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<tr>
<td>Contact Details</td>
<td>James Vallance</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Policy Team</td>
</tr>
<tr>
<td></td>
<td>New King’s Beam House</td>
</tr>
<tr>
<td></td>
<td>22 Upper Ground</td>
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For Recipient’s Use
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For further information about Patient and Public Involvement, please see the NHS Centre for Involvement website (www.nhscentreforinvolvement.nhs.uk) and the Department of Health Patient and Public Empowerment pages (www.dh.gov.uk/ppe).


This document can be provided in a larger font on request from www.nhscentreforinvolvement.nhs.uk.
Over the last decade there have been enormous changes in the landscape of urgent care services. Patient and Public Involvement in these services is, however, often misunderstood and therefore neglected. The term ‘urgent care’ includes services such as NHS Direct, NHS walk-in centres, intermediate care services, out-of-hours provision, minor injuries units and case managers for those with long-term conditions. Urgent care service providers increasingly include for-profit, not-for-profit and social enterprise providers – all now contribute directly or indirectly to urgent care provision.

Alongside these service changes in urgent care, a parallel set of reforms have been taking place, giving patients and the public a more direct say in shaping the NHS and delivery of healthcare services. This poses particular challenges for urgent care, where, unlike almost all other areas of healthcare, there is no stable or consistent patient or service user group that can be ‘owned’ by urgent care. Consequently, there is no easily constituted group that can be called upon to be involved.

*Our NHS, Our Future: NHS Next Stage Review – Leading local change*, published this year, emphasises the importance of involvement by patients and the public in the delivery of their care and in NHS services, effectively putting the patient at the centre of their care.
healthcare and the NHS. The Next Stage Review also announced the launch of the consultation on the NHS Constitution, which proposes that patients and the public will have 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 the spring of 2008, an expert panel of patients and professionals with urgent care and Patient and Public Involvement expertise was brought together to contribute to the development of a guide to Patient and Public Involvement that would support the effective delivery of urgent care services. The aim of the panel was to improve the patient experience of urgent care by maximising public involvement in the planning and provision of services. This document represents the outcomes of that work.

The emphasis of the guide is therefore on involving patients and the public in the early and ongoing development of urgent care services.

Joan Saddler, OBE
Director of Patient and Public Affairs
Department of Health
1. In the spring of 2008, an expert panel comprising expert patients and professionals from the fields of urgent care and Patient and Public Involvement (PPI) was convened.

2. The group met on two occasions with the remit of developing a guide to best practice in the involvement of patients and the public in urgent care provision and commissioning.

3. It was recognised that urgent care provision is very different from other types of NHS care provision because there is no readily available patient group that can be called upon to get involved.

4. The guide was organised around a wheel of involvement made up of eight spokes, which together make up the end-to-end process of PPI. Examples from the field of urgent care are provided to illustrate each part of the process.

5. The process starts by getting organisations to undertake an audit of existing PPI activity. Good PPI should comprise a balance of individual and group activity; proactive and reactive activity; retrospective and real-time activity; and direct and indirect activity. A simple map enables organisations to get a feel for the extent of activity and to identify gaps.

6. When undertaking any PPI, it is important for organisations to ask why they are involving people and what they are seeking to do through involvement, and then set clear aims and goals that can be monitored and measured.

7. Before embarking on any specific PPI activity, organisations should make sure that they identify what information they already have about that activity. In this way, activity can be planned sensibly and appropriately.

8. PPI involves the use of resources in terms of both money and time. Costs should be identified when planning activity so that PPI does not ‘fail’ because of a lack of resources.

9. Identifying who needs to be involved in PPI activity is dependent on the organisation’s aims and goals. It might be appropriate to segment the target population into smaller groups by age, gender, location or other characteristics.

10. The methods chosen for the PPI activity should match the nature of the activity, the people the organisation wants to involve, the resources available and the aims and goals. A list of possible PPI methods is provided.
11. Evaluation is a key phase in the PPI Urgent Care Wheel and is also the most challenging phase. Identifying the impact of involvement requires the use of a range of different outcome measures, including measures of patient experience, which are not always simple to capture.

12. Providing feedback to those who have been involved is the final phase of the wheel. The way in which organisations do this will influence how much trust and confidence patients and the public have in them and will also influence how prepared people are to continue to be involved in the future.
Why a guide for urgent care?

Urgent care is defined as the ‘range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care needs and appropriate prompt response to that need’ (Direction of Travel for Urgent Care: A discussion document, 2006, page 16). The vision for urgent care was set out in NHS Next Stage Review: Our vision for primary and community care. The vision is that every member of the public should be able to expect integrated local services that provide access to urgent care, 24 hours a day and 365 days a year (NHS Next Stage Review: Our vision for primary and community care, 2008).

While Patient and Public Involvement (PPI) has become increasingly common in many parts of NHS organisations, it has, as yet, played little role in urgent care settings. This is because of the special challenges that involvement presents in the context of urgent care. Unlike almost all other areas of healthcare, there is no stable or consistent patient or service user group that can be ‘owned’ by urgent care. Therefore, there is no ready-constituted group that can be called upon to be involved except in ad hoc ways. So why do organisations need to be concerned about involving patients and the public in urgent care? We suggest the top ten benefits for you and your organisation below – and there are many more. Examples of how these benefits can be realised can be found throughout this guide.
Why a guide for urgent care?

Ten benefits of involvement

1. PPI will lead to improvements in care and a truly patient-centred service.
2. Patients are likely to be more satisfied and happier with services if they have played a part in their design.
3. If members of the public better understand what services do, they will better understand which services to use and when to use them.
4. PPI will help organisations that provide urgent care services meet the quality standards outlined in the National Quality Requirements in the Delivery of Out-of-Hours Services (2006), particularly Quality Requirement 5.1
5. PPI will help demonstrate that organisations providing urgent care services are actively responding to Core Standard 172 (Healthcare Commission, 2006) as well as other vital signs, targets, standards and outcomes.
6. Involving staff in decisions about the planning, delivery and evaluation of services is a way of gaining an expert public view, as well as enhancing motivation and morale. It is worth noting that public opinion about services is significantly influenced by staff views.
7. In an NHS where organisations are in competition, demonstrating excellence in PPI can give an organisation a competitive edge when bidding for contracts or when undergoing contract reviews.
8. There is a legal requirement for all organisations providing NHS-funded services to demonstrate that they have involved service users and the public in planning, evaluating and developing their services (through Section 11 of the Health and Social Care Act 2001, Section 242 of the National Health Service Act 2006 and Section 233 of the Local Government and Public Involvement in Health Act 2007).
9. World-class commissioners need to ensure that they involve patients and the public throughout the commissioning cycle, including when commissioning urgent care services, as outlined in World Class Commissioning: Competencies (2007).
10. Involving people in decision making is a good way of demonstrating to the public that the service provides value for money. Remember that these services are funded through public money – people will support organisations better if you tell them how you are spending their money and why.

1 Quality Requirement 5 states that ‘providers must regularly audit a random sample of patients’ experience of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits’.
2 Core Standard 17 states: ‘The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.’
Part 1

Why a guide for urgent care?

Who is the guide for?
The short answer is that it is for any organisation that provides or commissions urgent care services, the staff within those organisations and interested members of the public. This includes:

- senior leaders, including the chair, chief executive and directors or senior managers within organisations that provide or commission urgent care services;
- clinicians and non-clinical staff working in urgent care settings;
- those who manage and organise urgent care provision, whether based in an NHS, for-profit, non-profit or social enterprise;
- directors with responsibility for service reconfiguration;
- commissioners;
- patients and members of the public who have an interest in this area;
- PPI professionals, i.e. those people who play a significant role in PPI across an organisation providing urgent care services, such as people working in the NHS in the Patient Advice and Liaison Service (PALS);
- service improvement leads;
- PPI leads in strategic health authorities (SHAs) in their role to quality assure community engagement;
- local authority health overview and scrutiny committees (OSCs);
- voluntary organisations; and
- community groups.

What is the guide for?
This guide aims to help you to strengthen involvement in urgent care and meet the national and local imperatives around PPI in order to:

- help the NHS make better, more responsive decisions about urgent care services – including the commissioning of services – which take account of the views and preferences of local people, groups and communities;
- clarify the existing involvement and consultation requirements within the urgent care system;
- identify ways to make involvement and engagement processes more efficient and effective in urgent care;
- embed involvement within the mainstream of urgent care provision and commissioning rather than it being an activity undertaken only when there is a proposed major change or a problem that needs solving; and
- show how the NHS should approach involvement and consultation work in urgent care.

3 This guide has been written with providers of urgent care services as its prime audience. Commissioners will, however, find the guide useful in enabling them to understand the types of PPI that service providers could and should be providing.

Why a guide for urgent care?

How to use the guide
To get the most from this guide, each organisation that provides urgent care services should make an honest and robust assessment of where it stands in relation to:

- public understanding of the organisation and the services it provides, the need for change, the planned way forward and any emerging options for change;
- the effectiveness of recent and current involvement and consultation activity around urgent care – including work with staff;
- the ways in which it engages with its local community, particularly the Local Involvement Network (LINk); and
- plans for ongoing work to build a system of involvement and consultation that is integrated throughout each organisation that makes up the urgent care system.

In Part 2 of this guide we suggest ways to help organisations get started on this assessment. It is the right time for organisations to take stock of what they are doing in terms of involvement activity so that they can plan and prioritise effectively and reap the key benefits of effective involvement. After undertaking a baseline assessment, each organisation and the urgent care system as a whole (including those who commission services) should feel one of the following:

- well prepared and enjoying positive public confidence. For those in this category, this guide will act as an advisory checklist;
- that good community and staff involvement is ongoing but there is still a perceived lack of public confidence. In this case, the guide will help with plans for further work; or
- that public confidence is low and community and staff involvement has not been effective. This guide will provide comprehensive and up-to-date advice based on evidence and practice. It will also provide links to relevant statutory guidance and some tools to help plan and undertake robust engagement and consultation processes.

Before we go on, we have included a few ‘myth busters’ about PPI – things that you might have heard, and might even identify with?

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\(^5\) We are aware that not all staff are yet familiar with LINks and so have included a brief review in Appendix 1 of this guide.
## Why a guide for urgent care?

### Myth busters

<table>
<thead>
<tr>
<th>Myth</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPI is difficult to do</td>
<td>Yes it can be, but if you think of involvement as a lot of varied small and simple activities on their own it need not be difficult.</td>
</tr>
<tr>
<td>We might open a Pandora's box and not be able to please the public because there are too many differing views</td>
<td>You are never going to please everyone, but, on the whole, people respond reasonably when they are given sufficient information to enable them to understand the realities within which the service functions.</td>
</tr>
<tr>
<td>It will all just be tokenistic</td>
<td>Good involvement means asking people for their views early, so they can genuinely influence your plans, and making sure that people have really good information and evidence about available choices.</td>
</tr>
<tr>
<td>PPI is expensive</td>
<td>It certainly can be expensive if you do not do it. Some organisations have been involved in lengthy acrimonious consultations and legal challenges when they got it wrong! PPI does not cost the earth and it can save resources if you get your service improvements right.</td>
</tr>
<tr>
<td>We might have to change our plans if we ask the public</td>
<td>Correct.</td>
</tr>
</tbody>
</table>
### Why a guide for urgent care?

#### Myth busters

<table>
<thead>
<tr>
<th>Myth</th>
<th>Corrected Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>You only need to consult people if you are making big changes to services</td>
<td>Wrong. Under the new legislation you must involve people in decision making on an ongoing basis – not just when there is a significant variation to a service.</td>
</tr>
<tr>
<td>There is no point doing any PPI because our previous attempts at establishing user groups have failed – we just attract the same old suspects</td>
<td>Try a different approach or, better still, a range of different approaches. There are lots of examples where PPI in urgent care has worked, so look at these and adapt them for your organisation and community context. You might not get it right every time but you will not always get it wrong either.</td>
</tr>
<tr>
<td>We already know what the public wants so this is all a waste of time and money</td>
<td>Your assumptions may be wrong. You may be surprised about what the public’s views really are when they are asked. You never know what innovative ideas patients and the public may bring to the table – they may improve services or care and might even save you money.</td>
</tr>
</tbody>
</table>
How to involve patients and the public in urgent care

Patient and Public Involvement – driving forwards
Building any involvement system for developing, monitoring and evaluating healthcare services is complicated and takes time. In urgent care, involvement is even more challenging because there is no readily available user group to call upon to get involved. In the next section we present Patient and Public Involvement (PPI) as a set of different phases and processes, illustrated with examples from urgent care. We have called this the PPI in Urgent Care Wheel. It is based on the PPI cycle developed by Tritter et al. (Improving Cancer Services Through Patient Involvement, 2003).

Patient and Public Involvement in Urgent Care Wheel
The different components within the wheel relate to one another: each phase of the process builds on previous work and leads to the next phase. You and your organisation can start your involvement journey at any point on the wheel, although there are clearly some phases that are more obvious starting points than others, depending on the nature of the involvement activity.

We have kept the discussions of the various spokes of the wheel deliberately brief but have signposted different sources of information so that you can follow up issues of particular interest.
How to involve patients and the public in urgent care

PHASE 1
Map existing activity

All organisations need to know what PPI activity is going on within the services they provide. It is a requirement to involve people, and organisations need to be able to provide evidence of PPI activity and its impact when they are bidding for contracts, taking part in contract reviews, demonstrating that targets and standards have been met and so on. For providers of out-of-hours services, National Quality Requirements in the Delivery of Out-of-Hours Services (2006) sets out expectations that organisations will regularly audit patient experience, including PPI activity.

Undertaking a brief audit of involvement activity – say over the last six months – will give you a good starting point for moving forwards with new activity, will help to embed existing good practice, and will identify existing capacity within your organisation. Auditing activity does not need to be complex, although using a short, standardised form fed back to a co-ordinator can help generate a coherent database systematically and will make it easier to sort and share evidence and examples. As a starting point, a simple grid like the one in Figure 2.1 will suffice. There is also a range of available tools that can be utilised, such as the checklist from Patient Insight: Harnessing the power of public opinion (www.drfosterintelligence.co.uk/news Publications/localDocuments/Patient_Insight.pdf) as well as the Royal College of General Practitioners’ Out of Hours Clinical Audit Toolkit (www.rcgp.org.uk/docs/Quality Out of Hours Toolkit final.doc).

Figure 2.1

<table>
<thead>
<tr>
<th>Which service area?</th>
<th></th>
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<tbody>
<tr>
<td>What were the aims?</td>
<td></td>
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<tr>
<td>Which organisations did you work with (statutory, voluntary, etc)?</td>
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<tr>
<td>What was the approach?</td>
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<td>How was the work evaluated?</td>
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<td>What was the outcome/impact?</td>
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How to involve patients and the public in urgent care

When auditing activity, it is useful to remember that PPI covers a spectrum of activity including:

- user participation in decisions about treatment and care;
- user involvement in service development, e.g. planning and design of services, commissioning;
- user evaluation of services;
- user involvement in teaching; and
- user involvement in research.

Therefore, when you undertake your mapping you should include activity from the whole spectrum of involvement activities. Below we have identified some sources of information that should be readily available to support your mapping and ongoing audit:

- Patient and staff survey data
- Data from complaints, concerns and compliments
- Feedback from commissioners and other key stakeholder groups
- Inspection data from, for example, the Healthcare Commission and internal audits
- Clinical audit data
- Committee membership, i.e. user representation
- Feedback through your website
- Patient satisfaction/patient experience data (locally gathered – paper versions and on electronic handsets)
- Comment cards (from patients and staff)
- Recent consultations
- Expert patients involved in teaching staff
- Patients involved in any research activity
- Past PPI forum reports and new Local Involvement Network (LINk) feedback, reports or recommendations.

Once you have completed your mapping, you should be in a strong position to identify where the gaps in your PPI activity are, and this will enable you to take steps to plug those gaps. You should be looking for a balance of activities in your map. In Figure 2.2 we have included some of the essential elements of a good system and we have provided a couple of examples to help you with this idea. For example, you should have activity that is aimed at involving individuals and groups, you should be supporting involvement that is both direct and indirect, and so on. We expand on these elements in the following sections of the guide.

**Figure 2.2**

<table>
<thead>
<tr>
<th>Elements</th>
<th>Individual</th>
<th>Direct</th>
<th>Reactive</th>
<th>Real-time</th>
<th>Collective</th>
<th>Indirect</th>
<th>Proactive</th>
<th>Retrospective</th>
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How to involve patients and the public in urgent care

Examples
Involving a service user on a performance monitoring committee would be:
■ individual, direct, proactive, real-time involvement.

Using trends from patient survey data to plan service changes would be:
■ collective, indirect, reactive and retrospective.

One final point – it really is worth keeping the map ‘live’ and adding to it on an ongoing basis. It is much easier to update your lists of activities regularly than to have to keep starting from fresh, and you will find these lists enormously useful for all sorts of purposes (see ‘Ten benefits of involvement’, on page 8).
How to involve patients and the public in urgent care

**PHASE 2**
Define aims and goals

- Why are you involving people?
- What do you want to change, evaluate or develop?

Identifying why you are involving people is absolutely fundamental to becoming a good involvement organisation. We have seen examples in our work across the country where people have been motivated to volunteer to be part of a PPI group or system, but they are not then approached to ‘do’ or ‘be’ anything and so, not surprisingly, they become disengaged. We have also heard of situations where people have taken part in a consultation but found out later that the decision had already been made and so their input was worthless. In both cases the emphasis has been on recruiting people to be involved, without giving thought to why. If, for example, financial constraints mean that there is only one choice, then do not involve people on the pretext that there are different options for proceeding. It may be appropriate to consider a minimal change as one possible option.

You should then be able to answer clearly the key question about why you are involving people, for example we want to know what the experience of patients has been in x; we want to know what people’s expectations are about y; we want to make sure that we have members of the public involved in prioritising our clinical audit programme so want representation on z committee.

The next question to answer is what do you want to change, evaluate or develop? We mentioned in Phase 1 that there is a broad range or spectrum of reasons why you involve people, from individual participation in treatment decisions to involvement in research. When answering this second question, think about where the involvement fits into the spectrum of activity (see page 15) and consider two further distinctions to help define your aims and goals:
How to involve patients and the public in urgent care

- Is this a continuous and proactive involvement activity, such as including members of the public on key decision-making groups within your organisation or setting up a reference panel to support ongoing decisions about service redesign?
- Is this an activity that is responding to a particular issue identified through audit or raised, for example, by the LINk (see Appendix 1)?

We have chosen two examples to illustrate the need for clear aims and goals – one is a proactive example and one a reactive example.

**Example 1**
Croydoc is an out-of-hours service provider covering Croydon Primary Care Trust (PCT), Kingston PCT and Sutton and Merton PCT. A single clinical governance group that meets every eight weeks includes not only PCT managers, GPs from the three PCTs and staff from Croydoc, but patient representatives as well. One of the functions of the group is to review anonymised complaints data and significant events, and the aim of including patient representatives was to bring the patient perspective to the table. The group has greatly benefited from the patient perspective in ensuring that lessons are learned and learning is disseminated. For example, the service has been able to instigate improvements in communicating information about waiting times to patients. The patient representatives also bring a perspective of pragmatism when clinicians are overly self-critical.

**Example 2**
The Royal London Hospital in Whitechapel was experiencing increasing demand for its A&E services. Between 2002 and 2004 the number of Tower Hamlets patients had doubled. Many patients were attending with problems that were best dealt with by staff based in community settings.

This system of service provision was not sustainable and it highlighted the need for a radical urgent care strategy that made better use of community services as providers of urgent care. This way the A&E department could focus its attention on more specialist and trauma cases and could empower the patient to use services, including self-care, effectively.
How to involve patients and the public in urgent care

In 2006, Tower Hamlets PCT commissioned an external organisation to undertake market research, including both primary and secondary research to identify who was using A&E and to help understand attitudes and behaviours towards service use locally.

Research focused specifically on the age, gender and ethnicity of repeat attendees at the local A&E department over a two-year period. It included a large number of Bangladeshi males aged 20–29 years and many children under four years. Interviews, consultation events and focus groups also took place to gain a greater insight into the repeat users of A&E.

The market research report that was produced was the foundation for a comprehensive programme called ‘Get the Right Treatment’ and enabled the programme team to set an informed and clear list of aims, including:

- to use marketing techniques to understand populations in order to support effective communications;
- to educate local populations and front-line staff on different types of care and care settings in their local areas;
- to encourage patients to self-care or seek local community-based alternatives for their urgent care needs, where appropriate; and
- to raise awareness of the wide range of local healthcare professionals and their skills among local residents.

Following the research and the setting up of the programme aims, a warm-up campaign, known as ‘Local Heroes’, was implemented to test marketing approaches and responses in the short term. Independent evaluation showed that this short campaign resulted in a 6.4% drop in A&E attendance over a three-month period.

PHASE 2

Identify how you will feed back
Map existing activity
Define the aims and goals of new activity
Identify existing information
Identify available resources
Identify people
Identify methods
Work out how you will evaluate the activity
How to involve patients and the public in urgent care

PHASE 3
Identify existing information

The third spoke of the PPI in Urgent Care Wheel is about identifying existing information relating to the activity in which you are seeking to involve people. This is an essential part of the involvement process in order to:

- avoid undertaking activities that are already taking place elsewhere;
- enter into an activity or process with the best available evidence to hand;
- identify what sorts of activities have been successful in the past; and
- identify the staff who have experience and expertise in involvement, and who can help identify what has been done before as well as advising on appropriate approaches.

A good starting point is to make sure that you are aware of legal and policy information that relates to the activity, relevant large-scale research and any relevant public health or demographic data.

We refer again to the spectrum of involvement on page 15. If your involvement activity is about, for example, the evaluation of a service, then you would want to ensure that you have all the information available about that service, such as:

- complaints, concerns and compliments concerning that service;
- any incidents relating to that service;
- any central or local policy drivers relating to that area;
- any audit data relating to that area; and
- any public health data relating to that area.

You will then be in a position to build an evidence-based evaluation process designed around what you now know are the issues you need to concentrate on.
How to involve patients and the public in urgent care

The following two brief examples highlight the need to identify existing information.

Example 1
First we return to Tower Hamlets and their project on getting the right treatment. The PCT had been able to identify that the numbers of patients going to A&E had increased, and, using audit and public health data, it was also able to identify which specific groups of the population had increased usage most. Using these existing data, the PCT was able to identify the need to target males aged 20–29 from the Bengali community. It was then, with the local general practices, able to write to individual patients from the two general practice lists, telling them about the services offered by the GPs and by other community-based services that provide urgent care advice and treatment. As a result, the practices noted an increase of 8% and 16% respectively in appointments made by this group of men over a three-month period.

Example 2
Our second example comes from an out-of-hours provider, Urgent Care 24. The provider was reviewing the results of a patient survey with a non-executive director and the medical director. The group noted that an issue for patients using the service related to communication when seeing GPs whom they had not previously met, a typical experience in out-of-hours provision. Further exploration of this issue using other audit data and information from other existing sources highlighted that this was a widespread issue.

As a result, Urgent Care 24 has developed a multifunctional information sheet for patients that is designed to tell patients who the out-of-hours provider is, who to contact if they get worse and how to contact them, and the name of the clinician seeing them. It also leaves a space for the clinician to give written advice on their condition and how to manage it.

The initiative has been supported by training and its implementation was planned in such a way that it involved the whole team, including receptionists and drivers.
Involvement costs money. A dedicated and realistic budget is crucial to support involvement activities across an organisation. The last thing you want is to run out of funds part way through an activity. The fourth spoke of the PPI in Urgent Care Wheel relates to identifying resource requirements for PPI activity. You need to consider including:

- staff time;
- fitting the methods to the resources;
- reimbursement of people’s expenses or reward and recognition for their time; and
- support for staff and people you involve.

### Staff time

Involvement activities do not have to be excessively expensive and you will find that the most significant resource requirement is staff time. When you are planning your activity you need to make sure that all staff involved are clear about what they must do and deliver, by when and in what form. However, it is easy to forget about staff when you are focusing your efforts on getting patients involved. It is vital, for example, that you build into your activity things like staff annual leave; for example, if you have a consultation closing on a particular date, you need to make sure that the person or people who are going to analyse the feedback are available and have the capacity to complete the work.

### Fitting the method to the resource

We discuss more on methods of involvement on page 28. In an ideal world, the method would be chosen because it is the best way of involving people. However, most organisations have limited resources and methods should be chosen that meet the aims and goals of the activity but are also consistent with the available budget and expertise. For example, written surveys sent directly to people’s homes are a good way of reaching large numbers of people, but you need to calculate the cost of developing, printing and posting the questionnaire and including a prepaid envelope for the response – what at first seems a quick, cheap way of reaching a lot of people can be quite expensive. You need to consider whether an unsolicited questionnaire would get the information you want.
How to involve patients and the public in urgent care

Would you, for example, be able to find out similar information by handing out surveys to all attendees at your service over a period of a week, asking them to complete them before they leave and drop them into a conveniently placed box?

It is always worth considering whether you can ‘piggy back’ your activity on another project.

Example 1
If your organisation is placing an advertisement in local papers about your services, you might be able to include in the advertisement details of a particular involvement activity. This embeds the recruitment process in the existing advertisement process.

Example 2
If another part of your organisation or colleagues in the local authority are sending out questionnaires, consider whether you can add a couple of questions that will tell you the information you want rather than sending out a separate survey, which will double the expense. You can offer to split the costs.

Reimbursement of expenses or payment
You must make sure that people who get involved in your activities are not disadvantaged financially and should make provision to pay at least out-of-pocket expenses at the event. An organisational policy on reimbursement for PPI helps to demonstrate that participants are valued for the time they give to involvement work. The Volunteering England website contains excellent information about volunteer expenses (see http://volunteering.org.uk/Resources/information/on-lineinformationsheets/).

Whatever you do, you should try to ensure that, as far as possible, it does not cost patients and the public to get involved. There are some examples of good practice in this area.

Example 3
NHS South East Coast has set up a new patient engagement group called the People’s Engagement and Development Network. The first task for the group, in recognition of the importance of making sure that participants are properly reimbursed, was to write its own guidelines on reimbursement for volunteers. The reimbursement guidelines cover public transport costs, mileage costs in line with the Volunteering England guidelines (see above) and parking charges and, if food is not provided at the meeting, participants are given up to £10 for meals if they are travelling to or from home over a mealtime. It covers child support and the cost of respite care or care cover and interpretation costs. Reimbursement is paid in cash at the time of the meeting or, where requested, in advance. Alternatively, travel tickets can be pre-ordered and purchased and sent out to participants.
How to involve patients and the public in urgent care

Organisations should also consider whether it may be appropriate to pay people for their time (see Reward and Recognition, DH, 2006, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_4126863) or offer other rewards or incentives. This may be particularly appropriate for ongoing forms of involvement, like membership of decision-making boards, as well as where you want to attract people for specific purposes but are struggling to get people involved without an incentive. For example, Tower Hamlets PCT has been very successful in attracting young people (typically a hard-to-reach group) by offering gift tokens. Organisations should make sure that within their reward and recognition policy they ensure that potential participants in receipt of Department for Work and Pensions benefits are made aware of the impact of being offered rewards.

Support

Resources are about more than money and time. The staff, patients and the public undertaking or affected by involvement work need to be supported and may need training. This is particularly the case where patients or members of the public are engaged in ongoing activity within an urgent care organisation. At the NHS Centre for Involvement we are encouraging members of the public undertaking formal PPI roles within organisations to use our Passport to Involvement (www.nhscentreforinvolvement.nhs.uk), which highlights the need for members of the public to receive training and support for their roles.

Organisations need to ensure that training needs (for staff, patients and the public) are regularly reviewed, as training is vital to the success of PPI. It should be noted that patients can be valuable and valued teachers of staff, just as staff can be valuable and valued teachers of patients and the public. We have provided an example of this below, as well as a far-reaching training initiative aimed at training trainers to support service users in making decisions about where to go for urgent care treatment.
How to involve patients and the public in urgent care

Example 4

The ‘Trust me I’m a patient’ workshop is a powerful method of learning, and feedback from participants has been excellent. By the end of July 2008, 1,500 employees in the NHS had attended 41 workshops. The delegates have ranged from chairs and chief executives of PCTs, NHS trusts and mental health trusts through to front-line staff and patients.

‘Trust me I’m a patient’ is an interactive workshop to help healthcare staff, managers and leaders in the exciting challenge of involving patients, their carers and the public. The sessions use drama and expert facilitation and run for approximately two to three hours. The workshop simulates real issues that managers grapple with every day about how to effectively involve patients and the public in local decisions and healthcare issues.

Example 5

As a result of a series of patient events in Tower Hamlets, two key issues emerged: one, people are unaware of the full range of urgent services that are available; and two, they are unsure how to define the seriousness of their illness or problem, therefore A&E is often attended as a default. The PCT used this information to produce a directory of services and an urgent care training pack for health trainers and professionals in conjunction with the London Ambulance Service. The pack contains information on how to use urgent care services and self-care and contains a DVD to explain information and promote discussion and dialogue with their community.
How to involve patients and the public in urgent care

PHASE 5
Identify people

In the first instance, those you wish to involve are likely to be in one or more of the following categories:

- patients or carers/advocates;
- potential service users – including specific groups of people who are considered to be either ‘excluded’ or ‘hard to reach’;
- the general public;
- members of local voluntary and community organisations;
- commissioners of services; and
- service providers.

You can then segment these groups into smaller subsets by characteristics such as age, gender, known illness, occupation and so on. You will then need to decide how many of each category or how many groups you will involve. It is useful to consider Phases 5 and 6 of the PPI in Urgent Care Wheel together, as the involvement methods selected need to be appropriate for the people you are intending to involve. The methods will also determine the number of people you will need to involve. For example, a questionnaire can reach a far larger number of participants than one-to-one interviews, but to be relevant has to have a large number of responses.

We have taken two examples – one from urgent care services, and the other from a national organisation that illustrates how you would select people depending on the scale of the activity and aims and goals.
How to involve patients and the public in urgent care

Example 1
In Stoke-on-Trent, the PCT wanted to look at why patients made the decisions that they did about where to get their urgent care treatment. The PCT undertook two related activities: they targeted patients attending a walk-in centre to ask them why they had chosen to attend that facility rather than any other; and they simultaneously asked members of the public in a local shopping centre where they would go to access urgent care services and why. This dual approach meant that they were able to capture the views of real-time patients as well as members of the public who are potential patients, i.e. to gain the patient and the public perspective. While this sort of approach does not provide accurate representation, it does give useful intelligence to help guide the next stage of work, which is to develop information for the local population about service provision.

Example 2
The Health Protection Agency (HPA) wanted to develop an approach to involving the public in its work. It started by commissioning MORI to interview a representative sample of people across England about their knowledge and understanding of the HPA and to identify their key public health concerns and priorities. All of the more than 1,500 respondents were also asked if they were interested in working with the HPA in the future. Some 510 of the respondents expressed an interest.

The second phase of the work involved carrying out interviews (face-to-face or on the phone) with key stakeholders, including public health leads, commissioners, environmental health officers, SHAs, government departments, local authorities, voluntary organisations and arm’s-length bodies.

The third phase involved focus groups with members of the public in different locations. All 510 respondents from the MORI poll were written to and asked if they wanted to participate in focus groups. The 333 respondents who were interested were invited to one of four locations around the country (Leeds, London, Birmingham and Exeter) based on the HPA region in which they lived. Forty-two people participated in the six focus groups that were held. Participants were offered £150 to attend for the day and this covered their travel and any out-of-pocket expenses and recognised the contribution that they made. A very diverse set of people participated, ranging in age from 18 to 80, and including students, those in work, unemployed people, those who stay at home and retired people.
How to involve patients and the public in urgent care

PHASE 6
Identify methods

Methods of involvement
In Appendix 2 we have included a summary of over 30 methods of involvement. You can find further information about how to use these methods at www.nnhscentreforinvolvement.nhs.uk. As we have stressed before, the involvement process involves an integrated series of phases that build on each other. Spoke six of the PPI in Urgent Care Wheel relates to your choice of method or methods. You will need to consider all of those questions identified in earlier phases:

- Why are you involving people?
- What are your aims and goals?
- What have you done before in this area? What has worked and what has not worked?
- What resources (money, people, time) do you have at your disposal?
- Which segments of the community do you need to involve?

What we are trying to stress is that the method or methods must fit the activity. For example, questionnaires and focus groups are fairly traditional methods of collecting information in the context of service evaluation and development. There are also other methods such as workshops and partnership forums that can be used, as well as information technology-based methods such as blogging and SMS feedback.

Workshops, for example, offer a useful method of bringing people from different backgrounds together for problem solving and can be used at various stages of service development. Partnership forums, on the other hand, offer the opportunity of involving users in a more formal, longer-term capacity. Partnership forums take a number of different forms. They can be made up of mixed groups, including professionals and users, and can include other stakeholders such as complementary therapists or members of the public.

They generally raise the profile of user perspectives within organisations and can have formal links with NHS structures as well as acting informally in an advisory capacity.
SMS messaging and blogging provide a means of enabling people who may not wish to be identified to provide feedback about their experience of services. In urgent care settings, one of the largest groups of service users is children and young people, and this is a group that can be difficult to engage with, as we highlight below.

**Example 1**
Tower Hamlets PCT has very recently commissioned an external organisation to analyse the use of its A&E department by young children between the ages of 0 and 5. The analysis also focused on paediatric pathways to and from A&E to see if they were being utilised fully and if there were any gaps in provision according to perceived and actual need.

The work also included running two focus groups made up of parents from across the borough.

The PCT learned that the number of patients coded VO8 (discharge/referral with no treatment) increased after 7pm and at weekends, when other primary care services were closed, which suggested the need for a shift in opening hours of more appropriate services. Other project ideas that emerged from this work included an urgent care directory for children, self-care classes run by health visitors or from newly established children’s centres, and a young mum ‘buddying’ scheme. The trust is currently recruiting a project lead to take these initiatives forward.

**Example 2**
In 2006, the Barts and the London Hospital in East London set up a young patient forum. The forum meets monthly and has about 10 members aged between 12 and 17. It is supported by a part-time facilitator and has directly influenced the self-medication policy, children’s food menus, transitional care pathways (from children to adult services) and the soon-to-be-launched children’s website. The trust has recently started to run a monthly discussion group for parents.

There are, of course, many times when a single method of involvement will not be sufficient and the nature of activity requires a mix of methods in order to maximise involvement. This is more likely to be the case when a system-wide engagement activity is planned. We provide an example below from Doncaster where the PCT developed a complex plan for maximising involvement in the redesign of unplanned care services.
How to involve patients and the public in urgent care

Example 3
In Doncaster PCT a range of involvement methods was used to involve local patients and the public:

- At the outset, members of the public were recruited to participate in a major event at which the proposed whole-system redesign of urgent care services was simulated. People were recruited to act as part of patients in the simulation exercise, and the event also served as a major stimulus for public involvement in urgent care – the event was widely reported in the local media.

- Local press articles – bi-monthly articles in the Doncaster press were released (articles may take the form of social advertising).

- A bi-monthly release to local radio and interviews were used.

- A section of the PCT website was developed that gives generic information and progress.

- An email facility was provided for patients and the public to use to communicate with the PCT via a dedicated mail box.

- The Destination 2009 newsletter is distributed to GP surgeries and direct to those who have expressed an interest in receiving it. Newsletters are also sent to three prison settings.

- Hard-to-reach groups – PCT black and minority ethnic (BME) leads and specific ways to communicate with these groups of people, e.g. Chinese elders, Pan Afrique, the travelling community, Turkish and Asian women’s groups, people with learning disabilities and the BME population.

- To further enhance public involvement, an unplanned care patients’ panel has been formed. The first meeting was held in May 2007. Members consist of patients’ forum members and general members of the public who have expressed an interest in being involved. Some meetings are held out of hours to enable working people and carers to attend.

- The PCT has plans to develop a social marketing and education plan. The plan will focus on how the PCT will work with diverse communities with the aim of understanding effective ways to change the social behaviour of the public.
Evaluation is a crucial aspect of PPI, although PPI involves complex processes, some of which are only apparent long after the actual involvement exercise, and is not simple to measure.

A strategy for evaluation must reflect the previous phases of the wheel. Just as you chose a method of involvement that was fit for purpose, so you must choose an evaluation process that reflects why you are involving people (who), what the focus is (what), and the methods you will use (how).

Evaluation is absolutely fundamental to the other phases within the wheel. After you have planned and implemented your activity, you must evaluate it to see if it has had an impact and whether that impact is an improvement. This not only helps you in your current work but will inform future activity.

We have provided two examples below. The first details an unsuccessful attempt to engage users of day services and the second provides details of the evaluation undertaken after the introduction of guidance following feedback from users of palliative care services.

**Example 1**
As part of a review of mental health services in Torbay, a meeting was organised with service users at the NHS headquarters over a splendid lunch on a midweek working day. The organisation publicised the meeting well to encourage mental health service users to come along and give their views in a non-threatening environment. Only two service users turned up for the meeting. It was quickly identified that this was not the appropriate method to seek views. Instead, a team visited day centres within the area and over the next three weeks they were able to speak to 150 service users.
How to involve patients and the public in urgent care

Feedback was terrific. This was largely due to the activity taking place in ‘home territory’ in a safe, familiar and comfortable environment that offered security to service users. Managers felt that this was a salutary lesson: if they really want to effectively engage and consult, then they have to go where the people are and not expect people to come to them.

The visitors came up with some excellent ideas and went away with the aim of continuing this work in their classrooms. The day was deemed a success, with the young people gaining an understanding of social enterprise, what Local Care Direct provides, and how they and their families might contact Local Care Direct for any future care, if required.

Example 2
Local Care Direct (an out-of-hours provider based in West Yorkshire) wanted to promote the idea of social enterprise and social responsibility locally. The provider was aware that the curriculum for schools now contains a social enterprise element and so invited groups of children from the local high school to visit. The aim was for them to hear about social enterprise, find out about Local Care Direct, and also think of some ideas that could benefit their own community.
How to involve patients and the public in urgent care

PHASE 8
Provide feedback

- generic, routine and regular reporting; and
- targeted feedback.

Routine feedback
We mentioned in the first part of the guide that there are benefits of PPI that relate to meeting quality requirements, standards, targets and so on. Developing a system of regular reporting about PPI to your organisation's board (or equivalent body) provides evidence of the types and intensity of activity and can help provide a basis for informed decision making. This demonstrates that PPI is being considered at the highest levels within the organisation. Board papers of NHS organisations and most equivalent papers from independent sector organisations will often be made public on websites, and this permits members of the public to get feedback about their own and others’ involvement in the organisation if they know where to go. It is good practice for senior managers to take time to thank those who have made valued contributions to the organisation publicly at board meetings as well as personally and periodically in writing.

Other forms of routine feedback can be linked to how information is gathered. In urgent care settings this is more complex than in a community hospital or clinic, where people either spend a long period of time or are regular visitors. For example, in a clinic you can have a comment box and then regularly review comments and respond to them by placing the organisation’s response above or near the box. There is no reason why you should not still do this in an urgent care setting, but you might also consider developing ways to respond through your website, for example.
How to involve patients and the public in urgent care

Targeted feedback
Targeted feedback to participants who have, for example, contributed to a consultation or who have participated in a focus group about a service redesign proposal needs to fit the purpose of the consultation or activity. Ideally, you should make sure that, if individuals have made the effort to write to you with their views on a personal level, you make the effort to reciprocate and respond personally.

Example 1
After holding a series of focus groups to help formulate the PCT’s urgent care strategy, the chief executive of Tower Hamlets PCT wrote to each participant with a copy of the new strategy, thanked them for their involvement and set out the changes that were made as a result of their input.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changing for the Better: Guidance when undertaking major changes to NHS services</strong>, Department of Health, 2008.</td>
<td></td>
</tr>
<tr>
<td><strong>Local Government and Public Involvement in Health Act 2007</strong>, (particularly Section 233).</td>
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<tr>
<td><strong>National Audit Office report on the provision of out-of-hours care in England, 2006.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>National Health Service Act 2006</strong> (particularly Section 242).</td>
<td></td>
</tr>
<tr>
<td><strong>Our health, our care, our say: A new direction for community services</strong>, Department of Health, January 2006.</td>
<td></td>
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</tbody>
</table>


Principles for Practice: Involving service users and carers in healthcare education and training, Trent Strategic Health Authority, December 2005.


World Class Commissioning: Competencies, Department of Health, 2007.
The work to develop this guide was undertaken by Dr Jayne Taylor and Professor Jonathan Tritter from the NHS Centre for Involvement and funded by the Department of Health Urgent and Emergency Care Team. The work was co-ordinated by Dr Nicholas Reeves on behalf of the Department of Health Urgent and Emergency Care Team.

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**Expert panel members:**
- Agnelo Fernandes, CROYDOC, OOH service in Croydon
- Trevor Gay, CFEP UK Surveys
- Antony Chuter, Member of the South East Coast SHA People’s Engagement and Development Network, and Lay Member of the RCGP Patient Partnership Group
- Carl Edmonds, Tower Hamlets PCT
- Rebecca Kilburn, Local Direct Care, Huddersfield
- Alicia O’Caithain, University of Sheffield
- David Randall, Primecare
- Nicholas Reeves, Urgent Care programme, Department of Health
- Jayne Taylor, NHS Centre for Involvement
- Jonathan Tritter, NHS Centre for Involvement
- Ram Thiagarajah, Swindon Urgent Care Users Group
- Nigel Wylie, Urgent Care 24, Liverpool
Local Involvement Networks

Information contained within this appendix is based on a series of fact sheets and guidance, which can be found at www.nhscentreforinvolvement.nhs.uk.

Local Involvement Networks (LINks) will be set up in all local authority areas with social service responsibility by January 2009. Once the LINk has been set up, it will need to work in different ways with local NHS commissioners and with health and social care providers of services.

Commissioners of health and social care services are obliged to respond to a LINk when it requests information about a particular service that they have commissioned. They must also respond to reports and recommendations made by the LINk.

It is important to build a strong working relationship with a local LINk as it can also be helpful for a health commissioner or provider to act as a vehicle to involve and consult with local people about their experiences of health and social care.

The LINk might also work with a commissioner to consult local people about proposed changes to the commissioning of health and social care.

Commissioners and providers might usefully work with LINks and:

- provide LINks with Patient and Public Involvement information, such as data relating to complaints, incidents and other data when they are requested to help inform the LINk about an emerging issue (an issue raised by a member of the public or an organisation); and

- comply with requests to enter and view premises under certain circumstances in line with regulations and the Code of Conduct on LINks visits. For comprehensive information about when a LINk can visit a health setting, please see the Department of Health’s Code of Conduct on LINks visits, which is available on the National Centre for Involvement website (www.nhscentreforinvolvement.nhs.uk).

For more information about the legal requirements concerning working with LINks, together with helpful guidance and information, please visit the following sites: www.nhscentreforinvolvement.nhs.uk www.dh.gov.uk/ppe
## Methods of involving people

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Key attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publications, media releases and displays</td>
<td>Written with no requirement for dialogue, but can provide information on how consumers can participate.</td>
</tr>
<tr>
<td>Patient charters/constitutions</td>
<td>Written statements setting out what patients and customers should expect from who. These should specify service conditions and provide pathways for complaint and possibly redress for consumers.</td>
</tr>
<tr>
<td>Use of art in involvement</td>
<td>Anything from large-scale public art projects to small events. Can be used in conjunction with other methods and aims. Useful way of engaging with people who are reluctant to express views.</td>
</tr>
<tr>
<td>Use of theatre in involvement</td>
<td>Anything from large-scale to small events. Useful way of triggering views through the use of scenarios and storytelling.</td>
</tr>
<tr>
<td>Consumer-friendly administrative procedures</td>
<td>Reviewing and reforming administrative communication with consumers to encourage Patient and Public Involvement and partnerships for health.</td>
</tr>
<tr>
<td>Project groups</td>
<td>Instigated by organisations to advise on specific issues and/or to guide a project. Time limited. May be used to demonstrate the value of Patient and Public Involvement to key players.</td>
</tr>
<tr>
<td>Surveys (questionnaires)</td>
<td>Means of gathering information. Agenda set by organisations. Scope of information limited. Quantifiable, but you need to know what you want to ask and have an appropriate array of respondents.</td>
</tr>
<tr>
<td>In-depth patient interviews</td>
<td>Extended, semi-structured (usually) face-to-face interviews. Provide rich information from selected consumers. Useful as a follow-up to surveys to explore particular issues and/or for specific population groups, but time consuming.</td>
</tr>
<tr>
<td>Focus groups</td>
<td>A facilitated discussion with usually about six to eight people for 30 minutes to two hours. People can be invited on the basis of who they are and what they can contribute to the discussion. Interactions among participants can help explore issues rapidly and in depth. Used for information collection focused on a specific issue (not for decision making) and can include various examples and props. Provides rich information, but may not be representative of all consumers.</td>
</tr>
<tr>
<td>Submissions</td>
<td>Oral and written presentation of views. Dialogue limited. Can attract consumers who are organised and in a position to put in a submission. Less articulate/literate, non-English-speaking background and/or socially disadvantaged consumers may be excluded.</td>
</tr>
<tr>
<td>Delphi technique</td>
<td>Formal process using a series of mailed surveys to selected individuals. Used for building consensus across consumers with conflicting views. May be useful for particular groups of stakeholders on specific contentious issues, but relies on good literacy skills.</td>
</tr>
</tbody>
</table>
# Methods of involving people

<table>
<thead>
<tr>
<th>Nominal group techniques</th>
<th>Small group process for clarifying priorities. May be useful for consumer involvement in identifying priority issues, allocating scarce resources etc. However, does not allow for much in-depth exploration of the issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestion boxes</td>
<td>Easy to implement, but may be limited in obtaining useful feedback. May attract negative and unhelpful comment. Only for use in conjunction with other strategies. Responses limited to those with time and literacy skills.</td>
</tr>
<tr>
<td>Hotlines and phone-ins</td>
<td>Information gathering. Relies on publicity and the phone being attended. Works best with skilled staff or volunteers to answer. Attracts respondents fairly indiscriminately.</td>
</tr>
<tr>
<td>Text (SMS) messaging</td>
<td>Information gathering. Useful for getting feedback from young people.</td>
</tr>
<tr>
<td>Complaints handling</td>
<td>Response to consumer feedback and complaints. Valuable resource because restricted to consumers who have identified possible area for service improvement. Requires staff understanding of value of complaints. Not representative of patient experience or necessarily the worst service experience.</td>
</tr>
<tr>
<td>Responding to user initiatives</td>
<td>How your organisation/team responds to enquiries or requests initiated by consumers. Developing clear policies, processes and skills to be ‘response-able’.</td>
</tr>
<tr>
<td>Workshops</td>
<td>Working meeting usually of 8–12 consumers, possibly with providers, to share information and to develop a shared approach to a specified issue. Participants usually have been selected on the basis of particular skills, knowledge or experience. Requires informed participants.</td>
</tr>
<tr>
<td>Patient advocates/consultants</td>
<td>Healthcare organisation employs person to consult with consumers and advocate on their behalf for service improvement.</td>
</tr>
<tr>
<td>Promotions and campaigns</td>
<td>Ways to get information out. Can be innovative and creative and can involve consumers, possibly through consultation in planning and partnerships in implementation.</td>
</tr>
<tr>
<td>Search conferences</td>
<td>Meeting of 30–50 invited people. Investigates a subject/issue in a planned manner. May use discussion paper as starter. Asks specific search question. Wide range of views canvassed. Answer(s) expected as outcome.</td>
</tr>
<tr>
<td>Distributing discussion papers</td>
<td>Written presentation of information for discussion. No dialogue involved unless structured. May, however, be used as precursor to public meetings or other discussion.</td>
</tr>
</tbody>
</table>
## Methods of involving people

<table>
<thead>
<tr>
<th>Public meetings and forums</th>
<th>Audiences usually over 20 people. Meeting structured to canvass views and/or debate an issue. Representatives, nominated by consumer groups/associations. Open to public.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seminars and conferences</td>
<td>Instigated by organisations to explore ideas/issues. May be expensive and, therefore, be restricted to those who can pay. Audiences over 20 people. Format structured. Informal or spontaneous input may be restricted, tending to give providers/professionals more ‘air time’ than consumers/community.</td>
</tr>
<tr>
<td>User councils, panels and reference groups</td>
<td>Structure and role prescribed by organisation but should be negotiated and written down. Input to whole organisation based on advice from consumers. Need to ensure and support user representative links with appropriate constituency. Representatives need to have tenure long enough to learn to be useful, but not so long that they become part of organisation.</td>
</tr>
<tr>
<td>Policy round tables</td>
<td>Invitations to discuss policy items. Structured. Convened to advise on the development of specific policy and implications.</td>
</tr>
<tr>
<td>Stakeholder representatives on your committees</td>
<td>Informing, training and supporting, stakeholder representatives. Ensuring they have a relationship with their constituency. Negotiated and recorded roles and terms of reference for all members of the committees they sit on. A medium- to long-term investment.</td>
</tr>
<tr>
<td>Advisory committees</td>
<td>Usually up to about 15 members. Role is to provide input on an issue/subject on the basis of expertise about an issue/experience. Members can be appointed or elected. Usually limited terms of reference.</td>
</tr>
<tr>
<td>Patient panels</td>
<td>Patients invited to focus on an area/issue. Usually structured.</td>
</tr>
<tr>
<td>Facilitating mutual support groups</td>
<td>Support to assist people, on their terms, about their issues. Groups can be consulted about service improvement. Clinicians can enter into partnership with groups as expert advisers.</td>
</tr>
<tr>
<td>Negotiation partnership</td>
<td>Patients, members of the public and providers work together to develop a written agreement as a basis for future process. May be part of consumer initiated participation. Requires clarity of objectives and good communication skills.</td>
</tr>
<tr>
<td>Networking</td>
<td>Informal relationship building with people who have common interests or goals. Will include building links to consumer organisations, advocacy groups etc.</td>
</tr>
<tr>
<td>Partnership of consumers and providers</td>
<td>Structured cyclical planning process with specified role for consumers in shared decision making with providers. Process and outcomes are a shared responsibility. Usually the result of years of development of Patient and Public Involvement and a strong consumer focus and culture in the organisation.</td>
</tr>
</tbody>
</table>
## Methods of involving people

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic logs (blogging)</td>
<td>Patients and members of the public provide ongoing continuous dialogue through website. May be consumer initiated. Informal relationship building with people with common interests or goals.</td>
</tr>
<tr>
<td>MySpace</td>
<td>Patients and members of the public can provide feedback in an anonymous form. Useful to receive feedback about sensitive areas of service provision or where patients do not want to be identified because of the nature of their attendance (e.g. sexual health and pregnancy conditions).</td>
</tr>
</tbody>
</table>