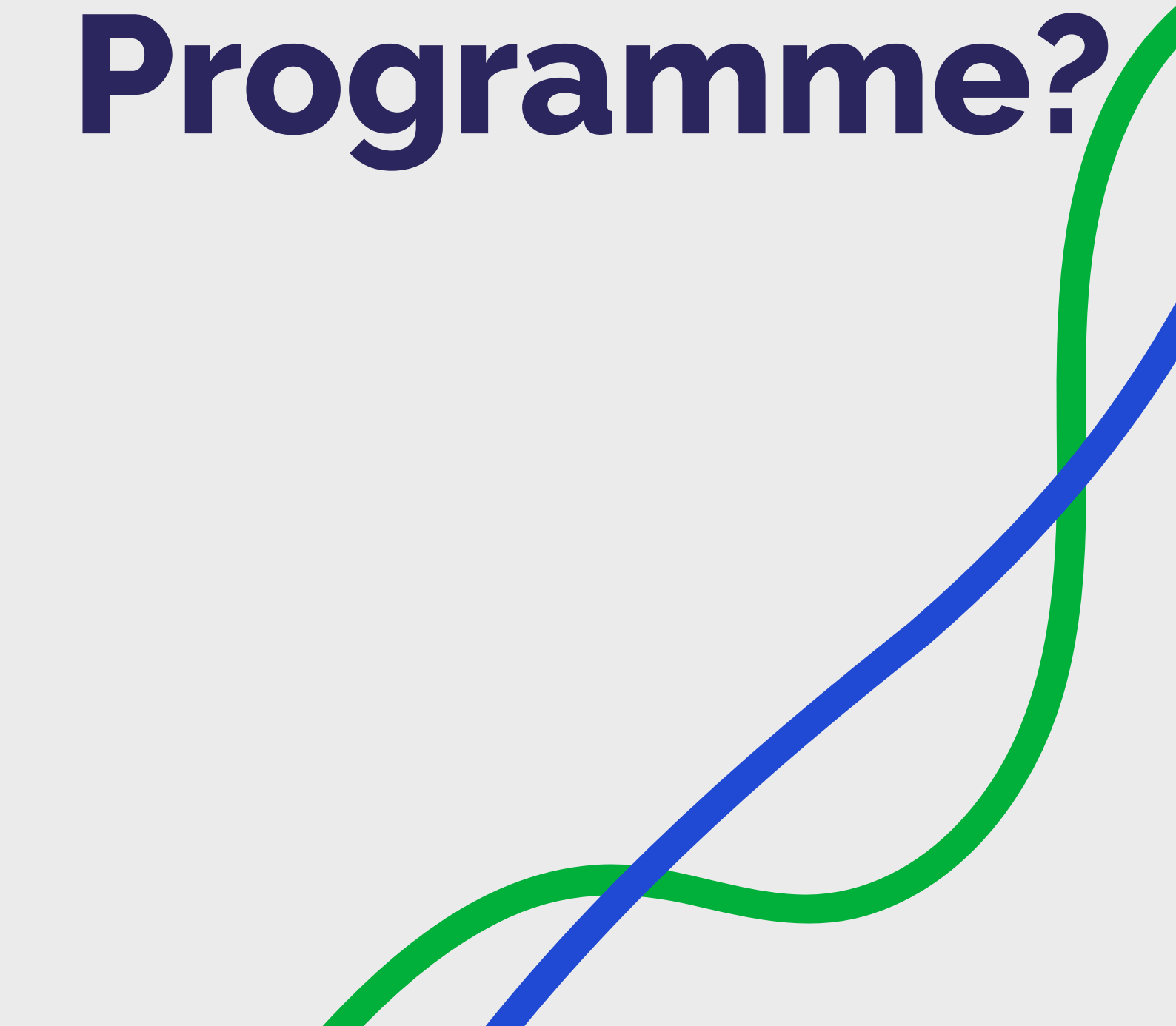
This Toolkit is the culmination of 19 years of involving people with lived experience of mental health conditions in medical education at Derby Psychiatry Teaching Unit. Patient and public involvement in teaching is required by policy, and co-production, where those with lived experience are equal developers of curriculum, content and delivery, is laid out as the gold standard of HCP education. But involving people with lived experience is not easy. There are many barriers to involvement, some of which are systemic such as policies and procedures. Some are resource-based such as having the time and the finances to adequately develop and maintain support structures. And some are personal, in breaking down stigma or navigating existing power dynamics in the classroom.

This Toolkit contains an explanation of the way in which lived experience is embedded within our teaching sessions. It contains detailed session descriptions and steps for involving people with lived experience, both as a volunteer and as an employed member of the teaching team. You will also find sample job descriptions, policies, recruitment literature and teaching materials.

Of course these are not prescriptive, but we hope these can be a helpful jumping off point for adaptation to your own context. By sharing our learning, we hope others can be enabled to overcome the pitfalls and hurdles that come along the way.

We hope you find this Toolkit useful and that it may help you take one step further towards co-production with those with lived experience, and training person-centred healthcare professionals.

Why have an Expert Patient Programme?



EP narrative from Meg

> "My mental health story starts when I was diagnosed with anorexia nervosa at 14. It has impacted on my life massively, including 3 hospital admissions, but I also believe that the tough times have made me a stronger person. My experiences have given me insight into what it's like for other people who are suffering with mental health. I believe that this can be used in a positive way to help others. I became an Expert Patient volunteer, as I believed that sharing my story, and insight into my experience, would help medical students learn better than they could from any textbook, and ultimately help patients in the future receive the best care.

At the beginning of the COVID-19 pandemic, I was recovering from a relapse after a difficult period and losing my job at the time. At this point I was not sure what my future looked like. I heard about the programme through my clinical psychologist, after talking to her about potentially looking into volunteering roles. I'm not exaggerating when I say it was one of the best things I ever did! I found it very rewarding and empowering, as you are essentially helping future doctors to be the best they can be, and they do learn so much. What I found most rewarding was knowing that I was making a difference, not only to a student's learning, but in knowing that I was helping a team of educators ensure that the next generation of doctors know the best way to care for patients with mental health problems, whatever speciality they decide to go into in future. I would say that this made me feel like I was doing something worthwhile. Knowing that people appreciated my time in volunteering for the role made me feel valued. This massively improved my mental wellbeing and general outlook on life. I developed more confidence and felt happier in myself, which vastly improved my progress in recovery.

It was challenging at times, having to open up and talk about things that are difficult for me, especially early on in my care or when I was in hospital. It was sometimes difficult to give feedback to the students as the pressure to come up with feedback put me on the spot a bit when I initially lacked confidence. But I would say that talking through my life experiences was a sort of therapy in itself, and helped me understand myself more. I also received amazing support from the facilitators to overcome these challenges, and because my wellbeing was the priority, I felt extremely comfortable in the sessions.

I have since become a Lived Experience Facilitator, working with the team in psychiatry teaching sessions and facilitating expert patient sessions myself. I love my new role, because I am passionate about the programme, and continue to find it incredibly rewarding. So, the Expert Patient Programme definitely opened doors! I would say to psychiatry departments that wish to involve patients in their teaching, very simply that they should! Both students and patients benefit enormously. Patients feel empowered and students learn so much!

intro duction

This Toolkit was co-produced by the members of the teaching team, Expert Patients (EPs) and students from Derby Psychiatry Teaching Unit (PTU).

It describes an initiative that has been running since 2009 where mental health patients are actively involved in teaching undergraduate medical students during their psychiatry placements. This Toolkit is an amalgamation of the materials and principles used by Derby PTU in their Expert Patient Programme (EPP).

A note about terminology

In the literature and in the field of medical and mental health professional education there is a huge range of terms used to describe a person with experience of a disability or health condition who is then involved in advising or educating about that disability or health condition. In our experience they have been called experts by experience, public contributors, patient educators, service users, lay facilitators and many combinations of these terms. A few years ago, we hosted a consultation with our EPs to decide how they wished to be referred to and 'expert patient' was the term chosen; yet this was still a controversial choice within the group. In this document we will refer to the patients involved in our education programme as expert patients, as this is the closest we can get to what they have chosen to be called.

The aim of this Toolkit is to describe the EPP in its fullness so that others may be inspired, and have the materials, to develop similar initiatives in other Local Education Providers nationally and internationally.

Background

Since the 1980s, the idea that patients and members of the public should have a say in their own care has led to many policy initiatives in the UK promoting partnership between patients and healthcare providers (1). In 2007 the Department of Health stated that 'patient and public involvement should be part of everyday practice in the National Health Service (NHS) and must lead to action for improvement'(2). The Health and Social Care Act update of 2012 enshrined the voice of patients in the healthcare system stating that all statutory health bodies in the UK have a duty to involve patients, carers and the public (3). This had implications for health professional training and in 2016 the General Medical Council then recommended that the development of medical school curricula should be informed by patients, families and carers as well as medical students, doctors in training, educators, employers and other health and social care professionals (4).

Although patient involvement in the UK is mostly policy driven, it is also hoped that involving patients and carers in health professional education will help to tackle some of the negative aspects of professionalization which seem to infiltrate western medicine, such as the decrease in student empathy and increase in mental health stigma over the course of their medical education (5). Even though patient involvement in medical education is growing, psychiatry has often lagged behind other specialities in its level of involvement (6). This is thought to be due to special concerns about consent and confidentiality, irrational expectations of the patients involved, emotional involvement, the ability to structure teaching appropriately, conflicts of interest and validity/reliability of assessments (7). It is also clear that, when patients are involved in teaching interventions, these are often ad-hoc, one off educational experiences for a specific group of learners rather than fully integrating patient involvement throughout a course (6, 8). If patient involvement in psychiatry is to become the norm, then there are many barriers to overcome.

Patient involvement has been found to have many positive effects on both the students and the patients involved. There is preliminary evidence that involvement of patients in medical education benefits students by increasing learner satisfaction (9), improving communication skills (10), increasing empathy, and improving understanding of the patient perspective and patient-centred care (1, 9, 11-13). There is also evidence that involvement in psychiatry

education is beneficial to the patients involved, that they feel empowered, that they are challenging the mental health stigma found in society and the current power imbalance existing between clinicians and mental health patients, that involvement helps with their recovery and also transforms the negative experiences of their mental health condition into something positive and helpful to others (14).

Patient involvement in health professional education can occur in a variety of ways and can include delivering sessions on history taking, giving formative feedback to students, sharing experiences of healthcare or personal experiences, developing mentoring relationships, involvement in summative assessments such as OSCEs, being part of a curriculum steering group, being consulted on the development of a new medical school department, participating in student selection or participating in the development of a course related to their own condition (1, 15). But there is very little information available on the support structures and governance required to make these roles successful and sustainable. There is still much to be learnt, especially about how to embed lived experience into an institution and avoiding tokenistic nods to patient involvement (15), so that partnership with patients in medical education becomes the norm. Many courses are eager to increase their level of patient involvement but require guidance in navigating the many barriers to its successful implementation and maintenance. This document is designed to show how the involvement of patients in our psychiatry placements has evolved over time in line with the governance set in place, institutional agreements and a model of increasing patient involvement (16). We wish to share our experience of setting up the EPP at Derby PTU with the hope that our experience may inspire other Local Education Providers across the country to do the same and give some guidance in how to set about doing this.

What is the Expert Patient Programme?

Overview

To get a sense of the Expert Patient Programme (EPP) we want to give a sense of what a medical student experiences of the EPP when they begin their psychiatry placement.

Liz, a student in her 1st year of clinical placements, gives an overview of the EPP:

"I went into my psychiatry placement really excited as I've been drawn to psychiatry ever since I wanted to be a doctor. When I learnt that patients had so much involvement in the teaching, I thought it was brilliant! It made me wonder why patients aren't involved in the teaching in other placements. No one knows a disease like someone who's got it. The whole placement consisted of about two days a week of ward-based teaching and two or three days' worth of more classroom-based teaching. All of the classroom-based teaching is centred around the involvement of people with lived-experience of mental health conditions.

On a Monday morning we will have our **Key Case** where an EP with a certain mental health condition shares their story about their condition, their symptoms, diagnosis and treatment history, which is an introduction to that condition. It's really good to have a certain mental health condition that we focus on for the week.

Tuesdays are mainly ward-based but throughout the placement we have the opportunity to practice our history taking in one-to-one **Expert Patient Sessions** and later on in the placement an **Expert Patient Clinic** where we take part in a mock outpatient clinic. That was the highlight of the placement for me. I really enjoyed that.

On a Wednesday morning is our **CBDT (Case Based Discussion Tutorial)** where each student prepares a presentation on a clinical case. That's followed by **PDSF (Professional Development Student Forum)** where we get to bring and discuss professional and ethical issues.

Then on a Thursday afternoon is our **Masterclass** when three or four students practice a clinical scenario and the rest of us watch. We all get a turn throughout the placement to practice these.

On Fridays we have **seminars** on various topics such as pharmacy, law, eating disorders, forensics and crisis. All the sessions had an expert patient or a member of the teaching team with lived-experience which I thought was brilliant."

Day	Time	Activity
Monday	AM	Key Case
	PM	Ward-based
Tuesday	AM	Ward-based
	PM	Ward-based/Expert Patient Sessions/Expert Patient Clinic
Wednesday	AM	CBDT and PDSF
	PM	Self study
Thursday	AM	Self study
	PM	Masterclass
Friday	AM	Ward-based/Seminars
	PM	Closing the Case

Schedule for the session

Duration of the session: 60mins

Introductions: 10mins

EP shares their personal experiences: 10-20mins

Student Q&A: 15-25mins

Debrief from lived-experience facilitator: 15mins

Key Case

Aims of the session

'Key Case' seminars focus on specific topics that the students are learning about. The sessions are facilitated by lived-experience facilitators (LEFs) and an EP and work with a group of approximately 15-20 students. The aims of this session are to help introduce the topic for the week, provide an opportunity for the students to explore the impact of the mental health condition that they are learning about with someone who has experience of it, and to help the student practice talking to someone about their experiences.

Students will be introduced to each topic from a lived-experience perspective where they will learn about: symptoms and diagnosis, the impact on life, stigma and the experience and impact of treatment from the patient perspective.

Students will be introduced to:

- How to ask questions about mental ill health
- How to do this in an empathic way
- Shown direct experiences of what is helpful and unhelpful
- The importance of social networks/support and environment

Set-up

- EP will meet with the teaching team prior to the session to discuss the content
- Students are asked to complete their e-learning reading on the topic area before the session

Content

- The LEF gives a brief introduction to the purpose and structure of the session. Students are encouraged to focus on the experience of the EP and to ask questions.
- The EP is reassured by the LEF that they don't have to answer all the questions asked and they can finish the session whenever they wish to.
- The EP shares a history of their experiences.
- Students are then invited to ask questions of the EP.
- The LEF fields these questions, makes sure the EP is happy to answer those questions and keeps the conversation moving.
- The LEF summarizes key learning points at the end, the EP may wish to leave before this.
- If the students have any questions that need to be answered by a clinical member of staff, these are communicated to the clinical facilitators (CFs) of the student's CBDT sessions later in the week.

Follow-up

- Individual follow-up for students will take place if they are in difficulty. The EP stories may trigger memories from students' own experience.
- Individual follow-up for EPs may take place, usually by the lived-experience team leader or a LEF – to ensure wellbeing, provide recognition/thanks and ensure they have contact information if they wish to receive extra support. If necessary, their case will be escalated according to the Involving Service Receivers/People with Lived Experience of Mental Illness in Student Education Policy (see appendix 1).
- Students asked to fill in feedback sheets (see Appendix 2)

"It's great the way it all revolves around the EPs' experiences. It's a really good reminder that in medicine the patient is first. You should very much treat the patient rather than the condition so the way the whole placement is set up with EPs woven into all the teaching is great."

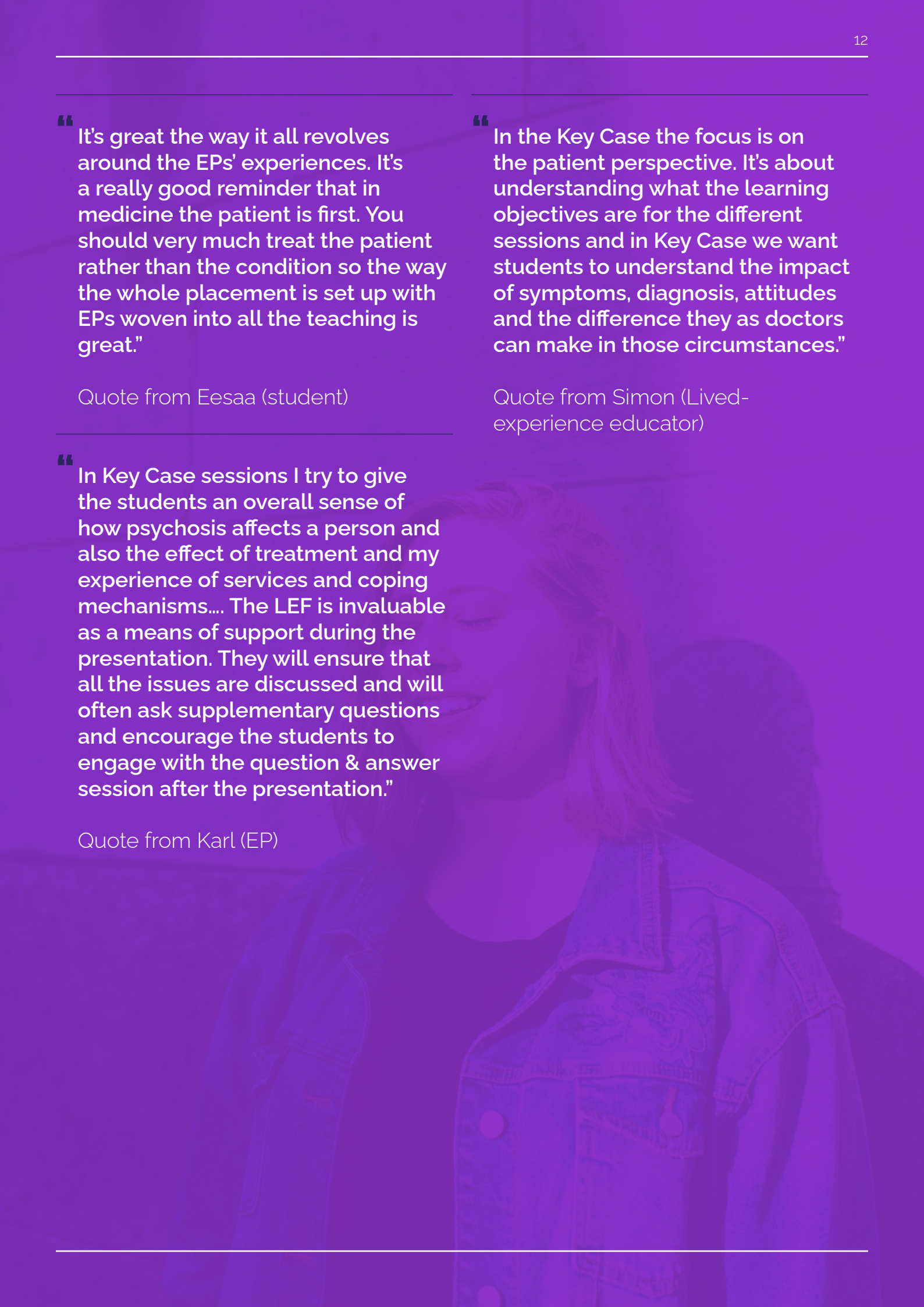
Quote from Eesaa (student)

"In Key Case sessions I try to give the students an overall sense of how psychosis affects a person and also the effect of treatment and my experience of services and coping mechanisms.... The LEF is invaluable as a means of support during the presentation. They will ensure that all the issues are discussed and will often ask supplementary questions and encourage the students to engage with the question & answer session after the presentation."

Quote from Karl (EP)

"In the Key Case the focus is on the patient perspective. It's about understanding what the learning objectives are for the different sessions and in Key Case we want students to understand the impact of symptoms, diagnosis, attitudes and the difference they as doctors can make in those circumstances."

Quote from Simon (Lived-experience educator)



Schedule for the session

Duration of the session: 2 hrs

Introductions: 10mins

Presentations: 15-20 mins each

Discussion: 20 mins eachs

Reflective Practice and closing the session: 5-10 mins

CBDT (Case Based Discussion Tutorial)

Aims of the session

A case-based learning approach is used for the clinical curriculum. These tutorials provide the opportunity for students to discuss a case which they have come into contact with during their clinical contact time and is relevant to the topic of the week. These discussions enable students to draw upon their online learning and how this relates to clinical application. These tutorials are smaller groups (10-11 students per group) and are facilitated by a Consultant Psychiatrist (Clinical facilitator, CF) and a LEF. These members of the teaching team remain consistent throughout the placement. Each student has the opportunity to present a case once during the placement and should prepare their presentation in advance of the tutorial. The other students are allocated parts of the discussion to facilitate as the tutorial progresses. Appendix 2 contains a detailed tutor and student guide.

Set-up

- The CF should be familiar with the attachment workbook, the intended learning outcomes and the online course content for that week's topic area.
- Students are given preparatory material available on their online course intranet. They also select a relevant case they have been in contact with during their clinical time.
- The CF and LEF discuss beforehand roles and responsibilities during the session. They also agree in terms of the tasks, what would be facilitated by the LEF and what will be facilitated by the CF.
- Students usually find it helpful to set up a moderated Microsoft Teams group chat to discuss and agree which students are presenting on the different weeks.
- Students are numbered so that presentations and discussion activities can be allocated for each session.

Content

- The CF reminds students about the importance of confidentiality and the need for the cases and discussions to remain in the meeting.
- CFs check whether students have had any challenges in their placement that week.
- CFs and LEFs check that students are ready to present.
- Students present their cases (usually the history, mental state examination and risk assessment).

The focus is on sharing experiences and types of presentation.

- The discussion is then led by the allocated students through the themes of the case's clinical features, differentials, risk management plan and biopsychosocial management. See appendix 3 for the detailed organisation of these roles.
- The professional and ethical dimensions of the case are discussed. If there are professional concerns about the case then the tutor will use school processes if students need further support or advice.
- The CF is mindful of the time taken for each presentation, assessing the content and the quality of each presentation, providing any missing information, answering any questions, encouraging feedback from the LEF during the discussion of each case and giving open or individualised feedback to the students.

- The LEF helps to guide the session along, prompts students in their tasks and brings their lived-experience when appropriate to the case.
- The CF then asks the students to consider what they have learnt so far and where they need to develop their learning (CFs may help to facilitate learning in these specific areas as the placement progresses).
- The CF ends the session by confirming the students' roles for the next sessions.
- Most problems that occur tend to be technical, the LEF helps the CF in ensuring that the session runs smoothly.
- CFs may decide to include a short break between presentations.

Follow-up

- The CF and LEF will then have a debrief among themselves in terms of students' levels of performance and any areas that require further focus or students who need more input. The session, as a whole, is also discussed and how it can be improved further.

"Every week we had [Lived Experience Educator], and it was good because after each of our presentations he will chip in with a little thing for us to think about, and even play devil's advocate sometimes, which again is useful. It's not always what you want to hear but it's pretty invaluable to have that."

Quote from Eesaa (student)

Schedule for the session

Duration of the session: 60 mins

Introductions: 5 mins

Discussion: 55 mins

Professional Development Student Forum (PDSF)

Aims of the session

The aims of these sessions are for students to engage with the professional and ethical issues that they witness or come across during their placement. These discussions are led by their CF and a LEF and take place directly after their CBDT sessions. Students are asked to bring professional or ethical issues to discuss. It is a safe place for students to discuss their feelings and opinions with their peers. The LEF bring their lived experience and clinical experience to these discussions. Although there is a theme allocated to each week to help guide discussion, the theme will be led by the issues and cases brought by the students. For an overview of the session and the topics allocated to each week see appendix 4.

Set-up

- Students are asked to reflect and bring any instances of professional or ethical challenge they have come across over the course of the placement.

Content

- If students do not bring their own instances for consideration the weekly allocated themes will be discussed, however it is not necessary for all themes and points suggested to be discussed. These are only to guide conversation.

Follow-up

- If any professional concerns are raised during a session that the tutor feels needs further attention they will follow up with the student and use school processes if students need further support or advice.

> "I think having [Lived-experience co-ordinator] there changed my attitude to be even more professional and more sensitive than I was before. It made me more considered about how I spoke which may not be the case when just talking to one of my colleagues or a bunch of doctors. I mean, I've had doctors say things to me about psychiatric illness which I think most patients would be appalled by."

Quote from Liz (student)


FEAR
LESS

Schedule for the session

Duration of the session: 2 hrs

Introductions: 5 - 10 mins

Each task: 6-8mins

Feedback: Approximately 10mins per task

Masterclass

Aims of the session

The purpose of the masterclass is to allow students to use their knowledge and develop their skills to undertake a range of clinical scenarios in line with the week's theme. The Masterclass teaching session allows students the opportunity to consolidate their knowledge and hone their clinical skills around a particular symptomology/diagnosis. Students are given the opportunity to role play specific tasks with a professional actor before receiving constructive feedback from a clinical and a lived experience facilitator, the actor and their peers. All students get the opportunity to complete at least one role play over the course of the placement. The remaining students act as observers and are given guidance sheets on the key points to look out for during each task. Observing students participate in feedback and discussions after each role play. The aims of this session are:

- to practice and develop communication skills.
- to enable students to practise history-taking skills in a safe environment.
- to allow time to explore and practice ways to deal with sensitive issues.
- to provide an opportunity to use knowledge gained from e-learning.
- to allow students to rehearse the skills they will use in clinical practice;
- to clarify communication and technical issues with the teaching staff.

Set-up

- Students are sent appropriate information via e-mail prior to each week's masterclass in preparation. This information includes the instructions for the tasks in which they will take the role of the doctor, an observer, or in the case of the first week, the patient (see appendix 5 for example student information).
- The actor for each week is sent the information about the week's scenario prior to the session (see appendix 6)
- CFs, LEFs and the actor discuss at the start of the session to ensure that the actor's role is clear throughout the session.
- The nominated student is further briefed to ensure they understand their task and advised on the recommended time. Another student is identified to keep track of the timings of the tasks.
- When the session takes place online, everyone is advised that all cameras apart from the actor and the nominated student are switched off for the duration of the task.

Content

- The session is split up according to the number of tasks each week.
- The objective is for students to use their knowledge and learning in addition to other clinical skills (communication, information gathering and giving, clinical reasoning, professionalism) to undertake a clinical scenario in a timely way. CFs and LEFs ensure that the student is encouraged to identify what went well in their task and other areas they felt could be improved upon. Other students are also encouraged to comment on their peer's interaction whilst having access to the observer information (appendix 5) to promote interaction within the session.
- The CFs and LEFs are mindful of the student's performance for each task, informally assessing specific areas for individual tasks and providing constructive feedback to the student whilst, encouraging other students to participate and provide their own feedback.
- On occasions, students may not have fully grasped the nature of the task and if this is the case they are supported, and guidance is provided by the facilitators.
- Sometimes participation from observing students may be limited and the facilitators may have to work hard to encourage interaction following each task by the student cohort.

Follow-up

- The CFs and LEFs have a debrief among themselves, in terms of student's level of performance on individual tasks, any areas that need greater focus and any students who need more support. Facilitators also discuss how the session can be improved in future.

> "[The LEF] would say 'OK, so from the patient's perspective, this is what I'm thinking', and it's so valuable. I guess if you want to be a good doctor who considers the patient side of things as well as the scientific side of things it's very useful. And that's not just for Psychiatry, right? You can take that kind of thing into other fields of medicine as well.
>
> Quote from Eesaa (student)

Schedule for the session

Duration of the session: 90mins

Introduction by the facilitator: 5mins

Student led interview: 60mins

EP and facilitator discussion: 10mins

Feedback: 15mins

Expert Patient Sessions

Aims of the session

This is an informal interview with an EP or carer for the student to practice their communication skills by taking a psychiatric history, assessing risk and carrying out a mental state examination. Students report that these are complex tasks, especially when asking sensitive questions, e.g. about suicide or trauma. Students can take time to develop rapport and practice talking about sensitive information in a safe environment, with lived experience facilitators observing and supporting. These sessions take place during the first two weeks of the student's placement and may be the students' first experience of a psychiatric interview. The aims of this session are for students to:

- practice developing rapport.
- practice taking a psychiatric history.
- practice assessing risk.
- practice carrying out a mental state examination.
- practice asking sensitive questions with empathy.

Set-up

- The EP is invited by the administrative team to complete availability sheets so appropriate sessions can be allocated to each EP (see appendix 7). The administrative team sends invitations to the EPs to attend EP sessions on the allocated days and times. The EP may have a meeting with the faculty team to discuss involvement, but not in preparation for each session, only the first.
- A reminder email is sent to EP the day before the session (see appendix 8) with a guide to explain the purpose of the session (see appendix 9).
- A crib-sheet email is sent to students to reassure students that the session is safe and supported, what happens in the session and how to present themselves (see appendix 10). Students are also sent a checklist of things that will be covered during the interview in the form of a history taking checklist (see appendix 11).
- The interview room is set up so that the EP and the student can easily talk to each other and the LEF is observing in the background.

Content

- The LEF begins by answering any questions the EP or student has and by reminding the student and EP of the aims of the session (see appendix 12).
- The EP is reminded that there is no pressure to be there and they can stop and leave at any time and this won't affect their involvement in future. The EP is also assured that they can choose not to answer a question.
- The student is given a hint, to start with the EP's first contact with mental health services.
- If the interview is taking place online the LEF then turns their microphone and camera off, or if the interview is taking place in person they sit in a corner of the room out of the direct eyeline of the interviewees.
- The LEF observes the session and writes notes on the student's communication, body language, eye contact, flow of conversation and person-centredness.
- After the interview the LEF re-enters the conversation thanking both for their involvement.
- The EP is asked to log off or leave the room for 5mins and think about the feedback they want to give to the students using the guidance sheet (see appendix 13). This feedback sheet is sent to the student and their sign-off consultant after the session. They re-enter the room or log back in after 5mins using the same link.
- Meanwhile the LEF asks the student how they think the interview went, prompting for positive and negative things. The LEF also asks if there is anything specific they would like feedback on.
- The EP re-enters the conversation and is asked how they think the interview went. The LEF prompts them to talk about the pace and tone of questions, language, whether they felt judged, whether they covered everything that was important (see appendix 14). The feedback that the student has asked for is woven in. The EP is always asked to state one thing the student has done well and one thing the student can improve on.

- The EP is thanked and reminded that they can contact the LEF or the lived experience coordinator for support after the session if they wish to.
- The EP leaves and the LEF asks the students how they felt about the feedback and then gives any additional feedback that they have noted.
- The student is then asked to report back to the LEF as if they were reporting back to a consultant in practice. This is more to make the student think about diagnosis and evidence from the history they have just taken rather than a right or wrong conclusion.
- The student is reminded that they can talk to the lived experience members of staff about anything they have struggled with in the session. The student is reminded to use what they have learnt in this session when talking to patients on the wards during their placement.

Follow-up

- LEF may follow up individual students in difficulty
- Individual follow-up for EPs may take place if necessary, usually by a lived experience educator/ coordinator – to ensure wellbeing, provide recognition/thanks, and suggest opportunities for future involvement, ensure they have contact information if they wish to receive extra support. If necessary the EPs case is escalated according to the Involving Service Receivers/ People with Lived Experience of Mental Illness in Student Education Policy (see appendix 1).

Ideally students will have two opportunities to take part in an EP session. Once towards the beginning of their placement and once in the second half of the placement. In the second session the LEF looks for progression from the first interview, looking at elements such as interview structure.

> "I had [EP]. She is so easy to get information out of. So much so it gave me chance to practise the technique of the 'redirect'. You know, "I hear what you're saying. If we've got time, we'll come back to it. But I've got a few questions I need to ask before the time runs out cause we've got 20 minutes and we've spent 40 minutes already"

Quote from Liz (student)

> "The sessions can be exhausting. Although I do enjoy talking to the students, my sessions typically take at least an hour and usually they are longer than this. Perhaps up to 90 minutes to go through my entire history and give feedback. Talking for this length of time is quite a challenge particularly when trying to frame the discussion and answers to any questions in a way which is accessible to the student and allows them to understand fully and context as well as the details of my experiences. After the session, I find it helpful to debrief with a member of the teaching team with a cup of tea and to discuss how we both felt the session went."

Quote from Karl (EP)

> "Patients do become upset in 1:1. And students too. It's about managing the situation. There can be something about letting it run it's course...I try and stay out as much as possible because we want the student to learn from the experience and reflect so if an EP gets upset, and they do sometimes, if I sweep in and take control then the student's opportunity to learn is reduced. If the student works it out themselves then they learn. Obviously if it all went horribly wrong then I'd shut it down and make sure the EP is ok and then that the student is ok but it's far better for the student to work it out for themselves and to learn and reflect on what was difficult."

Quote from Simon (LEF)

Schedule for the session

Duration of the session: 3 hrs

Briefing session: 15 mins

Student preparation time: 45 mins

3 rounds of patient reviews: 45 mins each (review 20 mins, feedback 15 mins, short break 10 mins)

Debrief: 30 mins

Expert Patient Clinic

Aims of the session

These sessions allow students the opportunity to practice skills in a replicated outpatient clinic environment. The aim is to provide a relaxed and encouraging learning environment where students will support one another and gain experience and knowledge through actively reviewing patients. Students are given the opportunity to interview an EP as a review assessment before receiving constructive feedback from the EP and from the other student present. Expert Patient Clinics provide students with a safe and encouraging learning environment to develop their skills. However, as EPs are 'real patients' there is some uncertainty as to how they will present on the day. This is all part of the experience for the student. These clinics normally take place in the second half of the students' placement when the student has had the opportunity to observe psychiatric reviews in outpatient clinics.

The aims of this Expert Patient Clinic sessions are:

- to enable students to practice and develop communication skills .
- to enable students to practice patient review skills in a safe environment.
- to allow time to explore and practice ways to deal with sensitive issues.
- to provide an opportunity to use knowledge gained from e-learning.
- to clarify communication and technical issues with trained facilitators.
- to practice for the consultations required for outpatient settings.

Set-up

- Clinics are organised with 3 EPs attending each session.
- 9 students attend each clinic
- EPs are contacted by a LEF the day before the teaching session to reassure the EP, confirm their consent to take part and address any concerns or questions.

Content

Introduction

- The clinic is facilitated by a consultant, a senior clinical nurse educator and a LEF.
- The students arrive for the session and are briefed on the aims of the session and the structure. They are given the opportunity to ask any questions and are then split into three groups of three students.
- In their groups the students decide which review they will complete with each patient. See appendix 15 for the organisation of the groups.
- The students are given preparation time to read the history of each patient and to prepare for the review. During this time the teaching team are on hand to offer information and support. Students are expected to work together in this process through discussion and research.

Patient assessments

- The EPs arrive an hour later than the students. They are given refreshments and asked to wait in the 'waiting room' as in an outpatient clinic. A LEF and a member of the admin team check in with the EPs to ensure they are comfortable and still willing to be involved.
- Each group of students are given their own 'clinic room' where they remain for the duration of the clinic.
- The student conducting the review will call the EP into the clinic room to complete the review. The review itself takes approximately 20 mins and is followed by 10-15 mins of group discussion. The EP provides the initial feedback, leading on to the group discussion and feedback from the CFs/LEFs and student peers. Learning points are identified before the end of the review and the students have the opportunity to clarify points or ask any questions.
- After the review is completed the EP returns to the waiting room. There is a short break between reviews and the EPs are supported by a LEF in the waiting room area.
- The process is completed with each group of students seeing three EPs and each EP being reviewed three times over the course of the session.
- Different types of reviews are conducted with each patient to prevent too much repetition for the EPs. For the different review types, see appendix 16.

Debrief

- Once all reviews are completed the students come together for a 30 min debrief led by a CF. Students are encouraged to discuss how they found the session. Where there are common themes these are discussed further.
- Main learning points are identified from the students and the session is brought to a close.
- All participants complete feedback forms

Follow-up

- Facilitators may follow-up individual students in difficulty
- Individual follow-up for EPs, usually by a LEF – to ensure wellbeing, provide recognition/thanks, and ensure they have contact information if they wish to receive extra support. If necessary the EPs case can be escalated according to the Involving Service Receivers/People with Lived Experience of Mental Illness in Student Education Policy (see appendix 1).

> "I find the EP sessions an absolute honour and privilege, to be part of the unit's team and everyone involved to shape potential future psychiatrists. The majority of the students are so willing to try, ask questions and show a great amount of interest to really get to learn more from me as an EP. I try to give them the freedom, flexibility and non-judgemental attitude to really get their confidence up, before going in to the 'real world' with very vulnerable members of public. Yes, it is exhausting sometimes when a student is struggling to ask questions and probe but by the next day my low mood is back where it normally is. I think the secret to the unit's success is everyone is equal, everyone works together and everyone from the top to the bottom helps to shape the course."
>
> Quote from Sam (EP)

> "I was surprised, pleasantly surprised at the realism of it. Because when you're in an OSCE, normally you don't quite have the heat of interviewing a real patient who's had real experiences. An actor will never really be able to fully replicate the way somebody with a certain psychological condition acts And so I think the realism of it helped me to feel the kind of the pressure it puts you under in that moment. Very good practice for the future."
>
> Quote from Eesaa (student)

> "It was a lot better than an outpatient clinic. While in the outpatient clinic it's very, very useful to actually see how one works, you're more in charge in this one and you've got a lot more responsibility."
>
> Quote from Liz (student)

The Set-up of the Expert Patient Programme

Setting up the EP programme was a long process with many hurdles. It involved leadership, culture change and working through practicalities and safety of patients, students and academic staff. In this section we will describe the process of setting up the EPP and explain how we overcame some of the obstacles. We will also show how embedding the patient experience in our teaching is an ongoing process where we are always asking, "what is the next step?".

How it all got started

Professor Subodh Dave and Alexa Sidwell

Leadership

Establishing and embedding lived experience into a teaching programme all begins with passionate leadership. There must be passion for the importance of lived experience in the programme leads which trickles down to the teaching team. In 2006, the new Graduate Entry Medicine (GEM) psychiatry programme introduced programme leads in the form of Teaching Fellows. The Teaching Fellows at Derby PTU had an ambition to progress and embed lived experience within the teaching programme. Their aim was to develop a range of clinical teaching activities with service users at the heart of its delivery. A senior clinical educator was specially appointed with the sole aim to develop this programme. As there was limited service user involvement, it was important to employ a programme lead with experience in service user involvement and strategy to help initiate change and overcome challenges, such as introducing new roles into an organisation and establishing an infrastructure.

> **"I was recruited in 2007 to lead development of the Patient Experience Programme, as it was called at that time. Having experience of working in service user involvement arenas, and of developing new service user posts such as Support Time Recovery workers and Youth Workers in Early Intervention, was helpful in introducing new roles into the PTU. At the time of my recruitment to the PTU, service user inclusion was still relatively new in medical education in psychiatry, although better established in physical health care such as the Derby GEM school Volunteer Patient programme in rheumatology."**
>
> Quote from Alexa Sidwell

The Consultation Group

A consultation group of service users was established at the start of the programme. This core group participated in advising and collaborating in the development of the new programme and helped recruit new team members and our first EPs. This ran in tandem with our participation as a research site for the Time To Change study, a programme in England to reduce stigma and discrimination against people with mental health disorders run by Mental Health Media, MIND, and Rethink and evaluated by the UK's Institute of Psychiatry at King's College London.

Governance

Working alongside knowledgeable, experienced partner organisations was crucial for the development of the programme as a safeguard of service users' welfare. Establishing links to numerous service user involvement programmes was essential in providing the guidance and structure required to build up the EPP over time. These programmes and organisations included Mental Health in Higher Education (MHHE), the Recovery Network, Rethink (Time to Change programme) and also links with local service user groups such as Derbyshire Voice and the local Mental Health Advocacy Group.
The MHHE group was especially helpful in enabling our PTU to gain expertise, support and guidance on how to develop the teaching programme inclusively and safely. They provided supervision for the process and networks who could be called on for advice. Their publication 'Learning from Experience: Involving service users and carers in mental health education and training'(16) became a point of reference for the process we would follow.

MHHE Ladder of Involvement

The MHHE introduced us to their 'Ladder of Involvement'. This is a framework for evaluating and progressing involvement adapted from Goss and Miller (1995)(17) and underpins the evaluation processes set out in the National Continuous Quality Improvement Tool for Mental Health Education. This was a useful tool used throughout the process of setting up the EPP.

Level 5: Partnership
Service users, carers and teaching staff work together systematically and strategically across all areas – and this is underpinned by an explicit statement of partnership values. All key decisions made jointly. Service users and carers involved in the assessment of practice learning. Infrastructure funded and in place to provide induction, support and training to service users and carers. Service users and carers employed as lecturers on secure contracts, or long term contracts established between programmes and independent service user or training groups. Positive steps made to encourage service users and carers to join in as participants in learning sessions even if they are not (yet) in a position to achieve qualifications.

Level 4: Collaboration
Service users / carers are involved as full team members in at least three of the following in relation to a course or module: planning, delivery, student selection, assessment, management or evaluation. This is underpinned by a statement of values and aspirations. Payment for teaching activities at normal visiting lecture rates. Service users / carers contributing to key decisions on matters such as curriculum content, style of delivery, learning outcomes, assessment criteria and methods, student selection and evaluation criteria. Facility for service users / carers who are contributing to the programme to meet up together, and regular provision of training, supervision and support. Positive steps to encourage service users and carers to access programmes as students.

Level 3: Growing involvement
Service users / carers contributing regularly to at least two of the following in relation to a course or module: planning, delivery, student selection, assessment, management or evaluation. Payment for teaching activities at normal visiting lecturer rates. However, key decisions on matters such as curriculum content, learning outcomes or student selection may be made in forums in which service users / carers are not represented. Some support available to contributors before and after sessions, but no consistent programme of training and supervision offered. No discrimination against service users and carers accessing programmes as students.

Level 2: Limited involvement
Outreach and liaison with local service user and carer groups. Service users / carers invited to 'tell their story' in a designated slot, and/or be consulted ('when invited') in relation to course planning or management, student selection, student assessment or programme evalutation. Payment offered for their time. No opportunity to participate in shaping the course as a whole.

Level 1: No involvement
The curriculum is planned, delivered, and managed with no consultation or involvement of service users or carers.

The balance of power

Having reviewed our position on the Ladder of Involvement it was apparent that we had made significant progress towards collaboration. However, there was evidence emerging about the balance of power between teaching professionals and service users involved in teaching (18, 19).
Over the past decade, Social Work courses had begun to recruit service users into teaching posts. Birmingham University recruited Service User Lecturers to teach on their Social Work courses. It was this that inspired the idea to recruit people with lived experience of mental illness into the PTU, to help shift the balance of power from clinicians, prevent tokenism, value participation, promote collaboration and move towards co-production of psychiatry education. By having people with lived experience recruited into our team it would help further embed the lived experience into the teaching programme. This led to the development of the Lived Experience Development Worker posts.

The Lived Experience Development Worker posts

To develop these posts a proposal was drafted and presented to the university course management committee. Because these were new posts, working within an environment where professionals were in positions of power, two posts were requested, so that they could support each other to voice their views and opinions. Funding for a trial period of one year was approved.
The job descriptions were adapted from the University of Birmingham's job descriptions for Service User Lecturers in their Social Work course and circulated to the consultation group. They were submitted to the Agenda for Change panel for banding and the post was assessed as a band four post. See appendix 17 for the full job description.
In April 2015, we recruited two people into post. Following review of their involvement, these were later made substantive.

Lived Experience Educator Post

Throughout their employment, the roles of the lived experience development workers were evaluated and reviewed in line with Trust Workforce policy with regular supervision and appraisals. One post holder desired to progress into a more formal academic role and was supported to complete a Certificate in Medical Education. A new role of Lived Experience Educator was developed for him. For the job description for this role, see appendix 17. He is currently studying for a Masters in Medical Education.

Lived Experience Facilitator Role

In 2021, a change in university organisation meant that we had a great increase in student numbers. As the number of students increased, we required a greater number of EPs to fulfil the teaching requirements of the course. We also wished to increase the employment and career opportunities available for EPs and design a job role where they could be supported in an understanding environment. We therefore developed the role of Lived Experience Facilitator. This role would be open to people without an undergraduate degree and was assessed at Agenda for Change band three.
The primary aim of this role was to facilitate the one-to-one EP sessions and to co-facilitate other teaching sessions with clinical colleagues. It was felt that many of the EPs currently volunteering on the EPP could fulfil this role and that it would enable clinical team members to move away from supervising these tasks to focus on the more skills-based teaching. For a job description of this role see appendix 19. One of the original, LEFs has now moved onto the Lived Experience Coordinator role and oversees the LEFs and the EPs involvement.

Future steps

Over recent years there have been great strides in improving the power balance of academic and lived experience faculty members. But we are aware that there are moves we could make to further ensure that lived experience is embedded in the culture of our teaching team. In future we would like to develop the EP training into a more robust and accredited training programme that could be recognised by other institutions.
There are also certain areas of patient experience that would require a special focus. We would therefore like our lived experience facilitators to develop specialities and lead on certain areas such as the involvement of BAME communities, learning disabilities or eating disorders.

Recruitment and Training of EPs

Recruitment and training of EPs is an important element of the programme as outlined in the Involving Service Receivers/People with Lived Experience of Mental Illness in Student Education Policy (see appendix 1). It is mostly overseen by the Lived Experience Educator/Coordinator and one of the senior clinical educators. The programme is always open to new EPs. There are not specific times when recruitment is 'open' or 'closed'. Due to the nature of the mental health conditions that the EPs live with there will be times when EPs are not able to take part in teaching and therefore it is important to keep recruiting a steady stream of EPs to ensure there are enough to cover all of the teaching slots and unforeseen absences.

There are four main sources of recruitment of EPs:

- Our service user community network e.g. on X.
- Psychiatrists suggesting involvement to their patients.
- Presenting at community groups e.g. the Bipolar UK group.
- Word of mouth on the wards we teach.

An example of the leaflet put into GP surgeries can be found in appendix 20.

First contact is normally made by the Lived Experience Educator/Coordinator by email or phone. In this conversation the potential EP is told about what takes place in the teaching unit and the set-up of the placements and teaching activities. The Lived Experience Educator/Coordinator often shares some of their own experience of mental health problems, seeking to reassure the potential EP that the faculty team at the PTU understand that there will be good days and bad days and that their mental health condition is not a barrier to them being involved.

After these initial conversations the potential EP is then invited to the PTU for a tour and a face-to-face conversation to answer any questions they may have about involvement. At this time, they are given an EP induction pack (see appendix 21). The induction pack contains an introduction to being an EP, summaries of various teaching activities (appendices 21, appendix 9), consent forms (appendix 22), a patient data form (appendix 23), information about claiming reimbursement (appendix 24 and 25) and a draft letter to inform their care team of their involvement in the programme (appendix 26) It is important in these conversations to be candid about how involvement can be triggering and distressing, but also explain the support that would be available to them. The potential EP may want to become an EP at that point, but they may also want some time to decide, in which case the Lived Experience Educator/Coordinator will contact them again after a week to see if they are still interested in getting involved. As a condition of involvement all EPs must give the PTU contact information for their care team or GP (see appendices 1, 22 and 23) so they can be contacted if needed. Throughout the process potential EPs are told that there is no pressure to be involved, that they can cease their involvement whenever they wish and that, if they have a bad day, it will not affect whether they are invited back again.

Becoming an EP is open to anyone who has experience of mental ill health, however EPs are made aware that violence or aggression in the teaching unit would not be tolerated and that the teaching activities are not a forum for complaining about services or students. The ethos is one that first and foremost aims to train the best doctors possible, therefore experiences of services may of course form part of their narrative but the aim of the session is educational.

Preparing for the teaching sessions is informal and personalised depending on what the EP requires. All EPs start by getting involved in the one-to-one EP sessions as this is thought to be the least threatening environment with only one student and one LEF present. The activities required in these sessions, of telling their history in response to student questions and giving feedback to students, are the foundation activities which are only elaborated on slightly for other teaching activities such as Key Case and the Expert Patient Clinic. The conversation about what other activities the EP would like to be involved in is often revisited when an EP comes to the PTU for a teaching session.

Increasing the diversity of Expert Patients

One of the concerns with service user involvement is that those who get involved are often not representative of the general population or of the patients that qualified doctors will care for. We recognised that our group of EPs represented a very narrow section of the patient population in Derby and we needed EPs who would be able to represent the diversity present in Derbyshire in terms of race, culture, gender, age and sexuality.

To do this we devised a strategy to intentionally encourage participation from more diverse communities.

1) Many of our EPs are recruited through the recommendation of their psychiatrist. We therefore informed psychiatrists that we were looking for individuals from more diverse communities.
2) We met with local community leaders from the black and minority ethnic communities through the local council BME forum and promoted the EPP.
3) We attended local community events such as world mental health day and Trust community events, hiring a stand and giving out promotional material.

This strategy was successful in increasing the diversity of our EP group.

Once this was achieved it was crucial that EPs were able to show the impact of their background on their experience of mental health services. These EPs were encouraged to reflect on how their cultural heritage, race or sexuality impact on their attitudes, beliefs towards mental health or the level of stigma and discrimination they may have received from the healthcare system. They are encouraged to speak about this when sharing their experiences in their teaching.

Over time, as the EPP expands it has become important to periodically re-evaluate the diversity of the EP group and whether we need to specifically target certain community groups to ensure that our EPs are representative of the general population.

Support for EPs

Simon Rose & Alexa Sidwell

The support processes that need to be in place to effectively, and safely, integrate people with lived experience of mental illness into the teaching of medical students can appear daunting. Our experience gained over the years that the EPP has been delivered in Derbyshire is that it does not need to be so. We have found a common sense, well thought out approach to be enough.

We suggest here that support falls into four areas:

1. Practical support needed to ensure that patients can take part in teaching activities
2. An established protocol to deal with the situation where patients are either unwell when they attend the teaching, or become unwell during the teaching
3. Broader support of teaching participants
4. Programme support

We argue that the first two criteria, above, are integral to the safe involvement of patients in educational programmes. The third is helpful to patient participants and can encourage a sense of belonging and support, such as one might find from colleagues. However, it is not essential to the running of a teaching programme involving patients.

Practical support for involvement in teaching

A common-sense approach that is focussed on the needs of the individuals involved is helpful. Whilst there is no single method that will be suitable to all potential EPs or teaching units, we feel that the following should be considered:

- An effective induction to the teaching programme is required. EPs should know what they are going to be asked to do, for how long, for how many learners and how they will be reimbursed for their time/expenses. Time should be taken to ensure that they fully understand the programme, including the emotional impact it may have on them and any potential financial implications, i.e. relating to benefits. (see appendices 21 and 25)
- The individual needs to know how the programme will benefit them, e.g. social contact, purpose and value to their work, how it might contribute to their skills development (for future employment)
- As a matter of good practice, EPs should be reminded that there is no pressure to take part in any teaching session, or indeed, do not need to take part in the whole session. Withdrawal from it will not impact on the care that they receive and will not preclude their involvement in future teaching activities. It is suggested that this is explicitly stated during induction and as part of the briefing of every teaching session.
- Support should be offered to deal with any practical issues that an EP may encounter which could become a barrier to involvement in teaching. As an example, it has been helpful to offer 'practice sessions' to allow some EPs to gain confidence in the use of online technologies during the COVID-19 pandemic. The characteristics of each individual need to be considered. E.g., think about the person that you are working alongside; if they struggle with reading and writing, expecting them to fill in feedback forms is not helpful, think about how you can enable learners to access the knowledge of the participant with the least amount of inconvenience to the EP concerned.
- Each session should end by checking in that the EP is 'OK'. It is essential to provide enough time to debrief, where identification of any issues or distress can be picked up early and discussed, and further actions arranged, if necessary (see section below). Best practice here is that EPs have a way of contacting the teaching team in the hours after a teaching session. Our EPs report that knowing they can contact the teaching team if they feel flat after their adrenalin levels subside is helpful. Our experience is that such contact rarely happens; however, having the scaffold around the EP in case it is needed is helpful.

When an EP becomes unwell

The teaching team should not become part of an EP's care team. However, sometimes information about a patient's health and well-being should be passed to their care team for follow up. This process is stipulated in the Involving Service Receivers/ People with Lived Experience of Mental Illness in Student Education Policy (see appendix 1).

We recommend that details of an EP's care coordinator (or CPN, consultant, GP) are recorded on induction into the teaching programme. Potential EPs complete a form in their induction pack, (see appendices 23 and 26). Participation in the programme should, we feel, be contingent on this information being provided. It is helpful to have conversations during induction around the fact that being unwell does not stop people taking part – but the teaching team owes it to the EPs who work with them to ensure, as much as possible, that they are safe and well.

Broader support

Supporting people to deal with ongoing issues in their lives, such as helping to complete benefits claim forms, support with dealing with utilities providers, references for employment (reliability, time keeping, character) and everything in between, helps to engender a sense of mutual respect and reciprocity. Whilst we have found this helpful in the development of strong, supportive relationships with our participant cohort, it is acknowledged that we have a well-resourced teaching department that is fully committed to collaborative ways of working. Other settings are not in the same position regarding resources. We consider this to be a 'nice to do if you can' rather than a process that is necessary to safely and effectively integrate patients into teaching.

Programme support

Regardless of resources, a teaching programme that involves people who have/are experiencing mental illness should strive for a culture that promotes and supports participation. Approaches that can enable this include:

- **Meetings** – to share information, including student feedback on the programme, to consult on developments, to socialise with other EPs and to provide any training that may be required. These meetings help EPs to gain a sense of value and purpose in their work.
- **Letters and newsletters** – to share up-to-date information. These newsletters provide information about current teaching and events within the department and other opportunities for participation, both inside and outside of the teaching programme.
- **Collaboration/co-production in developments in the teaching programme** – for example: reviewing curriculum and teaching materials, being on the interview panel in educational staff recruitment, participating in research in different roles e.g. reviewing literature or being part of a research advisory group, other teaching opportunities/roles. All of these can help prevent participation being tokenistic and promote a sense of value, purpose and belonging as well as respect for their personal development.

Challenges

Below we highlight a number of challenges we have experienced over the course of running the EPP and also the ways in which these have been overcome.

Role of the EP – Shifting from advocate to education

As a new role, many of the EPs we recruited have had limited opportunities to be involved in medical or mental health professional education. Some EPs' experience mainly included giving 'raising awareness' talks or presenting their views on their experiences for the purpose of service development. Transitioning from these contexts into providing practice/ learning opportunities was a challenge for some.

How to overcome this:
It was crucial to set out the rationale and learning outcomes clearly and to explain these to the prospective EP to clarify expectations. EPs needed to know that students had limited opportunity to practice their developing skills on real patients, that students valued the opportunity to practice taking histories in a safe environment and that they needed to develop these skills to make them better doctors.

We also reiterated the value of EP feedback. This reinforced why the sessions ran the way they did. That the EPs needed to see the students 'in action' to be able to comment on their ability, skills and attitude.

We also ensure that feedback from students is given to the EP group to monitor quality of the learning opportunity, and to explore how we could improve the programme. In this way the EPs become part of the ongoing monitoring and development of the programme.

Feedback skills

One of the criticisms received by students about the EP sessions was that some EPs struggled to give critical feedback on students' performance.

How to overcome this:
We developed a training workshop in giving constructive feedback and EPs have ongoing coaching from facilitators.

We have also found that EPs may need support when a student has struggled or performed badly. Teaching staff can prompt and guide the EP with specific examples from the interview and ask the EP how it made them feel, then explore with them how the student could do it differently. This is particularly useful and students highly value this three-way discussion.

This approach can also work for occasions where an EP is especially critical, in that the facilitator can guide the EP to areas where the student performed well. Reflection on the session with the EP afterwards can help them to become aware of the need for balanced feedback. If a student performs particularly badly, we schedule additional sessions with EPs with particular skills and experience in coaching students to develop their communication.

Policy and processes

When we set up the EPP in Derby, there were no other service user involvement projects within the Trust. We were therefore starting from scratch with our policies, procedures, governance and quality assurance.

How to overcome this:
We recruited a senior, experienced professional/ clinician, experienced in service user involvement projects, to identify and project manage what was required. Policies and procedures that were developed especially for the EP programme included:

- Workforce - recruitment, volunteering, safeguarding, support
- Remuneration policies and procedures - to support payments to EPs for expenses and remuneration (especially relating to tax declaration and those in receipt of benefits)
- Monitoring and service improvement – processes for collecting feedback, reporting, developing. See appendix 1

The EPP Lead focussed on these objectives and ensured integration in the organisational structure.

Teaching team

Not all clinical teaching professionals were/ are familiar with working with LEFs/EPs. Having EPs in teaching sessions involves a change of teaching style, power balance and may challenge their own attitudes and beliefs.

How to overcome this:
The learning outcomes of the session should be clarified for the clinician e.g. focusing on attitudes, empathy and communication. And the role of the clinician should also be clarified e.g. not to be overly technical.

Clinicians also needed to be taught the need for and how to brief before and debrief after the session, to ensure that EPs have the appropriate support and identify if additional support is needed.

Tick-box guide to setting up an EPP

Alexa Sidwell

1) Standards

Identify a standard to guide and benchmark against – we used the Mental Health in Higher Education (MHHE) Good Practice Guide: Learning from Experience. Involving service users and carers in mental health education and training.

2) Clarify the objectives

Identify the learning outcomes and how you want the programme to deliver these. Ours were:

- [ ] To promote/emphasize the need for empathy, consider the human experience of mental illness to bolster the 'clinical/scientific/theory' students learn.
- [ ] To teach the core competencies for the medical students to pass the placement, ie provide opportunities for students to practice these with real patients/carers (History taking, MSE, Safety/risk assessment.
- [ ] To increase opportunity for contact with service users.

3) Establish an infrastructure

Ensure that there is an infrastructure to support the delivery of the programme safely. This should include:

- [ ] Designing and recruiting a teaching team to include clinical teaching professionals and lived experience workers.
- [ ] Recruit/retrain teaching staff (clinical or 'lived experience' coordinators) to support the service users/carers who participate e.g. by providing debriefing, pastoral support.
- [ ] Recruit/retrain administrative staff to arrange sessions, make reimbursements/payments for expenses and remuneration, support practical delivery of sessions if virtual.

4) Establish funding and mechanism to make payments for reimbursing expenses and remuneration

Ensure that there is an infrastructure to support the delivery of the programme safely. This should include:

- [ ] Source funding (we ensured that our 'tariff', previously SIFT funding, was ringfenced for teaching and not absorbed into other Trust activity).
- [ ] Develop reimbursement and remuneration policy and procedure **(see appendix 1).**
- [ ] Ensure available support/guidance for service users/carers about earning in relation to tax and receiving benefits.

5) Recruitment

- [ ] Design job descriptions for teaching professionals and Lived Experienced workers.
- [ ] Recruit service users/carers – approach existing groups, approach clinical teams, local advertising campaign. Be clear about the objectives (student development, not a forum to challenge service provision) and the role and skills required (e.g. sharing their experience of their mental health journey, assessing student communication skills).
- [ ] Develop training for the team- clinical facilitators (facilitation skills, briefing and debriefing EP's, feedback skills), EPs (feedback skills, distinguishing subjective opinion from objective assessment)

6) Delivering the programme

- [ ] Ensure there is time to take stock. Support, Reflect, Adapt. May want to introduce away days for the team to discuss how things are going
- [ ] Start small. This allows for the above to happen more thoroughly. E.g. start with only one to one EP interviews. Build as experience and confidence grows.

7) Quality improvement

Inclusion of service users, carers and students in this process:

- [ ] The ongoing monitoring of the student experience of the programme and teaching quality through student feedback and surveys.
- [ ] The ongoing development of the programme, e.g. through the steering group, focus groups for specific projects.
- [ ] Establish feedback processes with the university.

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Glossary

Actor: Also known as a simulated patient, a person hired to play the role of a patient with a certain mental health condition

Agenda for Change panel: A panel of trained panellists who decide on the rate of pay for a job role in the NHS under the Agenda for Change legislation of 2004.

CBDT (Case Based Discussion Tutorial): A teaching activity where students present and discuss clinical cases they have been involved with.

CF (Clinical Facilitator): An individual with a professional clinical qualification (such as medical or nursing) responsible for training and educating students.

EP (Expert Patient): A person with a history of a mental health condition who has been trained to share their experience of their mental health condition with students to facilitate their medical education.

EPP (EPP Expert Patient Programme): The programme of teaching run by the Derby Psychiatry Teaching Unit involving people with lived experience of mental illness.

Expert Patient Clinic: A teaching session set up as a mock outpatient clinic where students can experience reviewing an expert patient.

Expert Patient Sessions: A teaching activity where students have the opportunity to practice history taking skills by interviewing an expert patient.

GEM (Graduate Entry Medicine): Graduate Entry Medicine is a pathway for graduates and degree-holders who want to study Medicine. The programme is accelerated, so usually takes 4 years to complete, instead of the 5 or 6 years that Undergraduate Medicine courses take.

History taking: The process of interviewing a patient to record the narrative of their mental health, their background and their previous contact with health services.

Key Case: These seminars are the first teaching session in each teaching week and introduce the mental health condition that is to be the focus of the week. These are facilitated by a clinical facilitator, a lived experience facilitator and an expert patient.

Lived Experience Educator: An employed member of the faculty team with lived experience of mental health issues and responsible for the running of the EPP.

Lived Experience Facilitator: An employed member of the faculty team with lived experience of mental health issues. They are responsible for the running of the EPP and responsible to the Lived-Experience Educator/Coordinator.

Masterclass: A teaching activity where an actor plays the role of a person with a mental health condition and students have the opportunity to review their mental health. These sessions are facilitated by a clinical facilitator and a lived experience facilitator.

MSE (Mental State Examination): A structured assessment of a patient's cognitive and behavioural functioning.

MHHE (Mental Health in Higher Education): A UK based organization that aims to increase networking and the sharing of approaches to learning and teaching about mental health and distress across the disciplines in higher education.

OSCE (Objective Structured Clinical Examination): Summative examinations undertaken by medical students at the end of their clinical placement years. They are designed to be an objective and standardised way of assessing a student's clinical competence. Students complete several tasks at different stations. Each station has trained examiners.

PDSF (Professional Development Student Forum): A teaching activity where students are able to bring and discuss professional or ethical issues they have encountered during their placement.

PTU (Psychiatry Teaching Unit): A multidisciplinary teaching team who teach and support medical students completing their psychiatry placements.

Service users: Members of the public who are currently receiving or who have previously received care/treatment from services. This term is used interchangeably with the term 'patient'.

References

1. Gordon M, Gupta S, Thornton D, Reid M, Mallen E, Melling A. Patient/service user involvement in medical education: A best evidence medical education (BEME) systematic review: BEME Guide No. 58. Medical teacher. 2020;42(1):4-16.
2. Health Do. Patient and public invovlement in the NHS. In: Health Do, editor. London (UK): House of Commons2007.
3. Health and Social Care Act. London UK: The Stationary Office; 2012.
4. Council GM. Promoting Excellence: Standards for medical education and training. London (UK): GMC; 2016.
5. Agrawal S, Kalocsai C, Capponi P, Kidd S, Ringsted C, Wiljer D, et al. "It was great to break down the walls between patient and provider": liminality in a co-produced advisory course for psychiatry residents. Advances in Health Sciences Education. 2021;26(2):385-403.
6. Spencer J, Godolphin W, Karpenko N, Towle A. Can patients be teachers? Involving patients and service users in healthcare professionals' education. London; 2011.
7. Babu KS, Law-Min R, Adlam T, Banks V. Involving service users and carers in psychiatric education: what do trainees think? Psychiatric Bulletin. 2008;32(1):28-31.
8. Horgan A, Manning F, Donovan MO, Doody R, Savage E, Bradley SK, et al. Expert by experience involvement in mental health nursing education: The co-production of standards between Experts by Experience and academics in mental health nursing. Journal of psychiatric and mental health nursing. 2020;27(5):553-62.
9. Agrawal S, Capponi P, López J, Kidd S, Ringsted C, Wiljer D, et al. From surviving to advising: a novel course pairing mental health and addictions service users as advisors to senior psychiatry residents. Academic Psychiatry. 2016;40(3):475-80.
10. Jha V, Quinton ND, Bekker HL, Roberts TE. Strategies and interventions for the involvement of real patients in medical education: a systematic review. Medical education. 2009;43(1):10-20.
11. Maplethorpe F, Dixon J, Rush B. Participation in clinical supervision (PACS): An evaluation of student nurse clinical supervision facilitated by mental health service users. Nurse education in practice. 2014;14(2):183-7.
12. McCusker P, MacIntyre G, Stewart A, Jackson J. Evaluating the effectiveness of service user and carer involvement in post qualifying mental health social work education in Scotland: challenges and opportunities. The Journal of Mental Health Training, Education and Practice. 2012.
13. Stickley T, Rush B, Shaw R, Smith A, Collier R, Cook J, et al. Participation in nurse education: the pine project. The Journal of Mental Health Training, Education and Practice. 2009.
14. Ward K, Stanyon M, Ryan K, Dave S. Power, recovery and doing something worthwhile: A thematic analysis of expert patient perspectives in psychiatry education. Health Expectations. 2022;25(2):549-57.
15. Dijk SW, Duijzer EJ, Wienold M. Role of active patient involvement in undergraduate medical education: a systematic review. BMJ open. 2020;10(7):e037217.
16. Tew J, Gell C, Foster S. Learning from experience: Involveing service users and carers in mental health education and training. Mental Health in Higher Education project; 2004.
17. Goss S, Miller C. From margin to mainstream: Developing user-and carer-centred community care: Joseph Rowntree Foundation York; 1995.
18. Chambers M, Hickey G. Service user involvement in the design and delivery of education and training programmes leading to registration with the Health Professions Council. London: HPC, Kingston University and St Georges University of London. 2012.
19. Levin E. Involving service users and carers in social work education: SCIE London; 2004.

Acknowledgements

We would like to give a huge thank you to the whole of the Derby PTU teaching team, past and present, not only to everyone who has contributed to the development of this Toolkit, but who have been instrumental in the development of the Expert Patient Teaching Programme over the last 19 years. Many people have been involved over the years.

We would like to thank Mary Wheatcroft who taught many of the original sessions.

Muriel Townley, Richie Wheatcroft, Jontie Norton and Amanda Hughes who were our first pioneer expert patients.

We would also like to thank Simon Rose and John Ryalls, who were our first employed lived experience members of staff.

Thanks to Ryan Tranter for using his graphic design skills to make this Toolkit attractive.

And, of course we would like to thank all of our expert patients who give of their time and themselves week in, week out to teach our students.

None of this could be possible without you.