

ENGAGEMENT IN THE COMMISSIONING CYCLE

A Guide for Service Users, Carers, the Public, GP's, Commissioners and other stakeholders in Mental Health Care Services



Best Practice Guidelines

Reference Tool for Commissioners - February 2011

SUPPORTED BY



**National Mental Health
Development Unit**

North West Mental Health Improvement Programme

A collaborative development programme between the NHS, Social Care, the Third Sector and Users and Carers to improve mental health across the North West



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Thanks go to all contributors of this document.

CHAPTER 1

Introduction

BACKGROUND AND PURPOSE OF THE PROJECT

In February 2010 the Mental Health Improvement Programme (MHIP) and the National Mental Health Development Unit (NMHDU) embarked on an innovative project to improve the effective engagement of service users, carers and other interested parties - including the wider public - in key areas of the commissioning cycle within mental health and related services.

MHIP and NMHDU tasked Making Space with examining various approaches to commissioning - using internal and existing external research - to build a case for future best practice. Overviews of the research and recommendations for embedding involvement and engagement in the process are contained in this guide document.

We have tried to give an honest overview of real, and perceived, barriers to engagement and involvement in the commissioning cycle of mental health services by service users, carers, GP's, commissioners, service providers and the general public, taking into account issues ranging from the importance of communication, location and timing, to the management of expectations between all interested parties.

If you are a commissioner, a GP or anyone involved in the design and production of frontline services - this guide is for you. We have tried to make it easy to navigate - a reference tool for anyone involved in the commissioning of services and who wishes to engage with the recipients of those services.

POLITICAL ENVIRONMENT

During 2010 the UK Coalition Government made clear its intention to transform the delivery of health services, including the handover of commissioning responsibilities to GP's.

In the National Health Service White Paper, 'Equity and Excellence: Liberating the NHS', published on 12 July 2010, there were a number of clues about the motivation of the government with regard to involving users, carers and the wider community.

They included:

- The need for GP Consortia to engage patients and the public, on an ongoing basis, as they undertake their commissioning responsibilities
- The need for GP Consortia to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local Health Watch bodies - for which local authorities are likely to be holding budgets), patient participation groups and community partners

It was clear from this that, although traditional healthcare commissioning would change, the need for organisations to involve people effectively in the process would become even more important. At the time of writing (February 2011) the White Paper had completed the consultation stage.

In December 2010, Sir David Nicholson KCB, CBE, Chief Executive of the NHS, confirmed the following transitional timetable:

2010/11

- Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) remain statutorily accountable and will encourage GP consortia pathfinders to emerge.

2011/12

- PCTs and SHAs will be statutorily accountable with more consortia pathfinders emerging and commissioning support units being developed, with the aim of having full coverage of the population by the end of 2011/12.
- PCTs will form clusters during 2011/12 to consolidate capacity, with some PCT staff being made available to emerging consortia.
- The NHS Commissioning Board will be created in shadow form and will focus on building its own capacity, developing the infrastructure of the new commissioning system, and overseeing planning for 2012/13 at national level.

2012/13

- PCTs and the NHS Commissioning Board will be statutorily accountable bodies with SHAs abolished on 31 March 2012.
- PCTs, through clusters, will be accountable to the NHS Commissioning Board.
- Authorisation of consortia by the Board will take place with all consortia to be fully or conditionally authorised by the end of 2012/13.

2013/14

- The new system will be fully established, PCTs will be abolished on 31 March 2013 and commissioning support units will move into social enterprise and joint venture arrangements.

UNDERPINNING PRINCIPLES OF ENGAGEMENT FOR COMMISSIONERS

The following principles formed the basis for the overall project:

- A clear purpose for the involvement of service users and carers
 - People need to know what they are getting involved in and why
- A positive organisational culture
 - The commissioner needs to be sure that the culture within the organisation providing the service is one where involvement can flourish. The factors that contribute to this include:
 - Leadership - focused on the interests of service users and carers
 - Governance - with service users and carers involved in its arrangement
 - Staff development - including the employment of service users and carers
 - Equality and diversity - providing everyone with the appropriate resources
- Provision of support to get involved
 - Where they seek to involve and engage a diverse range of people commissioners need to demonstrate flexibility in the following areas:
 - In the places where people meet together
 - Through practical and emotional support
 - By providing clear and accessible information in a variety of formats
 - By making prompt payment of expenses and fees
 - Through administrative support
 - When delivering training and building confidence/capacity
- Structures for empowerment and representation
 - Involvement needs to start with local groups and there needs to be a mechanism for connecting this to the MHIP and other regional and national programmes

DESCRIPTION OF METHODOLOGY

Simple methodology has been applied as, although important, the guide is not intended to be published as major research - rather as a well-informed 'helping hand'.

Outline Project Plan:

- i) Appointment of a member of the Making Space Executive Management Team to take overall responsibility for the project
- ii) Appointment of a member of the Making Space Development Team to assume day to day responsibility for the management of the project
- iii) Confirmation of the Implementation Team
- iv) Confirmation of the Steering Group*, including Carer & Service User representation
- v) Agree Research Protocols
- vi) Development of project implementation document including reporting schedule, communication plan & dissemination plan
- vii) Networking with potential test sites
- viii) Selection of test sites
- ix) Identification of Engagement & Participations Methods for testing
- x) Testing phase
- xi) Monitoring to take place throughout the project, including production of Interim Reports as per the specification
- xii) Evaluation
- xiii) Production of Final Report
- xiv) Dissemination

The central element to the research was to engage with eight Primary Care Trusts (NHS Commissioners) in the North West of England to become pilot sites for the project. Each site was asked to assess the effectiveness of their current practices and agree areas of focus in which the guidelines could be tested.

Pilot Sites

- Blackburn with Darwen
- Oldham

- Trafford
- Salford
- Wirral
- Cumbria
- Manchester
- Bolton

*The project was managed by a Steering Group consisting of user representatives, carers, and employees of Making Space, the NMH DU and the MHIP. (Appendix II)

COMMENTARY ON DATA GATHERING

Once they had agreed to participate the NHS Commissioners were asked to assess their relative strengths and weaknesses where service users and carers' involvement in commissioning was concerned. This was achieved by completing the self assessment tool (Appendix I).

The use of this systematic framework greatly aided the identification of the individual elements which impact upon the effective implementation of carer and service user involvement in local commissioning arrangements.

In general the information received from the NHS Commissioners, whilst useful, was anecdotal in nature, lacking any real evidence of quality involvement or otherwise. The commissioners who believed they had a model that worked were often simply verbalising their gut feel.

The Steering Group of users and carers proved extremely useful in the latter stages of the project presenting an alternative perspective to that of the commissioners - although this too was subjective information based on personal experiences.

The vision and recommendations arising from this document are based upon this research, alongside on-the-ground activity with participating pilot sites, and insights offered by other relevant research projects.

CHAPTER 2

Best Practice Commissioning...The Vision

“No decision about me without me”

SUMMARY

The NHS describes the commissioning cycle as an annual process by which commissioners are expected to deliver improved health and wellbeing outcomes.

There are eight stages to the cycle (within the model used by NMH DU (Figure 1)). Mental health professionals are well-placed to provide important information at a number of points in the cycle. Such professional involvement ensures that commissioning decisions and resource allocation meets the needs of people with mental health conditions and helps to highlight factors that may negatively affect their support and wellbeing.

Increasingly, service users and carers expect to be involved at all stages of the planning and delivery of services which directly affect them - this approach is recommended as it can lead to the desired co-production of services.

Various papers and other documents contained in ‘NHS Evidence - Commissioning’ (a collection of information resources for all those involved in commissioning for health and wellbeing managed by The Kings Fund) summarise the content for this guide.

www.library.nhs.uk/commissioning

“User involvement in the commissioning process is not well established and presently is more likely to occur in designing services than in assessing needs or evaluating services.”

It goes on to say,

“Much more thought needs to be given as to how best to involve users throughout the commissioning cycle.”

The aim of this guide is to highlight those areas where real engagement is practically ineffective and to focus on practical techniques to improve.

So why is service user involvement so important?

- Ethical imperative - It’s the right thing to do
- There are statutory and regulatory requirements - ‘Duty to Involve’ * refer to p.7
- Involvement has already resulted in essential improvements in the provision of services
- Service users are more likely to be satisfied with local services if they have played a part in their design
- It helps to maintain a focus on the ‘quality’ of the service user experience
- It demonstrates good governance and probity
- It ensures that decisions take account of the ‘expert’ recipients of services
- It provides an efficient use of resources

In an article entitled ‘Cases for Change: User Involvement in Mental Health Services and Research’, Marion Clark, Jon Glasby and Helen Leicester outlined some really important insights:

- Users are experts about their own illness and need for care
- Users may have different, but equally important, perspectives about their illness and care
- User involvement may improve the existing understanding of mental distress

- Users are able to develop alternative approaches to mental health and illness
- User involvement may be therapeutic in itself
- User involvement may encourage greater social inclusion
- There is widespread recognition that service users are experts, with an in-depth knowledge of mental health services and of living with a mental health condition
- By definition, no one else, no matter how well trained or qualified, can possibly have the same experience of the onset of mental illness, the

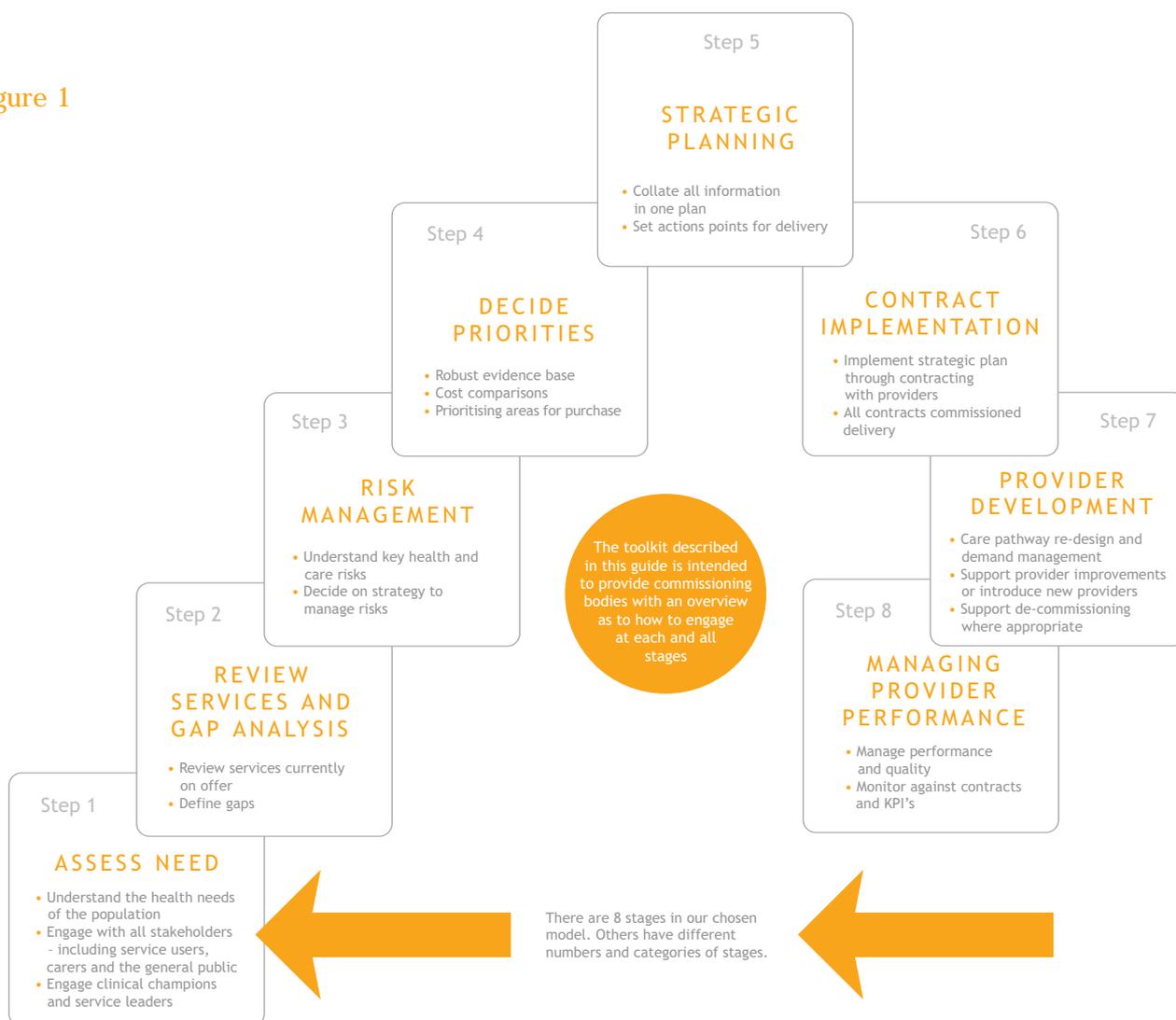
same initial contact with services or the same journey through the mental health system

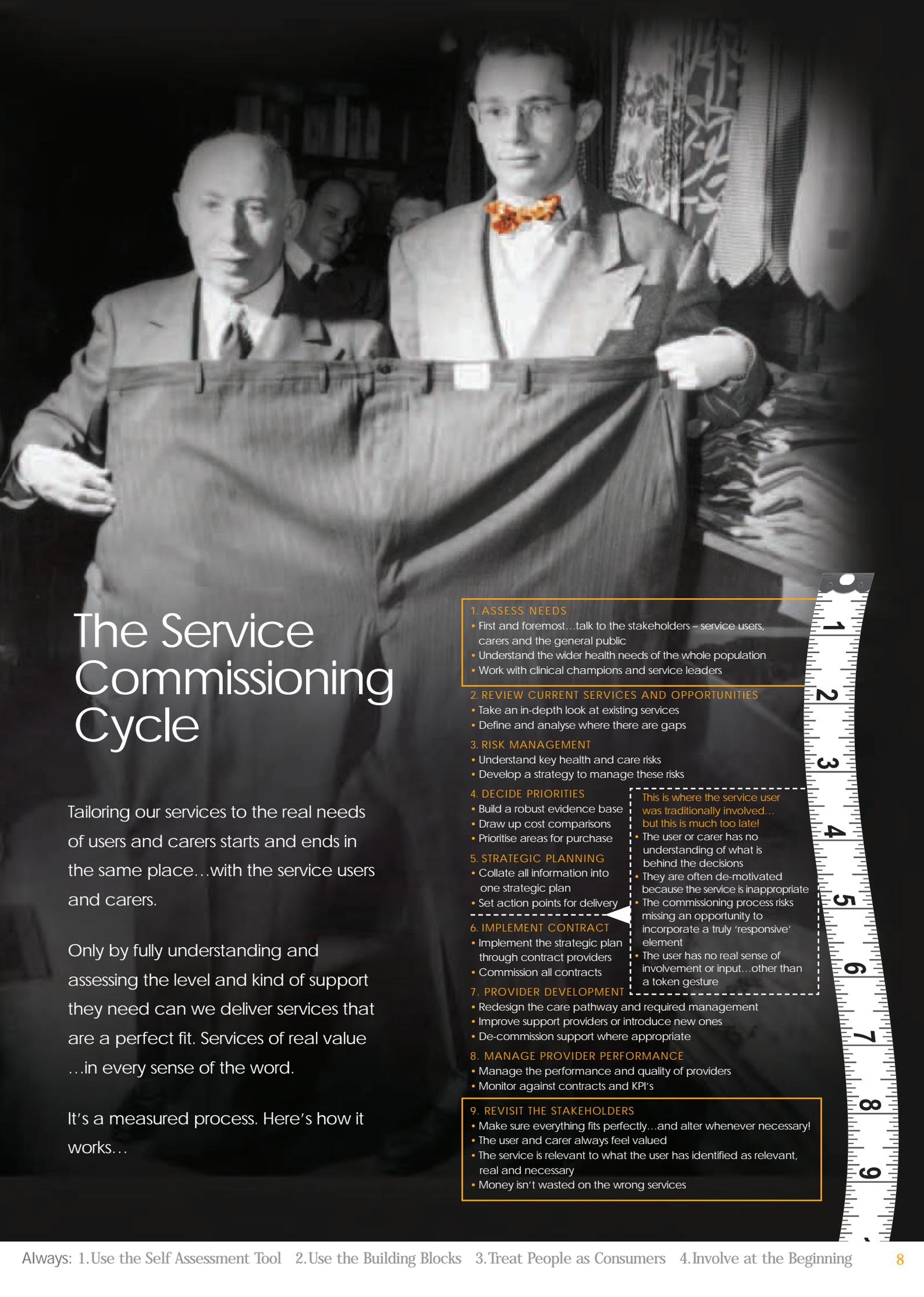
www.scie-socialcareonline.org.uk/repository/fulltext/96255.pdf

* Section 242 of the consolidated NHS Act 2006 places a duty on NHS trusts, primary care trusts and strategic health authorities to make arrangements to involve patients and the public in service planning and operation, and in the development of proposals for changes.

Part 7 section 138 of the Local Government and Public Involvement in Health (LGPIH) Act 2007 requires authorities to take those steps they consider appropriate to involve representatives of local persons in the exercise of any of their functions.

Figure 1





The Service Commissioning Cycle

Tailoring our services to the real needs of users and carers starts and ends in the same place...with the service users and carers.

Only by fully understanding and assessing the level and kind of support they need can we deliver services that are a perfect fit. Services of real value ...in every sense of the word.

It's a measured process. Here's how it works...

1. ASSESS NEEDS

- First and foremost...talk to the stakeholders – service users, carers and the general public
- Understand the wider health needs of the whole population
- Work with clinical champions and service leaders

2. REVIEW CURRENT SERVICES AND OPPORTUNITIES

- Take an in-depth look at existing services
- Define and analyse where there are gaps

3. RISK MANAGEMENT

- Understand key health and care risks
- Develop a strategy to manage these risks

4. DECIDE PRIORITIES

- Build a robust evidence base
- Draw up cost comparisons
- Prioritise areas for purchase

5. STRATEGIC PLANNING

- Collate all information into one strategic plan
- Set action points for delivery

6. IMPLEMENT CONTRACT

- Implement the strategic plan through contract providers
- Commission all contracts

7. PROVIDER DEVELOPMENT

- Redesign the care pathway and required management
- Improve support providers or introduce new ones
- De-commission support where appropriate

8. MANAGE PROVIDER PERFORMANCE

- Manage the performance and quality of providers
- Monitor against contracts and KPI's

9. REVISIT THE STAKEHOLDERS

- Make sure everything fits perfectly...and alter whenever necessary!
- The user and carer always feel valued
- The service is relevant to what the user has identified as relevant, real and necessary
- Money isn't wasted on the wrong services

This is where the service user was traditionally involved... but this is much too late!

- The user or carer has no understanding of what is behind the decisions
- They are often de-motivated because the service is inappropriate
- The commissioning process risks missing an opportunity to incorporate a truly 'responsive' element
- The user has no real sense of involvement or input...other than a token gesture



CHAPTER 3

Essential Checklist

COMMUNICATION

User groups often feel that the consultation process is often tokenistic - they believe that procedural and outcome measurements are already decided 'from above'. Best practice would be to involve people early, encourage participation and make it absolutely clear that it is their legitimate experience around which service provision decisions will be made.

Service users and carers comment that it is important for a commissioner to listen to them. This may seem obvious but 'real listening' needs a practical setting and careful preparation, with the needs of the individual or group being consulted given sharp focus.

MEETINGS

When setting up your meeting take into account the potential need for service users to take extra time, including breaks, for concentration to be sustained.

Every effort should be made to avoid an imbalance in the number of staff to service users and carers - if either too many, or too few, people from any of the stakeholder groups are deemed to be attending, address this in follow-up meetings.

Service users and carers need to express genuine concerns without being labelled as troublemakers. Attending meetings with 'professionals' can be daunting so make sure it is clear that meetings are organised by and on behalf of service users and carers.

Service users, carers and potential future users (the public) can offer insights that genuinely lead to better service delivery. Don't just tell people what you are planning and hope they accept it - find ways to prompt insight, pay attention to it and implement what is possible and positive.

TOP TIPS

- Involve service users and carers at the beginning of the process - let them identify what's missing in service provision now, and then focus on finding ideas that will fill those gaps
- Create an atmosphere of honest and open communication
- Make people welcome - experienced members should make an effort to engage with new people
- Establish clear guidelines - people are empowered when they know where they stand. Identify things that may be outside of your control, like limited budgets
- Give service users and carers the confidence to know that their involvement makes a real contribution to the delivery of services
- Draw up a role descriptor for user and carer representatives
- Establish a simple, accessible mechanism for people to attend
- Agree an agenda but be flexible around it - there should be free and open opportunities for people to express themselves
- Create a formal system for feedback
- Don't patronise
- Give honest feedback when service users and carers contribute
- Give background to desired outcomes and then allow service users and carers to develop the brief
- Make sure meeting notes are up to date
- Include service user and carer comments in meeting notes

SOCIAL MEDIA

There are a multitude of engagement channels that people may use to become engaged and involved. 'Social media' is an increasingly prevalent vehicle by which people make contact with their friends and peers, and commissioners are becoming more aware of its power

- Blogging, chat rooms, message boards
- Web casts
- Bulletin Boards
- Face Book
- Twitter



TOP TIPS

- Invite people to engage in Social media via Facebook, Twitter and other social networking sites. This may well attract younger carers and service users
- Engage with the people who use your services in ways that reflect their lifestyles
- Listen! Don't let handling complaints become procedure. What is a complaint telling you? Is it reasonable?
- Use a 'diary room' approach - allow people to tell you how they really feel (more detail in Appendix IV)
- So many people are excluded because they don't go to meetings. Technology permitting, Skype is a great way for people to share their views
- Create a 'gap box'. Each month/quarter/year launch an online 'gap box'. Tell the consumer what the gap is and ask for suggestions
- Arrange travel for people to get to places and that fits with their lifestyle

EVENTS

In some instances it was observed that organised events do not always facilitate 'involvement' - certainly not for all attendees. Many people will not speak out in a room full of delegates. The means of encouraging people to ask questions in

advance should be widened around the available media.

Once the learning has taken place and outcomes have been agreed, it is essential to make it crystal clear that the outcomes and recommendations have been reached because of the involvement of service users and carers. The praise and recognition should be directed towards the people who use the services.

Commissioners report back that engagement activities can sometimes feel aggressive, however we should recognise that change is challenging - it inspires everyone involved in the process and can facilitate innovative thinking and new ways of working.

The Standing Conference Model is an example of involvement adopted by a number of Primary Care Trusts in the North West. It is a pre-organised open event where there is a central theme to be discussed and also an opportunity for questions to be asked is provided

There is a view that this model, although generally seen as a move forward, is still not fully involving people - because of its format, the main tasks, including organisation and facilitation, are still dominated by the 'professionals'.

Service users commented that the Standing Conference can attract a 'single issue campaigner' who goes to an event with an agenda and then dominates the proceedings. Consideration needs to be given to how this might affect the other attendees and how to deal with this.

WIDEN THE NET - HEALTH CARE IS NOT A PRIVATE CLUB

The research indicated that decisions are seen to be made from 'on high' - by a small number of individuals. Only by canvassing ideas and opinions

from a wider pool of interested parties can initiatives be given legitimacy and consent. Our pilot commissioners felt this is the area in which they face the biggest challenges.

Using all means possible to reach people who have insight but do not become involved is critical to wider and more fulfilling engagement.

TOP TIPS

- Create a mini-marketing plan to promote engagement. Decide who you are talking to (include every different target audience), what you want them to do, and most importantly why they should do it?
- Be creative. Use people who have benefited from being involved to 'tell their story'. Using a powerful quote from someone who has influenced the way something is done and so had a positive impact, is much more effective than a report describing the importance of engagement
- Use mainstream media more creatively. For example, build relationships with editors of local radio stations, ask to be speakers on 'phone-ins' and use this as a way to 'recruit' new people who can make a difference
- Improve understanding by imagining yourself 'in other people's shoes'
- Remember to publicise practical information like parking availability and public transport links.
- Pick a subject - and get people to debate it - excitement will encourage greater involvement
- Remember - there has to be a reason for someone to do something. Consider all your promotional messages - do they really contain a compelling reason to get involved?
- The very latest information, involvement activities and minutes of meetings need to be made available as soon as possible and where they are easily accessed. The commissioner's website is a good place to locate them. They should be available by other means too (e.g. providers' websites and social networks, as above).
- Community Centres will display posters. Also grab the attention of many more stakeholders and

contributors by finding other places for publicity and promotional materials - such as GP surgeries, communal areas in service providers' premises and the various local authority and NHS premises

- While acknowledging that we are all dealing with important issues, all communication materials do not need to be 'serious' in all of their content. People are more likely to engage in discussion if the process involves interesting, fun and participative activities
- Avoid jargon - inspire confidence in people who may not have the professional training

AVOID JARGON

Commissioners have a responsibility to use language (spoken and written) that people understand.

Spending time with service users and carers - and really listening to them - can help bridge the gap between 'jargon' in communications and valuable language everyone is comfortable with.

We all search for simple labels for processes and initiatives. But even with the best of intentions, we can only know we have the right ones when they resonate with the people who use the services. Ask them! - outline what we think we mean by the labels we use (e.g. 'Engagement' - what do we mean?). Encourage service users and carers to give their feedback. Again ask them and keep asking yourselves, what can we do better?

TOP TIPS

- When producing press releases, documentation, advertising or minutes of meetings, nominate someone to be a Quality Checker or Translator. This should always be a service user or a carer
- Help people to feel comfortable. Carry out training activities, hold workshops, restrict professionals: mix more, give feedback on what has happened, arrange more events - run by and for service users and carers

MANAGING EXPECTATIONS

Communication becomes difficult between commissioners and service users when expectations are managed poorly.

When clear and honest expectations are agreed at the outset, then progress is much more effective.

- 1) Explain strategy - don't agree that something will be considered if it is clear that it cannot happen
- 2) Challenge - people prefer the truth much more than being patronised
- 3) Build a relationship of equals
 - a. Standing Conference is intended to provide an opportunity for people to say everything they want
 - b. In particular areas there is a high expectation on people to visit and spend time with multiple groups
 - c. Consider what terminology is acceptable? Who represents who? What do we need to be talking about?
 - d. Think about how much to involve carers and remember that not all people have carers
 - e. Debate is strong when carers and service users are together as equals and provide representation from all sides. Try not to 'exclude' and allow for the fact that some people are uncomfortable in large meetings
 - f. Always allow service user and carer representatives to truly ask their own questions - NOT those designed by the commissioning team

ONE EFFECTIVE COMMUNICATION METHOD

- Carers' Assessment Training DVD and Pack Carers UK, in partnership with SCIE and four 'Beacon' local authorities (Hertfordshire, Rochdale, Sefton and Sunderland), have made a DVD to support the training of front-line staff in carrying out effective carers' assessments. Called 'Listening to carers', carers speak of

their experiences of being supported through the assessment process.

www.listeningtocarers.public-i.tv

PUTTING SERVICE USERS AND CARERS AT THE HEART OF DECISION MAKING

Experts by Experience - an extract from the Joint Hampshire Mental Health Commissioning Strategy (2011-16)

"Commissioners and those delivering services will recognise the value of service user and carer input as 'experts by experience', from individual care planning through to service development and employment.

In order to demonstrate that people who use mental health services are being put at the centre of all that we commission, we will promote the importance of peer and service user led services and we will help develop them to take responsibility for the delivery of user led services and to be involved in the provision of other services, including statutory services..."

www3.hants.gov.uk/joint-hants-mhcs-consultation.doc



DIVERSITY...DIVERSITY...DIVERSITY

‘Commission for the greatest good, for the greatest need, rather than the greatest good for the greatest number’

User representation is only this if it truly includes the whole community and when its constituent members participate.

This point was made in a report written by Caroline White in the Health Service Journal in August 2009. ‘How to Commission for Equality and Diversity in the NHS’, is a platform on which approaches to equality and diversity can be built.

www.hsj.co.uk/primary-care/resource-centre/how-to-commission-for-equality-and-diversity-in-the-nhs/5004740.article

Issues arising from service user feedback:

- High numbers of people with mental health conditions are from minority backgrounds (as a percentage of the population as a whole)
- Service users can feel that they are lone voices especially when they are from minority groups
- They find it difficult to raise issues of equality on the agenda. Are the issues of the minority groups taken seriously? Is engagement catering for the issues of the minority groups?
- People appointed to professional and other positions of responsibility are predominantly white, middle class and British. Constant training is required to ensure that issues of equality and diversity are addressed competently
- All groupings need to ensure that they are as representative as possible of the community they are formed to champion - whether statutory or voluntary
- In considering diversity - widen the thinking to include ex-service people, lesbians, gays, heterosexual and transgender people, ex-offenders and people who are detained in hospital, people with disabilities and people of different ages and beliefs

TOP TIPS

- Always consider the Six Strands of Diversity: Age, Disability, Gender, Race, Religion or Belief & Sexual Orientation, and the linked groups Elderly, Dementia, Learning Disability, Detained Patients and Travellers
- Help people to see beyond ‘labels’. Service users and carers can sometimes perpetuate the label as a protective shield - get them involved in confidence building activities
- Examine how the law protects against discrimination and encourage discussion
- Undertake awareness education. Use an equality and diversity consultant to challenge perceptions and preconceptions. Make people think of their own position and that of others
- CATS - Citizens as Trainers. Carers of service users and service users themselves can explain, educate and train, using their own experience to challenge stereotypes



CHAPTER 4

Supporting Evidence

JOSEPH ROWNTREE FOUNDATION

The Joseph Rowntree Foundation's Independent Living programme published a study by Age Concern in May 2010 which considered 'user involvement in strategic commissioning'.

- The background and literature produced from this research can be found at the following web link:

www.jrf.org.uk/publications/users-local-services

The researchers set out to identify approaches to choice and control that have credibility with service users and can be practically applied. The research took place in London over six local authorities and looked at user groups that went wider than mental health, including offenders with alcohol and drug use, parents, physically disabled people, people living with HIV and people with learning disabilities.

The report considered issues of citizenship, entitlement, choice and control.

The key themes that emerged mirrored the findings of research previously carried out by NHS Commissioners including:

- So called experts and statutory staff are cautious about the viability of engagement - their view being that they are in a better position to reflect the views of the many than a select group of volunteers.
- Service users can be frustrated by a number of things:
 - 1) Lack of 'clarity of purpose'. It can sometimes feel like involvement for involvement's sake - this can lead to cynicism about why they are being involved in the initial stages
 - 2) Leadership. When it feels like it is not being driven strategically this can impact negatively on the quality of the communication. Mixed messages can be given to outsiders
 - 3) Tone. This should be set at the highest level and throughout the organisation to create an environment that is conducive to user involvement
 - 4) Obstacles to overcome:
 - a. Assessment processes are required for information
 - b. Feedback on quality assurance processes and activity should be provided
 - c. Insight into the uptake of services is required
 - d. Areas that cross traditional service sector boundaries need highlighting
 - e. Contributions are needed to widen the discussion in areas that transcend particular interests - such as transport and housing
- Other areas where commissioners believed it could be extremely useful to involve users include:
 - 1) Raising the profile of a particular service and translating that into increased funding. This could be a really powerful way to involve people
 - 2) Help in the re-design or de-commissioning of services
- The research outlines that there are three types of organisation:
 - 1) Those which are open and willing to engage with service users
 - 2) Those which are open - but not willing
 - 3) Those which are neither open nor willing

Key factors affecting success:

- Service users identifying different issues from those prioritised by commissioners
- Service sectors having their own cultural norms about the levels of service user involvement
- It can be difficult to find those people who are motivated and maintain motivation. What motivates a service user is often ‘the desire to get things done and put things back’
- Commissioners may not always want to work with the ‘usual suspects’ but, at the same time, they do recognise that certain people do have the skill and experience to bring about effective outcomes
- Managing conflicts of interest in the voluntary sector in order to manage service user involvement
- Service users need to be involved from the start. Where this has not been possible, or where different service users are involved, it is important to share the narrative of what has led to the point at which service users find themselves

‘INVOLVEMENT’ IN OTHER AREAS OF HEALTH - CANCER NETWORKS

Within the field of Cancer Care an inclusive approach has developed over a number of years, with early innovations being associated with partnership groups - a collaboration of patients, carers, clinicians and NHS managers.

These partnership groups performed the following role types:

- reference group
- service redesign or development projects
- vehicle for the identification of service user involvement representatives on other groups and committees
- information source and communication channel
- lobbying/campaigning on behalf of individuals whose lives had been affected by cancer

This approach has developed into a systematic process of service user and carer involvement and is known as the ‘Cancer Network’.

Cancer Networks bring together providers, commissioners, local authorities, voluntary sector organisations and users of cancer services (patients and their carers) to work collaboratively as a system, to plan and deliver high quality cancer services. Cancer Networks focus their activities upon such tasks as:

Planning and Prioritising

Development of ‘strategic service delivery plans’ and ‘action plans’

Implementing National Guidance

Ensuring that National Guidance is implemented locally

Influencing National Policy

Monitoring Compliance and Adherence

Monitoring how well services are applying guidelines, including auditing how services are performing and whether they are achieving their targets e.g. Peer Review. Sharing of good practice is also linked to this activity

Service Improvement and Redesign

Improving and modernising the way that different departments work together to deliver cancer services at various stages of a patient’s healthcare journey

Collaborative Commissioning

Communicating

Acting as a communication ‘hub’ by receiving and passing on information, emerging guidance and other cancer-related issues to health professionals and patients



SERVICE USER INVOLVEMENT PRODUCES BETTER OUTCOMES - MACMILLAN AND THE PICKER INSTITUTE

In 2007 The Picker Institute, working with Macmillan Cancer Support, produced a report entitled “Evidence on the effectiveness of strategies to improve patients’ experience of cancer care”.

This report concluded that evidence to demonstrate that service user involvement produces better outcomes was largely supported by “soft” evidence sources (such as questionnaires) rather than studies requiring in-depth statistical analysis.

Positives identified included:

- User involvement can positively contribute to making services more accessible through:
 - Simplification of appointment procedures
 - Offering longer opening hours
 - Making improvements in transport
 - Ensuring access for people with disabilities
- Involvement can lead to new services being commissioned and the production of new or improved sources of patient information

- Users welcomed the opportunity for involvement and benefited from improved self-confidence
- Studies have indicated the benefits of user involvement for those personally involved, including increased social contact, enhanced knowledge, skills and opportunities for learning and building self-esteem
- Studies provide some evidence that user involvement can have a number of beneficial outcomes: influence on policies, plans and services, and sharing of learning, resources and expertise across local health economies

However, the report also noted the following potential concerns:

- User involvement was employed to ‘rubber stamp’ decisions that had already been taken
- Decision-making may be slowed down when service users are involved
- A number of examples where involvement activities had not resulted in changes to the organisation and delivery of services



CHAPTER 5

Building Blocks of a Successful Model

What we have discovered

GETTING THE BASICS RIGHT

The project has identified four building blocks which are considered to be critical success factors for any involvement process:

- A) Clarity - about the scope and aims of service user and carer involvement
- B) Commitment - to act upon the results of consultation
- C) Timescale and Resources - to be agreed and available throughout the process
- D) Feedback - ongoing mechanisms to obtain the views of service users and carers

(A) CLARITY

Who, What, Why, Where, When?

Clear written documentation should be provided including:

- Outline description of the proposed commissioning activity
- Identification of the commissioning objectives
- Role description for those involved in the consultation process
- Background information to ensure that participants are fully informed

It is important to avoid situations where a decision has already been taken, with consultation arrangements merely put in place to “rubber stamp” the decision.

SALFORD MENTAL HEALTH DEVELOPMENT BOARD

USER/CARER REPRESENTATIVE ROLE DESCRIPTION (APPENDIX III)

PRIMARY PURPOSE OF THE ROLE:

To ensure the views of those individuals experiencing mental health issues or accessing mental health services - and their carers - are recorded and used to inform and develop services in mental health in Salford

MAIN DUTIES:

- To attend Development Board meetings
- To share experiences of mental health services with the board
- To promote the Development Board and its links to the Partnership Board to wider user/carers groups in Salford
- To encourage user/carers groups to become involved in the Development Board
- To support and encourage positive working relationships with all members of the Board
- To identify gaps in best practice and to support the Partnership Board in filling those gaps
- To ensure that personal responsibility is undertaken for reading minutes and reports generated by the Development Board
- To ensure that information discussed at the Development Board is disseminated to the various service user and carer groups across Salford
- To ensure that any information presented is free from jargon, abbreviations and over-complicated language and to challenge any use of the above
- To ensure that service users and carers are able to understand and participate in the discussions that are being held on mental health services

(B) COMMITMENT

A criticism of involvement/consultation processes is that there often seems little evidence that recommendations are actually implemented. This discourages potential participants and therefore effective outcomes.

Commitment to act upon consultations can be demonstrated by the following:

- Identification of individual(s) with overall responsibility for the involvement process, including the actions planned for subsequent stages of the commissioning process
- Implementation of policy framework, embedding consultation arrangements within the organisation's commissioning arrangements
- Publicising previous outcomes where consultation resulted in real service user and carer involvement, as in "You Said We Did"
- Slogans and visions need to have an undeniable truth - don't say you are listening until and unless people at all levels are committed

The "You Said We Did" approach is more usually applied in commercial organisations, so it is important that it is applied in an honest and respectful manner.

Equally "You Said We Couldn't Do...because... and here's how we changed" - is a powerful demonstration of commitment and is linked to providing opportunities for feedback.

Other methods of demonstrating a commitment to act upon consultation include:

- Take the criticism and change things e.g. foods in wards. Even small changes in response to consultation offer an excellent method of developing a culture of taking involvement seriously
- Check if the change has happened. (Perhaps keep a video diary?) Appendix IV
- Give a mandate for any question to be asked

- Have a clear focus for a particular event (Standing Conference)
- Let service users lead
- Make sure all processes and records are accessible - transparency is key

(C) TIMESCALE AND RESOURCES

Effective involvement is difficult to achieve if it is an 'add-on' to a process rather than being integral to the process.

Financial barriers to involvement can be removed by the provision of 'expense arrangements' (predominantly for travel, refreshments and materials - if none are provided) and, where appropriate, financial recompense for the expertise provided by service users and carers.

Non-financial recompense or reward should be considered where statutory benefits may be affected.

MAKING A REAL DIFFERENCE STRENGTHENING SERVICE USER AND CARER INVOLVEMENT IN NIMHE AND CSIP (CARE SERVICES IMPROVEMENT PARTNERSHIP)

PAYMENT AND REIMBURSEMENT POLICY GUIDANCE (ACTIVITIES) NOVEMBER 2007

- Participation in working groups, committees, recruitment panels, etc. Minimum hourly rate £5.52 - £15.00 (Average Rate: £9.50)
- Preparation/follow-up. Sessional rate (a session can be up to 3 hours) £10.00 - £20.00 (Average Rate: £16.50)
- Short presentation (30 minutes) £40.00 - £50.00 (Average Rate: £45.00)
- Long presentation (60 minutes) £75.00 - £80.00 (Average Rate: £77.50)
- Running half day workshop/training £125.00 - £150.00 (Average Rate: £140.00)

- Running full day workshop/training
£250.00 - £300.00 (Average Rate: £275.00)
- Meetings exceeding 4 hours) £75.00 - £250.00
(Average Rate: £170.00)
- Participation in high-level working groups, committees, etc., for instance meetings at National level. Relevant day rates TBA.

These rates and guidance were relevant from the date above and are subject to change - always use the most recent regulatory framework

In addition to financial resources, a range of other resources could be provided, including:

- Training programmes including:
 - Meeting and working in teams
 - Conflict resolution training
 - Confidence
 - Public speaking
 - Communication skills
 - Computer training
 - Interview skills training
- Access to Mentors/Peer support
- Access to an impartial information source
- Pre-meeting preparation (Pre-meetings before a main meeting are advantageous)
- Providing sufficient time for individuals to prepare for each meeting by issuing documentation well in advance (7 days should be the minimum)
- Travelling/transport to meetings needs to be considered - public transport routes and timetables or maybe clear route maps for drivers
- Meetings will ideally be set at times which avoid 'rush-hour' traffic

(D) FEEDBACK

As well as providing advice and timescales for follow-up/implementation to those individuals who have participated, it is important to allow participants to give their own feedback.

A lack of feedback can result in contributions becoming repetitive and can result in a loss of motivation for those participating.

This point was made in a February 2010 Sainsbury's Centre report, 'An evaluation of mental health service user involvement in the re-commissioning of day and vocational services', which stated that a lack of feedback can have a negative effect on service user motivation, trust and confidence.'

http://www.centreformentalhealth.org.uk/pdfs/service_user_involvement_in_recommissioning.pdf

POTENTIAL PITFALLS IN THE INVOLVEMENT PROCESS

The earlier section of this chapter dealt with approaches to making involvement work. Listed below are some of the common pitfalls which may be encountered:

- Inadequate planning of the involvement process
- Limited background/contextual information
- Lack of "user friendly" information
- Limited consideration of the impact of changes resulting from commissioning activities upon the individuals involved in the consultation processes
- Limited training and support for representatives
- Limited consideration of opportunities for conflict between representatives and other service users or staff members
- Individuals who just do not wish to be involved
- Unrealistic raising of expectations
- Loss of motivation if participants believe their voice has not been heard
- Failing to adequately resource the process



HOW SERVICE USER AND CARER INVOLVEMENT SHOULD WORK

TYPES OF INVOLVEMENT

DIRECT

Direct service user involvement, describes the process of individual service users actively participating within activities linked to the commissioning of services.

Examples of Direct Involvement:

- Consultation Panels
- Standing Conferences
- Partnership Boards
- Speak Out Forums
- Client Narratives
- Citizens Panels
- Citizens Juries
- Service User Forums
- 'Together We Can' Panels
- In-depth individual consultations
- Oral or written submissions in response to public requests
- Hot lines and phone-in's



INDIRECT

Indirect service user involvement, describes the process where the views of service users are obtained via various feedback mechanisms.

Examples of Indirect Involvement:

- Questionnaires
- Suggestion Schemes
- Complaints/Comments
- Arrangements
- Web based surveys
- Community Fun Days
- Involvement via Art projects
- Involvement via Theatre projects
- SMS Text Messaging Surveys
- E-communications (blogging etc)



CHAPTER 6

The Changing Environment

GP CONSORTIA

A fundamental change to the commissioning of mental health services within the NHS is currently being developed following the publication of the White Paper - Equality & Excellence: Liberating the NHS.

Under the proposals within the White Paper, most NHS commissioning, including mental health services, will be undertaken by GP Consortia.

An objective of this approach is to devolve the decision making process closer to local communities.

In order to ensure that the GP Consortia have the skills and expertise to undertake the commissioning process, they will be able to employ staff or outsource the process to a range of organisations, including:

- Voluntary sector organisations
- Independent providers
- Local authorities

GP Consortia will have a duty of public and patient involvement. However, the White Paper does not provide a blueprint for how this would work in practice, with the exception that some information within the White Paper confirms that GP Consortia will work closely with Local Involvement Networks (to be re-branded as Health Watch bodies) as well as patient participation groups and community partners.

Central to the change process is the newly established NHS Commissioning Board which will be responsible for setting the framework for GP commissioning, governance and approval of consortia and commissioning services not included

within the remit of the GP Consortia.

The NHS Commissioning Board will also undertake the task of promoting and extending public and patient involvement and choice.

It is also considered that the changing environment provides an opportunity to introduce innovation into commissioning arrangements. It is important to note that the 'Duty to Involve' will remain within GP Consortium commissioning arrangements.

HEALTHWATCH

In July 2010, the Government announced plans to set up an independent champion for health and social care consumers called Health Watch England. Local Involvement Networks (LINks) will become local Health Watch organisations.

Local Health Watch will be the local consumer champion across health and social care, retaining LINks' existing responsibilities to promote patient and public involvement, to seek views on services which can be fed back into local commissioning, to have continued rights to enter and view provider services, and to continue to comment on changes to local services.

Local authorities will fund the work of local Health Watch organisations and will contract support to help them carry out their work. Local authorities will have a legal duty to ensure that the activities and support for local Health Watch organisations are effective and value for money.

www.pals.nhs.uk/cmsContentView.aspx?itemid=2160

CHAPTER 7

Feedback from Focus Groups

During this project we used information taken from focus groups to inform our recommendations. This chapter summarises the content of these groups. They are grouped according to our Essential Checklist.

The Focus Groups consisted of individual service users and carers from the North West, who had an interest in the commissioning of mental health services.

COMMUNICATION

- Real empathy has to be at the core of the process
- Dealing with passionate views and emotions, even anger, is to be expected
- If people aren't used to commissioning this shouldn't lead to frustration as their experience in operational service issues is also valuable
- Adopting a "hands on" approach helps with an understanding of the implications of the commissioning decisions being taken
- Carers and service users may find it easier to engage with voluntary organisations. Can they be used as intermediaries?
- Re-tendering exercises can cause real rifts when not explained
- Issues of payment/rewards need to be resolved and choices offered
- Information should be circulated on time, to allow for dissemination amongst formal and informal networks
- Traditional communication methods still work, e.g. posters

WIDEN THE NET. HEALTHCARE IS NOT A CLUB!

- Networks that are already in place should be used
- Adapting messages to the audience e.g. Facebook and other social networking, may be more useful for young people's services

JARGON

- The language used to describe policies, processes and outcomes has to be clear
- Make the commissioning process understandable
- Use plain English

MANAGING EXPECTATIONS AND RESPECT

- Involve Service users and carers at the beginning
- People's 'lived experiences' should be respected
- Learning to 'set the context' allows longer timescales for ideas to flow
- Give people opportunities to explore big ideas
- There may be a time delay between recognition of the communication methods and a desire to participate
- Financial support such as travel expenses and payment of fees should be prompt. "Sometimes we don't get paid enough and don't get paid on the day which means it makes it difficult to pay out for transport"

DIVERSITY

- Small things make a difference
- Consider the whole person
- Treat carers and service users as equals

SERVICES

- Ask - What service is needed? How should it be designed?
- Don't focus on a medical model



- Be aware that one size does not fit all
- Target local needs as well as national priorities
- Share best practice
- Service descriptions need to accurately reflect the service e.g. a crisis line which only offers an answer-phone service should state that clearly

CURRENT THEME - PEER SUPPORT

Peer Support has been used in a range of situations, including an element of an individual's recovery plan.

However, peer support can also be used in a similar manner to service user development or carer support services to facilitate service user involvement within commissioning activities or service re-design activities.

CURRENT THEME - CO-PRODUCTION

Co-production is based upon the view that public services are best delivered with people rather than to people. Co-production goes beyond consultative or representative approaches - people who access services can also be responsible for shaping and participating in the delivery of services.

Service users should be regarded as an asset and encouraged to work alongside professionals as partners in the delivery of services.

CHAPTER 8

Summary

- 1) Service users are at the heart of development.
- 2) Marketing. Get people involved and try new approaches. Remember, if you always do what you've always done, you'll always get what you've always got!
- 3) Keep it simple - one time...one place.
- 4) Tough Love. Understand difficult people. Understand the background behind why people feel as they do - it is almost always to do with frustration about their life and almost never to do with you and your organisation. It is critical that you have positive intentions and that you act on them, communicate them, and then allow people to acknowledge.
- 5) We are all on the same side! You, and the people who use services, have the same issues and frustrations. This will help bond your relationship and encourage you to work together to improve things.
- 6) Attitude. Adopt the perspective that involvement provides you with the right answers. In a sense, if engagement and involvement are done properly then the services and the way they are delivered will be improved. If you really are partners in creating and delivering services then there is little room for people to complain.
- 7) User involvement can feel bureaucratic. In other words, that tried and tested phrase 'box ticking' should be an anathema. People spot it and it becomes counter productive.
- 8) Feedback is often sporadic and lacking in detail and commitment. Examine your current processes and act on your findings.



Final Reminders

Constant themes in involvement in the commissioning cycle appear below. Hold on vigilantly to them when examining your performance and delivery.

1) SELF ASSESSMENT

Honest self-criticism is a powerful motivator. Take a magnifying glass to your current systems and processes. Getting it right benefits your whole organisation and, most importantly, the people who use its services.

2) BUILDING BLOCKS

Clarity/Commitment/Timescales & Resources/Feedback. Apply the successful model outlined in Chapter 5 of this document.

3) TREAT PEOPLE AS 'CONSUMERS'

Think the same way great commercial companies do. Deliver a service which takes into account the wishes of the people who use your services. They will be more likely to engage positively with you.

4) INVOLVE PEOPLE AT THE BEGINNING

Don't expect people to be happy to do something that you wouldn't do yourself. Get the input of the people who will use your services right at the start.



Appendix I

Self Assessment Tool

INVOLVEMENT IN THE COMMISSIONING CYCLE ASSESSMENT TOOL FOR TRUSTS

NHS Trust

Contact name

INTRODUCTION

In recent information (11th February 2010) posted on the NHS Evidence website the following was reflected:

- 1) "NHS organisations need to be ever aware of the duty to involve users under section 242(1B) of the 2006 Act and may achieve this by developing a strategic approach to commissioning, agreeing how, when and where to involve users and being prepared to be creative and innovative." (1) p.95
- 2) "User involvement in the commissioning process is not well established and presently it is more likely to occur in designing services than in assessing needs or evaluating services." (1) p.96
- 3) "Users can often identify common-sense solutions and practical ideas for services that lie beyond the boundaries of traditional service provision. Their ideas may not have been considered by health professionals and are more likely to meet the needs of other users and deliver user-defined outcomes.

This tool is for trusts to examine current processes and honestly assess progress in relation to involving service users and carers in the commissioning cycle. It looks at each stage of the cycle.

HOW TO USE IT

The self assessment tool is simple to complete and its results will be used in two ways (1) they will form the basis of the discussion that Making Space has with you when we examine your current practices and then establish you as a test site for the project and (2) for us to analyse and make a collective (North West) assessment of the starting point for the project.

The questions ask you to assess your perception of your current practices at each stage of the commissioning cycle and there is also a request that if you score 3 or above in any aspect you indicate particular examples of why you have selected this score. The scoring system is a scale of 1-5.

LEVEL 1 - Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.

LEVEL 2 - Indicates you have involved service users at this stage and it was difficult to measure how successful it was.

LEVEL 3 - Indicates that you have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.

LEVEL 4 - Indicates you involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.

LEVEL 5 - Indicates that you involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.

1. ASSESSING NEEDS			
	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

2. REVIEW CURRENT SERVICE PROVISION

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

3. SPECIFY AND AGREE QUALITY OUTCOMES

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Notes: It is at this stage where public and user engagement will often take place.

4. DESIGN SERVICES AND PATHWAYS

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Notes: It is at this stage where public and user engagement will often take place.

5. CONTRACT WITH PROVIDERS. SHAPE STRUCTURE AND SUPPLY

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Notes: It is at this stage where public and user engagement will often take place.

6. MANAGE DEMAND AND ENSURE APPROPRIATE ACCESS TO CARE

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Notes: It is at this stage where public and user engagement will often take place.

7. CLINICAL DECISION MAKING

	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Notes: It is at this stage where public and user engagement will often take place.

8. MANAGE QUALITY PERFORMANCE AND OUTCOMES

8. MANAGE QUALITY PERFORMANCE AND OUTCOMES			
	RANKING	SCORE	COMMENTS/ EVIDENCE
1	Indicates you never involve service users and carers at this stage because you have not found the appropriate approaches.		
2	Indicates you have involved service users and carers at this stage and it was difficult to measure how successful it was.		
3	You have made significant progress in some areas of the commissioning cycle and that you are beginning to see the rewards of the approach you have adopted.		
4	You involve carers and users at most stages of the cycle and you simply have to transfer this to all stages. You are seeing and can evidence that your practices are proving successful.		
5	You involve carers and service users at every stage of the cycle, you see huge benefits from this and you have evidence that your practices are proving successful. You are seeing a tangible improvement in the quality of your services and can evidence this.		

Appendix II

The Steering Group

WILLIAM TOMKINS



With five children - three girls and two boys - William enjoys a strong relationship with his family.

He is a former service user and is a carer for his son and has involvement with his daughter who also uses Mental Health Services.

William has been active for a decade in a variety of groups including the User Advisory Consultative Team, Bolton, Salford and Trafford Mental Health Trust, where he was also the former Chair of the Patient and Public Involvement in Health.

William is a member of Collective Voice North West and participates in voluntary work for the Lancashire Care Mental Health Foundation Trust. He has also been with the development of Carers Assessment Audits, and produced a training package for recruitment and selection training for service users and carers.

The motivation behind the extensive work that William does is the desire to influence services so that they are always tailored to the needs of service users and carers.

SUSAN HAWORTH



Sue became involved in this project because she describes herself as having an interest in the 'wider agenda'. She is always asking "what determines improved mental health and how can service users achieve it?"

This, she believes, is commissioning and more. She enjoys operating within the two challenges. One is the desire to make a difference to what she sees as the disconnect between service users' daily lives and those who determine their options and services. The other is the fostering of recovery aims, empowerment, participation and positive self esteem, so more service users can have fulfilling lives.

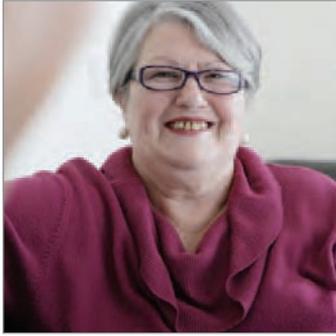
She is convinced that if commissioners and service users commit to the recommendations of this project much will be achieved in both areas of the challenges she describes.

Susan is the elected chair of the User Action Team, Greater Manchester West Mental Health NHS Foundation Trust.

She says, "I live with a mental health condition long term. Friends live with diabetes long term. They have been sick and semi conscious in hospitals. I have agonised with hypomania on the streets ...but we all like Coldplay!

That sums it up really well. Anything more obsessive would impede my recovery."

ANNE BROADHURST



In her personal life Anne has been happily married to Terence for 46 years and they have two children and although now retired, spent much of her working life in Law.

As a full time carer Anne became very active in trying to change things for people with a mental health condition - and their carers - several years ago.

She is a member of Making Space and is Chair of the Salford Carers Group for the organisation.

Anne's involvement started with the National Institute for Mental Health in England (NIMHE) and then the Care Services Improvement Partnership (CSIP) where she sat on the North West Development Centre's Development Board.

CSIP established the ROC and ROLE programme where, together with her Husband, Anne and approximately 15-20 service users and carers carried out a variety of projects.

Anne has also been a member of the Salford Mental Capacity Act Implementation Steering Group and was one of a group of volunteer trainers carrying out briefing sessions on the act for care home workers.

Anne, alongside her husband, eventually became involved in the Mental Health Improvement Programme where she became the Chair of the Expert Reference Panel for user and carer involvement.

Anne's current activism in mental health includes:

1) Chair/organiser - Making Space Service User

and Carer Support group in Salford

2) Lead Governor -

Greater Manchester West mental health NHS Foundation Trust

3) Chair -

Salford Mental Health Development Board

4) Member -

Salford Mental Health Partnership Board

5) Carer representative -

Salford Mental Health Forum

6) Carer member -

ROLE Network

She says, "I am passionate about mental health issues and will continue to work to improve services for service users and carers."

KAREN MACHIN



Karen Machin was a carer for 10 years as well as using services herself. During this period, her family lost jobs, friends and homes. They experienced services

across London and the South East, the South Lakes and Knowsley, before settling near family in St Helens.

Karen formed a Carers group, became a trustee of the local Carers Centre and volunteered with the Mental Health Promotions team as a way of returning to paid employment. She uses a variety of skills including facilitation, research, events organisation and film making. She now works freelance and is interested across a range of mental health issues for service users, survivors and carers, including young people.

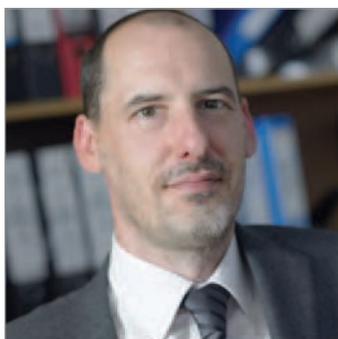
She believes strongly in prevention and was one of the North West pioneers for Mental Wellbeing Impact Assessments. She is a Lived Experience Advisory Panel (LEAP) member for 'Time To

Change', a campaign throughout England to tackle stigma and discrimination.

She delivers Peer Support Worker training courses for Making Waves, and is on the Peer Trainer Reference Group for the national Implementing Recovery Organisational Change (ImROC) project.

She is a founder member of the ROLE network, CIC, a social enterprise formed by service users, survivors and carers across the North West.
www.role.org.uk

PAUL GREENWOOD



Paul Greenwood is the MHIP North West's User, Carer and public engagement lead.

Paul has worked for CSIP North West since October 2004 as the Associate Lead on Workforce, engaged in support, time, recovery (STR) worker development, Ten Essential Shared Capabilities, New Ways of Working and a variety of other workforce issues. He led on the regional implementation of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. Paul also led the LINKS programme for the North West Joint Improvement partnership alongside working for two mental health trusts covering New Ways of Working and Implementing Legislation and CPA at a local level.

Previously, Paul has worked in mental health since 1986 in a variety of settings (predominantly day services). In 1999, after six years as a community psychiatric nurse, he became a Staff Development Officer for Oldham Social Services, including being an Approved Social Worker Agency Co-ordinator, children's rights trainer and user and carer trainer.

MAURICE BURNS



Maurice has extensive Board level experience in mental health in both the NHS and Local Government. His previous roles included a Local Authority Head of Mental Health Commissioning, Director of Mental Health in two large NHS Trusts and a regional Commissioning Development post supporting effective mental health commissioning. For the last two years he has combined his current national role with his work for Hertfordshire Partnership Foundation Trust. Maurice has particular interests in mental health and housing and has held a Non Executive Director role with a national Housing Association. He has also co-authored a recent policy publication by the Sainsbury Centre for Mental Health on "Implementing Recovery - A Methodology for Organisational Change".

Appendix III

Salford Development Board Process

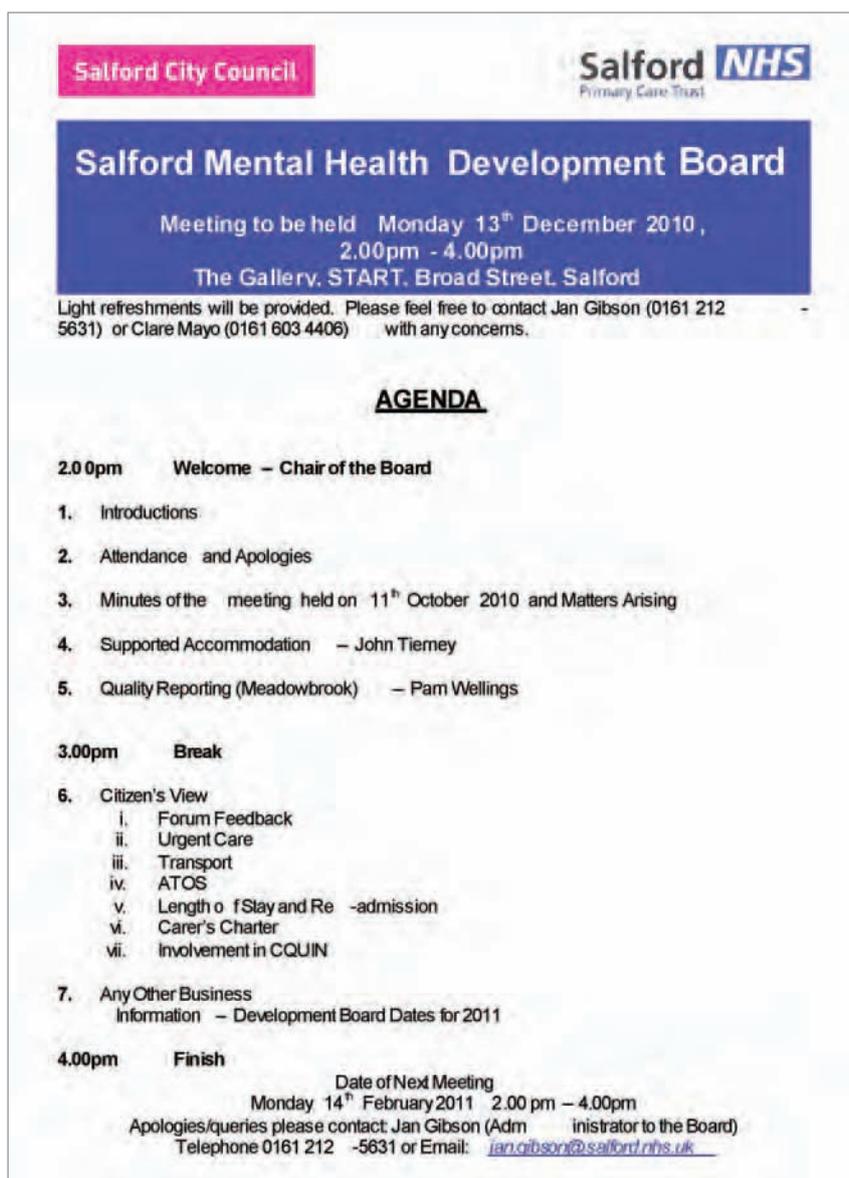
And supporting documentation

The following procedure extract gives some insight into how an involvement process has been embedded within the organisation's decision making processes:

Although the Development Board is not a decision making body, it plays a very important role in promoting the views of service users and carers. The Development Board provides a space for representatives from service user and carer

groups in Salford to get together to discuss issues related to mental health. These views are then fed through to the Partnership Board via the Citizen's View section of the agenda.

Papers due to be presented at the Partnership Board are brought to the Development Board as a working document to encourage service users and carers to provide comments and ask questions on the information presented.



The image shows a meeting agenda for the Salford Mental Health Development Board. It includes logos for Salford City Council and Salford NHS Primary Care Trust. The meeting is scheduled for Monday, 13th December 2010, from 2.00pm to 4.00pm at The Gallery, START, Broad Street, Salford. The agenda lists items such as Welcome, Introductions, Attendance, Minutes, Supported Accommodation, Quality Reporting, Citizen's View (with sub-items like Forum Feedback, Urgent Care, Transport, ATOS, Length of Stay, Carer's Charter, and CQUIN), and Any Other Business. It also provides contact information for Jan Gibson and Clare Mayo, and the date of the next meeting on Monday 14th February 2011.

Salford City Council **Salford NHS**
Primary Care Trust

Salford Mental Health Development Board

Meeting to be held Monday 13th December 2010,
2.00pm - 4.00pm
The Gallery, START, Broad Street, Salford

Light refreshments will be provided. Please feel free to contact Jan Gibson (0161 212 5631) or Clare Mayo (0161 603 4406) with any concerns.

AGENDA

2.00pm Welcome – Chair of the Board

1. Introductions
2. Attendance and Apologies
3. Minutes of the meeting held on 11th October 2010 and Matters Arising
4. Supported Accommodation – John Tierney
5. Quality Reporting (Meadowbrook) – Pam Wellings

3.00pm Break

6. Citizen's View
 - i. Forum Feedback
 - ii. Urgent Care
 - iii. Transport
 - iv. ATOS
 - v. Length of Stay and Re-admission
 - vi. Carer's Charter
 - vii. Involvement in CQUIN
7. Any Other Business
Information – Development Board Dates for 2011

4.00pm Finish

Date of Next Meeting
Monday 14th February 2011 2.00 pm – 4.00pm
Apologies/queries please contact Jan Gibson (Admin Inistrator to the Board)
Telephone 0161 212 5631 or Email: jan.gibson@salford.nhs.uk

Salford Mental Health Development Board

Minutes of the Meeting:
Monday 13th December 2010, 1pm -3pm
The Gallery, START, Broad Street, Salford

Present :

Anne Broadhurst (chair)	Making Space Representative
Zahid Alam	UACT/MSUF Representative
Andrew Atkinson	Voluntary Sector Representative
Peter Baimbridge	Service User Representative, Psychology Service
Samia Berkatali	Support – Salford Link
Nasseem Akhtar	Salford Link
Zobia Mahboob	Salford Link
Chrissy Thompson	Service User Champion, Pendlebury House
Helen Hills	PRT Salford Carers Centre
Keith Wilson	Partnership Board Representative
Martin Kerfoot	Salford Mental Health Forum
Clare Mayo	User Development Worker Mental Health
Angela Owen -Spicer	LD Partnership Board Representative
Sam Portnoy	HBAC/Partnership Board Citizen Rep
Zahid Siddique	Development Worker CHSC
Names in bold indicate Partnership Board Citizen Representatives	

Apologies: Tony Cribbin, Simon Grant, Ann Williams, Sam Portnoy, Debbie Yates

In Attendance :

Pam Welling	Greater Manchester West MH Foundation Trust
John Tierney	Project Manager - Supported Housing
Di Critchley (Observing)	User Development Worker

1. Welcome & Introductions

All attendees introduced themselves and apologies were recorded.

2. Minutes of the last meeting – 11th October 2010

Salford Mental Health Development Board

The above Board works for the following reasons : -

1. Mental Health Service Users and Carers Groups throughout Salford each nominate a person to represent their group on the Board.
2. This gives wide and diverse representation
3. Service Users and Carers issues and concerns are brought to the Board, discussed and the relevant directors and/ or managers are asked to attend to comment and develop a way of looking in partnership to address concerns.
4. On attendance directors and/or managers are asked searching questions.
5. The issues and concerns are then passed on to the Salford Mental Health Partnership Board by way of "The Citizens View".
6. Discussions then take place and the issue or concern is referred back to the Development Board for further work to be carried out and further attendance by the relevant personnel, who in turn keep the Development Board informed of progress on resolving the matter or why there has been a lack of progress.
7. This really is "You said – we did".
8. One of our recent successes has been the catering in the inpatient unit. This has recently been completely overhauled. Simple things like microwaves in the ward kitchens so that patients can make themselves a light supper. Menus have been completely revamped. The way the food is served to patients has also been overhauled.

For further evidence please see the attached Agenda and Minutes of the meeting of the Development Board held in December 2010.

Appendix IV

The Diary Room Approach

The use of video diary booths as a way of gathering people's experiences of mental health isn't new. 5 Boroughs Partnership Foundation Trust have been using this approach for some time to positive effect. The project aimed to promote a creative approach that not only drew out people's experiences but had a demonstrable impact on service improvement.

Each site responded positively to using this approach and managed the process, in an effective and meaningful way for users and carers, ensuring they were well informed and supported. It was important in the early stages of the project that, regardless of a patient's condition, it was key that a solution was found to ensure they could access the video booth or a community reporter.

The findings for many people across the three sites were not surprising although the impact of seeing the footage was no less powerful. What was clear throughout was a high level of respect for staff and an understanding of the stressful nature of their work. Many respondents on the video footage commented on a desire to support staff in making a difference and improving the service through working in partnership and not a 'them and us' approach.

The video booth itself created interest but it had its drawbacks. The booth felt claustrophobic and difficult to place within service settings due to background noise. People's Voice Media included a community reporter element with the booth. Community reporters are people with lived experience who are trained in journalistic

techniques to gather stories from local communities on local issues. This role offered more flexibility and put people more at ease to open up about their experiences.

Incorporating the video booth as one tool to gather people's experience into your quality strategy and quality accounts processes is key to measuring the impact on service improvement. Lancashire Care Foundation Trust has set out a process which embeds the video booth into its quality assessment visits.

This project was positively received by users, carers and staff and some improvements are already being made with others in the pipeline.

Each site sees the potential that this method of gathering people's experiences can bring in improving services. All three Trusts are looking to use the video booth across services with one trust currently running the video booth across its inpatient services.

www.northwest.nhs.uk/document_uploads/MentalHealthNews_July09/VideoDiaryRoomProject_FinalReport_8b3c6.pdf