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Assessing early feasibility of a novel innovation to increase consumer partnership capability within an Australian health innovation organisation using a mixed-method approach

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ABSTRACT

Objective Engagement-capable health organisations recognise that consumer engagement (also known as patient engagement, consumer engagement, patient and public involvement) must occur at every level of the organisation if it is to be meaningful and genuine. Despite this aspiration, health organisations struggle to adopt, implement, and embody consumer engagement capability in a way that has yielded impact. The Partner Ring (PR) is an embedded model for building staff capability for consumer partnerships. It is hosted by an employed Patient Partner. PR was implemented at the Agency for Clinical Innovation in New South Wales, Australia. The aim of this study was to assess the feasibility (acceptability, demand and practicality) of this innovation to increase consumer engagement capability.

Design One-group post-intervention mixed methods approach to assess feasibility.

Participants ACI staff engaged in the PR (n=40 of 89 members).

Data collection and analysis Qualitative data was collected through an artificial intelligence (AI)-driven interactive interview, with 40 responses received between 29 June and 12 July 2023. A framework analysis and Generative AI causal mapping were conducted to identify and visualise causal claims within the texts. Cost and session attendance collected from the same point in time supplemented the analysis.

Findings Findings were categorised by the following feasibility constructs: acceptability, demand and practicality. Almost all the respondents indicated their intent to continue using the PR and outlined personal benefits and professional benefits. For example, (n=23, 57%) reacted positively to the psychological safety of the PR, and professionally people identified attendance increased their knowledge and skills (n=23, 57%).

Conclusion The PR is feasible and likely to be an acceptable innovation for building staff capability and consumer engagement skills across a large health system or organisation. It could be adopted or adapted by other jurisdictions.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A consumer leadership and partnership approach was integrated into all aspects of the study.
⇒ The Partner Ring (PR) is the first of its kind of which we are aware—a patient/consumer-led and embedded model for building staff capability in consumer engagement.
⇒ An artificial intelligence-driven interactive interview was used to gather feedback from 40 members of the PR (all active members with a commitment to consumer engagement).
⇒ This was a one-group post-intervention study with a self-selected sample.
⇒ The data does not capture or include the perspective of the 38 members who attended one session but did not elect to participate in the study (these may represent an opposing view to the 40 who participated and rated the PR favourably).

INTRODUCTION

Consumer engagement is essential for designing quality, safe and patient-centred care. *A consumer is defined as a person who has used, or may potentially use, health services, or is a carer for a patient using health services.*[1]

Engagement-capable health organisations recognise that consumer engagement must occur at every level of the organisation to be meaningful and genuine.[2] Despite commitments and aspirations to engage, and despite there being quality and safety standards that stipulate consumer partnership in healthcare design and delivery, health organisations struggle to adopt, implement and embody consumer engagement capability in a way that has yielded impact. A systematic review published in 2021 found little evidence about the effect of community participation in terms of outcomes at both the community and individual levels.[3]

Internationally, frameworks to support patient and public participation abound, detailing the organisational mindsets, considerations and foundations that need to be

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in place to enable engagement.[4 5] The Beryl Institute's Experience Framework signals the link between human experience and consumer and community engagement.[5] A capability development framework was recently developed for building successful consumer and staff partnerships in healthcare quality and improvement.[6]

In Australia, health systems are accredited against the National Safety and Quality in Healthcare Standards. The Partnering with Consumers Standard 2 aims to create effective person-centred health organisations by partnering with consumers in the planning, design, delivery, measurement and evaluation of systems.[1] The Consumer Health Forum Australia also released a white paper called *Shifting Gears—Consumers Transforming Health* in 2018.[7] It outlines the transformation shifts required to deliver a person-centred healthcare system, with consumers as equal partners.

Powerful calls to action are many, yet integrated and embodied consumer engagement practice remains elusive and barriers to genuine, non-tokenistic consumer leadership remain across the health sector.[6]

While there is widespread agreement that consumer engagement is important, many organisations stumble over how to do it well.[5] Staff capability in conducting engagement is linked to successful engagement—both in terms of outcomes produced, *and* the consumers' *experience* of the engagement.[6] Yet in most instances, engagement capability remains the province of allocated engagement positions.[8] While it is important to a resource such roles, it is ideally everyone's responsibility to embed engagement within an organisation, and it must be resourced both in time and money.[9]

The Agency for Clinical Innovation (ACI) is an organisation within the public health system in New South Wales (NSW), Australia.[10] In 2020, the ACI appointed a Patient Partner, a lived experience role with significant consumer engagement experience. The Patient Partner (LN) established an innovation called the Partner Ring (PR) in February 2022 to help build staff engagement capability. It was designed to be a consumer-led initiative to model how genuine consumer leadership can occur within the system, and to address knowledge-to-practice gaps in staff engagement capability.

Our case study has two objectives. First, to describe the establishment of the PR, and second, to report on early indications of feasibility (acceptability, demand and practicality) from a small-scale pilot conducted between 2 February 2022 and 7 December 2022[11] at the ACI.

METHODS

Description of the innovation—the Partner Ring

The PR is an embedded, practice-based and consumer-led innovation designed to create the conditions to build staff consumer engagement capability across the ACI. A full description of the model is outlined in box 1 and the 'Rules of the Ring' are outlined in box 2.

Box 1 Description of the Partner Ring

Rationale:
Most people understand the reason why engagement is important, but many lack the understanding of how to do it. In the Partner Ring (PR) they are provided some practical tools and methods on how to do so, but this is also supplemented by a supportive and enabling culture that increases confidence and willingness to try engagement if they have not before or build upon their existing engagement practice.
Facilitator:
The Patient Partner (LN) led all facets of the PR, including set-up, administration, promotion, content, topic scheduling, session administration and facilitation. LN invited guest facilitators (including consumers) to cover any topics outside her area of expertise, and to provide some variety and differences in facilitators and facilitation styles. Guest facilitators were other subject matter experts within the Agency for Clinical Innovation (ACI). In all instances, guest presenters collaborated with LN in the session design.
Structure:
The PR is a fortnightly virtual gathering using a dedicated Microsoft Teams Channel.
Fortnightly 60 min sessions (22 PRs between 2 February 2022 and 7 December 2022).
Recruitment:
All ACI staff (n=230) were invited and eligible to join the PR. Membership was promoted through the ACI Intranet (posts, stories, links from relevant pages) and by word-of-mouth. Prospective members were required to request PR membership, which could occur at any stage during the pilot. There were no prerequisites or requirements for membership except for a willingness to build consumer partnership skills. LN sent members a welcome email, a copy of the 'Rules of the Ring' (see box 2) and instructions on adding the session appointments to their Outlook calendar. Members were added to a Teams channel and could access session recordings, notes, reference material and resources. They could also participate in group discussions via the discussion board on the Teams channel.
Content:
LN determined session topics based on direct requests from members, themes identified from coaching and support requests made by staff and teams across the ACI, feedback provided by consumers partnering with the ACI, and through monitoring and observing global trends and activity in consumer partnership. LN also draws on their own learnt experience from 13 years as an engagement practitioner, peer worker and manager of consumer participants. The Patient Partner's own experience is often used to illustrate key messages.
Session topics included operational 'how-tos' such as planning engagement, how to find and recruit consumers for consumer engagement activities, recruiting consumers, onboarding consumers per the New South Wales Health policy and guidelines, and creating psychological safety that will enable people to engage and partner with consumers in a trauma-informed way. Topics also addressed the more philosophical considerations of engagement and partnership. They included acknowledging power differentials, understanding how inequality exists in collaboration, and understanding privilege and how it plays out in consumer engagement.
Delivery strategies and processes:
Various techniques were used to engage members in each session, including virtual breakout rooms, virtual whiteboard activities, group brain-storming sessions, expert panels fielding Q&A, videos, content experts as guest speakers and debates. All sessions had a 'call to action' (eg, what will you do differently because of what you have learnt

Continued

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Box 1 Continued

today? Or, what is one lightbulb moment from today?), and members were asked to share their responses in the chat.
LN modelled relational engagement at the outset—an approach recognising and valuing that connections and relationships are the cornerstones of consumer partnership. The aim was to set a conversational, safe, inclusive and reflective tone for the PR which is now reflected in the *Rules of the Ring* (box 2).

Feasibility design

One-group post-intervention mixed methods approach.

Aim and objective

To assess the feasibility of the PR as a small-scale pilot implemented through the ACI in NSW Health. The areas of focus for feasibility included acceptability, demand and practicality.

Feasibility framing questions

The framing questions to guide the inquiry, data collection and analysis were informed by an established framework for designing feasibility studies,[11] as shown in table 1.

Setting

The ACI is part of the NSW Health system and is the lead agency responsible for the design and implementation of health innovation.[12] The ACI does not provide clinical services. There were approximately 230 staff members employed by the ACI at the point of conducting the case study.

Box 2 The 'Rules of the Ring'

'Rules of the Ring'
The 'Rules of the Ring' were co-created with members:

⇒ **Be brave:** Personally and professionally, we strive to be braver and have the courage to tackle the hard topics.
⇒ **Relationship:** We take the time to get to know one another. Relationships are the most important aspect of any work we do—we are all people first.
⇒ **Comfortable being uncomfortable:** We challenge ourselves to become more comfortable about uncomfortable subjects.
⇒ **We bring our whole selves:** There is no shame or judgement in the Ring. This is a safe place.
⇒ **Community:** The Ring is our community. Investing in each other and our community creates the space for authentic connection and learning together.
⇒ **We CARE:** About each other; about creating meaningful partnerships; about our interactions with others. The ripple effect of caring means we can provide a better service.
⇒ **Power:** In the Ring, we are mindful of POWER and PRIVILEGE. We recognise how they play out in the workplace and our partnership work.
⇒ **Safety:** We create a safe space to learn and share. We build safety into our engagement and partnership work.
⇒ **Value story:** Sharing story and experience creates true understanding and perspective. In the Ring we share stories.

Participant sample

A purposive sampling approach was used and all staff who were registered for the PR and who had attended at least one session were eligible to provide user feedback (n=78). These 78 staff were required to opt-in by responding to an email invite from the Patient Partner. 40 of the 78 members opted in. The participants were provided with a link to the artificial intelligence (AI)-driven interactive interview for completion between 29 June and 15 July 2023. Participation was voluntary, and the responses were anonymous. Consent was implied by the ACI staff member completing the AI-driven interactive interview. The sample does not include the additional 38 members who opted not to participate—and other ACI staff not engaged in the PR.

Data collection

Qualitative data was collected through an AI-driven interactive interview administered through Qualia by Causal Map between 29 June and 12 July 2023. Qualia uses generative pre-trained transformer 4 multimodal large language model.[13] AI has been used for interviewing in qualitative research, emerging as a promising approach that can offer advantages such as efficiency, scalability and consistency.[14] Data was stored in an SQL database at Amazon RDS, which uses industry-standard security and user data was deleted after 30 days. An interview script was used to structure and prompt interactions, and the questions were undirected and neutral. The script was designed by the two coauthors (LN and TLD-B) and is shown in box 3. Each interview began with a broad question about the respondents' experience of the PR, and then follow-up questions gleaned further information relevant to the elements of feasibility. The complete verbatim interview transcripts were downloaded for the qualitative analysis. The responses were anonymous. The cost of the PRR was estimated at the administrative level (ie, costs incurred to plan, set-up, coordinate and facilitate) using an agreed hourly rate ($A80.00 Health Service Manager Level 4). Session attendance was collected from the same point in time to supplement the analysis.

Data analysis

Framework analysis was conducted on the qualitative data using five steps: familiarisation, identifying a framework, indexing, charting, mapping and interpretation.[15] Data were coded line-by-line and deductively using the predefined focus areas for feasibility: acceptability, demand and practicality.[11] Data were indexed and charted into the matrix (using a Microsoft Excel spreadsheet). Iterative discussion among LN and TLD-B was used to resolve any issues or discrepancies. Data triangulation occurred descriptively with attendance data and costings, and the Consolidated Framework for Implementation Research was used as a foundational taxonomy to categorise determinants (barriers and enablers) of implementing the PR.[16] Generative AI causal mapping was used to identify and visualise causal claims within the texts.[17 18]

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Table 1 Feasibility areas of focus and framing questions

Feasibility areas of focus	Framing questions to guide the inquiry, data collection and analysis
Acceptability	► To what extent is the PR acceptable to ACI staff?
Demand	► To what extent is the PR used by ACI staff?
Practicality	► To what extent does the PR have a positive or negative effect on ACI staff? ► To what extent does the PR show promise of being successful, and what factors impacted implementation ease or difficulty?

ACI, Agency for Clinical Innovation; PR, Partner Ring.

Ethics

The PR was created and tested as a local capability initiative, and it was assessed as low risk and a quality improvement activity. All institutional and ethical requirements were adhered to during the study. Participants voluntarily responded to the invitation to provide feedback on the PR and were required to opt-in and then complete the online anonymous interview as part of the implied consent process.

Box 3 Artificial intelligence (AI) instruction and interview script

To enable a 'conversation' between the participant and the AI bot, it needed to be programmed with a 'script'. The script gave the AI bot its direction and the ability to ask clarifying questions when required.

Instruction to the AI bot

Use a positive tone and interact in a fun way. Always wait for the response and ask follow-up questions if you think the answer needs more detail. Be inquisitive, explore in more depth my responses and hold this task as a conversation. The dialogue must be smooth and natural, less like an interview and more like a conversation. You do not need to ask the questions verbatim.

To start the conversation:

'Howdy Partner, I hope you're having a good day. Today I want to ask you a few questions about the Partner Ring.'

How would you describe your experience of the Partner Ring?

What was it in particular about the Partner Ring that had the most immediate impact on you?

What did you like about the Partner Ring?

What did you not like about the Partner Ring?

Do you think the Partner Ring was beneficial?

Why do you say that?

Do you intend to continue participating in the Partner Ring?

Why do you say that?

In the middle of the conversation:

'Thanks so much for telling me your thoughts, I only have a couple more questions, and then you can get on with your day.'

What has been the most significant change in my life today because of my attending the Partner Ring?

What has been the impact or effect on how I partner, or plan to partner, with consumers?

What aspects of these impacts are significant/valuable to me and why?

Towards the end of the conversation:

Clarify if necessary to make sure you have understood the responses correctly. When everything is clear, summarise what I said and ask if the respondent agrees with the summary. If something needs changing, change it.

To end the conversation:

'Thank you. I really appreciate your time, the interview has ended, and you are free to get on with your day! Goodbye'.

Type the smile emoji and end the interview.

Patient and public involvement

The PR is a patient/consumer-led innovation, initiated, designed and delivered by the Patient Partner (LN). LN led all facets of the PR and is a coauthor of this feasibility study. PR sessions included consumer/lived experience speakers (n=13 across five sessions).

Reflexivity

Reflexivity is the process of critically reflecting on oneself as a researcher and is a key process in the construction of knowledge in qualitative research.[14] The coauthors (LN and TLD-B) reflected on their assumptions, experiences and choices in how to conduct the feasibility study. LN is the ACI Patient Partner and consumer advocate experienced in consumer engagement, patient and public involvement and peer work. TLD-B is a social worker experienced in qualitative research, and consumer and community engagement and is employed as the ACI Evidence Generation and Dissemination Manager. TLD-B was not involved directly in the PR. Both LN and TLD-B have personal beliefs in the need for and value of consumer engagement. LN and TLD-B both have professional relationships with members of the PR—hence the decision to use a data collection tool that provided anonymity. Participants were aware of the rationale for the study and of LN prior involvement in the PR.

Reporting guidelines

The Standards for Reporting Qualitative Research reporting guidelines for the reporting of qualitative research were used.[19]

Findings

The PR was established in February 2022, and 22×60 min sessions were facilitated between 2 February 2022 and 7 December 2022, as outlined in table 2.

All sessions were facilitated using Microsoft Teams, and session recordings were made available to all PR members. The framework analysis identified key themes related to predefined focus areas for feasibility: demand, acceptability and practicality.[7]

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Table 2 Partner Ring topics and attendance figures

Date	Partner Ring topic	Number of attendees
02/02/22	Welcome to the Partner Ring	13
16/02/22	Heartset and Dadirri	20
02/03/22	Honesty and transparency in engagement	15
16/03/22	Art of hosting	16
30/03/22	Plan and prepare	18
27/04/22	Power of storytelling	20
11/05/22	Advertise and recruit Part 1	15
25/05/22	Advertise and recruit Part 2	28
08/06/22	Onboard and orientation	21
22/06/22	Consumer engagement Q&A	19
06/07/22	Levels and mechanisms of engagement	18
20/07/22	Working with diverse groups Part 1	19
03/08/22	Engaging with refugee and migrant groups	26
17/08/22	Working with diverse groups Part 2	30
31/08/22	YCAT diversity panel	41
14/09/22	Diversity quiz and reflection	21
27/09/22	Codesign hacks—Part 1	22
12/10/22	Codesign hacks—Part 2	27
26/10/22	Creating an equitable participatory design experience	26
09/11/22	Relating with power and emotion in partnership practice	25
23/11/22	End of year quiz	21
07/12/22	Yearly review and feedback	28

YCAT, You Can't Ask That.

Demand for the Partner Ring

The average number of staff employed at ACI during the small-scale pilot was~230 and 89 (30% of all staff) had registered for the PR by December 2022. In total, 78 of 89 members (~89%) had attended at least one session during the pilot time frame.

The number of members attending each session ranged from 13 to 44, with an average of 22 members. Attendance at the sessions varied each fortnight, as shown in table 2. In total, 39 of the 40 respondents (97.5%) indicated their intent to continue using the PR.

Acceptability of the Partner Ring

Respondents unanimously described the PR in a positive way (n=40, 100%)—in particular, reacting positively to psychological safety (n=23, 57%).

> The sessions are hosted in a psychologically safe space allowing for authentic conversations and learning to occur with and from each other; The informality of the sessions opens up opportunity for creativity and innovative thinking. This has not been my experience in more formal meetings and groups. (Participant 26)

And the opportunity to increase their knowledge and skills (n=23, 57%).

> I have very much enjoyed being involved in the Partner Ring. I think that the group allows us time to stop and think differently about how we partner with consumers and the wealth of knowledge that is brought to the ring by facilitators and presenters has been invaluable. It's an open and vulnerable experience at times, but I feel like it forces us to put ourselves in the shoes of our partners and is building our capability in holding space and being responsive and conscious in partnerships. (Participant 22)

17 respondents reflected on how the PR boosted their morale in the workplace (n=17, 42%).

> There's no other opportunities, training or formats that teach what is learned in the ring. I think everyone in our organisation should spend time in the ring. (Participant 22)

There were high satisfaction levels that coalesced implementation delivery and quality. Positive factors related to the content included varying the topics, balancing theory and practice, scaffolding, interactivity and providing throughout yet challenging and relevant material (n=21, 52%).

> It's a space where ideas are inspected from every angle and where thoughts, ideas and the status quo are challenged. (Participant 21)

The group valued specific facilitation processes including:

- Check-in and checkout.
- Meta-planning using an interactive online whiteboard (see online supplemental figure 1) as an example of how the group reflected on the PR and identified opportunities for improvement collectively).
- Group work (with or without breakout sessions/ rooms).
- Discussion (including dialogue by using the chat function).
- Use of roleplays.

This variety in process also added to people's perception of the PR being an inclusive environment (n=20, 50%).

> The structure of Partner Ring is very inclusive - check in and out questions, use of chat function if speaking up is too much, use of breakout rooms to have discussions, ability to ask questions freely. (Participant 2)

Five respondents specifically mentioned the value in having access to the session recordings (n=5, 12%).

Respondents also reflected positively on the facilitation quality of the PR—in particular, the facilitator and

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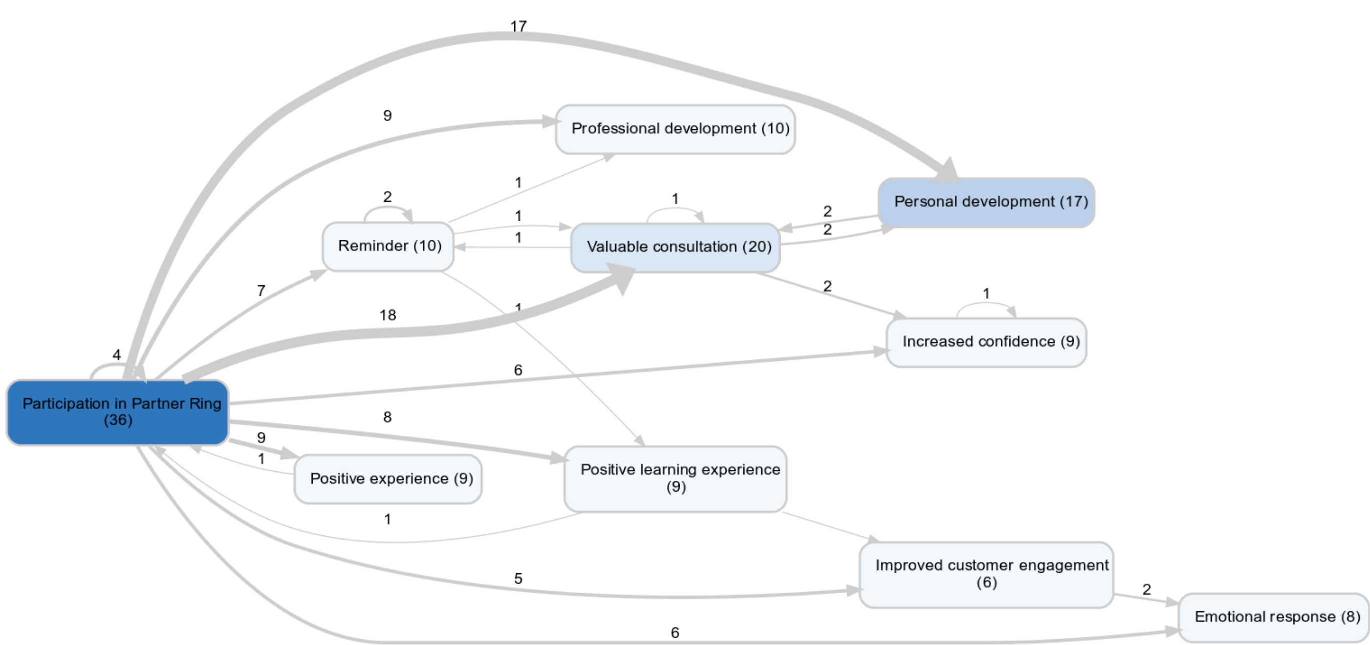

Figure 1 Causal map showing how the Partner Ring was beneficial. Citation coverage 50%: 165 of 314 total citations are shown here. Numbers on factors show source count, sizes show source count, colours show citation count. Numbers of links show source count.

their vulnerability, courage and authenticity when role-modelling relational engagement (n=21, 52%).

> Amazing facilitation by LN, she is so knowledgeable, real, funny, vulnerable and engaging. (Participant 15)

Respondents perceived that the facilitator was knowledgeable and skilled in group facilitation, which increased the delivery and quality of the PR. In the causal maps (figure 1), this factor is shown as valuable consultation, which was associated with increased confidence and personal development.

> I have really enjoyed it and have gotten a lot out of learning from others and their experiences. Although it can be challenging, I really like the way it expects/encourages everyone to actively participate when you're there. That's when you get the richest learning. (Participant 14)

However, a small number of respondents suggested that a hybrid mode (online with some face-to-face sessions) would enhance their experience of the PR (n=2, 5%), and others suggested a need for deeper learning (n=3, 7%).

> It's hard to get down to the detail and the devil is in the detail. It's a popular group which is good but sometimes that means we can't go deep. (Participant 28)

Practicality of the Partner Ring

The estimated administrative costs to plan, set-up, coordinate and facilitate the PR between 2 February 2022 and 7 December 2022 was $A14 080.00, as shown in online supplemental table 1. These costs were absorbed as business-as-usual for the Patient Partner role.

Almost all respondents indicated the PR was beneficial (n=39 of 40 respondents, 97.5%), and the reasons were broadly categorised into two themes: personal benefits and professional benefits. The causal claims are outlined in figure 1. Personal benefits included an overall positive emotional experience (n=9, figure 1), general personal development (n=17, figure 1) and increased confidence (n=9, figure 1) culminating in a positive emotional response (n=8, figure 1). These personal benefits were attributed to the inclusive environment created through the PR (n=36, figure 1).

> The Partner Ring provides an opportunity and safe space to develop confidence in working with others-specifically consumers. It is inclusive and respectful, and the space encourages open and honest communication. Individuals can express their thoughts and views without fear of judgement. (Participant 9)

Professional benefits included the PR's value in reminding respondents of the importance of consumer engagement (n=10, figure 1), and overall professional development (n=10, figure 1). Six respondents specifically mentioned improved consumer engagement, which was also mediated by the factor of valuable consultation (n=19), which collected references about a positive learning experience, which included learning the importance of teamwork and engaging with consumers.

> A leading-edge approach to building the consumer engagement capability of health staff and connecting them as a community. That it offers foundational learning experiences as well as exploring leading

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Table 3 Implementation enabler subcategories

Theme	Response rate	Quote
Relational connections (ie, role modelling)	n=34, 85%	'The reflection and acknowledgment that working with consumers in our professional roles means the armour of our professional self needs to come off.' (Participant 4)
Culture (ie, psychological safety, inherent belief in the value of consumer partnership, positivity)	n=40, 100%	'The facilitation of the positive and open environment to reflect and share our personal experiences, LN's role modelling of vulnerability and authenticity is a huge enabler in this.' (Participant 4)
Lead/facilitator (ie, a person with subject matter expertise)	n=25, 62%	'The organisers were always so vibrant, humorous and engaging, and others who presented did so willingly to share their knowledge and raw experiences.' (Participant 19)
Information technology infrastructure (ie, virtual tools)	n=15, 37%	'The breakout rooms provide more opportunities for engagement when meeting virtually.' (Participant 34)
Innovation source (ie, trustworthy and credibility of the Patient Partner)	n=21, 52%	'I think it's the environment and space created by Liz and the other facilitators. There's an attitude that there are no wrong answers, no stupid questions. The courage Liz models in so honestly sharing her own experiences and those of others is quite awe-inspiring.' (Participant 33)
Organisational alignment (ie, with the commitment and goals of the ACI Strategy 2023–2026)	n=15, 37%	'I've changed my approach to partnering with consumers - the traditional (old model) is no longer used and my consumer partnership plan attempts to model the knowledge gained from the Partner Ring; I provide and receive more feedback from my consumer partners, I get positive reinforcement about my approach; I do invest more time building and maintaining these relationships.' (Participant 7)
Innovation design (ie, quality and structure of the content and resources)	n=21, 52%	'The thing I like the most is the variation in presentations and structure of the Partner Ring.' (Participant 2)
Partnership and connections (ie, across ACI and NSW Health)	n=14, 35%	'The relationships I have built across the organisation with likeminded colleagues and an understanding of our commitment to consumer led engagement. It really is a highlight of my working week.' (Participant 8)

> edge topics - all in a situation where people can bring their whole selves and be their whole selves. (Participant 16)

Enablers coalesced eight subcategories: relational connections, culture, lead/facilitator, information technology infrastructure, innovation source, organisational alignment, innovation design and partnership and connections, as outlined in table 3.

The main barrier/obstacle to using the PR was a lack of time because of competing priorities (37%, n=15 of 40 respondents).

DISCUSSION

The PR is the first embedded, practice-based and consumer-led engagement capability initiative that, to our knowledge, has been evaluated and published. Our findings suggest that the PR has early indications of feasibility (acceptability, demand and practicality) from a small-scale pilot of the PR. Findings also suggest that the PR could support the translation of consumer engagement theory into practice. Further studies could consider a return on investment.

The first objective of our case study was to describe the establishment of the PR. The rationale, structure, facilitation, recruitment, content and delivery strategies and processes have been outlined, and other health organisations can replicate or adapt the model in their own context.

The PR emphasises how the 'relationships are the work'[20] in engagement practice, and the most necessary foundation for successful and mutually beneficial consumer engagement. It is an embedded model of continuous capability building that uses a three-pronged approach:

1. Role modelling relational engagement, using real-life examples and lived experience (personally and professionally) to illustrate and highlight good engagement practice.
2. Delivering instruction and guidance on how to 'do' engagement within the actual context of the members' workplace. This information is the core syllabus and the content that participants can then go and apply to their own work.
3. Discussing and debating deeper and more philosophical issues central to safe and equitable consumer engagement (eg, power differentials, diversity,

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psychological safety, trust, mutual open-ness). Through these discussions staff can explore how these issues impact the success of consumer engagement.

While it is likely that many organisations across the globe have in-house capability opportunities for their staff to learn about consumer engagement, information about their features and efficacy is yet to be made public.

We know of organisations globally that offer web-based, face-to-face learning, one-off seminars and conference talks about consumer engagement.[21 22] In Australia, the peak health consumer bodies provide short courses and training for staff and focus on the rationale for, and merits of engagement. However, none appear to be delivered by consumers, despite growing recognition of value.[23]

A point of difference is that the PR is designed and delivered by an employed consumer role. Our case study highlights how the Patient Partner's lived experience and real-life examples were a facilitator and enabler for acceptability. The power of story to increase understanding is well documented in the literature[24] and it is likely the Patient Partner's own lived and learnt experience added a richness of story to bridge from theory to practice.

There are other examples of other practice-based learning models where staff are teamed with lived experience roles, or an emphasis is placed on lived experience leadership and how to establish such roles. One example is the Foundations of Patient (Lived Experience) Leadership training, which lays the foundation for understanding patient leadership and is designed for patients and non-patients to explore different facets of this emerging social movement.[25] The King's Fund in England has the Collaborative Pairs programme, which has also been piloted in Australia. The 5-day developmental programme was designed to strengthen collaborative relationships with patients, carers and communities and disrupt the 'them and us' relationship dynamic in health and care systems.[26 27]

However, learning and capability uplift is limited to the people who participate. As far as we can ascertain, efforts to build capability have not been embedded across a large health system or organisation, which is a point of difference for PR.

Our findings signal that having the Patient Partner role embedded in the organisation may have been a driver for the PR's uptake—and it may have created trust, relationships, continuity, consistency, ownership and a point of contact for further information and advice. Other distinguishing features include the rolling and continual nature of the PR—every fortnight, same weekday, same time throughout the year. The PR is also more in line with a community of practice than a traditional learning and development model. It encourages members to bring their engagement examples for discussion, and the emphasis is on collaboration, mutual learning and community.[28] The supporting Teams channel with a filing system of resources for different phases of engagement, downloadable recordings of each session, accompanying notes and the interactive discussion board, create additional ways for members to participate, learn and share their consumer engagement experiences.

Our second objective was to report on early indications of feasibility (acceptability, demand and practicality) from a small-scale pilot of the PR. The overall findings are promising and suggest high acceptability—with almost all the respondents from a small sample of ACI staff indicating their intent to continue using the PR (n=39, 97%). The PR was a cost-effective ($A14 080.00) and time-efficient way to reach and support high numbers of staff (n=78) across the organisation to build capability. Attendance rates averaged 22 for each PR, but Teams analytics suggested high engagement outside of the sessions. Membership of the PR increased steadily and reached 89 ACI staff at the end of the pilot—which could signal a growing demand and intent to use across the ACI. Key enablers included relational connections, culture, lead/facilitator, information technology infrastructure, innovation source, innovation design, partnerships and connections and organisational alignment. The main barrier/obstacle was a lack of time because of competing priorities.

There are some limitations to note in interpreting the results of our study. First, our design was a one-group post-intervention study. We did not include ACI staff that were not members of the PR—and we recommend conducting a prospective organisational-wide questionnaire to gauge broader intention or interest in using the PR, and to identify any perceived barriers and enablers. Second, it was a self-selected and small sample of ACI that opted into the study (eg, 40 of 78 PR members—roughly 17% of the ACI workforce at that point in time). We can assume that some participants chose not to participate. The data shows an additional six interviews were opened (on Qualia) but not completed for reasons including breaking off too early and connectivity problems. Third, given the novelty of the PR and the lack of published literature—it is impossible to compare with like-innovations or initiatives.

Despite these limitations, our results suggest that PR is likely to be a feasible innovation for building staff engagement capability across a large health system or organisation. Several implementation enablers relate directly to the Patient Partner and their role in facilitating the PR (eg, role modelling, psychological safety, subject matter expertise and credibility). There could be value in creating a facilitation guide to enable the PR to be replicated in other health settings locally, nationally and internationally. Scaling the PR through a design that emphasises relational engagement, lived experience leadership and learning-through-doing would support the ability of services and individuals to embed engagement-capable practice across their organisations. We envisage this would further contribute to the growing field of evidence around consumer engagement, and the emerging evidence around the impacts of lived experience leadership. In addition, identifying indicators to measure meaningful consumer engagement will enhance efforts to evaluate it in the future.

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CONCLUSION

The PR was a consumer-led and embedded model for building staff consumer engagement capability across a large health innovation organisation in NSW, Australia. A feasibility study of a small-scale pilot signals acceptability, demand and practicality and other jurisdictions could adopt or adapt the model to build engagement-capable practices.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval The Partner Ring (PR) was created and tested as a local capability initiative, and it was assessed as low risk and a quality improvement activity. All institutional and ethical requirements were adhered to during the study. Participants voluntarily responded to the invitation to provide feedback on the PR and were required to opt-in and then complete the online anonymous interview as part of the implied consent process. Participants gave informed consent to participate in the study before taking part.

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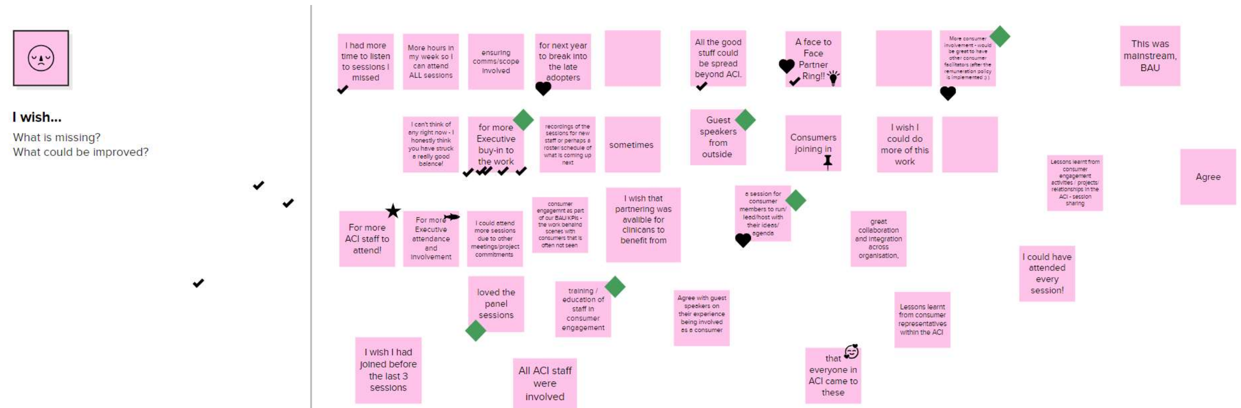
Supplemental Figure 1: An example of meta-planning using an interactive online whiteboard where in collaboration with members, ways to improve sessions were identified

The symbols used to highlight suggestions on the post-it note were chosen by the individual participants. They do not have a specific meaning.



Supplemental Table 1. Established costs for the Partner Ring

Administrative activity	Total hours per session	Cost rule
Plan	4	4 x $80.00 x 22 = $7040
Set-up	1	1 x $80.00 x 22 = $1760
Coordinate	2	2 x $80.00 x 22 = $3520
Facilitate	22	22 x $80.00 = $1,760
Estimated total ANNUAL cost	**AUS $14,080. 00**	