Evaluating the Engagement of Seldom Heard Groups in Commissioning Health Services

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SHARPENS YOUR THINKING

NHS Sheffield

EVALUATING THE ENGAGEMENT OF SELDOM HEARD GROUPS IN COMMISSIONING HEALTH SERVICES

EXECUTIVE SUMMARY

This report presents the findings of an evaluation of public engagement (PE) conducted by NHS Sheffield (formally known as Sheffield Primary Care Trust, and referred to in this report as the PCT). The focus of the evaluation was on engagement with "harder to reach" or "seldom heard" communities to inform the World Class Commissioning decisions made by the PCT (Department of Health, 2007). The evaluation took place between December 2008 and August 2009 and was conducted by a small team at Sheffield Hallam University.

With World Class Commissioning the obligation for the PCT to engage with the public and health service users, and to be equitable in this activity, came together under a banner of commissioning (Department of Health, 2007). This is aligned with a commitment to the involvement of citizens in order to drive up the efficiency or effectiveness of services, improve health and meet personalisation and patient-centred care targets. (Department of Health 2006, 2008).

Nationally the status and nature of public engagement has increased. However, PCTs are struggling with engagement of seldom heard groups, and demonstrating how public engagement impacts upon commissioning decisions (Picker, 2009).

AIM

To evaluate the level and nature of current public engagement regarding commissioning and develop recommendations based on the views of seldom heard groups (SHGs).

A number of groups and communities were selected by the PCT to be the focus of this project.

- Older people and also people with:

- Sensory impairment (Visual and Hearing)

- Motor/mobility difficulties

- Cognitive and learning difficulties

- Mental health problems

- A first language other than English

DESIGN

The project adopted a pluralistic approach and comprised six overlapping data collection approaches. These were mainly qualitative in nature.

1. An ongoing literature review to inform the emerging findings (December 2008-August 2009).

2. A consultation with voluntary and community groups (January – May 2009).

3. Observation of public engagement events and consultations held by NHS Sheffield (December 2008 – May 2009).

4. A small consultation with volunteers working with the PCT (June – July 2009).

5. A "critical friends" meeting with representatives from voluntary, local community and lay organisations working with NHS Sheffield (June 2009).

6. A telephone consultation with NHS Sheffield staff (June – August 2009).

FINDINGS

It is resoundingly clear that NHS Sheffield is ahead of the game in terms of public engagement when looking at the national picture (The Picker Institute 2009). Ongoing challenges include overcoming the legacy of previous unsuccessful public engagement activity, cultural barriers and partnership working across public and community settings. Progress is already being made by NHS Sheffield in addressing these.

Six themes emerged as key to a successful public engagement culture; credibility, consultation, collaboration, capacity, communication and commissioning. The findings are summarised using these themes.

It had been the initial intention to map the themes generated by this evaluation to the elements of the Department of Health's recently published engagement cycle (2009). However, following the analysis of participant's views and experience an alternative approach has been taken. The six themes listed above apply throughout the cycle of World Class Commissioning. Instead it is suggested here that they are the core elements of a successful engagement culture and should underpin the systems to support engagement, especially with SHGs.

CREDIBILITY

NHS Sheffield was seen to be more transparent and open with a genuine desire to develop new and improved methods of engaging with the communities they served. The new website, the continually growing and diverse volunteer programme and the Introduction to Community Development and Health training course were cited as successful initiatives that support PE.

However, participants suggested that past mistakes were recognised, addressed and processes were in place to ensure they were not repeated. If this was not done, it would compromise engagement with SHGs.

CONSULTATION VS CREATIVITY

"Consultation overload" was identified as a concern and a call made for an increase in participative and process driven methods of PE. Participants reported a lack of skills and confidence in some SHGs to participate in consultation based PE activity due to the pressure of living with the underlying condition, and its health and social consequences. More participative methods of PE were required to develop and empower communities and the individuals within them.

There was recognition within the PCT that there is no one way of conducting PE, especially with SHGs. This evaluation supported the use of more participatory PE methods. Strategies to do this include capacity building initiatives (e.g. storytelling and community reporters), joint planning and facilitation with communities, process rather than "one-off" PE approaches and judicious use of the Internet.

COLLABORATION

The findings indicate the potential for more collaborative working to facilitate PE with SHGs. Internal collaboration was improving and the PCT is being more pro-active in identifying expertise and knowledge from across the organisation.

The recommended move towards more participative methods of PE means PE can be regarded more as a participatory process allowing opportunities for partnership and collaboration. Community and voluntary groups may be trusted by people from SHGs, have extensive networks with individuals within the communities, and have insight and access denied to PCT staff. Participants recommended the PCT explores ways to work more collaboratively, with community organisations in planning and running PE activity and the possibility of contracting out aspects of PE work to community organisations.

CAPACITY

The findings indicate that capacity of the organisation and communities themselves impact upon the ability of NHS Sheffield to engage with SHGs. There was potential to build organisational capacity by identifying where the expertise is available in the organisation. Where necessary skills are not available from within the organisation there is potential to develop partnerships and knowledge transfer schemes with external organisations, for example in developing knowledge management systems to support PE. Increased joint working across Local Authority and

community organisations can also build capacity, including joint posts, secondments and work placements.

More participatory methods of PE such as storytelling, do offer a way of developing capacity within communities as well as generating information.

COMMUNICATION AND CULTURE

The evaluation indicates that new ways of communicating with the public are required to facilitate PE with SHGs. Whilst the Internet is a valuable resource, caution is needed to avoid over reliance. Participants recommended that, to be successful, PE has to work from within a culture, rather then "parachuting in" requiring the development of closer collaborations and partnerships, and in developing capacity within communities and working in more equal partnership in developing and delivering participative methods of engagement.

CREATIVE COMMISSIONING

Participants suggested a number of strategies to promote involvement of SHGs in PE that relate to commissioning decisions and activity. They include:

i. Commissioning the development, implementation and evaluation of new, creative methods of engagement that may be delivered by external organisations with participative expertise. Examples include story-telling and community reporters' schemes, and

ii. Commissioning out PE work to groups with good networks and established trusting relationships with SHGs and communities that are hard for the PCT to reach

iii. Scoping the nature of Service Level Agreements already held between NHS Sheffield and voluntary/community groups and local charities and explore the potential to expand their monitoring requirement to include generating patient experience data to inform PE.

RECOMMENDATIONS

APPROACH

1. Continue the development of Public Engagement (PE) approaches that recognise past mistakes and builds processes to ensure they are not repeated

2. Develop participative methods of PE that generate information for NHS Sheffield whilst developing the skills and capacity of those from Seldom Heard Groups (SHGs). Implement

joint planning and facilitation of PE events with representatives from the community and related organisations.

3. Develop methods of real-time engagement as close to health and social care service delivery as possible.

4. Adopt a social model of PE, rather than medical, to generate genuine engagement with SHGs.

5. Adopt approaches that consider PE as a process and avoid "one-off" consultations where possible.

6. Balance the use of Web 2.0 tools with other forms of PE activity to ensure all sectors of the community are not excluded owing to lack of intranet access etc.

SKILLS

7. Scope the expertise and skills required to plan and conduct participative and community development approaches to PE in SHGs, identifying where the expertise is available from within NHS Sheffield.

8. Develop ways to work more systematically across departments within NHS Sheffield that have the skills and knowledge to support PE.

9. Develop partnerships and knowledge transfer schemes with external organisations, where the necessary skills are not available from within the NHS Sheffield

COLLABORATION

10. Develop a strategy to formalise the links between volunteering and PE.

11. Explore the potential for joint working across NHS Sheffield, Local Authority and community organisations, including joint posts, secondments and work placements.

12. Develop better knowledge management systems to collate and disseminate learning from PE.

COMMISSIONING

13. Consider the suggestions made by participants related to commissioning decisions and activity.

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INTRODUCTION

This report presents the findings of an evaluation of public engagement conducted by NHS Sheffield (formally known as Sheffield Primary Care Trust, and referred to in this report as the PCT). The focus of the evaluation was on engagement with "harder to reach" or "seldom heard" communities to inform the World Class Commissioning decisions made by the PCT (Department of Health, 2007).

The evaluation took place between December 2008 and August 2009 and was conducted by a small team at Sheffield Hallam University. This World Class Commissioning (WCC) evaluation is the last in a collection of studies. Whilst this evaluation concentrated on public engagement with "seldom heard groups", the other components of the collection are:

- An evaluation of speech enabling software for use on the newly designed NHS Sheffield website.

- An evaluation of the new NHS Sheffield website.

- An evaluation of the use and potential of Web 2.0 tools to promote public engagement with seldom heard groups.

This work also complements the "*Toolkit for engaging seldom heard groups*" that was commissioned by NHS Sheffield in 2009 (Morris, 2009). The "Toolkit" lays out some basic principles of engagement and gives practical tips to NHS staff and organisations on how to engage the public and seldom-heard communities.

NHS Sheffield has already done a considerable amount of work in engaging seldom heard groups in commissioning local health services. They have a well established strategy for public and patient involvement, and representation and endorsement at an executive board level. This development is taking place at a time where there is an emphasis on public engagement in the NHS Constitution and key policy documents including Our Health Our Care Our Say (Department of Health 2006) and High Quality Care for All (Department of Health 2008a).

WORLD CLASS COMMISSIONING

With World Class Commissioning the obligation to engage with the public and health service users, and to be equitable in this activity, came together under a banner of commissioning.

The vision for World Class Commissioning (WCC) was first launched in 2007 (Department of Health, 2007). This policy defined WCC as:

> "… a statement of intent, designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way across any of the developed healthcare economies."

Competency Three of WCC states that:

> *"PCTs are responsible through the commissioning process for investing public funds on behalf of their patients & communities. In order to make commissioning decisions that reflect the needs, priorities & aspirations of the local population, PCTs will have to engage the public in a variety of ways, openly & honestly. They will need to be proactive in seeking out the views & experience of the public, patients, their carers & other stakeholders, especially those least able to advocate for themselves." (Department of Health, 2008b)*

Patient and public engagement is part of other competencies such as working with community partners (Competency Two) and leading the local NHS (Competency One).

It is now essential for PCTs such as NHS Sheffield to:

> *"fully engage and involve patients and the public as citizens in a dialogue about health needs, strategic planning, service design and decision making and communicate with them to increase understanding and confidence in using local services." (Department of Health, 2009)*

This policy is built on a belief that:

> *"effective community-led commissioning can empower individuals and communities by giving them the chance to voice their needs, while local ownership of the process will increase the relevance of services, and improve their uptake and sustainability. For commissioners, the 'World Class' commissioning agenda is about connecting development of services with the real requirements of communities, and increasing engagement and satisfaction with services". (Kramer, 2008).*

The Picker Institute (2009) have recently conducted a national survey to evaluate the early impact of the WCC framework on patient and public engagement in commissioning. It revealed that in most PCTs, WCC has driven a change in organisational culture, and increased the status and nature of public engagement. PCTs are working more strategically and systematically, with public engagement being seen as a "must-do". However, the report found that nationally, PCTs are over-reliant on public meetings and traditional consultation methods; are struggling to adopt more successful and participatory methods of engagement of seldom heard groups, and finding it difficult to demonstrate how public engagement impacts upon commissioning decisions (Picker, 2009).

PUBLIC ENGAGEMENT

Public participation in services has a long, if rather chequered, history stretching back over at least thirty years. In that time, the politics of participation have changed complexion and become more challenging. In the health context this has meant regarding patients and service users less as passive recipients of services and more as experts by experience. Recognising patients and

service users in this way has implications for the legitimacy of different sources of knowledge, the pooling of that knowledge, and the management of power relations, not only in patient-professional relationships, but also in the arrangements for commissioning, managing and reviewing health services.

There is a considerable literature and body of evidence about the successes and challenges of different kinds of national and local initiatives designed to secure the engagement of patients and service users, including some of the more seldom heard groups (examples include Richardson, 1983; Felce and Grant et al. 1998; Doel et al. 2007; Farrell, 2004; National Association for Patient Public Participation and NHS Alliance, 2006). Despite this, the concept of public engagement and involvement are poorly defined and understood (Waite & Nolte, 2006). The terms public engagement, involvement, participation and consultation are commonly confused or used synonymously.

Much of the published literature concerns the processes of engagement and an emphasis on being as participative as possible. There are many methods of engagement to draw on, depending on the aim and purpose of the activity. However, overall, there is a move towards more participative methods of engagement, rather than consultation and feedback (Blakey, 2005; Entwistle, 2009).

There have been different drivers propelling public participation, ranging from those that seek to secure the involvement of citizens in order to drive up the efficiency or effectiveness of services, to those that are designed to change the way services are configured and delivered so that they improve those health outcomes that patients and service user's desire. The present commitment to patient engagement is one that fits neatly with the latter and reflects a current policy commitment to personalisation and patient-centred care. (Department of Health 2006, 2008).

PATIENT AND PUBLIC ENGAGEMENT CYCLE

During the course of the evaluation reported here, the Department of Health commissioned *In*Health Associates to develop a tool to support NHS organisations in public engagement in World Class Commissioning. The Engagement Cycle and its purpose is summarised in Box 1.

BOX 1. THE ENGAGEMENT CYCLE

- The engagement cycle is a way of approaching Patient and Public Engagement (PPE) in World Class Commissioning.

- It is a representational model that highlights who needs to do what to engage patients and the public at each stage of the commissioning cycle.

- It can be used to facilitate improvements in World Class Commissioning, particularly concerning Competency Three - engaging with patients and the public.

- The engagement cycle is not a toolkit, but a starting point for thinking about PPE in commissioning. It provides checklists for action and will be developed to include links to policy documents, case studies, toolkits and other materials.

- It has been used so far to undertake assessments of who is doing what at each stage of the cycle, to help develop action plans, identify learning and support needs and as a basis for PPE strategies and organisational development plans.

(From: Department of Health 2009)

SYSTEMS AND PROCESSES

The Engagement Cycle was developed following an extensive consultation with NHS organisations and commissioners. During the consultation the key systems and processes required to ensure engagement was embedded throughout the organisation were highlighted. They are as follows:

- Senior commitment and leadership that creates a culture of engagement;

- Strategy for engagement stitched into all areas of work;

- Consistent approach to engagement across the organisation;

- Robust mechanisms to capture patient and public-derived data;

- Solid reporting & monitoring systems part of mainstream business;

- Clear roles, responsibilities and accountabilities;

- Adequate resources and practical support;

- Learning and development for staff and non-staff;

- Underpinned by principles of partnership working;

- Equalities and diversity as a cross-cutting theme.

It is clear from that, from the perspective of participants, NHS Sheffield has made progress and achieved much in terms of implementing and developing the above processes and systems. However, the findings of this evaluation emphasise the importance of NHS Sheffield revisiting these elements *explicitly* with a view to supporting PE with SHGs.

THE ELEMENTS OF THE E-CYCLE

As can be seen from the diagram in Box 1, the elements of the E-cycle are as follows:

STRATEGIC PLANNING:

- Engaging communities to identify health needs and aspirations;
- Engaging public in decisions about priorities;

SPECIFYING OUTCOMES AND PROCURING SERVICES:

- Engaging patients in service design and improvement;
- Patient-centred procurement and contracting;

MANAGING DEMAND AND PERFORMANCE MANAGEMENT:

- Capture and use of patient experience data;
- Patient centred monitoring and performance management.

PUBLIC ENGAGEMENT WITH "SELDOM HEARD GROUPS"

In terms of public engagement the main focus for policy makers is how to reach and engage communities that have been categorised as "hard to reach" or "seldom heard". The assumption is that by involving communities *"in design and delivery of services, including those whose voices have traditionally not been heard, will help to shape services to meet better their health and well-being needs"* (Kramer, 2008).

NHS organisations have a duty, as laid down in Section 242 of the consolidated NHS Act (2006) to involve and consult patients, carers, the general public and other organisations in planning, developing and delivering services. The NHS Constitution states that the public has the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

In addition, there is an obligation to ensure this engagement is in line with equality and diversity expectations. For example, in Standards for Better Health (Department of Health 2004) there is an expectation of NHS Trusts that "*the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services*" to ensure that all members of the population are able to access services equally and offer choice in access to services and treatment equitably.

However, engaging service users and communities equitably about diverse health services, when communities themselves are diverse, is a huge challenge (Blake et al, 2008). Again, the recommended models to do this successfully are more creative and participatory in nature (Picker Institute Europe, 2009; Entwistle, 2009; Blake et al, 2008; Pickin et al. 2002).

What follows is an overview of the findings of the evaluation of NHS Sheffield's engagement activity with seldom heard groups. A brief summary of evaluation methods is provided followed by the key findings. The report ends by considering the place of the findings in the newly developed Patient and Public Engagement Cycle (Department of Health, 2009).

AIM AND METHODS

AIM

To evaluate the level and nature of current public engagement regarding commissioning and develop recommendations based on the views of seldom heard groups. Recommendations will be on the level and nature of public engagement in PCT commissioning.

Following consultation with the Patient and Public Involvement (PPI) Team in NHS Sheffield a number of groups and communities were selected to be the focus of this project. These were amongst the communities that the PCT wanted develop and improve their dialogue and engagement work with. These groups were:

- Older people and also people with:
- Sensory impairment (Visual and Hearing)
- Motor/mobility difficulties
- Cognitive and learning difficulties
- Mental health problems
- A first language other than English

It is recognised that, by limiting the sample and data collection to these groups, the findings may not be transferrable to other communities. However, the time and resource restrictions of the project meant that a focus was required in order to obtain insight of any depth or value.

DESIGN

The project adopted a pluralistic approach and comprised six overlapping data collection approaches. These were mainly qualitative in nature.

- An ongoing literature review to inform the emerging findings (December 2008-August 2009).
- A consultation with voluntary and community groups (January – May 2009).
- Observation of public engagement events and consultations held by NHS Sheffield (December 2008 – May 2009).
- A small consultation with volunteers working with the PCT (June – July 2009).
- A "critical friends" meeting with representatives from voluntary, local community and lay organisations working with NHS Sheffield (June 2009).
- A telephone consultation with NHS Sheffield staff (June – August 2009).

Prior to any data collection from the public or PCT staff, the purpose of the service evaluation was explained and the voluntary nature of participation was made clear. Written notes were taken during all data collection stages and where possible any identifying information as removed.

Framework analysis methods were used to integrate and examine data from all stages (Ritchie & Lewis, 2003; Ritchie & Spencer, 1994). Framework analysis involves developing a thematic framework from *a priori* knowledge and early data. Emerging findings are then used to develop the framework and inform subsequent stages of data collection.

STAGE 1. LITERATURE REVIEW

An extensive web-based, literature search was undertaken. Sheffield Hallam University (SHU) and National Health Service (NHS) resources, PCT websites and search engines such as Google were used to access health and social care databases, policy and strategy documents. The search was limited to English language articles dated between 2000-2009.(Table 1).

The retrieved search articles and documents are categorised into two main sections Literature and Strategy and policy documents

To maintain the context of this study the titles and abstracts of papers highlighted in the search were screened by the Principle Researcher and member of the research team (MI). The articles excluded from further review included those exploring expert knowledge on specific, non-related areas, user involvement in research, purchasing specialist services, and article about clinical queries.

The articles and reports identified in the search were used to develop the context and are integrated into this report. A full bibliography of articles used from the search is provided at the end of the document.

TABLE 1: LITERATURE REVIEW DATABASES USED, SEARCH TERMS AND PARAMETERS

Context	Comment
Electronic databases	- NHS evidence (formally National Library for Health) - MEDLINE (EBSCO) - MEDLINE (CSA) - Cochrane Library Database - CINAHL plus - Web of Science - Pub Med - Google Search Engine.
Search terms	- Public/user involvement - Engaging hard to reach groups

Context	Comment
	- Engaging/seldom heard groups in commissioning - Public/community involvement in health commissioning - Public engagement/involvement in health services - Community consultation in health services
The context of terms	- Public engagement/participation in health care commissioning - Hard to reach/seldom heard groups' engagement/participation in health care commissioning. - user involvement in health care services

STAGE 2. CONSULTATION WITH VOLUNTARY AND COMMUNITY GROUPS.

SAMPLE

Two approaches were taken to identifying groups to participate in Stage 2. First, groups with a pre-existing relationship with the NHS Sheffield PPI team were identified through the PPI Team. In addition, an attempt was made to identify the groups not currently known to the PPI team. They were identified via staff in the Faculty of Health and Wellbeing at Sheffield Hallam University (SHU) and through Voluntary Action Sheffield (VAS). This strategy ensured inclusion of views from participants who are currently outside of NHS Sheffield's existing routine PPI consultations. They were recruited by members of SHU staff who work in the relevant specialist areas e.g. mental health and learning difficulties, and by the Healthy Partnership Team at VAS. In addition, groups currently engaged in work with the PCT were also identified by the PPI team and approached by them.

Some organisations were unable to participate within the timeframe and as a result participation from some groups was limited, for example, the visually impaired. It should be stressed that the aim was to recruit a range of organisations but not a representative sample. As such it is just a "snapshot" of views and caution should be taken regarding transferability of the findings. A few groups became known to the team during the course of the study. In some cases groups asked to participate and were keen to have their views considered. On a couple of occasions, the time restraints of the study meant it was difficult to accommodate this. The groups were directed towards the PPI team so that they could be included in future engagement events.

Consultation methods used here included group discussions with group members, small discussions with one or two staff or members of the group or discussions with public sector staff involved with the group or community of interest. The groups involved and consultation method used are summarised in Table 2. In addition to those listed in Table 2, a representative from

Healthy Partnership Team at VAS and the project Co-ordinator for the Health Champions scheme in Sheffield were also consulted.

Group	Community of interest	Consultation Method and Participants
Speaking Up for Action (SUFA)	Learning Disabilities	Attended regular meeting for group and individual discussions. 14 users and 4 carers participated.
Deaf Advice Service Sheffield (DASS)	Sensory Impairment	Discussion with 2 staff from DASS. Group discussion with 9 deaf users of DASS (3 men, 6 women) plus 1 deaf observer. Deaf facilitator, sign interpreter present.
Sensory Impairment Team, Sheffield City Council	Sensory Impairment	One-to-one discussion with a staff member of the team.
Sheffield Fibromyalgia Society	Mobility, Mental Health	One-to-one discussion with a member. Group discussion with 8 members of SFS, (7 patients, 1 carer; 1 man, 7women)
Expert Elders	Older people	Group discussion with 5 members of the Sheffield Expert Elders Network (2 men, 1 woman), plus written comments from one woman who could not attend.
Strategic Commissioning and Partnership, Sheffield City Council	Older people	Discussion with 2 staff members in Sheffield Council.

Group	Community of interest	Consultation Method and Participants
Asian Elders Caring Society, Pakistani Muslim Centre	Language, mental health	Attended regular meeting for a group discussion. 15 male participants >60.
Somali Special Needs Scheme	Language, mobility, mental health	Discussion with 2 project workers. The Scheme provides the Somali community with homecare services to the elderly, disabled and housebound in Sheffield.
Yemani Mens Group	Language	Group discussion with 4 men, first language Arabic.
Yemani Community Centre	Language	One-to-one discussion with a community worker.
Somali Community Centre	Language	One-to-one discussion with a staff member.
Pakistani Community Association and Multi-cultural Advice Centre	Language	One to one discussion with 1 staff member
Sheffield Adult Mental Health Association	Mental health	Meeting/discussion with four members of a mental health user group
Inclusive Living Sheffield (ILS)	Mobility, Mental Health, Cognitive Difficulties, visual impairment	Discussion with 2 staff members Group discussion with 9 users and 2 staff from ILS

Group	Community of interest	Consultation Method and Participants
Multiple Sclerosis Therapy Centre	Mobility, mental health	Attended Therapy centre for one-to-one discussions with 8 service users.
Sheffield LINk (Local Involvement Network)	All	Discussion with the Chair and Co-ordinator
Sheffield Parkinson's Disease Society	Mobility	Discussion with a SPDS Committee member and Regional Officer.
Mental Health Citizens Advice Bureau and Advocacy Service	Mental health	Discussion with 1 staff member
Sheffield Women's Asperger Syndrome Group	Mental health	The groups discussed a number of questions at a routine meeting and provided written responses.

The discussions were semi-structured. They were conducted using a topic guide (Appendix 1) developed from the related literature and explored:

- The level and nature of existing public engagement by the PCT regarding commissioning

- How participants are currently involved in public engagement with the PCT regarding commissioning

- Views on how participants think the public should be engaged with the PCT regarding commissioning

- Ways in which the PCT website can improve public engagement in commissioning

STAGE 3. OBSERVATION OF CONSULTATION EVENTS

Fourteen consultation events organised by NHS Sheffield were attended by one or two members of the evaluation team to observe. These are listed a summarized in table 3. A pro-forma was

developed to help structure the observation (Appendix 2). Notes were taken using the pro-forma structure.

Event	Description
Intermediate Care Services Consultation, Zest, 9 December 2008	Public meeting as part of the Consultation to improve intermediate care services in Sheffield. Medical consultant and PCT staff member both gave a presentation and facilitated a discussion. 4 members of the public attended.
Great Drink Debate, Howden House, 10th December 2008	2 PCT staff present in Howden House to discuss health issues related to alcohol with members of the public and ask them to complete the "Great Drink Debate" questionnaire.
Stakeholder Meeting on Mental Health and Wellbeing, Sheffield United Football ground, 11th December 2008	Large consultation event to review a draft strategy, following on from an earlier event in February. NHS Sheffield partners with Sheffield First for Health and Wellbeing. Even tactually run by Sheffield Care Trust. Approximately 140 people participated. Format included presentations and workshops.
Black, Minority, Ethnic (BME) Groups Mental Health Services Event (Colour of Health), Vestry Hall, Burngreave. 3rd February 2009	Stalls and presentations feeding back on ongoing community mental health/BME projects including Sheffield African Caribbean Mental Health Association and

Breakthrough: Sheffield multi-ethnic drugs service. Attended by approximately 50 people. |
| Chronic Fatigue Syndrome/ME service Consultation Day, St Mary's Bramell Lane, 4th February 2009 | Consultation event attended by 50 people containing presentations, workshops and feedback sessions. |

Event	Description
Healthy Sheffield Launch, Ponds Forge. 26th February 2009	City wide event showcasing work of public sector, community and voluntary organisations regarding health. Mixture of stalls, presentations and workshops. Attended by >100 people.
Evaluation of learning disabilities (LD) expert patient programme (EPP), SUFA, 16th March 2009	23 participants including participants, health professionals and carers. Feedback and consultation format. Part of the evaluation of LD EPP.
Improving mental health services for people from BME groups, Sorby House, Spital Hill, 19th March 2009	Event aimed at local organisations interested in tendering. 15-18 people attended. Presentation session on 'Getting ready for World Class Commissioning', questions and answers about the tendering process. Useful resources distributed.
"Health Matters" Launch event, Burngreave, 16th April 2009	Part of the Enhanced Public Health Programme work. Event aimed to engage local people in promoting health and well being. Information about local groups, health services and activities in the area. Approximately 70 local people attended stalls and workshops.
Men's Health Event, ZEST, 21st March 2009	22 men attended the event exploring emotional well-being and mental health service experience.
Disability Users Consultation Event, The Circle, 20th May 2009	Consultation event with 12-15 people with a range of disability, including learning and physical disabilities. Voiced concerns regarding existing services and recommendations to the PCT.

Event	Description
Volunteer Day, The Circle, 4th June 2009	The event was part of NHS Sheffield commitment to engaging with its local population to improve health and well-being. The purpose was to feedback to and consult with existing volunteers with NHS Sheffield. Approximately 34 people attended the day of presentations and discussions.
Warmth, Wealthy and Healthy Day, St Johns Memorial Hall Hillsborough	Run by Sheffield Housing Energy Action Team at the City Council. NHS Sheffield are partners. Community event with stalls and information provision. Attended by approximately 70 people during the day.

STAGE 4. VOLUNTEER CONSULTATION

A small number of volunteers were identified and recruited by the Volunteer Manager at NHS Sheffield. These members of the public were all involved in some way with different Expert Patient Programmes including those for adults with long-term illness and the supporting parents programme. The inclusion of volunteers in the sample allowed the exploration of the volunteer experience, links between volunteering and public engagement and potential for volunteers to support public engagement. The consultation with volunteers was conducted by telephone using an interview schedule. As with other components of the service evaluation, the purpose of the discussion was explained and only went ahead if the participant was in agreement. All were very willing to take part.

TABLE 4: VOLUNTEER PARTICIPANTS

Volunteer	Description
1	Expert patient participant about 5 years ago then trained as a tutor. Involved in the Supporting Parents Programme. Involved in and supports PCT public engagement activity.
2	Recent involvement in EPP after a stroke. Participated in one course.

Volunteer	Description
3	Expert patient participant and recently trained as a tutor. Long term illness since industrial accident many years ago. Involved in public engagement activity with the PCT.
4	Involved with the EPP for about 7 years as participant and then tutor. Several long term health problems.

STAGE 5. CRITICAL FRIENDS CONSULTATION

The "critical friends" meeting was held in June 2009. The purpose was to discuss emerging findings from the first four stages of the study for completeness and accuracy. Six participants were identified and recruited from five organisations contacted in earlier stages. The number of participants was limited in order to promote more in-depth discussion. Participants were selected to provide a range of organisations, initiatives and perspectives that would have insight or experience of public engagement. The meeting lasted three hours. It was a structured discussion where the emerging themes were presented in turn. After each one, the participants were asked if this resonated with their experience and whether there was anything to add or recommend. In the interests of confidentiality, details of the participants have not been included.

STAGE 6. NHS SHEFFIELD STAFF CONSULTATION

As a final stage of the evaluation staff members from a range of Departments were asked to comment on the emerging findings. They were asked if the findings mirrored their experience, were encouraged to challenge them and to provide examples of good examples of public engagement and areas for improvement. In total 11 staff were contacted by telephone from a list of potential participants suggested by the PPI Team. The number of interviews were conducted during the summer holiday season and during the swine flu pandemic. Both factors limited availability of staff and the number of interviews conducted.

TABLE 5: STAFF CONSULTATION PARTICIPANTS

Department	Number
Public Health	3
Strategy and Strategic Development	4
Communications	2
Patient and Public Involvement	2
Total	11

FINDINGS

Despite the breadth and range of people who took part, there was a great deal of agreement across the participants about the nature of the public engagement (PE)[1] activity with seldom heard groups (SHGs)[2] conducted by NHS Sheffield. Overall there was an acknowledgement that great progress had been made in recent years. Impressive improvements had been made despite the fact that NHS Sheffield is a relatively new organisation, formed following the merger of four smaller PCTs. Participants agreed that there was no easy answer to the question of how to conduct genuine and purposeful engagement with seldom heard groups, but they did provide useful ideas and insight.

However, some challenges did exist, including overcoming the legacy of previous unsuccessful public engagement activity, cultural barriers and partnership working across public and community settings. With regard to many of the PE issues of concern that were identified during the consultation, there were examples of how NHS Sheffield has started to address them. There are illustrations of how the PCT has started discussions or strategic responses to overcome the problems and challenges involved in constructive engagement with seldom heard groups.

It is resoundingly clear that NHS Sheffield is ahead of the game in terms of public engagement when looking at the National picture. When comparing feedback from this evaluation with the findings of The Picker Institute (2009) NHS Sheffield are achieving well. Like other PCTs there is as sense that World Class Commissioning (WCC), and the PPI expectations within WCC, have prompted organisational change and boosted the status of engagement. However, NHS Sheffield is not alone in seeking new ways to engage seldom heard groups. A common difficulty for PCTs is "*overcoming the difficulties of engaging 'hard to reach' / 'seldom heard', minority and disadvantaged groups and communities*" (The Picker Institute, 2009). Some of the issues and recommendations of the participants of this evaluation are mirrored by the participants of the national survey, with a call for more creative, participatory, collaborative and targeted approaches to engagement with SHGs.

The views, experiences and recommendations of participants have been analysed and are reported here in six themes; credibility, consultation, collaboration, capacity, communication and culture, and finally commissioning. These are not discrete, as elements within the themes overlap and interact with those in others. This serves to illustrate how complex an activity public engagement is. It is worth remembering that the purpose was not to report findings as representative of communities in Sheffield, but rather to use this evaluation as a way to identify issues, raise questions and make suggestions for the future.

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[1] Public engagement is subsequently referred to as PE.

[2] Seldom Heard Groups is subsequently referred to as SHGs

It had been the initial intention to map the themes generated by this evaluation to the elements of the Department of Health's recently published engagement cycle (2009). However, following the analysis of participant's views and experience an alternative approach has been taken. The six themes listed above apply throughout the cycle of World Class Commissioning. Instead it is suggested here that they are the core elements of a successful engagement culture and should underpin the systems to support engagement, especially with SHGs. It is therefore proposed that the "6Cs" of credibility, consultation, collaboration, capacity, communication, and creative commissioning should be placed in the centre of the E-cycle and the culture of NHS organisations.

CREDIBILITY

As stated above, feedback from this evaluation indicated that public engagement activity had improved since the creation of NHS Sheffield. A step difference in terms of "intention and action" was reported indicting increased credibility of NHS Sheffield in terms of PE activity. Examples of progress includes the new website (de Normanville et al, 2009) that clearly signposts the public to new and past PE activity and attempts to make the organisation and its decision making more transparent. In addition the continually growing and diverse volunteer programme was viewed as a positive vehicle for PE, as was the *Introduction to Community Development and Health Training* course.

Prior to the formation of NHS Sheffield PE experience was mixed, from the positive to very negative. There was a view from the participants that NHS Sheffield was becoming a more transparent and open organisation with a genuine desire to develop new and improved methods of engaging with the communities they served. However, those consulted recommended that past mistakes were recognised, addressed and processes were in place to ensure they were not repeated. If this was not done, they considered it would threaten PE with those currently contributing and would not facilitate engagement with those from SHGs.

There was consensus regarding past problems with PE and they were summarized well in one discussion with a community group. The prevailing view was that in the past PE had faltered because:

- it was not always clear exactly why a consultation is occurring, sometimes because of lack of information or the language use;.

- it was not always clear exactly what people are being consulted about, and what is really "up for change". For example in the past people had different expectations regarding potential action from a consultation e.g., services closed, opened or relocated. People may have false expectations about the impact of the consultation;

- of impressions that organisations "cherry-pick" what they want from PE and don't reflect the breadth of issues and concerns raised;

- a concern exists that in the past the big decision has been made already and the consultation is about the detail. People have had expectations unrealistically raised about what would happen as a result of the PE;

- what was being consulted on did not always match what was important to the people being consulted. The PCT and public were seen to have different agendas – especially people from seldom heard groups (SHGs). The PCT was seen to be driven by money and targets, the public are by their needs and experience of services;

- a lack of necessary support or resource to enable someone to participate in PE e.g., a sign interpreter present at a consultation or meeting where a member of the public with hearing loss was expected to contribute; time and support to interpret papers and information necessary to complete a survey or participate in a meeting; transport support where an underlying medical condition created mobility problems preventing attendance at a meeting[3];

- where people had struggled to get access to health care, this was demanding enough and did not facilitate participation in PE activity;

- it was not always clear who was accountable for interpreting findings from PE and for making subsequent decisions;

- there was a lack of feedback on what had happened since the consultation and what recommendations from the consultation have been acted upon;

- participants had not been thanked!;

- there had not been enough time built into the PE process for people with disability or communication problems to respond;

- there was a growing over-reliance on website communication and technology. Many people, including those from seldom heard groups do not or can not use the Internet; and

- there is a lack of recognition on how existing local organisations working with SHGs successfully engage with their communities, despite lack of funding and resources

The public and staff participants recognised potential to address the above points and the time was seen to be right to do this. Many of the issues discussed below address how this can be done. However, participants thought that if this was not done there was a risk of greater cynicism developing with an inevitable disengagement from PE activity. It was recommended that time was built in to do this otherwise attempts may be unsuccessful.

CONSULTATION VS CREATIVITY

A core concern of participants about the ability of NHS Sheffield to develop PE with SHGs was the current over-reliance on consultation as a method of engagement. This experience was also reflected nationally in the report from the Picker Institute (2009). The term "consultation overload" was used by participants from all sectors including the public and staff within

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[3] It should be noted that NHS Sheffield do provide transport and communication support to enable PE, however some participants cited past examples where this help had not been accessed or available.

community, public sector and NHS organisations. Various understandable reasons were provided to explain this. These included:

- Top down drivers direct the focus and direction of PE e.g., it is driven by policy requirements or linked to the PCTs targets and monitoring activity.

- There are demanding deadlines and a lack of time to conduct PE. This can lead to a reliance on more familiar approaches and formats to PE that are quick to enact.

- Systems and structures are not in place to support new and creative approaches to PE and to easily harness the skills and expertise of people across the organisation and outside of the PCT.

It was noted that, even in the period of this evaluation, progress was being made by NHS Sheffield in overcoming these challenges. For example, despite the enormous pressure on the organisation from the swine flu pandemic, the PPI, Communications and Public Health teams had worked collaboratively with their community partners and community development links to inform people from diverse and isolated communities, including SHGs, of the health risks and actions to take regarding swine flu.

When talking to individuals and groups from the SHGs who were the focus of this evaluation, they reported a lack of skills and confidence to participate in consultation based PE activity. This was sometimes compounded by a lack of ability to participate because of their underlying condition. At times the pressure of living with the underlying condition, (such a fibromyalgia, a profound hearing loss or mental health problem) and its health and social consequences, meant PE was just not a priority. This meant that more participative methods of PE were required that relied less on consultation and more on developing and empowering communities and the individuals within them. Unless methods can be found to conduct PE in a way that not only generates information for the organisation, but also develops the necessary skills and builds the capacity of those from SHGs, there is a risk that the experiences and needs of these communities will not be represented. There is also a need for ongoing monitoring of identifies barriers and obstacles to engagement.

Approaches that develop capacity in communities in terms of confidence and skills include community development approaches. There is considerable community development expertise within NHS Sheffield in departments such as Public Health. A recommendation made by some staff participants was to develop more proactive ways of planning PE that harnesses community development approaches and skills from across the organisation. One suggestion was, in addition to existing work, NHS Sheffield could identify a few priority areas for PE a year and work in a systematic and planned way, harnessing appropriate expertise from across the organisation.

There is recognition within NHS Sheffield, reflected in their strategy, that there is no one way of conducting PE, especially with SHGs, but a need to use a combination and tapestry of methods, techniques and approaches. As suggested by Picker (2009), PE with SHGs requires:

- Developing better collaborations with those organisations and key individuals placed within the communities you wish to engage with and

- Developing more participatory methods of PE that also improves capacity within the community.

Both these responses mean moving away from consultation based methods of engagement that are conducted and controlled by members of staff within NHS Sheffield.

The range of recommendations made by those who contributed to this evaluation include the following:

- Invest in methods of PE that develop skills and capacity of people in SHGs and communities of interest and where confidence may be low. Examples of such methods include:

- Story telling workshops

- Community reporter schemes

- Have joint planning and facilitation of PE events with the service provider/PCT working in equal partnership with a member of a community or related organisation.

- Develop method of real time engagement as close to health and social care service delivery as possible.

- Develop and invest in PE methods where communication occurs in peoples home.

- Adopt approaches that consider PE a process not on event and avoid "one-off" consultations where possible.

- Interest in the Internet and related technology Web 2 tools may be misplaced. It may appear an easy solution to including people from SHGs but it not the answer for all. There are, for example, generational differences in who does use or is willing to use Web 2 tools.

COLLABORATION

If NHS Sheffield is to overcome barriers to PE with SHGs, it is not possible to do it alone. Existing collaborations are growing between NHS and the public sector and community organisations. However, another recurrent theme from the findings here was the need for more collaboration at various levels; within the organisation, with the Local Authority and within the community. There was a call for better joint planning, joint strategies and a need to exploit one another's knowledge, expertise, systems, intelligence better for joint benefit.

INTERNAL COLLABORATION

Regarding better internal collaboration, this has been addressed above, in relation to the use of expertise, skills and knowledge of the broader organisation to support PE. NHS Sheffield is still a young organisation and it takes time to identify the varied and diverse resource that can be of

benefit to PE. Progress was being made and examples provided of PE collaborations between strategic development, public health, communications and PPI departments in the areas of muscular-skeletal conditions, care needs of the homeless and swine flu.

It was also suggested that different departments could help PE in very practical and tangible ways. For example, public health staff could offer advice on wording of survey tools to overcome communication barriers experienced by people who did not speak English as a first language. The Enhanced Public Health Programme (EPHP) supports community development and community driven initiatives to address health inequalities in 15 deprived Sheffield communities. People who work with the EPHP have extensive community networks and links. They have great insight and knowledge that can inform the structure and format of PE in a way that is accessible to SHGs. There is evidence that this is happening, but also a suggestion that it could occur in a more structured, systematic and planned way.

There is a large and growing volunteer workforce that NHS Sheffield can collaborate with to facilitate PE. A success of the new organisation is the developing volunteer workforce and infrastructure to support this. A wealth of opportunities are available to people including participating in consultations, the *Expert Patient Programme*, attending the *Introduction to Community Development and Health* Training, sitting on patient panels, strategy and planning committees and the Advisory Panel, Clinical Audit Panel, and becoming a Health Champion. This evaluation revealed some collaboration between the PPI team and volunteers. Volunteers were able to use their excellent links to communities of interest that the PPI team want to reach, including SHGs. However, a question was raised about how reactive this involvement was and whether there was potential for this to be more planned and systematic. There are plans to develop a strategic approach to linking volunteering with PE within the organisation. Such collaboration would be a welcome and useful development.

COLLABORATION WITH THE LOCAL AUTHORITY

Some participants reported that in some areas there was very effective joint working between the PCT and Local Authority. Collaboration in PE occurred in places, especially at a higher strategic level and at grass roots level. Examples of this were in the engagement activity with children and young people and older adults. However, there was a concern that this was not always the case. The risks were that organisations may unnecessarily repeat PE, impair credibility with the public and waste staff resource. Both the Local Authority and NHS Sheffield do a lot of PE work but they do not always involve one another in the planning, conduct, dissemination and application of findings. There was a call to improve this collaboration through:

- More joint posts at a strategic and middle management level e.g. LA and PCT.

- Strategies to share information systems and data. Both organisations collect vast amounts of routine data that could be valuable to identify people in SHGs and their needs as well as their use of services. Whilst there are data protection issues to overcome there is potential to explore more knowledge management across organisations to support PE with SHGs.

COLLABORATION WITH COMMUNITIES

As stated above, there was a move towards more participative methods of PE, rather than consultation based methods. This means PE can be regarded more as a process and less as independent one-off consultation events. With a move towards participative approaches, comes more genuine partnership and collaboration, earlier in the process.

The message from participants was that community groups and representatives need to be more involved in the planning and conduct of PE, rather than just called on to participate. They are able to advise on how to conduct PE in a way that is open, assessable and acceptable to people from communities seen to be "hard-to-reach". Community and voluntary groups may be trusted by people from SHGs and have extensive networks with individuals within the communities. This means the groups not only provide great insight into the community, they also have access denied to PCT staff. Two potential approaches are open to the PCT:

- Work more collaboratively, earlier on in the process, to plan and deliver programmes of PE jointly between community organisations and NHS Sheffield.

- Contract out aspects of PE work to community organisations. This could be of particular benefit where the community of interest or SHG is not geographically based or has a practical or cultural barrier to participating in PE.

CAPACITY

Various constraints on capacity have placed limitations on PE in the past in a variety of ways. This evaluation has highlighted a number of these constraints that need to be overcome in order to enable PE with SHGs to flourish. Issues related to capacity fall into two areas, i) NHS organisation and staff, and ii) communities and seldom heard groups.

Regarding staff, the issue of time and resource has already been touched upon. It is clear that NHS Sheffield have staff with considerable experience in PE. They have a PPI team who, are a dedicated and strive to conduct credible and purposeful PE. However, if PE with SHGs is to expand in a purposeful way the contribution of the whole organisation needs to be considered.

The impression from this evaluation is that in the first 18 months of the life NHS Sheffield much of their PE work has been focused on establishing the basic infrastructure to support PE and conducting top-down, policy and target driven consultation. They have been successful in doing this and have achieved much in a short time. In order to support this work and develop PE to incorporate the views of SHGs, the capacity of NHS Sheffield can be developed in a number of ways, some of which have already been raised.

- Scope the expertise and skills required to conduct participative and community development approaches to PE in SHGs. Identify where the expertise is available from within the

organisation. Develop ways to work more systematically across departments within NHS Sheffield that have the skills and knowledge to support PE.

- Where necessary skills are not available from within the organisation develop partnerships and knowledge transfer schemes with external organisations.

- Develop a strategy to formalise the links between volunteering and PE.

- Explore the potential for joint working across NHS Sheffield, Local Authority and community organisations, including joint posts, secondments and work placements.

- Develop better knowledge management systems to collate and disseminate learning from PE. For example, identify how to establish a repository of information on PE that could be kept to inform subsequent projects, services, or priorities on:

  o Ways of conducting PE with certain communities

  o Key messages and findings from previous consultations/involvement.

For communities, the issue of capacity to engage relates once again to time and resource. For some of the communities we spoke to there were what appeared to be insurmountable barriers to participating in PE as currently conducted. For example, members of SHGs may need more time to read, understand, translate information, and participate in process, need more time to respond and may need resource in terms of translation, interpretation, support. If this is not provided, the risk is that members of these communities may be excluded by default, not by intention. An example of this is where a community or advocacy group is sent a batch of PE questionnaires to circulate to users of their service or group. However, without time to sit down with potential respondents to interpret and explain the questions, the person is unable to participate. If the community organisation has limited resources, and their priority is to provide a support, advice or advocacy intervention, this interpretation does not occur. Here, there is no intention to exclude people from SHGs, but it occurs anyway.

Much of the discussion with the public in this evaluation focused around consultation, as this was the majority of the PE experience and activity. However, there were a few examples illustrating the challenge for people involved in more ongoing PE, for example, sitting on a service strategy and development group. Problems were highlighted about lack of provision of information prior to meetings in a way that was accessible and understandable to someone with a communication or language problem and recognition of the time it would take to decipher the necessary papers.

The second issue here, also raised previously, is about skills and confidence to participate in PE. An experience commonly reported was that there was a lack of knowledge of PE opportunities. If people from SHGs did know about them, they assumed the opportunity was not open to or accessible to them. Reasons for this included:

- A lack of underlying knowledge about the health issues involved.

- A lack of experience and confidence speaking in public.

- Mobility or communication problems.

- Low levels of self-esteem and self-efficacy.

- Inability to get transport or interpretation.

- Inability to understand information about the event and what it involves.

These substantial issues identify a need for investment in developing the capacity and ability of people from SHGs to participate in PE. By conducting more of the same consultation based activity, it will be difficult to overcome existing barriers to PE with SHGs. More participatory methods of PE such as storytelling, do offer a way of developing capacity as well as generating information. However, it may be advisable to invest in preparatory work first. For example, the deaf participants suggested NHS run health road shows for particular communities of interest that would provide information, start a dialogue in an unthreatening manner, provide adequate language and communication support and inform about further PE and volunteering opportunities.

COMMUNICATION AND CULTURE

Many of the issues relating to capacity and collaboration, also link with communication and culture. The participants who said they felt unable to access PE activity also reported knowing very little about what was available. For example, none of the groups we met with had seen the new *Prospectus of Volunteering* published by the PCT. Whist they reported that the range of opportunities were impressive, they had known little or nothing about them. A concern was raised that the document was a little too like a 'university prospectus' and whilst informative, may be off-putting and daunting to someone with low literacy and low confidence.

This indicates that new ways of communicating with the public are required. The new Website has evaluated well. Electronic communication has and does open up engagement of some individuals but for those who do not use such technology it does not address communication barriers. This is a continually challenging area for development and one that NHS Sheffield appears to be addressing. A recurring comment was that there should not be an over-reliance on technology or web-based communication strategies.

During the course of this evaluation restructuring and investment has taken place to embed communications more firmly in the engagement and standards work of the organisation. This will enable the expertise of the communications department to be better employed in overcoming some of the barriers to PE expressed by the participants. Such barriers, cited by participants of this evaluation, include the overuse of jargon, feedback of findings in wordy, overlong formats, and an overreliance on the Internet.

Many of the suggestions made by the participants are already being employed by NHS Sheffield. For example there is more evidence of staff "going out and being seen" in communities and using informal and formal networks of other PCT staff.

There was also a concern from some quarters that nationally driven restructuring of public sector services and organisations reflected a tendency to "go big". This threatened a sense of community and would create potential challenges for the NHS in conducting PE work. For example they cited the fact NHS Sheffield had been a merger of four smaller organisations to one city wide Trust, poly-clinics were replacing community based GP surgeries, and local assemblies were replacing local panels. The view was that this threatened community communication.

Participants recommended that, to be successful, PE has to work from within a culture, rather then "parachuting in". As indicted above this will require developing closer collaborations and partnerships, and in developing capacity within communities to play a role in planning and conducting, as well as participating in PE. Community organisations can provide support, translation, interpretation, transport and support for consultations but also work in more equal partnership in developing and delivering participative methods of engagement.

Community organisations and other participants called for PE to move more towards a social model rather than medical. Without this change it would be difficult to generate genuine engagement with SHGs. Amongst the concerns raised many related to cultural communication and language. Taking a more social approach will help to identify these issues in the planning and development stages, rather than too late in the process. For example, currently people from communities from a predominantly verbal rather then written culture struggle to contribute to PE. In addition, some of the PE and consultations cited have been charged with being "too conceptualized". The consultation questions were thought to be too, broad, and impossible to answer.

CREATIVE COMMISSIONING

Participants were asked to consider how PE activity should be conducted in the future in order to promote involvement of SHGs. A number of fairly fundamental suggestions were made by those who took part that relate to commissioning decisions and activity. They are reported here, but it should be made clear that these are not recommendations. They are merely presented as suggestions for discussions based on participants views. It was suggested that NHS Sheffield could consider the following:

- Whether some of the funding used for consultations could in the future be use to develop the infrastructure to support PE generally and with SHGs specifically. Such investment and infrastructure included developing networks to represent communities of interest and SHGs, better knowledge management systems to prevent duplication of work and store learning from PE for the future.

- The potential to commission the development, implementation and evaluation of new, creative methods of engagement that may be delivered by external organisations with participative expertise. Examples include story-telling and community reporters' schemes.

- The potential to commission out PE work to groups with good networks and established trusting relationships with SHGs and communities that are hard for the PCT to reach. Local

charities and community groups can help but they are vulnerable – especially in current economic climate. There may be potential for local organisations to conduct some PE work for NHS Sheffield and to be contracted to do so. Advantages include better access to communities, build capacity within communities, empower, develops infrastructure and generates funding for local organisations. Challenges include how this could be contracted and monitored. Some participants raised a concern that organisations may not respond favourably to this as it would change their identity. They may lose the sense of independence and see themselves as part of PCT.

- The need to scope the nature of Service Level Agreements already held between NHS Sheffield and voluntary/community groups and local charities. For example where there is a contract for the local organisation to conduct advocacy work with a SHG. Where the organisation is required to provide monitoring data is it possible to explore the potential to expand this requirement to include generating patient experience data to inform PE? This could be more in-depth or varied than patient satisfaction and could be qualitative in nature.

- The amount and type of community development resources required to reflect communities of interest, not just geographical area. Area based initiatives have made a difference in terms of addressing health inequalities linked to deprivation. However, an unwanted consequence of this type of investment and working may be that can exclude communities of interest. Some of the SHGs involved in this consultation are not geographically based. If communication, community development and other supportive infrastructure focuses exclusively on area based approaches there is a risk some SHGs will be further excluded from PE activity.

RECOMMENDATIONS

APPROACH

1. Continue the development of Public Engagement (PE) approaches that recognise past mistakes and builds processes to ensure they are not repeated

2. Develop participative methods of PE that generate information for NHS Sheffield whilst developing the skills and capacity of those from Seldom Heard Groups (SHGs). Implement joint planning and facilitation of PE events with representatives from the community and related organisations.

3. Develop methods of real-time engagement as close to health and social care service delivery as possible.

4. Adopt a social model of PE rather than medical to generate genuine engagement with SHGs.

5. Adopt approaches that consider PE as a process and avoid "one-off" consultations where possible.

6. Balance the use of Web 2.0 tools with other forms of PE activity to ensure all sectors of the community are not excluded owing to lack of intranet access etc.

SKILLS

7. Scope the expertise and skills required to plan and conduct participative and community development approaches to PE in SHGs, identifying where the expertise is available from within NHS Sheffield.

8. Develop ways to work more systematically across departments within NHS Sheffield that have the skills and knowledge to support PE.

9. Develop partnerships and knowledge transfer schemes with external organisations, where the necessary skills are not available from within the NHS Sheffield

COLLABORATION

10. Develop a strategy to formalise the links between volunteering and PE.

11. Explore the potential for joint working across NHS Sheffield, Local Authority and community organisations, including joint posts, secondments and work placements.

12. Develop better knowledge management systems to collate and disseminate learning from PE.

13. Consider the suggestions made by participants related to commissioning decisions and activity:

- Use some of the funding allocated for consultations to develop the infrastructure to support PE generally and with SHGs specifically.

- Explore the potential to commission the development, implementation and evaluation of new, creative methods of engagement that may be delivered by external organisations with participative expertise.

- Explore the potential to commission out PE work to groups with good networks and established trusting relationships with SHGs and communities that are hard for the PCT to reach.

- Consider the need to scope the nature of Service Level Agreements already held between NHS Sheffield and voluntary/community groups and local charities and how the data collected could be used to support PE with SHGs.

- Review the amount and type of community development resources required to reflect communities of interest, not just geographical area.

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APPENDIX 1 TOPIC GUIDE FOR CONSULTATION WITH VOLUNTARY/COMMUNITY GROUPS

The engagement of seldom heard groups in commissioning health services:

Sheffield PCT consultation

Topic Guide for consultation with voluntary/community groups

The Sheffield Primary Care Trust is interested in finding out what the public think about 4 things:

- What are the health needs of Sheffield people?
- What health services should be provided in Sheffield?
- What are the most important services?
- How can services be improved?

We want to know whether you think this sort of discussion with the public is useful and how it should happen.

Hand out PCT leaflet

1. Have you heard of the PCT?

2. Do you know what they do?

The PCT wants to communicate and engage with the people of Sheffield in order to help them decide:

- What are the health needs of Sheffield people?
- What health services should be provided in Sheffield?
- What are the most important services?
- How can services be improved?

3. Have you ever been involved in giving your opinion about what you like or dislike about health services in Sheffield:

Prompts:

Which service?

How did you give feedback?

Have you seen changes as a result?

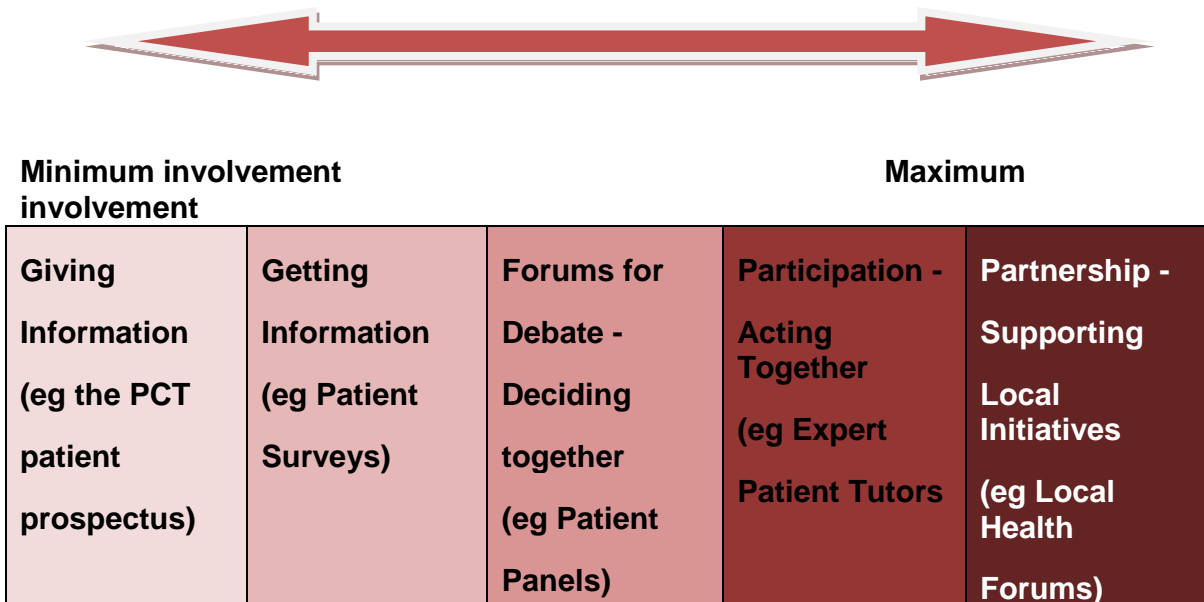4. Do you think it's important to ask the people of Sheffield about this?

Why?

5. How should the PCT do this?

Prompts:

Show the spectrum of involvement and ask what is the right level generally and for them.

Public involvement continuum

Minimum involvement involvement   **Maximum**

Giving Information (eg the PCT patient prospectus)	Getting Information (eg Patient Surveys)	Forums for Debate - Deciding together (eg Patient Panels)	Participation - Acting Together (eg Expert Patient Tutors	Partnership - Supporting Local Initiatives (eg Local Health Forums)

6. What would be the best way for the PCT to communicate with you and your group/organisation/community?

Prompts:

open question and then explore examples e.g. written communication, consultation groups, community events, local representatives / advocates / links, IT e.g. Internet, blogs, etc

7. Have you had any contact / communication with the PCT?

a) Why?

Prompts:

- *What was the reason for the communication?*

- *What motivated you to communicate?*

b) Who was it with and who initiated contact?

c) How?

- *Prompts:*

- *What was the nature of the contact?*

- *Was it successful/useful?*

- *What was achieved?*

8) Would you like to be involved in communication, engagement with the PCT in the future?

Why?

9) ***Key issues about how to engage with SHGs***

- Continuous involvement - not one off consultation

- Allow sufficient time - SHG may need longer to participate

- Don't start from the beginning each time

- Develop capacity and confidence

- Work in partnership:

- Strategy

- Data

- Engaging

- Let communities lead or run engagement,

- Develop staff capacity

- Franchise out responsibility to engage to voluntary and community groups

- Feedback

Could we have got this information in a better way?

Any other comments?

APPENDIX 2: CHECKLIST OF ISSUES TO CONSIDER WHEN OBSERVING A PCT CONSULTATION EVENT.

Checklist of issues to consider when observing a PCT consultation event.

Comment on:
- The nature of the event and processes used with description
- The appropriateness of the approach and processes

Advertisement:
- Where
- How
- What media?

Venue:
- Accessible,
- Central,
- Transport,
- Costs,
- Catering

Recruitment:
- The usual suspects?
- Open or invite only

Type of event:
- What is the purpose of the event
- What type of event
- Is it appropriate to the purpose?
- Is it a one off or part of an ongoing process
- What will happen to the findings?

Attendance:
- Who
- How many
- Mix of users / carers / professionals
- Diversity of attendees age, gender, demographic, ethnic, seldom heard groups
- Did the people attend that the PCT wanted to attend?

PCT presence:
- Who is running the event - PCT, lay representatives?

- Who is present from the PCT e.g. seniority within the PCT?

Public involvement continuum

Where did the event lie on the PCT continuum of public involvement?

If the event is part of a bigger process or piece of work, where does the whole project lie on the patient involvement continuum?

Ten steps to involvement

The principles of public engagement that the PCT follow are encompassed in the 10 Steps model.

Is it clear that the 10 Steps have been considered in planning and running this consultation event?

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