Patient and Public Engagement Toolkit for World Class Commissioning

Oxfordshire • Buckinghamshire • Milton Keynes
Berkshire West • Berkshire East • Hampshire
Southampton City • Portsmouth City • Isle of Wight
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Foreword

The NHS in South Central is committed to involving local people in how we plan, develop and deliver health services. We believe that only by involving the people that we serve will we truly be able to provide responsive, high quality services that reflect the needs of the people who use them.

World Class Commissioning is intended to have a direct impact on the health and well being of the population, driving improvements in outcomes for patients. It outlines how PCTs should be working to achieve outstanding performance in the way we commission health and care services. To meet the competencies identified in World Class Commissioning, we will need to transform the way we work, embedding continuous and meaningful engagement with patients, the public, clinicians and community partners. This toolkit will help you achieve world class engagement.

Our vision for better health services includes disabled people, people with impairments, older people, people with long term ill health, people from black and minority ethnic communities, and those who find it hard to access health services, for whatever reason.

This guide is targeted to commissioners based in PCTs, but provides managers from all parts of the health service and their front-line staff with an effective toolkit, a ‘how to’ guide to support them as they work to engage people.

I look forward to seeing staff use the toolkit to build on the good practice that already exists within the NHS in South Central.

G M Prager
Director of Clinical Standards and Engagement
Milton Keynes PCT
Chair, WCC PPI Steering Group

As Chairman of a former PPI Forum and now a member of the steering group formulating a LINk, I am pleased to see this Toolkit being produced. I am convinced that proper engagement with patients and the public is the right way forward for our health service. I hope that everyone involved in Commissioning will use this toolkit to help them better deal with people whatever their background

H F Dymond
Chair of the former Southampton City PCT PPI Forum
Acknowledgements

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- Berkshire East PCT
- Berkshire West PCT
- Buckinghamshire PCT
- Buckinghamshire Children and Young People’s Trust
- Inhealth Associates
- Isle of Wight PCT
- Lambeth PCT
- Newham PCT
- Portsmouth City Teaching PCT
- Southampton City PCT
- Westminster PCT
Purpose of the toolkit

This toolkit is primarily intended to support commissioners based in PCTs, but provides managers from all parts of the health service and their front-line staff with a guide as they work to engage people.

The aims of the toolkit are to:

- Create awareness of the need for public and patient engagement within our everyday activities.
- Promote an understanding of the wider issues relating to patient and public engagement.
- Provide practical guidance to enable staff from across the NHS, and commissioners in particular, to engage patients and the public in how services are planned, developed and delivered.
- Support work to make services more accessible and appropriate to a wider group of people. To support this, the toolkit provides specific information on working with groups traditionally termed ‘hard to reach’.
- Encourage a more pro-active, developmental approach to engaging people, including establishing long-term mechanisms for engagement.
- Acknowledge existing expertise and highlight examples of good practice.
- Support PCTs to achieve World Class Commissioning.
Starting Points: frequently asked questions

Involving patients and the public in everything you do is fun, satisfying and straightforward. This Toolkit is designed to support commissioners based in PCTs, but provides managers from all parts of the health service and their front-line staff with a guide as they work to engage people. It contains a lot of information, so if you are feeling daunted here are some questions you might be asking yourself…

1  What is patient and public involvement? see page 9

2  Who do we mean by ‘patients and the public’? see page 9

3  Why involve patients and the public? see page 10

4  Where do I start? see page 25

5  How do I know who to include? see page 28

6  How do I know which methods to use? see page 35

7  How do I engage ‘seldom-heard’ or ‘hard-to-reach’ groups? see page 79

8  How can I evaluate the effectiveness of the engagement process? see page 91
What is Patient and Public Engagement and why do we need it?

What is patient and public engagement?
Who are ‘patients and the public’?
Why involve patients and the public?
National and local structures to support patient and public engagement
What is Patient and Public Engagement and why do we need it?

What is patient and public engagement?

Patient and public engagement is the active participation of patients, carers, community representatives and groups and the public in how services are planned, delivered and evaluated. It is broader and deeper than traditional consultation. It involves the on-going process of developing and sustaining constructive relationships, building strong, active partnerships, and holding a meaningful dialogue with stakeholders. Effective patient and public engagement leads to improvements in health services, and is part of everyone’s role in the NHS.

Who are ‘patients and the public’?

Patient and public engagement should always seek to be as inclusive as possible. Patient and public engagement can encompass work with:

- Individual patients using a particular service, or NHS services more broadly;
- Patient groups or representatives based around a particular service;
- Patient groups or representatives based within the voluntary or community sector which relate to a specific issue or service;
- People who care for someone using health services;
- Local people, either on an individual or group basis, who do not necessarily use the service or services in question;
- Local voluntary and community sector organisations, these might include organisations working with particular groups, for example a Bengali women’s group;
- Other partner organisations.

Even when focusing on a particular service, it is normally helpful to consider not only current patients or service users, but also people who are not using the service. This is because not all those who need the service will be accessing it. Common reasons for people not using a service who might otherwise, and which services can address, include:

- they are unaware of the service;
- the service on offer does not meet their needs;
- institutional barriers prevent them.

Remember: staff often live in the local community and are potential or actual users of local health services, so should be engaged in their role as service users as well as in their role as members of staff.
Why involve patients and the public?

Meeting statutory requirements

PCTs, NHS Trusts and SHAs have a statutory duty to involve patients and the public whether by consulting or providing with information, or in other ways. This applies to:

- The planning and provision of these services;
- The development and consideration of proposals for changes in the way those services are provided;
- Decisions to be made by that body affecting the operation of those services.

Find out more about statutory requirements at:
www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/index.htm

Meeting regulatory requirements

The Healthcare Commission has signalled its intention to focus on a number of key areas in the annual health check 2008/09, including commissioning of healthcare services on behalf of local communities.

It has observed ‘We need to reflect the changes that are taking place in the way services are commissioned and delivered, and in how these services will be regulated’.

PCTs will be monitored on their achievement of the 11 World Class Commissioning competencies.

Find out more at:

Responding to Department of Health ‘must-dos’

The NHS Plan and Shifting the Balance of Power set out a vision of an NHS in which patients have more of a say about how healthcare is provided in their communities.

www.dh.gov.uk

Delivering real benefits

It is self evident, but worth repeating, that the NHS can meet people’s needs better if we listen to what people tell us, instead of relying on existing knowledge and assumptions. We can develop better, more responsive services if we involve and truly listen to not only those who are already using services, but those who are not.
National and local structures to support patient and public engagement

There are already a range of local structures that are nationally prescribed to support patient and public engagement. These include:

Support to individual patients in their own care

**Patient Advice and Liaison Service (PALS)**

Every NHS Trust and PCT must have a Patient Advice and Liaison Service (PALS). These are essentially service-focused teams (or in some organisations a single individual) who work to solve problems for patients on-the-spot and provide information and advice.

PALS also monitor trends in issues raised and so can sometimes provide information on services and wider organisational issues identified to them by patients.

Additionally, PALS often know their local community well and can provide a useful starting point for advice on planning patient and public engagement activities.

**Complaints system**

There is a national system for responding to complaints, which all NHS organisations are required to adhere to. Most NHS organisations have a dedicated complaints team, who co-ordinate responses to complaints and monitor trends in complaints.

Monitoring information held by the complaints team can potentially provide information on services and wider organisational issues identified to them by patients.

**Independent Complaints Advocacy Service (ICAS)**

Each NHS ‘patch’ has an Independent Complaints Advocacy Service, run by an external organisation, that supports people to make complaints about their NHS care or treatment.

Local accountability

**Overview & Scrutiny Committees**

All local authorities with social services responsibilities have a Health Overview and Scrutiny committee (HOSC). Membership comprises elected members of the local authority.

HOSC have the role of inspecting the NHS and have to be consulted by the NHS when major changes are planned. They also have powers to refer disputed
service changes to the Secretary of State for Health and can call NHS managers to give information about services and decisions.

As “major change” needs to be defined, it is vitally important that the HOSC, or its supporting officer, is notified at an early stage about any proposals to change or vary services, however small. Early discussion can prevent problems in the future. It will be for the HOSC to decide whether it is a “major change”. If it does, then it may require formal consultation as per the Cabinet Office Code of Practice on Consultation (please see section 3 “Determining formal consultation”).

For further information: www.cabinet-office.gov.uk/regulation/consultation/code.htm

**Patient & Public Involvement Forums (PPIFs)**

Up until April 2008, every NHS Trust and PCT was required to have a Patient and Public Involvement Forum. One of their roles was to work with NHS organisations to carry out their duty to involve and consult the public and to monitor how they carry out this duty.

Patient and Public Involvement Forums were replaced by Local Involvement Networks (see below) in April 2008, but your area may still have the remnants of a forum or forums, and these and the individuals who were involved in them could be a useful starting point for discussing and getting input into proposed patient and public engagement activities.

**Local Involvement Networks (LINks)**

Local authorities have been given £84 million in funding to support LINk activities between 2008-2011. Each authority is expected to contract an organisation (known as a host) to set up and then run a LINk. These hosts are expected to be in place by September 2008.

It’s up to each community, with the support of a host, to decide how they want their LINk to be run and what issues they want it to focus on.

A LINks role once it is up and running is to:

- ask what local people what they think about local healthcare services and provide a chance to suggest ideas to help improve services
- investigate specific issues of concern to the community
- use its powers to hold services to account and get results
- ask for information and get an answer in a specified amount of time
- be able to carry out spot-checks to see if services are working well (carried out under safeguards)
- make reports and recommendations and receive a response
- refer issues to the local ‘Overview and Scrutiny Committee’

Find out more at www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366
Commissioning and Patient & Public Engagement

World Class Commissioning Competencies

Patient & Public Engagement and World Class Commissioning across the commissioning cycle

Organisational systems and processes
Commissioning and Patient & Public Engagement

World Class Commissioning Competencies

The Vision World Class Commissioning is clear that PCTs must become trusted community leaders, working with their local population, partners and clinicians, leading the local NHS.

There are 11 competencies of which four are focused on achieving excellent public, patient and community engagement. World class commissioners will use these competencies to move towards ‘excellence’ which will in turn transform people’s health and well-being outcomes locally, with longer term aims of reducing health inequalities and promoting inclusion.

Since commissioning competencies can be taught, this toolkit will support the teaching, training and developmental process for commissioners. The competencies directly requiring the PCT to undertake stakeholder engagement activities are:

Competency 1:
To be recognised as the local leader of the NHS
PCTs should lead and steer the local health agenda in their community. PCTs will be the natural 1st stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

Competency 2:
Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
PCTs should not commission services in isolation. In addition to commissioning healthcare services, they will need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their local population. PCTs also share responsibility for undertaking a joint strategic needs assessment (JSNA) with local authorities. Partners include local government, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimise health gains and reductions in health inequalities.
Competency 3:
Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health

PCTs are responsible through the commissioning process for investing public funds on behalf of their patients and communities. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly and honestly. They will need to be proactive in seeking out the views and experiences of the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.

Competency 4:
Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation

Clinicians are best placed to advise and lead on issues relating to clinical quality and effectiveness. They are the local care pathway experts who work closely with local people understanding clinical needs. PCTs should ensure that through the involvement of clinicians in strategic planning and service design, services commissioned build on the current evidence base, maximise local care pathways and utilise resources effectively. Professional Executive Committees (PECs) have a crucial role to play in building and strengthening clinical leadership in the strategic commissioning process. Practice based commissioning (PBC) is the key methodology for this and should be maximised to drive innovative and transformational change.

A full description of each competency, the skills, processes and knowledge requirements, and example outputs, as set out by the Department of Health is included in Appendix A: World Class Commissioning Competencies.

Find out more at:
Patient and Public Engagement and World Class Commissioning across the commissioning cycle

This section describes the different stages of the commissioning cycle, and outlines for each stage:

- why patient and public engagement is needed;
- how engaging with patients and public can help the PCT to demonstrate World Class Commissioning;
- potential approaches to engaging with patients and the public.

Different approaches to involvement are likely to be necessary for each of the stages.

Developing a vision and strategy

Objective of this stage

The purpose of this stage is to develop a vision for health and healthcare that is shared across the PCT, local community and key stakeholders and from which the PCT develops its three to five year strategies to achieve the vision.

This means ensuring that community health aspirations are coupled with needs assessment and gap analysis activities in order to develop a shared local vision for the future of local communities.

Why patient and public engagement is needed

As tax payers and citizens, local people need to be involved in order to ensure that the local NHS builds a consensus – ‘permission to act’ – and is held accountable.

World Class Commissioning additionally requires PCTs to build their reputation amongst the local population. New Vital Signs within the operating framework require PCTs to demonstrate this.

Furthermore, the recent emphasis on extending the NHS’s focus beyond service delivery to lifestyle, prevention, and improving health must involve local people to be effective.
Meeting the requirements of World Class Commissioning

Undertaking this work will enable the PCT to demonstrate that it meets Competency 1 of World Class Commissioning – being recognized as the local leader of the NHS:

_PCTs should lead and steer the local health agenda in their community._

_PCTs will need to provide evidence of clear communication of local and national priorities, including consultation with the wider NHS community and patient and public involvement through partnership._

Involving patients and the public in its visioning work will enable the PCT to demonstrate that it meets the process and knowledge requirement of Competency 2 – work with community partners – that it:

_Shares across the local community its ambition for health improvement, innovation, and preventative measures to improve well-being and tackle inequalities._

It will also support the PCT to demonstrate that it meets Competency 3 of World Class Commissioning – engaging with the public and patients:

_In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly and honestly._

Approaches to doing it

Intelligence gathered by public health gives essential information about demographics, morbidity trends, population needs and inequalities. Additionally, current and potential service users can provide useful input to needs assessment and gap analysis work.

PCTs will need to supplement these traditional approaches with work with the wider community to understand:

- their own perceptions of their needs;
- their aspirations;
- where they feel there are gaps;
- what is working and not working from their perspective;
- what they feel the potential solutions might be.

Approaches to this could include:

- Public meetings
- Focus groups
- Seminars
- Open space events
- Health panels
- Citizens’ panels
Setting priorities

Objectives of this stage

The purpose of this stage is to engage the public in how decisions are made about choices about what services might be commissioned, and in making those decisions.

In practice, this stage might lead to commissioning services that are different from how services are currently provided (i.e. reconfiguration), or in some cases de-commissioning services.

Why patient and public engagement is needed

As in the case of developing their vision and strategy, PCTs need to involve local people as tax payers and citizens to ensure that the local NHS builds a consensus – ‘permission to act’ – and is held accountable.

Meeting the requirements of World Class Commissioning

Undertaking this work will enable the PCT to demonstrate that it meets Competency 3 of World Class Commissioning – engaging with the public and patients:

In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly and honestly.

Approaches

It means involving the public in

- Determining the principles that should underpin how priorities are set
- Ranking and priority setting
- Choosing a preferred strategic option(s)

Approaches to this are likely to include deliberative methods such as

- Seminars
- Citizens’ juries
- Health panels
Planning delivery

Objectives

This means ensuring that users and potential users of a service are involved in defining how services are provided, including contributing to service design and care pathways. This work should be led by the commissioner in conjunction with the service provider or potential service providers.

Why patient and public engagement is needed

Current and potential users of services need to be engaged in this process so that commissioners understand their lifestyles and choices and how services are used. Commissioners can build on this to ensure that services are developed and improved in the way that best meets people’s needs.

Furthermore, involving current and potential users of services, particularly those from groups who are often termed ‘hard to reach’, and whose views are traditionally less likely to be heard, can ensure that new service models and care pathways are identified, not only the existing, more traditional, patterns of service delivery.

Additionally, the Department of Health is keen that PCTs move beyond commissioning traditional provider organisations. There is a new emphasis on social innovation and finding different providers and ways of delivering services. Involving the community in planning delivery will support the identification and development of local community groups as potential providers of services and co-producers.

Meeting the requirements of World Class Commissioning

Undertaking this work will enable the PCT to demonstrate that it meets Competency 2 of World Class Commissioning – working collaboratively with community partners to commission services that optimize health gains and reductions in inequalities.

PCTs should not commission in isolation. Partners include local government, other PCTs, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimize health gains and reductions in health inequalities.

Approaches

This stage means involving current and potential service users in:

- Pathway design
- Designing service specifications
- Developing criteria for evaluating tenders
- Assessing potential providers
Approaches to this are likely to include:
- Working with lay representatives
- Service user forums / patient groups
- Health panels
- Surveys and questionnaires
- One-to-one interviews
- Targeting interested people

Managing quality and performance

Objectives

This means ensuring that the criteria on which the quality and overall performance of a service is judged includes patients’ experiences and views on that service.

Engaging patients and the public in this work will enable the PCT to demonstrate that it meets the processes and knowledge requirements of World Class Commissioning Competency 3 ensuring that patients and the public can share their experiences of health and care services and uses this to inform commissioning.

Why patient and public engagement is needed

PCTs are responsible for improving the quality of the services available to their local population. The current tariff system and implementation of patient choice are unlikely to drive up the quality of services on their own. PCTs need to actively engage in driving quality improvement in the services they commission. As part of this, PCTs need to understand what a quality service looks like from the perspective of those using it.

In addition, PCTs need to increasingly develop their role in managing the market of healthcare providers. Traditional measures of input, activity and output alone will limit the PCTs ability to understand the quality of service delivery and the performance of different providers. PCTs will need robust generic approaches to monitoring and quality.

Meeting the requirements of World Class Commissioning

Undertaking this work will enable the PCT to demonstrate that it meets Competency 3 of World Class Commissioning – engaging with patients and the public. The process and knowledge requirements of this competency include the requirements that the PCT:

* Routinely ensures that patients and the public can share their experiences of health and care services and uses this to inform commissioning.*

* Routinely invites patients and the public to respond to and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective.*
**Approaches**

PCTs will need to work with providers to clarify their own role and providers’ roles in relation to working with patients to assess providers’ quality and performance.

PCTs will need to involve current and potential service users in:

- Determining criteria for demonstrating that a service is of a high quality from a service user perspective
- Measuring the service’s performance against those criteria

Approaches to this are likely to include both quantative work with patients (i.e. methods that are able to capture the views of a large number of people, but in limited detail) and qualitative work (i.e. methods that capture the views of only a small proportion of the people concerned, but are able to explore these in more depth).

Potential approaches include:

- Surveys and questionnaires
- One-to-one interviews
- Focus groups
- Patient diaries
- Mystery shopping

**Organisational systems and processes**

This toolkit primarily focuses on individual patient and public engagement activities. However, to support genuine engagement, PCTs need the organisational infrastructure to gather and use data about patients’ and the wider public’s experience of and views on health and health services.

The PCT needs systems so that:

- Data from initiatives is fed into, and stored within, corporate knowledge management systems.
- Data is aggregated and ‘mined’ to identify trends in patients’ experiences or community needs and aspirations.
- Data can be interpreted in order to develop stories or meaningful narrative.
- Data provides a basis for learning and action to improve services.
- Data is fed into decision-making.
- Actions that reported back to stakeholders.
Planning for effective patient and public engagement and demonstrating World Class Commissioning

Checklist for planning patient and public engagement and evidencing World Class Commissioning
Planning for effective patient and public engagement and demonstrating World Class Commissioning

The section below identifies the key activities in planning an effective patient and public engagement initiative and how you might undertake them. It outlines how the different activities will help you to demonstrate World Class Commissioning.

It is followed by a checklist to support you to plan your activities and evidence that you are working to the World Class Commissioning framework.

1 Identify objectives and key issues or questions

Patient and public engagement is not an objective in itself. In most cases you will be reading this toolkit because you need to engage people as part of a specific activity or piece of work in progress within the PCT.

You should therefore consider:

- What is the central issue or key question(s) that you are seeking to engage people in?
- What part of the commissioning cycle does this represent? This will help you think about the most appropriate method to use.
- What level of influence will the process have? For example:
  - The findings will inform future plans.
  - The findings will form part of a range of inputs to a particular decision.
  - The people engaged can influence the decision-making process.
  - The outcome of the engagement process will be a decision.

World Class Commissioning

Recording how the findings will influence decision-making will enable you to demonstrate Competency 3: process and knowledge requirements:

- Routinely invites patients and the public to respond to and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective.
- Routinely ensures that patients and the public can share their experiences of health and care services and uses this to inform commissioning.
2 Determine whether formal consultation is required

One reason early discussion with the HOSC about variation of services is important is because it may suspect major (also known as “substantial”) change is being proposed. If it does, the NHS organisation proposing the change will probably be required to undertake formal consultation as per the Cabinet Office Code of Practice on Consultation. The NHS organisation will need to agree with the HOSC a minimum 12-week period during which the HOSC will undertake formal scrutiny in parallel with consultation by the NHS of patients and the public on the proposed change.

NB Across Hampshire an Assessment Framework for Substantial Variation has been agreed between the HOSCs and NHS. When a HOSC suspects an NHS organisation is proposing a major change, it requires that organisation to complete a Framework which will be discussed with supporting paperwork at a meeting of the HOSC.

Key stakeholders you will need to engage will include:

- Internal stakeholders, e.g. staff, voluntary workers
- Service users, their carers and other representatives
- Service user and Carer Groups directly connected to the service
- Statutory partners
- Your LINK – connecting you to relevant voluntary and community groups as well as interested parties
- Professional associations – eg BMA, RCN, UNISON
- Local Councillors (who may not be on the HOSC)
- Local MP(s)
- Local media
- Wider general public

3 Review available data

Once you have determined your objectives, you should explore what relevant information the PCT already holds, such as:

- data from previous engagement activities;
- national patient satisfaction surveys;
- existing monitoring systems, e.g. clinical audits;
- complaints;
- PALS;
- LINKs.

The Clinical Governance Committee is often a central collation point for all forms of data relating to patient and public experience of health services.
Other potential sources of data include:
- Service-related patient groups;
- Local voluntary organisations working with your target group.

It may be that there is already sufficient data to meet your objectives, although no amount of data will obviate the need for a formal consultation.

**World Class Commissioning**

Recording the existing evidence you have collated will help you to demonstrate one of the process and knowledge requirements of Competency 2: Open and effective shared knowledge and information processes which maximise use of local community intelligence and engagement.

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### 4 Identify decision-making and sign-off processes

Having determined that there is insufficient data to meet your objectives and / or you need to run a formal consultation, you should consider how the engagement work will relate to the wider activity or project it is part of.

For example:
- Where does the information you gather need to be reported? For example, the Steering Group of the wider project.
- How frequently does this group meet, and therefore which meeting should the outcome of the engagement work be taken to?
- What does this imply for the timescales of the engagement work?
- Which individual or group needs to sign-off your report of the findings before they can be fed back to people? Particularly if the work is sensitive or controversial you will need to establish a clear sign-off process. See the section on Feeding back.

At this point you should also make sure that your engagement work has commitment at the right level to:
- Ensure the necessary resources are available – this might be staff time and or / money;
- Act on the outcomes of the engagement.

**World Class Commissioning**

Recording how the findings will influence decision-making will enable you to demonstrate Competency 3: process and knowledge requirements:

- Routinely invites patients and the public to respond to and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective.
- Routinely ensures that patients and the public can share their experiences of health and care services and uses this to inform commissioning.
5 Determine target group to be engaged

The target group you wish to engage with might be as wide as the general public or as narrow as users of an existing service.

You will need to think about any ‘hard to reach’ or ‘seldom heard’ communities within your target group/s and service or disease specific patient groups.

Build a demographic profile of the target group – their age, sex, gender, ethnicity, and any other key characteristics. This will help you to identify appropriate activities and how to target them.

You may also need to think about whether you should involve the following people and groups, or let them know about the work you are undertaking:

- Local Overview and Scrutiny Committee;
- Local councillor(s) where not a member of the Overview and Scrutiny Committee;
- Local MPs;
- Local Involvement Networks;
- The local press.

6 Identify activity or activities to be used

Based on your objectives and the target group to be engaged, identify the most appropriate activity or activities to be used.

You should consider how will you involve:

- People from ‘hard to reach’ groups
- Local Involvement Networks
- Practice patient participation groups
- Disease-specific patient groups
- Relevant third sector organisations.

It may help to think about what level of engagement to table with the engagement continuum you need, from just giving information to true partnership.

Different groups may require different activities to involve them.

At this stage you should undertake a screening exercise to systematically assess and record the actual, potential or likely impact of the project on different groups of people, so that as far as possible, any negative consequences can be eliminated or minimised and opportunities for ensuring equality can be maximised. (This is the first stage of an Equality Impact Assessment).
The key questions that need to be assessed at this stage are:
- What are you looking to achieve in this activity?
- Who in the main will benefit?
- Does the activity have the potential to cause adverse impact or discriminate against different groups in the community?
- Does the activity make a positive contribution to equalities?

If the answer to the questions 3 and 4 is ‘yes’ then it is necessary to carry out a full equality impact assessment.

**World Class Commissioning**

Identifying activities and why you have selected these will help you demonstrate:
- Competency 1 process and knowledge requirement: to be skilled in a variety of public, community and patient engagement and involvement methods and communicates the local NHS priorities to diverse groups of people.
- Competency 3 skill: Proactive listening and communication skills to address the needs of all relevant stakeholders, including using third sector and community partners to seek and engage the voice of those who are seldom heard.
- Competency 3 process and knowledge requirement: Has a deep understanding of different engagement options, including the opportunities, strengths, weaknesses and risks.
- Competency 3 example output: Evidence of engaging hard-to-reach groups, such as through the Healthcare Commission’s ‘Data quality on ethnic groups’ indicator.

**7 Establish a working group**

Unless you are a complete hero, you will probably need help. This need not be as formally established as a working group – although regular meetings with all concerned do help you to ‘keep tabs’ on things and ensure everyone is ‘in the loop’.

In terms of who needs to be involved, and membership of the group, think about:
- Could service users or wider stakeholders be included in designing the process, running or evaluating it?
- Whose support do you need?
- Who needs to take action?

You should always engage with the service manager or managers of any individual services that you are seeking patient and public views on.
8 Set the parameters and principles for the work

This stage builds on the previous stages and should outline the parameters and principles that will guide the work.

The example principles below can be adapted, and provide a helpful check-point as the work progresses to ensure that your approach reflects best practice.

Example: Principles that underpin our work with patients and the public

- **Inclusive** – we will seek to involve the full range of stakeholders, including stakeholders from within and outside the NHS, people from different ethnic and socio-demographic groups, and people with disabilities. This is likely to involve different approaches for different groups.

- **Transparent** – we are committed to being open with stakeholders about the process, its parameters, information coming out from the engagement exercise and how their input will influence the decision-making process.

- **Genuine opportunity to influence decision making** – we will ensure that the views of those involved will genuinely contribute to the decision-making.

- **Feedback** – we believe it is important that those who are involved have the opportunity to hear information generated through the engagement process, how their involvement has contributed to any decisions, and what the decisions or next steps are. We will ensure that people receive feedback.

9 Plan the activity and evaluation

It cannot be emphasised enough that the best way to achieve effective engagement is to Plan! Plan! Plan!

Each of the methods described in the section on Methods of Engagement, includes how to plan the particular activity. At this stage you should develop an action plan that includes timescales and who will be responsible for particular actions.

You should also plan the recording, feedback and evaluation of the engagement process at this stage.

**World Class Commissioning**

Planning your evaluation will help the PCT to demonstrate that it meets Competency 3 process and knowledge requirement: undertakes assessments and seeks feedback to ensure that the public’s experience of engagement has been appropriate and not tokenistic.
11 Report back

Your reporting should include both the findings of the engagement process and an evaluation of how effective the engagement process has been.

In addition to writing a specific report in relation to the engagement activity, you should also report the engagement work you have undertaken and its findings within your commissioning plans or other reports relating to the wider work that this has formed part of. You should also record how the findings from your engagement activity have influenced any decisions made, plans or actions.

For advice on reporting back see Recording, feedback and evaluation below.

World Class Commissioning

Planning in advance how you will report the findings of the engagement process will help you to demonstrate:

- **Competency 1 example output**: Regular commentary in reports, findings, commissioning plans and other communications as to how it has consulted on issues and intends to represent the wider NHS community.

- **Competency 2 process and knowledge requirement**: Actively shares relevant information so that informed decisions can be made across the commissioning community.

- **Competency 3 process and knowledge requirement**: Ensures that patients and the public understand how their views will be used, which decisions they will be involved in, when decisions will be made, and how they can influence the process, and publicises the ways in which public input has influenced decisions.

Checklist for planning patient and public engagement and evidencing World Class Commissioning

This checklist is designed to help you:

- Plan and implement a patient and public engagement initiative;

- Review its effectiveness once you have completed the work;

- Demonstrate how the PCT is meeting the requirements of World Class Commissioning.

You should complete this checklist BEFORE undertaking your engagement initiative to help you plan it. This will also form the baseline against which you can assess the effectiveness of the initiative once it has been completed.

AFTER you have completed the patient and public engagement work, you should review the checklist and update it as appropriate. This will help you to reflect on the effectiveness of the patient and public engagement work and evidence how the PCT is meeting the requirements of World Class Commissioning.
### Planning for effective PPE

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#### What are the objectives and key issues or questions that you are seeking to answer through the engagement process?

#### What influence will the process and its findings have?

#### Is formal consultation required?

#### What relevant evidence or data might the PCT or partner organisations already hold?

#### What is the timetable for this activity, given the decision-making and sign-off processes that it needs to align with?

#### Who are the target group or groups that you wish to engage with?

#### What activity or activities will you use to engage with this group or groups?

#### What support or resources will you need to undertake these activities?

#### How will you evaluate whether the engagement has been effective?

#### How will you report the findings of the engagement process to those who have been involved and to wider stakeholders?
Methods of engagement

Giving information
Getting information
Forums for debate
Participation
Partnership
4 Methods of engagement

Aspiring to World Class Commissioning competencies 3 and 4

Outlined below are a range of methods of engagement. It is likely that you will need to use more than one method for a single engagement exercise.

It may help to think about patient and public engagement as a continuum, ranging from minimum involvement – just providing information to people – to maximum involvement – working in partnership. The table below might help you think about the most suitable activities for what you are trying to achieve. To shape and change behaviour, you must employ tactics at the right hand side of the table. Only by real involvement and interaction are you able to achieve a change in behaviour.

<table>
<thead>
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Giving information

Aspiring to WCC 1 and 3, there are a wide range of mechanisms for giving information.

Common mechanisms include:

- Exhibitions
- Written information, including:
  - Leaflets
  - Posters
  - Newsletters
  - Press releases to local press and radio

In general, you should seek advice and support from your communications lead to plan and execute information giving exercises. For this reason, only exhibitions are discussed in this section.

If you are considering developing information, further guidance is given in the section Developing written information.
Exhibitions

Exhibitions aim to convey information in a primarily visual form, with the support of one or more members of staff to distribute written information and respond to immediate questions.

Pros

- Exhibitions can potentially be targeted to specific audiences by their location, e.g. in the workplace, schools, shopping centres, community centres, clinics, conferences and trade fairs.
- Exhibitions can reach people other mechanisms might not, for example, people who would not attend an event or read information they are given or sent.
- Exhibition displays can be supported by more detailed information that people can take away.
- If the exhibition is staffed there is an opportunity for people to discuss the issue and information in more detail.

Cons

- Although there are a few mechanisms you can use to record feedback, in reality it is very difficult to capture the views that people have.
- If the exhibition is staffed, this can be resource intensive.
- If the site or timing is wrong, the number of people you reach may be limited.
- Exhibition stands at conferences and other venues may be costly.

Planning your exhibition

- Agree the key objectives for holding the exhibition (e.g. awareness of a service, to change behaviours)
- Identify the key audiences for the exhibition.
- Based on the key audiences, identify the best site or sites, and timing.
- Plan how you will promote the exhibition, e.g. posters, flyers, press releases.
- Design! Design! Design!
  - The display should be visually enticing to encourage people to visit the stand. For example, you might include pictures, maps, diagrams and models.
  - Information should be easily legible from a distance (no small print)
  - Information should be straightforward, easy to understand and avoid jargon.
- Exhibitions are most effective when they are staffed. Ensure the staff attending are well informed about the issues being outlined, and can discuss these with local people.
- Develop more detailed information that people can take away. You may need to think about whether this should be provided in different languages. See Developing written information.
Plan how you can capture people’s views – you might design a simple feedback form, invite people to write their comments on a poster on the stand, have a comment book or other mechanism. You may like to use a prize draw or other mechanism to encourage people to give you feedback.

Consider how you will evaluate whether the exhibition has been successful – number of people visiting the stand, number of comments received etc.

Consider how you might provide feedback to people who have visited the exhibition, the target audience and the public more widely.
Getting information
Aspiring to World Class Commissioning competencies 3 and 4

Surveys and questionnaires
Surveys and questionnaires can help to generate information from a large number of respondents.

Pros
- You can potentially gather data from large numbers of people
- You can design a sampling framework to survey a representative sample
- Findings can be easier to analyse as the questions (and potentially the responses) are clearly defined
- Findings provide quantitative data on how many people hold a particular view or prefer a particular option
- Questionnaires are quick and easy for people to complete, and do not need to be supervised or completed on-site
- You could use a professional organisation to do the work, which would give more independence

Cons
- The questions are determined by those designing the survey, and can omit issues of major concern to people
- Findings are not in-depth as there is no opportunity to explore issues, ideas or experiences further
- People are less likely to complete questionnaires and questions that seek more qualitative data
- Questionnaires are unsuitable for people who have problems with literacy, for example, people with learning disabilities, and people who do not speak English as a first language
- Depending on how questionnaires are distributed and targeted and the response rate, findings may be unrepresentative of your wider target population
- The NHS uses this format often and you need to ensure you are duplicating work already underway as there is the chance of ‘survey fatigue’ with recipients

Planning your questionnaire or survey
- Be clear about what you want to find out from the questionnaire and why.
- Whose views are you trying to elicit? Are the people you need to collect information from likely to complete a questionnaire?
- You may want to create a ‘sampling frame’ that describes the characteristics of people you want to collect information from and in what proportions.
Consider how to distribute the questionnaire to reach people in your target audience – e.g. mailing list, handed out at an event, available to take away from a clinic or site, web-based, emailed. To increase the return rate, multiple methods of distribution are usually best. Beware: postal surveys rarely have more than a 5% return rate, even with a stamped addressed envelope.

- Always pilot the questionnaire with some people from your target audience and revise it based on their feedback.
- Consider offering an incentive (e.g. a gift voucher to one person completing the survey, drawn out of a hat) to encourage a higher response rate.
- Consider how you will feedback the outcome of the questionnaire to those who have been involved – particularly if people are completing the questionnaire on an anonymised basis.
- Provide a well-written cover letter or sheet that will engage people in your target audience and encourage them to complete the questionnaire, and explains how you will use the findings and how you will provide feedback to people who want it.
- If you agree to feed back, ensure you this in and ensure you do it!

**Designing your questionnaire or survey**

- Give your questionnaire a short title that is meaningful to the people you want to complete it.
- Include clear and concise instructions on how to complete the questionnaire.
- Include information on how to return the questionnaire.
- Check you are only asking the questions that you really need answers to – the longer your questionnaire, the lower the completion rate! Two sheets of A4 is ideal.
- Plan how you will analyse the findings – this will help you to make sure the questionnaire design meets your needs!
- Ask for some demographic information to help you understand who has completed the surveys.
- Put the most important questions at the start of the survey, this means that partially completed questionnaires will still contain important information.
- Use coloured rather than white paper – peach, pink and yellow are proven to promote attention and thought to each answer.

For help designing your questions, see the section on **Designing questions for surveys, questionnaires and interviews**.
EXAMPLE
Neonatal Intensive Care Unit Appeal – Isle of Wight PCT

The Neonatal Intensive Care Unit is in great need of being relocated and refurbished to be able to care for NICU Babies in a pleasant, warm and safe environment.

In order to fully understand what was required/expected a Questionnaire was sent to existing and previous patients of the Maternity Unit.

Following feedback from the questionnaire, a NICU Fundraising Appeal has begun. The PCT is asking everyone from patients, members of the public and staff to become involved in helping raise money to provide the best possible care for NICU babies.
One-to-one interviews

One-to-one interviews can be conducted face-to-face or on the ‘phone.

Semi-structured interviews allow for more qualitative information, and aim to get feedback or explore and issue and enable interviewees to express their own feelings and concerns.

Structured interviews can be used to get quantitative data, but are less flexible for getting qualitative information, as they do not provide an opportunity for users’ views and perceptions to be explored in any detail. Their findings are easier to analyse than those from semi-structured interviews.

Pros

✔ Possible to get a good cross section of the population and reach specific groups e.g. by using interviewers who speak community languages.
✔ Semi-structured interviews provide a framework for discussion and freedom to explore people’s views in more detail.
✔ Can specifically target the characteristics of people you want to interview.
✔ May involve people who would find it difficult to attend an event or feel inhibited speaking in a group
✔ Independent view can be achieved by using external organisations to do the interviewing.
✔ Response rate can potentially be improved by using community organisations – although beware of potential bias in the reporting.

Cons

✗ Expertise is needed in preparing the questions.
✗ Setting up interviews can be time consuming.
✗ Without significant investment of resources, the number of people interviewed is likely to be comparatively low, so findings are open to criticism that they are not representative.
✗ Analysis of findings from semi-structured interviews is time consuming and requires skill.
✗ Some client groups may necessitate the interviewer to be chaperoned or have CRB clearance.

Planning your interviews

● Be clear about what you want to find out from the interviews and why.
● Clearly define whose views you are trying to elicit. You may want to create a ‘sampling frame’ that describes the characteristics of people you want to interview and in what proportions.
● Identify how many people you will interview – this will have significant resource implications in terms of setting up the interviews, holding the interviews and analysing the data afterwards.
Consider how to identify and recruit interviewees that match the sampling frame you have identified – for example, are they already on a database e.g. a patient information system, are they based in a clearly defined geographical location, do they belong to a particular community group?

Consider offering an incentive to encourage people to take part.

Determine whether you will use face-to-face or telephone interviewing.

If you are using face-to-face interviewing, will this be in a single location – e.g. on-site where a service or community group is based, or will you go out to meet with interviewees in different locations, such as their home or workplace.

If interviewees are coming to you, you may need to consider providing travel expenses and refreshments.

Always pilot the interview questions with some people from your target audience and revise it based on their feedback.

Based on the number of interviews you intend to hold, recruit interviewers. These could potentially include people from community groups or the wider community. It is likely you will need to provide people who have not been interviewers before with brief training.

It is good practice to provide interviewees with draft notes from their interview for comments and corrections before these are incorporated into the wider reporting framework.

Consider how you will feedback the outcome of the interviews to those who have been involved.

**Designing an interview framework**

Prepare a brief introduction for the interviewer to use at the start of every interview. This should include:

- introducing him or herself
- explaining the purpose of the project
- explaining what will happen during the interview
- telling the interviewee that you will send them a copy of your notes for checking, before these are incorporated into the wider reporting
- explaining how the information from the interview will be reported, including any issues relating to anonymity
- describing how participants will be provided with or can get feedback on the findings and how they have been used if they would like it

See the section on designing questions for surveys, questionnaires and interviews.

At the end of the interview, the interviewer should:

- Thank the interviewee for taking part
- Re-iterate that he or she will send a copy of the notes for checking
- Re-iterate how the interviewee will be provided with or can get feedback.
Patient diaries

Patients or carers follow a set of guide questions to keep a personal written record of their treatment and care over a period of time.

This method can be used as an alternative to in-depth face-to-face interviews.

Pros

✔ Over time, involving people in keeping diaries can help to develop a relationship of trust.
✔ Diaries record events and feelings as they happen.
✔ The use of guide questions enables you to explore the issues you are interested in.
✔ The diary approach provides qualitative information, allowing patients and carers to reflect, explain and suggest ideas and solutions.

Cons

✗ The person completing the diary will usually feel they have invested a lot of time and effort and will want to see some clear actions resulting from it.
✗ As completion of the diary is unsupervised, responses to the guide questions may stray away from the point.
✗ Diaries can be very time consuming to analyse.
✗ Those who have literacy problems may not be able to take part.

Planning a patient diary exercise

- Involve service users in designing the guide questions to ensure they cover the areas you are interested in and areas of concern for service users.
- Always pilot the guide questions with some people from your target audience and revise them based on their feedback.
- Identify how many patients you would like to complete a diary, and over what period.
- Consider how you will recruit patients to complete the diaries.
- Put confidentiality guidelines in place.
- Consider how you will respond if you are concerned about the performance of a health professional or a particular incident as recorded in a patient’s diary. Be clear about this with participating patients.
- Brief patients before they start, explaining face to face how the diary should be completed.
- Explain clearly how the information collected through the diaries will be used.
Mystery shoppers

‘Mystery shoppers’ are volunteers who audit services by pretending to be service users, then report on what they find. Mystery shopping has been used most commonly with young people to assess services such as those providing sexual health advice.

Pros

✔ ‘Mystery shopping’ can help to assess the customer care aspect of services.
✔ As real patients are not involved, there are no confidentiality issues.

Cons

✗ This method can’t be used when mystery shoppers would have to display symptoms or be prescribed medication for their conditions.
✗ Mystery shoppers are not generally able to explore an issue in-depth.
✗ Mystery shoppers do not necessarily bring expertise or experience of a service as a user.

Planning ‘mystery shopping’

• Be clear about your objectives and what you want to find out.
• To avoid a negative backlash from the service involved, work with the service to ensure they support the work. Do this by explaining the project aims and how it will be undertaken.
• Consider who you want as mystery shoppers – this should include both people who reflect the characteristics of current users of the service, and people who reflect the characteristics of people who do not currently use the service.
• Based on who you want to be your mystery shoppers, consider how to recruit them. This might be through contacts with other organisations, giving talks, or displaying posters.
• Provide training to your mystery shoppers. Ideally this should be over at least two sessions.
  – The first session can focus on getting to know each other, exploring the role of a mystery shopper, agreeing appropriate behaviour for the mystery shopper, exploring and agreeing the issues that the service will be audited against, and introducing a practical task (see below: Task 1).
  – The second session can focus on introducing the scenarios that will be used to audit the service, role playing the scenarios and trouble shooting any problems that might come up (see below: Task 2).
• Systematically go through each scenario and identify any risks and how these should be managed. For example, in a scenario where a young woman seeks advice about avoiding pregnancy, she may be offered an on-the-spot pregnancy test. In this case, the agreed strategy to avoid the risk of exposure or embarrassment might be to say that she has no time, but will return the next day.
Task 1
It is a good idea to give mystery shoppers an initial, relatively easy practice task after their first training session. An example practice task would be to find out how easy it is to get information about services within a limited time, using a scenario such as:

*A friend wants to get some condoms, but doesn’t have any money to buy them – can you find out where he should go?*

Task 2
Task 2 would be to actually use the service, role playing a scenario such as:

*You are going to a service because you want some free condoms. This is the first time you have asked for condoms. If you are under 16, your partner is a similar age to you. You have spoken to your parents about this, or are planning to, and you are happy about your relationship.***

Running the mystery shopping exercise
- Mystery shoppers should be able to choose the services they want to visit and the scenarios they want to use.
- Mystery shoppers should use false names and addresses, and carry with them a letter from a senior manager certifying that they are legitimate mystery shoppers, in case they want to get out of an awkward situation.
- Each mystery shopper should be given an assessment form on which to write up their views of the services, based on the standards already agreed in training.
- Set a limited time period for the visits and for completion of the assessment forms.
- The project worker should be on call during the period of the visits, and should check in with mystery shoppers occasionally to make sure all is OK.

Reporting back on mystery shopping
- Consider holding a half-day event for mystery shoppers to:
  - share their findings and experiences;
  - agree a format for the report;
  - ask for volunteers to help produce the report;
  - get feedback on how the project went.
- The final report should be based on the feedback from each mystery shopper’s assessment form and from the discussion at the half-day event.
- A good way to provide feedback is to invite service managers to an event where mystery shoppers can feed back their findings directly to service managers, through either giving presentations or adding individual comments to a presentation.
- Make sure you feed back to mystery shoppers what actions service managers intend to take as a result of their assessments.
- Reward or recognise the mystery shoppers’ involvement. A social event or outing may be one way of doing this.
Citizens’ panels

Citizens’ panels are generally used to build a picture of a community’s priorities, or to get a measure of public opinion on a specific issue a health organisation is working on.

Panels are generally made up of 1,000 to 3,000 people (depending on the size of the population they represent) and members reflect the demographics of the local community. Membership of the panel is normally for a fixed period, e.g. two years, after which response rates and engagement tend to decline.

Three or four times a year, panel members are surveyed, commonly by postal survey, on their views of a particular topic or topics the organisation is working on. Panel members may be given additional information in advance or alongside the survey to support them to develop a more informed view.

Many local authorities have a citizens’ panel, which may be used by NHS organisations.

BEWARE: Panels are a long-term commitment

Pros

✓ Panel members are recruited to reflect the demographics of the local community and can therefore be seen as representative of the views of the wider community.

✓ Panels generally involve a larger number of people than other forms of engagement, and their findings therefore, tend to hold more credibility.

✓ Due to the complexity of recruiting and managing the panel and analysing its findings, panels are commonly run by external organisations (e.g. MORI), which gives further independence and credibility.

Cons

✗ Panels are complex and resource intensive to recruit, maintain and analyse their views. This means they are usually run by external organisations, which can be expensive.

✗ Panels have all the disadvantages associated with surveys in general – e.g. more likely to generate quantitative rather than qualitative information, potentially exclude people with literacy problems etc.

✗ It can be difficult to maintain the enthusiasm of panel members, leading to a decline in the return rate of surveys.

Planning your panel

• Check whether there is already an established panel, e.g. through your local authority, that you might use or buy into.

• If you need to establish your own panel, investigate the resource implications – e.g. use of an external, specialist agency – and whether these will be available and can be secured over the medium to long term.

• Identify how the findings from Panel members can be fed into the decision making process.

• Plan the areas you wish to consult on well in advance.

• See the sections on Designing your questionnaire or survey and Designing questions for surveys, questionnaires and interviews.

• Consider how you will provide feedback to Panel members.
Forums for debate

Aspiring to World Class Commissioning competency 2

Meetings with existing patient, carer or voluntary sector groups

Groups may be based around a specific service, client group, interest group, or geographical location and may be run by the public or voluntary and community sector.

Pros

✔ It may be comparatively easy to arrange to attend one of the group’s regular meetings.

✔ Those attending the group already have particular experience, concerns or expertise in the issue that you are seeking to discuss.

✔ The group has a collective knowledge that does not rely on the views of one individual.

✔ Initial contact and discussions can lead to a productive on-going relationship.

Cons

❌ Groups could be biased or limited in their range of views.

❌ Groups are unlikely to include a representative spread of the population in terms of age, gender or ethnicity.

❌ Groups will not capture the full spectrum of stakeholders with an interest in the issue you wish to discuss.

❌ Well established groups may suffer from ‘over consultation’.

Planning your meeting

- Contact the PCT patient and public engagement lead and / or your local Voluntary Service Council to find out which local group or groups it might be appropriate for you to meet with.

- Clearly identify the objectives of meeting with the group. However, be aware that the group may raise issues or wish to discuss topics that are not on your agenda. You will need to consider how you manage this.

- Consider whether you intend this to be the start of on-going partnership working, or a one-off initiative, and be clear about this with the group.

- Consider whether you will host a meeting, or participate in an existing meeting that has been arranged. If you plan to participate in an existing meeting, you may find you need a longer lead-in time if the group has agendas planned in advance, or that the group are not able to dedicate as much time to the discussion as you would like. If you are hosting the meeting, see guidelines for planning an event.

- Provide a briefing to the group in advance on the issue(s) you wish to discuss with them.
• Prepare the information you need to present to them at the meeting in order to start the discussion, and the questions you wish to pose.

• Consider how you will make a record of discussions at the group – you may wish to bring a note-taker with you, as you are likely to be involved in the discussion.

• Agree how you will feed back to the group.
Public meetings

A public meeting is open to anyone to attend and may be based on a set agenda or on issues raised at the meeting. In the past public meetings have tended to be the ‘default setting’ for formal public consultation activities, but more recently they have been used more creatively for more constructive engagement with the public.

Pros

- Opportunity to reach a wide range of people, and potentially everyone with an interest in the issue to be discussed.
- Enhances accountability, as the public can directly challenge those responsible for decision-making.
- Can combine information giving with discussion.

Cons

- Public meetings are resource intensive, in terms of staff time planning and running them, and costs associated with publicity, venue hire, and refreshments.
- Unless well promoted, or debating a controversial issue, there may be a low turn-out.
- Participants are not generally required to book in advance, so numbers are unknown until the day, making the design of the session harder.
- As participants are not generally required to book, you have no control over who attends, and those attending may be unrepresentative.
- The event may only attract interested parties, lobby or pressure groups.
- There is the potential for interest groups to ‘hijack’ the meeting with their particular issues or views.
- A single meeting is rarely sufficient, as no one day, time or location will suit everyone.

BEWARE: Public meetings on sensitive or controversial issues (e.g. A&E or other closures) are likely to attract a large audience, who are often angry, and the opportunity for genuine informed discussion will be lost. You should consider other mechanisms for engaging people in debate on controversial issues.

Planning your meeting

- Plan the publicity well in advance and in a range of formats – e.g. press release, flyers, posters.
- You may also need to consider inviting the your local media. If so, you will need to have plans in place for handling the media and make sure your staff are well briefed.
Select a chair for the meeting who has the right skills and is perceived as clear and fair. You may like to consider whether the Chair should be someone from outside the PCT, as this can help with ensuring a balanced approach to different views and take some of the ‘heat’ out of moving the discussion on from a particular issue or person.

- Consider which members of PCT staff or clinicians you might need to attend to answer questions.
- Consider whether to invite Non Executives and clinicians to bring a different perspective to the debate.
- Arrange seating to encourage participation. This means avoiding theatre-style layout, and using a horse-shoe or ‘cabaret’ arrangement.
- Encourage speakers from the PCT and the public to introduce themselves.
- Ensure that participants have the information they need to contribute effectively. This may include giving a brief presentation and providing handouts.
- Ensure that the meeting provides a balance of presentation and discussion, with sufficient time for people to discuss the issue.
- Plan how you will provide feedback.

EXAMPLE
Open meetings in Berkshire West

Objectives
To inform their plans for commissioning services in the next few years, Berkshire West PCT ran three public engagement events in different locations during May and June of 2007.

The aims of the events were to:

- Gather public opinion on local health services.
- Gain a better understanding of what’s important to local people in terms of the types of health care they want to receive.
- Find out how people want to be involved in planning health services in the future.

In addition to these events, the PCT also ran a questionnaire throughout May and received a total of 437 responses.

Who attended
In total 68 people attended across the three events. Participants came from a range of backgrounds, including patients, carers, members of voluntary sector organisations, local authority/social services colleagues, local councillors within each of the areas, and a small number of the PCT’s own staff. There was also good representation from the black and minority ethnic communities. Although there was generally a very good age mix, the events did not attract many young people.
Format of the events

The events were facilitated by an external facilitator.

Following a short presentation on the Commissioning Strategy and the role of public engagement, participants worked in small groups to discuss six healthcare scenarios and the services they felt would be needed – including services that are currently available and potential gaps in service. Each group then fed back their discussions to the wider group.

During the lunch break, the external facilitator and planning team identified and summarised themes and issues that were common to all the scenarios, as well as some that were specific to individual topics and fed these back to the whole group after lunch, who were then invited to add further key points to the summary.

In the afternoon, participants worked in small groups to consider how the PCT can really enable members of the community to influence commissioning decisions.

Findings

Throughout the discussions there was strong focus on the individual as both the key player in health decision making and also as the source of knowledge and understanding of their own conditions.

Key themes were identified under the following headings:

- Co-ordinated information and communication
- First port of call
- Co-ordinated services
- Sustainable Voluntary and Community Sector services
- Equitable Access
- Seeing the person in context
- Targeted services – the right service in the right place
- Importance of preventive services
- Self-management
- Consistent and effective discharge
- Gaps in provision and support for those with mental health issues
Focus groups

A focus group is a discussion led by a facilitator, usually with up to 12 people, to discuss specific issues or topics.

Pros

✓ Allows you to identify a framework for discussion, whilst providing freedom for participants to contribute the content.
✓ Useful for providing an overview of issues and identifying issues to be explored in more detail or with a greater number of people later.
✓ Good way to explore issues in depth and get qualitative data.
✓ Interaction between participants may generate further thinking and ideas.
✓ Facilitator can ask for responses to be clarified or seek further information in particular areas as issues emerge.
✓ Can be an empowering and learning experience for participants.
✓ Can bring similar people together and help in forming an on-going group for consultation and involvement.
✓ Good way to involve those who cannot read or write, wish to communicate in languages other than English, or have other special communication needs.

Cons

✗ Generally involve only a small number of people relative to the wider target population, so are not good for gathering quantitative information and are open to the criticism that participants’ views are unrepresentative.
✗ Resource intensive to set up, run, analyse and report on.
✗ Confidentiality harder to ensure.
✗ May generate a large amount of information that, due to the more flexible approach, is not directly comparable across groups.
✗ Requires a skilled facilitator to ensure everyone is enabled to participate fully.

Planning your focus group

● Be clear about what information you want from the focus group. A focus group will help you to understand what views people hold and why, not how many people share this view.

● Consider who your target audience is – participants in a group should ideally be broadly similar in terms of age/gender/ethnicity and other criteria relevant to the focus of the discussion. You may want to develop a quota system, so that participants are representative of the wider group whose views you are interested in. However, it is not necessary to include a representative of each section of your target audience in your group, such as one disabled person, one older person, one parent… Remember: carers can be effective advocates for service users, but also have their own concerns that may differ from those of the person for whom they are caring.
- Ensure you have an appropriate environment, that is comfortable, accessible, and will be free from outside interruptions and distractions. You may like to hold the session at premises already used by the group you are trying to reach, for example at a youth club, as this can improve attendance.

- Consider if there is a particular day or time that is most or least convenient for people.

- A focus group, or small discussion group, works best with between 6 and 12 participants. This number gives scope for a range of different opinions and can generate a good discussion between participants, whilst still providing a safe and non-intimidating environment in which everyone feels comfortable contributing.

- Plan how to recruit people, this might include a variety of methods including leaflets, posters and direct individual invitations. It can be effective to recruit people in partnership with other agencies, for example recruiting young people through a youth worker, or older people through a luncheon club. However, be aware that you do need to know numbers in advance – too many people and the group becomes unmanageable, too few and the group loses its benefits. It is wise to recruit slightly more people than you need, to allow for people not turning up. You may want to consider offering an incentive, such as a gift voucher.

- You should meet expenses for people attending, such as travel and childcare.

- Consider whether you need to provide focus groups members with a briefing in advance to support a more informed discussion.

- Ensure that you have a skilled facilitator who is able to give participants confidence to participate, ensure that everyone has an opportunity to express their views, and can be flexible. You may wish to consider using an independent facilitator, as this can help to give people confidence to express their views, and reassurance that their individual views will be treated confidentially.

- Plan how you will record the discussion, you may want to have a note-taker and / or make a recording of the session.

- A focus group or small discussion group should last between 1½ and 2 hours – everyone’s concentration will decline after this!

- Design questions that are open and flexible enough to explore unanticipated issues that come up. A good plan is:
  - Ask an introductory question to get participants discussing the topic in general, for example: everyone here has a long-term condition. What are some of the aspects of living with a long-term condition?
  - Linking questions enable the facilitator to move from the broad general discussion to the more specific area of interest. For example: what particular issues might you need help or support with?
  - Key questions address the key issues you want to cover in the session. You should have no more than six or seven key questions, such as: what sort of service would help? How should such a service be publicised?

- Ensure that refreshments are available when participants arrive and throughout the session.
Running your focus group

- Organising the venue: Ensure that any special requirements are catered for, for example
  - disabled access
  - hearing loops
  - interpreters
  - special dietary requirements

- It’s boring, but… the facilitator needs to arrive early to ensure:
  - The room is well-sign-posted and easy to find;
  - The layout is correct (normally seating in a horse-shoe shape)
  - The refreshments have arrived!

- The facilitator needs to bring, or ensure that the room will include:
  - Flip chart stand, flip chart paper and flip chart pens (never trust the venue to provide the latter!)  
  - Name badges
  - Paper and pens for participants (people often like to have these available, even if you do not plan for participants to use them during the session).

- At the start the facilitator needs to:
  - welcome people to the group,
  - introduce him or herself and the note-taker (if there is one),
  - explain the group’s purpose,
  - explain what will happen during the session
  - explain how the information from the group will be reported and used
  - describe how participants can get feedback if they would like it
  - get people to introduce themselves.

- Set some ground rules, for example:
  - confidentiality within the group,
  - one person to speak at a time,
  - allowing everyone an opportunity to speak,
  - no jargon,
  - respect for others’ opinions and experiences.

- Allow time for the groups to develop and feel comfortable talking in front of and sharing information with each other.

- Use open ended rather than closed questions to encourage discussion, such as ‘why’ and ‘how’ rather than ‘how many’.

- Check the main points with group members before the end of the session.
● Finish by:
  – Summarising the discussion in broad terms
  – Repeating information already given on how the results will be reported and what will happen next
  – Thanking participants

**Analysing your findings**

● Look for trends – comments that were made by several people
● Look for unexpected findings – these can be extremely revealing
● Remember that tone and context can be as important as the actual words spoken
Seminars

Seminars are discussion groups that aim to impart, exchange and receive information and views. There is normally much greater input from the facilitator than in a focus group, and participants may well include a mixture of professionals, public and patients. Depending on the design – for example, you might include group working, as well as plenary discussions – seminars can accommodate a range of numbers of people.

Pros

✓ There is an opportunity to put across information to inform the debate, so can generate informed discussion.

✓ Participants may come from mixed backgrounds – e.g. health professional, service manager, service user – so will have a (rare) opportunity to hear views from others’ perspectives. This can potentially lead to more informed discussion and thinking.

✓ Provides qualitative information about people’s views.

✓ Existing groups with an interest in the issues to be discussed are likely to find this process engaging and rewarding.

Cons

✗ Generally involve only a small number of people relative to the wider target population, so are not good for gathering quantitative information and are open to the criticism that participants’ views are unrepresentative.

✗ Resource intensive to set up, run, analyse and report on.

✗ Confidentiality harder to ensure.

✗ Requires a carefully planned programme and skilled chair / facilitator to ensure everyone is enabled to participate fully.

Planning your seminar

- Consider the balance of participants that you want at the seminar – professionals, patients, public.

- Based on the participants you want, consider the best mechanism for inviting people. You may wish to have participants who have been specifically identified and personally invited e.g. by letter.

- Provide travel and other expenses to patients or members of the public attending.

- Consider whether participants should be given materials in advance – but bear in mind that people don’t always read them!

- Plan the design of the seminar carefully:
  - You will need to bear in mind that if you invite a combination of professionals and others, they will have different starting points in terms of their knowledge and understanding of the issues to be discussed. This means designing the programme in a way that allows for this.
– The programme should include a balance of presenting materials and discussion – too much presentation and the seminar may become boring and discussions will be curtailed.

– Depending on numbers, you may like to split participants into discussion groups, that then feed-back to the plenary group.

• Consider how the discussions will be captured – for example, you might need a note-taker at each table if the programme includes group work.
• Consider how you will feed back to participants.

EXAMPLE
Communications and Involvement Strategy for Bicester Hospital, Oxfordshire PCT

Context
The future of community healthcare in Bicester has been under discussion for a number of years. It has led to uncertainty within the local community concerning the type of facility which will replace the existing hospital, and the extent of services which will be provided. The local community’s confidence in the NHS and its ability to deliver on its promises has been seriously undermined. The PCT is now in a position to make an announcement about the future of Bicester Hospital and its services, including the controversial issue of whether or not hospital beds will be provided.

Aims
• To update local people on the future of Bicester Hospital and open up discussion on a replacement facility
• To involve stakeholders in the process leading up to the development of the new primary care centre
• To promote the benefits of the new facility to local people and begin to rebuild trust and address current negative perceptions

Target Audiences
• Local community of Bicester
• Town and District Councillors and officials
• MP
• Hospital staff
• GPs and commissioning groups
• Media
• ‘Save Bicester Hospital’ opposition group
• PPIF
• Voluntary groups
• Acute Trust and SHA
**Key messages**

- Tackle head-on the 30 bed issue and lay the ground for 10-12 beds using current bed ‘usage’ as a rationale.
- Move the debate forward and focus on advantages of the new primary care centre by showcasing similar centres around the country – highlighting the benefits it will bring to local people.
- Open up discussion around generic issues such as location of the new facility; access for local people and other tangibles that can be talked about at this time. Promote the community forum as helping to guide the process, in partnership with the PCT, throughout the coming months.

**Methodology**

1. **A two day open event**
   - An open day format where people will have a chance to look at information in a positive environment and ask questions informally.
   - A series of exhibition boards which will outline the current state of play, and present a vision for the future without committing the PCT to any particular model or services.
   - There will also be an opportunity for the public to engage with the PCT by ranking the PCT’s criteria for the project and suggesting their own priorities.
   - Staff to be present to answer questions as necessary.
   - An evening event for key influencers to make them feel ‘special’ and, importantly, ensure they all get the same message at the same time.

2. **Community Forum**
   - Will contain hand-picked representatives of different community groups to create a diverse panel of varying interests.
   - May inevitably contain antagonistic voices but the remit of the group will be to aid the development of the primary care centre.
   - Not a decision making body – more of a sounding board and group for finessing aspects of the plans.
   - External facilitation from Communications Management.
Café consultations

Café consultations are a way of enabling a large group of people to discuss questions in an informal and creative way. It does this by creating a relaxed, café-type environment, in which people can talk to others in small groups, and move between groups to meet new people and get a fresh perspective.

Café consultations normally take approximately 2 hours.

To be successful, café consultations really need to involve 20 people or more.

Pros

- You can determine who the most appropriate participants are, for example, this could be people that represent a cross-section of the local population or stakeholders in a particular issue, and could include health professionals.
- Café consultations enable participants to both share knowledge and generate ideas.
- The use of mixed and changing groups during the course of the event means that participants hear the same issue from different perspectives, developing their own thinking.
- Café consultations generate qualitative information from a potentially large group of people.

Cons

- It is helpful if the event is run by someone who is experienced in running café consultations.
- Café consultations can be expensive, as you will need to pay for room hire and refreshments, as well as the staff time organising them.

Planning your café consultation

- Identify the objectives of the event – i.e. the questions that you want to ask or areas you want to explore with participants.
- Identify the target group of participants.
- Plan how to invite people in order to reach your target group(s).
- Consider naming your event – for example the ‘carers café’ or the ‘connecting café’.
- Plan how you are going to create a comfortable, café style environment – for example:
  - Playing soft music when people arrive
  - Creating a banner with the name of the café
  - Covering the tables with table cloths
  - Putting flowers on the tables
- Develop a ‘menu’ of about four questions that you want the groups to discuss.
Running your café consultation

- It’s boring, but… the facilitator needs to arrive early to ensure:
  - The room is well-sign-posted and easy to find;
  - Tables are laid out cabaret style with sufficient room for everyone, including wheelchair users, to move between them;
  - Put the ‘menu’ of questions to be discussed on each table;
  - Make sure the refreshments have arrived!

- The facilitator needs to bring, or ensure that the room will include:
  - Flip chart stand, paper and pens for the front of the room
  - Flip chart paper and pens for each of the tables
  - Name badges
  - Table-cloths

- At the start the facilitator needs to:
  - Welcome people to the group.
  - Introduce him or herself.
  - Explain the purpose of the café.
  - Explain why you are using a café style for your event. Explain that often important conversations happen in informal settings
  - Explain what will happen during the session.
  - Ask every table to choose a ‘host’ who will stay at that table and make sure that the main points discussed are recorded on the flip chart paper covering the tablecloth. (Although it is not true to the café consultation methodology, you may find it helpful to identify willing hosts in advance).
  - Ask everyone to discuss the questions for 20 to 30 minutes and record their responses in words, pictures or diagrams on the flip-charts covering the table cloths.

- After 20 to 30 minutes ask everyone except the ‘hosts’ to move to other tables to discuss the same questions for 20 to 30 minutes with different people.

- Ask the hosts to explain to newcomers arriving at their table the main points of the previous discussion.

- After people have moved between tables two or three times, discussing the questions for 20 to 30 minutes each time, ask each table to spend a few minutes considering the main points raised at their table.

- Ask each ‘host’ to tell everyone at the café the main points their table has agreed.

- When all the ‘hosts’ have spoken, you can ask the whole group questions such as:
  - What is emerging here?
  - Are there any patterns to the feedback we have heard?
  - If there was a single voice in the room, what would it be saying?

  You may want to record these plenary discussions on a flip chart.

- At the end of the session, you may invite people to walk round the table cloths and look at them, and add any comments that occur to them using post-it notes.

- Finish by:
  - Summarising the discussion in broad terms
  - Describing how the findings will be reported and what will happen next
  - Thanking participants
Participation

Working towards World Class Commissioning competencies 2 and 3

Health Panels

Health panels are primarily used for exploring local people’s views on policy issues and the allocation of NHS resources. Panels are usually made up of 8 to 12 people drawn from patients and the public to reflect local demographics. Each panel member has a fixed term and is then replaced by a new member.

Pros

✔ Panels are made up of people recruited for their characteristics in terms of age, gender, ethnicity and location of residence, rather than their particular interests or knowledge about health issues, and represent a cross-section of the population.

✔ Complex issues can be discussed and deliberated by people in an informed way.

✔ Panels can provide useful views on resource allocation and priorities between treatments.

✔ Panels receive relevant information beforehand to enable them to give reasoned and informed opinions.

✔ Taking the views of panels into account when making decisions can help to demonstrate accountability.

✔ Panels can meet at regular intervals, which helps develop a dialogue with local people.

Cons

❌ The information given to panel members is drawn up by professionals, who can only anticipate the type of information needed from their own perspective. It may be unknowingly selective or inadequate.

❌ If too many issues are discussed there may be insufficient time to allow much debate and panel members may end up just giving their views, rather than the reasoning behind them and developing their own thinking.

❌ The success of the panel discussion is heavily dependent on the skill of the facilitator.

❌ Panels do not provide quantitative information because the number of people taking part is too small.
Planning a health panel

- Determine the best method for recruiting a representative sample of local people. Recruitment criteria should be open and transparent.
- Identify someone to plan and co-ordinate the panels. Amongst other things, this person will need to co-ordinate the collation of information on the issues the panel will discuss.
- Consider how you will determine what issues the panel should review. These should be a combination of your agenda and ideas from the panel.
- Be clear at the outset of each panel meeting how the panel’s views will feed into the decision-making process.
- Use a skilled facilitator.
Citizens’ Juries

Citizens’ Juries are particularly appropriate for involving the wider public in decision-making about setting priorities and strategic planning choices. NHS organisations can pose difficult questions, for example on the prioritisation of services, which involve value judgements in reaching a decision.

The jury consists of 12 to 16 members of the public, and members are drawn from a cross-section of the local population.

The jury meets for several days, during which time it hears evidence from key ‘witnesses’ – e.g. health service commissioners, service managers, interest groups. Jurors are also able to ask to hear from additional witnesses identified through the process. After hearing all the evidence, the jury considers the issue in depth before making recommendations to the NHS organisation.

Proceedings are commonly open to the general public to attend and listen to, but they are not able to participate.

The process is normally facilitated by an independent moderator.

Pros

✔ Jurors broadly reflect the characteristics of the wider population, so bring a degree of representativeness.

✔ Jurors participate as citizens, so, in theory they are not direct stakeholders, but seeking the best outcome for local people as a whole.

✔ Jurors are provided with information from a wide range of perspectives, with time to discuss it in detail, and so are able to come to an informed view.

Cons

❌ As with all activities involving a limited number of people, jurors are open to criticisms of being unrepresentative.

❌ Although jurors are drawn from the local population, their views and values may not reflect those of the wider population.

❌ Jurors may not be able to articulate their views and concerns.

❌ Citizens’ Juries involve a huge amount of resources (estimate about £25,000) in terms of planning (months) and execution.

❌ The jury may not be able to reach consensus on its recommendations.
Planning your Citizens’ Jury

- Start planning about three moths before you want to hold the Citizens’ Jury.
- Define the issue under review carefully. Juries are generally able to focus on only one issue.
- Ensure that there is senior level commitment to following the recommendations of the jury. This may not ultimately be possible, but the process will lose credibility if the findings are rejected wholesale, or there is not a full and proper explanation of why they cannot be implemented.
- Establish a clear sign-off process for agreeing how the recommendations will be reviewed and accepted for implementation.
- Due to the resources and time involved, ensure that there is senior level commitment to the process and meeting its cost.
- Identify a wide range of witnesses who will bring expertise and different perspectives, and book them well in advance. You should think about including commissioners, service managers, clinicians, patient representatives, democratic representatives (e.g. elected members from the local authority).
- Identify the demographic make-up of jurors and plan your recruitment process accordingly. You may need to recruit more jurors at the outset than you need, to allow for some not ultimately participating.
- Provide jurors with training to understand and fulfil their role and feel confident doing so.
- Book a skilled independent moderator to run the event.
Open space events

Open space events are a large group event (15 people upwards), where participants themselves create their own programme around a pre-determined theme. Apart from the theme, there are no speakers and no set agenda, so participants decide exactly what is discussed and when.

Open space events are generally run over one to three days, although it is possible to run shorter versions.

Pros

- Open space events can generate ideas and thinking completely determined by participants.
- Open space events can accommodate a large number of people.
- Open space events work well with a diverse range of participants, in terms of background – e.g. health professional or other stakeholder – demographics and other characteristics.
- Participants only need engage in discussion areas that interest them, hopefully ensuring that they are fully involved, rather than disengage at different points during the process.

Cons

- Although the theme is pre-determined, it is impossible to predict the areas of discussion that will be generated participants, therefore some areas may be left unexplored.
- Open space events can be complex to manage on the day.

Planning your open space event

Identify the theme or question for the event. This should frame the widest context for your discussion in a positive way. For example ‘How do we improve the health of people living in Erewhon?’

Identify the target participants for the event. It normally works best to invite a range of people from different backgrounds and different viewpoints.

Running your open space event

- It’s boring, but… the facilitator needs to arrive early to:
  - Ensure the room is well-sign-posted and easy to find;
  - Ensure tables are laid out cabaret style with sufficient room for everyone, including wheelchair users, to move between them, or that there are ‘break out rooms’ that different groups can use;
  - Number the tables / rooms, to help people get to the right place during the event
  - Create an ‘agenda wall’
  - Create a ‘news wall’ with space for people to put up flipcharts.
The facilitator needs to bring, or ensure that the room will include:
- Flip chart stand, paper and pens for the front of the room
- Flip chart paper and pens for each of the tables / rooms
- Name badges

At the start the facilitator needs to:
- Welcome people to the group.
- Introduce him or herself.
- Explain the purpose of the event and its central theme or question.
- Explain the key principles of open space events:
  - Whoever comes are the right people
  - Whatever happens is the only thing that could have
  - When it starts is the right time to start
  - When it’s over, it’s over
- Explain the Law of Two Feet:
  - At each discussion group, people can leave when they wish, or join another group, when they feel they have contributed or learnt all they can.
  - This means people have to take responsibility for what they care about, using their own two feet to move to whatever place they can best contribute or learn.
  - There are two types of behaviour you might observe. ‘Bumblebees’ are people who flit from group to group, cross-pollinating. ‘Butterflies’ are people who may spend some time outside of any group, either thinking alone, or chatting to one other person.
- Explain that anyone can convene a small group to discuss any topic they care about, related to the theme of the event.

The facilitator then allows participants some time to think about which topic they’d like to discuss. Then participants who would like to talk about a particular topic related to the theme write the topic name, their name, the meeting time and table / room on a post it note. Each participant can generate as many topics as they like. Participants then stick their post-it notes with topics for discussion on the Agenda Wall.

The facilitator then goes through the topics with the group, and gets people to sign up for discussion groups and create their own individualised ‘programme’ of groups they will attend.

Then the groups start.

The participant who put up the topic is the ‘convenor’ of that discussion group, and is responsible for recording (or ensuring that someone records) the key points from the discussion on a flipchart. Ask them to record the discussion in such a way that it can be understood by someone who did not attend their group. When the discussion group finishes, the convenor should put the flipchart recording the group’s discussions on the news wall.
About 40 minutes to an hour before the end, everyone should reconvene for a plenary session. For the first part of the session they should view the different posters on the news wall.

The facilitator should then lead a discussion:

- Checking all the issues of concern have been discussed
- Identifying issues that have emerged as critical or key through the process
- Ranking the issues in priority order

Find out more at www.openspaceworld.org
Partnership

Aspiring to World Class Commissioning competencies 1 and 2

Community development

Community development involves local people in identifying their own health and social care needs and finding ways to address them. This might be through influencing and informing commissioners and providers and other key agencies about how the community can help shape service provision. It is likely to involve supporting the community to set up and sustain support systems and projects.

Community development is likely to become more prominent as the NHS is increasingly encouraged to commission more innovative models of service provision from non-traditional providers.

Pros

- Community development focuses on lay, rather than professional, views, allowing local people an opportunity to consider what they think they need to improve their health and well-being.
- It provides assessments in areas where the health and social care needs are often directly related to poverty and cannot be tackled in isolation from other agencies and the community.
- It commonly requires and facilitates collaboration between agencies and brings together statutory and voluntary sector agencies and local people.
- It strengthens local community infrastructure and as such can provide a basis for leveraging in other resources and funding.
- It can support local communities to develop their confidence and self-esteem and enable individuals to develop new skills and knowledge.
- It is long-term, and so allows in-depth understanding of health concerns and aspirations and the determinants of health.
- It can be very locally focused – centring around a particular estate or GP practice.

Cons

- It is a long term commitment.
- To be successful community development involves developing effective relationships with partner agencies and the community. This takes time and commitment.
- The results are unpredictable.
- Local people’s views may differ from health professionals’ and others’ views of what is needed.
- Needs identified locally cannot automatically be implemented, as they often involve other agencies, factors or dynamics.
- The outputs might be costly to implement.
It is likely to be costly, as at the very least it will require resources to run the process, pump-priming to set up projects and support to evaluate them. There may not be an outcome for a long time.

Planning for community development

- Ensure that your organisation is prepared to make a long-term commitment.
- Consider engaging partner organisations in the process early.
- Identify any joint commissioning or formalised partnership arrangements that the work will feed into.
- Identify a budget to support the community to develop their own projects and support networks.
Working with lay representatives

**Pros**

- Lay reps generally bring some experience or expertise in the issues.
- Because lay reps attend meetings on an on-going basis, you can build a positive relationship with them.
- Because lay reps are involved on an on-going basis, they can develop additional expertise in the issues.

**Cons**

- No matter how many lay reps are on a particular group, they can never be representative of the full range of stakeholders.
- A single individual may find it difficult to speak in a meeting of professionals.
- If no other engagement mechanisms are used, their involvement can appear to be a token gesture.

**Defining the lay rep’s role**

- People must be clear in what capacity you are seeking to involve them, and realistic on how that involvement could influence change.
- Are you looking for someone to represent an organisation, or particular interests, or their own views as an individual?
- Are you looking for someone who could communicate and articulate lay views to particular groups and audiences?
- Decide what qualities, skills or experience your lay reps will need.

**Finding your representatives**

Decide how many reps you will need. Bear in mind that a single individual may find it difficult to speak in a meeting of professionals.

Be clear and open about the methods you are going to use to make your selection.

- Use a variety of recruitment methods. Advertise, consult community and voluntary organisations, use leaflets and flyers. Use other languages where appropriate.
- Design an application form and selection process. Forms should be clear, simple and non-discriminatory. Interviews should be informal, but consistent.
Meetings

Involvement doesn’t have to take place at a meeting – you can consult by telephone, letter, questionnaire, or e-mail. But sometimes there’s no substitute for face-to-face discussion. Meeting can promote a greater understanding on both sides, and a discussion can create development of ideas and projects. In this case, invite lay reps to a meeting. But don’t assume lay reps are waiting to be asked – they lead busy lives!

Expenses

All out of pocket expenses should be covered – we are paid to be there and we claim expenses for the costs associated with being there. Expenses might include travel costs – mileage or public transport fares – parking costs, or replacement care or childcare.


Supporting representatives

Provide relevant training and background information, for example:

- A working knowledge of the NHS
- Information about the project in question
- How to be effective on a committee
- How to influence decision-makers
- Provide information in the format the lay rep finds convenient

Provide support for representatives with special needs

- Choose a location which is accessible for those who have mobility problems, and for those who do not drive.
- Convenient start and finish times. Remember that some medication has ‘early in the day’ side effects.
- Take account of family or work commitments.
- Provide communication support, such as sign-language interpreting.

Monitor effectiveness and provide support

- Do you have a better understanding of the issues?
- Has this influenced decisions in any way?
- How have the lay reps experienced the involvement?
  - Influencing the agenda
  - Gaining information
  - Making their voices heard
  - Making their opinions count
Meeting with lay reps – tips for organisers

Before the meeting

- Check availability of the lay rep. Lay reps will need to know the timing and frequency of meetings and any other work, such as reading background information.
- Check whether they have any special requirements, such as communication support, mobility or dietary needs.
- Briefly say what the meeting is about and what contribution they can make. For example you might ask them to offer a patient perspective, or challenge jargon and assumptions.
- Tell them who will be there, the names of the professionals, and what job they do, and any other lay representatives.
- Give them some broad examples of what might be discussed. This might be how to set up a new service or improve an existing one. It could be how to make it easier for people to access a service, or how to publicise a service.
- Reassure them they will be able to follow what is being said, and then encourage all authors of papers to write in plain English.
- Tell them what the ‘rules’ are about information sharing and privacy – if a lot of confidential information is to be discussed, you might want them to consider asking them to sign a confidentiality agreement to example from Buckinghamshire PCT below.
- Be clear about what influence they really have – some decisions may have already been taken, and it’s important to be honest about this.
- Send an agenda and minutes of any previous meetings with a map.
- Notify of any changes or cancellations.
- Make arrangements for expenses to be paid, and make sure lay reps know they can claim these.
- Ensure that there is a supply of water or other refreshment available.
- Provide a contact name and number, so the lay rep can call if they need further information before the meeting.

During the meeting

- Make sure everyone is introduced and that lay reps are welcomed.
- After each item, the chair should check whether lay reps have a further contribution to make – it can be really difficult for lay reps to claim an equal voice.
- Jargon should be limited and clear explanations given when it has to be used.
- Lay reps’ contributions should be indicated in the minutes. This shows they have been listened to.
- At the end of the meeting make it clear what will happen next and how their contribution will be used.
After the meeting

- The chair should check for further questions from the group.
- Make a point of thanking lay reps before they leave – after all you have been paid to be there – they haven’t!!
- Follow up after the meeting to ensure that there are no outstanding issues that were not expressed at the meeting and to check how they felt about it e.g. the way it was conducted and whether they felt welcomed.
- Tell them about any action which resulted from the meeting – many lay people get involved in order to make a difference. If they feel they haven’t, they may leave the group.
- Make sure expenses are reimbursed as quickly as possible.

*With thanks to Buckinghamshire PCT*

Tips for lay reps going to a meeting

- Ask who else will be attending – which professionals and if there are other lay reps from voluntary or support groups.
- Don’t feel pressurised into speaking at a first meeting – you may want to absorb the information and return to the next meeting with a better idea of what you want to say.
- Remember that meetings are not only to hear lay people’s views, but also so that you can understand the professionals views and difficulties.
- If you want to speak, catch the chair’s eye and raise your hand, and keep it raised until you receive a response.
- It can help to write down your comments to read from.
- Don’t make yourself vulnerable by exposing too many personal details.
- Do not be afraid to question the meaning of jargon and acronyms.
- Remember that you were invited to the meeting and that we value your contribution.
- Afterwards, don’t be afraid to let the person who invited you to the meeting know how it went from your point of view.
- Your contribution is very valuable!!

*With thanks to Buckinghamshire PCT*
Buckinghamshire PCT, Confidentiality agreement

We ask all volunteers as a condition of their involvement to sign a confidentiality agreement.

This agreement says that all volunteers will treat any information gained while working within the PCT, including information relating to patients, with the strictest confidence. Breaking with this agreement would automatically prevent a volunteer from continuing their work within the PCT.

Information concerning patients (including non medical matters such as attendance, relationships, age etc.) must be regarded as information for PCT purposes only, and must not be discussed outside the PCT or with members of the public who may be visiting the PCT. Please note that this ruling also applies to talking to the press. Any enquiries from the press should be directed to the Trust Communications Officer.

It is in the interests of all voluntary workers to be aware of this requirement, so you are asked to sign the section below stating that you fully understand this agreement and its implications.

I have read the conditions regarding confidential information in the PCT stated above, and fully understand the implications, and agree to adhere to them.

Name

Signature

Date
Service User Forums / Patient Groups

User forums are groups to 10 to 20 service users who meet on a regular basis to discuss topics of concern to them as users of a project or service. The forum has a recognised mechanism for feeding into the decision-making of a project or service.

User forums involve longer-term engagement with people who are key stakeholders and generally well-informed about the issues and service available.

Pros

✔ By definition, members of the group use the service and therefore bring some experience and / or expertise in the issues.

✔ Because the meetings are on-going basis, you can build a positive relationship with the forum members.

✔ Because forum members are involved on an on-going basis, they can develop additional expertise in the issues.

Cons

✗ Service users on the group may be unrepresentative of the views of wider service users.

✗ A service user forum cannot capture the views of potential users who are for some reason unable or unwilling to access the service.

Establishing a user forum

- Be clear about the remit of the group, for example, to provide the means for patients to provide feedback about the service and make positive suggestions to improve it.

- Consider how you will recruit participants, some approaches include:
  - On notice boards in the service reception area
  - Through local voluntary/support groups
  - Leaflets/handouts at reception
  - Approaching people directly

- Plan your agenda to ensure it is relevant and interesting in order to maintain engagement. Agenda items should take into account the views of staff and patients.

- Service user forums tend to operate most effectively if staff representatives as well as patients are present.

- Provide feedback from the group to all staff and the rest of the patient population.

Further information is available from the National Association for Patient Participation, the umbrella organisation for patient participation groups within primary care. See www.napp.org.uk
EXAMPLE
Terms of Reference for a Patient Group based in a GP Practice, Southampton City PCT

Objectives

– To encourage the involvement of patients in developing and improving services in the practice.
– To encourage the involvement of patients in their own care.
– To regularly review the results of the Patient Survey.
– To share information on national NHS developments which will affect patients of the practice.
– To regularly feedback actions agreed upon by the group to its members and patients of the practice.
– To regularly review these terms of reference in order to ensure that they remain relevant.

Activities of the Group

– The Group will meet every two/four months
– The Practice will be the venue and the meetings will take place early evenings
– Correspondence, agendas etc will be the responsibility of the Practice Manager.

EXAMPLE
Patients with a Disability Working Group, Isle of Wight PCT

This is a group of around twelve members who either have a disability themselves or work for a community based disability service such as Isle of Wight Society for the Blind and the RNID.

The group discuss and change services design/facilities and general awareness of disability issues around all NHS services on the island. They also have an input into the DDA and what they feel should be completed as a matter of priority.

EXAMPLE
The Reference Team, Isle of Wight PCT

This is a very new group of service users who have experienced or is experiencing a mental health problem or that has had formal contact with or use the mental health services. The group is involved in defining the issues of concern to them and in making decisions about factors that affect the lives of people with mental health problems.

It aims to:

– represent the views of mental health service users at a local level with a view to improving the provision of services
– raise public awareness of mental health issues, tackle stigma and to educate around areas of concern.
Valuing diversity: involving all

Marginalised groups
Understanding the context and challenges
Identifying when you need to use different or targeted methods of engagement
Target groups and issues to consider
5 Valuing diversity: involving all

Marginalised groups

Some groups of people have particular difficulties, not only in accessing services, but also in making their lack of access to services known to those who commission, plan and provide services. Terms such as ‘excluded’, ‘marginalised’, ‘hard-to-reach’, ‘seldom heard’ and ‘disadvantaged’ are commonly used to describe people who are excluded from mainstream social systems.

Examples of such groups include:
- People who are disadvantaged by poverty and associated inequalities;
- People who do not speak English as a first language;
- People with hearing, speech or visual impairments;
- People with learning, communication or cognitive difficulties;
- People with physical disabilities;
- Mental health service users;
- Older people;
- Young people – i.e. teenagers and children;
- People who are housebound;
- Homeless people;
- People who have previously experienced or continue to experience discrimination such as racism or homophobia;

Understanding the context and challenges

The concerns of marginalised groups have generally been seen as separate or different from those of the wider population – this ‘separateness’ can mean that their issues are treated as peripheral to the mainstream agenda. However, marginalised groups are users of mainstream services as well as specific services and their views are just as important as those of members of the wider public.

Engaging with marginalised groups has been seen as part of demonstrating good equalities practice – this has sometimes led to superficial adjustments that exacerbate the problems of tokenism.

Engagement initiatives have rarely involved marginalised groups in the planning – without involving people in planning, we may fail to understand the barriers to their participation and so are unable to design processes that encourage and enable them to be involved.

Marginalised groups may not be ‘organised’ into defined and accessible communities – this means that groups have previously been and potentially continue to be excluded.

Marginalised groups often need a longer and more sustained time table of involvement. This is so that barriers may be broken down and an environment of trust
created. It is important to specifically meet needs of time of the event, crèche facilities, transport, accessible venues, facilities such as induction loop systems, signers, interpreters, special dietary requirements and the provision of information in different ways. In addition, events should be aimed at specific groups and communities and emphasis placed on confidentiality and the value and benefits of their input.

Identifying when you need to use different or targeted methods of engagement

Traditional methods of engagement often fail to reach marginalised people. For example, focus groups with a cross-section of people may not work for older people who are not able to go out without support.

When identifying whom you need to involve and which groups in particular you might need to target, compare the characteristics of the people who use the service with those of the wider population and those who have been involved so far. Where you find gaps, consider carrying out special initiatives to target under-represented groups to ensure that they have the opportunity to have their views heard and taken into account.

It is likely that you will need to use a wide range of different engagement methods, some tailored specifically to meet the needs of particular groups.

Target groups and issues to consider

As a general tip, public health often do targeted work with specific groups that health services find ‘hard to reach’ and may be able to recommend forums or other mechanisms that you can use.

Minority ethnic communities

- Minority ethnic communities are not a homogeneous group, it is important to understand the specific needs of the different ethnic groups you wish to engage with.
- Time and resources are needed to build relationships and trust with communities, and in particular with people who may be less visible within these communities, such as women, disabled people or people with mental health problems.
- Well established communities often have strong networks, and these social groups can help to encourage people from BME communities to engage. They offer a sense of safety which, in turn, offer leads to other involvement activities.
- Community leaders can provide useful input. However, this is not a substitute for engaging with people directly.
- There is evidence to suggest that text-based methods of communication, even where these are translated, will not be accessible to all members of some minority ethnic communities, as people may speak but not read English, or may not read the language that they speak. This implies more visual methods of communication and face-to-face engagement are more likely to be effective.
- Gender issues are particularly relevant for some minority ethnic groups.
• Some ethnic minority communities conceptualise health and illness differently, so their understanding of, for example mental health problems, will be different. These differences need to be understood and addressed through the engagement process.

• In some cases cultural and religious belief systems can hide issues of disability, making it harder for people to engage with services or get involved in engagement activities.

EXAMPLE
Cardiology workshop, East Berkshire PCT

The PCT worked in collaboration with the National Centre for Involvement and the local acute trust, Heatherwood & Wexham Park Hospital Foundation Trust, with cardiac patients from South Asian community on communication with this patient group.

The PCT set up a workshop for patients from this group who had some experience of the cardiology service and who were keen to express their views on their experience.

Publicising the workshop

The PCT used existing contacts to promote the workshop through:

• Chaplains – who recruited individuals to attend
• Pakistan Welfare Association
• Hindu Temple of Slough
• Slough Mosque
• Slough Gurdwara
• Cardiology support groups

Key Staff along cardiology pathway from both Acute Trust & Primary Care were invited to attend (including Cardiologist, CCU Staff, GPwSI, smoking cessation, health activists, rehabilitation, Lead CHD GP)

Initial invites were sent out by letter then followed up by phone and face to face meetings.

At the event

Although the workshop was held on a Friday afternoon (Prayer time for Muslims) the number of people who attended was brilliant, with 15 patients, from different religious and ethnic backgrounds.

What next?

The workshop went well and as a result of public feedback the PCT has developed a simple guide to accessing health services which is in very plain English and supported by visual images. This is not only accessible for people with language barriers but also those who are visually impaired, those with learning disabilities and children & young people.
Children and young people

- If you are setting up an activity or event that is not linked in with the school curriculum, it needs to take place after school, at weekends or during school holidays.
- Particular effort needs to be made to involve children who are disabled, have learning disabilities, or have domestic and care responsibilities, which make it difficult for them to participate.
- Provide free refreshments and other goodies (balloons or stickers for younger children, music or vouchers for older ones), as this will encourage people to get involved.
- Make sure that staff working with children have an enhanced CRB check, and that at least two workers are with the children at any one time. You will also need to comply with the relevant Child Protection Policies.
- Run activities where children and young people already go – tapping into established groups means less time spent on recruiting groups, and you can work with children where they already feel comfortable.
- Be honest and upfront with young people about any constraints that may limit what they are able to influence.
- Think what age group you wish to attract and design the activity accordingly. Use language appropriate for their age group and ability.
- Use a range of methods that will engage children and young people in expressing themselves directly. It is always good to be prepared with several ideas about what you would like to do, in case the young people aren’t responding well.
- Make it fun, with games and creative activities.
- Possible ways to involve young people include:
  - Community fun days
  - Workshops in the community
  - Health projects in schools
  - Art and creative media projects
  - Surveys
  - Prize draw contests and drawing contests
EXAMPLE
Buckinghamshire Children and Young People’s Trust, Every Child Matters Event

Buckinghamshire Children and Young People’s Trust held an event to find out from local children:

- Which of the Every Child Matters outcomes they thought were the most important.
- What issues they felt were most important to children in Buckinghamshire.
- How things could be improved for children.

37 children and young people from across Buckinghamshire attended, ranging in age from 7 to 10 years.

Activities were carefully planned to keep the children interested and engaged and to make the event enjoyable. Examples of the activities used include:

Icebreaker – Human Bingo
All children were given a ‘Bingo’ sheet divided into 15 squares. Each square challenged the participants to find people who fit into a certain category. The children asked other children what category they fitted into and they wrote their names in one of the fifteen boxes. When the boxes were complete the participants shouted ‘Bingo!’ The activity got children moving around, talking to each other and finding out each other’s names. This was important because the majority of children did not know one another.

Diamond ranking / snake activity
The children were asked to put the five Every Child Matters Outcomes in order of importance. Each outcome was printed on a piece of card. The children worked together to decide which order the outcomes should go in. They were given the choice to put the cards into a diamond shape or a long snake shape. The activity helped the children identify which of the Every Child Matters outcomes were the most important and set priorities together as a group.

At the end of the day, the children and young people were given an evaluation form and asked to give a picture response against a number of questions:

- Good (smiley face)
- Ok (face neither smiling nor not smiling)
- Poor (frowning face)

Comments included some children saying ‘Can we come again tomorrow?’ and ‘We want to do it again’ and parents said the event was ‘excellent’.
Carers

Carers are both users of mainstream services – and sometimes specialist services – and providers of service.

- When organising events, it is important to consider the potential impact on their caring responsibilities. Carers can receive either cash payments or vouchers for short breaks through their local authority.
- You should also provide travel expenses and refreshments.
- Not all carers are adults, you may need to make explicit efforts to engage with young carers.

Learning from the event

Some of the learning from the event to help plan future events was:

- More exciting activities were needed such as using a climbing wall.
- It would have been useful for staff and children to have had use of a microphone.
- Consultation to be given to how children and young people are identified to attend.

EXAMPLE

Sexual Health Promotion, Isle of Wight

Isle of Wight PCT has undertaken a series of activities to engage young people in sexual health promotion, including:

- Conducting Mystery shoppers exercise around young peoples sexual health services and Pharmacies.
- A young person consultation day, Wight 2 B Heard which this year had sexual health band teenage pregnancy as one of the focused areas.
- Introducing a quality mark called FACT the design for which was chosen after consultation with young people.
- The Youth Service film team, made up of young people, have made a film on chlamydia for young people which was premiered at a local theatre and is now available across the Island to schools.
People with sensory impairments

- People with complex or additional needs often find that only one need is addressed. For example, deaf people with learning disabilities may find that those disabilities are addressed at the expense of their needs as a deaf person, or vice versa.
- Providing communication support, such as BSL interpreter, can be expensive, but should not mean that people with communication needs are excluded from participation.
- Text-based communication methods may not be suitable for people with sight impairments. Documents should describe clearly and in large font how information can be obtained in alternative formats.

People with cognitive and learning disabilities

- A key issue for this group is the assumption that they are unable to understand the issues and make choices.
- Provide information in an accessible format – i.e. short sentences, large print, pictures.
- It is important to explore the best ways of communicating with individuals, particularly people with more than one impairment.
- People may need advocacy support to prepare for meetings or discussions.
- People may need advocacy support to participate in meetings or discussions. But do not just talk to the advocate. Engage the service user and talk to them, even if the advocate needs to answer on their behalf.
- Families trying to protect people whom they see as vulnerable can restrict their participation.
- Work with advocacy and self-advocacy groups.
- Staff are likely to need specialist training in working with this group.

Older people

Older people make up the largest single group of patients using the NHS – people over 65 account for two-thirds of hospital patients and 40% of all emergency admissions.

Older people from minority ethnic groups are more likely to experience difficulties in accessing information or communicating their needs.

Anecdotally, older people are less likely to say they are unhappy with the service that they receive.

- Work with existing older people’s groups and voluntary organisations, such as Age Concern.
- When you gather people together, always ensure the venue is accessible, offer travel expenses and provide refreshment.
- Be aware that technology-based systems of communication and engagement, such as email and the internet, may not be effective at reaching older people.
EXAMPLE
Coffee mornings for older people, Portsmouth City PCT

Background
The Older People’s Mental Health Service (OPMH) wanted to develop an involvement process that is part of the way staff work and organisations operate rather than a one-off activity. The challenge was therefore to address the very real ethical and practice issues involved in listening to people with dementia, and providing the time, skills and commitment that this requires.

Establishing a User Involvement Steering Group
A User Involvement Steering Group was set up to include 2 service users and 6 members of staff from the OPMH team. Carers were not invited to joint the group, to ensure it is service user focused.

The group aims to:
- Develop service user involvement across OPMH service
- Ensure service users are engaged in consultation activities across the OPMH service
- Ensure feedback from service users is appropriately integrated into service development
- Raise awareness of the work of the service user steering group across the PCT

Organising coffee mornings
So far the Group has organised 3- monthly coffee mornings for service users. Service users are invited to attend by staff on the wards and day hospital. A great deal of facilitation by staff but in a relaxed atmosphere has reaped the reward of genuine service user involvement, especially as the event has attracted increasing attendance. Staff chat with service users over a cup of coffee with biscuits and record their thoughts.

The group has also set up a monthly coffee morning specifically to gain service user involvement in the new build of an OPMH unit.

Outcomes
In response to feedback from the coffee mornings there have been changes to information on wards (e.g. regarding medication, menu) and new signage on wards. In addition, the Day Unit has been re-designed and refurbished.

Service user comments about being involved include:
“It’s given me something to look forward to. I’m especially looking forward to the new building”

“It gives me the feeling not to slow down but to carry on as people are interested in my view”
“You feel more in control”

“It makes you feel moulded in with everything else so it’s not just staff and patients separately”.

Next steps

- The service is now looking to hold similar coffee mornings in community settings to gain the views and ideas, notably of those who do not access the service.
- The service wants to extend the scope to include the experience of people with more severe dementia.
- Staff taking forward service user involvement are now going out to colleagues to: offer specific skills such as support with surveys, advertise and support events with their service users and encourage service user participation in their particular areas of practice.
Refugees and asylum seekers

A refugee is a person who has left his/her own country and is unwilling or unable to return there ‘owing to a well founded fear of persecution’, and whose claim for asylum has been accepted by the host country he/she is living in.

An asylum seeker is a person who has applied for asylum status in a host country. They may subsequently become recognised as a refugee.

Refugees and asylum seekers are often among the most vulnerable and socially excluded groups of people.

- A significant proportion of refugees will have experienced severe physical or psychological trauma, or both, in their country of origin.
- Some will have faced racially motivated abuse in this country.
- Many will have found it difficult to gain employment at the same level as in their country of origin.
- They may not speak English.
- Refugees and asylum seekers from communities who are newly arriving in the UK are less likely to have a network of organisations able to help and support them.
- Refugees and asylum seekers are more likely to have had negative experiences of statutory agencies in their country of origin, and may also fear that information they provide will influence their application for asylum. This means that you will need to work hard to build a relationship of trust, and need to be clear with potential participants about how their information will be used, and confidentiality.
- Work with any existing organisations for refugee and asylum seekers, but also consider how you can engage those who are not connected with a group or organisation.
- When you gather people together, ensure you offer refreshments and travel expenses
Recording, feedback and evaluation

Recording
Feeding back
Evaluation
6 Recording, feedback and evaluation

Aspiring to World Class Commissioning competency 3

Recording

When you design any kind of event – be it focus groups, public meetings, seminars, or something else – build in to the design your thinking about how you want to report back. This means being clear about the key areas you want to cover and the key questions you are seeking answers to, and making these explicit in the design of the event. That way the event will be structured so that the discussions that you have are already laid out in ready-made report headings.

Consider how you will capture discussions during the event well in advance. It may be, depending on the number of participants and design of the event, that you use more than one recording mechanism. For example:

- If you are running a focus group, you may want to have a note-taker and / or make a sound recording of the group. It is nearly impossible to both facilitate and record.
- If you are holding a seminar with 20 people, with plenary discussions you may use a flip-chart or note-taker for the plenary discussions.
- If you are holding a seminar with 20 people, which includes small group work you may have a note-taker on each table. Alternatively you could ask the table to nominate a note-taker to return notes to you at the end of the session, but beware: note-taking by participants who are nominated by their table is often poor, or people fail to return the notes to you. You could ask the group to capture key points from their discussion on a flip chart.
- Depending on the design of the event, you might design a short, focused feedback questionnaire and ask participants to record their views at the end of each session, or at the end of the event overall.

Feeding back

Who to feedback to

You need to consider your different audiences for feedback from the engagement exercise. These are likely to include:

- Those who participated in the engagement activity.
- The wider group you were seeking to engage with (this might range from people with a specific interest in the issue, such as users of an individual service, to members of the public generally).
- Staff in the service or area under discussion.
- Partner organisations, such as the local authority.

You need to consider whether the different audiences will need to receive the feedback in different levels of detail and different formats or using different feedback mechanisms.
What to feedback

It is important that you communicate both what you found as a result of the engagement work you undertook, and how those findings will be used to influence any decisions or future actions. It is ideal if you are actually able to tell people what will happen as a result of their engagement.

How to plan your feedback

The more controversial the area under debate, the more sensitive the feedback, and the greater the care with which it needs to be handled.

You should be aware that once you issue a report or information to patients, members of the public, or staff you lose control of how far it is circulated and it is effectively in the public domain. In the worst case scenario, that means sensitive issues can end up being reported in the press.

In order to ensure that you can manage how information is circulated, you must establish during the planning process what the sign-off process for the feedback will be before it is made available to people. For example,

- can it be signed off by the overall Steering Group for the work that the engagement activity relates to?
- does it need to go to the Clinical Governance Committee?
- does the Director need to agree it?

Be aware that limiting the circulation of negative findings will not necessarily limit how far they go. Sometimes it is better to tackle it head on, for example by issuing a press release that outlines the key findings and explains how the PCT is going to take these forward.

In cases where the work is sensitive or the findings are potentially controversial, you should involve your communications lead in planning how to manage them.

What mechanisms to use

Given that almost every engagement activity has a range of stakeholders, both in terms of those who were involved and those who are interested in the findings, it is likely that you will need a range of feedback mechanisms.

These might include:

- A written report
- A summary poster
- A newsletter or short briefing
- Presenting at the meetings of interested groups
- Presenting at internal meetings and forums
- Issuing a press release.

If there are a wide range of meetings whose participants are interested in hearing feedback, you may like to develop a standardised presentation, which different people involved can give.
Evaluation

Evaluation of how effective your patient and public engagement activity or activities have been is always going to be complex and open to debate. As with all aspects of patient and public engagement, the key is to plan how you will evaluate at the outset, as you will need to collect data during the process.

Planning for evaluation

- Be clear about the objectives of the engagement and the key issues or questions that you are seeking views on. This way at the end of the process you will have a clear picture of whether your questions have been answered.
- Identify the target group you wish to engage with – this might be as wide as the general public or as narrow as users of an existing service.
- Build a demographic profile of the target group – their age, sex, gender, ethnicity, and any other key characteristics.
- For each engagement activity, develop a target number of people you hope to involve – this may be very rough e.g. for the number of people visiting an exhibition, or very precise, e.g. for the number of people attending a series of focus groups.

Capturing evaluation information during the engagement process

- Try to record the numbers of people you have engaged.
- The best way to record information about the participants and their views on the engagement process is by asking them. Consider designing a form (or forms) to capture information about your participants. This might include:
  - demographic information
  - their experience of the engagement process
  - contact details for them to receive further information or be involved in the future
- Keep it short and simple – the longer and more complicated the form, the lower the return rate.
- People attending some kind of event are more likely to complete a form than people simply visiting an exhibition stand.
- Self completed forms will not work for people who have literacy problems.
Example monitoring form:

Thank you for attending our focus group. Please help us by taking a couple of minutes to complete this brief form. The information that you give us will only be used for monitoring purposes.

About you

1. Are you
   - [ ] A member of staff
   - [ ] Service user
   - [ ] A carer
   - [ ] Member of the public

2. How would you describe your ethnic background?
   - [ ] British
   - [ ] Irish
   - [ ] Any other white background
   - [ ] White and black Caribbean
   - [ ] White and black African
   - [ ] White and Asian
   - [ ] Any other Asian background
   - [ ] Any other mixed background
   - [ ] Chinese
   - [ ] Any other ethnic background

3. Do you have a disability?
   - [ ] Yes
   - [ ] No

4. How old are you?
   - [ ] Under 20
   - [ ] 21 to 35
   - [ ] 36 to 50
   - [ ] 51 to 65
   - [ ] Over 65
About the event

To what extent do you feel you received the information that you needed?

☐ Completely  ☐ Very much  ☐ Slightly  ☐ Not at all

To what extent did you feel able to give your views?

☐ Completely  ☐ Very much  ☐ Slightly  ☐ Not at all

How enjoyable did you find the event?

☐ Very enjoyable  ☐ Quite enjoyable  ☐ Slightly enjoyable  ☐ Not enjoyable

Are there any other comments you would like to make?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Keeping in touch

If you would like to hear the outcome of the event you have been involved in today, or would like us to contact you about future work we are doing to involve people, please provide your contact details below.

☐ Yes, I would like to hear the outcome of the event

☐ Yes, I would like to be contacted about future work to involve people

Name

Email address

Postal address

Telephone no

Thank you for completing this form, please return it to the facilitator.
Writing-up your evaluation

- Compare the target number of people you hoped to engage with the actual number of people involved.
- Compare the profile and characteristics of the people you hoped to engage with the actual profile and characteristics of the people who were involved.
- Review the extent to which your original objectives were met.
- Outline feedback from participants on their experience of the process.
- Describe how the findings of the engagement exercise will be taken forward – demonstrating the impact of the engagement.
General tools

Developing written information
Designing questions for surveys, questionnaires and interviews
Planning a meeting or event
Targeting interested people
General tools

To support achievement of World Class Commissioning competencies 1, 2 and 3

Developing written information

Written information can be extremely helpful because it can:

- reinforce any information given orally or in other formats;
- give more details than you can give verbally;
- be kept for future reference;
- be shared with others.

However, before developing any written information, consider whether this is the best approach. Bear in mind that not everyone can see, read or understand written information.

The kind of communication that you select will vary according to the importance, length, complexity of frequency of the communication involved, and more than one type of communication could be appropriate.

Alternative formats include:

- Videos with subtitles
- Videos with sign language interpretation
- Information displayed on a computer screen
- Text phones
- Teletext displays
- Documents in large print, Braille, easy read, pictures, and/or Makaton
- Information on audiotape
- Information on computer disk
- Telephone services to supplement other information
- Large print

Key questions to help you plan your written information

- Who is the audience for your information (age, sex, disability, ethnic and cultural background etc.)?
- What information are you trying to give?
- How will your audience affect the content, style and presentation of your leaflet?
- How will the leaflet link in with other information you are providing, for example verbal information given in a consultation?
- How will the information be distributed?
Style of writing

- Use headings to help patients find their way around the leaflet – a good trick is to use questions and answers.
- Use numbers and bullet points when you are making several points under one heading.
- Sentences should always be simple and usually short.
- Avoid jargon and technical or clinical terms. If you must include them, make sure you give a clear explanation of what they mean.
- Use personal pronouns (I, we, you) to help the reader identify with the material. For example, compare ‘the patient will be in a supine position’ with ‘you will be asked to lie down’.
- Write as you would speak, rather than in an academic style – active verbs make information easier to understand. For example, compare ‘The procedure will be explained to the patient’ with ‘Your therapist will explain the procedure to you.’
- Do not split words at ends of lines, and avoid hyphenation.
- Ensure you use plain English.

Layout

Use large, readable fonts

- The minimum type size, recommended by the R.N.I.B., for standard format is 12 point
- But 14 point is now commonly used
- The most commonly used large point size is 18 point.

Use a heavier font weight

Typefaces are usually available in light, normal, semi bold or bold weights. The light options should be avoided, since there is less ink to provide the contrast needed with the background.

- Use medium or bold fonts, avoid light fonts.
- Use bold for emphasis, or on the design devices, rather than using upper case, since words are often recognizable by their shape.
- Avoid use of Italics.

Use a clear font style

The human eye reads by recognizing the shapes of words. Text which has been set in italics or capitals or underlined is usually more difficult to read, since it is harder to recognize word shapes if the letters are all the same height or set at an angle.

- Choose a clear, easy to read typeface. Arial is usually a good clear font to use.
- Avoid highly stylized typefaces, such as these ornamental or display typefaces: Vineta BT Gothic E
- Avoid capital letters and underlining in words, titles and the body of text as these make it harder to identify letters, so reading becomes harder.

**Use plenty of white space**
- Text is easier to read when broken up into short paragraphs with plenty of space.
- Always align text to the left margin only – do not completely justify it. When text is aligned to the left, it is easy to find the start and finish of each line and the spacing between words is even.
- If you are using columns, make sure there is a large margin to separate them.

**Use colour and contrast**
Sharply contrasting colours are much clearer for people with sight impairments. Preferences vary, but black on white or black on pale yellow are generally regarded as the clearest combinations.

**Use pictures**
Some people, for example those with a learning disability, find communication with pictures easier to understand than written text.
- Where possible use pictures alongside text to help communicate your message.
- People who have a sight impairment often find images difficult to recognise. Illustrations should be line drawings with clear bold outlines, and photographs should have a clear definition.

**Designing response forms**
People with visual impairment often have larger handwriting and need larger spaces to write in. Make sure that any tick boxes or writing boxes are well spaced and large enough.

**Translating written information**
You need to decide whether to get your written information translated into a specific language, based on the level of local need. It is important not to just translate a leaflet from English into another language before first checking with communities that the information in it is still relevant to them. Particular issues or sensitivities in their community might also need to be taken into account.

**Catering for the needs of different groups**
The following advice is taken from the Toolkit for Producing Patient Information, DoH, 2003.

**Patients who are elderly**
Use large cleared print, at least fourteen point or larger. Do not use patronizing language.
Patients who are not ‘ill’
It may be appropriate to address patients who do not see themselves as ill as clients or service users, for example, pregnant women or people using social services.

Patients who are children
Address children as individuals, use plenty of illustrations, try to adjust your language to their age and do not talk down to them. Avoid clipart.

Patients with learning difficulties
The text needs to be simplified, using more symbols and pictures. Use audio-tapes and videos. Consult support groups and individuals.

Patients with hearing difficulties
Use written information. You may need to establish if the client is able to read, as not all who are hard of hard of hearing or deaf can read and may be literate in sign language only. Use carers, text phones or British Sign Language interpreters.

Patients with sight difficulties
Use the large bold print at least a fourteen point, or larger. Use the audio tapes, electronic text, the internet or Braille. Reversed out text (i.e. text where the background is black and the writing is white) should be used sparingly, and you need to make sure the contrast between text colour and background colour is easy to read.

Patients whose first language is not English
Use a translator to text from a guaranteed source where appropriate. Certain languages are spoken and not read, so it is important to check this. Where appropriate, use other media, including tapes, videos and interpreters.

Patients who have a reading problems
Use audio tapes and videos.

‘Expert’ patients
Patients with long term medical conditions, such as diabetes or eczema, will usually have a very good understanding of their condition. The information for these patients may need to be specially researched by experts or they may need guidance on where to find the latest reliable information.

Choosing the paper
Glossy surfaces can create a glare, which makes text and images difficult to recognise, whilst lightweight or thin paper can allow print from one side to show through to the other.

- Always use paper with a matt finish.
- Do not laminate posters.
- Ensure printing does not show through from one side to the other.
Further resources

www.nhsidentity.nhs.uk/patientinformationtoolkit/patientinfotoolkit.pdf

The Royal National Institute for the Blind (RNIB) produces guidelines for providing information to people who are visually impaired called the See it Right pack. Download them from the website:
Designing questions for surveys, questionnaires and interviews

- Avoid leading questions that imply a certain type of answer.
- Closed questions are easier to analyse than open questions and can potentially be machine-read. Examples of closed questions include:
  - dichotomous questions, that is questions that require a ‘yes’ or ‘no’ answer
  - Multiple choice questions, where the respondent chooses from a number of pre-determined options
  - Scaled questions where the response is graded on a continuum (for example, where the respondent is asked to grade how helpful the reception staff were on a scale of one to five, with five being extremely helpful)
  - Matrix questions where a series of questions are listed down the left hand side and have the same response categories (for example, this is an efficient use of page space and respondents’ time.

Open questions ask for unprompted opinions and are good for eliciting responses that are more truly reflective of the opinions of the respondents, or where the range of responses is not tightly defined. But:

- They require more time and thought on the part of the respondent, so response rates can be lower
- The questions may be interpreted in different ways, so you may get answers to different questions than the ones you asked
- The responses are more difficult to analyse
- Keep it simple and avoid jargon
- Re-word negative statements as positives, and always avoid double negatives
- Ask one question at a time
Planning a meeting or event

This section provides a practical guide to planning a meeting or event.

1 Draft agenda / programme

You need to design the programme for your event. It will help if you are clear about the objectives of the event and who the audience will be.

2 Contact and brief speakers

Depending on the design of your event, you may need to prepare a brief for any speakers, or individuals who are attending in a professional capacity.

3 Identify target number of participants

In order to plan for the venue, you need to be clear about how many participants you expect to attend the event.

Bear in mind that, depending on the nature of the event, you should generally expect to invite about 20% more people than you actually need. This will allow for less people than are invited wishing to attend. It is also the case that people who have booked to attend, often drop out on the day.

4 Identify date

When picking a date you will need to consider:

- Availability of a suitable venue
- A date that everyone who must attend, e.g. keynote speakers, facilitator, can make
- In general it is best to pick a date that does not fall around public holidays, school half term, religious festivals or other major events – attendance will be poor if your event co-incides with England playing in the world cup!

5 Promote your event / invite participants

Generally, you should invite people / start promoting your event six weeks beforehand.

Depending on your target audience, and the number of people, you may use different approaches to inviting people:

- Phone call
- Personalised letter
- ‘Dear colleague’ letter
- Flyers
- Posters
- Advert in the press

When planning how you promote your event, consider whether you need to know the names of the individuals who will attend in advance, or if you need to know how many people will attend. If so, you will need to build a booking mechanism into your promotional materials.
Use the booking form to check whether people have:

- any requirements to help them participate in the event (e.g. need an interpreter, need a stenographer etc.)
- special requirements in relation to the menu (e.g. kosher, halal, vegetarian)
- any other particular needs

### 6 Book your venue

As a matter of good practice you should always ensure that your venue is wheelchair accessible. Ideally it should be close to good public transport links and easy to find.

You will need to let the venue know:

**Room requirements**

- The number of people that the plenary room needs to seat;
- How many, if any, break-out rooms you require and how many people these need to accommodate

**Layout**

For each room, you will need to specify the layout, this might be:

- theatre style (people sitting in rows – good for viewing presentations, but not good at generating group discussions)
- cabaret (people grouped around a series of tables – excellent for enabling small group work)
- boardroom (people grouped around a single large table – the most common layout for small to medium sized meetings)

**Stage**

Depending on the programme, you may need:

- lectern
- top table
- panel discussion
- interview set

**Catering**

You will need to let the venue know the numbers and timings of each time you want refreshments. For example,

- registration/arrival tea/coffee
- am tea/coffee
- lunch buffet/sit down
- pm tea/coffee

You might also consider whether you prefer a sit-down or buffet-style lunch. Buffet-style often provides a good opportunity for people to mix and network.
Equipment

All the equipment you need is generally available from the venue, but some items you may incur an additional charge.

- PA System
- Screen
- PowerPoint
- Video
- Back/front projection
- Roving mikes
- Lapel mikes
- Autocue

Recording

It may not be possible to arrange this through the venue, but consider whether you need:

- Video recording
- Recording
- Transcription

7 Consider communications support

Consider whether you need to book any particular communications support. This might include:

- Spoken language interpreter
- BSL interpreter
- Stenographer or other support to people who have a hearing impairment

8 Prepare materials

Materials you are likely to need to prepare include:

Promotional/invitation materials

- Invitation letter
- Poster
- Leaflet
- Press release
- Booking form

Pre-event materials for participants

- Joining instructions
- Programme
- Any brief information you want participants to read in advance (bear in mind that they may not bother)
At the event

- Name badges
- Programme
- Handouts of presentations
- Any other brief information
- List of participants
- Evaluation form

9 Plan budget

In preparing the budget, take account of:

- All costs associated with the venue
- Any costs associated with the use of an external facilitator or speakers
- Any costs associated with the preparation and production of materials.

Targeting interested people

Some ideas about how you might target people who are interested in the issue you want to gather views on are:

- Identify the characteristics of people who will be interested in this issue – e.g. people with a long term condition, parents with young children, older people etc.
- Speak to your patient and public engagement lead to find out if they are aware of any other related work in progress that you might ‘piggy back’ on, or any individuals or groups that you might get in touch with.
- Speak to your PALS team, to find out if there are any groups or individuals who have raised issues related to the area you want to discuss.
- Speak to your local Voluntary Services Council to find out if there are any voluntary or community groups you might get in touch with that reflect the characteristics of the people whose views you are interested in.
- Identify places where people who match the characteristics of those whose views you are interested in are likely to be, where you might target to distribute information about meetings etc. For example, parents might be outside schools at the end of the school day, older people might attend a luncheon club.
- Consider what mechanisms you might use, for example, email, internet, posters, flyers.
- If you are doing work on a particular service, then consider working with Expert Patients, both in terms of getting their views, and in terms of using them to help you gather the views of others.
- Expert patients are a skilled and knowledgeable resource. Be aware however, that they can hold views that are not representative of the views of the wider patient group.
Contacts
8 Contacts
1 What is PPE

2 Commissioning and PPE

3 Planning for effective PPE

4 Methods of engagement

5 Valuing diversity

6 Recording, feedback and evaluation

7 General tools

8 Contacts

9 Appendix
Appendices

World Class Commissioning Competencies
World Class Commissioning Assurance System
Appendix A: World Class Commissioning Competencies

The sections below are an extract from World Class Commissioning Competencies and cover the key competencies that require elements of patient and public engagement.

The full document can be found at www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Competencies/index.htm

Competency 1: To be recognised as the local leader of the NHS

PCTs should lead and steer the local health agenda in their community. PCTs will be the natural 1st stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

Why being recognised as the local leader of the NHS is a key competency

PCTs should lead and steer the local health agenda in their community. PCTs will be the natural first stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

Skills

- Listens to partner NHS organisations and other providers.
- Signals future priorities of the local NHS.
- Has good presentation and influencing skills, for example in reputation management.
- Has good organisational development skills.

Processes and knowledge requirements

The PCT:

- Is clearly and visibly recognised and sought as the leader of the local NHS and is respected by its community and business partners as the primary source of credible, timely and authoritative advice on all matters relating to the NHS.
- Is able to articulate the values of the NHS – fair, personal, effective and safe – and applies them to its strategic planning and decision making.
• Is skilled in a variety of public, community and patient engagement and involvement methods and communicates the local NHS priorities to diverse groups of people.

• Understands the strengths and weaknesses of local NHS organisations, including practice based commissioners, and develops their competence and capabilities.

• Understands the commissioning requirements of other PCTs when entering into lead commissioner arrangements, and effectively manages contracts on their behalf.

Example outputs

• Clear communications policy and ability to respond to individual, organisational and media enquiries regarding the local NHS.

• Regular commentary in reports, findings, commissioning plans and other communications as to how it has consulted on issues and intends to represent the wider NHS community.

• Interaction with all local NHS organisations, assuring, developing, and promoting their functions.

• Board with a clear understanding of reputation management as well as effective stakeholder management.

Competency 2: Work with community partners

Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.

Why working with community partners is a key competency

PCTs should not commission in isolation. In addition to commissioning healthcare services, they will need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their local population. PCTs also share responsibility for undertaking a joint strategic needs assessment (JSNA) with local authorities. Partners include local government, other PCTs, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimise health gains and reductions in health inequalities.

Skills

• Development of partnership agreements.

• Database management.

• Partner relations skills:
– enquiry response;
– feedback evaluation;
– website management;
– performance advice;
– data quality assurance;
– accountancy;
– spreadsheets.

● Presentation and influencing skills.

Processes and knowledge requirements

The PCT:

● Proactively seeks partnership with appropriate agencies, both within health and beyond, using defined legal agreements and frameworks.

● Creates formal and informal partnering arrangements as appropriate to different relationships.

● Has up-to-date knowledge of the strengths and weaknesses of the commissioning community in which it operates, identifying key local participants and potential partners (both statutory and non-statutory) to optimise improvements in outcomes.

● Advises and develops local partner commissioning capabilities where there will be a direct impact on joint commissioning goals.

● Shares across the local community its ambition for health improvement, innovation, and preventative measures to improve well-being and tackle inequalities.

● Influences partner commissioning strategies, reflecting NHS core values.

● Uses the skills and knowledge of partners, including clinicians, to inform commissioning intentions in all areas of activity.

● Actively shares relevant information so that informed decisions can be made across the commissioning community.

● Monitors and evaluates the effectiveness of partnerships.

Example outputs

● Full engagement locally through effective and innovative local strategic partnerships and workforce planning processes.

● Robust and aligned local area agreements informed by JSNAs.

● Evidence of collaboration with other commissioning agencies, optimising cost efficiency through shared service agreements.

● Open and effective shared knowledge and information processes which maximise use of local community intelligence and engagement.
Competency 3: Engage with public and patients

Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.

In other sections, we have highlighted aspects that have particular relevance to patient and public engagement. The reader should assume that all the text below is highlighted in bold and written in capital letters!

Why engaging with the public and patients is a key competency

PCTs are responsible through the commissioning process for investing public funds on behalf of their patients and communities. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly and honestly. They will need to be proactive in seeking out the views and experiences of the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.

Skills

- Proactive listening and communication skills to address the needs of all relevant stakeholders, including using third sector and community partners to seek and engage the voice of those who are seldom heard
- Patient and public relations skills:
  - enquiry response;
  - engagement event management;
  - feedback evaluation;
  - website management;
  - survey management;
  - report-back mechanisms in appropriate formats
- Presentation and influencing skills

Processes and knowledge requirements

The PCT

- Routinely ensures that patients and the public can share their experiences of health and care services and uses this to inform commissioning.
- Has a deep understanding of different engagement options, including the opportunities, strengths, weaknesses and risks.
- Routinely invites patients and the public to respond to and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective.
- Ensures that patients and the public understand how their views will be used, which decisions they will be involved in, when decisions will be made, and how they can influence the process, and publicises the ways in which public input has influenced decisions.
Proactively challenges and, through active dialogue, raises local health aspirations to address local health inequalities and promote social inclusion.

- Creates a trusting relationship with patients and the public, and is seen as an effective advocate and decision maker on health requirements.
- Communicates its vision, key local priorities and delivery objectives to patients and the public, clarifying its role as the local leader of the NHS.
- Responds in an appropriate and timely manner to individual, organisational and media enquiries.
- Undertakes assessments and seeks feedback to ensure that the public’s experience of engagement has been appropriate and not tokenistic.

Example outputs

- A PCT prospectus that meets national and local requirements.
- A clear and well-managed public information strategy and the use of social marketing techniques.
- Training available for all staff in appropriate techniques, including media handling.
- Evidence of PCT engagement with communities and representative bodies, such as Local Involvement Networks, practice patient participation groups, disease-specific patient groups and relevant third sector organisations.
- The publication of health and well-being educational material specific to local health needs and aspirations.
- Evidence of engaging hard-to-reach groups, such as through the Healthcare Commission’s ‘Data quality on ethnic groups’ indicator
- Patient and public survey data and evidence of its impact on commissioning activity
- Local community profiles that proactively identify and seek out communities that experience the worst health outcomes, and through dialogue and engagement raise local health aspirations.
**Competency 4: Collaborate with clinicians**

Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation

**Why collaborating with clinicians is a key competency**

Clinicians require effective support from the PCT to enable meaningful engagement and empowerment of GPs to maximise clinical impact through Practice Based Commissioning, (PBC).

Clinical leadership and involvement is a critical and integral part of the commissioning process. Clinicians are best placed to advise and lead on issues relating to clinical quality and effectiveness. They are the local care pathway experts who work closely with local people and understand clinical needs.

PCTs should ensure that, through the involvement of clinicians in strategic planning and service design, commissioned services build on the current evidence base, maximise local care pathways and utilise resources effectively. Professional Executive Committees (PECs) have a crucial role to play in building and strengthening clinical leadership in the strategic commissioning process. PBC is a key methodology to drive innovative and transformational change.

**Skills**

- Clinical relations skills: engagement strategies; relationship building; network design; feedback evaluation; website and intranet management; survey management
- Effective presentation and influencing skills of PEC members
- Operational and project management skills to implement new ways of working

**Processes and knowledge requirements**

The PCT

- Encourages broad clinical engagement through appropriate and meaningful devolution of commissioning decisions, including maximising clinical impact through the development of PBC
- Engages and utilises the skills and knowledge of clinicians to inform commissioning intentions in all areas of activity, including setting strategic direction and formulating commissioning decisions
- Builds and supports broad clinical networks, including across provider boundaries, to facilitate constructive multidisciplinary input into pathway and service design
- Builds and supports informed clinical reference groups, such as PECs, ensuring that clinicians and practice based commissioners have full and timely access to information, enabling local commissioning decisions to be made
- Builds and supports clinical engagement in strategic decision making and assures clinical governance structures via PECs
• Oversees and supports PBC decisions to ensure effective resource utilisation, reducing health inequalities and transforming service delivery
• Works with clinical colleagues, such as PECs, along care pathways to spread best practice and rigorous standards to hold clinicians to account
• Works in partnership with clinicians along care pathways in commissioner and provider organisations to facilitate and harness front-line innovation and drive continuous quality improvement

Example outputs
• Evidence of developed mechanisms for clinical engagement, such as lists and local awareness of formal and informal opportunities, terms of reference for relevant committees, board
• Evidence of appropriate and timely information dissemination, such as correspondence and communication protocols.
• Strong whole-community clinical networks, led by a well-functioning PEC that proactively communicates and supports the decisions they make.
• Well-governed and effective clinical reference groups, with minuted meetings and clear links to other plans, such as children and young people’s plans.
• Production and timely dissemination to practices of indicative PBC budgets, together with regular activity and financial information in accessible formats.
• Evidence of regular and active dialogue with local clinicians, seeking their data and information needs, supporting engagement that turns information into:
  – knowledge and action
  – well governed and effective clinical reference groups, with minuted meetings and clear links to other plans, such as children and young people’s plans

Full details can be found at
www.dh.gov.uk/283841B_NHS_WCC_competencies.pdf
Appendix B:
World Class Commissioning Assurance System

The Department of Health has developed a commissioning assurance system to measure each PCT’s performance against the competencies.

- Each competency is measured against four levels, where 4 is the highest.
- For each level, there are criteria which will be used to identify which level best describes the PCT.
- Each of the levels is measured on an additive basis, so the PCT will need to fulfil every element in level 1 to progress to level 2.

The competencies will be measured in a number of ways during the commissioning assurance process. A combination of self-assessment, metrics and evidence collection, 360 feedback and external panel review will be used to determine a final rating for each competency. The first step in the process will be a PCT’s self-assessment of their current position against each of the competencies, where the PCT will use the criteria to come to identify which level they feel best describes their current organisation.

The measurement system and levels for the four key competencies that require patient and public engagement are set out in full below. This is an extract from Department of Health Competency Measures.

Find out more at:

Competency 1 – Are recognised as the local leader of the NHS

PCTs should lead and steer the local health agenda in their community. PCTs will be the natural 1st stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

Reputation as the ‘local leader of the NHS’

Does not meet Level 2 requirements

- Key stakeholders somewhat agree that the PCT is the local leader of the NHS.
- The PCT has an understanding of its current and intended reputation, with strategies in place to address this.
- The PCT participates in the local health agenda.
- Local population agree to some extent that the local NHS is improving services.

Reputation as a change leader for local organisations

Does not meet Level 2 requirements

- Key stakeholders somewhat agree that the PCT significantly influences their decisions and actions.

Position as an employer of choice

Does not meet Level 2 requirements

- Staff satisfaction is neutral, and staff metrics are in line with the national average for PCTs:
  - Recruitment
  - Retention
  - Satisfaction

- Staff satisfaction is positive, and staff metrics are above national average for PCTs:
  - Recruitment
  - Retention
  - Satisfaction

- Staff satisfaction is positive, and staff metrics are in upper quartile of national performance for PCTs:
  - Recruitment
  - Retention
  - Satisfaction
### Competency 2 – Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities

PCTs should not commission services in isolation. In addition to commissioning healthcare services, they will need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their local population. PCTs also share responsibility for undertaking a joint strategic needs assessment (JSNA) with local authorities. Partners include local government, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimise health gains and reductions in health inequalities.

<table>
<thead>
<tr>
<th><strong>Creation of Local Area Agreement based on joint needs</strong></th>
<th><strong>Ability to conduct constructive partnerships</strong></th>
<th><strong>Reputation as an active and effective partner</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does not meet Level 2 requirements</strong></td>
<td><strong>Does not meet Level 2 requirements</strong></td>
<td><strong>Does not meet Level 2 requirements</strong></td>
</tr>
<tr>
<td>• PCT and the local authority agree in a timely ways, on LAA priorities</td>
<td>• Key stakeholders somewhat agree that the PCT proactively engages their organisation to inform and drive strategy, service design and resource utilisation</td>
<td>• Key stakeholders somewhat agree that the PCT is an active and effective partner in delivering health objectives</td>
</tr>
<tr>
<td>• LAA targets directly address the needs highlighted in the JSNA</td>
<td>• The PCT has worked with partners to produce a Joint Strategic Needs Assessment which identified the health needs of the population</td>
<td>• PCT has set out clear milestones with partners, on key initiatives and has a track record of delivery</td>
</tr>
<tr>
<td>• PCT and LA both independently accountable for LAA targets</td>
<td>• The role of the PCT in the Local Area Agreement and the delivery of targets partnership is effective</td>
<td>• PCT works with PBC leads to agree commissioning plans</td>
</tr>
<tr>
<td>• PCT and the local authority have worked with local strategic partners agree local area agreement priorities</td>
<td>• Key stakeholders agree that the PCT proactively engages their organization to inform and drive strategy, service design and resource utilisation</td>
<td>• Key stakeholders agree that the PCT is an active and effective partner in delivering health objectives</td>
</tr>
<tr>
<td>• Local area agreement priorities are based on joint needs as assessed though the joint strategy needs assessment</td>
<td>• Shared posts in place where appropriate</td>
<td>• Key stakeholders strongly agree that the PCT is an active and effective partner in delivering health objectives</td>
</tr>
<tr>
<td>• The PCT is clearly engaged in the local area agreement negotiation and delivery</td>
<td>• The PCT has worked constructively and effectively with partners to produce a Joint Strategic Needs Assessment which identified the health needs of the population</td>
<td>• Multiple partnerships across a broad range of settings to support health and wellbeing agenda</td>
</tr>
<tr>
<td>• PCT creates joint accountability and clearly delegates roles with local partners for all key targets</td>
<td>• The local population agree to some extent that the PCT works with local organisations to provider services that people need</td>
<td>• Key stakeholders strongly agree that the PCT is proactively engages their organisation to inform and drive strategy, service design and resource utilisation</td>
</tr>
</tbody>
</table>

**Level 1**

**Level 2**

**Level 3**

**Level 4**
Competency 3 – Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health

PCTs are responsible through the commissioning process for investing public funds on behalf of their patients and communities. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly and honestly. They will need to be proactive in seeking out the views and experiences of the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.

### Influence on local health opinions and aspirations

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not meet Level 2 requirements</td>
<td>The PCT has effective strategies for communicating with the local population</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Key stakeholders somewhat agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population leading to demonstrable change</td>
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<td></td>
<td>• PCT actively promotes independence, health, wellbeing, and personalisation of services</td>
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<td></td>
<td>• PCT ensures patient expectations are in line with best practice</td>
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<td></td>
<td>Key stakeholders agree that the PCT has proactively shaped the health opinions and aspirations of the local population leading to demonstrable change</td>
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### Public and patient engagement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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</thead>
<tbody>
<tr>
<td>Does not meet Level 2 requirements</td>
<td>The PCT has a strategy in place that actively and continuously engages patients and public in PCT business</td>
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<td></td>
<td>• PCT actively listens to, understands and responds to public and patients</td>
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<td></td>
<td>• PCT can demonstrate how local engagement including regular 2-way dialogue with links has influenced some aspects of commissioning</td>
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<tr>
<td></td>
<td>• PCT proactively disseminates information to the public and patients</td>
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<td></td>
<td>• The local population somewhat agree that the local NHS listens to the views of local people and acts in their interest</td>
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<td></td>
<td>PCT demonstrate that they know the impact of their involvement and engagement and know how effective it is through evaluation</td>
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<td></td>
<td>• PCT formally involves patients and public in review of services</td>
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<td></td>
<td>• Information from patients and the public has a direct impact on quality and improvement</td>
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<td></td>
<td>• PCT can demonstrate how they support LINKs and voluntary groups to capture patient/public views which have affected commissioning plans</td>
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<tr>
<td></td>
<td>• The local population agree that the local NHS listens to the views of local people and acts in their interestservice design and resource utilisation</td>
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<td></td>
<td>• Shared posts in place where appropriate</td>
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<td></td>
<td>• The PCT has worked constructively and effectively with partners to produce a Joint Strategic Needs Assessment which identified the health needs of the population</td>
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<td></td>
<td>• The local population agree to some extent that the PCT works with local organisations to provider services that people need</td>
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<tr>
<td></td>
<td>Key stakeholders strongly agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population leading to demonstrable change</td>
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### Delivery of patient satisfaction

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<tr>
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</thead>
<tbody>
<tr>
<td>Does not meet Level 2 requirements</td>
<td>The PCT actively reviews trends in patient feedback, including complaints, PALs and patient survey data sent to providers and initiates improvements as a result</td>
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<td></td>
<td>• The local population agrees that the NHS is helping to manage and improve the health and well being of the population</td>
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<td></td>
<td>PCT carries out its own surveys and follows up on impact as required</td>
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<td></td>
<td>• PCT demonstrates how patient feedback – survey data, patient complaints and PALs queries have driven commissioning decisions</td>
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<tr>
<td></td>
<td>PCT demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions</td>
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## Competency 4 – Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation

Clinicians are best placed to advise and lead on issues relating to clinical quality and effectiveness. They are the local care pathway experts who work closely with local people understanding clinical needs. PCTs should ensure that through the involvement of clinicians in strategic planning and service design, services commissioned build on the current evidence base, maximise local care pathways and utilise resources effectively. Professional Executive Committees (PECs) have a crucial role to play in building and strengthening clinical leadership in the strategic commissioning process. Practice based commissioning (PBC) is the key methodology for this and should be maximised to drive innovative and transformational change.

### Clinical engagement

- Does not meet Level 2 requirements
  - PCT can identify several non-PEC clinicians that have made substantive contributions to PCT strategy, planning and policy development
  - Clinicians are regularly present and actively participate in PEC meetings
  - PCT seeks views of broad clinical group
  - PCT has delegated authority to clinicians as required to drive the agenda

### Dissemination of information to support clinical decision making

- Does not meet Level 2 requirements
  - Quality of care and quality information is regularly shared
  - PCT proactively solicits and disseminates status updates and quality improvement ideas from all practices on a regular basis
  - The quality, format and frequency of information is perceived as appropriate by PBCs

### Reputation as leader of clinical engagement

- Does not meet Level 2 requirements
  - Key stakeholders slightly agree that the PCT pro-actively engages clinicians to inform and drive strategy, service design and resource utilisation
  - Key stakeholders agree that the PCT pro-actively engages clinicians to inform and drive strategy, service design and resource utilisation
  - Key stakeholders strongly agree that the PCT pro-actively engages clinicians to inform and drive strategy, service design and resource utilisation

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**LEVEL 1**

- PCT can identify several non-PEC clinicians that have made substantive contributions to PCT strategy, planning and policy development
- Clinicians are regularly present and actively participate in PEC meetings
- PCT seeks views of broad clinical group
- PCT has delegated authority to clinicians as required to drive the agenda

**LEVEL 2**

- PCT engagement includes clinicians that represent all healthcare and well-being delivery methods
- Active clinical leadership across PCT agenda
- Facilitate links between primary and secondary care clinicians to support commissioning
- The local population agrees that the NHS is working well with GPs and hospital doctors to improve the health and well being of the population

**LEVEL 3**

- PCT engagement also includes other representatives e.g., consortia reps, local social care, and allied health practitioners
- All engagement groups actively drive PCT planning and service development
- Clinical engagement supports ongoing improvement of patient outcomes

**LEVEL 4**

- Quality reports include recent clinical evidence and benchmarks
- PCT has taken steps to reduce unacceptable clinical variations
- Quality reports include recent clinical evidence, benchmarks, and changes in clinical practice
- PCT can calculate PBC return on investment