NHS
County Durham and Darlington

Patient & Public Involvement Toolkit: a quick guide to support healthcare commissioners.

"No decision about me without me"

Rt. Hon. Andrew Lansley
Secretary of State for Health
Liberating the NHS

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Contents

1. Introduction and purpose of the toolkit

This toolkit supports engagement throughout the commissioning cycle. It provides links to key channels and a range of techniques for informing, engaging and involving patients, carers and the public. The toolkit is for all commissioning staff to make use of and will be under continual development. The Equality Duty will apply throughout this guide.

In carrying out any engagement it will be necessary to ensure that an engagement plan or section features in the project plan for the specific piece of work to be carried out. Costs, risks and other resources will need consideration prior to action. Support in considering these issues and in carrying out engagement is available from the Involvement Team.

This toolkit will:

- support healthcare commissioners in identifying engagement needs at the appropriate stages of the commissioning cycle
- provide links to a range of techniques for informing, engaging and consulting with patients, carers and the public

The toolkit user will need to consider which level of engagement is appropriate to the work that is being carried out.

This toolkit is also intended to support clinical commissioning groups in preparing for authorisation. See *Developing Clinical Commissioners towards authorisation* below.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130318.pdf

Comments?

If you have any comments about this toolkit or ideas to improve its content, please contact the Communications and Involvement Team:

Mary Bewley, Head of Communications and Involvement – mary.bewley1@nhs.net

Paul Scott, Involvement & Scrutiny Liaison Manager – paul.scott4@nhs.net
(Please note – Jill Simpson is currently on maternity leave.)

Involvement Officers:

Juliet Carling – julietcarling@nhs.net
Gill Irving – gill.irving@nhs.net
Nicola Hepple – nhepple@nhs.net

2. The Communications and Involvement Team

As part of the Communications and Involvement team, involvement officers are conduits between commissioners and patients, carers and the public. They offer an advisory and facilitative service to empower commissioners, as the recognised experts, to undertake and take ownership of engagement activity.

If you are planning any engagement activity or communication, the team can advise and, where appropriate, facilitate contacting various voluntary groups and/or third sector organisations on your behalf. For example, we could invite members to attend Focus Groups, distribute questionnaires or ask for expressions of interest in a specific involvement opportunity such as participation in a procurement panel. Our aim is to expand these mechanisms and ensure that it is as inclusive as possible to enable those seeking to reach the diverse communities of NHS County Durham and Darlington to do so.

Contacting the Communications team

The Communications team can assist with communication activity. For advice on writing press releases, media enquiries, website content, social media and discussing positive news stories including publications please email the communications team: cd-pct.communications@nhs.net

3. What do we mean by 'engagement'?

The terms involvement and engagement are often used interchangeably. When we say 'engage' in this toolkit we use it in the sense of getting involved, so that to engage someone is to attract their attention, make connections with them, ask for, record and use their views when making decisions about health services.

Engagement encompasses a range of audiences and activities.

Strategic engagement involves ensuring partner organisations, any monitoring bodies and key local influencers are kept informed and involved as appropriate. This may mean developing working relationships and/or sharing updates with local NHS providers and commissioners, strategic health authorities, local authorities, overview and scrutiny committees and Members of Parliament.

Patient, public and carer engagement is primarily about listening to feedback from local people with a view to informing service improvements. Target audiences may include patients currently accessing care, potential service users, carers, advocates, relatives and family members of service users, patient representative groups and local taxpayers.

Engagement activity may range from informing patients to proactively seeking views through to the co-production of services with full participation from patients. Engagement can be proactive and reactive, formal and informal, quantitative and qualitative. Patient involvement also encompasses the personalisation agenda and an increasing priority to ensure individuals are active partners in their own care.

4. Who is responsible and why do it?

Real patient and public involvement is not about ticking boxes, it is about NHS organisations developing relationships and working in partnership with local communities. We must recognise and value the benefit of listening and responding to the local population.

Involvement is central to our business. By listening to our local population we are better able to meet their needs and provide more effective and efficient services.

It is important for any organisation that is responsible for commissioning services to think about the ethos or principles that they will adopt as part of their organisational development. This means they should make it everyone's business to work with local people to ensure their views are integral to the planning, implementation and delivery of services, as well as engaging with them to improve health and wellbeing.

This could mean:

- demonstrating change as a result of engagement
- providing senior commitment and leadership
- being clear about why you are involving people
- explaining what can change and what is not negotiable
- defining who needs to be involved and likely to be affected
- ensuring that methods suit the purpose of engagement
- making special efforts to include seldom heard groups
- being clear how views will feed into decision-making
- providing feedback about action you intend to take
- ensuring people have support to get involved

5. What is our Equality Duty?

The public sector equality duty consists of a general equality duty which is set out in the Equality Act itself, and specific duties which are imposed by regulations.

The aim of the general equality duty is to integrate consideration of the advancement of equality into the day-to-day business of public authorities. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
2. Advance equality of opportunity between people who share a characteristic and those who don't.
3. Foster good relations between people who share a characteristic and those who don't.

These three elements are the three 'arms' or 'aims' of the general equality duty.

The new duty covers the following eight protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. People with those characteristics are referred to as protected groups. People who are considering, undergoing or have undergone gender reassignment are referred to as transsexual people.

See Section 12 for more information.

6. Why involve and engage?

Briefly - to inform commissioning intentions, strategy development, and plans etc., to identify unmet health needs, to 'sense check' commissioning intentions.

Patients, carers and the general public are central to everything we do as an organisation. Listening to what patients tell us will help to deliver a better standard of care and improve the healthcare of our population. Involving patients and the public in the planning, monitoring and development of health services is not only good practice but also a legal duty for all NHS organisations.

Patient participation allows patients to be involved in shaping the services we commission. We need to ensure that we engage with the wider population including taxpayers, actual service users, potential service users, relatives, carers, advocates, patient representative groups, health interest groups etc.

There are many short and long term gains to be obtained from identifying and addressing engagement needs at the outset of a project including:

- insights into positive and negative aspects of existing services
- understanding of who are key to a project's success
- informed and empowered service users
- greater community awareness of service
- more use of choice and greater involvement in own care
- more people using services
- more satisfied patients from better experience of service
- positive public image for service
- higher quality health services
- healthier communities

Please note - engagement is also a statutory requirement.

Section 242 of the NHS Act 2006 (formerly Section 11 Health and Social Care Act 2011), which came into force in November, 2008, strengthened the statutory duty on all NHS organisations to make arrangements to consult and involve patients and the public in:

- the planning and provision of services we commission
- the development and consideration of proposals for changes in the way those services are provided
- decisions made by us that affect the operation of those services

The duty applies when a proposal or decision impacts on the manner in which services are delivered of the range of services available.

7. The Commissioning Cycle explained

"Commissioning is the means to secure the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population into services for users which:

- Deliver the best possible health and well-being outcomes;
- Provide the best possible health and social care provision;
- Within the best use of available resources."

The process must be equitable and transparent and open to influence and change from all stakeholders via a process of ongoing dialogue and involvement.

Commissioning can be thought of as a series of activities all of which are sequential and equally important, hence the term, the "Commissioning Cycle". Commissioning activities can be grouped under the key elements of analyse, plan, do and review.

Analyse - Assess needs and review current service provision.

Analysis of population needs, current market provision, guidance and best practice, risks and resources are all essential. This element of the commissioning cycle involves activities such as:

- Clarifying the priorities, whether local or national, and the research and notable best practice examples of delivering particular services/meeting the identified priorities.
- Undertaking needs analysis to identify the current and likely future needs of the whole population for the relevant services.
- Mapping and reviewing services across agencies to understand provider strengths and weaknesses and identifying opportunities for improvement or change in providers.
- Identifying the resources currently available and agreeing future resources across agencies.
- Analysing the risks involved in implementing change and/or continuing with the status quo.

Plan - Decide priorities, design services

This involves identifying the gaps between what is needed and what is available, and planning how these gaps will be addressed. Activities include:

- Undertaking a gap analysis to review the whole system and identify what is needed in the future.
- Planning and designing services to meet needs.

- Writing a commissioning strategy which identifies clear service development priorities and specific targets for their achievement.

Do - Shape structure of supply, manage demand to ensure appropriate access to care, clinical decision making

This element requires commissioners to develop effective relationships with providers, capacity build as necessary, ensure that the services needed are delivered in ways which efficiently and effectively deliver the priorities and targets set out in the commissioning strategy. Activities include:

- Ensuring a good mix of service providers, offering users an element of choice in how their needs are met.
- Developing good communications and effective relationships with existing and potential providers.
- Making arrangements to ensure service quality, including identifying the quality assurance criteria that should be included in contracts in order to ensure services meet the standards required.
- Purchasing new services and de-commissioning services that do not meet the needs of users.

Review - Managing performance

Reviewing the success of contracts in meeting the commissioning priorities, delivering the specification and meeting the needs of service users. Analysing the extent to which they have achieved the purpose intended. This element of the commissioning cycle involves activities such as:
- Collating and reviewing the information and performance data across the range of services and contracts from a range of different perspectives.
- Developing systems to bring together relevant data on finance, activity and outcomes.
- Analysing any changes in population need, reviewing the overall impact of services, and considering the effectiveness of service models across the market to respond to different needs.
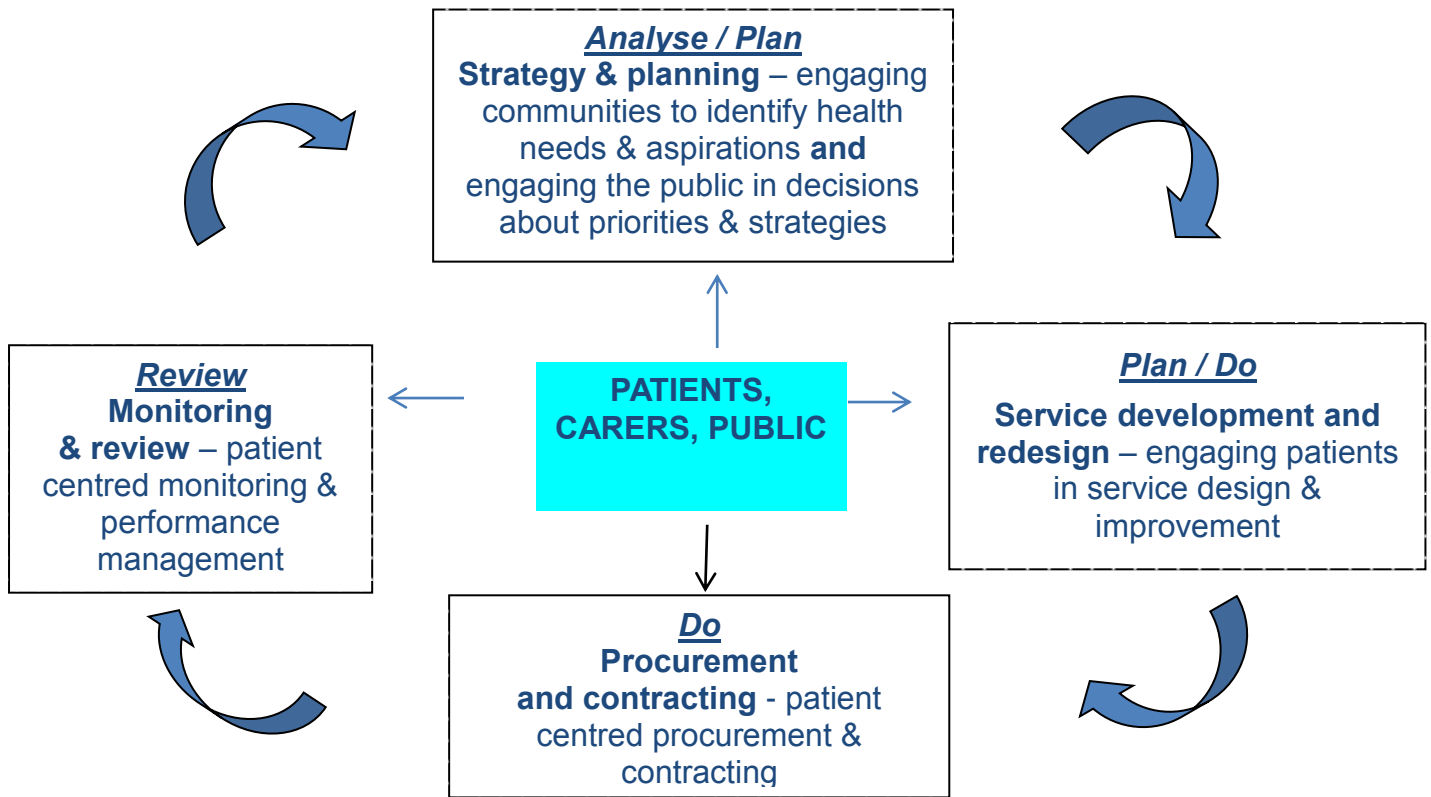- Identifying revisions needed to the strategic priorities and targets.

Joint Commissioning

The same requirements and principles for engagement apply equally to services which are jointly commissioned. In many ways where services are commissioned jointly it is important that all commissioning partners engage in one engagement process. In doing this mixed messages are not sent or received about the service being commissioned.

Whilst there is one engagement process partners should use multiple engagement methods as proposed in this document. Examples of joint commissioning can include regional service commissioning across several NHS areas e.g. North East Ambulance Service or local authority commissioners and NHS commissioners working together to commission a joint service e.g. intermediate care. Engagement support and resources from NHS organisations and local authorities can be co-ordinated to support this.

8. How to engage within the Commissioning Cycle

The diagram below outlines how people are engaged throughout the commissioning cycle.

Analyse / Plan
Strategy & planning – engaging communities to identify health needs & aspirations **and** engaging the public in decisions about priorities & strategies

Review
Monitoring & review – patient centred monitoring & performance management

PATIENTS, CARERS, PUBLIC

Plan / Do
Service development and redesign – engaging patients in service design & improvement

Do
Procurement and contracting - patient centred procurement & contracting

There are **three** main stages to engagement within the commissioning cycle:

1. Strategy and planning:

- Engaging communities to identify health and social care needs and aspirations
- Engaging the public in decisions about priorities and strategies

2. Service development and procurement:

- Engaging people in service design and improvement
- Patient and service user centred procurement and contracting

3. Monitoring and review:

- Patient and service user centred procurement and contracting
- Patient and service user centred monitoring and performance management

9. Suggested techniques to use at each stage of the commissioning cycle

1. Strategy and planning

- Consult with local partners – use their networks and structures to reach communities
- Work with LINks/HealthWatch
- Identify and work with easy to overlook groups
- Lay representation
- Use outcomes of needs assessment work
- Develop ongoing dialogues with key groups
- Use tools and techniques to engage stakeholders in planning and prioritisation work e.g. stakeholder events, practice patient forums
- Produce clear information about all decisions made

2. Service development and procurement

- Look at previous data and information before commencing new involvement work.
- Standardise project plans and business cases to include an engagement analysis and plan.
- Ensure local providers and clinicians are involved appropriately.
- Use service improvement and pathway redesign techniques and experience.
- Use a range of approaches e.g. practice patient forums, e-surveys, collation of existing patient experience data
- Use evidence from involvement work to develop outcomes, measures and specifications for contracts.
- Involve patients in process of developing content of contracts.
- Engage voluntary sector in identifying potential ideas.
- Representation in procurement process.
- Clearly communicate the role of public on panels.
- Involve patients and the public in supporting decision making about budgets – known as Participatory budgeting

3. Managing demand and performance management

- Use patient experience data and patient centred performance indicators
- Develop access to timely data e.g. use of hand held devices, online dialogue.
- Involve patients in service clinical quality review groups
- Use patient centred methods of collecting data e.g. mystery shopping, patient stories
- Involve patients in quality visits with focus upon patient centred quality

- Review provider quality accounts
- Involve patients in service delivery assessment – use reference groups, focus groups, patient satisfaction surveys

Key considerations

WHAT do we want to know?
What are health priorities of local people, how best should local health-funding be spent over next financial year(s) etc., what do local people think of clinical priorities.

WHY monitor and review?
By monitoring and reviewing services we provide we ensure continuing service improvement. Patients and the public will be actively involved in developing tenders, identify potential providers, participating in tender processes and panels and making decisions on resources.

KEY tasks / challenges
Getting the timing right so that engagement happens before commissioning plans/strategies are signed off, map existing customer feedback i.e. what are PALS/complaints telling us, what's coming through quality agendas etc.

WHO we need to engage?
Citizens, taxpayers, general public as well as active service users – see section on 'Who we need to involve and engage'

10. Who we need to involve and engage – routes to consider

Making sure we leave no-one out of our engagement

To meet the principles of good engagement participants have to be representative of the local community in NHS County Durham and Darlington. We must not omit involving all people from our diverse communities, for example travellers, disabled people, Black and Minority Ethnic (BME) people, people of different faiths, older and younger people, Lesbian, Gay, Bisexual and Transgender (LGBT) individuals. All engagement must be inclusive and representative unless there is a defined and reasoned explanation why not.

Defining 'easy to overlook' groups

The term 'easy to overlook', also sometimes referred to as 'hard to reach' or 'seldom heard' is widely used to describe those groups or communities who experience social exclusion and disempowerment. They are generally perceived by agencies as being by their nature difficult to engage.

Whilst some groups are well serviced by local networks and groups, some individuals or groups find it difficult (or are unable) to take advantage of available opportunities. This could be, for example, because of an impairment, language or cultural difference, time limits or financial constraint.

There is no single list that defines all groups of people we find hard to reach. Even if there were a list, it would not be common to every organisation. In some areas, groups that are regarded as difficult to engage elsewhere are highly involved with local networks.

Hard to reach groups may include homeless people, drug users, refugees , economic migrants and asylum seekers, Gypsies and Travellers, disabled people, people with mental ill health, minority ethnic groups, young people and those who live in relative rural isolation. To engage with these groups well, it is important to target them directly.

Many other groups are difficult to contact such as the small business community and working people.

All hard to reach groups are made up of individuals. Some may not want to be contacted by statutory organisations or services, and others may feel these services have let them down and lack confidence in the system. Sometimes hard to reach groups are relatively easy to find, but may not wish to be involved.

It is essential that when developing your engagement strategy, particular consideration is given to engaging with locally appropriate 'easy to overlook' groups such as:

- physical inaccessibility, for example older or frail people
- language
- cultural perceptions and traditions, for example disadvantaged young people
- social expectations, for example children and young people who are often not considered as appropriate to be engaged with and who themselves often do not expect to be taken seriously
- working people / shift workers

To overcome barriers that prevent or discourage participation or involvement, consider using interpreters, visual aids, adapting facilities for disabled people, providing care for dependents, be flexible over timing, location and transport and try to use 'neutral' or safe buildings, for example community centres.

The Involvement Team or the Patient Advice and Liaison Service (PALS) can advise on how to arrange for signers, interpreters or translators. The PALS team act as intermediaries, often helping patients who struggle to access health services. They can be contacted on freephone 0800 195 7998, email cd-pct.pals@nhs.net

Personal contact at the earliest possible stage of any engagement activity will help identify obstacles and ways to overcome them. No matter how small the first contact, once you have started it will be easier to continue a dialogue. When people have become involved, take time to listen to what they say. Hearing more about what groups who may not normally talk to NHS organisations have to say is essential to understanding their areas of interest and concern.

Routes to consider

MY NHS

Accessed through www.cdd.nhs.uk MY NHS is a growing database of members of the public, patients, carers, organisations and key individuals who have already participated in previous engagement activities or who would like to be kept informed and to be involved in the future.

MY NHS has its own section of the NHS County Durham and Darlington websites which actively promotes all the different kinds of engagement and consultation currently in progress and completed by NHS County Durham and Darlington its partners, this can also be used to further promote your engagement activity and/or communication, and to feedback.

We would encourage you to ask anyone who shows an interest or participates in engagement activity to register to MY NHS to ensure their continued engagement. Membership is reviewed annually, for the purposes of Data Protection, and all information is securely stored.

Patient, Service User and Carer Database

NHS County Durham and Darlington continues to use a patient, service user and carer database to target activity and invite participation in specific pathway design and development and service reviews, engaging on a needs driven basis. A targeted approach is used to identify actual/potential service users. This can be through direct contact with service users, in addition to utilising the database. The latter is probably most valuable in terms of engaging the population in decisions about priorities and. strategies.

Patient Reference Groups (PRGs)

A number of GP Practices across NHS County Durham and Darlington have a Patient Reference Group – sometimes called 'Friends of the Surgery' or simply the 'Patient Group'. Patient Reference Groups make an important contribution to the well-being of their communities. Their activities include health promotion, information provision, service delivery and strategic input to the Practice.

Groups or individual members may be able to contribute to a variety of engagement activities, and can act as a gateway to the wider Practice population. It can be useful to involve PRGs in engagement activity around the accessibility and availability of services and the strategic direction of primary care in the locality.

They are also a key part of any engagement regarding developments with their associated Practice. Patient Reference Groups are supported by their associated Practice, usually the Practice Manager, and all contact with the group is via the GP Practice.

Benefits of a patient reference group are that patients will:

- Feel involved and empowered by being able to influence local health services
- Have more confidence in the practice. GP commissioning consortium and its services
- Have a greater understanding and appreciation of health service issues and decision making
- Develop their skills and confidence by taking part in regular meetings and discussions
- Enhance their local knowledge and build new relationships.

Third Sector organisations

Once you have identified your stakeholders and the scope of your involvement activity, it is important to consider if there are third sector organisations who manage a membership database of local voluntary and community sector groups to contact. They may also be able to distribute information on your behalf. Engaging with the voluntary and community sector is an important part of informing and involving the local community and / or specific groups of patients, carers and members of the public.

Voluntary Organisations can act as a gateway or point of contact with the individuals or groups they represent and may also be able to offer advice around how to encourage a particular group of people to contribute and suggest ideas for overcoming any barriers to involvement.

Groups of stakeholders with specific interests can be approach by groups such as Age UK, MIND, Council for Voluntary Service (CVS), Deaf and Deafened, MENCAP, the Stroke Association, Carer Support Groups, Society for the Blind, Gay Advice etc.

Local Involvement Networks (LINk)

LINks are independent networks made up of individuals and community groups who work to improve local health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

LINks are responsible for:

- finding out what people think of their local health and care services
- giving people a chance to suggest ideas to care professionals that help improve services
- looking into specific issues of concern to the community.
- making recommendations to the people who plan and run services and ensuring a response is received from those people within a specified time period
- asking for information about services and ensuring information is received within a specified time period
- carrying out visits, when necessary, to see whether services are working well.
- referring issues to the local council's health overview and scrutiny committee if it seems that action is not being taken.

NHS County Durham and Darlington has a policy of offering all communication and engagement opportunities to the two LINks (www.linkcountydurham.co.uk and www.darlingtonlink.co.uk) who can assist with distributing information, responding to wider engagement and consultation activities and carrying out consultations on our behalf.

If you plan to contact the LINk(s) or would like further information please get in touch with a member of the Communication and Engagement Team; who can provide further information and put you in touch with the two local LINks.

HealthWatch

HealthWatch will be the new independent consumer champion and a statutory part of the Care Quality Commission (CQC), to champion services users and carers across health and social care.

HealthWatch locally should provide a patient advocate role, championing issues for patients, and a scrutiny and challenge function in relation to local commissioners and providers. Local authorities are currently looking at how they will commission local HealthWatch. Health and Wellbeing Boards should be the place where commissioners and providers of services explain and are challenged on how they are carrying out their responsibilities.

HealthWatch could offer opportunities to work across local authority boundaries in partnership with other areas when NHS service changes encompass more than one local authority area. HealthWatch could also be charged with responsibility for liaising with groups with protected characteristics to ensure that consultation met all requirements in this area.

Please note – this toolkit will be updated as HealthWatch evolves.

Area Action Partnerships (AAPs) - County Durham only

Area Action Partnerships have become a key mechanism for working with local communities and provide comprehensive geographical coverage. The AAPs are currently being reviewed by Overview and Scrutiny to assess if they are fit for purpose and fit for the future.

The Council's 14 Area Action Partnerships (AAPs) have been set up to give people in County Durham a greater choice and voice in local affairs. The partnerships allow people to have a say on services, and give organisations the chance to speak directly with local communities. They are working with existing community organisations to focus their action and spending on issues important to local communities.

A key focus of the AAPs is consulting and engaging effectively with local communities to ensure the Council and partners are focused on people's needs. AAPs are well placed to provide a mechanism for involvement of the public on general or cross-cutting matters in respect of health and social care (e.g. major

redesign of the system) and for raising awareness of consultations that are underway .

A recent scrutiny review of the AAP`s concluded they are fit for purpose and play a pivotal role in understanding the needs of their area, acting upon those needs and influencing service delivery.

Health Networks – County Durham only

There are five Health Networks in County Durham, which were established in 2010 to facilitate joint local working between partner agencies and the third sector. They have a specific focus upon addressing health and wellbeing and reducing health inequalities in communities identified as having the greatest level of need. Each Health Network has prioritised three areas for development and is accountable to the Health and Wellbeing Partnership.

Health Networks are not a vehicle for consultation and engagement, but do offer important access to networks and local community groups within their scope. They include a wide range of stakeholders such as voluntary sector organisations, Town and Parish Councils, local people, and communities of interest.

Health Networks now have a good range of partners involved and focus very much on no improvement without engagement.

In Darlington, the Health and Wellbeing Network is supported by eVOLution Darlington.

Durham County Council engagement support

There is a substantial support infrastructure within the County Council, NHS and third sector providing expertise and capacity in working with communities, in communication, in managing surveys, in facilitating consultation and engagement and so on.

Public and Patient Involvement teams in the NHS and Community Engagement teams in the Council exist and are in a good position to work together to support commissioners with consultation and engagement.

Specialist teams also exist to support more vulnerable communities to ensure such voices are heard i.e. learning disabilities, users and carers with mental ill health.

Other routes and resources

Durham County Council has a useful publication called "The Tools and Resources for Community Engagement and Consultation" - it includes a toolkit on Community Engagement. **Please contact the Involvement Team for more information.**

Carers centres are independent, charitable organisations providing information, advice and support to carers. The centres offer a wide range of local, confidential support services to adult and parent carers. The centres provide direct access to carers across the County. Carers Centres are very effective network with access directly to their community.

Clinical Quality Service Groups continue to focus on patient experience, working with key providers such as County Durham and Darlington NHS Foundation Trust and Tees Esk and Wear Valley NHS Foundation Trust, who provide feedback and respond to user issues.

Special Interest Groups, Partnerships and Forums - there are numerous groups, partnerships and forums operating across the county which are important networks for undertaking consultation and lobbying on behalf of service users/patients with specific conditions.

These can have an influential role in commenting and advising on issues linked to their community. Examples are the County Durham and Darlington user and carer forum for adults with mental ill health exists, and the Learning Disability Partnership Board. There are also equivalent arrangements for young people,

Additionally, there are a number of third sector organisations such as the Stroke Association, Macmillan Cancer Support and British Heart Foundation, which both advocate and provide support to individuals and groups.

Involvement and engagement teams from both NHS County Durham and Darlington and local authorities are able to advise on appropriate groups and networks for any activity.

11. Levels of engagement

There are different types of involvement, and you would need to consider the level and type of engagement appropriate in order to meet your objectives i.e. you would select a different approach to engaging on "Seizing the Future" which had an impact on the whole population compared to a minor change to a specific service e.g. development of an older peoples service which would require a more targeted approach.

If you already have a clear steer on a decision or initiative then it is probably unwise to commit resources to anything more than information giving or "low level" engagement. The greater the level of engagement involved, the greater the opportunity to empower patients, carers and the public and build capacity. High levels of involvement such as collaborating or empowering have greater resource implications in terms of both time and cost, as the public and stakeholders who you are engaging with may require a great deal of support.

Dimensions of Engagement

← Dimension →			
Patients as partners in their own care	Service redesign, improvement and review	Wider strategy development	Community engagement as a means of improving health
Minimum Engagement			**Maximum Engagement**
←			→

Information Giving	Consultation[1] / Receiving Information	Involvement and Participation	Partnership

[1] Consultation has developed a particular meaning in relation to NHS bodies and often refers to the formal process required under legislation in respect of substantial change or variation of services provision

Informing

Communities need to know how to access services, so that they can have their say and get involved in influencing those services, decisions and policies. Key principles of good communication are outlined in the Communications Toolkit.

Consulting

Consultation allows people to have their say about the decisions and services that affect them. It needs to provide genuine opportunities for people to take part and for their views to be heard and acted upon.

Involvement and participation

Involvement is the most interactive form of engagement which is over and above being informed and consulted. It needs to give the ability for genuine influence over decision-making and delivery and can include influencing or directly participating in decisions, co-designing or commissioning services and working with commissioners to judge how good services are.

Key principles of involvement are:

- be the default position rather than the exception, so that all NHS services seek to include stakeholders and representatives of local people in the design of policies and services as matter of course.
- encourage direct participation in decision making, so that people are empowered wherever possible
- encourage aspects of services themselves to be delivered directly by the users of those services, for example by voluntary groups
- encourage people to work with commissioners in assessing services
- be inclusive and accessible
- be transparent so that it is clear how the involvement has fed into the final decision-making

Partnership

Partnership refers to more formal, collaborative mechanisms through which community development can be strengthened. These can include patient led organisations which provide services to their own or a client group, large group processes, Local Involvement Networks and Area Action Partnerships. An example of partnership working would be formal membership of a Clinical Commissioning Group as a lay member.

12. The Legal Requirements to Engage

There is specific legal duty to consult with people in the cases of gender and race, however in the area of Disability we should not only consult, but we also have a specific legal duty to involve disabled people. Engagement needs a defined target audience. This can be drawn from any group of stakeholders. It might be all residents in the locality, people from a particular area or group, users of a particular service, or possibly non-users of the service whose views might be important. http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm

Legislation and Policy

There are several statutory requirements surrounding patient, carer and public engagement which mean that not involving local people is not an option. The legislation listed below mandates all NHS organisations to involve patients in the planning and provision of services and any proposals for service change. It includes obligations to consult relevant Overview and Scrutiny Committees (OSC) and work with Local Involvement Networks.

- Section 242 of the NHS Act 2006
- Section 244 of the NHS Act 2006
- The Local Government and Public Involvement in Health Act 2007 -
- NHS Constitution

Useful links to statutory legislation:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089787

http://www.legislation.gov.uk/ukpga/2007/28/contents

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/COI_NHSConstitutionWEB2010.pdf

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129124

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128196.pdf

The draft Health Bill 2011 reinforces these legislative requirements and requires GP Commissioning Consortia to seek outcomes which deliver a positive patient experience. Furthermore, the Revision to the Operating Framework for the NHS in England 2010/11 introduced four tests for all proposals for service reconfiguration which requires all proposals to demonstrate:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice

Where there is insufficient assurance that the four tests have been properly applied, the Secretary of State for Health may ask the Independent Reconfiguration Panel to review the case and make recommendations to him.   Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services affecting large numbers of patients across a wide area.

Substantial variations require a 'Formal Consultation' to be carried out. This process will last a minimum of 12 weeks and will incorporate a variety of information giving, engagement and involvement methods to gather opinions on a specific subject.

Equality Act 2010

The new Equality Act 2010 provides a new cross-cutting legislative framework to:

- protect the rights of individuals and advance equality of opportunity for all
- update, simplify and strengthen the previous legislation; and
- deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

It requires commissioners of services to take Equality and Human Rights into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

The Equality Delivery System through which this is delivered states that organisations should:

"Improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience".

This means that when we plan and deliver services we need to make sure that:

- We have measures in place to identify and tackle any barriers to using our services
- We provide people with the support and information they need to use our services in a way that meets and takes account of their individual needs

- We support people to make informed choices about their care and treatment and understand their rights
- We have strong systems in place to gather feedback and capture experiences from the people who use our services and use this to improve the things we do.

13. Planning Your Engagement

Planning - planning is crucial, it is important to plan well in advance. Please see the flowchart below which sets out the key steps in involving patients and the public.

Are you clear about why you need to involve patients/public?

Yes   **No** → **Refer to page 11 "How to engage within the Commissioning Cycle"**

Have you completed the PPI project outline form?

Yes   **No** → **Refer to www.cdd.nhs.uk**

Have you effectively planned your engagement initiative and referred to the toolkit?

Yes   **No** → **Refer to page 26 "Planning your engagement"**

Have you decided which methods and approaches to use?

Yes   **No** → **Refer to page 35 "Tools and techniques of engagement"**

Do you know how you will evaluate and feedback on your PPI initiative?

Yes   **No** → **Refer to page 29 "Recording, Feedback and Evaluation"**

Points to consider

What do you want to know?
Be clear about what you are inviting patients/public to be involved in e.g. is the work aimed to give and / or receive information or do you intend to get people more involved?

Why do you want to know this information?
Is this an information giving exercise or is the intention to enable patients to have a greater say in decisions?

What are you going to do with the findings obtained?
The results of involvement and consultation must be properly considered before any decisions are made.

Why work with other organisations?
Involvement work is resource intensive, resources and experience can be shared if more than one organisation is involved.

Consider involving the following groups as appropriate:
- local people
- patients specifically involved in the service change process
- carers
- people who have identified issues through complaints/PALS dept.

What level of involvement is required?
- make the best of what you have
- plan well in advance, define your timescales is to work backwards from this date
- be honest and up front about what options, possibilities are available
- take it seriously – all involvement consultation needs to be done in the genuine spirit of wanting to listen and take notes of what is being said.

Overcoming barriers to involvement:
- tell people clearly and simply what is involved in the process, and what difference they can make
- tell patients that the involvement you are offering is not just another 'token effort'
- recognise that sometimes people will not want to be involved.

It is worth remembering some basic rules such as ensuring:
- font sizes are 12 point or larger where possible
- translation services for the most commonly spoken languages in County Durham and Darlington are offered
- where possible large print (16 point), Braille and audio versions of publications are available on request

- arrange for signers, interpreters or translators as required (see page 14)
- always give feedback (whether the outcome is positive or negative).

When to monitor and/or evaluate?
Monitoring and evaluation arrangements should be put in place early and not added later once the work is underway. To measure how things have changed as a result of involving and consulting patients and the public, it is important to have a clear view of how things were before the process began.

Was it successful?
How do you measure success?

For most people – staff, patients and the public – it is the outcome of the discussions that are most important and, the changes that happen as a result of their involvement. If nothing changes as a result of patients talking to you they will have doubts about whether it is worth doing again.

ALWAYS feedback both the positives and negatives – *"You said, We did"*

Sources of information

Consider the following sources of information to support your planning:

- **Joint Strategic Needs Assessment (JSNA)** - the purpose of JSNA is to pull together in a single, ongoing process all the information which is available on the needs of our local population ('hard' data i.e. statistics; and 'soft data' i.e. the views of local people), and to analyse them in detail to identify the major issues to be addressed re health and well-being, and the actions that local agencies will take to address those issues.
- **CQUIN** - the PCT uses use national inpatient, outpatient, A&E and GP survey results and also a combination of national and local patient experience standards in making Commissioning for Quality and Innovation (CQUIN) agreements with our main providers. CQUIN is a national payment framework which enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.
- **Patient experience** - local patient experience include by trends from Patient Advice and Liaison Service and complaints data, and other service user feedback sources. Examples are around quality of meal provision in hospital, and equality and diversity. HealthWatch will play a key role in gathering this information.

14. Recording, Feedback and Evaluation

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 ready-made report headings.

Consider how you will capture discussions during 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 or post-it notes,
- 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 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.

The following may help as a guide to information that might be given in feedback.

Summarise:
- patient views and highlight differences
- the final decision and why it was made
- how patients' views influenced the decision.

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 be agreed at senior level?

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 carer and public engagement activity or activities have been is always going to be complex and open to debate. As with all aspects of patient carer 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:

    o Demographic information
    o Their experience of the engagement process
    o 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 people who have literacy problems.

15. The Formal Consultation Process

If you intend to make a substantial variation to a service, or this is a possible outcome of the project, for example moving premises and/or changing the way services are delivered, there will be a legal requirement to formally consult.   Section 244 of the NHS Act 2006 (which replaced Section 7 of the Health and Social Care Act 2001) requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for significant development or substantial variation of a health service. A significant development or substantial variation is not defined in the regulations; however, consideration must be given to the following when determining whether or not a proposal is substantial or significant:

- changes in accessibility of services
- impact of the service on the wider community and other services, including economic impact, transport and regeneration
- number of patients affected; NB: proposals affecting a small group may still be deemed substantial if that group will need to access the service for many years
- changes to methods of service delivery
- anticipated controversy of proposals i.e. changes to historical service provision
- changes to governance arrangements

Health Overview and Scrutiny Committees (OSCs) or Panels are made up of elected representatives of the local community; each local authority has established a number of Scrutiny Panels or Committees, who are responsible for monitoring and scrutinising health.

Involving OSCs as part of wider activity to engage with patients, carers and members of the public has a number of recognised benefits as they have close links to, and awareness of the needs of the local population. They may also be able to highlight existing evidence of the views of local communities. An awareness of the Committee's current work plan and areas of interest may enable you to identify areas where joint working could be undertaken.

If you plan to contact the OSC or would like further information please get in touch with the Communication and Engagement Team; who can provide further information and put you in touch with support teams from the two OSCs in County Durham and in Darlington.

Formal Consultation will usually involve a number of methods from giving information to engaging. The process will normally take 13 weeks and will begin with a Consultation Document that sets out:

- why the organisation is consulting
- the options (if appropriate)

- what the organisation seeks to achieve from consultation
- how the organisation will conduct the consultation

Pre Consultation (6 – 8 week lead in)

- develop and agree Consultation and Communication Plan(s)
- stakeholder Mapping
- equality Impact Assessment
- agree consultation activity (finalise plans accordingly)
- brief relevant Boards / Committees, for example Overview and Scrutiny
- develop and produce Consultation materials, for example literature
- distribute Public Consultation Document

Consultation

- consultation activity, for example public meetings, drop in sessions and questions
- collect and collate comments / feedback and acknowledge responses

Post Consultation (4 – 6 weeks)

.
- produce Consultation Report
- report to formal Board / Committees (decision makers)
- feedback to public
- pursue any relevant additional issues highlighted during the Consultation
- consider engagement going forward

During consultation, it is best practice to report the outputs / feedback received via meetings, leaflets, letters, and telephone conversations or any other method, to allow all parties to view and comment on responses received. The end of the consultation process will be followed by the production of a Consultation Report. This will reflect the original Consultation Document and will summarise and provide analysis of all of the responses received during Consultation as well as the decision of the organisation. This should be circulated to all those who took part in the Consultation and made available to the wider public. In some cases, Formal Consultation will result in involvement, where Service Users join in designing services.

Please let the Involvement Team know if you are planning on undertaking any engagement activity which may constitute Formal Consultation.

16. Tools and Techniques of Engagement

The ultimate aim of engagement is to give the public direct influence over NHS decisions, so that we offer the right services in the right way for the people who use them and that services in individual areas reflect the individual needs of people in the locality.

The Tools and Techniques of engagement resource in this toolkit, which is not exhaustive, outlines a number of techniques that can be used to achieve effective engagement. Before choosing a particular technique, a number of issues have to be considered:

- what information needs communicating or collating?
- how much will the information be used?
- how much time is available?
- what resources are available?
- what is the nature of the service/initiative?
- how will any outcomes be fed back to participants?

Engagement Tools and Techniques

The following are included:

- Exhibitions / Displays at Events
- Leaflets and Written Documents
- Web Based Media
- Self-Completed Questionnaires / Surveys
- Focus Groups
- Meetings with Patient and Carer Groups
- Public Meetings
- Discovery Interviews
- Electronic voting
- Social media

Good practice examples are also included.

Exhibitions / Displays at Events

PROS	CONS
• You may reach members of the public you may not normally reach. • If staffed it provides the opportunity for representatives of the organisation to exchange information with the public. • A good opportunity to raise the profile of the organisation and publicise what it does. • An opportunity to give the public other relevant information to take away or point them in the right direction.	• You provide the public with the opportunity to give you their wide-ranging agenda. You may not be able to respond. • If you choose the wrong site you will waste time and money. • Resource intensive if staffed all the time.

If you do decide to mount an exhibition you will need:
- careful advanced planning
- venue to be easily accessible, near places people will be visiting
- staffing at all times by the right people
- to be actively promoted, for example press/radio adverts, posters, flyers
- to look good – professionally designed stand and/or material
- to be interactive with the public
- the right amount of information to enable people to make informed comments or be directed to further information sources
- information in different languages, or interpreters, as appropriate

Checklist: Tick when completed	
Is the site relevant to the locality or users of the services being consulted upon? Is it where local people go?	
Has an individual been given responsibility for preparing and co-ordinating information for the event?	
Do you need a leaflet or other handouts?	
Do you need a leaflet or other handouts?	
Do you need interpreters?	
Have you ensured that the exhibition looks attractive?	
Can the event be left unattended?	
How will you record comments?	
Are the staff well briefed?	
How will messages from the public be handled and acted on?	
How can you evaluate the event?	
Is the purpose of the event clear to everyone involved at the outset?	

Leaflets and Written Documents

PROS	CONS
• A document may be a starting point in a consultation or engagement activity. • It is an accepted way of disseminating information. • An opportunity for the organisation to make a statement. • Keeps the public informed and aware of the issues. • It is a record of the organisation's position at that point in time.	• A document becomes outdated quickly. • There is no guarantee it will be read. • Sometimes there are too many around. • Can be seen as expensive.

If you want to go ahead consider:
- is this the best way to give information to people?
- ideally a document should be tested with a range of people from the target audience before it is published
- a consultation document should be followed by a report document outlining the changes that have been made as the result of the involvement and consultation and the next steps
- information must be accurate, understandable and targeted
- what other information do people need to read in the document for context?
- are you clear on who the audience is and how to reach them?
- need to give the right amount of information – not too little, not too much
- the document is part of the process, not the process itself
- the production of a clear readable document is a specialised resource intensive task

Checklist: Tick when completed	
Does it follow corporate guidelines?	
Plain English, jargon free. Do you need editorial skills?	
Are you going to produce a summary?	
Do you need either the main document or summary translated?	
Do you need to consider other media, for example; audiotape, video, Braille?	
How is it to be distributed?	
Would built-in response forms be a good way to get feedback?	
If it is draft, does it say so on each page?	
Is the format and length suitable for the target audience?	
Do you need a glossary?	

Web Based Media

The web can be used to simply inform, for example through a corporate website, or to engage and consult. This might be through online surveys, by setting up a discussion forum or by encouraging discussion through social media such as Facebook – see page 45.

PROS	CONS
• Potential to reach large numbers of people • Potential to reach a younger audience than usually attend public consultation events • Easy for people to respond from their own home or local library	• An emerging process – NHS skills in this area are likely to be limited • Potential for negative comments which then stay 'live' • Possibility of others hijacking agenda • Not everyone can access the internet

If you want to go ahead consider:
• are you clear about the objectives?
• are you prepared to respond to negative comments?
• have you got support for people with no online access, for example printed material?

Checklist: Tick when completed	
Who will monitor responses/comments?	
How will you encourage people to visit the site or your page?	

Self-Completed Questionnaires / Surveys

The Involvement Team have a questionnaire template to support you. A freepost address is also available for the return of paper based surveys.

PROS	CONS
- A way of gathering relevant and quantifiable information. - Information obtained will be relevant to the issue. - If well done information can be collected from large numbers or representative samples. - Can be done face-to-face (but increased costs) – or by 'phone / web / paper. - Flexible and adaptable to a large number of issues. - Can give base-line data on something to be monitored or measured against.	- Not good for qualitative information (unless free text questions used) - Not in-depth, no opportunity to explore ideas/issues/experiences further. - Could be a low response rate or unrepresentative sample. - Provides only a 'snapshot' in time. - Can be administratively unwieldy. - Cost: professional help may be needed to design and carry out the survey

If you want to go ahead consider:
- is the topic area appropriate?
- is information required quantifiable or able to be categorised?
- are the people you want to engage with likely to fill in the questionnaire?
- how large a sample?
- do you have a database or sampling frame of people you want to collect information from?
- do you want free text boxes to allow respondents to add comments?
- surveys need timescales, how long will your survey run for?

Checklist: Tick when completed	
Who is the target audience?	
Do you need help with sample size/ representation?	
How will you distribute the questionnaire – e-mail, web site, postal?	
Have you time to collect answers in person or will you use postal services?	
Who will decide on the questions?	
Who will do the data analysis? Will you need outside help for this?	
Will the information be of any use if low response rate?	
Will you send reminders?	
Could you find methods to improve response rates?	
Have you agreed how to feedback outcomes to the respondents?	
Will you be offering interpreting services?	

Focus Groups

In-depth discussion groups of six to twelve people that focus on a specific issue/topic. Focus Groups can be used to follow up on quantitative responses and 'drill down' further into qualitative feedback.

PROS	CONS
- Interaction may produce new ideas. - Participants can be recruited to specific criteria. - Allows a framework for discussion, but content emerges from inter-action of group members. - Skilled facilitation can help all views to be heard. - Facilitator can interact directly with the group and provide clarification information and interpret non-verbal responses. - Can empower participants. - Can include people with literacy/language problems. - Can reach non-English speakers if the right facilitator found. - Can provide in-depth information on views and feelings. - Can elicit views of those who think they have nothing to say. - Can bring similar people together – group may be sustained.	- Group norms may inhibit some members: need good facilitation to overcome this. - Does not generate 'evidence' as such. - Mix of participants may not work well depending on the topic. - Not a rigid process so difficult to make comparisons between groups. - Potential cost or time implication for facilitator and note taker. - Confidentiality a problem: need group rules to be formulated at the start. - Mixed groups of lay and professionals may need special handling. - May be difficult to find a facilitator with a range of language skills. - May need to hold a number of groups to validate findings between groups. - Gender, age, ethnicity of facilitator may influence the discussion. - Not all those invited may turn up. Optimum size 8 – 10.

If you want to go ahead consider:
- what sort of questions do you want answering: 'why', 'how many', 'what'? For example, why people hold a view, how many hold a certain view or what are the issues/solutions?
- focus groups help understand what views people hold and to explore why: they do not tell you how many share this view

Checklist: Tick when completed	
Criteria to use for selection of participants?	
How to recruit participants – will you need professionals to do this?	
Is this method appropriate for the subject matter?	
Is the sample appropriate?	
How much money can you spend on venues and facilitation?	
Numbers in group – how many will you realistically attract and will you need to split into a number of smaller groups?	
Paying travel costs?	
Are you prepared to put time into developing the group?	
Who will facilitate – are they trained?	
Who should be the note taker?	
Venue?	
Best time of day?	
Would you video or record the audio of the discussion?	
What are the agreed ground rules, for example, respect, confidentiality? (available from Involvement Team)	
What questions should you ask?	
What level of information do participants need?	
How long should each meeting last?	
Maximum of 2 hours then a break/refreshments.	
How will you analyse the data?	
What will you do with the data?	
How will you feed back the outcomes?	

Refreshments provided. NB Catering needs to be culturally appropriate and accommodate different dietary requirements.

Meetings with Patient and Carer Groups

Voluntary, community, user/carer groups focus on a common condition or geographical area. They can be locally based or branches of a national group. They may be support groups or 'user view' groups. They may have a set agenda or be unstructured.

PROS	CONS
• A 'captive' audience which is knowledgeable and committed. • Quite quick to organise and make contacts. • Can be useful for contacts for future focus groups. • Can build on on-going partnerships. • Collective knowledge which does not rely on view of one individual. • Way of accessing target groups including 'easy to overlook'.	• Can only offer feedback on areas specific to their experience. • They can be subjective or limited in range of views. • Possible lack of objectivity – do you need to ask other users as well?

If you want to go ahead consider:
- do you know what groups already exist in relation to the issue?
- are you clear about the purpose of the meeting? Who has set it up?
- are you prepared to discuss the group's agenda as well as their views?
- what will you do about those views that are not on your agenda?
- how easily can you put across your agenda? Is it easily understood?
- have you got resources/venue/ time?
- is this a one off or the start of a series?
- remember you are not the only expert at the meetings

Checklist: Tick when completed	
Does the group meet regularly, where and when?	
Arrange a time and place that suits the group	
Have you given the group enough prior notice?	
Have you given the group clear information about the purpose of the meeting beforehand?	
Will you provide refreshments?	
Will you provide travel expenses and an interpreter or other required support?	
Have you made it clear if this is a one-off or an on-going relationship?	
Have you agreed on the method of feedback to the group?	
If this work is on-going have you agreed how you are going to work together in the future?	

Public Meetings

Open invitations i.e. anyone can choose to attend, but usually a set agenda. Use creatively and interactively but beware these can be very difficult to manage and are rarely the best option in isolation.
However they are an expected part of Formal Consultation. You may wish to use the voting system at your public meeting which could be used to record questions and evaluate public opinion and comments afterwards.

PROS	CONS
• Opportunity for a wide range of people to comment or raise issues or directly challenge decisions. • Opportunity for NHS County Durham and Darlington to put their side of the story. • Public relations value. • Provides opportunity for joint consultation with other organisations. • Offers the public a chance to challenge issues directly which increases accountability. • Provides an indicator of problem areas and local issues not previously known – where to focus in future.	• May be a low turnout. • You have no control over who attends and what happens. • Beyond control, for example, if a participant says they represent a wider view • May be seen as a quick fix and tokenistic. • Significant time and money required, for example, hire of venue, advertising, sound systems, travel expenses, refreshments • Lay bodies and pressure groups may simply see the public meeting as a chance to challenge authority. • Voluntary sector needs advance warning of event • May only attract specific people – lobby/pressure groups. • There is never a best time or place for everyone. • May need to hold more than one meeting.

If you want to go ahead consider:
- why do you want a public meeting: would other methods be better suited?
- are you willing and prepared to deal with conflict?
- are you willing to deal with the unexpected?
- will you have a structured presentation and/or provide supplementary information on the day?
- is the organisation's staff confident and competent to answer questions on a range of issues?

- could you talk about the issues to key individuals more effectively?
- public meetings are often win-lose
- could NHS County Durham and Darlington/local voluntary groups have information stands?

Checklist: Tick when completed	
Appropriate venue identified?	
Disabled access?	
Sufficient car parking? NB need for disabled provision.	
Is venue well known? How many will it hold?	
Is it accessible by public transport?	
Best time?	
School holidays: will these affect arrangements?	
Are you going to allow informal meeting time before meeting starts?	
Who will be on the platform?	
Will senior staff attend and answer questions?	
Where will people who might answer questions be: on platform or with audience?	
Seating arrangements. NB wheelchairs/Sensory Impairment/lighting	
Would you wish for Non-Executive Directors and clinicians to be in the audience as observers for a different perspective?	
Who should chair this meeting? (Perhaps an independent chair or Non-Executive Director)	
How basic is the information you need to give to set the scene?	
Agenda?	
Do you need a sound system/loop system/British Sign Language interpreter?	
Presentation of information: avoid jargon and patronising tone	
Would it be best to have specific experts present to answer specific questions?	
Will speakers need a presentation pack and training?	
Do the public need an information pack?	
How do you anticipate the public will receive your message?	
Is the meeting to inform, engage or provide information?	
What can the meeting change? How will concerns be raised?	
How will you feed back to those attending? Will there be an attendance list?	

NB: If you are likely to attract hostile groups plan for this.
Refreshments: consider cultural / dietary needs and perception.

Discovery Interviews

The importance of obtaining the opinions of service users has long been recognised and, traditionally, most contact has focused on measuring their satisfaction with the services they receive. Discovery Interviews were developed by the NHS Heart Improvement Programme in 2000 and have since become widely used in the UK National Health Service as a service improvement tool and patient involvement mechanism.

The Discovery Interview Process, a technique for listening to patients and carers and using their narratives to improve care, is discussed in this article. This approach has been used in the pilot phases of the UK Coronary Heart Disease Collaborative and Critical Care Collaborative.

For further information please follow the attached link:

http://www.improvement.nhs.uk/discoveryinterviews/documents/DI_Guide_0809.pdf

Electronic voting

Electronic voting encompasses different types of voting using an electronic means of casting a vote and electronic means of counting votes. These can include hand held voting devices, kiosks using electronic screens.

Social media

Social media is the term commonly given to internet and mobile-based channels and tools that allow users to interact with each other and share opinions and content. Social media involves the building of communities or networks and encouraging participation and engagement.

The expectations of services users are changing and they now have the means to take on a more active role in engaging with the organisation. This also requires organisations to manage the feedback, ideas and demands that will emerge.

Social and digital media are now working alongside, rather than replacing, traditional media. These open up opportunities for sharing of information and views, and networking.

The implication for patients and members of the public is that they are now able to use these media to test messages and information provided by organisations, act as 'communities' with a more powerful voice, and expect to be listened to. Patients seeking information in order to make decision are able to access information, opinions, advice, conversations and join relationships.

The following are some of the main social networking tools, and how they might be used to support engagement.

Social networks
Social networks are places where users can have their own page but also share information and stories. They tend to gravitate around particular groups and work on the basis of 'friendship' where users choose to connect with other users and share content with them. Some will only let members read what is there and others are open to anyone.

Examples of social networks are Facebook, MySpace and Bebo where users can set up their own pages and share information. These allow users to create groups with their networks around issues or ideas.

These could be used to access stakeholders' existing social networks, to build 'friends of' groups around services, build communities of 'friends' who can lobby on behalf of the organisation, and listen to users' interest and concerns.

Management of ongoing involvement would have resource implications in terms of time.

Blogs
These are regularly updated webpages where new content goes at the top. They can now include commentaries, citizen journalism and campaigns. Many Blogs are about or refer to health issues, and allow readers to leave comments which can develop into new conversations. Service users and stakeholders will talk to each other through Blogs which provides opportunities to learn from this community.

Opportunities could include time limited blogs which tell the story of a project or new development, and comments and questions on health bloggers' sites. This would require a Blogging Policy to be in place, and training and support for staff. You can set up a free account at www.wordpress.com

Wikis
A Wiki is a website where anyone can edit any page and add new links and pages. Many organisations now use Wikis to share information, good practice and networking. They have been used to develop new service ideas by bringing together ideas and contributions.

Wikis could be used to manage partnership projects, develop strategic documents across the organisation, and provide a consultation space for stakeholder engagement. It would be important to ensure that all contributors feel that their contributions are equally valued, and to clearly define required outcomes. You can set a free account at www.wikispaces.com

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YouTube
YouTube is one of a number of free sites that offer space for users to upload video, create their channels and form groups around videos and areas of interest. More users are likely to visit YouTube than an organisation's website. You can create a free YouTube account at www.youtube.com

You Tube could be used to create video diaries of a project or event, enable stakeholders to tell their stories, and create video feedback channels for service users. It can also be used to post information videos for patients and service users. Challenges would include managing comments and questions, and ensuring representatives appear natural and credible on their video contributions.

Twitter
www.twitter.com is a micro-blogging and networking site. You can post a short message or 'tweet' of up to 140 characters to your twitter page from your computer or your phone as a text message. Your tweets are ordered on your Twitter page like a blog. Other Twitter users can choose to follow you. When they do, your Tweets are sent to them for free.

Twitter is a good way of keeping up to date with news and getting instant response to ideas. It can be used to build a network of professionals to use as a sounding board or source of information, or networking around an issue, project or service development. However, you would need to consider what public facing stories can be told in 140 characters or less.

Podcasts
Podcasts are audio blogs. Users subscribe to a podcast through a feed which pulls the latest version down to their computer. There are many podcast search engines which allow users to find podcasts on particular subjects.

Patients, stakeholders and the community may tell their health stories in sounds, and health professionals also use these to share their experiences and idea. Podcasts enable those people who are less confident in writing to tell their stories. They are an economical means of communication as they do not take long to record. You can upload these to your blog.

Podcasts could be used to enable commissioning group leads, clinicians, frontline staff, service users and stakeholders to tell their 'stories' from their perspective. It would be important to establish the 'voice' of the organisation, and who would be best placed to edit and produce podcasts.

Good practice examples

Development of intermediate care services strategy
In 2009 and 2010, NHS County Durham and Darlington worked with both Durham County Council and Darlington Borough Council to develop a strategy for intermediate care services. A range of different engagement mechanisms were used to ensure the strategy was informed by patients' and carers' experiences of intermediate care services. People who had recently used such services took part in focus groups, while other patients and carers took part in face-to-face, 1:1 interviews. The feedback was obtained over a three month period with the different methods of engagement enabling people to select the form of participation that most suited them, thus maximising input.

A draft strategy was circulated to all individuals who had participated and additional public meetings organised, to enable further comments and views to be obtained over a further three months.

Improving Access to Psychological Services
In 2009, the views of patients and members of the public were gathered to inform the development of a service specification for an expanded psychological therapy service covering County Durham and Darlington. An 'Anxiety and Depression' survey was developed and used to collect views. Copies of the survey were sent to GP Surgeries, community venues and the two Local Involvement Networks in County Durham and Darlington. The survey was also made available via the internet on **www.haveasay.org.uk** and was publicised through local press and also through local voluntary and community organisations newsletters. The feedback helped to shape the content of the service specification.

Young People's Centre
More than 450 young people were involved in the development of plans for a young people's health facility in Chester le Street in 2009. Engagement activity was facilitated by a local agency, Investing In Children, overseen by NHS County Durham and Darlington and Durham County Council. Activities undertaken included an Investing in Children Agenda Day, arts 'pre-consultation' events, a web-based and written survey and a review of existing research reports and academic reports.

Communicating with the wider practice population
Having been established for some time, a local Patient Reference Group identified an information gap after members felt that local people were not always fully aware of the wide range of services on offer at the practice. The group suggested to the practice that a newsletter be developed and the practice manager took this forward, with support from the local Primary Care Trust. Patient forum members helped to agree items for the newsletter such as practice opening times and details of local clinics such as flu clinics. The group now has an agreed newsletter template which will be populated by contributions from both the forum members and the practice on a quarterly basis.

17. Sources of information

Real Involvement: working with people to improve health services, Department of Health 2008

Commissioning Framework for Health and Wellbeing Services, Department of Health, 2007

Developing Clinical Commissioners towards authorisation, Department of Health 2011

The Functions of GP Commissioning Consortia: A Working Document, Department of Health 2011

The rough guide to experience and engagement for GP Consortia, NHS Institute for Innovation and Improvement 2011

Communications Toolkit: Making communications work for you, NHS County Durham and Darlington, 2011

Section 242 of NHS Act 2006

Section 234 of the Local Government and Health Act 2007

Section 244 of NHS Act 2006

Sections 221, 224 and 225 of the Local Government and Public Involvement in Health Act 2007

The National Health Service (Complaints) Regulation 2004 and Amendment Regulation 2006

Equality Act 2010