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FOREWORD BY DAVID NICHOLSON

The NHS continues to evolve. In order to keep up with developments in technology and medicine, adapt to the needs of all patients and be fit for purpose in the 21st century, NHS leaders must make sure that the bar is raised on how important decisions about changes and improvements to services are made and implemented and how users have shaped change.

To do this, the NHS needs to have a better understanding of when and how it involves users, and how to listen and respond to what it has heard. One of the five pledges to users in Lord Darzi's *NHS Next Stage Review: Leading Local Change* is that 'You will be involved'. This guidance will assist NHS leaders to be more confident in their approach to good involvement practice which will lead to better decisions being made because there have been opportunities for the views and opinions of users to influence each step of the process.

The NHS is expected to make sure that proposals for plans to develop services or change the way in which they operate will benefit the users of those services as well as improve clinical standards and deliver value for money to the taxpayer.

We all recognise that making changes on any scale can be difficult and may provoke powerful reactions from some stakeholders. The NHS needs to be much better at involving all stakeholders. This includes patients and their representatives, carers, members of the public, clinicians, staff and political leaders, and it needs to become more open and transparent about why it is proposing changes, what it is proposing to change and what it believes the benefits will be for the people who use the services.

Whether change is on the scale of a major service reconfiguration or how a particular service operates, the NHS must get better at explaining why change is needed. It must make sure that people who use or may use local health services are actively involved in the planning of services, and the development and consideration of proposals for changes that impact on the provision of services and decision-making.

The legislation makes changes to the duty to involve and consult users of health services. The changes include new duties and arrangements for strategic health authorities and primary care trusts about carrying out involvement and reporting on how the views and opinions of users given during a consultation have influenced commissioning decisions.

This guidance will help NHS organisations undertake real involvement and will lead to commissioning decisions that better reflect the needs, priorities and aspirations of users.

ACKNOWLEDGEMENTS

We have produced this guidance with the close involvement of the Section 242 Reference Group. We would like to thank everyone and their organisations for their support, advice and hard work.

We would also like to thank the many organisations and individuals who were involved in scoping the guidance, those who have commented on the draft guidance and those NHS organisations that provided examples of patient and public involvement work and scenarios for inclusion in the guidance.

See appendix 1 – Acknowledgements

In particular, we would like to thank Jenny de Ville for writing this guidance.

▶▶ INTRODUCTION

Real involvement
Working with people
to improve health services
October 2008

ABOUT THIS GUIDANCE

The guidance is set out in two parts with the intention that each part can be used as a reference and guide. The introduction provides background information to the legislation and other useful contextual information.

Part 1 – guidance on section 242(1B), the duty to involve and good involvement practice

Part 1 includes statutory guidance that NHS organisations must have regard to (in accordance with section 242(1G) of the NHS Act 2006) when undertaking their duty to involve under section 242(1B) of the NHS Act 2006.

It provides advice and guidance on how NHS organisations can carry out involvement activity. Chief executives, executive teams, non-executive directors and all other staff responsible for commissioning and providing services for the NHS should familiarise themselves with this guidance.

Part 1 has four sections

Section 1 – The obligation under section 242(1B) of the NHS Act 2006.

This section explains the meaning of section 242(1B), what it means for strategic health authorities (SHAs), primary care trusts (PCTs), NHS trusts that are not relevant Welsh bodies and NHS foundation trusts.

Section 2 – The framework. This section provides a framework for undertaking involvement activity in accordance with section 242(1B).

Section 3 – How to carry out involvement. This section provides practical help, advice and suggestions which the NHS might find helpful in planning and undertaking involvement activity. It includes a number of recommendations, references to related guidance, links to websites and a set of suggested checklists.

Section 4 – User involvement in commissioning and contracting. This section looks at involvement in the stages of the commissioning cycle, practice-based commissioning and specific commissioning situations when section 242(1B) applies.



Points to note

1. Section 242(1G) of the NHS Act 2006 states that NHS organisations must have regard to any guidance given by the Secretary of State as to the discharge of the organisation's duty set out in section 242(1B). 'Have regard to' means that an NHS organisation must properly consider and take into account the guidance when undertaking the section 242(1B) duty. That does not mean that the NHS organisation must comply with the guidance in all cases, but it must have good reasons for any decision to depart from it.
2. All documents referred to in this section are listed in the references and further reading section of the guidance which can be found at the end of part 2.
3. Where this guidance refers to sections 17A, 24A, 242A, 242B and 242(1B) of the Act, those references are to sections of the National Health Service Act 2006, unless otherwise specified.

Part 2 – sections 17A, 24A and 242B of the NHS Act 2006, includes guidance on reporting on consultations and information about section 242A of the Act

Part 2 is not statutory guidance. It explains the legislation set out in sections 17A, 24A and 242B of the NHS Act 2006. It gives guidance about each section of legislation and about Regulations made under section 242B and directions made in relation to sections 17A and 24A. It also provides information about section 242A of the Act.

References and further reading and the appendices can be found at the end of part 2.

Who and what this guidance is for

This guidance is to help people working at a range of levels in SHAs, PCTs, NHS trusts and NHS foundation trusts, from chief executives, directors, commissioners and managers to front-line staff, to:

- understand and follow the legislation that requires them to make arrangements to involve users in planning, developing and delivering health services commissioned and provided by the NHS;
- develop robust involvement practices that will stand up to scrutiny; and
- help make sure that the outcomes from sound involvement practice inform all decisions that are taken about changes to national health services and, where applicable, to report on consultations.

The examples in part 1 of this guidance are used to illustrate how different NHS organisations have approached specific involvement activities. NHS organisations should note that what has worked well for one organisation may or may not be the right approach for another organisation. Each NHS organisation should find the approach that is right for the level of involvement needed and for the users it is planning to involve.

This guidance may be of interest to overview and scrutiny committees (OSCs), Local Involvement Networks (LINKs), voluntary organisations, community groups and the many people who use or may use the NHS.



Points to note

1. The guidance mainly refers to users, taking the definition from the NHS Act 2006 that a user is someone who is using health services or who may use health services. Additionally, the Act refers to a duty to involve users, directly or through representatives. We recognise that carers are a very important group of people who have a valid role as representatives of users and as potential users themselves. Whenever the guidance refers to users or patients and the public, this includes carers as users or patient representatives.
2. The duty set out in section 242(1B) applies to SHAs, PCTs, NHS trusts that are not relevant Welsh bodies and NHS foundation trusts. A relevant Welsh body is an NHS trust, all or most of whose hospitals, establishments and facilities are in Wales.
3. Wherever this guidance refers to NHS organisations, it is referring to those NHS organisations listed above to whom the section 242(1B) duty applies.

BACKGROUND

Over the past few years, the NHS has been getting better and better at involving users in the development, planning and delivery of health services. While nationally there are many examples of innovative practice, there is still little evidence that involvement is a mainstream activity alongside other policy and performance requirements. Rather than being embedded in the day-to-day activity of NHS organisations, involvement continues to be viewed as a marginal activity, largely centred on process and dependent on the commitment of individual managers.

There is scant evidence to show that involvement activity is stitched into all the strands of NHS organisations' work, including their decision-making processes; of how organisations have listened and responded to what users have told them; or of how health services have been shaped according to the needs and preferences of users. However, there is evidence that suggests that some NHS staff, including those working at an executive level, do not properly understand the involvement legislation or what it means for how an NHS organisation needs to work. We also know that the NHS is not always:

- sure about when it needs to involve users;
- clear about whether involving users is the same or different to consulting them;
- ready to involve people at the very beginning of a process;
- clear about what can be influenced;
- open and transparent in the way it consults with users, which can lead to mistrust and the belief that many consultations are a sham; or
- prepared to listen and respond to what users are telling them.

World class commissioning, the operating framework for 2008/09 and the Next Stage Review reflect the shift of involvement to the forefront of the policy agenda and establish it as one of the key developmental challenges for NHS organisations. High-performing organisations are increasingly mainstreaming and embedding involvement activity in all aspects of their work.

As commissioners, PCTs have a particularly important role in gathering and acting on the views of users, including those who are 'easy to overlook'. Some PCTs are already testing out new approaches such as building up a local membership, forming joint governance and planning arrangements with their local council, and finding innovative ways to target and seek the views of their populations. All PCTs should work with their communities to choose an approach that suits their local circumstances.

Leading Local Change, part of the Next Stage Review, includes five pledges that PCTs are expected to have regard to. Pledge 4 is 'You will be involved'.

This guidance should help PCTs and other NHS organisations identify who they need to involve and what they need to do to deliver better involvement practices.

This people-centred, responsive agenda will make sure that the NHS is more locally accountable and shaped by the people who use it. To make this happen, NHS organisations may need to:

- establish new ways of working;
- forge new relationships both internally and externally; and
- make sure that user involvement is moved from the margins into the mainstream of every NHS organisation that is responsible for planning, commissioning and providing health services.

To deliver this responsive agenda, all the NHS bodies to whom section 242(1B) applies need to have regard to this guidance and may find some of the examples and suggestions helpful.

THE CONTEXT FOR THE LEGISLATION

User involvement is integral to many recent national policies. These include the following.

The operating framework for the NHS in England 2008/09

The operating framework for the NHS in England 2008/09 states that:

“the NHS must get much better at listening and responding to the patients who use our services, the staff who provide them and the citizens who fund them.”

One of the areas in which the NHS needs sustained improvement is public engagement.

“Commissioners have a responsibility to ensure that their local communities have the opportunity to be fully engaged in the decisions they take, and to take greater efforts to communicate what they are doing and why to their populations.”

“PCTs will want to ensure that they and NHS providers:

- adopt a systematic and rigorous approach to seeking, collecting and acting on the views of individuals and partners in the local community, as required by Section 242 – not just during periods of change but on an ongoing basis;
- create greater opportunities for their communities to make their voices heard, raising awareness of those opportunities and empowering patients and the public to use them and LINks;
- take greater responsibility for communicating with their local populations and stakeholders to ensure better understanding of, and confidence in, local NHS services.”

Our NHS, Our Future: Leading Local Change

Leading Local Change sets out how, where necessary, the NHS can change through the leadership of clinicians and the support of patients and the communities in which they live. It makes five pledges that PCTs should have regard to, one of which is:

“You will be involved. The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have a chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.”

Appendix 2 – The five pledges in Leading Local Change

Patient and public involvement in world class commissioning

World class commissioning, published in 2007, recognises that the commissioning landscape is changing, and that a shift from traditional models of commissioning is required. People are living longer, their lifestyles and aspirations are changing (and may need challenging to achieve better health outcomes), and the nature of public health is evolving.

This shift may require new and innovative partnerships to be forged between NHS organisations commissioning services, users, local authorities, clinicians and providers.

World class commissioning sets out the vision for meeting these challenges and identifies organisational competencies which are described within 11 headlines, one of which is:

“Engage with public and patients

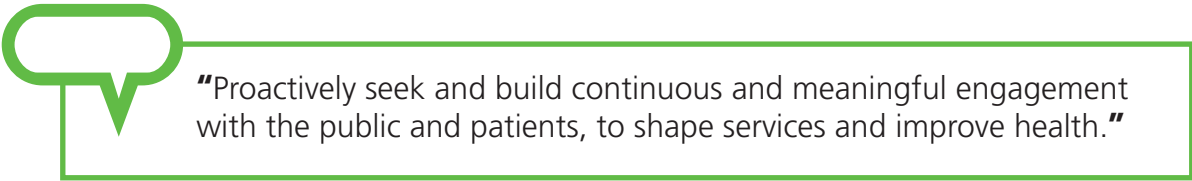
Commissioners act on behalf of the public and patients. They are responsible for investing funds on behalf of their communities, and building local trust and legitimacy through the process of engagement with their local population. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, world class commissioners will engage with the public, and actively seek the views of patients, carers and the wider community. This new relationship with the public is long term, inclusive and enduring, and has been forged through a sustained effort and commitment on the part of commissioners. Decisions are made with a strong mandate from the local population and other partners.”

Introduction: The context for the legislation

The commissioning competencies are the knowledge, skills, behaviours and characteristics that underpin effective commissioning. They are the platform for a commissioning organisation's development programme. This guidance will help commissioners understand the involvement legislation and assist them to effectively engage with users.

Some innovative ways are being used to engage the most marginalised members of our communities, yet far too many people still feel that the NHS does not identify or properly address their concerns, particularly when tough decisions have to be made.

To become world class, PCTs are increasingly required to:



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

Continuous and meaningful engagement will increasingly lead to commissioning decisions that reflect the needs, priorities and aspirations of users. PCTs need to give more thought as to how they will identify and meet the needs of people who experience the greatest inequalities. Addressing inequalities in health outcomes will require different approaches and styles of engagement with different communities. In turn, this will lead to the commissioning of different service offers based upon the world-class intelligence and information gained.


See part 1 section 3 page 63

Many of the skills and knowledge requirements set out in *World class commissioning* for this competency already exist within PCTs but reside with the patient and public involvement (PPI) lead or within PPI teams. Historically, it is these people who have had the lead or sole responsibility for the involvement work in their organisation and PPI work has been bolted on to the ‘real business’ of the NHS.

Appendix 3 – NHS world class commissioning competencies

NHS Constitution

The draft NHS Constitution underlines the fact that public and user involvement should be part of the fabric of the NHS by setting out a right for people to be involved. It says:



“You have the right to be involved, directly or through representatives, in the planning of healthcare services, in the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”

WHAT 'INVOLVEMENT' REALLY MEANS

Section 242(1B) of the NHS Act 2006 (the duty to make arrangements for involvement) is not prescriptive about what constitutes 'involvement'. The term is not defined, but the provision makes it clear that users may be involved by being consulted, or by being given information, or in other ways. Users may be involved directly or by representatives. Engagement, consultation and participation are all words that can be used to describe different types of involvement activity.

Many people working in the NHS believe that involving users means doing something different to consulting with them. This is not necessarily the case, as a number of activities can constitute involvement, including consultation.

When you are planning involvement activity, you need to think about proportionality and appropriateness, understand and use a spectrum of involvement, and know when to use the different activities which range from giving information through to active participation in planning the provision of services.

See part 1 section 3 page 68

Whatever form of involvement you are undertaking with users, you are undertaking the activity for the same reasons, to:

- discuss with them their ideas, your plans, their experiences, why services need to change, what they want from services and how to make the best use of resources; and
- make sure that the services you are responsible for planning, commissioning or providing meet their needs and preferences.

Good involvement practice:

- happens early and continues throughout the process;
- is inclusive;
- is informed;
- is fit for purpose;
- is transparent;
- is influential – it makes a difference;
- is reciprocal – includes feedback; and
- is proportionate to the issue.

According to *World class commissioning*,



"Decisions are made with a strong mandate from the local population and other partners."

It is good practice to be able to show how users have been involved and how your organisation has listened and responded to what has been said. Involvement activity should be driven by a genuine desire to know what matters to users.

WHY EFFECTIVE INVOLVEMENT IS SO IMPORTANT

NHS organisations should develop long-standing and inclusive relationships with users so that they have a clear and up-to-date understanding of the views, needs and preferences of the people for whom they commission and provide services.

These relationships can be built up over time, and to do this organisations may need to find effective ways of having conversations with their communities that can be developed in a systematic way and, as needed, around specific service issues and initiatives. Where this way of working becomes part of the everyday culture or practice of an organisation, there should be benefits for staff and users.

It will give users a better understanding of the issues faced by the NHS and of why their health services may need to change. They should have more:

- information about the health of their community and local health services;
- commitment to, and ownership of, the local NHS;
- trust and confidence in local health services;
- ownership of solutions;
- awareness of the complexities and constraints of healthcare planning;
- influence over how and where health services are provided; and
- health services that meet their needs and preferences.

Where involvement is undertaken as an integral part of the normal, everyday business of an NHS organisation, staff should be able to do their jobs better, and the organisation should:

- have a better understanding of the needs and priorities of the local community;
- make better decisions;
- design services that reflect the needs of users;
- provide services that are efficient, effective and more accessible; and
- experience less conflict and adverse media attention as there is an increase in user satisfaction.



Example

Staff in NHS South West who routinely involve users say, "Involvement is absolutely crucial to developing services. If we are starting from scratch we must have people who have had the experience and involve them from the earliest stage."

▶▶ PART 1 SECTION 1

THE OBLIGATION UNDER
SECTION 242(1B) OF THE
NHS ACT 2006

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THE LEGISLATION – SECTION 242 OF THE NHS ACT 2006 EXPLAINED

The National Health Service Act 2006 consolidated much of the current legislation concerning the health service. Section 11 of the Health and Social Care Act 2001, the duty to involve and consult, became section 242 of the NHS Act 2006. Section 242 was amended by the Local Government and Public Involvement in Health Act 2007. The duty on English bodies to involve users can be found in section 242(1B) of the NHS Act 2006.

Section 242(1B) of the NHS Act 2006 comes into force on 3 November 2008.

Appendix 4 – Section 242(1B) of the NHS Act 2006



Point to note

In the following section, the blue text is taken directly from the Act. The explanations are in black.

SECTION 242(1B) OF THE NHS ACT 2006 – PUBLIC INVOLVEMENT AND CONSULTATION

Section 242(1B) applies to “relevant English bodies”.

Relevant English bodies are:

- strategic health authorities (SHAs);
- primary care trusts (PCTs);
- NHS trusts (which are not relevant Welsh bodies); and
- NHS foundation trusts.



Point to note

A relevant Welsh body is an NHS trust that has all or most of its hospitals, establishments and facilities in Wales.

The duty under section 242(1B) – what NHS organisations must do

Section 242(1B) of the Act states, “Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in –

- a) the planning of the provision of those services,
- b) the development and consideration of proposals for changes in the way those services are provided, and
- c) decisions to be made by that body affecting the operation of those services.”

Section 242(3) states that an organisation is responsible for health services if:

- “a) the body provides or will provide those services to individuals, or
- b) if another person provides, or will provide, those services to individuals –
 - i) at that body’s direction,
 - ii) on its behalf, or
 - iii) in accordance with an agreement or arrangements made by that body with that other person.”

NHS organisations that have a responsibility for commissioning or providing health services must make arrangements to involve users.

Who should be involved?

Section 242(1B) requires that “users . . ., whether directly or through representatives, are involved”. Section 242(1F) provides that a person is a ‘user’ of any health services if they are someone who is using the services or someone who may use them.

Users can be involved “directly or through representatives”. The term ‘representatives’ is frequently misused and misunderstood. Representatives are people who are in a position to speak on behalf of other service users. A person is a representative when they are representing the views and opinions of another person or a group of people, such as a patient participation group or an organisation like Age Concern or Mind. People are representatives when the views they share are the opinions of the people they are representing, which may not be the same as their own.

See part 1 section 3 page 60

What is involvement?

Section 242(1B) of the Act requires that users “are involved (whether by being consulted or provided with information, or in other ways)”.

A number of activities can constitute involvement. Think about proportionality and appropriateness, understand and use a spectrum of involvement, and know when to use the different activities which range from giving information through to active participation in planning the provision of services. It is important to understand what the most appropriate approaches could be at the various stages of the commissioning cycle.

See part 1 section 3 page 68 and section 4 page 104

When should users be involved?

Section 242(1B) of the Act states that users should be involved in the following matters:

- “ a) the planning of the provision of those services,
- b) the development and consideration of proposals for changes in the way services are provided, and
- c) decisions to be made by that body affecting the operation of those services” .

Part 1 Section 1: Section 242(1B) of the NHS Act 2006 – public involvement and consultation

Under a), users must always be involved when the provision of health services is being planned. For example, this may follow a needs assessment or a strategic or service review. Planning the provision of services can take place at:

- strategic level, for example the reconfiguration of mental health services across an SHA or PCT area;
- service level, when plans are being developed for the configuration of a service or services, for example maternity services; or
- NHS trust or NHS foundation trust level, for example when planning to provide a service from a different site.

Under b) and c), users must only be involved if the implementation of the proposal or the decision, if made, “would have an impact on –
a) the manner in which the services are delivered to users of those services, or
b) the range of health services available to those users”.

Users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered. For example, users must be involved in the development of a range of options for the way community services could be provided within a PCT area, not just asked for their opinion on a model that has been developed behind closed doors by health professionals and managers.

Users must be involved where a decision will change the way a service operates if the change affects the manner in which those services are delivered or the range of services offered; for example, the time a family planning clinic is open or when an NHS trust plans to provide a service from a different hospital/site.



Points to note

1. There is no requirement to involve users where proposals for change or a decision to be made by an NHS organisation, for example a change of provider, does not result in changes to the service that affect the way in which that service is delivered or the range of services available.
2. Provision of services can also include services provided jointly.

SECTION 242(1G)

Section 242(1G) states that: “A relevant English body must have regard to any guidance given by the Secretary of State as to the discharge of the body’s duty under subsection (1B).”



Point to note

‘Have regard to’ means that an NHS organisation must properly consider and take into account the guidance when undertaking the section 242(1B) duty. That does not mean that the NHS organisation must comply with the guidance in all cases, but it must have good reasons for any decision to depart from it.

Statutory guidance as to when or how often involvement under section 242(1B) is to be carried out and the form it should take can be found in this guidance.

▶▶ PART 1 SECTION 2

THE FRAMEWORK

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THE PRINCIPLES OF LOCAL ACCOUNTABILITY AND EFFECTIVE INVOLVEMENT

These principles are intended to support good governance, decision-making and user involvement. They are based on the principles for accountability in the NHS Confederation's report *Principles for Accountability* and the NHS Centre for Involvement's key principles of effective patient and public involvement.

NHS involvement practices should be:

- **clear, accessible and transparent**
 - People in all parts of the organisation need to be clear about what involvement means, have a shared understanding of its purpose and be clear about the difference between working for and working with patients and the public.
 - Be clear about the objectives of the work, its rationale, relevance and connection to organisational priorities.
 - Make it clear to people what you are doing and why and how their views will feed into the decision-making processes.
 - Find out and use what is already known about people's views and expectations.
 - If systems are complex and difficult to explain, the public are likely to feel excluded from those 'in the know'. Transparency must be the core part of any local practice and it must be easy to find out what decisions have been taken and the reasoning behind them.
 - Make sure that patients and the public have the support they need to get involved.
- **open**
 - Be open about what can change and what is not negotiable, and the reasons why.
 - Share the information and knowledge you have, so people can understand the issues.

Part 1 Section 2: The principles of local accountability and effective involvement

- **inclusive**

- Identify the right people to involve and make special efforts to reach out to the people who are 'easy to overlook'.

See part 1 section 3 pages 60 and 63

- Avoid sectional interests and enable a wide range of views to be gathered and taken into account when decisions are made.

- **responsive**

- NHS decision-making practices should be responsive to the concerns of users and able to demonstrate openly how these have been considered and responded to in the decisions made.

- **sustainable**

- The aim should be to develop relationships over a period of time with continuity on both a personal and organisation level. This builds trust.

- **proactive**

- It is important to be proactive and comprehensive in your approach to involvement. Organisations should be upfront about difficulties that may need to be addressed. This enables interested parties to be involved in finding solutions.

- **focused on improvement**

- Involvement is a means of finding ways to improve services, not an isolated activity.
- Organisations need to be able to demonstrate what has or has not changed as a result of involvement activity.
- Establish and embed systematic approaches to involvement that are directly linked to corporate decision-making.
- Make sure that there is commitment and leadership from the board, the chair, the chief executive, directors and clinical leaders.
- Support staff and equip them with the necessary skills.

All NHS organisations should consider adopting these principles and approaches when planning and undertaking involvement activity.

BUILDING AN 'INVOLVING' ORGANISATION

Developing an organisation that embeds involvement in its core values, behaviours, systems and processes is a significant challenge for some NHS organisations.

Organisations are at different stages in their development and there are no quick fixes. In some organisations, getting this right may require sustained leadership and effort over a number of years. Organisations that are good at involving users and working with partners should be able to deliver improved health services and better value for money. This section explores how NHS organisations may tackle the challenges of building an 'involving' organisation.

A high-performing organisation

A high-performing organisation:

- does not see involvement as an isolated activity or a hoop to jump through. It sees its users as a valuable source of information, who are able to provide an insight into their needs and wants, and feedback on their experiences;
- targets people who are 'easy to overlook' and those at risk of health inequalities to give them an equal opportunity to get involved;

See part 1 section 3 page 63

- invests in developing the capability and capacity of its staff and makes sure that they have the skills and knowledge to undertake effective involvement activity;
- considers the benefits of taking a social marketing approach to involvement work;

Appendix 5 – Other things to consider

- undertakes a health impact assessment (whenever this is necessary) and makes sure that it involves the right people;

Appendix 5 – Other things to consider

- makes good use of the intelligence it receives from existing data as well as involvement activity;
- consistently provides an audit trail that sets out who was involved and how, in what decisions, and what action was taken as a result; and
- utilises a range of techniques to involve users.

See part 1 section 3 page 68



Point to note

NHS organisations are not expected to adopt this model in its entirety but may find it helpful to consider the following elements when creating their own model of an 'involving' organisation.

Governance

The NHS organisation thinks about building in user involvement to its governance structures so that there are mechanisms in place for user representatives to be part of the decision-making processes for the organisation's commissioning decisions.



Example

Hull Teaching Primary Care Trust (PCT) is designing a membership system similar to the membership model for foundation trusts. The intention is for there to be three basic constituencies, individual membership drawn from patients and the public, staff members and voluntary and community sector members.

There will be three tiers of membership: core members, 'NHS Hull Champions' and a shadow board of governors. The core members will play a largely reactive role and the 'champions' will work proactively with the PCT as partners supporting locality boards to identify health priorities. Members of the shadow board of governors will be elected from the 'champions'; they will establish a programme of work defined by them, in line with the PCT's corporate objectives.

Leadership

Executive teams, board members, senior managers and clinical leads are upfront with their support for involvement activity and consistently recognise the benefits of doing it well.

Improving the organisation's approach to involvement activity includes developing stronger networks in the local community. This is one of the chief executive's objectives.

The board steers and scrutinises planning and development work to make sure that there is evidence of appropriate involvement activity. There is a standing agenda item on involvement.

This interest is mirrored by the strategic health authority (SHA) which sees involvement work as an important developmental priority and keenly monitors and reviews the robustness and effectiveness of this work within the organisations in its area.

The organisation has an executive director who has lead responsibility for involvement work and this is a major part of their role. Each directorate has a senior manager who is formally accountable for involvement activity and a number of involvement 'champions'.

In a PCT, the professional executive committee (PEC) plays an important role. Its members are visible in public debates and its leaders create a culture of transparency and openness that encourages trust and respect. To do this, the PEC takes time to get involved with particular initiatives so it can get close to the 'shop floor' and keep in touch with what matters to users.

Capacity and capability

Involvement work is mainstreamed and integral to the organisation's core business, and is everyone's business. Personal objectives are set that include relevant involvement practice. Personal development plans reflect the needs of individual staff in relation to this objective and the organisation's competency framework for user involvement. The information is collated to inform the organisation's training programme.

Managers and staff throughout the organisation recognise and understand their responsibilities around user involvement and are confident at using and developing involvement skills. Advice and support is sought from the experienced operational lead, whose role is increasingly focused on developing and transferring skills to the workforce and contributing to organisational development rather than being the sole person who undertakes involvement activity for the organisation.

All staff understand what good involvement looks like and how a responsive organisation operates. Induction and regular training and development opportunities make sure that staff have a shared vision of:

- what matters to patients and carers – what a good patient experience feels like;
- how users' views contribute to decision-making at both an 'individual' and 'collective' level across the spectrum of activities;
- what section 242(1B) of the NHS Act 2006 is about; and
- how organisations learn and change in order to become genuinely responsive to the views and experiences of users.



Example

Birmingham East and North PCT provides practical 'how to' guides for staff on various aspects of patient and public involvement (PPI). It also has a set of PPI standards so that teams can assess their level and identify gaps and opportunities to do more. PPI is included in the lunchbox sessions to keep staff informed of current requirements and developments.

Use of existing information

NHS organisations have large amounts of valuable data within their knowledge management systems, which are accessible by all staff and users (via the website) which provide:

- a central point for recording, collating and updating routine data the organisation collects about patient experiences, for example waiting times and infection rates, and self-reported data;
- a record of current involvement activities and links to reports on feedback, organisational responses and relevant resources;
- Patient Advice and Liaison Services (PALS) and complaints data; and
- ways to systematically use the data to identify areas for service improvement.

Managers routinely access the data, commission further data-gathering exercises where there are gaps and seek advice from the involvement 'experts' and Local Involvement Networks (LINKs). Data is routinely fed into decision-making processes.

Finance

The organisation has a dedicated and realistic budget allocated for user involvement activity. The finance director, strategic lead and operational lead for involvement have early business planning discussions to make sure that the resource requirements are understood and that a model for resource allocation is agreed. Departments such as organisational development and public health are prepared to allocate additional funding for involvement activities where this is appropriate.

Planning and reporting processes

The organisation invests considerable effort in scoping and planning its involvement activity. It involves users in identifying and defining any problems and challenges, and in agreeing the priorities for action at an early stage. It gives people information, makes the best use of resources and health impact assessments, and considers using a social marketing approach.

It considers:

- why it is planning involvement activity;
- what it needs to find out;
- who it needs to involve;
- when and how best to reach the right people, especially those who are marginalised and most vulnerable to ill health;
- how it will use the information to help it make the best decision; and
- when and how it will feed back to people it has involved to explain what has happened as a result of their involvement.

The organisation thinks creatively about the people who may be 'easy to overlook' and, where appropriate, works with other local organisations and LINKs to find the most appropriate techniques for involving them.

See part 1 section 2 page 35 and section 3 page 63

When there are challenges and disagreements about priorities for changing health services, the conflict is discussed openly with the community.

Working with partners and users

Although not directly part of its obligation under section 242(1B), the organisation has a:

- strong relationship with the local authority and its local partners, including voluntary and community groups and users, and conducts its business in an inclusive, open and transparent way. It sees itself at the heart of the community and takes an active role in strengthening it. The chief executive and executive team establish and nurture these relationships;
- presence and high profile in the community and is openly accountable for its performance, actions and behaviours. It reaches out to people in non-health settings such as shopping and leisure centres and users feel comfortable and confident about offering their views on local health services and talking about their experiences. It develops robust and continuing relationships with community groups representing marginalised and vulnerable people and the senior leaders of local health organisations are recognised in the community;

Part 1 Section 2: Building an 'involving' organisation

- recruitment and support/training programme for users who put themselves forward to be representatives on groups and committees. The recruitment process helps to select the right people, and the support and training helps these people to be clear about their role and to contribute effectively. People who become involved are given ongoing support throughout the duration of their involvement with the organisation; and

Appendix 6 – An example of a role and person specification for a user representative

- reimbursement policy and makes sure that, where it is appropriate and in accordance with the reimbursement policy, people are properly valued for their contributions, in a way that does not affect any benefits they may receive.

See part 1 section 3 page 60 and checklist 1 page 86

See references, resources and further reading

INVOLVING PEOPLE WHO WORK IN THE NHS

The NHS is the biggest employer in Europe, employing around 1.3 million staff. This large group of people are also citizens, local residents and users of local health services, and often they will be family or friends of patients.

Although not directly part of the duty imposed by section 242(1B), it is good practice for commissioners and providers to involve staff and others working in the NHS such as GPs, hospital consultants and nursing staff, many of whom will be key partners from early on in an involvement process. It is also possible that staff may be users, in which case NHS organisations have a duty to involve them under section 242(1B).

People working in the NHS have considerable knowledge and understanding of their service and clinical good practice and they may have ideas on how a service can be improved. You may find it helpful to let staff know about any changes that are being planned, developed or consulted upon, to make sure that they are informed about the proposals and that they are given opportunities to get involved from the beginning of the process.

There should be clinical support and leadership for all major changes to health services. You could achieve this by:

- identifying who would be the best clinician to maximise clinical (especially medical) leadership in the development of proposals;
- making sure that the clinical benefits and the infrastructure that is needed to deliver the changes are understood;
- finding clinicians who:
 - are leaders in the service;
 - have respect from their peers;
 - are prepared to get involved in the engagement process;
- providing media training for staff who have lead roles in the involvement process;
- making sure that appropriate clinical staff are involved throughout the process; and
- developing ‘user champions’ who are prepared to work alongside clinicians to give the users’ perspective and talk about their experiences.

Part 1 Section 2: Involving people who work in the NHS

On occasion some staff, including clinicians, see themselves as representing users' views. Without involving users, they believe that they know what they need and want. It is important that clinicians, GPs and other staff understand:

- what it means to represent users' views as they cannot assume that their own views are the same as patients' views – to do this, it is important that they hear patients' own experiences and about their ideas and concerns;
- why their views (as staff and users) are being sought; and
- that they may be able to represent users' views, as long as they are speaking with their agreement, or as users themselves.

It is important for staff to recognise and understand the different ways in which they might be involved. Under section 242(1B), they might be involved as:

- users of services; and
- representatives of users of services.

They might also be involved as practising clinicians in their professional capacity although there is no obligation on NHS organisations under section 242(1B) to involve them in that capacity.

See part 1 section 3 page 60

A member of staff may be engaged in the involvement process because they are able to:

- explain the rationale for a particular change and make recommendations;
- balance professional interests with those of users;
- make the best use of resources;
- update colleagues on advances in a medical field; or
- use patients' experiences to help reflect on their practice.

As a user, they might be involved because they:

- have personal experience of living with an illness or using a particular service;
- are a friend, relative or carer of someone who lives with a condition;
- know other people and families in similar situations;
- have knowledge of research and practice relating to their condition;
- know many people in the community and are widely trusted;
- have experience as an activist; or
- are a formal representative of a consumer group or organisation.

The responsibilities that go with the role of the user representative might include:

- feeding back the experience of other people as well as their own;
- checking back with people in their network or who they are representing;
- informing their networks; or
- sharing the views and preferences of users.

WORKING WITH LOCAL INVOLVEMENT NETWORKS (LINKs)

What is a LINK?

A LINK brings together local people, organisations and groups that want to improve health and social care services in their area. Many different people and organisations can be part of a LINK and this means different groups and types of people that make up the local population may be able to join. LINKs members could include:

- carer networks
- patient transport groups
- older people's forums
- local business groups
- support groups for specific service users
- faith groups
- patient groups
- minority ethnic groups
- tenants' groups
- NHS foundation trust governors
- neighbourhood renewal networks
- youth councils
- self-advocacy groups
- individuals.

What do they do?

LINKs look at all health and social care services in their area. It does not matter who provides the services – the NHS, a local authority, a private company, a social enterprise or a charity. LINKs:

- promote and support involvement of people in commissioning, providing and scrutiny of care services;
- monitor the way health and social care services are commissioned and provided, and gather the views and experiences of people using them within the local area;
- reach out to local communities and provide opportunities for them to have their say in the way local services are planned and commissioned; and
- convey the views and experiences of people to the organisations responsible for commissioning, providing, managing and scrutinising the services, and make recommendations on how they can be improved.

Part 1 Section 2: Working with Local Involvement Networks (LINKs)

This feedback should enable commissioners, including practice-based commissioners, specialist commissioners, commissioners in local authorities and joint commissioning groups, to have a better understanding of the services people wish to receive and to negotiate contracts for services that meet the needs and expectations of local people.

LINKs are a source of information that is valuable to organisations in helping them commission and provide services that are responsive and accountable to local people.



Point to note

Commissioners are expected to create a range of opportunities to involve users throughout the commissioning cycle. Working with the LINK is one way of obtaining their views but should not be seen as the only way to involve users.

See part 1 section 3 page 68

See www.nhscentreforinvolvement.nhs.uk for more information about LINKs.

WORKING WITH PARTNERS

Although not a requirement under section 242(1B), working in partnership with statutory, third sector and independent providers may help NHS organisations to achieve better outcomes from their involvement activity. Within the NHS, providers and commissioners should consider working closely together to make sure that there is a planned, co-ordinated approach to involvement activity. This would enable resources and skills to be properly utilised and the outputs routinely and openly shared.

Beyond the NHS, strengthened partnerships with local authorities may be increasingly used to support and encourage the joint planning and undertaking of involvement activity. Local authorities have a complementary best value duty of involvement and, where possible, NHS organisations and local authorities should share information about the needs and preferences of their local population as part of integrated needs assessments and commissioning.

Planning processes should include an early assessment of each organisation's readiness and capability to achieve the desired outcome. Reaching out to people who are 'easy to overlook' increasingly requires the development of partnerships with third sector and voluntary organisations such as faith groups and community workers.

See part 1 section 3 page 63

On some occasions, involvement work may require specialist skills and expertise that are not available in either the local NHS or the local authority. At these times, you might consider securing the services of a specialist independent provider of market research which uses a range of technology and techniques for surveying public opinion.

To secure the greatest potential benefits NHS organisations, along with their partners in other agencies both in the public and voluntary sector, should be working together to:

- maximise the potential gains of undertaking involvement in a more coherent, co-ordinated and integrated way; and
- minimise the prospect of ignorance, misunderstanding and confusion on all sides which may waste resources and result in missed opportunities.

A partnership approach

Working with partners requires good communication and the sharing of appropriate and non-confidential information about the needs and wants of people, in a climate of openness and trust, subject to the organisations involved complying with any rules about data protection and confidential information which might restrict what they share. Joint appointments of staff with recognised expertise in user involvement may also provide a useful way to promote a partnership approach.



Example

Neighbourhood development officers working at ward level in Birmingham East and North PCT identify who the key people are in the local communities and how to reach them. Engaging certain faith groups after Friday prayers has proved to be a good vehicle for sharing information. Health plans and priorities informed by local communities have been incorporated into constituency plans.

The benefits of joint working

Health bodies, local government organisations, other public bodies and organisations – including the police and organisations working in the criminal justice field – and the voluntary sector should be aware of what each other are doing in the area of user involvement and how their individual activities connect and interrelate.

Users are not usually aware of the boundaries and distinctions between the different providers. They are more interested in the delivery of seamless quality care.

You may find it helpful to establish a joint approach to involving users in planning, commissioning and delivering patient-centred services. User involvement can be the glue that binds organisations and agencies together. Having a common task can promote:

- a mutual understanding between agencies;
- legitimacy for the work;
- dialogue between different agencies; and
- shared agendas, goals and objectives, and information and resources.

Working in partnership may help organisations to:

- get a better picture of what is happening in an area;
- identify and work to fill the gaps; and
- make more imaginative use of resources.



Example

In Derby the drug strategy sits within the Community Safety Partnership. The drug strategy team employed by Derby City PCT delivers the strategy and is responsible for all the drug service provision in the city.

A users' forum has proved to be very proactive in engaging with the drug strategy team, commissioners and providers on service delivery. The group, known as Derby First Forum, is fully independent and autonomous of any treatment provider, strategic body or sponsor, and is funded through a small change grant. The forum:

- assisted in a consultation exercise on a new drug treatment model;
- was actively involved in the assessment of tender bids;
- engaged in the consultation on the Government's new drug strategy;
- is developing a peer-led harm reduction and overdose prevention DVD;
- developed and delivered a training programme;
- feeds into the harm reduction strategy for the city; and
- is actively involved at a number of levels in designing and developing drug treatment and harm-related literature for users and professionals.

Public sector organisations, including health bodies, are increasingly required to work in partnership to tackle the challenges facing their communities.

Appendix 7 – Joint planning processes that present opportunities for joint involvement activity

▶▶ PART 1 SECTION 3

HOW TO CARRY OUT
INVOLVEMENT

Real involvement
Working with people
to improve health services
October 2008

UNRAVELLING SOME MISCONCEPTIONS ABOUT 'INVOLVEMENT'

1. What is pre-consultation?

The term 'pre-consultation' is a term sometimes used by people in the NHS to describe involvement activity that happens early on in an involvement process. It suggests that another form of involvement activity precedes a consultation and that these activities do not have the same importance as a consultation. This is a misconception that often causes confusion as to the level of involvement required. Section 242(1B) requires NHS organisations to make arrangements to involve users, whether by being consulted, provided with information or in other ways. The duty therefore covers the whole range of involvement activity, including both 'pre-consultation' involvement and consultation itself.

The level of involvement:

- needs to be relevant to the issue;
- is best viewed as a continuum ranging from giving information through to participation; and
- needs to match the circumstances and context in which it is to take place.

For example:

- giving information
- getting information
- debating
- participating.

See part 1 section 3 page 68

In this section, the chapter on techniques includes a continuum of involvement and a range of different techniques that you can consider using depending on what you want to achieve. Good practice is to:

- consider where it would be applicable to use a range of approaches;
- be clear about why you have selected a particular method or methods;
- know how different approaches will fit together and how and when you will provide feedback to users on what has happened as a result of their involvement; and
- focus on outcomes and how they have been influenced through involvement activity.

See part 1 section 3 page 68

2. What is a ‘formal consultation’?

‘Formal consultation’ is a term used by many people in the NHS to describe the statutory requirement imposed on NHS bodies by the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. These regulations require NHS organisations to consult with overview and scrutiny committees (OSCs) when they are considering a proposal for a substantial development of the health service in the area of the local authority, or for a substantial variation in the provision of a service.

What is little understood is that the duty to involve users, set out in section 242(1B) of the NHS Act 2006, is also ‘formal’ as it is a legal requirement. There is a common misconception that if the OSC is not consulted, because a proposal is not a substantial variation or development to a health service, users do not have to be involved. This is not the case. NHS organisations must involve users where section 242(1B) requires arrangements to be made for involvement activity, irrespective of whether the OSC is consulted or not.

HOW TO APPROACH INVOLVEMENT PRACTICE

Commissioners and providers will become 'world class' when they have the capability and capacity to buy and deliver the health services people want. To achieve this goal they will have to have a thorough understanding of patients' experiences and the needs and preferences of users.

The major challenges for NHS organisations are to:

1. Identify and involve the users who are 'easy to overlook'. Until this is done well the most marginalised, isolated and deprived people in the community may be excluded from involvement processes.



Recommendation

NHS organisations should consider working with local partners, Local Involvement Networks (LINks) and other organisations in the community such as national or voluntary organisations, local charities and community and faith groups, to identify appropriate ways of involving people who are 'easy to overlook'. In this way, inclusive processes can be developed and NHS organisations should gain a better understanding of the needs and preferences of the whole population.

See part 1 section 3 page 63

2. Understand users' lack of knowledge of the planning and commissioning processes in the NHS.



Recommendation

NHS organisations may achieve this by:

- having a better understanding of how to identify who they need to involve; and
- developing role and person specifications to recruit the right people into specific roles, for example to attend meetings, and provide training and support programmes where needed.

See part 1 section 3 page 60 and appendix 6 for an example of a role and person specification for user representatives

3. Refrain from using jargon and complex language that is difficult for people to understand.



Recommendation

NHS organisations may find it helpful to review the language they use to communicate with people and make sure that they use high standards of plain English in all written and oral communication.

4. Make use of existing non-confidential data on patients' experiences.



Recommendation

NHS organisations may achieve this by establishing early warning systems to collate and review existing data on patients' experiences.

Commissioners and planners will find it helpful to be aware of, understand and make use of this data and use it to inform the development of commissioning plans and decision-making processes in a systematic way. The data could include the regular national surveys conducted by the Healthcare Commission, local data gathered by LINKs, and data from Patient Advice and Liaison Services (PALS), complaints and from previous, relevant involvement activity.

5. Make sure that there is strategic level prioritisation of patient and public involvement.



Recommendation

NHS organisations should give careful consideration as to the best place for user involvement within their structures. Wherever it sits, user involvement will need to be integral to all other directorates or departments, including commissioning.

6. Act on the results of involvement work in the course of making planning and commissioning decisions and monitor this process.



Recommendation

NHS organisations should consider establishing robust and sustainable systems to provide ongoing evidence of how the outputs from meaningful involvement activity have been used to inform planning and commissioning decisions. The outputs may also have a bearing on the development of Local Delivery Plans and inform Local Area Assessments.

See part 1 section 2 page 37

HOW TO PLAN INVOLVEMENT ACTIVITY

Questions to ask before you start

User involvement activity requires careful planning and NHS organisations should be clear about what they want to achieve. The following is a set of questions you might wish to consider at the planning stage. If the answer to any of the questions is not clear, then it may be appropriate to hold off the involvement activity until there is clarity. By making sure that the work is focused and integral to the mainstream work of the organisation, there is a greater chance of it achieving its purpose.

1. How does this work fit with the organisation's overall strategy?
2. What does the NHS organisation need to know and what do users need to know? For example, there will be occasions when an NHS organisation may be providing information rather than seeking it.
3. What is the cost and what are the benefits?
4. How much controversy will it generate (in the light of similar changes, or general issues of trust and confidence in the NHS)?
5. What work has already been done with users, and what was the outcome?

When you have the answers to all the questions, you may be in a better position to plan involvement activity.

The processes outlined below may help in arranging involvement activity.

Think about...

1. What do you need to find out from users and what should you tell them?

At the beginning of any planning process, commissioners need to be clear what they need to find out from users and exactly how and when they intend to use the results. This is important when planning the work and is vital if you are to have local accountability. Users should be made aware of:

- the range of ways they can be involved;
- why they are being involved;
- in what capacity they are being involved;
- how they will be given information;

- any constraints;
- what is negotiable – what can be changed as a result of their input;
- when and how they can expect to get feedback on how their views were used and what influence they have had; and
- the decisions made and the rationale for them.

2. Why do you want this information?

What is the purpose of doing the involvement work? Are you involving users for the right reasons and at the right time? Is the focus to inform commissioning plans and decisions, is a service being reviewed or do you need to tell users about a change that is being implemented? Is this an information-giving exercise or is the intention to enable users to have a greater say in which services are commissioned or how services are delivered?

See part 1 section 3 page 53

3. Who should be involved and what methods would be best to use?

To have an informed approach to who should be involved, consideration must be given to who is or could be affected by any proposed changes, and how. Think about other departments within the organisation and other organisations and individuals in the community. You may need to carry out a health impact assessment and undertake a stakeholder analysis to make sure that you focus your effort and resources in the most appropriate places. This will avoid failing to involve people or organisations that may have an interest.

If you are considering doing a health impact assessment it should be carried out at the planning stage of the process and the information used to inform the stakeholder analysis.

Appendix 5 – Understanding health needs assessments, health impact assessments, health equity audits and race equality impact assessments

It may also be helpful to consider working with some of the tools used in social marketing to group users and to help the process of designing involvement approaches tailored to their needs.

Appendix 5 – Taking a social marketing approach

The extent of both the health impact assessment and the stakeholder analysis will be determined by the scale and complexity of the proposed change; for very small schemes where the impact is minimal there could be just a handful of users, and for a large scale reconfiguration there could be hundreds. Consideration of all views is important.



Points to note

1. You must involve users, whether directly or through representatives.
2. A person is a 'user' of any health service if they are someone who is using the services or someone who may use them.
3. 'Users' includes people who are 'easy to overlook' and those who do not access services despite having a need.
4. Although not required under section 242(1B), people working in the NHS should also be involved.

See part 1 section 3 pages 60 and 63

When doing a stakeholder analysis remember to consider:

- relevant pressure groups;
- gender, disability, ethnicity specific groups;
- community groups and community activists;
- carers, friends and families of patients;
- people who have identified issues, for example complainants, PALS clients; and
- other staff.



Suggestion

Early in the planning process undertake a stakeholder analysis and remember that you may need to undertake a health impact assessment that is proportional to the scale of the work.

What methods or techniques you decide to use will depend on the level of involvement required, who you are planning to involve and if you need to give information and/or gather information. It is important that you understand why you are choosing to use a particular method and that you are clear why, in different circumstances, one method may be more appropriate than another. For example there may be times when it is appropriate to only give information to users.

See part 1 section 3 page 68

4. What are the givens and what is it possible to influence?

Be clear about what is feasible. If there are constraints say so at the beginning. Be careful not to raise people's expectations if you are unable to deliver in a short time. Be open and realistic about when decisions will be made and how long it will take to implement the changes. Remember that you may need to involve users or consult again if plans change, and that you may also need to involve users in the implementation phase.

5. What is the organisation going to do with any information or feedback it obtains?

Before you plan involvement activity, think carefully about how the information you obtain will be used. There is no point in spending time and effort involving users if there is nowhere for the findings to go. If changes are made that have not been informed by the views of users it could rightly be seen as a 'done deal'.

- What are the implications and the reasons for not meeting the preferred option?
- What flexibility does the organisation have to respond to different ideas put forward?
- What flexibility is there in the Local Delivery Plan for doing things differently?

See part 1 section 2 page 37

- Have decisions already been made which have implications for the ability of the outcome of this work to influence change?

6. Will you need to work with other organisations?

It may be beneficial to work with other organisations. These may include other public sector and third sector providers, and private and independent organisations. This is because:

- users do not always recognise organisational boundaries;
- involvement work can be costly, and resources may be shared and knowledge and experience pooled if more than one organisation is involved;
- working with other organisations facilitates learning and best practice;
- working across a local health economy develops a consistent approach;
- some groups in the community may have 'involvement fatigue' because other organisations are 'fishing in the same pool' on a range of issues. There may be opportunities to involve some groups through Local Strategic Partnerships. Consider working with the OSC and LINKs.

See part 1 section 2 page 35

7. Will users who get involved need to be supported/reimbursed?

- What support people who get involved need depends upon what they are involved in:
 - do people need help to get to the venue?
 - do people need information in different formats, languages or media?
- Are the questions asked or the discussions you will engage people in likely to evoke strong emotions? For example, asking people to recount their experiences of using chemotherapy services may be upsetting to some people.
- What support will people need if this happens?
- How might this be provided both during and at the end of the discussion?
- How will patients' anonymity be protected?
- What other type of support may people need?
- Every organisation should have a reimbursement policy. In developing that policy you might consider:



Suggested reading

Reward and Recognition

The principles and practice of service user payment and reimbursement in health and social care.

A guide for service providers, service users and carers, Department of Health, 2006 (second edition)

Once all this has been thought through, it is important to give people all the information they need to help them decide whether or not they want to get involved in giving their views.

8. How will you provide feedback to people who have been involved? Do you need to provide feedback to every individual who was involved or could this be done through a notice or some kind of circular?

There are good reasons why it is important to provide feedback to those who have been involved:

- Feedback promotes openness and accountability and develops confidence and trust, which is the basis for a sustainable relationship of any sort.
- Effective involvement will often require an iterative process.

9. How will the feedback be used to inform the decision-making process?

Think how the feedback obtained from involvement activity will be used to inform the development of proposals and influence decisions. It is important to:

- build a true picture of patients' experience and what users think;
- involve users in the development of the options that will be consulted on;
- develop an ongoing dialogue or relationship with the community; and
- build trust and confidence.

See part 1 section 3 page 82



Points to note

1. Consultation is one way of involving users when you may seek their views and opinions on proposals they have helped to develop.
2. Irrespective of whether the OSC is consulted, NHS organisations are required to make arrangements as set out in section 242(1B) of the NHS Act 2006 to secure the involvement of users (whether by being consulted, or provided with information, or in other ways) in:
 - a) planning the provision of services;
 - b) the development and consideration of proposals for changes in the way services are provided, if the implementation of the proposal would have an impact on the manner in which the services are delivered or the range of services available to users; and
 - c) decisions to be made affecting the operation of services, if the implementation of the decision would have an impact on the manner in which the services are delivered or the range of services available to users.

If new services are planned and procured centrally by the Department of Health, for example intermediate treatment centres, and an NHS organisation is not responsible for those health services, it will not have to involve users or consult the OSC. However, where services are planned centrally and procured locally, the NHS organisation responsible for procuring the service must involve users and consult the OSC where necessary. In addition, it should be noted that an NHS body may have a duty to involve in relation to proposals or decisions which it has not itself generated: the issue is whether the proposal affects the services for which the NHS body is responsible. So a local NHS body may need to involve users if a national decision to procure a treatment centre has an impact on other services for which the body is responsible (see the judgment in *R (on the application of Fudge) v. South West Strategic Health Authority and others* (2007)).

Co-ordinating involvement activity

Although not a specific obligation under section 242(1B), there are important reasons why it may be beneficial to consider co-ordinating involvement activity, particularly on major changes across local health economies. These are to:

- set and achieve consistently high standards of consultation;
- share best practice and expertise on approaches to consultation so that NHS organisations can learn from each other;
- share common data between services and organisations. The discussions one organisation is having with users may spread to other service areas and it is important that the information is shared;
- share the cost of a consultation;
- make sure that the views of all relevant groups and communities have been taken into account in drawing up and consulting on plans for change;

Part 1 Section 3: How to plan involvement activity

- make sure that the consultation is as effective as possible and that particular groups and individuals do not get 'consultation fatigue'; and
- make sure that there is a co-ordinated approach on issues that cut across more than one organisation.

Again, although not a specific obligation under section 242(1B), it may be helpful to work closely with different agencies, for instance joint working with the local authority, for many of the same reasons.

See part 1 section 2 page 37

Monitoring and evaluating involvement processes

Monitoring is used to assess progress against a plan. Its purpose is to support project management and accountability.

Evaluation is an assessment of the impact of an involvement process. It is usually undertaken upon the completion of a piece of work or at a point built into the process at the start. The purpose is to determine what has worked and what hasn't, and to develop an iterative process that builds on experience.

You need to be clear about what you are evaluating. The involvement strategy and the processes undertaken should be included in an evaluation. The focus should be on whether the aims and objectives defined for the work before and during the planning stages of the process have been achieved.

Monitoring and evaluation arrangements should be part of the initial plan for a consultation, and not added later once the work is under way.

HOW TO WORK OUT THE RIGHT INVOLVEMENT OR CONSULTATION PROCESSES

An involvement process may include a consultation and in many cases you will need to undertake a health impact assessment and stakeholder analysis so you are clear about who you need to involve.

Appendix 5 – Understanding health needs assessments, health impact assessments, health equity audits and race equality impact assessments

When must an overview and scrutiny committee (OSC) be consulted and when does the duty to involve users under section 242(1B) apply?

The duty under section 242(1B) and the duty to consult the OSC under regulations made under section 244 are two separate legal requirements and involve different processes that may possibly overlap. The word ‘formal’ is sometimes used to try to distinguish the requirement to consult the OSC and this has led to some confusion.

See part 1 section 3 page 41

Section 242(1B) is about involving users. Section 244 is about the functions of OSCs. The regulations made under section 244 set out when the OSC should be consulted. There is no other piece of legislation placing a general obligation on the NHS to consult users or the public.

Where a proposal constitutes a substantial development of the health services in the area of the local authority, or a substantial variation in the provision of services, the OSC will need to be consulted. If the NHS organisation does not consult the OSC when it should have done, lack of consultation is a ground for referral to the Secretary of State for Health. If the OSC does not need to be consulted, NHS organisations may still have a duty to involve users under section 242(1B).

Section 242(1B) always applies when NHS organisations are planning the provision of health services. Where an NHS organisation is developing and considering proposals for change or making decisions affecting the operation of services, section 242(1B) only applies if implementation would have an impact on the way in which services are provided or the range of services provided is affected. If a change does not concern planning the provision of health services or will not impact either on the way a service is delivered or the range of services provided, the duty does not apply. The two scenarios below illustrate when there is no requirement to involve users, whether by consulting them, providing information or in any other ways.



Q: A call centre for a national service is based in the region. It is being closed. Do we have to consult all of the region or just the area it is based in or the entire country? It will not affect the delivery of the service but will affect premises, jobs and staff.

A: Is the closure of the call centre part of an NHS organisation's plans for the provision of services? Is the NHS body responsible for commissioning or providing those services to its local population, or will the closure have an impact on other services for which the body is responsible?

If it is simply a change of contractual arrangements or of personnel then it may not be part of the NHS organisation's plans for providing services. If not part of planning the services, this does not trigger the duty to involve users under section 242(1B).

If the closure of the call centre would not have an impact on the manner of service delivery or the range of services available, the NHS organisation responsible for the call centre would not need to consult with users under section 242(1B) (a).

Involvement under section 242(1B) is not about involving users on a regional or national basis, it is about involving people who use or may use those services, so who should be involved would depend on who is or might be affected. If the body is not responsible for the services, but the closure may affect other services for which it is responsible, then the duty may apply.

Even if the NHS organisation is not required to involve users under section 242(1B), there are other rules and procedures relating to the impact of proposed changes on jobs and staff.



Q: An out-of-hours co-operative has notified the primary care trust (PCT) that it will not continue to provide services. The PCT is preparing to go out to tender for a new out-of-hours provider. Should a consultation take place?

A: Is the change in provider part of the PCT's plans for the provision of services?

If the change of provider is not a result of the PCT's planning arrangements then the duty under section 242(1B) (a) would not be triggered.

If the change in provider does not have an impact on the manner in which the services are delivered or the range of services available to users, the duty to involve under section 242(1B) will not arise.

If the change in provider results in, for example, a change in the current configuration of services, there would need to be appropriate involvement activity.

The PCT should be aware that if the proposal constitutes a substantial development of the health services or a substantial variation in the provision of services the OSC will need to be consulted.

The following scenarios are examples of areas where there has been a lack of clarity about the right involvement process.

Each scenario has an outline process that provides a steer to help work through who needs to do what, when and how. There is no 'one size fits all' model and you need to be clear from the start why you are involving users. Once you are sure about the purpose and who you need to involve, it should be easier to understand what you need to do.



Q: An NHS trust based on multiple hospital sites in a city wants to co-locate a specific service onto a single site to improve patient safety, outcomes and experience. The service will be delivered from the same number of beds, by the same staff, but it will be provided in a more appropriate environment with faster access to diagnostics and complementary specialisms. Who does the trust need to consult?

A: The NHS trust's plans to co-locate will trigger the duty under section 242(1B) because it is part of the trust's plans to provide services. Trusts should always involve users in the development and consideration of proposals and on decisions affecting the operation of services, where the proposal or decision will affect the way in which those services will be provided, for example, where a service will be provided from a different environment or site.

The NHS trust is responsible for arranging the involvement activity. In addition, if the PCT is also responsible for those health services, it too will be under an obligation to involve users. To avoid duplication, the NHS trust and PCT might agree how involvement will be handled, but each organisation should be aware of its duty to involve users.

NHS organisations should also be aware that, if the proposal constitutes a substantial development of the health services or a substantial variation to the provision of services, the OSC will need to be consulted.



Q: A PCT is planning a consultation on its urgent care strategy in the next few months. It has been told that local elections will be held at the end of April and is unsure as to whether a consultation at that time would create a problem. What should it do?

A: The obligation to involve users under section 242(1B) will arise even if there is a local election. Where that obligation arises during the period of a local election the PCT might have to give more careful consideration to how it will carry out the involvement activity to satisfy the duty. For example, during a local election it may be necessary to have a longer period of involvement.

If the proposal constitutes a substantial development of the health services or a substantial variation to the provision of services, the OSC will need to be consulted. The PCT should be aware of the timings for local elections and plan consultations with the OSC accordingly.

It may be helpful to look at www.cabinet-office.gov.uk



Q: Last week the PCT proposed to the strategic health authority a set of measures including the closure of a ward for elderly people at X hospital. The closure is in line with its older people's strategy that was consulted upon, but there is now a question about whether it needs to consult on this. If it does need to consult there will be an impact on the immediacy of any financial savings that may be possible. The PCT agrees it is a reduction in capacity rather than a substantial variation in services, but others may not share that view. What does the PCT need to do?

A: The PCT must comply with its duty under section 242(1B) to involve users in planning the provision of services and in developing and considering proposals to change services, if the implementation of the proposal will impact on the manner in which the services are delivered or the range of health services available.

If the consultation on the older people's strategy specified that the impact of reducing capacity would mean that the elderly ward at X hospital would close, and users were involved in the development of that proposal, the PCT will have satisfied the section 242(1B) duty and would only need to involve them again if the proposal or decision changes.

The PCT will need to take a view as to whether the proposal constitutes a substantial development of the health services or a substantial variation to the provision of services. If it does, the OSC will need to be consulted. If the PCT does not consult the OSC and the OSC is of the view that it should have been consulted, the matter can be referred to the Secretary of State for Health.



Q: A PCT has consulted on a mental health strategy that will improve services, placing them closer to home. This has been approved, although it was contentious as the plans will see a reduction in the financial value of the provider's contract. The PCT is now moving to implement the individual schemes that make up the strategy; should it consult on the individual schemes?

A: Under section 242(1B), the PCT has a duty to make arrangements to involve users in developing and considering proposals to change services, if the implementation of the proposal will impact on the manner in which the services are delivered or the range of health services available.

If the consultation included proposals for and detail about the individual schemes, the PCT only needs to undertake more involvement if the implementation of the plan would involve further development or consideration of proposals or any further decisions would have an impact on the manner in which the services are delivered or the range of services available.

The PCT should be aware that, if the proposal constitutes a substantial development of the health services or a substantial variation to the provision of services, the OSC will need to be consulted.



Q: A city-based PCT wishes to put dermatology services out to tender. A local district general hospital has been providing these services for some time. A large specialist teaching hospital has expressed an interest in providing these services, as have a number of other local acute providers. What part of the commissioning process can local people be involved in and how can they influence the final decision?

A: Section 242(1B) requires users to be involved in planning the provision of services which may involve a change of provider if that is part of the PCT's plans. Users should be involved in all the stages of the commissioning cycle.

See part 1 section 4 page 95 and references, resources and further reading

It is also good practice but not a requirement under section 242(1B) to involve users throughout the procurement process.



Q: A GP surgery needs to be relocated. As property prices are high the PCT has claimed that issues of commercial sensitivity relating to the choice of location have meant that no involvement has taken place to decide where the surgery should be located. The PCT has concluded negotiations and agreed a deal. When should the PCT have involved local people to make sure that the process was meaningful?

A: Regardless of the sensitivity of the property issues, the PCT has a duty under section 242(1B) to make arrangements to involve users before taking decisions which affect the way in which services are delivered. The PCT should have involved users in the consideration of the proposals to relocate the GP surgery and in any decisions made affecting the provision of those services.

HOW TO FIND THE RIGHT PEOPLE TO INVOLVE

Section 242 of the NHS Act 2006 defines a 'user' as a person who is using services or who may use services. Within the broad definition of 'user', those involved might be members of the public, patients, carers, members of self-help and support groups, or members of user groups or a LINK. Any of these people may also act as representatives.

The following explanations are offered as a guide to help think through which types of users are likely to be called on in any given involvement context.

Members of the public

A member of the public may have been a patient or they may have gained their knowledge through the experiences of a member of their family or a close friend. They are likely to have views and opinions based on these experiences as well as what they read and hear about in the media. Most members of the public are likely to have views on what they think they may need if they are ill or need emergency treatment.

Members of the public may be consulted on strategic issues and major reconfigurations and may have views on smaller changes. Their views may be influenced by campaigners and the local media so it is important to provide a range of opportunities to talk with people in order to identify what the main issues and concerns really are.

Patients

Patients are all people who have a relationship with healthcare professionals who may provide care at different times in their life. They know about, and can describe and judge their own experiences of healthcare. They can also raise points of satisfaction or concern, but they cannot necessarily speak for other patients. Through their experiences, they might gain knowledge of a range of services and are often in a good position to give their ideas on how services could be improved.

Carers

Carers are people who often have a wide experience of healthcare both from their perspective as a carer and as a user. Through these experiences they gain knowledge, insight, views and opinions of the health services they encounter and may represent the views of the people they care for, which may be different to their own.

Members of self-help and support groups

Self-help and support groups are often disease specific, providing mutual support and advice to their members, new patients and their families. The support groups may be local branches of national organisations such as Age Concern or Mind. They will have collective knowledge and experience of a range of services and as such are often in a good position to reflect the range of views held by patients with a specific condition or disease.

User groups

User groups may focus on a particular hospital, service or condition. One of their purposes is to work with the NHS to provide feedback and improve services for patients. They could be a patient group attached to a GP surgery who meet to pool their knowledge and experiences to improve the services offered by the practice, a cancer network partnership group or a hospital user group.

User groups will usually have an understanding of the policy context surrounding their particular sphere of interest. They may be very active in developing policies and standards with the local NHS and take part in reviews of services such as peer review in cancer services.

Representatives

Representatives, who may fall within any of the preceding groups of people, often have a wide knowledge of the range of views held by service users and are able to represent these to NHS organisations during involvement processes. They are likely to have general and abstract knowledge and be in a position to articulate patient perspectives on issues such as the opening times of GP surgeries or access to community services where professional views may differ. Representatives could be councillors who represent communities or faith leaders as well as patient representatives or carers.

A limitation of some patient representatives is that unless they are users or carers they can apply theoretical principles to situations. They may lack both the recent personal experience of patients and the detailed specialised knowledge of self-help and support group or user group members, so they may not always be able to identify the problems at a local level.

When planning involvement activity it is important that you involve the right people; and once you have found and involved them, that they feel valued and are treated appropriately. The following extract is based on the reflections of one person's experience and shows how easy it is to alienate people who are prepared to work with you.



Example

Steering and joining – one person's reflection

When people are invited to join a group that has already met to do some preparatory work, or when people who have begun to work together are joined by others, there are issues of 'expectation'.

For example, a core group may meet:

- Are there terms of reference, or are they expected to make their own plan for the critical path of the task?
- Do members of the core group know who will be joining them or do they only know that more people will join them?
- Do members of the core group make task and process plans for the people who will be joining them? The 'task' being what has to be done, the 'process' being 'how do we work together?'.

This brings up not only issues of 'expectation' but also of 'feelings'. If the core group does too much of the task, what will be the expectation and feelings of the people who join them – the 'joiners'?

As a joiner, I wish to feel welcome and welcomed, to:

- have the task confirmed and the purpose for doing it explained – commitment comes through mutual agreement to a common purpose;
- know what has to be achieved and by when;
- have my relevance to the group explored by the people managing the event – the 'steerers', so they know what I can offer;
- take part in a review of what has been done so far to see if it touches my expertise and exchange views to gain agreement and my commitment to the future work of the group; and
- mutually agree the future work plan for what the entire group will now be doing.

So how do the steerers, by doing too much, irritate or fail to gain the commitment of the joiners? The answer is in many ways; these are a few. By:

- 'telling' the joiners what to do without telling them why, this leads to purposeless work;
- being patronising in that they have been working on the task and have decided how it should be done without at least checking the skills being brought to the process by the joiners, and looking for synergy;
- seeing themselves as managing the joiners;
- seeing the joiners as a threat to the work they have already done; and
- seeing other people's ideas as a challenge to their own.

Building on ideas should be activated by 'Yes AND', rather than 'Yes BUT'.

HOW TO FIND PEOPLE WHO ARE 'EASY TO OVERLOOK'

'Hard to reach' and 'seldom heard' are terms used in the public sector, particularly in the NHS and social services to refer to:

- people who do not frequently engage in public consultations;
- minority groups, such as non-English speaking people, people from black and minority ethnic communities, gay men and lesbians and homeless people;
- young people, older people and people living in rural communities;
- hidden communities such as drug users, sexually active teenagers and sex workers;
- vulnerable groups that may require different ways of communicating such as people with learning disabilities, those with a visual impairment and people with a mental illness;
- faith groups;
- people who are difficult to contact;
- people who fail to access the services that are available;
- people who tend to have poorer health; and
- people who are just uninterested and/or disillusioned.

It is easy to overlook these people, and it will help to make sure that you involve the right people if you are clear from the outset exactly who you need to involve in the work you are planning. In carrying out the duty under section 242(1B), you should also consider the statutory duties to have regard to the need to eliminate discrimination on the grounds of race, gender and disability and to promote equality of opportunity.



Points to note

1. The term 'hard to reach groups' implies that these people live in homogeneous communities or distinct groups, although the reality is that these groups rarely exist.
2. No one is really 'hard to reach' but some people are harder to reach, and may require more time, money, effort and creativity on the part of the organisation to seek them out and involve them appropriately.
3. There are people within these 'groups' who may like to get involved but for a range of reasons are unable to do so. These include people who are housebound or lack confidence, and those people who it is not convenient to communicate with, for example, people who do not have access to the internet/email in their homes.

You will probably find that local authorities, county councils and public health departments all have different ways of categorising the people for whom they are providing services.



Example

In a report for Kent County Council (KCC), the nine main groups of people who are most in danger of becoming trapped in the spiral of deprivation and who need targeted assistance if they are to be helped back into more fulfilling lives were identified as:

- the long-term unemployed over 50;
- school leavers with low educational attainment;
- youths with a record of repeat offending;
- young people in care or leaving care;
- lone parents;
- people lacking basic life and social skills and who lack basic literacy or numeracy skills;
- people with alcohol or substance addictions;
- people with health problems or learning disabilities or who are applying for low-level, long-term incapacity benefit; and
- transient or seasonal groups, including refugees, asylum seekers and the homeless.

The public health strategy for Kent in 2007–08, produced by the PCTs in Kent and KCC, recommended six priorities, most of which would impact on the nine groups identified above, and identified a number of groups that are more prone to particular health problems:

- gypsies and travellers because a travelling lifestyle makes routine healthcare more difficult;
- people of Asian origin because they are more likely to have a genetic tendency to heart disease;
- people living in deprived circumstances because they are likely to have greater health problems than those who are affluent; and
- prisoners because they are more likely to have poor health (both mental and physical).

In Kent Social Services' own toolkit, the 'hard to reach' groups include:

- children and young people;
- homeless people, the gypsy community and travellers and learning disabled people;
- gay and lesbian communities;
- older people;
- people from minority ethnic communities and other people whose first language is not English;
- people with disabilities; hearing impairments; mobility needs; sight impairment; who use mental health services; and refugees and asylum seekers.

Part 1 Section 3: How to find people who are 'easy to overlook'

From the various categories used in Kent, Eastern and Coastal Kent PCT identified six categories, each with a number of sub-categories. These are set out in the table below and show how it is possible to think about the people who may be 'easy to overlook' in different ways.

Category	Sub-category
Children and young people	School leavers with low educational attainment Youths with a record of repeat offending Young parents including teenage mothers and fathers Children with mental health illness Sexually active teenagers Children with learning difficulties Children from ethnic communities whose first language is not English Young people who fail to access the services available
Hidden communities	Drug users Sex workers People with alcohol addictions People with mobility needs The housebound Carers
People who are uninterested and/or disillusioned	People who tend to have poorer health The long-term unemployed over 50
People who require different ways of communicating	People with learning difficulties People with hearing or sight impairment People from minority ethnic communities and other people whose first language is not English People lacking basic life and social skills and who lack basic literacy and numeracy skills
Sexual orientation	Gay, lesbian, bisexual and transgender people
Transient groups	Homeless people Gypsies and travellers Refugees Asylum seekers



Suggestion

It may help to look at how 'groups' are categorised in your area, make any adjustments according to the local demography and use those categories to help you find the people you really need to involve.

There are ways of reaching most 'groups' in the community, but some of them may require additional support to engage with on a level playing field. There is no easy answer to how it should be done. The single most important piece of advice is, where actual groups exist, talk to them about the best way to involve them.

See part 1 section 3 page 68

Another suggestion is to make use of those people who have existing expertise in working in any capacity, paid or unpaid, with particular groups. Some people have no trust in their local health services, the local authority or other agencies. Where this may be the case, people who they do trust may act as intermediaries. For example, it may be possible to work with community leaders, other community workers, health visitors, local councillors or the community press. Part of the long-term strategy should be addressing these issues by building relationships with these people.

It is important to find out what the needs of the different groups you wish to involve are. For example, you may need to:

- hold events during the day, during the evening and/or at weekends or all three;
- provide crèche facilities;
- make sure that venues are accessible for disabled people (for their transport and wheelchairs);
- provide facilities such as induction loop systems for use with hearing aids, signers and interpreters;
- provide information in different ways, such as large print sizes; accessible language, on CD and translated into the languages spoken locally;
- find out whether people have special dietary requirements; and
- reimburse people for their time in line with the local reimbursement policy.

TECHNIQUES FOR INVOLVING USERS IN COMMISSIONING, PLANNING AND DELIVERING HEALTH SERVICES

The involvement continuum – what level of involvement is required?

Involvement can be viewed as a continuum with different levels. The level of involvement should be matched to the circumstances and context in which it is to be used. For example, giving information to local people in order that they can become more informed about an issue might be the most appropriate level of involvement when an organisation is beginning to think about redesigning a service. Certainly, it is more difficult to involve people in a meaningful way if they are not well informed. Similarly, a more participative technique is likely to be appropriate when the same organisation is determining priorities.

The diagram on page 70 sets out a continuum with different levels of involvement. A range of possible techniques to use at each level can be found later in the section.

It is possible to carry out a technique in a 'more' or 'less' involving manner. An example is focus groups, which have become an increasingly popular method of involvement in health and social care. Originally designed as a research technique to **get information** from participants, they are often used in the NHS as a method to involve participants in a **forum for debate**. Unfortunately focus groups are sometimes used as a method of **giving information** whilst being presented as a real opportunity for participants to have their views heard. The diagram shows several examples where techniques can 'slide' along the continuum. There is no reason why the techniques should not be used in this way; the important points to consider are:

- the level at which the technique is to be used;
- the intention for which it is to be used; and
- whether using the technique is likely to provide you with the information you need to find out or give out the information you need to.

Directional symbols are used to indicate where it is possible to 'slide' a technique along the involvement continuum.



Generally, as you move along the continuum in the direction of participation, there will be more opportunities to become more involved in any debate.

You are encouraged to be creative in designing hybrids and innovative techniques that really suit the needs of the people you are involving as well as being most likely to deliver the outputs required. It is often useful to talk to community leaders and those people who work with the groups you want to involve, to find out what they think is the best way of engaging the people you are seeking to involve.

Selecting techniques

There is not a simple 'route map' that can be used to pick the most appropriate techniques. This is for a number of reasons. There are big differences between service areas, NHS organisations, geographical areas, local circumstances and local communities.

It is tempting to decide to adopt a technique that has worked successfully in other areas or with other participants without first thinking through if this is really the best technique to use in the given context. Think carefully about why you want to use this technique and what you want to achieve, and try to identify any barriers. If there are potential barriers, will the technique selected help to overcome them?

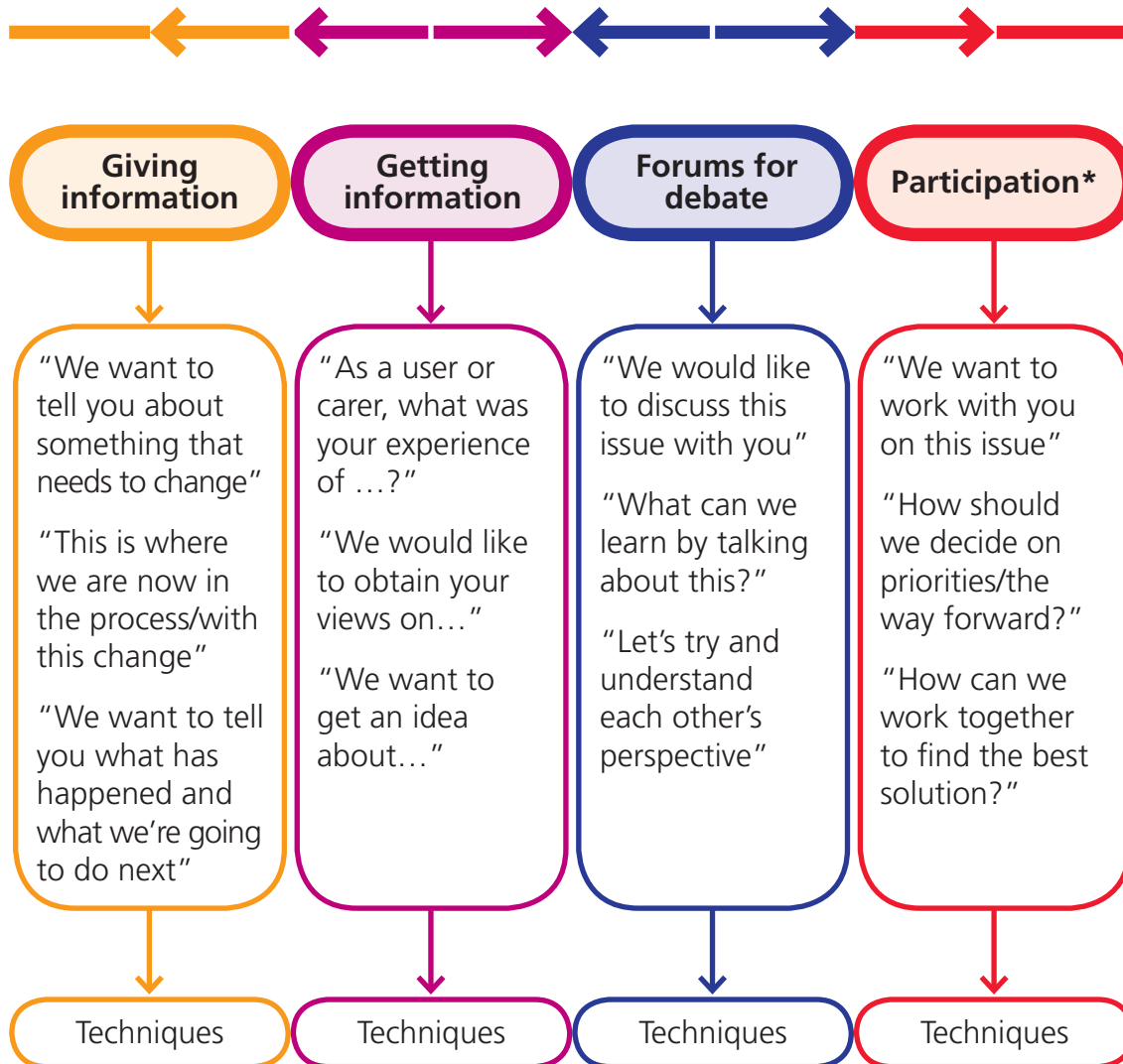
When developing and redesigning services you may wish to consider taking a social marketing approach. This is an adaptable approach that can be tailored to different contexts and timescales.

Appendix 5 – Taking a social marketing approach

The diagram on page 70 shows the involvement continuum with the different levels of involvement. It includes statements to help you think through what you want to achieve from an involvement technique at each level. This is a guide to help people who are planning involvement consider at what level they need to operate.

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

The involvement continuum (1)



*In certain cases, the continuum is extended beyond participation to partnership. Examples of where users and the NHS have worked in true partnership are peer reviews of cancer networks, where users act as reviewers alongside professionals, and as decision-makers in some residential settings.

Once you have determined the level at which you need to operate, we suggest you develop a set of criteria that reflect the requirements and the context for the involvement activity, and use them to help you think through which techniques or series of techniques and hybrids would be best to use.

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

Using an example of a PCT that wants to find out whether a sexual health clinic meets the access needs of young adults, the criteria might include:

- 1 we want to hear the views of young people who are 'easy to overlook';
- 2 we want to enable participants to voice their own ideas and issues;
- 3 the technique has to be suitable for target group – young adults;
- 4 it needs to facilitate the capture of the type of information we require (qualitative in this case);
- 5 it must be undertaken within the available involvement budget; and
- 6 it has to happen within the specified time frame.

Plot the range of possible techniques that could be used in the left column. Rate out of ten the extent to which the techniques meet each of the criteria and plot across the table. The techniques with the highest scores are those most likely to achieve the best result.

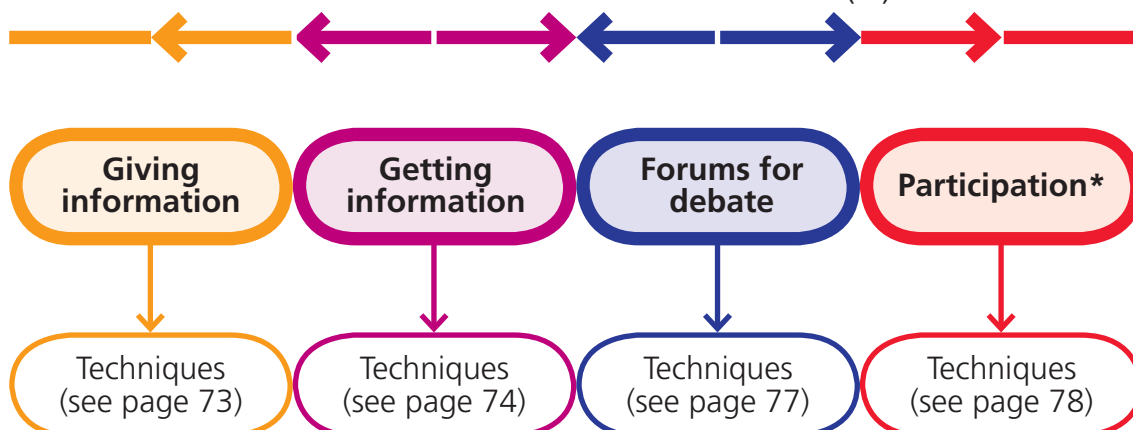
Technique	Extent to which technique meets criteria						Total
	1	2	3	4	5	6	
Focus groups	4	7	6	7	10	10	44
Health panel	3	5	5	6	0	10	29
Story telling	7	7	7	8	10	10	49
Shadowing	2	1	2	8	10	0	23
Blog	3	4	7	6	10	0	30
Semi-structured one-to-one interviews	6	5	6	6	10	0	33

In this fictitious example it can be seen that most suitable technique to use is story telling and that the least suitable is shadowing.

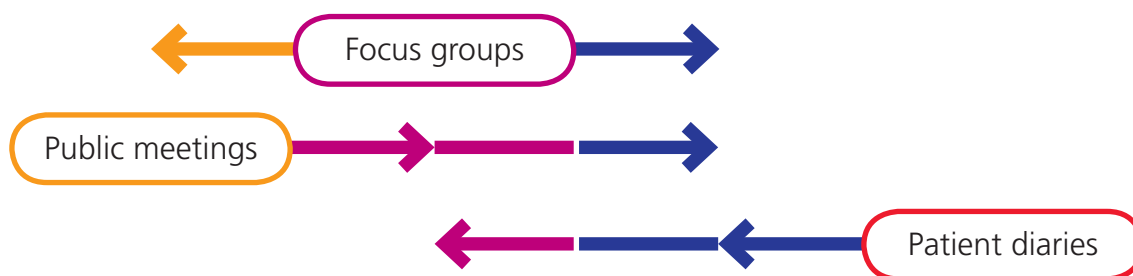
The table above is based on the work of the New Economics Foundation (www.neweconomics.org).

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

The involvement continuum (2)



Examples of how techniques can 'slide' along the continuum depending on how the technique is used and the intention of those operating the technique:



*In certain cases, the continuum is extended beyond participation to partnership. Examples of where users and the NHS have worked in true partnership are peer reviews of cancer networks where users act as reviewers alongside professionals, and decision-makers in some residential settings.

This section offers a range of techniques that can be viewed as an 'à la carte' menu enabling the most suitable approaches for the work in hand to be selected. They are arranged in sections that relate to the involvement continuum on pages 70 and 72. A good resource for different techniques is www.peopleandparticipation.net

Giving information

Displaying information

The objective is to convey information in a visual form. Audiences may be specifically targeted. For example, particular geographical locations, groups or communities.

- Websites
- Leaflets, newsletters and other written information including email bulletins
- Display boards/exhibitions
- Texting
- Podcasts/DVDs

Media

Information can be conveyed either as an advertisement that you pay for and control, or as editorial that is free, but is not within your control.

- The press
- Radio
- Television

Public meetings



A meeting for which there has been an open invitation. There may be a set agenda or discussion may focus on issues raised at the meeting. In the past, public meetings have tended to be used as a method of giving information, but may not be the best way to do this. They can be used creatively to get information from participants or as a forum for debate.

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

Getting information

Citizens' panels

A citizens' panel is a large, demographically representative group of citizens regularly surveyed to assess public preferences and opinions. Local authorities are likely to have a citizens' panel.



Focus groups are guided discussions of a small group of people. They are normally one-off sessions, although several may be run simultaneously in different locations.



Example

Birmingham East and North PCT held a focus group for young men of south Asian origin in an internet café to find out why they do not use smoking cessation services. Their views and ideas, included using images of people they can relate to, are informing the development of the service.

Surveys/e-surveys

Surveys include a group of techniques that measure the opinion of a sample of people. Depending on the particular technique employed, quantitative or qualitative data or a combination of both will be obtained.

- Self-completed questionnaires
- Semi-structured one-to-one interviews (including discovery interviews)
- Structured one-to-one interviews
- Online surveys
- Telephone surveys



Example

When the Mid Kent Treatment Centre, which is a chemotherapy unit run by an independent provider at Maidstone and Tunbridge Wells NHS Trust, first opened in 2006, it became clear that the pathway for patients attending the oncology centre was very poor as patients were waiting a long time for treatment.

Some patients attended the patient and public involvement group to voice their concerns and staff conducted one-to-one interviews either in person or on the telephone to explore with patients why they were having a poor experience and to give them an opportunity to say what they wanted to change. From this feedback, a new set of standards or metrics was agreed, which led to service improvements and has given patients confidence that they will be treated quickly.

Shadowing



Shadowing allows staff to gain a new and different perspective of the patient's experience by accompanying a patient or user as they use services. An agreed period of time is spent shadowing an individual and lessons learnt are used to improve future services.

Artwork,
photography
and other
creative means



A range of techniques that avoid the need for participants to communicate in words, asking people to create visual images is one way of engaging them at a different level.

- Digital stories
- Video diaries
- Photography
- Sculpture
- Painting and drawing

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

Mystery shopper

Mystery shopping is a way of auditing services through the involvement of trained user volunteers. Mystery shoppers have been described as 'under cover' service users.

Example

The results Walsall Hospitals NHS Trust received from the 2005 national in-patient survey highlighted the need for it to take action to improve patients' experiences. Volunteer patients undertook mystery shopper activities and presented the feedback at a diagnostic workshop attended by patients and staff. Customer care priorities to develop into standards, from which measures could be formed, were identified at the workshop.

Requested and spontaneous views

Information obtained by this range of methods can be requested about specific issues or may be spontaneous as a result of an ongoing organisational initiative (it may be more effective around a particular issue).

- Comments cards
- Polling
- Telephone responses
- Electronic responses
 - Email responses
 - Video diaries
 - Online consultations

Online consultations utilise the internet to ask a group of people their opinion on an issue (typically a policy in the development stages). An unlimited number of participants can be sent information about the subject or download it online and respond via email or comment on a website.

Open surgeries/ conversation cafés



Conversation cafés or open surgeries are informal dialogue methods which invite people to take part in discussions about topical issues in an informal setting.

Point to note

PALS and complaints.

Both good sources of existing information.



A range of techniques that aim to impart, exchange and receive information. Discussion groups will usually be facilitated; they may be face-to-face or organised electronically. They can be used to target existing patient and carer groups, interest groups and support groups or set up for a specific purpose.

- Electronic discussion groups
 - Blogs
Blogs are online journals or noticeboards where individuals or organisations can provide commentary and critique on news or specific subjects such as politics, local events or health matters. Some blogs function like personal online diaries.
 - Chatrooms/online discussion groups/forums
These are web tools that allow discussions to be held online. They allow participants to post their own comments online which distinguishes them from one-way communication tools such as email bulletins.
 - Webchat
'Real time' webchats are based on instant messaging (e.g. MSN). This is a new and informal way to gather information from different stakeholders and to answer specific questions they may have. Participants are invited to contribute to the discussions, but normally anyone can observe the proceedings online even if they cannot contribute.



Example

Western Cheshire PCT undertook a quantitative survey, held a number of group discussions and ran a deliberative event to ask people about their views and experiences of general practice, out-of-hours services, and accident and emergency services.

People's contact details were obtained from electoral registers. The people who took part in the discussion groups and the deliberative event were able to give detailed feedback on their experiences of using general practice and out-of-hours services. For example, the PCT discovered that most people living on very low incomes were not aware that they could get a taxi to the out-of-hours centres and have the fare reimbursed.

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services



Health panels have primarily been used to explore people's views on 'live' policy issues and the allocation of health service resources. Participants are usually recruited using a quota sampling technique to reflect the socio-economic make-up of the area. Membership is refreshed on a regular basis.

- Virtual panels



Beginning with a specific and clear question, the participants identify issues and prioritise them. The same question or topic can be used with different groups of people, for example staff, patients and carers, and the issues and priorities compared. A session usually lasts about three hours.



Point to note

Overview and scrutiny committees.

OSCs can be forums for debate.

Participation

Co-design/
co-production

The key to co-design is to see it as a mutual (peer) learning process, whereby the 'winners vs losers' of historic approaches to consultation become the co-producers of solutions to complex, never-ending problems. It is based on the work of the Tavistock Institute and is linked to action research.



Suggested reading

Experience Based Design Guidance, NHS Institute for Innovation and Improvement
www.institute.nhs.uk/quality_and_value/introduction/experience_based_design.html

The OpenDoor report describes the co-production of a service that aims to deliver better access to health and social care for people in Grimsby who normally do not attend traditional services. This project was commissioned by North East Lincolnshire PCT
www.nsms.org.uk/public/CSView.aspx?casestudy=45

Deliberative events/21st Century town meeting

Deliberative event is a generic term for dialogue events where the focus is on deliberation. Some deliberative events record/measure what the participants think about an issue having had an adequate chance to reflect and deliberate on the questions at hand.

- With polling/without polling
- Face-to-face and/or electronic
- 21st century town meetings
21st century town meetings involve a large number of people (between 500 and 5,000) in deliberating on local, regional or national issues and make use of modern technology, including wireless voting pads and networked laptops. They combine the benefits of small-scale, face-to-face discussions with those of large group decision-making.
- Round table workshops

Citizens' juries

Citizens' juries consist of a small panel of non-specialists, modelled on the structure of a criminal jury. The group set out to examine an issue of public significance in detail and deliver a 'verdict'.

Part 1 Section 3: Techniques for involving users in commissioning, planning and delivering health services

← User groups

User groups are groups of service users that meet regularly to discuss the quality of a service and other related topics. They help to identify the concerns and priorities of other service users and can lead to the early identification of problems or ideas for improvements.

- Cancer network partnership groups

← Story telling/
patient diaries

These techniques invite participants to capture and record their experience of health services in a way that can be fed back to staff. Staff discuss the insights obtained and work with participants to make improvements. The techniques can be used in a variety of ways – from being a means of getting information through to being a vehicle for working in partnership.

Participatory appraisal

Participatory appraisal is broadly an empowerment approach that seeks to build community knowledge and encourages grassroots action. It uses many visual methods which makes it especially useful for participants who find other methods of participation intimidating or complicated.

Forum theatre

Forum theatre is an interactive form of theatre that encourages audience interaction and explores different options for dealing with a problem or issue. This technique is used to work with socially excluded and disempowered groups.

World café

World café is a method that makes use of an informal café for participants to explore an issue by discussing in small table groups. Discussion is held in multiple rounds of 20–30 minutes with a plenary at the end of the event.

Large group processes – also referred to as citizens' summits

- Future search
Future search conference is a way for a community or organisation to create a shared vision for its future. It engages a large group of stakeholders who take part in a highly structured process lasting ideally two and a half days.
- Open space
Open space is a meeting framework that allows unlimited numbers of participants to form their own discussions around a central theme.

Peer review

Peer review is a process used for assessing a service or the effectiveness of a network. People working at the same level, as equals or peers, carry out the assessments to make sure that specified criteria or standards are being met. This technique enables trained users to work as part of a team alongside professionals to review services. Peer review has been extensively used in the review of cancer services.

Deliberative mapping

Deliberative mapping involves both specialists and members of the public. It combines varied approaches to assess how participants rate different policy options against a set of defined criteria.

See part 1 section 4 page 104 for a table illustrating the possible techniques to use at the different stages of the commissioning cycle

HOW TO MAKE BETTER DECISIONS

Whatever the scale of change NHS organisations will find it helpful to be clear about the process they will use for taking decisions at the start of the involvement process. NHS organisations should aim to have decision-making processes that are open and transparent so users can understand how decisions will be reached and how their views and opinions will be used.

The duty under section 242(1B) requires involving users in decisions to be made by NHS organisations where that decision would have an impact on the way in which services are provided or would affect the range of services provided.

It is good practice for a decision-making process for a major change such as the reconfiguration of health services to demonstrate:

- that there has been an objective evaluation and inclusion of stakeholder responses, from early involvement, throughout any consultation and in the final decision-making;
- that there has been proactive involvement of users from the beginning of the planning or change process;

See part 1 section 3 page 46

- that there is a clear description and audit of how any decision-making criteria were developed and applied in the final decision-making;
- recognition of the potential impact of proposed changes on bordering health and social care services;
- evidence of how external organisations have been involved in the decision-making process, as appropriate; and
- that there is a clear monitoring process that involves users, to track progress and audit outcomes.



Suggested reading

Changing for the better: Guidance when undertaking major changes to NHS services, Department of Health, May 2008

For a large-scale consultation, it may be helpful to have a decision-making process that has the following elements:

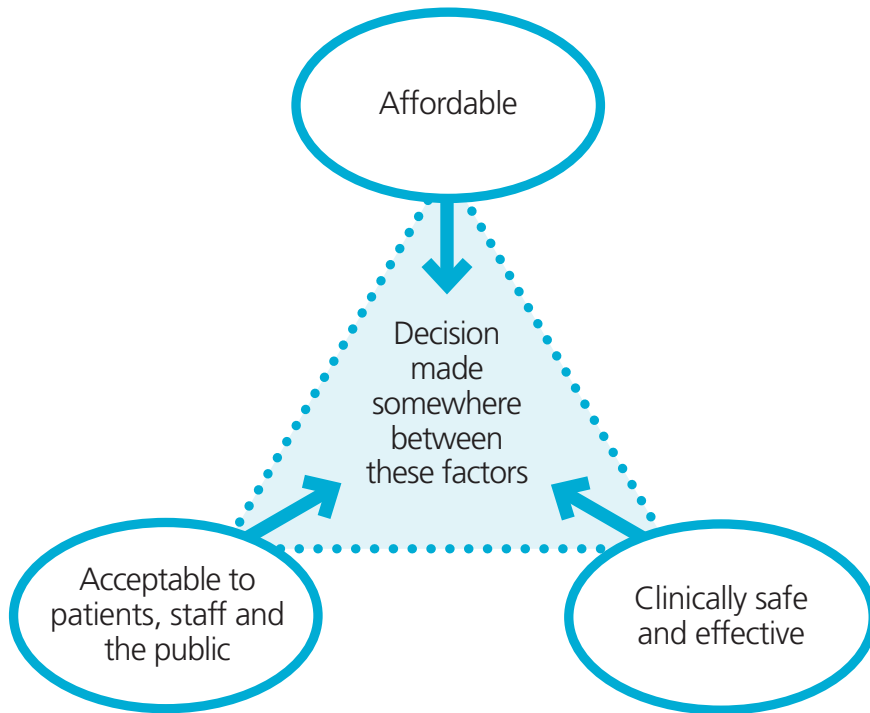
1. Draft decision-making criteria developed and shared with the OSC and LINKs. These could be finalised at the end of the consultation to include any additional factors raised during the consultation.
2. A decision-making process, signed off at board level.
3. A consultation document that includes:
 - the decision-making criteria, how they were developed and how they will be applied; and
 - a feedback form with a set of questions, based on the main points that have emerged during earlier involvement activity and framed in such a way that they can support the decision-making process. The answers should be considered alongside other relevant factors and used to inform and contribute to the final outcome.
4. A dedicated team to receive and systematically record the written responses received including emails and petitions.
5. A decision taken before the consultation begins as to which responses will be sent an acknowledgement.
6. Any petitions received formally recorded in the analysis of the responses. (Organisations could consider whether it would be relevant to invite petitioners to present their petition at a board meeting.)

See part 1 section 3 page 84

7. An independent analysis team appointed to take responsibility for providing regular updates of themes from the feedback received and to provide a full report at the end of the consultation.
8. Regular meeting with the OSC and LINKs that wish to be involved to feed back emerging themes and to say how the information will be used to inform or further develop the decision-making process.

Part 1 Section 3: How to make better decisions

The diagram below is purely illustrative. It can be used to help explain to users how their contributions have been taken into account along with other factors when decisions are being made. Each of the ovals illustrates the criteria that could be used to assess the options. For example, solutions need to be affordable, clinically safe and acceptable to the users. Ideally, the decision will be made somewhere in the middle of the triangle, as close to the centre as possible.



Petitions

Some people may respond to a consultation on a major service change by signing a petition. Petitions are most likely to be submitted when people think that a valued service is going to be lost or put at risk or if they do not want a service to be located in their locality.



Points to note

1. A consultation is not a referendum, i.e. a public vote. Attention should be given to appropriate ideas and arguments, rather than the largest number of signatures. (It is often easier to sign a petition than to take the trouble to find out precisely what is being proposed, or the implications of the proposal.)
2. People may be misled by petitions, which may not provide information on the subject of the consultation and may focus on a single issue or the wrong issue, for example, saving a hospital when the hospital is not threatened with closure.
3. Remember that an NHS organisation could be criticised for not taking into account relevant material when making decisions. An organisation must decide whether any petition is relevant in the circumstances.

CHECKLISTS

NHS organisations have an obligation to involve users when they are:

- planning the provision of health services;
- developing or considering proposals for changes in the way health services are provided, if the implementation of the proposal would have an impact on the manner in which the service is delivered to users, or the range of health services available; and
- making decisions that will affect the operation of a health service if it would have an impact on the manner in which the service is delivered to users, or the range of health services available.

The level of the involvement activity required will be dependent upon the scale of the change. Not all involvement activity will require you to tick all the boxes on this checklist. For example, if you are planning to provide information you may not need a dedicated team or budget, unless this is an element of a bigger involvement process. Likewise, if you are arranging to get some information from users as part of a review for a small-scale service improvement change you probably won't need the chair and board to be involved in the process but you will need to make sure that the right people are involved.

See part 1 section 3 pages 60 and 63

The following checklists might be useful tools to help carry out involvement activity. Each activity will be different and will not necessarily require all the points on each checklist to be met. In each case a judgement will need to be made about which parts of a checklist might be helpful.

1. A suggested checklist for planning involvement activity

Would you find it helpful to:

- have a dedicated budget
- identify a lead person and/or a dedicated team of people to both plan and do the work
- agree the principles for how the team will work together, who will do the work and who will make the decisions
- identify a senior clinical lead who will make sure that other clinicians are involved in developing the proposals and who is prepared to work with the team, other staff and stakeholders, including users, throughout the process

- make sure that the chair and board are informed and, if appropriate, actively involved at every stage in the development of any proposals that may be consulted on and that they are prepared to take an active role
- make sure that the right people are involved and that your process is as inclusive as possible. To do this identify the services that will or may be affected by any of the changes you are considering and where necessary undertake a health impact assessment and stakeholder analysis. Consider involving local authority and social services officers in this work

See part 1 section 2 page 27 and appendix 5 – Understanding health needs assessments, health impact assessments, health equity audits and race equality audits

- involve the OSC and LINKs
- draft an involvement plan and a communications strategy that are integral to the service planning process and appropriate to the scale of the proposed change
- make sure that you have effective communications processes in place to respond to and where necessary correct any misleading information that enters the public domain, and to publicise the involvement process
- make sure that you are planning to use a range of innovative and creative ways to involve users, particularly those who are ‘easy to overlook’
- be clear about:
 - who you are going to involve;
 - what it is you are going to discuss;
 - what information you need to give people at the start of the process to assist them to engage in the discussions; and
 - what points you are asking people to give their views on
- think how to explain clearly to users what you are involving them in, in a way they are likely to understand. Try to think about what questions you would ask if you were in their place. Use plain English in documents and correspondence and take advice from community leaders about translating written material
- have systems in place for capturing and analysing feedback
- plan who is going to make the decisions and what the decision-making process will be at each stage

If you are involving users in developing options for a major change consider:

- preparing Q&As for staff and users and a discussion document;
- organising training for the clinicians and staff who will front the discussions with users and providing training for people who may be talking to the media, the public and stakeholders – you might want to ask advice from your partners about how to address particular unfamiliar audiences, for example local councillors;
- appointing someone from outside the organisation (possibly an academic institution), to independently evaluate the involvement process and to provide a steer throughout it; and
- appointing an independent organisation to analyse the feedback and report back to the planning group the issues raised early on in the involvement process.



Points to note

1. You need to understand the council/scrutiny split in local authorities – make sure that you involve council executives as community leaders and public service partners in developing the proposals and commissioning plans and that you have a discrete consultation with OSCs in a separate but possibly parallel exercise if you need to.
2. Find out how local authorities handle this split and don't make assumptions.



Suggestion

Involvement activity may mean you need to **give information**

Involve users right from the start of the process, and explain to them why changes have to be made and how this may change local health services – you are not expected to have the answers, these will become clearer as the process evolves. Also consider when it might be appropriate to involve OSCs and other stakeholders.

If you need to produce information make sure that you have versions that meet the needs of different groups and communities that you are involving, for example children and young people.

Use your website, but do not use this as your sole means of communication – be aware of the 'digital divide'.

Go out and talk to people in the places they go to and find ways of getting information to people through different channels. For example, ask health visitors to talk to young mothers and visit day centres to speak with service users but make sure that they have been involved and understand the issues.

Set up systems for involving people who work in the NHS.

See part 1 section 3 page 33

get information or hold **forums for debate**

Use a wide range of appropriate methods for involving users, consider working with the LINK, the local authority, social services and the OSCs.

It is a good idea to keep accurate and comprehensive records in one place of all the views and ideas you are given – emails, letters, minutes of meetings and notes of telephone calls all form your evidence base.

You should always provide feedback

Use the information gathered to help you design any options you will consult on and to inform your commissioning decisions. Carefully consider any new ideas that have been put forward and be prepared to say how you did this.

2. A suggested checklist for planning a consultation with users

When you plan to undertake a consultation in line with the Cabinet Office Code of Practice on Consultation, first consider using Checklist 2 for planning the involvement activity.

To make sure that your consultation process is robust it is good practice to:

- make sure that you have a business case which sets out the clinical benefits of making the changes and how they will benefit users
- think about the timing of a consultation. If over Christmas and New Year or during the summer holidays, add on a couple of weeks and avoid times when local or national elections are being held
- think about the length of your consultation and make use of the Cabinet Office Code of Practice in making your decision
- take stock of who you need to consult – check if any new groups/organisations were identified during the earlier involvement phase
- be clear what you are consulting on and what you want to achieve
- be prepared to make any changes to your original plans – as the process progresses. Be up front about why you need to do this and consider whether you will need to undertake further consultation
- make sure that options are based on sound clinical evidence and made in the best interests of patients, and that you can explain this to users in a way they can understand
- prepare consultation documents for the different groups of users you will be consulting, for example children aged 5–11 and teenagers and people with learning difficulties

See appendix 8 – A suggested outline for a consultation document on a major change

- make sure that your consultation document will stand up to a legal challenge – have you said what you learned during earlier involvement activity and described how you considered and have responded to the issues raised during this time?
- rely on more than one method for disseminating your consultation plans



Suggestion

During the consultation **give information**

If it is a major change and you are producing a consultation document, use it to tell people what you learned from earlier involvement activity and show how you have used the views and ideas to shape the options you are now consulting on. If you have not been able to use all the ideas, explain what you have not been able to respond to and say why not.

Organise opportunities for users to **participate** in debates

Organise a wide range of activities to enable users to take part in the debates.

Where appropriate make sure that you have clinicians to lead the debates, who:

- know how to handle conflict;
- fully understand all the issues, and
- know what you are trying to achieve.

Work closely with the media and, where possible and appropriate, involve them in the discussions.



Suggestion

Providing feedback and making decisions

You should:

- explain to users the processes and timetable you have in place for making decisions

See part 1 section 3 page 82

- feed back to the people who gave you information about what you learned and tell them how you plan to use their ideas to inform the decisions you are going to make
- allow sufficient time to consider carefully the views collected during a consultation and to test any new ideas that may emerge during the consultation before any decisions are made, and be prepared to show how you have done this
- provide feedback on whether you have achieved your objectives, and explain why you may not have been able to do everything that was suggested during the consultation and how you arrived at your conclusion



Point to note

If the OSC is not consulted because it does not need to be, NHS organisations still have an obligation to involve users under section 242(1B) irrespective of whether the OSC is consulted or not.

3. Recruiting, training and supporting users to contribute to meetings – a suggested checklist for best practice

It is important that you recognise that most users who are invited or volunteer to join a committee or other meeting as a user 'representative' may not understand or fully appreciate what their role is. People may need to be offered training and ongoing support if they are to have a voice at the table and be in a position to make meaningful contributions to any discussions. NHS organisations may need to consider whether:

- commissioners and providers have capacity and capability to carry out user involvement and respond to users' views, and the skills to interpret everyone's views; and
- users have the skills and knowledge that will help them to get the most out of being involved.

Users may need to be given adequate training and support to help them to get involved in commissioning, but as there are many different ways that they can get involved, this means preparing them appropriately for their different roles. For example, a user may:

- join an advisory group or board as a user representative; or
- take a job previously held by a professional such as chair of a board.

This has important implications for developing appropriate training as this may range from needing a basic understanding of how commissioning processes work, through to developing the necessary skills and confidence to take on a high-level position. Training may help to empower people and give them confidence to contribute in new and different ways.

Have you carefully considered:

- why you are involving people – what is the purpose and what are the expected benefits
- how this work fits with your organisation's overall strategy
- if you have/need a budget to do this work
- what you want to achieve
- how feedback will be used to inform decisions
- who should be involved
- how people will be selected/recruited – do they have the skills to do what is being asked of them? Some NHS trusts and cancer networks have recruitment procedures with the role and person specification clearly set out.

Appendix 6 – An example of a role and person specification for user representatives

Part 1 Section 3: Checklists

- what skills people may need to have
- what training/ongoing support users might need
- who will provide the training/ongoing support
- what information people might need – what is their present level of knowledge/understanding, what format will the information need to be made available in?
- people's area of expertise
- what is expected of these people and what they can expect
- how you will make sure that everyone understands the discussion, i.e. that health professionals do not use jargon, and that people are 'keeping up' with the debate and have equal opportunities to contribute and ask questions and/or for a further explanation
- how you will make sure that users' views and opinions are heard and that they are not patronised
- what your reimbursement policy is

Think about

The points made by the 'joiner' in Steering and Joining.

See part 1 section 3 page 62

A person should feel welcome and welcomed. They should:

- have the task confirmed and explained;
- understand the purpose of doing it – remember that commitment comes through mutual agreement to a common purpose;
- know what is to be achieved and by when;
- have their relevance to the group explored by those steering it;
- review what has been done so far to see if it touches their expertise and exchange views to gain agreement and commitment to the future work of the group; and
- mutually agree future work plans for what the entire group will be doing.

Commissioners may wish to consider establishing commissioning partnerships along the lines of the cancer network partnerships. These groups are able to offer a valuable resource of trained and experienced users, many of whom may have the capacity to get involved in a range of commissioning decisions. To do this effectively, commissioners must be prepared to:

- develop effective recruitment strategies;
- make sure that users feel motivated so they stay involved;
- invest in the group; and
- offer continuous support and training.

▶▶ PART 1 SECTION 4

USER INVOLVEMENT IN
COMMISSIONING AND
CONTRACTING

Real involvement
Working with people
to improve health services
October 2008

USER INVOLVEMENT IN COMMISSIONING AND CONTRACTING

Commissioning is a complex, multi-level process encompassing a wide range of decisions and people. The term 'commissioning' can be used to describe many levels of decision-making, from top-level strategic decisions made by commissioning boards, through to the smallest decisions about a particular service. NHS organisations need to be ever aware of the duty to involve users under section 242(1B) of the 2006 Act and may achieve this by developing a strategic approach to commissioning, agreeing how, when and where to involve users and being prepared to be creative and innovative.

Where both the primary care trust (PCT) and the NHS trust have an obligation to arrange involvement activity it may be sensible to join forces or agree which organisation is in the best place to undertake the work. Each organisation must be satisfied that any arrangements it makes with another organisation satisfy their own duty to involve users under section 242(1B). A PCT is not relieved of the duty to involve just because the NHS trust leads the involvement activity.



Example

Over 800 local people were actively involved in the development of Suffolk PCT's commissioning strategy for 2008–13. Events included open workshops led by senior clinicians, and meetings with specific groups such as people from black and minority ethnic communities, people with disabilities, and young people.

Local people told the PCT that they wanted more help to stay well and the confidence to know that services would be there when they need them.

In response the strategy will focus much more on improving health and preventing ill-health and there are plans to improve access to care and develop more locally based services particularly in community settings.

User involvement in the commissioning process is not well established and presently it is more likely to occur in designing services than in assessing needs or evaluating services. For example, one or two user representatives may attend a commissioning meeting, but there are many other decisions that precede or follow this stage. Much more thought needs to be given as to how best to involve users throughout the commissioning cycle.



Points to note

There is an obligation under section 242(1B) of the NHS Act 2006 for NHS organisations to involve users in:

- a) planning the provision of services;
- b) the development and consideration of proposals to change services where those proposals would have an impact on the manner in which services are provided or the range of services available; and
- c) decisions that would affect the operation of services, where the implementation of the proposal or the decision (if made) would have an impact on the manner in which those services are provided or the range of services available.



Suggestion

The NHS Institute for Innovation and Improvement has charts and systems that may be of help to commissioners.

www.institute.nhs.uk/no_delays/introduction/commissioning_for_no_delays.html

The commissioning cycle is made up of a number of stages. These include:

- reviewing existing services;
- planning – assessing needs, deciding priorities and designing services;
- tendering – agreeing the specifications for tenders and contracts;
- choosing providers and agreeing terms and conditions with the chosen provider;
- monitoring – managing performance and evaluating services to make sure that good quality services are delivered. The findings from this stage also need to inform planning in the next cycle.

In order to develop innovative, patient-led services it may be appropriate to involve users in all stages of the commissioning cycle. It is important that commissioners:

- develop a strategic approach to involvement so they know the way that different groups and communities want to or can be involved;
- work with users throughout the cycle; and
- make sure that their views and preferences are considered at each stage.

Reviewing

You may find it helpful to use available data from Patient Advice and Liaison Services (PALS), complaints, Local Involvement Networks (LINKs), national surveys and other sources to find out about patients' experiences of using existing services. This will provide you with information about what is working well and what may need to change.



Example

Medway PCT held a focus group and a workshop to look at the patient pathway for adults with psoriasis. The aim was to gather opinions from people who use the services on where they go for advice and treatment; what they value about existing services; and what could be improved in order that practice-based commissioners could commission better services, delivered from appropriate settings.

Initial conclusions included:

- there is potential benefit to patients, GPs and hospital-based dermatologists in redesigning services so that elements currently provided by GPs and/or at hospital are delivered in the community;
- the system for obtaining repeat prescriptions, whilst it works well, could be streamlined to reduce the number of visits a patient has to make to their surgery; and
- it can take 18 weeks from first consultation for a flare-up to receiving effective treatment.

Planning

User involvement in this stage should be in:

- **assessing local needs** – consider using existing information such as results from the GP access survey or the Quality and Outcomes Framework (QOF) survey to help assess patients' experiences. Think about how you might involve users, for example through the LINK or by undertaking a survey to assess need. Will you need to get information, for example, to find out where users think it would be best to site a GP surgery to improve access?
- **identifying priorities** – feedback from user involvement activity can be used to help decide priorities
- **risk management** – should you find out 'what's going to cause a noise locally?' to enable you to take account of local politics?

Where users may be able to add particular value in the planning stages is in:

- providing a user-led view of the patient journey, identifying where there is unmet need as well as users' priorities for solutions; and
- challenging assumptions about priorities that may have been defined by government targets or clinicians. For example, the present emphasis on waiting times for cancer treatment may not be as important for users as targets suggest. Some people may feel rushed through their treatment and prefer to have more time to sort out their lives.

Involvement activity will assist in making decisions that more accurately reflect users' needs and preferences.

There is an area of involvement that, in spite of being a duty in the legislation, is underdeveloped and undervalued. This is the role of users in contributing to ideas for planning new types of service. Users can often identify common-sense solutions and practical ideas for services that lie beyond the boundaries of traditional service provision. Their ideas may not have been considered by health professionals and are more likely to meet the needs of other users and deliver user-defined outcomes. Involving users in this process may help commissioners to think 'out of the box' and deliver innovative and patient-centred services.



Example

Derby City PCT employed local parents involved in a Sure Start programme who had been trained as community researchers by Leicester De Montfort University. Their role was to find the views of over 100 parents in Derby to inform a large-scale workforce programme to redesign health visiting and school nursing services. In addition to providing valuable information for the workforce review, the process helped to develop the confidence and self-esteem of the people involved, who continue to be active within their community.

Tendering

User involvement could help to improve the quality of services if users are given a greater say in a specification for a tender (which could then form the basis of a contract). Section 242(1B) is about gathering users' views and experiences to help inform the decisions the NHS will take. It provides an effective lever to influence quality standards for patient-centred services, for example, in setting standards for pathways for specific treatments that include handover arrangements and the continuity of care.

Involving users appropriately throughout the tendering process should make sure that there is fairness in the process. This is an approach used by social care.



Example

In Westminster, users were involved in developing the specification and review of the contract for an independent living centre for adults with a disability. Their input led to the service being divided up in such a way that smaller organisations that did not have a previous history of tendering could bid competitively to provide different parts of the service.

Choosing between providers

Seeking users' views at this stage in the cycle is obligatory where a change of provider will impact on the way a service is offered or the range of services available. It has the following benefits:

- it demonstrates to the providers that the views and concerns of users are a high priority;
- it makes sure that providers have regard to users' issues; and
- involving users in developing a scoring system would make sure that the final decision is influenced by their views.



Example

When it became clear that two GPs in one practice would be leaving, South Birmingham PCT needed to appoint an alternative provider and agreed that it would involve patients in the development of the specification and the appointment of a new provider.

At one of a series of meetings for the practice population, patients were invited to establish a patients' panel. The aim was to involve the panel in setting up the new practice. Two representatives were nominated by the panel to join the PCT project team for the appointment of the new provider. The patient and public involvement (PPI) manager provided them with support throughout the process and made sure that they were fully engaged in:

- agreeing the specification;
- reviewing the pre-qualification questionnaires;
- shortlisting submitted tenders;
- agreeing interview questions;
- interviewing four potential providers and asking questions about PPI; and
- making recommendations to the PCT board.

In addition, the project team made two visits to potential sites and made recommendations on the sites from a patient's perspective. Members of the PCT Disability Advisory Group and Breathe Easy also visited the sites and gave their opinions.

The patients' panel received feedback on the tendering process and agreed how it would work with the new provider. Posters were displayed in the practice to inform patients of progress.

The panel representatives said:

"We had no idea how much work was involved in finding new GPs and have learned so much about how you make sure the GPs do all the things we want them to do. We really believe we have been involved in the project team, people really listened to us and took on board what we said."

Contracting

Section 242(1B) of the NHS Act 2006 places a duty on NHS organisations to make arrangements to involve users. This is an obligation which they cannot depart from. When contracting with a third party there is still an obligation to involve users. One way in which the obligation may be fulfilled is by making it part of contractual requirements. Organisations may also secure user involvement in any other way that is appropriate.

Monitoring and evaluation

User involvement in this stage of the process is good practice although not specifically required within section 242(1B). Involving users in monitoring and evaluating health services is an essential part of making sure that the investment delivers a truly patient-centred service rather than one that health professionals consider to be a good quality service.



Points to note

1. Section 242(1B) does not apply to general practitioners, other primary care practitioners such as pharmacists, dentists and opticians, or independent and third sector providers.
2. Where NHS organisations commission and procure services from independent providers they are still under a duty under section 242(1B) of the NHS Act 2006 to make sure that they make arrangements to secure the involvement of users. One way of achieving this may be through contractual arrangements with the service provider to involve users.

SPECIFIC COMMISSIONING SITUATIONS WHEN SECTION 242(1B) APPLIES

Strategic health authorities

The duty under section 242(1B) applies to NHS organisations responsible for health services. Strategic health authorities (SHAs) do not generally commission healthcare services, the only current exception to this being the nationally commissioned services that are commissioned by London SHA on behalf of the ten SHAs.

Nationally commissioned and funded services are for those very rare diseases and interventions where the annual national caseload is under 400 and the provider centres are limited to those designated by Ministers.

The list of services that are to be nationally commissioned is set out in the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) Regulation 2002. Currently there are 40 nationally commissioned services; examples include heart and lung transplant, rare cancer services and secure forensic mental health services for young people. The SHA responsible for nationally commissioned services has a duty under section 242(1B) to make arrangements to involve users in respect of those health services for which it is responsible; these include the nationally commissioned services.

Primary care trusts

PCTs should note:

1. Section 242(1B) also applies to the PCTs for which the ten specialised commissioning groups (SCGs) act as formal joint committees in commissioning specialised services across the area of the SHA. Each individual PCT that is a member of an SCG retains responsibility for its statutory functions and these include the duty of involvement. It is expected that each PCT shall make arrangements to make sure that user involvement is carried out.

2. The duty to involve users does not apply to general practitioners, other primary care practitioners such as pharmacists, dentists and opticians, or independent and third sector providers.
3. NHS organisations that commission and procure services from independent providers are under an obligation to make arrangements to secure the involvement of users. One way in which this may be done is through the contract with the independent provider.



Point to note

When making arrangements to fulfil the obligation set out in section 242(1B) of the NHS Act 2006 there is other legislation NHS organisations need to be aware of. This includes the Disability Discrimination Act, the Race Relations Act and the Sex Discrimination Act.

Appendix 5 – Other legislation and guidance you need to be aware of

SUGGESTED APPROACHES FOR INVOLVING USERS IN COMMISSIONING

	What you need to know – the strategic approach	Operational approaches you may consider using
Assess needs – fact finding	<ul style="list-style-type: none"> • Baseline – population • Public health – demographics • Royal Colleges • National service frameworks (NSFs) • Finance • Statutory guidance, e.g. Improving Outcomes guidance for cancer services • National targets – local need • Local Area Agreements (LAAs), Local Strategic Partnerships (LSPs) • PCT strategic plan • Healthcare Commission reports 	<p>Get information</p> <p>Obtain information from:</p> <ul style="list-style-type: none"> • local communities • users and local interest groups • relevant health professionals • voluntary organisations • LINKs <p>and use the web to gather insights and further information.</p>

	What you need to know – the strategic approach	Operational approaches you may consider using
<p>Review current service provision – where are the gaps and what are the local issues?</p> <ul style="list-style-type: none"> • mapping provision • identifying issues and needs 	<ul style="list-style-type: none"> • Benchmarks • National standards • Specification of a gold standard service – gap analysis against current services • Who are the providers? • What do people think? – reputation, value for money <p>Process</p> <ul style="list-style-type: none"> • Identification of priorities > expectations > making effective use of resources > user feedback > assessing outcomes – are they improving? > identification of priorities <p>Work with:</p> <ul style="list-style-type: none"> • GPs • practice-based commissioners • local authority • finance 	<p>Feed in needs assessment results</p> <p>Undertake a stakeholder analysis</p> <p>Identify people who have not been engaged and people who may need to use the services – use innovative ways. For example, offer young people phone top-ups as an incentive</p> <p>Give information</p> <p>Give a clear outline of what you have been told to deliver and why</p> <p>Get information</p> <p>Forums for debate</p> <p>Use workshops, focus groups, informal discussions, structured interviews, feedback forms, case studies to:</p> <ul style="list-style-type: none"> • get feedback – gather experiences through patients’ stories and find out what’s working well/ not so well

Part 1 Section 4: Suggested approaches for involving users in commissioning

	What you need to know – the strategic approach	Operational approaches you may consider using
		<ul style="list-style-type: none"> • Review experiences – users and carers – use information from trusts’ complaints, PALS, OSC reports • Engage relevant organisations • Networks and partnerships • Healthcare professionals – primary and secondary • Social care • Education/schools • Voluntary organisations
<p>Decide priorities</p>	<ul style="list-style-type: none"> • Statutory guidance – e.g. Improving Outcomes guidance for cancer services and Cancer Reform Strategy • Clinical safety • National priorities • Local priorities – for example direct services vs support services • Affordability – cost benefits/patients’ benefits 	<p>Forums for debate</p> <p>Participation</p> <p>Develop criteria and agree local priorities</p> <p>Consider setting up a service reference group to scrutinise the process and advise</p>

	What you need to know – the strategic approach	Operational approaches you may consider using
Re/design service	<ul style="list-style-type: none"> • Identify what needs to change – use outcomes • Think about the standards, quality, value for money, capacity, skill mix, demand, innovation – new technologies • Find out about the outcomes from previous significant consultations – e.g. Fit for the Future • Benchmark against care pathways, e.g. NSFs, improving outcomes guidance (IOG) • Be clear who the service is for • What will the service look like? Use NSFs, IOG etc 	<p>Give information</p> <p>Keep people involved along the way</p> <p>Forums for debate</p> <p>Participation</p> <p>Involve specialist teams</p> <p>Trigger point for wider engagement, e.g. for sexual health involve patients, schools, youth groups, local authority, medical and clinical teams, older people</p> <p>Consult on options and/or pathways</p>
Shape of structure of supply	<ul style="list-style-type: none"> • Report back • Draft tender specification • Identify providers to invite to tender 	<p>Participation</p> <p>Use service reference group to involve users in development of service specification and preferred provider specification or</p> <p>Consider setting up a panel to draft tender specification, evaluate tenders and make decision on preferred providers</p>

Part 1 Section 4: Suggested approaches for involving users in commissioning

	What you need to know – the strategic approach	Operational approaches you may consider using
Manage demand and ensure appropriate access to care	<ul style="list-style-type: none"> Ongoing monitoring 	<p>Get information</p> <ul style="list-style-type: none"> on patients' experiences, including those who are 'easy to overlook'
Managing performance (quality, performance, outcomes)	<ul style="list-style-type: none"> Outcome measures – clear plan in service level agreements (SLAs). Include expected: <ul style="list-style-type: none"> standards targets Need to be measurable and realistic 	<p>Participation</p> <p>Involve users in setting local standards</p> <p>Devise and introduce patient experience metrics into contracts</p> <p>Get information</p> <p>Use feedback from:</p> <ul style="list-style-type: none"> complaints PALS LINKs <p>Obtain feedback from stakeholders – including GPs, users, community groups, schools, colleges</p>
	<ul style="list-style-type: none"> Start process again Continuous, ongoing review 	

INVOLVEMENT IN PRACTICE-BASED COMMISSIONING

Practice-based commissioning (PbC) is a scheme through which GP practices voluntarily take on the management of the health and care budget for people registered at their practice. Those involved in PbC work closely with the PCT and front-line clinicians to design and commission a range of services that best meet the needs of their local practice population.

Practice-based commissioners can redesign existing services and develop new services. Although practice-based commissioners should be encouraged to actively involve their practice population when they are making plans to change the way services are delivered, they are not under an obligation under section 242(1B). That obligation remains with the PCT in this situation. One way in which the PCT can discharge the duty is by making arrangements for practice-based commissioners to undertake user involvement but the PCT must be satisfied that those arrangements meet their own obligation under section 242(1B).



Point to note

PCTs have responsibility for making sure that there is user involvement in service planning and development. Where practice-based commissioners are making decisions about services, the PCT will remain responsible for meeting the duty to involve users under section 242(1B).

Again, although there is no obligation on practice-based commissioners, it is good practice for them to provide opportunities for users to get involved in:

- identifying priorities for action;
- defining problems with existing pathways of care;
- developing solutions to those problems;
- monitoring the changes; and
- deciding how savings should be spent.

Patient participation groups (PPGs) are one way for practice-based commissioners to involve their local community. PPGs are not driven by a national agenda and evolve to meet local need. Their activities vary enormously, as do the needs of individual practice populations. Practices are rewarded financially if they discuss their action plan (based on the results of the patient experience surveys) with a patient group. The PPGs of practices that are members of a PbC consortium may collaborate to form a consultative forum for the PbC consortium.



Example

The West Norfolk Patient Partnership is a local group of PPGs that meet every six months to consider the needs of the local population. It makes sure that the user's perspective influences the plans and decisions made by the West Norfolk PbC Consortium.

PCTs are responsible for signing off PbC commissioning and business plans and need to make sure that:

- the collective plans for all practice-based commissioners are available for the overview and scrutiny committee and the public to scrutinise. The plans should be included in the PCT prospectus; and
- PbC commissioning and business plans demonstrate how users have been involved in the development, design or redesign of services and that processes are in place for involving users in monitoring the contract and evaluating the services.



Suggestions for GP practices

Invite patients to work with staff to select new doctors and clinical staff.

Establish a patient participation group or panel.

Where possible, work with community development workers.



Suggestions for PbC groups

Invite community development workers to join the group.

Link up patient participation groups to advise the PbC group.

Involve patients in:

- choosing priorities for investment and disinvestment;
- monitoring quality;
- identifying problem areas and success areas of service provision; and
- deciding on how to spend any savings.



Example

The implementation of an integrated community service for people with chronic obstructive airway disease is one of a number of major developments to reduce avoidable emergency admissions to hospital included in PbC plans in Somerset.

Somerset PCT engaged with key stakeholders and had a separate strategy for making sure people with chronic obstructive airway disease were fully engaged in the procurement procedure. It identified three work streams:

- patient involvement in the selection of the provider of the new service;
- patient involvement in the design of the new service; and
- ongoing patient involvement in the performance management and service improvement of the new service.

Patients and stakeholders were involved from an early stage in the planning process and played an integral role in evaluating tenders and identifying a preferred provider for the new services.

The selection of the provider of the new service was undertaken through a process of competitive tendering. Patient representatives from voluntary groups and the Somerset Patient and Public Involvement Forum were invited to be part of the tender evaluation panel. At the end of a briefing session, held to help people understand the tendering process and how they could make a valuable contribution, people were asked to consider whether they still wished to participate. Three people went on to work with the local GPs, external clinical experts and PCT managers to evaluate the tenders and make recommendations to the PCT board on which organisation should be awarded the three-year contract.

The results of the patient feedback exercise were used to inform the design and delivery of the new service and a service that meets the needs of patients has been commissioned. Patients will be actively involved in evaluating the new services and supporting ongoing performance management and service improvement.

Further advice and guidance for practice-based commissioners can be found in *Practice based commissioning: practical implementation*, Department of Health, 2006.

▶▶ PART 2

GUIDANCE ON SECTIONS 17A, 24A
AND 242B OF THE NHS ACT 2006,
INCLUDING GUIDANCE ON REPORTING
ON CONSULTATIONS AND INFORMATION
ABOUT SECTION 242A OF THE ACT



Point to note

Part 2 is not statutory guidance.

SECTION 17A – REPORTS ON CONSULTATION ABOUT COMMISSIONING DECISIONS



Point to note

In the following section, the blue text is taken directly from the Act. The explanations are in black.

Section 17A of the NHS Act 2006 states that “Each Strategic Health Authority must, at such times as the Secretary of State may direct, prepare a report – a) on the consultation it has carried out, or proposes to carry out, before making commissioning decisions, and b) on the influence that the results of consultation have on its commissioning decisions.”

What section 17A means for a strategic health authority

Section 17A requires a strategic health authority (SHA) to prepare reports on consultations it has carried out that relate to any commissioning decisions it has taken and consultations it is proposing to carry out, before it takes any commissioning decisions. The report should show how feedback from the consultations has influenced commissioning decisions.

‘Commissioning decisions’ in relation to an SHA are decisions relating to the purpose of securing, by arrangement with any person or organisation, the provision of services that are part of the NHS.

Only NHS London presently commissions healthcare services as it hosts the national commissioning of 40 very specialised services.

Directions from the Secretary of State specify the times at which the SHA must prepare a report, the periods the report should cover, the matters the report has to deal with, and the form, content and publication of those reports.

An SHA must also “...at such times as the Secretary of State may direct, prepare a report –

- a) on any relevant consultation carried out by the authority, and
- b) on the influence that the results of any relevant consultation have had...”

SECTION 24A – REPORTS ON CONSULTATION ABOUT COMMISSIONING DECISIONS

Section 24A of the NHS Act 2006 states that “Each Primary Care Trust must, at such times as the Secretary of State may direct, prepare a report – a) on the consultation carried out, or proposed to be carried out, before the making by the Primary Care Trust of commissioning decisions, and b) on the influence that the results of consultation have on its commissioning decisions.”

What section 24A means for a primary care trust

Section 24A requires a primary care trust (PCT) to prepare a report on any consultations carried out by any person, or proposed to be carried out by any person, before it makes commissioning decisions. The report must address the consultations carried out by any person and how that consultation has influenced the PCT’s commissioning decisions.

‘Commissioning decisions’ in relation to PCTs are decisions as to the carrying out of its functions under Parts 4–7 of the NHS Act 2006. Those parts of the Act deal with primary care services.

Directions from the Secretary of State specify the times at which the PCT must prepare a report, the periods the report should cover, the matters the report has to deal with, and the form, content and publication of those reports.

DIRECTIONS TO SHAs AND PCTs ABOUT REPORTS ON CONSULTATION IN RELATION TO COMMISSIONING DECISIONS

The times that both SHAs and PCTs have to report on consultation in relation to commissioning decisions and the content of those reports is set out in directions given by the Secretary of State. SHAs and PCTs must comply with those directions.

Directions to SHAs about reports on consultation in relation to commissioning decisions

Section 17A of the NHS Act 2006 requires the SHA to prepare a report that covers consultations it has carried out (looking back) or proposes to carry out (looking forward) before making commissioning decisions, and the influence that those consultations have had on those commissioning decisions.

The *Directions to Strategic Health Authorities about reports on Consultation with regard to Commissioning Decisions 2008* make provision about when the SHA must prepare reports and what the reports must cover.

The Directions only relate to reports on commissioning decisions which are decisions that relate to the purpose of securing, by arrangement with any person or organisation, the provision of services as part of the NHS.

The Directions provide detail about what the 'looking back' part of the report must cover which includes who was consulted, what they were consulted about and the results of the consultation.

The forward looking section of the report must cover who the SHA proposes to consult and what they propose to consult them about.

The first reports will cover the period from 1 April 2009 to 31 March 2010 and must be published between April and September 2010. Thereafter they will be prepared and published annually between 1 April and 30 September of each financial year.

The reports can be published in whatever way the SHA considers appropriate and may be included in any other document prepared by the SHA.

A copy of the report must be available for a period of at least one year from the date the report is published or until the next year's report is published, whichever is the longer period. A copy of the report must also be available:

- on the SHA's website; and
- for inspection at any office of the SHA.

Directions to PCTs about reports on consultation in relation to commissioning decisions

Section 24A of the NHS Act 2006 requires a PCT to prepare a report that covers consultations that it has carried out (looking back) or is proposing to carry out (looking forward) before making commissioning decisions, and the influence that those consultations have had on those commissioning decisions.

The *Directions to Primary Care Trusts about reports on Consultation with regard to Commissioning Decisions 2008* make provision about when the PCT must prepare reports and what the reports must cover.

The Directions relate only to reports in relation to commissioning decisions which are decisions as to the carrying out of the PCT's functions under Parts 4–7 of the NHS Act 2006. Those parts of the Act deal with primary care services.

The Directions also specify that PCTs must prepare a report on consultation about commissioning decisions relating to carrying out functions that are not covered by Parts 4–7 of the NHS Act. Those reports can be included in the reports on commissioning decisions made under section 24A.

Part 2 Directions to SHAs and PCTs about reports on consultation in relation to commissioning decisions

The Directions provide detail about what the looking back part of the report must cover which includes who was consulted, what they were consulted about and the results of the consultation.

The forward looking section of the report must cover who the PCT proposes to consult and what they propose to consult them about.

The first reports will cover the period from 1 April 2009 to 31 March 2010 and must be published between April and September 2010. Thereafter they will be prepared and published annually between 1 April and 30 September of each financial year.

The reports can be published in whatever way the PCT considers appropriate and may be included in any document prepared by the PCT.

A copy of the report must be available for a period of at least one year from the date the report is published or until the next year's report is published, whichever is the longer period. A copy of the report must also be available:

- on the PCT's website; and
- for inspection at any of the offices of the PCT.

INFORMATION ABOUT SECTION 242A

Section 242A of the NHS Act 2006 makes further provision about SHAs involving users.

Section 242A:

- imposes a duty on the Secretary of State to make regulations; and
- those regulations will impose a further duty on SHAs relating to the involvement of users.

This legislation is not yet in force. The Department of Health is currently working on implementing this legislation.

Section 242A places a duty on the Secretary of State to make regulations to require SHAs:

“to make arrangements which secure that health service users are, directly or through representatives, involved (whether by being consulted or provided with information, or in other ways) in prescribed matters.”

‘Users’ means the people to whom health services are being or may be provided in the area of the SHA.

Health service users may be involved directly or through representatives. ‘Representatives’ are the people who are in a position to speak on behalf of those users.

See part 1 section 3 page 60

The ‘prescribed matters’ to which the legislation refers will be set out in regulations. The regulations and guidance will reflect the outcome of the review of involvement and consultation that is taking place as part of the Next Stage Review.

SECTION 242B

Section 242B of the NHS Act 2006 gives the Secretary of State the power to make regulations that enable SHAs to direct PCTs in certain circumstances in relation to involvement activity.

The regulations made under this section are the National Health Service (Directions by Strategic Health Authorities to Primary Care Trusts Regarding Arrangements for Involvement) (No. 2) Regulations 2008. Those Regulations come into force on 3 November 2008.

The Regulations give SHAs the power to direct PCTs about the arrangements for involving users of health services that a PCT is required to make under section 242(1B) of the NHS Act 2006.

What the regulations under section 242B mean for SHAs and PCTs

A direction under these Regulations may only be given where the SHA:

- is of the view that involvement in relation to a particular matter may more appropriately be carried out by the SHA instead of the PCT; and
- will make arrangements to involve the same people that the PCT would have involved; and
- is satisfied that the arrangements made by the SHA would satisfy the duty placed on the PCT by section 242(1B).

If an SHA directs a PCT not to involve users or to stop an existing involvement exercise, the PCT would not be in breach of its section 242(1B) obligations provided that it complies with that direction.

If the SHA issues directions, those directions must:

- be in writing; and
- specify the matter to which the direction relates.

Directions can be given by the SHA to the PCT where the PCT has already begun involvement activity so the directions may also include:

- any aspects of the involvement activity that the PCT must complete;
- details of the arrangements that have to be made to end the involvement activity; and
- that the users who would have been involved by the PCT should be notified about the effect of the direction.

SHAs may also issue directions to PCTs to act jointly on an involvement activity.

Where the SHA issues directions to the PCT about a particular matter, the SHA and the PCT must provide relevant information to each other. The relevant information for an SHA to provide to a PCT is any information requested by the PCT that is relevant to the functions of the PCT and has been obtained by the SHA as a result of the involvement activity or is held by the SHA and related to the involvement activity.

The PCT must provide the SHA with information that is requested by the SHA and that the SHA reasonably requires to make arrangements for the involvement activity or the involvement activity itself.

▶▶ REFERENCES AND APPENDICES

Real involvement
Working with people
to improve health services
October 2008

REFERENCES, RESOURCES AND FURTHER READING

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Service Improvement: Quality Assurance of Major Changes to Service Provision, Sir Ian Carruthers' letter to David Nicholson, February 2007. Gateway Reference 7857

Social marketing works! A powerful and adaptable approach for achieving and sustaining positive behaviour. A short introduction for NHS staff. National Social Marketing Centre, December 2006

Substantial variations and developments of health services, Centre for Public Scrutiny, December 2005

User involvement in commissioning: report of scoping study for Macmillan Cancer Support, 2007

World class commissioning, Department of Health, December 2007

Resources

Staff Involvement – Better decisions, better care

Department of Health, 2003

This resource pack aims to help organisations promote and implement staff involvement through partnership working with staff and their representatives. It includes accompanying resource sections that offer frameworks of approach and working examples of staff involvement in the NHS, and gives access to further sources of support and reference material.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4071622

The Contact, Help, Advice and Information Network, CHAIN, is a network that enables people in health and social care to exchange ideas and knowledge, and facilitates networking between people who have a common interest. There are currently four main components of CHAIN and a number of cross-cutting thematic sub-groups and special interest groups which enable members from different components of the network to focus on areas of common interest. One of these is patient and public involvement.

A number of organisations support CHAIN. These include the National Institute for Health Research and the Institute for Innovation and Improvement.

CHAIN facilitators send out relevant information and help to find examples of how other organisations have approached involvement work. For example, a person wanted to know if anyone had experience of involving people with dementia in the development of services. A request sent to CHAIN members brought 15 varied and interesting responses.

CHAIN is free to join and use. To join CHAIN visit <http://chain.ulcc.ac.uk/chain/index.html>

APPENDIX 1

ACKNOWLEDGEMENTS

Membership of the Section 242 Reference Group included representatives from:

Birmingham East and North PCT	NHS South West
Bristol PCT	NHS West Midlands
Derby City PCT	NHS Yorkshire and the Humber
Dudley PCT	Walsall PCT
Gloucestershire PCT	West Essex PCT
NHS Norfolk	West Kent PCT
NHS North West	

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Brian Fisher, GP
David Gilbert, Project Director, Patient and Public Involvement, Croydon PCT
Richard Miles
Mike Waddington, South Essex Partnership University NHS Foundation Trust
Dr Charlotte Williamson, Picker Institute
The Centre for Public Scrutiny
Eastern and Coastal Kent PCT
Kent and Medway Cancer Network
Macmillan Cancer Support
NHS Alliance
NHS Centre for Involvement
NHS Confederation
NHS Institute for Innovation and Improvement
West Sussex PCT

APPENDIX 2

THE FIVE PLEDGES SET OUT IN LEADING LOCAL CHANGE, NHS NEXT STAGE REVIEW, MAY 2008

1. Change will always be to the benefit of patients.

This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety.

2. Change will be clinically driven.

We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.

3. All change will be locally-led.

Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions.

4. You will be involved.

The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.

5. You will see the difference first.

Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

APPENDIX 3

NHS WORLD CLASS

COMMISSIONING

COMPETENCIES

Engage with public and patients

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

Why do PCTs need this competency in order to become world class commissioners?

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.

What are the sub-components of this competency?

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

Process 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 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, organisations' 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 aspiration.

APPENDIX 4

SECTION 242 OF THE

NHS ACT 2006

UK Parliament Acts/N/NA-NG/National Health Service Act 2006 (2006 c 41)/Part 12 Public Involvement and Scrutiny/242 Public involvement and consultation*

Chapter 2 Public Involvement and Consultation

242 Public involvement and consultation

(1) This section applies to –

- (a) relevant English bodies, and
- (b) relevant Welsh bodies.

(1A) In this section –

“relevant English body” means –

- (a) a Strategic Health Authority,
- (b) a Primary Care Trust,
- (c) an NHS trust that is not a relevant Welsh body, or
- (d) an NHS foundation trust;

“relevant Welsh body” means an NHS trust all or most of whose hospitals, establishments and facilities are in Wales.

(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in –

- (a) the planning of the provision of those services,
- (b) the development and consideration of proposals for changes in the way those services are provided, and
- (c) decisions to be made by that body affecting the operation of those services.

(1C) Subsection (1B)(b) applies to a proposal only if implementation of the proposal would have an impact on –

- (a) the manner in which the services are delivered to users of those services, or
- (b) the range of health services available to those users.

*This legislation came into force on 3 November 2008.

(1D) Subsection (1B)(c) applies to a decision only if implementation of the decision (if made) would have an impact on –

- (a) the manner in which the services are delivered to users of those services, or
- (b) the range of health services available to those users.

(1E) The reference in each of subsections (1C)(a) and (1D)(a) to the delivery of services is to their delivery at the point when they are received by users.

(1F) For the purposes of subsections (1B) to (1E), a person is a “user” of any health services if the person is someone to whom those services are being or may be provided.

(1G) A relevant English body must have regard to any guidance given by the Secretary of State as to the discharge of the body’s duty under subsection (1B).

(1H) The guidance mentioned in subsection (1G) includes (in particular) –

- (a) guidance given by the Secretary of State as to when, or how often, involvement under arrangements under subsection (1B) is to be carried out;
- (b) guidance given by the Secretary of State as to the form to be taken by such involvement in any case specified by the guidance.

(2) Each relevant Welsh body must make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on –

- (a) the planning of the provision of those services,
- (b) the development and consideration of proposals for changes in the way those services are provided, and
- (c) decisions to be made by that body affecting the operation of those services.

(3) For the purposes of this section a body is responsible for health services –

- (a) if the body provides or will provide those services to individuals, or
- (b) if another person provides, or will provide, those services to individuals –
 - (i) at that body’s direction,
 - (ii) on its behalf, or
 - (iii) in accordance with an agreement or arrangements made by that body with that other person,

and references in this section to the provision of services include references to the provision of services jointly with another person.

(4) Subsection (5) applies to health services for which a Strategic Health Authority is not responsible by virtue of subsection (3), but which are or will be provided to individuals in the area of the Strategic Health Authority, and for which –

- (a) a Primary Care Trust any part of whose area falls within the Strategic Health Authority’s area, or
- (b) an NHS trust which provides services at or from a hospital or other establishment or fa-cility which falls within the Strategic Health Authority’s area,

is responsible by virtue of subsection (3).

(5) A Strategic Health Authority may give directions to Primary Care Trusts falling within paragraph (a) of subsection (4), and NHS trusts falling within paragraph (b) of that subsection, as to the arrangements which they are to make under this section in relation to health services to which this subsection applies.

APPENDIX 5 OTHER THINGS TO CONSIDER

1. Other legislation and guidance

When planning involvement activity there is other legislation and guidance that you need to be aware of. This includes the following:

Consulting overview and scrutiny committees

Section 7 of the Health and Social Care Act 2001 made provision for regulations that require SHAs, PCTs and NHS trusts to consult overview and scrutiny committees (OSCs) where they have under consideration any proposal for substantial development of the health services in the area of the local authority, or for a substantial variation in the provision of a service.

Section 7 is now section 244 of the NHS Act 2006 and the wording of the Act and the regulations remains the same.

The Disability Discrimination Act 1995 (as amended by the Disability Discrimination Act 2005)

places a general duty on public authorities when carrying out their functions to have due regard to:

- eliminate unlawful disability discrimination and harassment related to disabilities;
- promote equality of opportunity for disabled persons;
- take steps to take account of people's disabilities;
- promote positive attitudes towards disabled people; and
- encourage disabled people to participate in public life.

The Race Relations Act (RRA) 1976 (as amended by the Race Relations (Amendment) Act 2000)

makes it unlawful for a public authority exercising its functions to do anything which constitutes racial discrimination. It also places a general statutory duty on specified public authorities to have regard to the need to eliminate unlawful discrimination and promote equality of opportunity and good relations between different racial groups.

The Sex Discrimination Act 1975 (as amended by the Equality Act 2006)

makes it unlawful for a public authority exercising its functions to do anything which constitutes sex discrimination or harassment. It places a general duty on public authorities to have regard (when carrying out their functions) to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity between men and women.

The Cabinet Office Code of Practice on Consultation

is currently being revised following a review that included 'Effective Consultation'. The new code will form an important element of an overall approach to engagement. It will be accompanied by more and better guidance on reaching different sectors of society and the economy.

2. Taking a social marketing approach

When NHS organisations are developing and redesigning services, they may wish to consider using a social marketing approach. This is an adaptable approach that can be tailored to different contexts and timescales. In line with good planning and development it has some core stages:

- Scope
- Develop
- Implement
- Evaluate
- Follow-up.

The ultimate effectiveness and success of social marketing rests on whether it is possible to demonstrate direct impact on behaviour. It is this feature that sets it apart from other communication or awareness raising approaches, where the main focus is on highlighting information and helping people to understand it.

An important distinction between social marketing and commercial marketing is that social marketing is an interactive, partnership-based approach in which both parties – the NHS organisation and the local networks and groups through which they involve users – learn to change their behaviour.

The National Social Marketing Centre (NSMC) has produced an introductory leaflet for NHS staff, *Social marketing works! A powerful and adaptable approach for achieving and sustaining positive behaviour*. This leaflet helps to explain a social marketing approach and can be accessed at www.nsms.org.uk

On the same website there is a ten-point checklist for assessing social marketing programmes and the national benchmark criteria for social marketing.



Example

NHS Yorkshire and the Humber has a social marketing programme that is a national pilot commissioned by the Department of Health to examine how a more systematic and sustainable approach can be taken to delivering social marketing interventions.

There are ten projects in the NSMC-led programme, one of which is the Doncaster unplanned care project. The objective for this project is to reduce attendance at A&E of patients registered with those surgeries with the highest attendance figures. It aims to achieve this by understanding some of the patient and clinical behaviours that drive current usage patterns.

The use of urgent care services within Doncaster PCT is increasing year on year and although there have been improvements in the provision of unplanned care, an increasing number of patients are demanding more access to services provided by the NHS, using urgent or emergency services to fulfil this need.

A number of GP surgeries with particularly high A&E attendance have been identified and a pilot focus group for GPs and practice staff from one practice has been held, with another planned for patients.

Learning from these pilot groups will inform the process for the focus groups that will take place with the other practices. The insight gained will be used to inform the development of the required intervention. Early findings suggest that a mix of interventions is likely to be required.

3. Health needs assessments, health impact assessments, health equity audits and race equality impact assessments

Health needs assessments

A health needs assessment (HNA) is a method of reviewing the health needs and issues facing a given population. It helps organisations agree priorities and resource allocations that will improve health and reduce inequalities.

In recent years, national health policies have strengthened links between HNA and service commissioning. PCTs are responsible for assessing the health needs of their local community and preparing plans for health improvement.

Health impact assessments

The purpose of a health impact assessment (HIA) is to:

- identify the potential health consequences of a proposal on a given population; and
- maximise the positive health benefits and minimise potential adverse effects on health and inequalities.

The starting point for an HIA is a proposal (policy, programme, strategy, plan, project or other development) in the process of being developed. An HIA should be carried out during the planning process for early involvement activity. The main output is a set of evidence-based recommendations to inform the decision-making process for that proposal. The recommendations aim to highlight practical ways to enhance the positive aspects of the proposal, and to remove or minimise any negative impacts on health and inequalities.

NHS organisations should consider undertaking a health impact assessment for all proposals affecting health services. Although there is no statutory requirement to do this, their preparation and publication make sure that interested people can:

- understand why change is being proposed;
- understand how and to what extent proposed changes may impact on them;
- understand the estimated costs and benefits of proposed measures; and
- identify potential unintended consequences.

A health impact assessment should include a rigorous and robust examination of a proposal's potential impact upon each of the equality strands – ethnicity, disability and gender. It is good practice to consider other dimensions such as age, sexual orientation and religion or belief.

The Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005 require public authorities to publish a Disability Equality Scheme. The scheme has to include a statement of the public authority's methods for assessing the impact of its policies and practices, including proposed policies and practices, on equality for disabled people.

Health equity audits

The aim of a health equity audit is to identify how fairly services are distributed in relation to the health needs of different groups and areas. The overall aim is not to distribute resources equally but relative to health need. The process assists organisations' planning and decision-making processes and determines whether the distribution of health outcomes, healthcare or the determinants of health are inequitable or unrelated to need. The purpose is for health services to help narrow health inequalities by taking positive decisions on investment, service planning, commissioning and delivery.

Appendix 5: Other things to consider

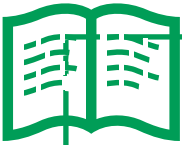
Documenting inequalities is common; what is less common is the clear targeting of services to identified needs, and reviewing the impact of interventions designed to reduce inequalities in health.

Equity is concerned with how fairly resources are distributed throughout a group of people according to population, not individual need. Audit is concerned with systematically understanding a situation and then identifying and taking action.

Race equality impact assessments

The purpose of a race equality impact assessment (REIA) is to work out how an organisation's policies or functions will affect people from different racial groups, pre-empting the possibility that the policy could affect some racial groups unfavourably. REIAs look at proposed policies as well as enabling the monitoring of policies once implemented.

An REIA may involve substantial participation by interested people. Organisations are required to consult on their findings and publish the results of impact assessments.



Suggested reading

Clarifying approaches to: health needs assessments, health impact assessment, integrated impact assessment, health equity audit, and race equality impact assessment, Health Development Agency, 2005
www.nice.org.uk:80/niceMedia/documents/clarifying_approaches.pdf

APPENDIX 6 AN EXAMPLE OF A ROLE AND PERSON SPECIFICATION FOR A USER REPRESENTATIVE

Kent and Medway Cancer Network: role and person specification for user representatives

1. Background

It is now fully recognised that the delivery of effective cancer services must be informed by the voices and experiences of patients who have had cancer or the carers of people with cancer. Disease Orientated Groups (DOGs) that relate to specific tumour sites (e.g. breast, colorectal, lung) have been established in each of the 30 Cancer Network areas in the UK. These are led by a medical consultant and include a range of NHS healthcare professionals who have specific expertise to bring to the process of improving services in the relevant cancer site. The role of the user representative is as a dedicated expert speaking on behalf of other patients and carers and feeding back issues from the DOG to members of the Partnership.

2. Role specification

The user representative attends and contributes to meetings of the DOG. The aim is for the work of the DOG to be informed and influenced by the views and experiences of patients and to make sure that decisions about service planning and the delivery of care are influenced by patients and carers and for them to participate on an equal basis in the work of the DOG.

The user representative will be the link between the members of the Partnership, the Network and DOGs.

Appendix 6: An example of a role and person specification for a user representative

3. Tenure of appointment and accountability

Nomination will be through the Kent and Medway Cancer Partnership [users and health professionals are members of cancer partnerships, and the partnerships work alongside cancer networks to provide mutual learning opportunities] or the Network Team and appointment will be for a period of **two years**. Accountability will be to the Kent and Medway Cancer Partnership, which the user member must attend regularly to give feedback from the site specific group and to gather views and information to take back to site specific group meetings.

4. Person specification

The user representative must:

- be a current or past cancer patient or a carer who has recent (in the last 5 years) experience of the specific tumour site;
- be objective and have a balanced approach, drawing on and using their own and others' experience to contribute to the specific group debates and decisions;
- be committed to working collaboratively with the DOG and with the Partnership for which they act as a two way channel of communication;
- be prepared to voice the opinions of the users they are representing as well as their own and to contribute to the multi-disciplinary debate in the site specific group;
- commit, as a minimum, to attend the regular meetings of the DOG and provide feedback to the partnership when asked to do so;
- be aware of the content of the guidelines and protocols for the site specific group and of any additional key documentation; and
- actively seek opportunities for developing his/her skills and knowledge in order to deliver the role effectively. (Undertake the Macmillan Cancer Voices Training.)

5. Financial support

The user representative is able to claim for legitimate expenses incurred in the role as detailed in K&MCN Policy for Payments Relating to User Involvement. These would normally be confined to travelling expenses (to meetings, conferences and events) and conference fees. Expenses are claimed through and authorised by the K&MCN Partnership Facilitator.

Notes for user representatives on making an effective contribution

Initially, new user representatives may feel the need to take a 'low profile' in DOG meetings until they start to understand the DOG's remit and priorities and who the key players are. The following sets out ways to make it easier to become actively involved in the meetings, rather than just being a passive presence:

- Ask for a list of the DOG membership, by name and job title, with a very brief description of the job role of each member.
- Arrange to meet with any other user representative(s) on the DOG before attending the first DOG meeting.

- Ask the DOG Chair to introduce you and all the other members at all meetings.
- Ask the DOG Chair to spend a short time with you before the meeting to explain anything you don't understand in the papers and seek any explanations or information you need during the meeting to help you to contribute.
- Obtain copies of the guidelines and protocols for the tumour site, and familiarise yourself with them as best you can.
- Read agendas and papers in advance of meetings so you can plan out any questions you may want to ask or comments you might wish to make.
- Recognise that, like all the healthcare professionals in the DOG, you are also an expert in your own right – an expert in the patient experience of the services they manage and provide.
- Remember that the 'dumb' question or the question that 'no one likes to ask' often makes people stop and re-focus on the basics.
- Liaise and work closely with any fellow user representative(s) on the DOG and seek opportunities to meet with user representatives on different DOGs or on same site DOGs in another Network area.
- Make sure that you keep the Partnership updated, copying them in on any relevant papers you receive as a DOG member.
- Never use the DOG to pursue your own agenda – there are other avenues for this. Try to make clear in all you say and do that you are there as an objective expert and a representative of many other patients and carers.

The Kent and Medway Cancer Network acknowledge the input of Avon, Somerset and Wiltshire Cancer Network User Involvement Group in the development of this specification.

APPENDIX 7 JOINT PLANNING PROCESSES THAT PRESENT OPPORTUNITIES FOR JOINT INVOLVEMENT ACTIVITY

Comprehensive Area Assessments (CAAs)

CAAs provide the first independent assessment of the prospects for local areas and the quality of life for people living there. They put the experience of citizens, people who use services and local taxpayers at the centre of a new local assessment framework, with a particular focus on those whose circumstances make them vulnerable.

CAAs cover issues like reducing inequalities in health and education, increasing the availability of affordable housing, reducing the fear of crime, improving educational achievement, attracting investment and reducing each area's carbon footprint. The focus varies from place to place depending on local priorities.

Joint Strategic Needs Assessments (JSNAs)

The Local Government and Public Involvement in Health Act 2007 placed a duty on upper tier local authorities and PCTs to undertake Joint Strategic Needs Assessments. This process identifies the current health and well-being needs of a local population, informs the priorities and targets set by Local Area Agreements (LAAs) and leads to agreed commissioning priorities that aim to improve outcomes and reduce health inequalities.

Local Strategic Partnerships (LSPs)

LSPs are non-statutory, multi-agency partnerships that usually match local authority boundaries. They bring together at a local level the different parts of the public, private, community and voluntary sectors, allowing different initiatives and services to support one another so that they can work together more effectively.

They provide the forum for collectively reviewing and steering public resources through identifying priorities in Sustainable Community Strategies and Local Area Agreements. As non-statutory bodies they are not the ultimate decision-makers on these plans. All target-setting and contractual commitments proposed by LSPs must be formalised through the relevant local authority, or through one of the other LSP partners.

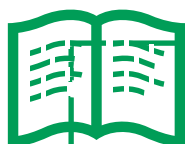
Sustainable Community Strategies

The purpose of a Sustainable Community Strategy is to set the overall strategic direction and long-term vision for the economic, social and environmental well-being of a local area, typically for 10–20 years, in a way that contributes to sustainable development in the UK. It tells the ‘story of the place’, the distinctive vision and ambition of the area, backed by clear evidence and analysis. The Local Government White Paper *Strong and prosperous communities* set out that the Sustainable Community Strategy must provide a “vehicle for considering and deciding how to address difficult cross-cutting issues such as the economic future of an area, social exclusion and climate change”.

Local Area Agreements (LAAs)

LAAs set out the ‘deal’ between central government and local authorities and their partners to improve services and the quality of life for local people. As such the LAA is a shorter-term delivery mechanism for the Sustainable Community Strategy, agreed by all members of the LSP. The Sustainable Community Strategy provides the story of the local area and should therefore articulate the longer-term ambition, evidence and rationale beyond the focus of a three-year LAA.

PCTs, NHS trusts and NHS foundation trusts have a duty to co-operate and must be involved in helping to determine any target in the draft LAA which will relate to it and in doing so must co-operate with the responsible local authority (section 106(3)(a) of the Local Government and Public Involvement in Health Act 2007). Following agreement of the LAA local authorities and partner authorities are required to ‘have regard’ to all those targets they have signed up to in the LAA.



Suggested reading

Further information is provided in statutory guidance *Creating Strong, Safe and Prosperous Communities*, Department for Communities and Local Government, 2008

APPENDIX 8

A SUGGESTED OUTLINE FOR A CONSULTATION DOCUMENT ON A MAJOR CHANGE

Foreword – signed by lead clinician, chair and chief executive

Summary

1. Why change – the story so far

- Potted history of policy changes in the NHS to illustrate how the NHS has continuously evolved since it was established in 1948
- National initiatives influencing change, including Our Health, Our Care, Our Say, health reform programme and the European Working Time Directive (EWTD)
- Making the best use of local resources, value for money for the taxpayer
- The main messages – change is an essential part of service improvement

2. What this means for local services – the vision

- How the vision was developed – what local people have told you they want from local services
- Clinically sustainable in terms of safety, clinical governance, training and catchment areas
- Financially sustainable
- Deliverable – what this would mean for the way services are provided locally, how staffing would meet the EWTD requirements, any substantive planning constraints
- What this means for the way our staff would work
- The main messages – the benefits to clinicians and users of providing services in this way

Appendix 8: A suggested outline for a consultation document on a major change

3. The proposals/model/options we are consulting on
 - How the views of local people influenced the development of the proposals – what we heard, how we have responded
 - The proposal/model/options
 - What this would mean for you – where you live
 - The main messages

4. About this consultation
 - How to get more information
 - How to have your say
 - Questions – what do you need to know from local people in order to make robust decisions?
 - The main messages – what is most important for your organisation

5. What will happen after the consultation
 - How decisions will be made
 - The main messages – open, honest, transparent

6. Appendices – supporting papers, national policies and any other relevant, useful information



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