EMBARGOED UNTIL MEETING

NHS Greater Glasgow

Greater Glasgow NHS Board

Board Meeting

Tuesday 20 August 2002 **Board Paper No. 2002/53**

CHIEF EXECUTIVE

CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE: DRAFT INTERIM GUIDANCE

Recommendation:

Members are asked to note this report.

1 BACKGROUND

1.1 The attached draft guidance replaces the Scottish Home and Health Department 1975 Circular entitled 'Closure and Change of Use of Health Service Premises'. We have been asked to offer comments and the purpose of this paper is to set out a proposed response to the Scottish Executive Health Department (SEHD). Our proposed response has been informed by a dialogue with the Local Health Council. The Executive have also established a stakeholder consultation process on the Interim Guidance which is currently underway.

2 CONTENT

2.1 Two important points of content:

- Greater Glasgow NHS Board (GGNHSB) has always gone beyond the narrow confines of the 1975 Circular in its approach to consultation. There are a significant number of examples:
  - A massive consultation exercise on the Acute Services Strategy.
  - User involvement in developing the Maternity Strategy.
  - The Mental Health User Network.
  - Various fora organised by health promotion staff.
  - Trust patient liaison and involvement arrangements.
  - User and carer engagement in joint community care planning with Local Authorities.
  - User fora for addiction services and focus groups for the Alcohol Strategy.

- In March 2002, the paper (Attachment 2) was approved by the Board to enable us to further develop the agenda of public involvement. Since then a major public involvement event has taken place and we have established a Glasgow Patient Involvement Network to provide:
  - leadership and co-ordination,
  - support and facilitation.
  - knowledge management,
  - resource provision,

  and establish public involvement firmly at the centre of the activities of the NHS in Greater Glasgow.

Chief Executive
0141 201 4642

3 PROPOSED RESPONSE

3.1 The renewed emphasis in the Draft Guidance on patient, public and community involvement is welcome. We have a programme of work in place to develop our local approach to public involvement and to deliver on the commitments made in the December 2001 SEHD guidance, 'Patient Focus and Public Involvement', which followed up commitments made in the Scottish Health Plan.

3.2 While welcoming the guidance and its emphasis, in general terms, we have a number of specific points to make in response:

- **Stratification:**
  The most fundamental issue is the absence of any stratification in the paper in the form of consultation appropriate for different service changes. Paragraphs 12 – 14 are relatively specific in referencing back to existing guidance on substantial change, but paragraph 18 proposes consultation on all service change with all affected groups and communities. That requirement will generate unrealistic expectations with its potential interpretation that any individual should be consulted on any change – it is difficult to see how such a requirement could be workable in practise. For example, would putting additional staff into a local mental health centre be expected to require full consultation with the local community?

  Stratification of interests is also absent from the document. Our general approach would be to place service users and carers at the centre of involvement and consultation.

- **Primary Care:**
  There is a lack of reference to the role of LHCCs in public consultation and involvement and the paragraph 16 reference to primary care does not offer adequate encouragement or direction to primary care practitioners.

- **Local Authorities:**
  The guidance fails to take account of the fact that on many issues we increasingly work in tandem with Local Authorities and thought needs to be given to developing guidance to public bodies, in general, rather than simply focussing on the NHS.

- **National Policy:**
  The draft guidance does not adequately acknowledge that GGNHSB will often be required, to varying timescales, to implement National Policy which may severely restrict the ability for local consultation to influence outcomes or, when centrally set timescales are short, to even enable a meaningful local process. An example of recent, nationally defined requirements is waiting times targets, where local opinion might have generated a different set of priorities.

  On a more positive note, the section on requirements for a valid consultation, paragraphs 23 – 33, are in line with our own developing policy. Consideration of the Draft Guidance should also promote us to be more systematic in identifying proposals for service change and development as early as possible. It is proposed that the Local Health Plan process and document should include clarity on significant changes for the year ahead with an indication of the process for public involvement associated with that particular change.

4 CONCLUSION

4.1 The focus on consultation and public involvement in service change is a positive one which we welcome. The 1975 Circular needed review and significant updating. However, National Guidance needs to be realistic in its scope and avoid generating public expectations on the breadth and depth of consultation which cannot be met and simply run the risk of discrediting NHS consultation processes.

NHS
HDL (2002) 42

SCOTTISH EXECUTIVE

Health Department
Directorate of Service Policy and Planning

21st May 2002

Addresses

For action
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Chief Executives, NHS Trusts
Chief Executives, Special Health Boards
Local Health Councils
Voluntary Health Organisations

For information
Chief Executives, Local Authorities

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Dear Colleague

CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE – DRAFT INTERIM GUIDANCE

1. *Patient Focus and Public Involvement,* which was published in December of last year, contained a commitment to revise the current guidance on closure and change of use of health service premises.

2. Draft interim guidance has now been prepared and is being issued widely to the NHS and other interested parties. A copy is attached for your information. In addition the guidance is available at www.involvingpeople.org.uk.

3. The Scottish Consumer Council (SCC) and Scottish Health Feedback (SHF) have been commissioned to consult key stakeholders on the draft guidance. In the meantime, NHSScotland bodies are expected to adopt the principles set out in the draft guidance.

4. If you have any comments on the draft please send them to Ms Jan Quinn (see opposite for details).

5. This interim guidance will subsequently be revised to reflect the outcome of both the SCC/SHF work and a consultation on a revised public involvement structure for NHSScotland which will issue shortly. The report of a recent wide-ranging pre-consultation exercise on this issue, is also available at the involving people website.

Yours sincerely

GODFREY ROBSON
Director of Service Policy and Planning

INVESTOR IN PEOPLE

CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE

DRAFT INTERIM GUIDANCE FOR CONSULTATION

Scottish Executive Health
Health Planning and Quality Division

3 May 2002

REVISED GUIDANCE ON CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE

About this draft guidance

1. This draft guidance replaces the Scottish Home and Health Department circular entitled 'Closure and Change of Use of Health Service Premises', dated 3 June 1975 (the '1975 guidance').

2. This is interim guidance for NHSScotland and will be revised again once the new public involvement structure outlined in *Patient Focus and Public Involvement*, has been put in place (April 2003). A full public consultation on a public involvement structure, and a new role for Local Health Councils, will be carried out during 2002.

3. Consultation can fall into a range of differing categories, for example:
   - A means of collecting views on a fairly open-ended topic
   - A means of collecting views on the pros and cons of alternative proposals
   - A means of collecting views on a specific proposal
   - A means of developing a proposal or option.

Within NHS Scotland public involvement should be a key feature of consultation.

Why involve patients, public and communities?

4. *Patient Focus and Public Involvement* which was published in December 2001, sets out a framework for NHSScotland which aims to change the culture of the health service in the way in which it interacts with the people it serves and the way services are delivered. The paper signals that it is no longer good enough to simply do things *to* people; a modern healthcare service must do things *with* the people it serves.

5. In this respect, patient and public involvement is a **very important** part of improving the quality of service provided by NHSScotland, and needs to be given a high priority.

6. Effective public involvement can

- be a potential catalyst for change
- provide a real opportunity to build public trust
- help achieve a step change in public health
- help strengthen public confidence and contribute to rebuilding our NHS.

7. Public involvement can also reduce the risk of providing inappropriate services or services that do not deliver in a way people want or need them. It can provide a different perspective that might otherwise be overlooked by professionals and managers and can result in some very different and innovative solutions. As a result there is the potential to improve service quality as well as becoming more responsive.

8. Public and patient involvement is a specific commitment in *Our National Health* to

- give patients a stronger voice
- involve people and communities in the design and delivery of the health service

> *We value the NHS as a public service which belongs to the people. Patients, staff and communities have a right to be involved in decisions which affect them.*
>
> *Our National Health page 50*

9. An awareness of the importance of public involvement is not new, but there has at times been a tendency for it to be seen as an 'add on', or simply a lower priority requirement. Guidance has stressed the importance of taking the views of the public into account when making decisions and has over time become more specific, but still the public often complains of 'tokenism' and of feeling excluded.

> *Services need to be responsive not just to the needs of individual patients but also to the preferences of the public at large. To redesign services from the perspective of patients – and to reflect this in all aspects of health service planning – requires finding our what patients and communities want; and consulting them over proposals for change.*
>
> *Designed to Care, page 9, Scottish Office, 1997*

10. NHS Boards and Trust must strengthen existing partnerships and develop new working partnerships with people who use their local services and ensure opportunities for patient and public involvement are integrated as the norm in the way they work.

11. The voluntary sector links into the Health Service in a number of ways at national and local level. Like the NHS the voluntary sector is a complex amalgam of different organisations, often with very different interests, and of variable size from small self help groups to national organisations. The voluntary sector is important, not just in terms of engaging users more effectively, but as a partner for service delivery. It is therefore **very important** to ensure the voluntary sector has a role in planning services.

When statutory consultation is necessary

12. The role of Local Health Councils and their involvement in service change has often been seen as public involvement. This is not the case, and has come about due to the provisions of Regulation 6(1) of the National Health Service (Local Health Council)(Scotland) Regulation 1990 (SI 1990 No 2230). This states that "every relevant Health Board shall so far as is practicable consult each Council in its area on any substantial development or variation in any of the services for the provision of which the relevant Health Board is responsible".

13. Of the various provisions in these Regulations it is the word 'substantial' that has caused the most uncertainty. It is difficult to provide any definition of what constitutes a substantial variation in service. What may be considered substantial in one Board area may not be in another. This is a matter that calls for common-sense taking account of the proposed change and its effect on health service users. The permanence of a proposed change is not, however, a guide as temporary solutions should also be consulted on if the proposals significantly affect service users.

14. The presumption should always be to involve those affected, those who might be affected, or those with an interest in a proposed service change, at the earliest possible stage.

Regular dialogue and close involvement with relevant stakeholders in the development stage may ease the formal consultation process.

Management changes

15. There is no current requirement to consult on changes in management structures or organisational changes which do not affect service users. However, it is good practice for key stakeholders, health councils and interested voluntary organisations to be kept informed of such changes.

Primary care

16. The requirement for Boards to consult also covers proposals that amount to substantial developments of, or variations in, those aspects of primary care in which Boards have a role to play, for example, strategic plans for primary care services, location of general practitioner premises, out of hours services. The requirement to consult does not, however, cover the way in which practitioners choose to organise their own practices but they should be encouraged to consult their patients about such changes.

Public Involvement in service change

17. NHS Boards need to take a pro-active and positive approach to issues that need public involvement in areas of potential service change.

18. NHS Boards should note that:

- 'end process' consultation is not acceptable
- they should consult on all service change including new services
- they should develop proposals for service change in partnership with all affected groups and communities
- they should formally consult on the outcome of that development process.

19. The key principle should be that involving the public is part of an integrated process of communication and discussion; where communities, public, patients and NHS staff have opportunities to influence decision-making. An inclusive process may not always result in universal support for a proposal but it should demonstrate an NHS that listens, is supportive and has genuinely taken account of views and suggestions.

20. NHS Boards will be expected to be able to clearly demonstrate that they have followed these principles for service change proposals. Any inadequacies identified will be addressed by the Performance Assessment Framework, and appropriate action taken in-year.

21. As with the 1975 guidance, proposals for major service change, including closure of existing premises, will require Ministerial approval. As well as demonstrating that appropriate and adequate public involvement has gone into developing the proposals, NHS Boards are required to submit their final proposals and a report on the outcome of consultation to the Minister for Health and Community Care for final approval. The Minister may require further consultation where he feels public involvement has been inadequate.

22. An example framework, which demonstrates the use of a variety of mechanisms for involving the public when considering a significant service change, is attached at **Annex A.**

Requirements for a valid consultation

23. A consultation exercise should have the following features:

Adequate information

24. When formal consultation takes place, a consultation document will need to be produced. This must be easy to understand and must be readily available. It must contain sufficient information for the reader to be able to understand the reasons for the proposals and to come to an informed conclusion. It needs to explain the perceived benefits that are expected to flow from the change. It should also include information about contacts for further information or clarification and a list of those being consulted.

25. As service change is an evolving process, it may not always be possible to provide all the necessary information at the beginning of a consultation process. If this is the case, it should be made clear at the outset and an indication given of what will be available and when. One option might be for a two-stage or pre-consultation process to refine policy and develop a proposal for formal consideration.

Adequate time

26. Involvement should start as early as possible and sufficient time should be allowed for any consultee to consider and respond to the proposals. It is usual practice to allow three months for consultation exercises on proposed service changes, but it may be reasonable to allow a shorter period where the circumstances justify it (e.g. where the details of the proposal have already been the subject of public debate or intensive public involvement). It should be noted that even if information about a proposed change has been in the public domain and interested parties have made their views known, this does not remove the need for a formal consultation.

Genuine consideration

27. The consultation document may indicate a preferred option, but it must also be clear that all responses to the consultation will be considered. In particular, the Board must give genuine consideration to any alternative suggestions that are put forward as a result of the consultation.

28. It is good practice to consult a wide range of interested parties and members of the public. A failure to do so could lead to the consultation process being flawed and any decision invalid.

29. If a proposal is likely to affect the population of more than one NHS Board area, then stakeholders in both communities should be consulted. In these circumstances it is reasonable for one Board to lead on the consultation provided all interested parties are consulted.

30. A diagram showing a consultation process is attached as **Annex B**

Early and ongoing communication

31. Although a period of formal consultation on specific proposals may be appropriate at some stage, the key principles for consultation should form part of a broader ongoing process of the Boards' communication with, and involvement of, communities, service users and the public.

32. Consultation needs to begin when proposals for service change are at a formative stage and before they have become decisions. It is good practice to involve all interested parties in discussion about the issues affecting local services both generally and in respect of specific areas. It is also good practice to have ongoing discussions with all interested groups as specific issues are explored and proposals are developed.

Openness

33. One of the key principles of *Patient Focus and Public Involvement* is to build public confidence in the NHS. An important factor in achieving this will be an open and clear processes for planning and consulting on service change. It is good practice to publish a plan that sets out a clear process and timetable. It is also good practice to involve local stakeholders in the development of such plans.

Methods of consultation

34. Traditionally, consultation has tended to follow a regular pattern, based around the publication of a formal consultation document and formal public meetings. Such methods can play an important part in consultation, particularly in formalising proposals and inviting responses. However, there are many other ways in which consultation can take place and which can help maximise user input to the process.

35. **Annex C** sets out a brief overview of some of the techniques that are available. While some methods may be more successful than others for achieving a particular outcome or for reaching specific sectors of the community, there is no one method that can be said to be the best. Different situations will require different approaches.

36. **Annex D** provides an aide-memoire to good practice

Scottish Executive Health Department
Planning and Quality Division

April 2002

ANNEX A

Model/example of a Framework for Public Involvement in a Major Service Change

1. **NHS Board agrees a process** that provides a clear timetable for decision making, identifies who and when to consult and the range of approaches that will be used.[1]

2. It is important to ensure that **service users are involved in developing any alternatives/options prior to proceeding with a formal consultation** process.

3. **Initial stage of the consultation process should have a number of participative sessions** to gain views of key interest groups on a range of options.
   - user groups
   - doctors and clinical staff
   - nurses and other professional staff
   - trade unions
   - professional advisory committees
   - Trusts
   - community groups
   - Local Health Councils/other patient representative groups
   - Local authorities

   Participants should be positively encouraged to attend by awareness raising efforts such as newsletters etc and should be sent briefing packs in an appropriate format, in advance of the sessions.

4. **Feedback session and full public debate.**
   It is important to feedback and share all the comments made. It is also important that the public is aware of the feedback and is not disadvantaged when entering into a public debate.
   - Feedback session to present key issues from the open session to the various groups giving groups opportunity to comment on the summarised points.
   - Full public debate. Important to record all views and to ensure these are well publicised. (e.g. newsletter or newspaper.)

5. **Focused consultation groups**, made up of service users, should be used to ensure patient experiences are incorporated.

6. **Obtaining a wider perspective of public attitude and links to community planning process**. Well planned surveys, possibly using established local council/citizen panels.

7. **Seeking written comments**. Although it is important to ensure people realise that anyone can submit written comments, it is also necessary to ensure written comments are sought from others (local councils, local councillors, MSPs and MPs, Ambulance Service - where ambulance services might be affected). NB this is not intended as a definitive list.

8. **Recommendation for change and feedback**. A process with this level of involvement at the early stages is more able to take account of different perspectives. Feedback loops will be

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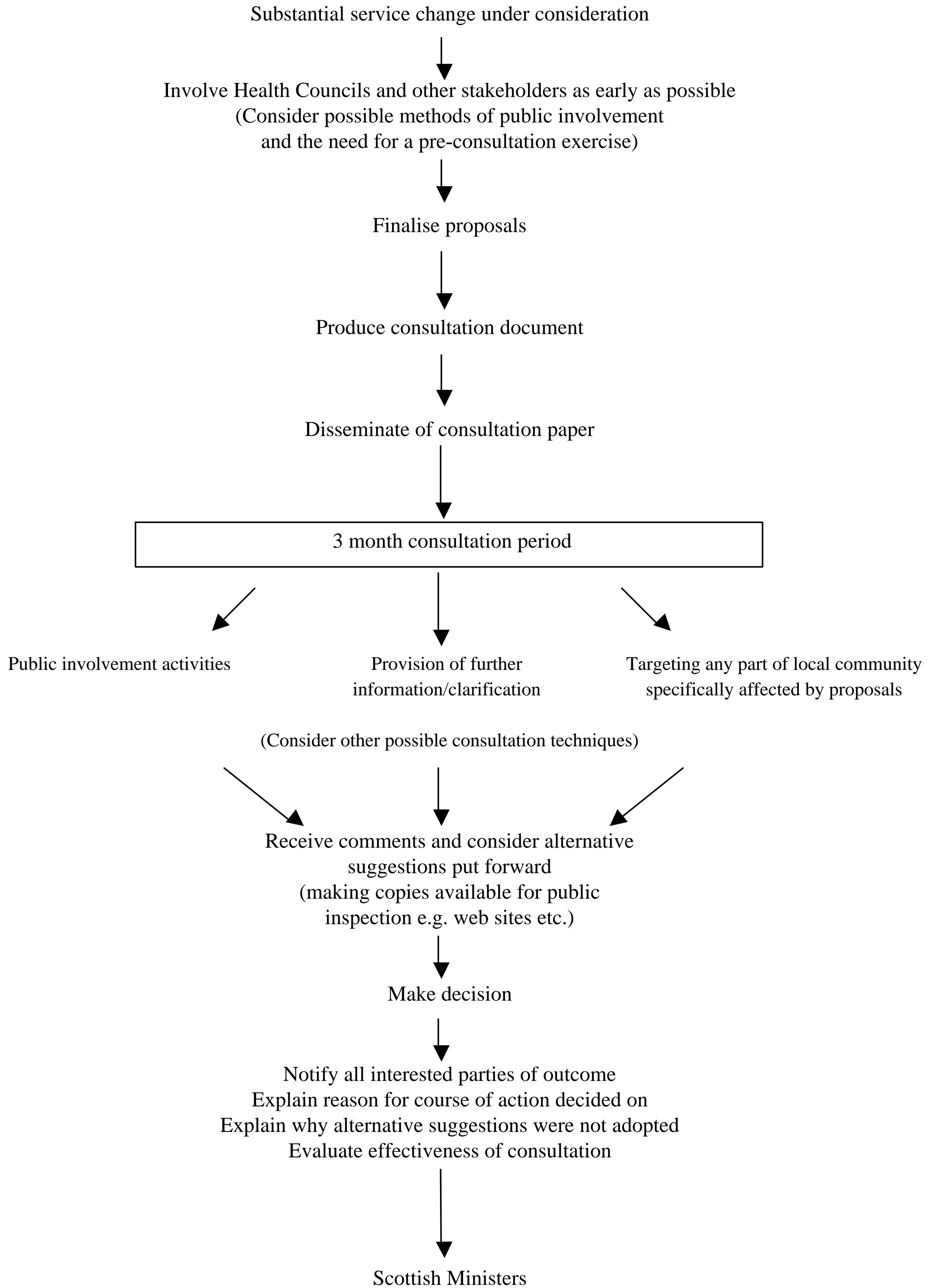
[1] 'Building Strong Foundations: Public Involvement in the NHS' a toolkit for developing patient and public involvement will assist NHS Boards.

important even after a decision is made and even if it there was general support for the proposal, with opportunities for making people who have been involved and the wider public aware of the outcome.

ANNEX B

PUBLIC CONSULTATION



ANNEX C

EXAMPLES OF DIFFERENT APPROACHES TO INVOLVING THE PUBLIC[2]

1. Health Forums

A Health Forum is normally an on-going series of public meetings held with voluntary and community groups and representatives from local health services and local authority services. The agenda for the meeting is open and allows people to highlight their concerns and queries.

Any action that is taken is on a multi-agency basis and there must be feedback to the relevant patient/service user/carer groups.

It is also possible to create health forums from local people. Potential training requirements of forum members must be identified to ensure they feel able to participate fully in discussions.

This approach provides opportunities for local people to raise their concerns and is an integrated, whole system, multi-agency approach. As a result it encourages joint working.

2. Open House/ Open Surgeries

A time when members of the public have the opportunity to meet with a representative of the organisation/health system and ask questions face to face.

3. Panels

Panels can be very helpful to inform planning and help prioritise decisions requiring a wider population view.

Citizens Panels/Talk Back Panels

Used to gather views on plans, service developments and specific health issues. The membership of Citizens Panels and 'Talk Back Panels' should match the demographic profile of the area covered with a rolling membership that allows new members to be substituted every 4-6 sessions. These approaches are often features of Local Government and Health Boards should see this as a potential opportunity for sharing and joint working.

User/Carer Panels

These are more commonly used in secondary care where service users and carers maintain a longer-term relationship with the service (e.g. cancer, diabetes, mental health services), but can be readily adapted across the system. Members have direct experience of the services being discussed and a genuine desire to make services better for future service users and carers. A panel approach provides an opportunity for direct liaison and feedback between panel members and service providers and members can become involved in design and implementation of service developments.

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[2] See 'Building Strong Foundations: Public Involvement in the NHS'

Citizen's Juries
A Citizen's Jury is generally made up of 12-16 local people recruited to represent the general public in a community. They hear evidence and discuss specific policy issues that may have an impact on their community. Members of the Jury are given the opportunity to listen to and cross-examine expert witnesses in order to help them develop an informed opinion and to make recommendations for action.

Key stakeholders form a steering group to oversee the Jury's development. This group makes key decisions about witnesses to be called, material to be presented to the Jurors. The Jurors are able to request additional information, including witnesses, during the course of the Jury. The Jury is paid to attend and at the end of their deliberations they make a decision on the question that was posed.

4. Patient Councils

Members of the public are used to inform local decision-making. Anyone who is interested can be involved to provide a mix of skills, age, sex, ethnic group and other socio-demographic characteristics.

The Patient Council in some areas have hosted patient awareness meetings on specific topics suggested by the public, e.g. stress, coronary heart disease and strokes. Their advantage is that they can pull together a cross section of the public, encourage two way dialogue and provide an opportunity to respond directly to patient questions.

5. Whole System Conferences

A Whole System Conference enables interested parties from a wide variety of groups to contribute to service development plans. An invited audience, representing key interest groups, meets to try and reach a consensus view on a particular issue. It should involve people with a range of different interests, such as medical, nursing, managerial, community, voluntary, users and carers.

6. Seminars/Workshops

These are formally organised discussion groups that aim to share, exchange and receive information. They provide an opportunity to engage in multi-disciplinary discussion, to explore difficult issues in detail and encourage sharing of experiences and good practice.

7. Group work

Advisory Groups
Advisory Groups need to include a mixture of professionals and patients and can ensure views of user go direct to key health professionals. These can be permanent groups with regular meetings; thus ensuring advice is always available.

Focus Groups
These groups are usually relatively small, 6-10 people, and provide opportunities to discuss an issue in depth but in an informal setting.

User Groups
Useful mechanisms for keeping users of a service in touch with the people who provide it. This sort of group can be useful in a variety of settings and levels.

8. Newsletters

Whilst not really a method of public involvement, newsletter can provide a useful approach to keeping the public informed for raising awareness of public involvement issues and for giving feedback to a wider audience. Articles for newsletters can be commissioned from a range of sources (Health Promotion, specialists working in NHS Trusts, voluntary and community organisations, the Health Board, the Executive, health care professionals, practice staff, patients and local people etc.)

A newspaper is relatively inexpensive and can easily be used to target selected groups or focus on specific issues, but their most significant drawback is that people might not read it and see it as 'Junk mail'.

9. Making results more representative

Consultation can produce results that do not represent the views of local people as a whole. Those responsible for setting up consultation exercises should avoid methods in which consultees select themselves and should instead look carefully at how a statistically representative sample of the population might be identified and targeted.

It is also very important to consider the make up of the local community and to avoid the risk of token consultation or involvement. It would, for example, be a mistake to expect one person to be able to represent an area's black and ethnic minority community unless they can tap into the whole spectrum of cultures, interests and needs concerned. Also, when considering young people, boys will often have very different views and priorities to girls. Care should therefore be taken to ensure that when targeting consultation at these groups every effort is made to obtain the views of as wide a range of people as possible. Questions might be worded in a way that seeks to draw out the various perceptions and perspectives of a diverse target group. In addition, special efforts should be made to reach excluded groups such as young and old people, gypsy travellers etc.

ANNEX D

AIDE-MEMOIRE TO GOOD PRACTICE

The following ideas are designed to help those who are involved in consultations on service changes. This aide-memoire is not designed to be used as a mechanical checklist, nor are the ideas in it an exhaustive list of good practice. However, they are drawn from the key principles of consultation and the experience across the NHS.

It is good practice to include all stakeholders such as local health councils, local support groups, local patient participation groups and voluntary organisations.

Ongoing involvement and communication with local users, groups and the public

Do you have a strategic plan for systematic and continuous involvement and communication with service users, user representative groups and the public more generally?

Do you have good relations with your Health Council? Do they attend Board and Trust meetings and are they generally engaged in discussions about local health service planning and development issues?

Do you regularly seek to publicise and invite debate about local health service planning and development issues?

Do you seek to listen to and inform local community and voluntary groups about service planning and development issues?

Do you know what issues are important to different groups of local people?

Consultation on proposals for specific service changes

Have you raised and discussed the underpinning issues before developing proposals for change?

Have you involved local service users and other interested parties from the outset?

Have you actively sought the views of likely interested local groups?

Have you developed a consultation plan clearly identifying the consultation process and timetable? Were local service users and other interested parties involved in its development?

Are any public meetings, conferences, focus groups etc well planned (e.g. have arrangements been made for these to be independently chaired and facilitated)?

Have you arranged meeting for a time when people can come (for example people who work or have child care arrangements to make)?

Have you supported local service users and interested groups in developing their own proposals?

Have you allowed choice by presenting fairly argued options?

Have you explained why any particular option is preferred?

Have you considered raising issues, publicising proposals in local newspapers (especially free papers)?

Have you built up relationships with the local media (newspapers, journalists, radio and television)?

Information

Have you considered what information you might be asked for (what you have readily available or can easily provide may not be sufficient)?

If you know relevant information will not be available at the beginning of the consultation have you indicated when it will be provided?

Have you provided contact details for further information or clarification?

Have you thought about providing information that meets the needs of all service users e.g. from ethnic minorities, or those with a physical or sensory impairment?

Timescale

Have you allowed sufficient time for people to consider your proposals and to respond?

Did you discuss the timetable with local service users and other interested parties?

Have you made allowances for problems arising from the time of year (e.g. Christmas and the summer holiday months)?

Consideration of responses and feedback

Have you taken into account all responses to the consultation?

Have you clearly explained the reasons for final decisions, including why alternative proposals have been rejected? (It is good practice to publish a written explanation – this need not address each individual response, but rather cover general themes of responses).

Have you set up a process for keeping respondents briefed on progress with implementation?

ATTACHMENT 2

NHS Greater Glasgow

Greater Glasgow NHS Board

Board Meeting

19th March 2002 **Board Paper No. 02/20**

Tom Divers, Chief Executive, Greater Glasgow NHS Board
Jim Whyteside, Communications Manager, Greater Glasgow NHS Board

Implementing Best Practice in Consultation and Public Involvement

Recommendation:

Members are asked to:

- Consider the implications of recent Scottish Executive Guidance on public involvement
- Determine the next steps to take forward public involvement in NHS Greater Glasgow

1 Introduction

At the Board Meeting of 29th January, two Non-Executive Directors requested an opportunity to discuss consultation and public involvement. This paper has been drafted in response to that request. In recent weeks also, the Minister for Health and Community Care has restated and reinforced the importance of public involvement in providing a foundation for change in the NHS. On 14th December 2001, new guidance entitled *Patient Focus and Public Involvement* was launched by the Scottish Executive and this places specific obligations on NHS Boards. This paper summarises these obligations, provides an overview of previous and current practice in addition to experience culled from recent public involvement exercises.

2 Defining Public Involvement

2.1 As the debate about Public Involvement has extended in the last few years, it has become clear that different organisations and individuals have applied different definitions to the concept. The words ‘consultation’, ‘public involvement’, ‘patient involvement’ and ‘public engagement’ have been used almost interchangeably.

2.2 So what is it? A working definition is that public involvement covers an entire spectrum of communication and direct engagement that can variously affect the public at large or particular elements of the local population, different types of patients or specific interest groups and public representatives. It can be described in terms of the following four broad and simplified elements in Table 1.

Table 1

Information	Information supports all public involvement. Without information people cannot in turn be aware of issues, choices and constraints – the NHS has been criticised for failing to provide sufficient, appropriate and accessible information for patients and the public. Information may be disseminated by many means, including leaflets, posters, promotional campaigns and advertising, the media and web-sites.
Awareness	Only though awareness can people form opinions based on an accurate understanding of key issues and so contribute to debate about service development. The term ‘community capacity building’ is used to describe a process were awareness is encouraged in a sustained way, in localities or across the area.

Table continued overleaf.

Consultation	The term most often confused with wider public involvement. Consultation is the process of measuring and attempting to understand public or patient opinion on a given issue or service. It is not a popular vote, but a way of factoring in public perception to decision-making along with all of the other considerations which must be taken into account. Perception is not an issue of 'right' and 'wrong' no matter how many people share it – in some circumstances the NHS may be right to try to change commonly held opinion (e.g. as regards smoking and diet), in others it may offer a clear direction for service prioritisation or development. The are many ways of conducting consultation including formal surveys, Citizen's Panels and Juries, public meetings, open space events, focus groups and passive approaches such as complaints procedures and Opinionmeters. Each has its own merits depending on the people whose opinion is to be tested and the detail of response required.
Direct Engagement	There are many good examples already taking place across the NHS in Greater Glasgow of steering groups, patient forums and other arrangements that allow members of the public to have a direct role in either changing services or managing operational activity. For example, service users were recently engaged in assisting the development of the modernising mental health agenda and, of course, the Local Health Council has an active role on the NHS Board. In local authorities the public may have a direct role in assisting departments to conduct 'Best Value Reviews', where the purpose and direction of services is tested and redefined on a continuous basis.

3 NHS Circular No. 1975 (GEN) 46

3.1 Until December 2001, the only formal guidance offered by central Government on public involvement was the '1975 Circular'. This was issued on 3rd June of that year by the former Scottish Home and Health Department and was intended to deal specifically with the issues of the 'closure and change of use of health service premises'. It addressed only 'local consultation' rather than the wider aspects of public involvement.

3.2 The 1975 Circular covered:

- The circumstances in which decision-making would rest either with the Secretary of State or with local managers
- Guidance as to which organisations should be subject to consultation (Local Health Councils, area professional committees, local authorities and staff associations – although it was left to Health Boards to have discretion as to other groups and individuals to be included)
- The minimum period of consultation (3 months)

3.3 The implication in the 1975 Circular is that consultation would be conducted by a written presentation of proposals triggering formal, written submissions by the persons and organisations being engaged with. The Circular has in recent times been subject to much criticism in the Scottish Parliament because of its simplistic and outdated content.

4 Our National Health and Patient Focus and Public Involvement

4.1 Between 1975 and 2001, a variety of initiatives tied to particular services or localities levels were being taken forward to improve public involvement in the NHS. In the late 1980s and 1990s, as the internal market was introduced to the NHS, encouragement was given to the adoption of the marketing concept as way of recognising and acting upon public opinion. In practice the introduction of *The Patient's Charter* proved to be the main yardstick for engagement. In the latter years of this period, two notable initiatives were *Designed to Involve*, which focussed on public involvement in the development of Primary Care Services, and *Allies in Change* which involved mental health service users in service planning.

4.2 The first new, major strategic announcement on public involvement appeared in December 2000 from the Scottish Executive when it published the Scottish Health Plan *Our National Health.* The plan included the following commitments:

- Production of a detailed change programme to increase public and patient involvement in the NHS
- Development of Local Health Plans in each NHS Board area with local health improvement plans tied to community planning processes in each local authority area
- An expert group to support and advise NHS Boards on the management of change to the configuration of local health services
- NHS Boards to put in place effective communications arrangements
- Improvement of communications through the 'patient's journey'
- Improvement of the quality and accessibility of information supplied by the NHS in Scotland
- Investment in building NHS capacity to engage with communities
- Training for staff and managers to facilitate a patient-centred approach
- Each local NHS Board area to have at least one *Partners in Change* project (the successor to *Designed to Involve* and *Allies in Change*) in place by December 2001

4.3 The launch of *Patient Focus and Public Involvement* on 14th December 2001 was the first step towards a detailed change programme. This document offers initial guidance on public involvement and will be followed by further information and it supplants the 1975 Circular. Set out within the document are a number of binding obligations upon NHS Boards as shown in Table 2.

Table 2

Framework Theme	*Task*	*Timescale*
Building Capacity and Communications	Staff training and development to include the principles of a patient-focused approach, including effective communications and public involvement (induction, pre qualification professional training, CPD and professional training, leadership development).	Ongoing
Building Capacity and Communications	NHS Boards and Trusts to establish an intensive communications training programme for all staff.	Ongoing
Building Capacity and Communications	NHS Boards and Trusts to demonstrate that they have developed a diverse range of modern and appropriate methods for communicating with their local communities.	Ongoing
Patient Information	NHS Boards and Trusts to support and apply the advice and guidance offered by a new national Patient Information Network, which in turn will oversee a quality assurance process.	To be reviewed by late 2004
Patient Information	NHS Boards to work in partnership with the SE and Scottish Consumer Council to produce a 'package' that will replace the Patient's Charter.	June 2002
Involvement	The NHS Board to designate a Director with responsibility for Public Involvement.	This reinforces previously issued guidance: Catriona Renfrew has this role
Involvement	The NHS Board to produce a sustainable ongoing framework for public involvement.	March 2003
Involvement	NHS Boards and Trusts to strengthen existing partnerships and ensure opportunities for Patient and Public Involvement are integrated and in-line with policy for that Board area.	Ongoing
Responsiveness	NHS Boards to work with local authority partners to ensure advocacy arrangements are in place and working effectively.	December 2001
Responsiveness	NHS Boards to take account of and act on the recommendations made in *Fair for All*.	March 2003
Responsiveness	NHS Boards must adopt agreed guidelines and recommendations for conducting surveys.	To be published 'early 2002'

4.4 As can be seen in Table 2, a number of key initiatives and pieces of guidance will emerge from the Scottish Executive in the coming months. However, the Executive has made it clear that the framework 'themes' are broad and overlapping – it is up to NHS Boards and Trusts to take forward local, detailed programmes and actions.

4.5 One of the most far-reaching proposals in *Patient Focus and Public Involvement* is that a single Scottish Health Council replaces the current system of Local Health Councils. This is seen as advantageous in removing perceptions of bias arising from the current arrangement where funding and recruitment of Local Health Councils is facilitated by NHS Boards. It is proposed that the Scottish Health Council would have local offices in each NHS Board area, which in turn would be advised by a local steering group of volunteer citizens. Linked to this arrangement would be a Patient's Forum in each NHS Board area. The Executive intends to issue a consultation document on these proposals by the end of this month.

5 Existing Practice within NHS Greater Glasgow

5.1 Since the reconfiguration of NHS Trusts in 1999, local NHS organisations have been engaged in developing both public Involvement policies and initiatives, as follows:

5.1.1 **Greater Glasgow Primary Care NHS Trust** – The Trust's Public Involvement Policy was published in the late autumn of 2001. The policy was developed by a Trust-wide steering group and benchmarked to comparable activity in a variety of public and private organisations. The policy offers a range of principles of guidelines and a checklist which helps NHS staff ensure that cognisance is given to the factors that determine successful public involvement. It is should be noted that LHCC managers have responsibility for organising local public involvement programmes on behalf of their Co-ops.

5.1.2 **North Glasgow University Hospitals NHS Trust** – Also produced in 2001, the North Glasgow Trust's External Communications Strategy addresses itself to communication with patients and the public and patient involvement. The document sets out principles and values and identifies the key stakeholders, notably a proposed North Glasgow Patient's Forum, as well as good practice such as the establishment of specialty-based patient focus groups.

5.1.3 **South Glasgow University Hospitals NHS Trust** – The South Glasgow Trust's Communications Strategy also dates to 2001. It covers such issues as media management, links with community organisations and local elected representatives and the establishment of a Trust steering group to take forward electronic communications.

5.1.4 **Yorkhill NHS Trust** – Over the last few years Yorkhill has undertaken a number of initiatives to inform and involve users of services, to update them on progress and to give them a greater say in how services are developed and delivered. These have included the organisation of a number of workshops and forums for parents, patient support groups, ethnic minority groups and staff and the creation of a new Family Council and Disability Forum. Feedback from these groups has helped shape an action plan which is being taken forward by a number of groups within the Trust. The Trust has also sought public involvement in the Yorkhill Option Appraisal in a number of ways, including the creation of a Yorkhill Future Group, the commissioning of a market research project and the widespread distribution of a newsletter called *Talkback*.

5.1.5 **Greater Glasgow NHS Board** – Aside from formal large-scale consultation exercises (see 6, below) NHS Board staff continuously pursue a range of public involvement activities of lesser scale and controversy but of no less importance. The Health Promotion Department is involved in a large spectrum of public involvement – for example, in recent months the Young People's Health Team have conducted survey work, development of health information formats and direct engagement in service development.

The Planning and Community Care Directorate supports a series of service-specific consultations which cumulatively help to shape public involvement in the development of the Local Health Plan. One of the Directorate's significant achievements has been to secure £130,000 of funding to establish the Mental Health Network Greater Glasgow. The Network's role is to support mental health service users and to contribute to the Modernising Mental Health agenda.

5.2 Public involvement in all its forms is also being progressed at departmental, ward and practice level across all local NHS organisations. Many front-line staff and managers are actively engaging patients and the public in service development and change. The Greater Glasgow Health Council Awards held on 28th February 2002 highlighted many examples of best practice - for example: ongoing patient appreciation for the Podiatry Department of the Southern General Hospital (which had previously radically altered the role of the service following a patient survey).

5.3 Elsewhere, NHS Argyll and Clyde has appointed an officer with direct responsibility for policy, standards and implementation. NHS Highland is developing an 'Ethical Decision-Making Framework'. This is intended to demonstrate to all stakeholders the processes and considerations that would always be considered by the NHS Board when taking any decision, as well as ensuring that the public/patient 'voice' is heard. As part of this initiative Highland NHS Board is establishing a Public Involvement Committee.

6 Lessons Learned from Recent Public Involvement Activity

6.1 The two largest consultations of recent years have been on Acute Services and the Secure Care Centre. Both highlighted the need to consider modern and proactive processes and the section below is confined to a summary of a number of clear lessons that emerged between late 1999 and 2002:

- Different consultation techniques suit different audiences and circumstances – a comprehensive and socially inclusive consultation will require the application of a full range of such techniques (the principle of 'horses for courses' – a summary of consultation techniques is at Appendix One)
- Pre-consultation testing might have helped with refining and making more accessible the information presented to the public and the process of consultation itself
- Large scale consultations based on major strategies run the danger of dwarfing and obscuring the human aspects of service change
- There is a danger that if there is more than one major consultation going on at one time that there is the potential for public (and staff) confusion
- There has to be a team responsible for planning and implementation of major consultations – the infrastructure in place has not always been able to meet expectations
- 'Corporate' level public involvement requires significant resourcing
- The process has to be tied into a clear communications strategy – at times the public was exposed to 'glaring silences' when the consultation process lulled – single issue groups with an agenda were able to exploit this
- New concepts – such as Ambulatory Care Hospitals – are very difficult to introduce without 'showing' examples, perhaps through pictures and computer models
- Due to a combination of mixed reading abilities in the general population and the trend towards more sophisticated means of information delivery and layout, traditional, wholly text-based consultation documents may therefore have a limited application
- Passive consultation based on written responses favours affluent and articulate groups
- Information distribution arrangements are difficult in an urban area like Greater Glasgow – no provider of door to door distribution services can guarantee 100% coverage. Save an expensive combination of advertising in the *Daily Record, Herald* and *Evening Times*, no particular local or national titles reach a majority of the Greater Glasgow population

7 Public Involvement Events, 22 March and 10 May 2002

7.1 In the run up to the establishment of the Board of NHS Greater Glasgow, it was clear that there were no common standards of public involvement across local NHS organisations. Nor was there any way to collectively respond to anticipated Scottish Executive guidance emerging after *Our National Health*.

7.2 It was therefore agreed by the former HIP Steering Group that staff from across NHS Greater Glasgow be brought together to organise events aimed at founding a local public involvement 'framework'. From the outset it was agreed that the framework would:

- Not be another strategy – it would focus on aiding NHS staff to deliver more effective public involvement
- Have at its core a network of front line, junior and middle management NHS staff with a degree of responsibility for public involvement

7.3 It was further agreed that the network of NHS Greater Glasgow staff would be used to:

- Define techniques in public involvement
- Demonstrate good and bad practice in addition to the sharing of good practice from within and outside the NHS
- Define problems and needs (such as training and support)
- Allow the sharing of resources and expertise between different organisations
- Allow the commissioning of joint work between different organisations
- Provide a clear point of reference for local contact/reference/debate on public involvement and a link point to the proposed national Scottish Public Involvement Network
- Allow the co-ordination and monitoring of public involvement activity to avoid duplication and clashes (e.g. minimise 'consultation fatigue')
- Provide a platform on which to introduce new NHS Board and national policy on public involvement consistently across the local NHS system

7.4 Two events have now been organised on behalf of approximately 130 NHS staff with Local Health Council participation. The first event, an all day session on 22nd March, is intended to bring all participants up to speed on emerging policy and current practices. It will focus on the 'how to' of public involvement as much as the 'why'. The second event, on the morning of 10th May, is intended to allow staff to have a direct say on the way the proposed network should be organised and sustained.

7.5 This is an incremental, staged approach, which may in time be appropriate for joint working with local authorities and other partner organisations.

8 Issues for the Board to Consider

8.1 This paper should have given Board members an impression of the lengthy history and vast range of what is now termed public involvement. The drive towards greater public involvement will cost money. As we have learnt from direct experience, we face a contradiction – on the one hand we are expected to properly engage with the public; on the other, we are criticised for 'wasting' resources if we organise comprehensive public involvement activity, such as in the case of the Secure Care Centre.

8.2 The final consultation on the Secure Care Centre required expenditure of approximately £100,000. It is easy to understand why levels of expenditure like this are required when it is understood that a *single* half page advertisement carried in the *Herald, Evening Times* and *Glaswegian* costs £9,000.

8.3 It is also true that few staff within the NHS are trained or have the spare capacity to conduct surveys or focus groups. This means that outside expertise has to be bought in. At current prices, expert facilitation of a single focus group of 10 people would cost £800 and a quantitative survey of 1000 people upwards of £6,000. Nevertheless, public involvement, in its broadest sense, has to be an integral component of service delivery.

8.4 In helping the Board to determine a way forward for Public Involvement, it is suggested that there is debate around the following issues and recommendations:

- There is a need for a response to the key tasks in *Patient Focus and Public Involvement,* notably staff training and a Public Involvement Framework
- A core team of staff, preferably a component of the proposed new Communications Function for NHS Greater Glasgow, should be designated
- This core team will report to the Director responsible for Public Involvement and will be responsible for major 'corporate' public involvement activity
- In recognising that most public involvement takes place at Trust and service level, the core team will also have the role of supporting and helping to sustain the Public Involvement Network shortly to be built across NHS Greater Glasgow
- That consideration be given to discrete budgets to support 'corporate' public involvement, the Public Involvement Network and major training initiatives
- That the issue of staff involvement be taken up for discussion with the Local Partnership Forum
- That meetings be set up with MSPs, MPs, local authority elected members and partner organisations to discuss future arrangements pertaining to public involvement
- That principles for fair and socially inclusive public involvement are agreed and that there is an arrangement at Board level to allow monitoring of their application and effectiveness

9 Conclusion

Board Members are asked to agree if these recommendations are acceptable and what the next steps should be.

Appendix One – Consultation Methodologies and their Uses

Preparation and Pre-Consultation	Brainstorming	A technique for a relatively small group of people to generate a large number of ideas in a short time
	Nominal Group Technique or 'Snowball'	This can be used with large groups of people. Following sub-division into smaller groups, set questions are answered and the answers brought together for a plenary session in which the top preferences are agreed
	CATWOE	A process designed for use with a group in order to generate clear identification of all the factors affecting a given issue from beginning to end
	Community Profiling	A group approach to constructing a description of an area which covers the economic, social and environmental factors that would inform decision-making
	Cost/Benefit Analysis	A complex technique, commonly used as a management tool, which compares the advantages and disadvantages of different options alongside their (not necessarily financial) costs
	Five W's Plus H	A simple checklist for agreeing options and who should be consulted and involved in decision-making
	For and Against	A simplified version of Cost/Benefit Analysis
	Mind Maps	A graphical technique for smaller groups to help find solutions to problems
	Skills Audit	A way of allowing a group to identify the skills held by its members and then allocate problems or tasks based on the best fit of skills
	SWOT Analysis	A very well known technique for analysing problems and issues
Information Provision	Campaigns	The co-ordinated delivery of a variety of forms of information in different ways in a finite period of time. The most effective approach to disseminating the information/options needed to support a consultation exercise
	Exhibitions	Portable exhibition panels provide a flexible back up to meetings and campaigns in that, if properly designed with plain language and images, they allow the public to absorb information at their own pace in virtually any setting.
	Leaflets, Posters, Adverts and Newsletters	The foundation of any consultation exercise – they must be accessible (both physically and in terms of language), to the point and targeted at the key stakeholder groups

Appendix One – Continued

	Websites	A flexible and effective way in which to convey information (and also conduct online surveys and feedback). However, while a majority of the local population still does not have Internet access, a majority of younger people (especially through schools) do
Consultation	Quantitative Methods	A structured form of survey designed to provide a broad 'snapshot' of the opinion of a statistically representative sample of people
	Qualitative Methods	Methods which explore opinions and the motivation behind them in depth
	Citizen's Panels	A sample of 1000 – 1600 people in a local authority area who are representative of the social and demographic mix. They will participate in consultation exercises or smaller group discussions in the course of the year
	Customer Complaints Systems	These systems can be used to track both negative and positive opinion and trends in service delivery
	Focus Groups/Group Discussions	A small number of people – no more than 12 – convened with the help of a trained facilitator to provide qualitative information on opinions or given issues
	Past and Future	A small group exercise which uses past experience to suggest future service options
	Opinionmeters	A nine letter keypad usually set in a free-standing display which allows the public to self-complete a short questionnaire
	Public Meetings	A traditional way of providing the public with information and receiving feedback. Recent innovations using electronic 'anonymous voting' kits can allow meetings to be structured in such a way as to overcome disruptive protest groups and overly strident participants who might prevent quieter members of the public from expressing their view
	Surveys	Surveys are a straightforward way of obtaining a representation of public opinion. They can generate a high level of response and the results can be weighted to suit the appropriate socio-demographic mix. They can be conducted face to face, in the street or on the doorstep, in the home or workplace, by telephone or by post. They can be very expensive however
	User Panels	A small representative group of service users who can offer qualitative insights to general data

Appendix One – Continued

	Citizen's Juries	A Citizen's jury will consist of no more than 25 people drawn from a particular community who will spend a number of meetings going through a particular issue in great depth. It is an effective way of gaining opinion from a group of people who have been through rigorous 'capacity building'
	Design Game	A small group technique where patients can use models of proposed new facilities in order to suggest the most appropriate layout
	Games and Role play	This can work with small groups to help the public understand the variety of different factors and constraints that impinge of the decision-making of others
	Planning for Real	This is similar to the design game but is intended for neighbourhoods so that local residents can use three-dimensional models to have a say in decisions affecting the locality – this could be run in tandem with local authorities or allow residents to input to the integration of, say, a new hospital in their area
	Priority Search	A computer-aided survey process which allows people to set out their priorities. It can also be adapted to allow ranking of decision-making factors in situations where a difficult choice must be made