

**APEX Guide on Public
and Patient Engagement**
Attaining World Class Competency
in Practice-Based Commissioning



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World Class Commissioning

The notion of a health (and not just 'healthcare') provider market is becoming more widely understood and accepted within the NHS. The development of a health provider market means that PCTs have to commission using a much wider collection of tools and competencies than before. Recent NHS reforms have focused on the provider 'supply' side of the NHS market, and also on the payment and regulatory aspects that 'bind' the commissioner and provider. Although some aspects of the 'demand side' of the market have been the focus of reform, there had been no fundamental examination of the capability of commissioners to operate to a 'world class' standard, prior to the introduction of the WCC framework. This is therefore possibly the first comprehensive initiative of its kind in any advanced healthcare system.

In 2007 the Department of Health therefore announced that it wanted the NHS to dramatically change the way in which it commissioned services so that commissioning would 'add life to years and years to life' and would focus on achieving 'better health for all, better care for all and better value for all'. The way in which this would be achieved focused both on how commissioning was undertaken and the competencies needed to do it, along with how well the organisations with responsibilities for commissioning – the PCTs, through their Board and their organisations – demonstrated their commissioning expertise. In autumn 2008, each of the 10 SHAs undertook an assurance process to measure their PCTs against the 11 competencies that describe a high standard for commissioning and against three fundamental aspects of effective organisations – strategy, governance and finance. The aspiration is that each PCT improves year-on-year, and aims for a 'world class' standard (i.e. 'level 4') of commissioning. It is not expected that PCTs will become 'world class' overnight: this journey will take 3–5 years.

PBC is an integral part of the PCT's overall commissioning processes and is therefore fundamentally important in relation to world class commissioning. If a PCT is to become world class, it follows that it needs to ensure that its practice-based commissioners are contributing to this journey, with their commissioning activities becoming increasingly better developed. Within a world class commissioned NHS, the overriding challenge over the next few years will be how those working in the NHS respond to, and make critical resource decisions within, a fundamentally different and challenged financial position, as the impact of the recession 'bites' within the NHS. Commissioners (PCTs with their practice-based commissioners) will have to make tough decisions about decommissioning as well as commissioning – bringing cost, quality and a focus on outcomes together. PBC – as a vehicle by which this happens, with clinician commissioners working with their PCT commissioners – is going to be fundamental to this process.

APEX – background

APEX – the Alliance for PBC Excellence – is a joint initiative between the NHS Alliance and Novartis Pharmaceuticals UK. APEX is a practical, collaborative network, driving best practice and catalysing positive change for patients through practice-based commissioning (PBC). The APEX membership comprises a multidisciplinary group of PBC leaders who are representative of all SHAs, and includes local PBC Group Chairs, SHA Commissioning Heads, and PCT Chief Executives. The NHS Alliance has been very active in supporting PBC, including a number of initiatives within the Department of Health's PBC Development Framework and this has provided key information about what needs to be in place to enable PBC to flourish and play its part within a World Class Commissioned NHS (see reference section for more information).

The APEX series of guides

This is one of a series of guides that are intended for use as tools to help PBC leaders tackle the competencies of the World Class Commissioning (WCC) Framework. The Framework includes 11 competencies in all, and each of these is divided into three elements that can be measured from levels 1 to 4, with the highest level (4) being indicative of 'world class'.¹

This guide (No.4 in the series) focuses on the 3rd competency – public and patient engagement – and was developed by APEX through telephone research, Focus Group meeting discussions and subsequent authorship by the following principal contributors:

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Defining 'Public and Patient Engagement' (WCC Competency 3)

The DH definition of WCC 3 is: *'Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health':*

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

There are three discrete elements of this competency and local health communities are assessed against each. The criteria that characterise the highest level of competency (level 4) are shown below.

Elements	Criteria for Competency Level 4
A Influence on local health opinions and aspirations	<ul style="list-style-type: none"> The PBC consortium has proactively shaped the health opinions and aspirations of the local population
B Public and patient engagement	<ul style="list-style-type: none"> PBC 'has successfully deployed innovative approaches to engagement which (i) have been shared (ii) have led to high levels of engagement with hard-to-reach groups and (iii) accessed non-traditional partners, e.g. criminal justice system' PBC 'can demonstrate how proactive engagement and partnership arrangements with the local community including LINKs [Local Involvement Networks] is embedded in all commissioning processes and drives decision making' The PBC consortium 'demonstrates that they know the impact of their involvement and engagement' and can demonstrate improvements resulting from it 'The local population strongly agrees that the local NHS listens to the views of local people and acts in their interest'
C Delivery of patient satisfaction	<ul style="list-style-type: none"> The PBC consortium 'demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions'

Initially, it will be helpful for PBC groups to ask local people for their views on priorities and proposals that the PBC group would like to develop. However, a more complete process would be a more or less continuous dialogue with local people who would be an integral part of the priority setting and development with the professionals.

Note the important distinction between recording patient 'experience' and patient 'satisfaction' data (Element C in the table). The first records what actually happened to patients and the second records how patients currently or subsequently feel about the service they received, in light of their experiences.

If a health community is operating at the highest level of competency what does it look like?

- Overall, it will be clear (and recognised by all parties) that local people have significantly influenced the work and outcomes of the PBC process
- The PBC consortia and the PCT as a whole will see that responsiveness to their local population is an essential part of being an effective NHS organisation
- Local people will be key partners in:
 - setting the agenda for priorities and development for the PBC consortia overall
 - defining problems in pathways of care
 - helping define and design solutions to these problems, using their expertise
 - monitoring the effectiveness and acceptability of the solutions
 - decision making on how to spend savings
- There will be a clear organisational pathway through which the views and recommendations of local people can be transmitted clearly to the PBC consortia
- There is effective ongoing dialogue between the PBC consortia and the populations they serve; this includes poorly served groups, such as migrants and others who have greatest difficulty in accessing appropriate services

How to use this APEX Guide on Public and Patient Engagement

Who should use this guide?

This guide is intended to support members of PBC groups or practices, clinicians and managers, in both describing what a world-class standard of public and patient involvement (PPI) could look like, as well as offering concrete suggestions for reaching this level. World class commissioning was initially designed for PCTs, but as commissioning will increasingly devolve to practices, PBC will need support in rising to the challenge.

How to use this guide

Firstly, use the simple baseline self-assessment checklist opposite to assess, *in general terms*, 'where you are now', in relation to your access to the resources and skills needed for this competency.

If your answer to any of the checklist questions is 'No', then read on, as this guide is intended to help you understand why the answers should be 'Yes' in each case, and what you might be able to do to influence some local changes.

Each of the three elements of this competency are considered in turn: for each, we have set out to describe what it means to achieve a high level of competency in practical terms, and information is cross referenced, where appropriate, to 'real-world' examples that illustrate situations or case studies that are representative of best practice or the high standard of competency expected.

Refer to the three main checklists in turn and work through the steps described, * which will help you recognise:

- how to establish where you are now, in relation to a high level of competency (level 4)
- what you need to do to improve your competency position
- what challenges or obstacles you might expect to face (or be already encountering) and how you might approach and resolve them
- what a high standard of competency 'looks like' – i.e. what kind of indicators or markers you can use for assurance that you have reached level 4

***The stepwise process for working through the three main checklists is described in detail for each of the three elements (pages 8, 12 and 18)**

	BASELINE SELF-ASSESSMENT	Yes	No
Q	Can you demonstrate that local people are an integral part of: <ul style="list-style-type: none"> ◦ setting the agenda for priorities and development for the PBC consortia overall? ◦ defining problems in pathways of care? ◦ helping define and design solutions to those problems, using their expertise? ◦ monitoring the effectiveness and acceptability of the solutions? ◦ decisions on how to spend savings? 	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have a clear organisational pathway through which the views and recommendations of local people can be transmitted clearly to the PBC consortia?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have a public and patient involvement (PPI) strategy and a communications strategy for your PBC consortium?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have a policy on how local people and local organisations can get involved with your committees or decision-making processes? (which would outline arrangements for support, expenses etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Q	Are you in contact with your local LINKs (Local Involvement Network)?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you know of any community development workers locally, either funded by the PCT or the local authority?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you know where all your Patient Participation Groups (PPGs) are, and do you have a plan for supporting new and existing PPGs?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have a means of identifying local people who might want to help the PBC consortium?	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have an approach that separates out involvement at both an individual and a collective level? <ul style="list-style-type: none"> ◦ 'Individual' means at the level of the consultation: involvement here means supporting patients in sharing decision making about the management of their own conditions. Intervention here might involve making available decision aids and online access for patients to their GP records ◦ 'Collective' means an approach that enables local communities, both of geography and interest, to become part of the commissioning process 	<input type="checkbox"/>	<input type="checkbox"/>
Q	Do you have a database that can accept and analyse comments, recommendations and feedback from staff and patients?	<input type="checkbox"/>	<input type="checkbox"/>

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What your next plan of action should be

Overall

- Make a list of priorities to decide which elements you need to work on most, using the results of your baseline self-assessment and after working through the checklists
- Decide how you will tackle the gaps and what you need to do to put things right
- Decide how and when you will monitor your progress
- Check back to your baseline assessment and the 'Markers of progress' columns for each element on a regular basis

Organisational development

- Write a PPI strategy* and a communications strategy for your PBC consortium
- Develop a policy on how local people and local organisations can get involved with your committees or decision-making processes. This would outline arrangements for support, expenses, for instance
- Consider using software such as Microsoft Access® to develop a database:
 - Contact Lewisham LINKs (www.lewishamlink.org.uk) for an example

Practical development at the individual level

- Start to investigate:
 - Decision aids (Cochrane database) (www.cochrane.org)
 - Access for patients to their GP records online, via EMIS (Egton Medical Information Systems Limited) (www.emis-online.com) and RAC (Record Access Collaborative) (www.record-access-collaborative.org)

Practical development at the collective level

- Begin with a particular pathway that the PBC consortium is keen to improve; firstly identify local patients who can contribute to the redesign, possibly through LINK or other means; secondly begin to work through the processes for:
 - defining problems in pathways of care
 - helping define and design solutions to those problems, using the expertise of LINK
 - monitoring the effectiveness and acceptability of the solutions
- Get in contact with your local LINKs via the National Association of LINK Members (NALM) (www.networks.nhs.uk/networks/page1177)
- Identify community development workers locally, either funded by the PCT or the local authority via the Community Development Exchange (CDX) website (www.cdx.org.uk)
- Identify where all your PPGs are, then develop:
 - with the National Association of Patient Participation (NAPP), a plan for supporting new and existing PPGs (www.napp.org.uk)
 - a means of identifying local people who might want to help the PBC group (it might be best to do this in relation to a specific piece of work, such as redeveloping a musculoskeletal pathway)

*See **EXAMPLE 1** (Appendix)



ELEMENT (A) INFLUENCE ON LOCAL HEALTH OPINIONS AND ASPIRATIONS

What characterises this element?

PBC has a responsibility to communicate well with its local population, to inform about local health issues, to support positive health behaviours and self-care, and to keep health high on people's agendas. Furthermore, it is incumbent on the PCT and PBC to jointly and proactively collect information on the perceived, expressed and unmet needs of patients – a process that ensures that local opinion on health is first fully understood and taken on board, before any influence or 'shaping' of such opinion is brought to bear. Shaping health opinions requires trust, honesty and confidence, and this communication process underpins the trust that the local population will have in the NHS. The clearer we are about what is important – and that we are willing to discuss and share information and responsibility in an adult way – the more swiftly and effectively will change and improvements occur.

The role for PBC is therefore to explore the health opinions of public and patients and 'co-produce' with the PCT an agreed, mutual vision for health that is fully appropriate for the local population. Similarly, in the light of recent and projected future financial constraints on the NHS, and the corresponding difficult commissioning / decommissioning decisions that will inevitably result, it will be vital (as well as a legal requirement) to ensure that local opinion has been incorporated into the decision-making process. There will inevitably be trade-offs to be made which will be contentious and may even invite legal challenge – so it is crucial that commissioners demonstrate they have engaged the public in making these difficult decisions.

How to strive for world class competency in influencing local health opinions and aspirations

Step 1 – Assess your general position

There is one principal descriptor for this element, shown below. For this descriptor, ask yourself the associated questions, which will tell you, *in general terms*, your current position, in terms of this competency:

The PBC consortium 'has actively shaped the health opinions and aspirations of the local population'

- | | |
|---|--|
| Q | Is expertise available in health promotion, marketing and public health, including support from the Public Health (PH) Department of the PCT? |
| Q | Is there engagement of the local population through dialogue, with information going to and coming from PPGs and other local groups with an interest in improving health and wellbeing? |
| Q | Is the population informed about improvements to local health systems that have been achieved? |
| Q | Are you using all of the various means of communication available, including websites, community radio, email, parish council newsletters, local newspapers, PPG newsletters and social networking opportunities? |
| Q | Are your communications genuinely engaging and not patronising, with room for disagreement and offering a voice to users and carers themselves? – communications should not be merely a vehicle to convey or justify unpopular decisions |

Step 2 – Address shortcomings/deficiencies

Refer to [Checklist 1](#) and, under the first column, headed 'Challenges and obstacles', ask yourself whether any of the scenarios/situations depicted apply in your case, which will tell you the areas and issues that you may need to address in order to advance, in terms of this competency.

Step 3 – Assess your progress

Refer to [Checklist 1](#) and, in the middle column headed 'Markers of progress', ask yourself each of the associated questions listed, which will tell you whether you are advancing, in terms of your progress toward higher competency.

Step 4 – Recognise what 'level 4' looks like

Finally, referring to the last column in [Checklist 1](#) (headed 'High-competency standard'), familiarise yourself with the scenarios shown that typify the 'world class' standard expected and which will indicate whether you have reached this level of competency in each case.



CHECKLIST 1: ELEMENT (A) – INFLUENCES ON LOCAL HEALTH OPINIONS AND ASPIRATIONS

THE PBC CONSORTIUM 'HAS PROACTIVELY SHAPED THE HEALTH OPINIONS AND ASPIRATIONS OF THE LOCAL POPULATION'		
CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD
<ul style="list-style-type: none"> • Communications budgets tend to sit with the PCT 	<ul style="list-style-type: none"> • Are the PCT and PBC consortia working together to improve communications? 	<ul style="list-style-type: none"> • PCT and PBC consortia have agreed dedicated communications resources
<ul style="list-style-type: none"> • PBC consortium and PCT views may be at variance, making it impossible for them to agree on a mutual vision of the local population's health needs and aspirations 	<ul style="list-style-type: none"> • Do the PCT and PBC consortia have agreed priorities for joint messages? 	<ul style="list-style-type: none"> • High levels of understanding among the local population of the jointly agreed messages
<ul style="list-style-type: none"> • Local population may resist attempts to shape their opinions and aspirations and regard them as patronising or lacking in honesty 	<ul style="list-style-type: none"> • Is there an increasing level of trust in the commissioning process? • Is influencing the local population nuanced by listening to issues raised by local people? (For instance, weight loss may need to precede smoking cessation) 	<ul style="list-style-type: none"> • PBC has systems in place to communicate to, and receive feedback from, the local population • Local people play an active part in determining the 'shaping' messages
<ul style="list-style-type: none"> • Traditional media routes often prefer negative or controversial stories 	<ul style="list-style-type: none"> • Does the PBC consortium have a clear strategy to communicate, using a wide variety of techniques? 	<ul style="list-style-type: none"> • The PBC consortium conveys and receives messages using networks developed locally, such as village or parish newsletters, social networking, email, radio, dedicated health promotion events, PPG/practice newsletters and websites etc.
<ul style="list-style-type: none"> • Public Health (PH) may be too busy to help 	<ul style="list-style-type: none"> • Are you in touch with PH to identify key health messages for your local population? 	<ul style="list-style-type: none"> • PH are supportive of all initiatives and willing / able to provide the necessary support and expertise where required





ELEMENT (B) PUBLIC AND PATIENT ENGAGEMENT

What characterises this element?

This element is the core competency of PPI. It can be difficult to reach the highest competency level and a range of approaches are needed. The most likely single approach to meet the need is community development, as it offers flexibility, penetration and the ability to create a dialogue between PBC and its population.

Another powerful approach is to support the development and initiation of PPGs across the area, offering feedback and involvement for practices. In addition, if PPGs join together they can be a potent force to influence commissioning. Other approaches include that taken by Principia (www.nottinghamprincipia.nhs.uk), which offers comprehensive patient involvement in commissioning in their locality.

It should be recognised that there is a strong and often unappreciated emotional and psychological aspect to PPI. It involves exposing staff and the organisation as a whole to scrutiny and direct feedback. In order to use this feedback effectively, and not to be upset or defensive about any criticism, the organisation needs to be confident in itself and the staff need to have confidence in their organisation and the NHS.

Successful engagement has many benefits:

- The PBC consortia and the PCT as a whole will see that responsiveness to their local population is an essential part of being an effective NHS organisation
- Local people are engaged at all stages of the commissioning processes and actively involved in identifying problems and their associated solutions
- The LINK, PPGs and other community groups feel a growing sense of ownership of the commissioning process
- Individuals are more actively involved in looking after their own health and more opportunities are seized to secure feedback on services and their development (e.g. at health promotion events, flu clinics, community fairs, workplaces, etc.)
- Networking mechanisms that are established allow all sections of the community to influence commissioning decisions

How to strive for world class competency in public and patient engagement

Step 1 – Assess your general position

There are four principal descriptors for this element, shown below. For these descriptors, ask yourself the associated questions under each that will tell you, *in general terms*, your current position, in terms of this competency:

(1) PBC 'has successfully deployed innovative approaches to engagement which (i) have been shared (ii) have led to high levels of engagement with hard-to-reach groups and (iii) accessed non-traditional partners, e.g. criminal justice system'

- Q Is the development of social networks seen as a priority activity for PBC?
- Q Does engagement occur over a wide arena and at every potential opportunity? – e.g. at local schools, workplaces, flu clinics, local assemblies and via community outreach groups?
- Q Is it acknowledged that 'hard-to-reach' groups should preferably be regarded as 'easily overlooked', and that most groups can be reached if a suitable approach is used?
- Q Is it similarly acknowledged that some people may feel that they are not 'worthy' to participate in the engagement process?

(2) PBC 'can demonstrate how proactive engagement and partnership arrangements with the local community including LINKs is embedded in all commissioning processes and drives decision making'

- Q Are local people involved in the review and approval of business plans and in the regular review of all aspects of engagement activities?
- Q Are governance structures in place that require public and patient engagement at all levels of the PBC consortium?
- Q Has a clearly and mutually understood protocol been established to cover both the relationship of PBC with the PCT and the partnership arrangements with LINKs?
- Q Is all feedback from various sources being collected and collated?

Step 2 – Address shortcomings/deficiencies

Refer to [Checklist 2](#) and, under the first column, headed 'Challenges and obstacles', ask yourself whether any of the scenarios/situations depicted apply in your case, which will tell you the areas and issues that you may need to address in order to advance, in terms of this competency.

(3) The PBC consortium 'demonstrates that they know the impact of their involvement and engagement' and can demonstrate improvements resulting from it

- Q Are there systems in place for collecting, recording and analysing feedback from the local population on local health activities, services etc., using simple quantitative measures – e.g. numbers of complaints; people's responses when asked whether they approve of an innovation, or have perceived an improvement as a result of it; numbers of people / new people currently engaged in projects and numbers who have continued to be involved?
- Q Are there systems in place also for other means of outcome / performance measurement and to check whether the process has resulted in the desired outcomes – e.g. audit trails, meeting minutes; 'before and after' assessment by stakeholders; SMART (specific, measurable, achievable, relevant, timely) objectives?

(4) 'The local population strongly agrees that the local NHS listens to the views of local people and acts in their interest'

- Q Is it acknowledged that there is a collective responsibility for all staff to ensure that the views of public / patients are always noted and fed back on all possible occasions?
- Q In instances where there seem to be profound disagreement between the local NHS and the population, are efforts focused on building up trust over time through communication to ensure that people can see others' points of view and remain on a politically even keel?.
- Q Is there confidence that the PBC consortium or the PCT, after listening to public and patients' views, can justify and demonstrate that their decisions are in the interests of the local population, even where this may not appear to be in line with these views?

Step 3 – Assess your progress

Refer to [Checklist 2](#) and, in the middle column headed 'Markers of progress', ask yourself each of the associated questions listed, which will tell you whether you are advancing, in terms of your progress toward attaining higher competency.

Step 4 – Recognise what 'world class' looks like

Finally, referring to the last column in [Checklist 2](#) (headed 'High-competency standard'), familiarise yourself with the scenarios listed that typify the 'world class' standard expected and which will indicate whether you have reached this level of competency in each case. (Refer also to the case studies in the Appendix).

CHECKLIST 2: ELEMENT (B) – PUBLIC AND PATIENT ENGAGEMENT

(1) PBC 'HAS SUCCESSFULLY DEPLOYED INNOVATIVE APPROACHES TO ENGAGEMENT WHICH (I) HAVE BEEN SHARED (II) HAVE LED TO HIGH LEVELS OF ENGAGEMENT WITH HARD-TO-REACH GROUPS AND (III) ACCESSED NON-TRADITIONAL PARTNERS, E.G. CRIMINAL JUSTICE SYSTEM'

* See **EXAMPLE 2** (Appendix)

CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD*
<ul style="list-style-type: none"> Innovative approaches are likely to involve costs with benefits that are not fully understood 	<ul style="list-style-type: none"> Has a strategy been agreed that commits the PBC consortium to apply community development techniques in line with NICE guidance? 	<ul style="list-style-type: none"> Community development structures are in place, including mapping of all relevant local organisations and flexible outreach; the process will ask questions derived by the health professionals and identify new issues raised by local people
<ul style="list-style-type: none"> Engagement opportunities are not always recognised and exploited 	<ul style="list-style-type: none"> Is an engagement strategy in place that shows how existing local groups will contribute to commissioning decisions and how PBC consortia can make use of expertise within the system? Is record access and shared decision making routinely available for patients? 	<ul style="list-style-type: none"> The PBC consortium will be actively engaged with the Local Involvement Network, PPGs, carers' organisations and other key voluntary bodies; will make use of health promotion contacts; and will collaborate with others, including local strategic partners
<ul style="list-style-type: none"> Language of hard-to-reach groups has proved misleading and needs demystifying 	<ul style="list-style-type: none"> Does the PBC consortium understand how to engage with communities where greatest health gains can be expected? 	<ul style="list-style-type: none"> PBC works with existing community groups, going to pubs, cafes, workplaces, faith-based organisations, day centres, etc. to share and learn
<ul style="list-style-type: none"> Joint strategic working can seem remote and disconnected to PBC consortia but is essential to accessing the 'non-traditional' partners 	<ul style="list-style-type: none"> Does the PBC Board have an agreed approach to working with partners in order to commission services more appropriately? 	<ul style="list-style-type: none"> The PBC consortium is able to describe and evidence its work with non-traditional partners and to identify the resulting health / efficiency gains
<ul style="list-style-type: none"> Development of social networks is not seen as a priority for PBC activity 	<ul style="list-style-type: none"> Has the PBC Board discussed the health benefits of social networking and allocated resources accordingly? 	<ul style="list-style-type: none"> Local social networks have been encouraged and, where necessary, commissioned by the PBC consortium. PPGs are networked across the PBC area and supported to play a more active role in commissioning decisions
<ul style="list-style-type: none"> Decisions too often seem to be made in a 'top-down' fashion 	<ul style="list-style-type: none"> Has an audit trail been developed of changes and decisions that were instigated as a result of the views of local people and groups? 	<ul style="list-style-type: none"> Participatory budgeting has been introduced whereby local people are given control of a proportion of the commissioning budget to meet agreed objectives

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(2) PBC 'CAN DEMONSTRATE HOW PROACTIVE ENGAGEMENT AND PARTNERSHIP ARRANGEMENTS WITH THE LOCAL COMMUNITY INCLUDING LINKS IS EMBEDDED IN ALL COMMISSIONING PROCESSES AND DRIVES DECISION MAKING'

* See **EXAMPLE 3 (Appendix)**

CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD
<ul style="list-style-type: none"> Integration of LINKs is problematic: since it is also meant to perform a scrutiny function, conflicts of interest may result 	<ul style="list-style-type: none"> Does PBC have a strategy for engaging with the local population, including a protocol to cover its relationships with LINKs? 	<ul style="list-style-type: none"> LINKs are kept fully briefed on the commissioning plans and activities and are able to influence these, as is the wider community; an annual report is made public, describing future engagement opportunities and the consortium keeps the public informed through a website
<ul style="list-style-type: none"> Not every practice has a PPG and some are not designed to engage in wider commissioning work 	<ul style="list-style-type: none"> Does every practice have a PPG? Does PBC have a strategy to work with existing PPGs and to capture the views of patients in practices that don't have such groups? 	<ul style="list-style-type: none"> PPGs have a relationship with their PBC consortium and feel supported and engaged in this work, including provision of information and training opportunities Business plans are signed off by local people, either through LINKs or other relevant and appropriate organisations
<ul style="list-style-type: none"> Involving patients and the public is seen as cumbersome, time-consuming and likely to attract people with their own agendas 	<ul style="list-style-type: none"> Are there training programmes across the PBC to raise awareness of the benefits of greater patient and public engagement? 	<ul style="list-style-type: none"> Lay voice is represented in all areas of PBC decision making, ideally with a powerful voice at Board level
<ul style="list-style-type: none"> Engagement is too often seen as tokenistic and lacking in meaning 	<ul style="list-style-type: none"> Are local people invited to advise on how the engagement exercise should work? 	<ul style="list-style-type: none"> Engagement work is reviewed annually in a process that is led by independent local people All business plans have to be signed off / approved by an independent lay body
<ul style="list-style-type: none"> Driving the whole process from enquiry to contracting is too complex for PBC and engagement will raise issues that PBC cannot address 	<ul style="list-style-type: none"> Are there clearly agreed parameters for engagement work, making clear what can be influenced? 	<ul style="list-style-type: none"> PBC takes a view of improving quality, as seen by local people, and works with the PCT to ensure that providers respond to the views expressed
<ul style="list-style-type: none"> A considerable amount of feedback is not currently being captured 	<ul style="list-style-type: none"> Has the PBC Board agreed on the range of mechanisms that should inform their work? 	<ul style="list-style-type: none"> PBC makes use of complaints data, Patient Advice and Liaison Service (PALS), Care Quality Commission, clinical governance expertise, surveys, etc. when developing commissioning intentions
<ul style="list-style-type: none"> Lines of responsibility between PCT and PBC are not always clear, with respect to engagement 	<ul style="list-style-type: none"> Is there a clear accountability agreement between PCT and PBC consortia? 	<ul style="list-style-type: none"> PBC complies with the accountability arrangement and its changes are made explicit
<ul style="list-style-type: none"> PBC is not seen as relevant by local communities 	<ul style="list-style-type: none"> Does the PBC consortium address the issue and agree how it will ensure active engagement? 	<ul style="list-style-type: none"> A membership scheme – or at least a sophisticated contacts database – is in place, as a means of securing an ongoing relationship

continued

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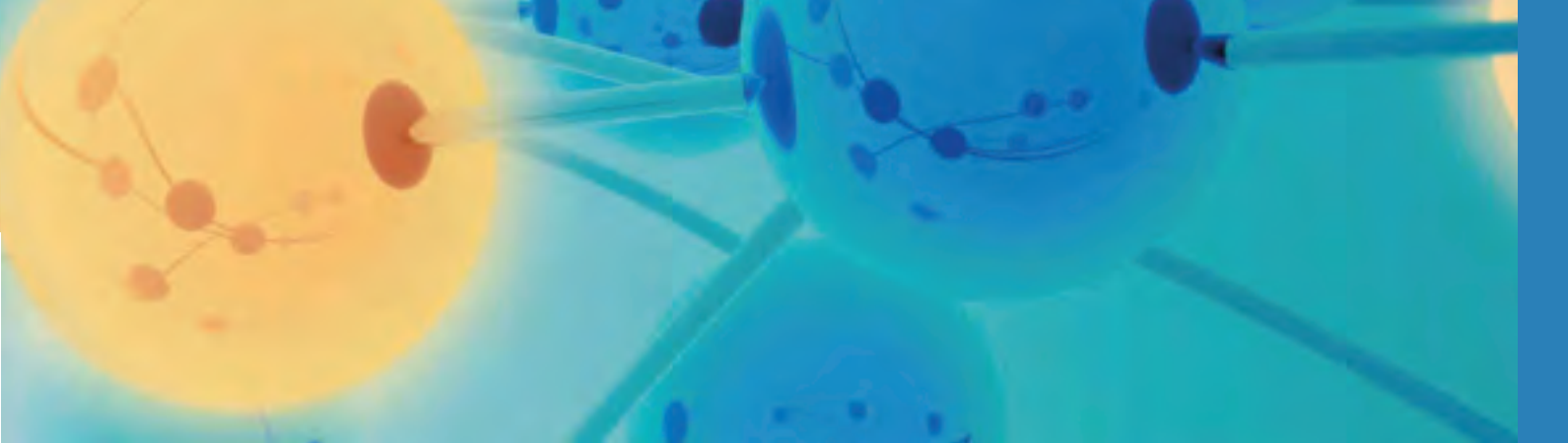
(3) THE PBC CONSORTIUM 'DEMONSTRATES THAT THEY KNOW THE IMPACT OF THEIR INVOLVEMENT AND ENGAGEMENT AND CAN DEMONSTRATE IMPROVEMENTS RESULTING FROM IT'

CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD
<ul style="list-style-type: none"> Some of the easiest ways to measure engagement may not reflect its true impact 	<ul style="list-style-type: none"> Despite the apparent obstacles, have PBC consortia begun to log the volume of involvement using quantitative methods? 	<ul style="list-style-type: none"> The PBC consortium knows how many people: <ul style="list-style-type: none"> – they have engaged with – are 'new' – are involved on an ongoing basis – are offering feedback – are satisfied with the handling of their complaints etc.
<ul style="list-style-type: none"> Some of the more promising forms of engagement can be more labour intensive 	<ul style="list-style-type: none"> Has the PBC Board demonstrated a commitment to investing in capturing patients' 'stories'? 	<ul style="list-style-type: none"> Patient stories are routinely collected as part of any service redesign project, ideally with 'before' and 'after' experiences captured
<ul style="list-style-type: none"> Difficulty in communicating that no changes might be made, following engagement, and that this might still be the best outcome 	<ul style="list-style-type: none"> Does PBC report on every engagement exercise? 	<ul style="list-style-type: none"> It is made explicit where engagement has made a difference to commissioning plans and programmes, with an audit trail showing where engagement has altered outcomes
<ul style="list-style-type: none"> Much of the engagement work required should be (but is not) carried out by providers 	<ul style="list-style-type: none"> Does PBC have a system in place to ensure that patient feedback is built into all contracts or Service Level Agreements? 	<ul style="list-style-type: none"> PBC can show how the feedback received has been acted upon and how it will influence future commissioning

(4) 'THE LOCAL POPULATION STRONGLY AGREES THAT THE LOCAL NHS LISTENS TO THE VIEWS OF LOCAL PEOPLE AND ACTS IN THEIR INTEREST'

CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD*
<ul style="list-style-type: none"> Activities are too resource intensive 	<ul style="list-style-type: none"> Has PBC agreed how it will feed back successes or problems? 	<ul style="list-style-type: none"> Simple strategies are in place, such as the 'You said, we did' approach, favoured by some local authorities
<ul style="list-style-type: none"> It is difficult to know what is worth communicating – too much complexity may be a 'turn-off' for people 	<ul style="list-style-type: none"> Does PBC have access to communications expertise which, itself, includes extensive patient and public engagement? 	<ul style="list-style-type: none"> Simple models are used, such as PPG notice boards and newsletters, local magazines of schools and social organisations
<ul style="list-style-type: none"> The need to explain why changes were not made in response to recommendations 	<ul style="list-style-type: none"> Is a general acknowledgement given to local people by PBC to show that it is tackling certain issues – i.e. by asking: 'If this response to you is unsatisfactory, please let us know'? 	<ul style="list-style-type: none"> There is a growing number of interactions with local people, with acknowledgement from both the local population and organisations that the PBC consortium is genuinely interested in helping to improve their health
<ul style="list-style-type: none"> Staff are often negative about the NHS and this can 'pollute' initiatives on engagement 	<ul style="list-style-type: none"> Is PBC considerate of the need to cultivate a sense of pride in the NHS locally? 	<ul style="list-style-type: none"> Staff have become feedback champions – listening to what patients say and feeling that it is their job to help improve the service; good service has led to good feedback – a 'virtuous circle'





ELEMENT (C) DELIVERY OF PATIENT SATISFACTION

What characterises this element?

Obtaining data is not difficult – using it intelligently is. The key is to obtain data from a variety of sources – from places other than your local area, questionnaires, outreach work etc. – and see if it tells a consistent story that urges change. The PCT should then help with the contracting requirements so that the new Service Level Agreement (SLA) reflects the implicit recommendations of local people.

Consideration of this element should be closely linked to the following:

- The 'Quality Accounts' mechanism for public reporting on quality²
- The 'Commissioning for Quality and Innovation' (CQUINS) framework³
- Patient-defined outcomes – for examples see the materials developed by the Picker Institute (www.pickereurope.org)

How to strive for world class competency in delivering patient satisfaction

Step 1 – Assess your general position

There is one principal descriptor for this element, shown below. For this descriptor, ask yourself the associated questions, which will tell you, *in general terms*, your current position, in terms of this competency:

The PBC consortium ‘demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions’

Q	Is qualitative and quantitative information collected from patients, the public and carers on a routine basis, processed in a consistent manner and the resultant information added to the sum of knowledge about the local population’s healthcare needs and aspirations?
Q	Can the PBC consortium demonstrate that this accumulated intelligence actually makes a difference to commissioning decisions?
Q	Are the wider public, including healthcare staff, regularly informed about the changes and improvements being made as result of acting on the integrated data obtained, including why and how the improvements were achieved through listening to patients’ experiences?
Q	Are all service changes systematically evaluated both before and after, in order to understand whether the change is an improvement from the patient perspective?
Q	Where satisfaction levels are declining, is the PBC consortium committed to understanding the causes of any deterioration and the views of patients and the public on how this can be reversed?

Step 2 – Address shortcomings/deficiencies

Refer to [Checklist 3](#) and, under the first column, headed ‘Challenges and obstacles’, ask yourself whether any of the scenarios/situations depicted apply in your case, which will tell you the areas and issues that you may need to address in order to advance, in terms of this competency.

Step 3 – Assess your progress

Refer to [Checklist 3](#) and, in the middle column headed ‘Markers of progress’, ask yourself each of the associated questions listed, which will tell you whether you are advancing, in terms of your progress toward higher competency.

Step 4 – Recognise what ‘world class’ looks like

Finally, referring to the last column in [Checklist 3](#) (headed ‘High-competency standard’), familiarise yourself with the scenarios listed that typify the ‘world class’ standard expected and which will indicate whether you have reached this level of competency in each case.

CHECKLIST 2: ELEMENT (C) – DELIVERY OF PATIENT SATISFACTION

THE PBC CONSORTIUM 'DEMONSTRATES HOW ONGOING INTEGRATED PATIENT EXPERIENCE DATA SYSTEMATICALLY DRIVES COMMISSIONING DECISIONS'		
CHALLENGES & OBSTACLES	MARKERS OF PROGRESS	HIGH-COMPETENCY STANDARD
<ul style="list-style-type: none"> The current default position is that users are difficult to manage and are likely to be problematic 	<ul style="list-style-type: none"> Is a strategy in place to begin by focusing on particular groups, such as high users of A&E services? 	<ul style="list-style-type: none"> There is communication with the wider public and healthcare staff to explain how patient experience has changed commissioning outcomes
<ul style="list-style-type: none"> Local people may lack the confidence to challenge 	<ul style="list-style-type: none"> Has PBC established a culture of openness? 	<ul style="list-style-type: none"> Local people are supported in pushing for what matters to them
<ul style="list-style-type: none"> No agreed methods for data collection etc. are in place Much of the hospital data on patient experience is analysed by the hospitals or PCTs, as PBC data is too parochial 	<ul style="list-style-type: none"> Does PBC take a view on the data that it wants to capture? Is there an awareness that different databases (e.g. for cardiology, urology) may have to be merged? Have you started to obtain simple patient data through questionnaires, patient stories and hand held-machines, asking questions such as: 'Would you recommend this service to your family?' Have you signed up to 'Patient Opinion' via its website? (www.patientopinion.org.uk) Are the views of carers captured? 	<ul style="list-style-type: none"> PBC routinely captures qualitative data such as patient 'stories'/ diaries – i.e. 'my first day/night' – along with widespread use of patient-reported outcome measures Other sources of data include: <ul style="list-style-type: none"> Quantitative measurement (hand-held machines; 'before / after' surveys; patient opinion / choices; 'would you recommend this service to your family?') The rich data from community development All routine data are fed into a central searchable database held by PALS which, ideally, is consistent across the country and intended for making comparisons / contrasting service quality SLA insists that centralised hospital data are disaggregated for use by PBCs

REFERENCES AND SOURCES OF FURTHER INFORMATION

References

1. World Class Commissioning: competencies. Department of Health. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080958
2. The Quality Accounts mechanism for public reporting on quality. Available from: NHS Information Centre: www.ic.nhs.uk
3. The Commissioning for Quality and Innovation (CQUINS) framework. Available from: www.institute.nhs.uk

Sources of further information

The Cochrane Collaboration
www.cochrane.org

Commissioning for Quality and Innovation (CQUINS)
Available from: www.institute.nhs.uk

Community Development Exchange (CDX)
www.cdx.org.uk

The Engagement Cycle: Patient and Public Engagement (PPE) in World Class Commissioning
Available from: www.pcc.nhs.uk

Dr Foster
www.drfoosterintelligence.co.uk

Egton Medical Information Systems Limited (EMIS)
www.emis-online.com

HealthSpace
www.healthspace.nhs.uk

National Association of LINK Members (NALM)
www.networks.nhs.uk/networks/page/1177

National Association for Patient Participation (NAPP)
www.napp.org.uk

NHS Institute for Innovation and Improvement:
www.institute.nhs.uk

Patient and Public Engagement Toolkit for World Class Commissioning
Available from: www.institute.nhs.uk

Patient Opinion
www.patientopinion.org.uk

Picker Institute
www.pickereurope.org

Record Access Collaborative (RAC)
www.record-access-collaborative.org

APPENDIX – BEST-PRACTICE EXAMPLES AND CASE STUDIES

EXAMPLE 1

Lewisham PCT: Integrated Communications and Engagement Strategy

Lewisham PCT recognises that public and patient engagement involves more than merely consultation on service development and change – it is an ongoing dialogue with NHS staff, local people and wider stakeholders (partners and agencies) which informs understanding of the local communities and their health needs, and encourages active involvement. The PCT has developed an Integrated Communications and Engagement Strategy, a key purpose of which is to ensure that the PCT achieves the best skills in WCC Competencies 1 and 3 and becomes one of the most responsive PCTs in London.

In order to define how it engages and communicates with local people, the PCT has developed a 'stakeholder map' and a '360-Degree Group' of key audiences with whom the PCT benchmarks their engagement and communications. It ensures that communication and engagement with local people is effective by:

- Social advertising – i.e. where advertising is appropriate as part of a wider social marketing approach
- Community development initiatives
- Providing environments and formats for information exchange that people find comfortable, and establishing relationships in which they are not intimidated or patronised
- Taking particular care to include all communities and constituencies, especially those at risk of health inequalities
- Reaching people through the media they already use
- Minimising jargon, and providing explanations of technical information
- Establishing a two-way dialogue, and using feedback to shape services

The whole of the PCT, from the Board downwards, will be made aware of their responsibilities for PPI in their daily work. Feedback from patients and staff will be fed into a database that will enable a systematic approach to listening, when combined with the data from outreach and community development work. This local intelligence will be fed into the Commissioning for Quality Group, which has a specific remit to understand, analyse and respond to the views and recommendations of local people and patients.

Detailed delivery plans are being developed for each of the programme areas within the Commissioning Strategy Plan, which will be regularly evaluated to measure the success of the strategy.

Retrospective reports covering the preceding year will demonstrate:

- the extent to which patient and public priorities have shaped commissioning plans
- the effectiveness of links with key partners and agencies, and joint planning
- A review of news releases and evaluation of coverage during the preceding year

In addition, the overall impact of the strategy will be evaluated against the 'high-level' outcomes sought, including:

- Improving services and health outcomes
- Changing levels of awareness, attitudes or behaviour among patients and the public
- The WCC competencies
- The SMART communications and engagement objectives

EXAMPLE 2

Black and Minority Ethnic (BME) Customer Service Project (NHS Bristol)

This project has established 26 reporting/communication centres serving various Somalis, Pakistani, Sikh, Polish, African-Caribbean, African and Chinese communities, amongst others.

The initiative aimed to establish a direct line of feedback from BME service users to NHS decision-making structures. Armed with this information the Patient Advice and Liaison Service (PALS) officers work with service managers and commissioners to tackle individual cases and, where necessary, recommend structural change to the way that services are delivered to different communities.

Rather than being merely a vehicle for gathering complaints, the centres have developed into sophisticated communication centres where information about NHS consultations, services and public health messages (in particular mental health, cancer and TB) is disseminated. Workshops are run at the centres to inform the community about NHS structures and other activities.

This communication centre network and its associated 'frontline' staff has enabled NHS Bristol to use innovative approaches for gathering information and local community views through a variety of means, such as public events / gatherings and local radio broadcasts. The information received is acted on, and has resulted in changes at both acute trust and community levels.

Robust evaluation of the results has shown that there is an increased level of satisfaction with services since the project has been in operation. The resultant local perception is that the network has developed into a strong communication channel between BME community organisations and NHS Bristol:

- 'All the issues which have been raised by our community were seriously taken into consideration and precise actions were taken to address these' (Pakistani Welfare Association)
- 'This service has empowered our members by increasing their input into the vital services available (PALS). They feel more confident about voicing their opinions' (Equality Group, Barton Hill)

EXAMPLE 3

Framework for public and patient involvement within Principia, a non-profit company operating in Rushcliffe, South Nottinghamshire

Principia, Partners in Health is a practice-based commissioning cluster that is implemented as a company limited by guarantee, and a DH pathfinder Social Enterprise. Patient and public involvement (PPI) is at the heart of the organisation's philosophy and structure. Its Board of Directors is constituted under company law and carries out the normal role of a registered company board. It comprises six lay representatives (two of which are, respectively, the Chair and Vice-Chair), three GPs and three community clinicians. The Board is supported by two governance groups, both of which have representatives from the Principia management team as members:

(1) *The Clinical Reference Group (CRG)*, comprising three GPs, three community clinicians (in each case a different set of individuals to those on the Board) and a lay representative who is also a member of the Patient Reference Group (PRG: see below).

The CRG is responsible for the 'technical' clinical governance of the company. It evaluates all the business cases that are raised in support of new or modified care pathways; evaluates areas of abnormal spend against budget; and ensures compliance with Principia's approved pathways and prescribing guidelines. The CRG also encourages clinical involvement from all professions involved with providing care to patients in the area served by Principia, as well as acting as the host for the Urgent Care Group (UCG) and its subordinate Task and Finish (T&F) groups. A Principia T&F group has three core members – a GP, a community clinician and a lay representative – and this core group is able to co-opt other members as required. The UCG has the responsibility for investigating spend in the non-elective area and developing methodologies to reduce the number of unnecessary admissions to secondary care. It comprises several GPs, community clinicians, a community pharmacist, information and financial specialists and a lay representative.

(2) *The Patient Reference Group (PRG)* has a core membership of seven lay representatives (one of whom is its Chair and another

who sits on the CRG). It also includes a co-opted lay member who has a special interest in equality and diversity issues both locally and at a national level. Further members / participants include:

- A GP practice manager
- A representative from the local Council for Voluntary Services (CVS)
- Two lay Board Directors, who provide the link to the Principia Board of Directors
- A member of the county PCT clinical governance section
- A representative of the PCT PALS group

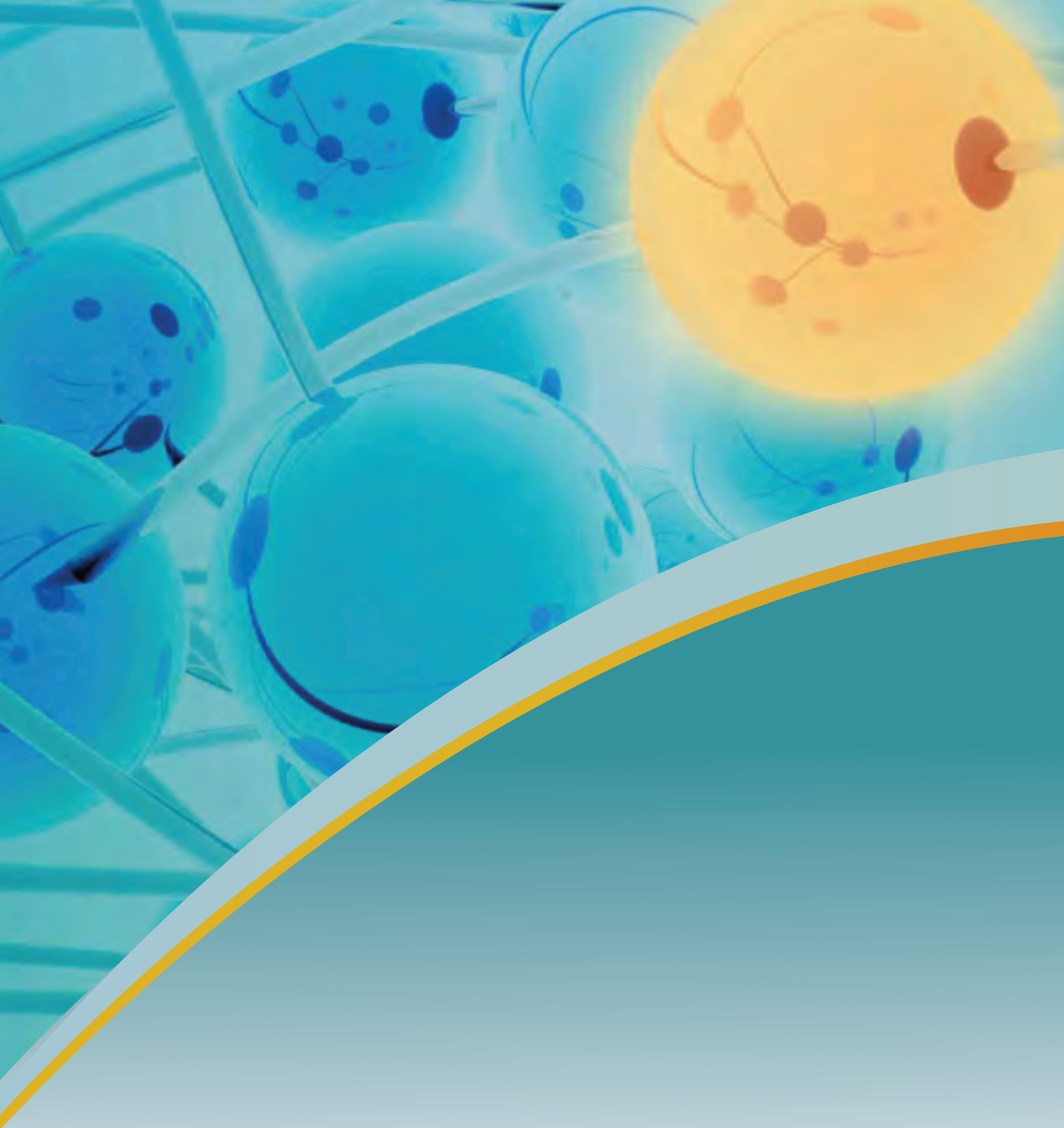
The PRG is responsible for ensuring that the public and patients' views are always at the forefront of all activities within Principia.

Rather than have a membership structure like that of a Foundation Trust, all patients registered with a Principia member practice automatically become a Principia Beneficiary, with the open option to be further involved or not, as it suits them. PRG lay members are also involved in county PCT activities, with members sitting on the County Engagement Sub-Committee and the County Quality Forum, amongst others. It was recognised early on in the development of Principia that a group of eight cannot be fully representative of the Beneficiary population, so the PRG is supported by the Principia Health Network – an open-access membership group that has approximately 750 registered members and from which T&F lay representatives are recruited. The Health Network is organised and administratively managed by the local Community and Voluntary Services (CVS) but is responsible for providing a wider community link for the PRG. The Health Network has recently been registered as a locality group within the County LINKs organization, as the PRG cannot take this role due to the conflict of interest between its commissioning role and the scrutiny role of LINKs.

As part of the continuing development of the Principia structure each member GP practice is required to have a functioning Patient Participation Group (PPG). The aim is for each individual PPG to have a structure and a function that reflects the needs of the practice whilst also supporting the activities of the PRG and CRG. These PPGs will be able to provide an even wider spread of public and patient involvement throughout the organisation, from the local level, via Principia, through to county-wide and national levels.



Notes



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