INFLUENCING COMMISSIONING IN HEALTH AND SOCIAL CARE

How the LINk can add value to public engagement

Report of a Study for the Birmingham Local Involvement Network and its statutory sector partners

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The report uses a qualitative approach to derive a series of conclusions and recommendations about how the LINk might be more influential in the future. These are based solely on our interpretation of the evidence presented to us by the respondents. As such the views offered here are entirely our own and any errors of interpretation are solely due to the authors.

CONTENTS

SUMMARY

PURPOSE

This report is based on extensive interviews, focus groups and other research carried out between May and October by a team from the Welsh Institute for Health and Social Care, University of Glamorgan. The purpose was to look at how the Birmingham LINk could be most effective in influencing the commissioners of health and social care in the city. It describes what an influential LINk would look like to commissioners; it also looks at what commissioners need to do to facilitate the work of the LINk. The emphasis throughout is on 'adding value' to patient, service user, carer and public engagement, by creating an effective partnership between the LINk and the NHS and City Council, which recognises the independence of all parties, and the need on occasion for constructive criticism.

AIMS

The LINk

The LINk should aim for the following; further detail on each is contained in Section 2.1:

Success Criterion	How would you assess it
1. New faces	Some unfamiliar participants, speaking for themselves
2. New communities	Groups and issues that are relatively unknown by commissioners
3. New information	Perspectives not already available; new levels of understanding
4. New thinking	Evidence-based, independent-minded, new solutions
5. Broad 'membership'	Reasonably numerous/representative; different ways of engaging
6. Reliable	Reasonably rigorous in research and presentation
7. Constructive	Often suggesting solutions or ways forward
8. Coordinated	Efficient approaches to engagement
9. Good feedback	Groups and individuals reporting positively about the LINk
10. Aligned with timetables	Often just ahead of commissioners' agendas
11. Big issues	Focusing on issues of serious detriment
12. Savvy	Using levers effectively

The Commissioners

Commissioners should aim for the following in their relationship with the LINk; further information on each can be found in Section 2.2:

Success Criterion	How would you assess it
1. Transparency	Share and agree decision-making processes with the LINk; agree timescales in advance
2. Honesty	Inform the LINk about real objectives and (formal and informal) constraints; invite challenge
3. Approachability	Provide the LINk with easy access to relevant decision-makers; provide alternative methods of interaction (verbal, written, etc.)
4. Respect	Ensure 'organisational body language' shows respect; be clear about mutual expectations
5. Corporate unity	Ensure that all decision-makers share respect for/understand the LINk; invite LINk feedback on commissioners' performance
6. Timing	Explain constraints; flexible response to LINk's own agenda/timescales
7. Listening	Understand the LINk's perspectives, needs and priorities; ensure that decision-makers interact directly with the LINk
8. Sharing	Assume all information should be provided to the LINk; proactively explain systems/data, etc.
9. Coordinating	Look for synergies with the work of the LINk; design joint/shared approaches where appropriate
10. Feedback	Keep the LINk informed about how its views were used; explain why LINk input is not accepted (where applicable)
11. Behaviours	Agree parameters of behaviour in advance; void unnecessary antagonisms; reflect jointly on behaviours
12. Shared wins	Find issues/areas which can address commissioners' and the LINk's priorities

Any merger of the three Primary Care Trusts will eventually result in the development of new health commissioning structures and processes, but will not materially affect the substantive issues discussed in the report, which are not dependent on organisational form.

Recommendation 1

The LINk and commissioners separately should reflect on the criteria set out above, and decide:

a. Are these a fair and reasonable set of criteria to which we would wish to subscribe?

b. What are the implications of each for our organisation?

Recommendation 2

The LINk and commissioners together should reflect on those criteria by which they wish to be assessed, and agree a shared Concordat. This should set out in some detail how each party will act in order to ensure that the criteria are met.

Recommendation 3

The LINk and the commissioners should agree a process for reflecting on their performance against the criteria, and learning from that reflection. The process should include participation by the most senior staff, be informed by the views of services users, patients, carers and the public, and report publicly on progress against clear performance criteria.

THE WAY FORWARD

Choices for the LINk

There are six key strategic choices for the LINk as it builds up its own priorities, work plans and structures (further detail is provided in Section 2):

Issue	Choice: the balance between…
a) City-wide vs local	… issues which have clear relevance across the city, and those which really only concern one locality or group
b) Health, social care, or both	… issues which only relate to either health or social care, and those where both services are inextricably connected
c) Multiple agendas vs. limited resources	… addressing all significant issues, and choosing those where the LINk could make the greatest impact
d) Proactive vs. reactive	… responding to all issues raised with the LINk, and deliberately choosing issues to pursue against an objective set of criteria
e) Independent/scrutiny vs. cooperative/co-production	… scrutinising and maintaining strong independence, and working collaboratively with agencies to make improvements
f) Network vs independent	… facilitating the work of the network of affiliated bodies, and doing independent work with the public as 'the LINk'

Recommendation 4

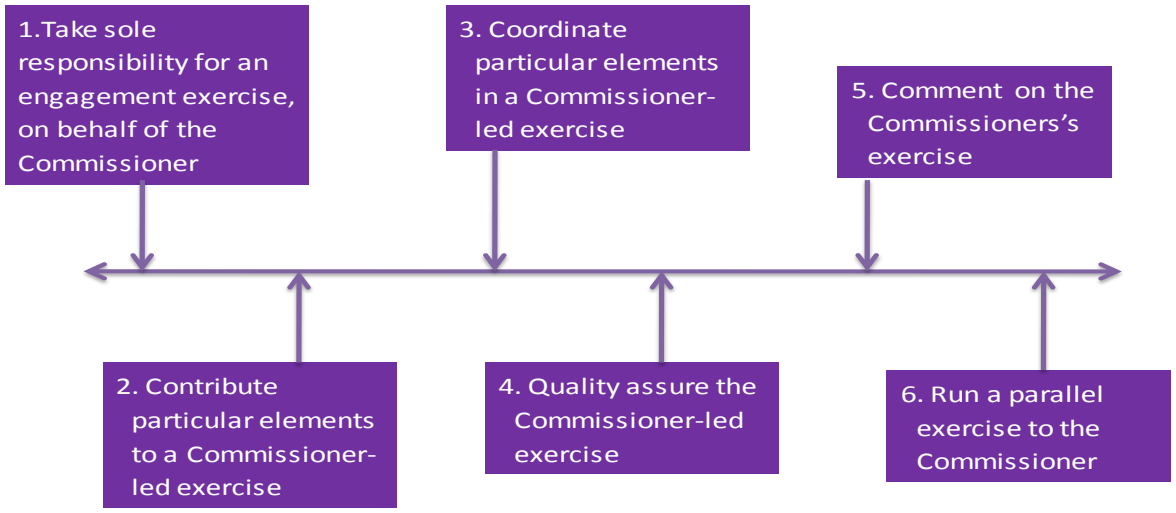
The LINk should reflect on the issues represented by the issues/choices set out above, and use these as a basis for setting its own strategic direction. The material presented in Section 2 of this report can inform this discussion.

Recommendation 5

Based on this discussion, the LINk should agree a practical set of criteria for determining its own work priorities.

Choices for the LINk and Commissioners together

There are several aspects of the practical working relationships between the LINk and commissioners which require early discussion and mutual agreement. There is a range of different ways in which they can work together:



As a checklist for action, the key areas include the following (discussed in Section 3):

What	Who	See Sections
Agree annual timetable for joint working	LINk, Be Birmingham, BHWP, Primary Care Trusts, BCC Adults and Communities, Overview and Scrutiny Committee, BCC Constituencies, Foundation Trusts, BVSC, CQC. (See Section 3.1.1)	3.1.3-3.1.10
Agree annual work plan		3.1.3-3.1.10, 3.2
Agree approaches to joint working		3.1.2
Develop understanding on behaviours		2, 3.3
Agree lines of routine communication		2, 3.3
Agree information sharing protocols		2, 3.3

Recommendation 6

The LINk and the relevant bodies should discuss and agree the various issues set out above, using the material presented in this report. A joint forum should be created for the purpose, linked to the arrangements outlined in Recommendation 3.

SECTION 1 | PURPOSE AND BACKGROUND

1.1 PURPOSE OF THE REPORT

This report is written for the Birmingham Local Involvement Network (LINk) and its various partners in health and social care in Birmingham – especially the commissioners of services: the Adults and Communities Directorate of Birmingham City Council (BCC); the three Primary Care Trusts (PCTs); and the relevant parts of the Be Birmingham Local Strategic Partnership (LSP); and those with a close interest in their work like the Overview and Scrutiny Committee (OSC), Birmingham Voluntary Service Council (BVSC) and others.

The aim is to inform the discussions within the Birmingham LINk about its future direction and ways of working, by giving an insight into the perspectives of commissioners, and setting out some of the alternative ways forward. Drawing on the results of an extensive set of interviews, focus groups and workshops, and applying lessons learned elsewhere, the report explores the ways in which the LINk might add value to the work currently underway on public engagement in health and social care in Birmingham. It also highlights ways in which the commissioners themselves can help to forge a productive relationship with the LINk.

Section 2 describes a possible future 'destination' in the relationship between the LINk and commissioners:

- what an 'influential' LINk in Birmingham might be doing, and how it could maximise its influence;
- looking at the ways in which the LINk can influence commissioners, by understanding their perceptions, hopes and aspirations in relation to the LINk;
- commissioners' responsibilities in the relationship with the LINk.

Section 3 explores the external factors which might influence the LINk's choice of a possible 'route' forwards:

- the processes, structures and co-ordination for bringing the LINk and commissioners together (Section 3.1);
- the broad topic areas on which the LINk could most profitably build into its work plan (Section 3.2);
- how the LINk should go about its work, in terms of its behaviours and relationships (Section 3.3).

Section 4 draws some conclusions and makes some recommendations.

The focus throughout is principally on the *external* environment – on the opportunities outside the LINk – rather than on how the LINk should organise itself internally. There is in some places information received from respondents which touches on the internal working of the LINk. That data is reported here only to reflect accurately what we heard and should be read in that way, and not be seen as an attempt to dictate to the LINk a *modus operandi*. The report is as concise as possible, consistent with clarity.

1.2 THE RESEARCH

The research on which this report is based was conducted by a team from the Welsh Institute for Health and Social Care (WIHSC) between May and October 2009. Following approval from BCC's research governance processes, a variety of approaches and types of 'data' were gathered and analysed by the team, including:

- A review of the literature on LINks and their immediate predecessors;
- Face-to-face and telephone interviews with people from commissioner organisations in Birmingham, including the three PCTs, BCC's Adults and Communities Department, and the Be Birmingham LSP, as well as the Care Quality Commission and others;
- Interviews with several local councillors;
- Interviews, focus groups and workshops with people from a variety of third sector and other organisations with an interest in health and social care issues in Birmingham and more widely;
- Workshops to share and validate the emerging findings.

In each of these approaches - interviews, focus groups, workshops - the team had two main objectives. First, to *understand* the realities and potential of engagement in Birmingham, as perceived by the participants, including their personal and their organisation's aspirations and concerns for such engagement. Second, where appropriate to *challenge* the evidential and value bases for those views, in the light of evidence from other sources.

A summary of the terms of reference and a list of the organisations and people who took part is at Appendix 1.

1.3 OPPORTUNITIES AND CHALLENGES: FACTORS FOR BIRMINGHAM LINk TO CONSIDER

1.3.1 Purpose of LINks

LINks have been designed to fit within a new world of health and social care commissioning, and their remit and terms of reference complement those of the statutory bodies with whom they will work (see Box 1). A brief summary of the evolving context of health and social care commissioning is provided in Appendix 3.

Their task, therefore, is to 'add value' to this common endeavour, by carrying out those tasks which they are particularly well-suited to deliver. An important element in this is their independence. So, they may choose to work closely in collaboration with commissioners and others, or they may choose to maintain their distance, commenting from a position of relative detachment. Each sort of approach carries its own strengths and weaknesses (which are discussed later in this report), and may be appropriate in different circumstances.

BOX 1 | Role of LINk

- Promote and support the involvement of people in the commissioning, provision and scrutiny of health and social care services;
- Obtain the views of local people about their needs for, and experiences of, health and social care services and make these views known to those responsible for commissioning, providing, managing or scrutinising those services;
- Enable people to monitor and view the commissioning and provision of care services in their locality;
- Make reports and recommendations about how health and social care services could be improved, to people responsible for commissioning, providing, managing or scrutinising those services.

LINks should focus on three outcomes:

- Services that are shaped to meet peoples' needs;
- Services that are improved as a result of people's experiences;
- Local people having confidence in the validity and transparency of health and social care bodies' decision-making.

Source: Department of Health (2007) *Getting Ready for LINks - Contracting a host organisation for your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.16

1.3.2 Challenges and opportunities facing Birmingham LINk

All of the factors set out above are relevant in Birmingham. However, the LINk inherits some element of disillusion over the abolition of its predecessors. As two interviewees expressed it:

> *'The LINk should be in theory the best thing since sliced bread, but it has suffered from being another change'*[*]

> *'The abolition of the four CHCs [Community Health Councils] had been painful – people felt used and abused by the DH[Department of Health] – and now their successors [PPI Forums] were also to be abolished'*

The interviews with the various stakeholders highlighted four other key aspects of the situation in Birmingham which the LINk may wish to consider as it charts its way forward (see Table 1).

A final theme which emerged in many interviews and discussions concerned the future:

> *'because of short-term funding for the LINk itself, people will wonder – will they still be around? They need to establish measurable, achievable goals'*

This uncertainty is not a fatal barrier to partnership working – many organisations are used to short-term funding – but it does reinforce the urgency of the LINk making its mark.

[*] Quotes in italics throughout the text are taken from interviews and focus groups conducted as part of the research for this project. All are anonymised, in accordance with the agreement made with each interviewee.

1. Size and Diversity	2. Public Engagement Legacy
The Birmingham LINk has to relate to one of the largest and most diverse populations of any LINk in England. The city's population currently stands at about 1 million and is expected to increase to 1.1m by 2026. It is relatively youthful (a quarter under 18), ethnically diverse (the white population is projected to fall from 65% of the total in 2001 to 48% of the total by 2026), and will see significant out- and in-migration.	Many people remember both CHCs and PPI Forums, and opinions are sharply divided about their respective merits. This legacy creates opportunities – the LINk is bequeathed a lot of knowledge and expertise – but also challenges. Commissioners are anxious to avoid what they characterise as single-issue and personality-dominated lobbying, and a sole focus on particular institutions, narrow client groups and the NHS.
3. Crowded Field	**4. Multiple levels**
The statutory bodies have developed significant public and patient/client/carer engagement structures and relationships of their own in recent years, and substantial expertise in some areas. There may be added value in the LINk also working in these fields, but there are dangers of duplication. There are other client groups and populations where commissioners acknowledge their own gaps, and where the potential added value of LINk involvement is more obvious.	The LINk does not have a unified commissioning body with which it can relate. Rather, the NHS divides into 3 commissioners, and BCC operates both departmentally (e.g. Adults and Communities) and geographically (e.g. Constituencies). Be Birmingham brings these bodies together on some issues but not all. In addition, the NHS and Adults and Communities operates varying degrees of separation between 'commissioning' and 'provision', with potentially several dozen providing bodies of various sorts.

Table 1 | Challenges and Opportunities for Birmingham LINk

SECTION 2 | AN INFLUENTIAL LINk: COMMISSIONERS' PERSPECTIVE

'The Board relies on getting high quality quantitative and qualitative data in order to make decisions…The LINk should be ideal in helping us get data'

This Section focuses on the key question: 'What would be the characteristics of an influential LINk in Birmingham?' This is the 'destination'. Section 3 considers how to become such a LINk – the 'route' to be followed.

The concern in Section 2.1 is with the perceptions of the commissioners (and other key statutory stakeholders), on the basis that the LINk needs to understand their aims and objectives, and the constraints they work under, if it is to be able to influence them. In deciding how it wishes to proceed, the LINk will of course need to weigh these perspectives alongside its other objectives. Section 2.2 turns the mirror round towards the commissioners and considers their responsibilities in developing this relationship with the LINk which will 'add value' to public engagement in Birmingham.

2.1 WHAT COMMISSIONERS NEED AND WANT FROM THE LINk

'Hitherto, the patients' voice has only been whispering to commissioners'

We have interviewed a good cross-section of decision-makers in the statutory health and social care organisations in Birmingham, have discussed these ideas extensively with them, and have related the local discussions to the evidence from elsewhere. What emerges from such stakeholders is a relatively consistent and coherent set of priorities for the LINk, based as always on an element of self-interest ('what would help me do my job?'), and on an element of the 'greater good' ('what would be in the interests of the people of Birmingham?'). This understanding should help the LINk decide on its own priorities and ways of working, but it is important to repeat: these are merely views which the LINk may wish to consider, not instructions which it must follow.

'Need' and 'want' are treated as separate categories here, although in practice there is considerable overlap between them. What commissioners 'need' is largely an objective list of LINk characteristics and outputs which will help facilitate their work and support them to deliver against their various non-negotiable agendas. Their 'wants' also include characteristics which relate to the discretionary element of commissioners' work – things they don't have to do, or particular ways of working which are not mandated but come from specific value bases or locally-derived priorities. Both are important, both may change over time, and the intersection between them is a particularly fruitful area upon which the LINk might wish to focus. Both categories include the ability of the LINk to change the 'agenda': to ensure that

commissioners focus on topics that they would not necessarily have prioritised without the influence of the LINk.

Commissioners' needs and wants fall into two broad categories:

- Outputs – what commissioners want the LINk to deliver;
- Processes – key features of the way in which the LINk goes about producing the outputs, which either enhance or detract from its utility to commissioners.

Both are important. Clearly, the outputs matter; but so do the processes which lead to them, because significant 'failures' in the way in which the LINk goes about its work may undermine the utility of its work to commissioners, and therefore its influence. Figure 1 below plots these processes and outputs.

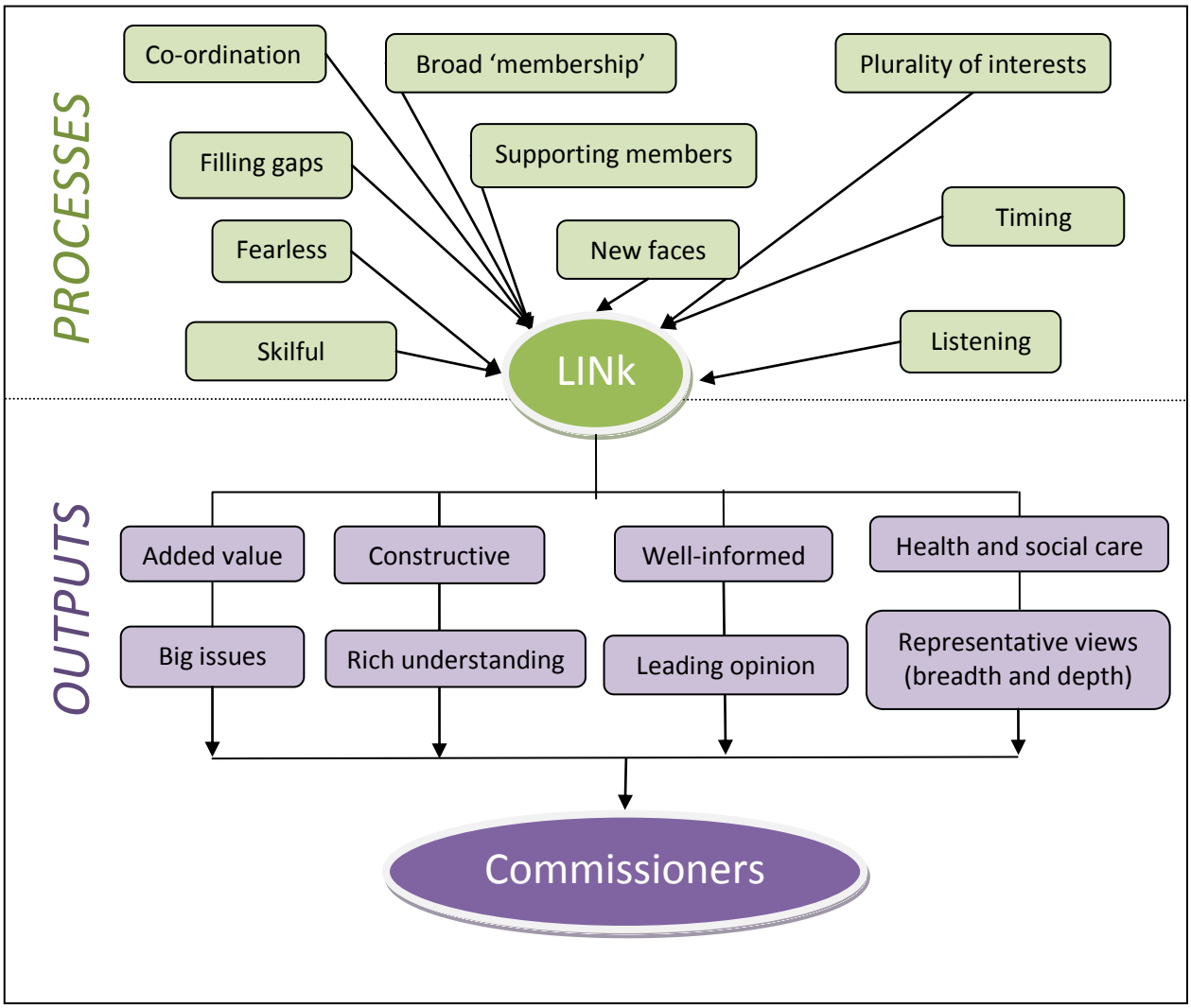


Figure 1 | Processes and outputs in the relationship between Birmingham LINk and commissioners

The views of the different commissioners are reported here. In most cases, there was unanimity about both outputs and processes; any differences of view are highlighted in the text.

2.1.1 Outputs

The 'outputs' from the LINk will take a variety of forms, including routine monitoring of services, contributions to others' research (e.g. facilitating access to people), the results of the LINk's own research, alternative visions for service development, different views of priorities, and others. Commissioners had clear views on what they would regard as useful, and therefore about how the LINk might influence them.

Added value, not duplication

There are already many ways in which statutory bodies go about engaging their clients/patients and the wider public: *'by pooling effort [I hope] we might end up with something bigger than the sum of our parts'.* Whilst there may be some rationalisation of these processes in the future – and many commissioners expressed a desire to see such a process – many will remain, and commissioners were firmly of the view that a major challenge facing the LINk was to ensure that its outputs *complemented* those coming from existing processes, rather than *duplicating* them:

> *'If I went to the LINk with an issue I would like to think they would tell me things I don't know'*

Three principal areas of potential added value were identified:

- Enhancing the quality of the engagement with existing groups;
- Reaching groups of people not adequately served by existing mechanisms;
- Bringing together sources of information not currently synthesised.

Constructive not destructive

There was some difference of opinion on this issue amongst the commissioners interviewed for this study. On the one hand, most would prefer to deal with a LINk which produced alternative suggestions rather than only criticising what is currently in place or being proposed:

> *'we would like to see LINks flagging up issues to the PCT… to act as a commissioning resource. We would like the LINk to offer solutions as well as problems'*

On the other, there was a recognition by some that it was not always possible to generate alternatives, in the time and within the resources available to the LINk. Such a limitation should not prevent the LINk from criticising the work of commissioners, where it deems it necessary.

In terms of the *balance* of the LINk's work, several interviewees expressed a hope that the LINk would not become a body that only – or even predominantly – engaged in criticism, and seldom generated suggestions which the commissioners could use to effect improvement. There was also a hope that the LINk would engage cooperatively with commissioners and that therefore, for example, some outputs from the LINk would have been developed jointly with commissioners.

Well-informed views, not repeating myths

Several interviewees expressed a measure of frustration about previous engagement work which sometimes tended only to repeat what these interviewees regarded as 'myths'. Examples given included views on the role of day care services for people with learning disabilities and the general state of ward cleanliness. In the former, it was claimed that people were not really presented with any evidence which challenged the value of such services, and considered how alternatives might actually be better; and in the latter, anecdotes about poor cleanliness were not put in the context of other available evidence which might suggest a different picture. The result was not very well-informed discussion.

In general, it would be useful for commissioners to understand *why* people believe what they do, what such views are contingent upon, and how people's views might change if exposed to different evidence and viewpoints. Such a process might also facilitate the consideration of complex matters in more informed ways. So, using the examples in the previous paragraph, it would perhaps be useful to present people with evidence with which they are not already familiar, give them an opportunity to assimilate and challenge it, and see whether it convinces them, and whether their views change as a result. Such 'reflective' research had not been a common feature of previous public engagement, in Birmingham or elsewhere.

Health and Social Care

As indicated earlier, government policy is to bring health and social care commissioning closer together, and the LINk has a role to play in helping to bring this about. From a citizen's perspective, the need for this 'joining up' is obvious. Many commissioners emphasised that it would be useful, therefore, if the LINk were to choose to focus on issues where health and social care connectedness was particularly important for clients, and to hold the health and social care commissioners and providers jointly to account: *'I hope that the LINk can beak down some of the health and social care boundaries'.* By so doing, the LINk could encourage the necessary joint working, and foster a perspective which addressed clients' totality of need, irrespective of organisational boundaries.

Big issues, not trivia

Commissioners generally had a clear view about the issues that 'matter'. They would have many of the following characteristics:

- Affect significant numbers of people;
- Have long-lasting implications;
- Affect the use of significant resources;
- Have major quality implications;
- Affect significant inequalities of provision;
- Relate to national priorities;
- Relate to pre-determined local priorities.

In general, they would also be matters dealt with by commissioners – i.e. not matters relating to the day-to-day operational decisions taken by service providers. However, most interviewees readily acknowledged that such a distinction can be hard to make in practice. So, for example, there was little doubt that health needs assessment, major service re-design, de-commissioning, or prioritisation were commissioning decisions. However, there were many 'operational' matters that might well have commissioning implications. For example, hospital car parking charges or service management structures might be primarily matters for service providers not commissioners; but in some circumstances they might become concerns for the commissioner.

There would always be some ambiguity in relation to the definition of a 'commissioning' issue. Interviewees readily accepted that the definition of 'big issues' was always open to debate, and that it would be entirely appropriate for the LINk to argue that particular issues really did matter, even if commissioners initially argued that they did not. For example, some service changes might affect small numbers of people in profound ways, but would probably still be legitimate areas of concern for the LINk.

Rich understanding, not shallow generalisation

Some interviewees criticised previous public engagement work for being superficial, leading to generalisations about people's views which did not pay sufficient attention to differences of opinion between groups, or recognise the subtlety and contingent nature of people's views on complex issues. Public perspectives are often nuanced, and it was argued that the LINk would not be well-served by work which did not recognise this.

Leading opinion, not following common mistakes

There was a strong hope that the LINk would sometimes move ahead of public opinion and lead the debate:

> *'If the LINk comes in as a new organisation to refresh thinking, it will make a positive contribution'*

Examples given related to challenging common assumptions about ward cleanliness where the evidence contradicted what was popularly believed, and supporting new models of service delivery where they genuinely represented an improvement, even though they may be opposed by some current service users. This latter was identified by most interviewees as being a key feature of commissioning (or service re-engineering) over the next few years.

The difficulties and dangers in such an approach were readily acknowledged, and commissioners would need to ensure that they did not undermine the perceived independence of the LINk by co-opting them too closely into their work, and also recognise the constraints on the LINk's freedom of manoeuvre. Commissioners also need to ensure that they can produce convincing evidence to challenge popular perceptions where they are erroneous.

Representative views, not narrow and elitist

Commissioners will place a high value on the ability of the LINk to represent credibly a 'representative' set of public views on any given topic:

> *'The usual few attend all the forums… I see the same faces at the city-wide and local ones. You have to ask, "Are we actually reaching people? Are they representative?"'*

The term 'representative' is, of course, a difficult one both to define and to measure, particularly for the sort of qualitative research and other work which will probably dominate the activities of the LINk.[1] Commissioners generally did not define representativeness in numerical terms (e.g. x participants, y communities), but there was a general assumption that they would 'know it when they saw it'. Two dimensions were important:

- Breadth – evidence, in the processes and outputs from the LINk, that the views of appropriately diverse groups of people had been obtained. Diversity might include geographical spread, ethnicity, language, religion, age, economic circumstances or any other parameter relevant to the topic under consideration;
- Depth – that the outputs are based on sufficient numbers of people within the representative groups, and on appropriately rigorous processes, to ensure that results are robust.

An often used term in this context was 'the hard to reach' – LINk would need to engage with communities which traditionally have not engaged with commissioners. The term in fact provoked much debate in the interviews and focus groups, with an argument from many that communities were not actually 'hard to reach' if the effort were made: *'they're not hard to reach, just easy to avoid!'*. The lack of easily defined and measured parameters of

[1] 'Validity' is a close synonym for 'representativeness' as used here

representativeness emphasises the need for the LINk to work closely with commissioners, especially in the early days, to generate a shared understanding of what is required.

2.1.2 Process

Coordination

There is abundant evidence of public engagement work in health and social care across Birmingham. The different statutory bodies (commissioners and providers), as they go about discharging their responsibilities to engage, create mechanisms which suit their needs at the time. Often these are somewhat isolated initiatives, with each agency pursuing its own strategy, in response to their own statutory and other responsibilities. This is not necessarily problematic – many issues can be addressed in isolation – but many interviewees also argued that there is scope for greater coordination of effort, in order to maximise efficiency and to reduce the burden of consultation on the communities concerned:

> *'There has been an* ad hoc *approach to patient engagement – a vast array of tools and approaches but not used strategically or consistently'*
>
> *'With everything going on in Birmingham, there have been a lot of meetings – there is consultation fatigue'*

The efficiency gains could be several:

- Sustaining more comprehensive engagement work;
- Requiring fewer engagement experts to support the work;
- Ensuring that people's needs were addressed in the round, and not in organisational silos;
- Sharing intelligence.

The advent of the LINk has two impacts on this. First, the advent of another organisation raises the potential for even more disconnected engagement work – thereby exacerbating the problems. Second, it creates an opportunity for a measure of coordination, as the LINk looks across health and social care agendas, and develops and maintains an engagement infrastructure which could lead to a rationalisation of effort. It will wish to consider, on a case by case basis, whether it would be appropriate to use its own machinery for consultation, or whether it might be better to use the existing machinery of the statutory and third sectors.

Some interviewees expressed concern that the LINk would not be willing to engage in this coordinated way, because of what they saw as a potential over-concentration on its uniqueness and statutory responsibilities:

'There's been lots of rolling of eyes about the LINk. People need to recognise that it is part of a myriad of ways of engaging. There needs to be honesty that the LINk is one mechanism and not the mechanism – LINks need to recognise that they are not the centre of the universe'

Filling gaps

Closely related to the concerns about coordination, most interviewees advocated that the LINk should map those communities and issues in Birmingham which are relatively poorly served by current engagement efforts, and ensure that it plugs those gaps. This should not be the LINk's exclusive focus – it will also probably want (for good reasons) to ensure that it does some work with groups and issues which may already be on the radar of the statutory agencies. Nevertheless, filling gaps should be a strong priority.

Identifying gaps will be a task for the early months of the LINk, and will continue to be an important task. Interviewees identified potential gaps in several categories:

- Subsets of user groups – whose needs are significantly different from the generality of service users, but which for various reasons have not been well engaged to date e.g. people with learning disabilities from South Asian communities
- Population sub-sets – particular communities in the city with a variety of different health and social care needs, who are not currently well-represented in engagement processes e.g. some newly-arrived communities
- Large sections of the population who are not currently within the service delivery criteria of agencies but who nevertheless have significant needs e.g. people across the city with social care needs who fail to qualify for social care because their means are too great.

The LINk may also have a role in preventing unnecessary research – pointing out where sufficient research and consultation has already been done. Some interviewees saw examples of research for no good purpose:

'There is a lot of consultation duplication…and there's a failure to use information from consultation that has already been undertaken. Very rarely is it grown organically from what has previously gone on – there's a new game in town and this is it and these are the structures we need to set up. There is an issue of organisational and individual memory being ignored or forgotten'

Broad 'membership' base

Most interviewees were clear that the LINk would need to demonstrate a broad membership base. They were less clear on how to define the two key elements of this, however:

- 'broad' was generally thought to include communities who are not traditionally well-represented in other forums, and would also include sub-sets of communities who otherwise were generally fairly visible (e.g. a broad representation of gender, age and other factors). No-one offered a definitive list of such communities and aspects;
- 'membership' was interpreted to include both those who were formal Members of the LINk, and also people who wished to express a view on an issue of importance to them but who would not choose formally to join LINk. This notion of 'variable geometry' in membership – different forms of association with LINk, suited to the needs of the participants – was a key concept for many.

While most interviewees thought that the LINk would need to be able to claim a 'reasonable' number of members, they were reluctant to define what that number might be. Most thought the size of membership claimed by Foundation Trusts was a meaningless indicator – they questioned how active such members were – but when pressed, some suggested that perhaps a figure of 2,000-or so members for the LINk might be reasonable.

New faces

One yardstick that most commissioners said they would apply to the LINk was its ability to produce 'new faces', by which was meant the extent to which the people who contributed to the work of the LINk were currently unknown to commissioners. This would not mean that 'old faces' were of no interest – interviewees readily acknowledged the important contribution that well-known and well-informed people would still make. However, it would be important for a significant proportion of the LINk's members to be newly-engaged in these issues. This would help to ensure that the 'burden' of being the actively engaged citizen would be shared more widely (and therefore sustainably): *'we need new faces to take up the challenge'*. It would also help to meet the concerns expressed by many commissioners that the LINk could become dominated by people who were active in the PPI Forums (*'people and personalities scaring others off'*), and who these interviewees felt were reluctant to engage with the new agendas: *'people who have a foot in the past have dragged it'*.

Supporting of members

Closely related to the 'new faces' point was the importance placed on the LINk's role in supporting its members to gather and express their own views. It was recognised that such work was vital to bringing new people into engagement activity, and that the LINk would gain in credibility if it acted as an 'amplifier' of community voices, rather than trying always to speak on their behalf: *'LINks put people round the table'*.

Plurality of interests

Commissioners were somewhat divided on the question of whether the LINk should present one view on a topic, or just represent all the views of which it was aware. Some expressed a

preference for the former, arguing that the LINk should apply its judgement to controversial issues and (wherever possible) provide commissioners with unequivocal guidance. Others, however, argued that many issues were multi-faceted, and that the LINk would have done its job if it faithfully reflected that diversity of opinion to the commissioners. It was even argued that the LINk would have questionable legitimacy if it were to decide which of a variety of community views was 'right':

> *'LINks should not always try to speak with one voice… there are several perspectives which cannot be reduced to one… politicians will become suspicious of the LINk if it always condenses issues to one response'*

Good at listening to people

Some interviewees said that they would judge the LINk on its ability to listen to people's views. Based in part on their experience of other engagement work, these interviewees were well aware of the difficulties of really listening to people's views, and not assuming that one knew what people were trying to say. Listening skills would be a marker of a mature LINk that was genuinely reflecting people's concerns and not trying to impose its own agenda and understanding.

Timing

Each statutory organisation produced a timetable of events which would relate to public engagement. These included annual commissioning cycles, and also processes for decision-making with their associated public engagement. It was argued that the LINk should be aware of these, and able proactively to engage with commissioners' timescales.

Some interviewees also acknowledged, however, that such formal timescales were variable, and that issues were placed on agendas outside these formal processes. It was important, therefore, that commissioners and the LINk ensured an appropriate level of mutual understanding about the reality of these processes, and that the LINk and commissioners were not unfairly criticised if the formal processes were sometimes adapted to meet circumstances.

Skilful research

Reflecting the Output criteria which relate to conventional measures of research excellence (reliability and validity etc), commissioners would expect to see the LINk (and especially the Host staff) conducting research with an appropriate awareness of research quality. There was a large measure of realism in these discussions, with commissioners all too aware of the compromises necessary given limited resources and other constraints.

Fearless

Finally, some interviewees said they would value a LINk that was not afraid of challenging vested interest, wherever it found it. This might include standing up to commissioners and providers, the government, and even to community groups, where there was clear evidence that people were behaving irrationally or irresponsibly, or where the public interest was being compromised unacceptably: *'having a campaigning function would be good… if there is legitimacy in the voice then this is OK… where would we be without pressure groups?'*. Several topical examples were quoted in interviews where a LINk could have proved the ultimate bulwark against appalling care – including acute health care in Mid Staffordshire, and learning disability services in Cornwall.

A tension emerged in the interviews, however, between this desire to be fearless on the one hand, and a strong hope that the LINk would not spring 'surprises', and that most issues would be resolved without recourse to public acrimony.

2.2 WHAT COMMISSIONERS CAN DO FOR THE LINk

There is a significant literature about the nature and role of public engagement in public policy and services, and what can be done to enhance or impede it. Whilst being informed by that literature, this Section has a far more modest purpose: to offer a few, very practical suggestions to commissioners in Birmingham about how they can make the city's LINk more effective, to mutual benefit.

Transparency and honesty

There is considerable scope for obscuring and dissembling in relation to the processes of commissioning. It is very difficult, for example, for the lay person to grasp how decisions are made, when and by whom, on the basis of what evidence, what scope there is for local determination, and what trade-offs are implicit in the decisions. There may be an element of self-interest in commissioners not striving to make processes transparent; there is also a genuine problem resulting from the inevitable complexity and ambiguity of much of the work of commissioning. However, as the relationship with the LINk matures, and as trust, respect and mutual understanding replace insecurity, suspicion and incomprehension, transparency should become the goal. Early steps should include: *'sitting down with the relevant LINk people, agreeing what's distinctive about the LINk, and agreeing rules of engagement that reflect their independence'.*

Complete honesty is probably unattainable, but an early frank discussion about how each party (LINk and commissioners) can help the other would be a useful start. This report provides ample raw material for such a discussion.

Approachability

This has two aspects. First, the LINk needs to know who to talk to in each organisation about particular issues. This is important to clarify facts, and also to resolve issues informally. The LINk therefore needs a set of contacts of sufficient seniority, who will make themselves reasonably available when the LINk makes contact. Second, the most senior staff in the commissioning organisations also need to demonstrate that they take the LINk seriously, and expect their staff to do so. Ready metrics of such an attitude include the willingness to make oneself available for meetings, a willingness to engage in frank discussion, and early evidence of responding reflectively and honestly to the LINk's views.

Respect

The 'organisational body language' of commissioners will be constantly assessed by the LINk to detect any difference between espoused and lived values. Commissioners should remember that what they do will be scrutinised at least as much as what they say.

Corporate unity

Related to the above is the need to ensure that all parts of the commissioning organisation share and adhere to the same views of the LINk. There was some evidence (in the interviews and from the literature) of different cultures in those parts of the organisation which had a predominant interest in engagement (the 'PPI professionals'), and those (often with more senior staff) whose concern was with commissioning and performance management, and regarded engagement as a small part of what they do. Commissioners will need to ensure that both parts exhibit the same behaviours with regard to the LINk.

Timing

Whilst it is reasonable for commissioners to expect the LINk to be aware of, and responsive to, the externally-imposed deadlines and timetables under which they work, the commissioners can help the LINk in this by doing the following:

- Explain the timing constraints to the LINk;
- Ensure that the LINk is aware that there are also often 'informal' opportunities to raise issues, and where timetables might be mutable;
- Recognise - and accept the legitimacy of the fact - that some issues will arise as matters of urgency for the LINk, and should be responded to accordingly.

Listening

In practice, it is quite easy for commissioners to accept that the LINk needs to understand the commissioners' perspective, rather than thinking of the LINk as having important and subtle

messages of its own to impart. As one commissioner explained: *'it's too easy to slip into going along to meetings because we have something to say, rather than going along to listen'*.

Sharing

In general, commissioners have access to much more information than the LINk. This covers most aspects, from government policy to activity data. They should start from the presumption, therefore, that it is their responsibility to redress this imbalance, and to share information with the LINk, on a routine basis, rather than waiting to be asked.

Coordinating

If the greater coordination of effort across the range of public engagement is to be achieved, commissioners need to assess their approach to engagement on the basis of an objective division of labour: engagement should be done as efficiently as possible, by whichever of the partners is best placed to do it. This will be constrained by statutory and other obligations, but should ensure that engagement practices are appropriately challenged.

Feedback

Feedback should take two forms. First, commissioners should inform the LINk about what has happened as a result of its work - explaining, for example, how the results of a consultation affected their final decision. Second, commissioners and the LINk should feedback to each other on their perceptions of the performance of the other – including both 'hard' (easily quantified) and 'soft' (relationship and behaviour, etc.) aspects of performance. This should form the basis of mutual reflection.

Behaviours

Some of the aspects discussed above can be codified into a set of specific behaviours. These might include guidance on 'surprises' (an issue which was mentioned in many interviews), on the use of 'enter and view' powers, and on recourse to the media.

Shared wins

The legitimacy mentioned in several of the interviews will be bolstered if both the LINk and commissioners can point to some early examples of tangible influence by the LINk in relation to significant commissioning decisions.

SECTION 3 | BUILDING AN INFLUENTIAL LINk

This Section of the report is about how to move towards the vision of an influential LINk set out in Section 2. It is not intended to be prescriptive – indeed, the LINk may decide that it does not like certain aspects of the vision. Rather its purpose is to bring together the views and perspectives of the people in the various statutory and other bodies who have been engaged by this research.

Three broad sets of issues are considered in turn:

3.1 **Processes, structures and co-ordination** – how does the LINk relate to the ways of working of the health and social care commissioning organisations and how can the LINk work best with all the other bodies involved in public engagement?

3.2 **Determining a work programme** – what are the broad topic areas on which the LINk could most profitably concentrate in the short term?

3.3 **Qualities and values** – how should the LINk go about its work, in terms of its behaviours and relationships?

3.1 PROCESSES, STRUCTURES AND CO-ORDINATION

This section looks first at the organisations in Birmingham with which the LINk will need to establish a relationship (3.1.1). It then explores the range of options open to the LINk and commissioners in relation to joint working (3.1.2). Finally, it considers in turn some of the unique aspects of the potential relationships between the LINk and the different bodies in Figure 2 (3.1.3 – 3.1.10).

3.1.1 LINk external relationships

Relationships between the LINk and three sets of local organisations in particular will be critical to its ability to influence commissioning and other strategic decision-making:

- Be Birmingham LSP (particularly the Birmingham Health and Wellbeing Partnership);
- the three Primary Care Trusts (PCTs); and
- the Adults and Communities Directorate of BCC.

These are the key commissioners of health and social care for the city. Appendix 3 considers in detail these local organisations and their engagement structures. It is hoped that this detail will help to inform the LINk as it establishes new relationships with the commissioners and develops joint work plans. The possible merger of the three Primary Care Trusts will eventually result in

the development of new health commissioning structures and processes, but will not materially affect the substantive issues discussed in the report.

Five other relationships are also important – those with:

- Overview and Scrutiny Committee;
- NHS Foundation Trusts and the Sandwell and West Birmingham NHS Hospitals Trust;
- the constituency structure within BCC;
- Birmingham Voluntary Services Council; and
- the Care Quality Commission.

Each of these relationships is considered in turn hereafter, and is represented in Figure 2.

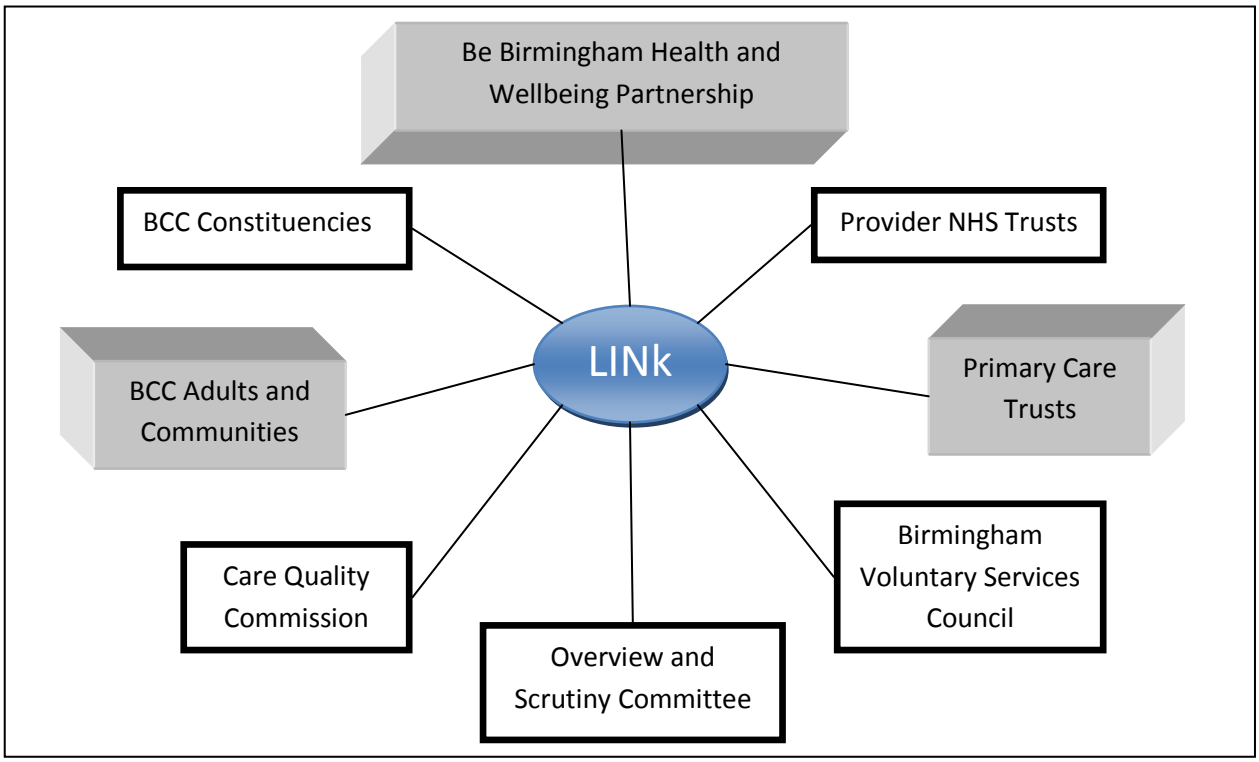


Figure 2 | Relationships for LINk

3.1.2 Joint Working with Commissioners

It seems likely - from the published guidance, from practice elsewhere in England, and above all from the views expressed to us in Birmingham - that the LINk and commissioners will often choose to collaborate on issues of mutual interest. This will not invariably be the case, and the LINk will probably wish to safeguard its independence of action where this is needed.

If joint working with Commissioners is to be successful, the collaborative arrangements will need to be designed so as to preserve the characteristics of an influential LINk set out in Section 2, and draw on the helpful working arrangements of good commissioners.

There was general agreement amongst interviewees across the statutory sector in Birmingham that they needed to develop with the LINk a clear rationale for who does what. Several potential divisions of labour were suggested, which the LINk may now wish to consider in the light of its own priorities and resources. They are presented here as a spectrum of joint working (Figure 3), ranging from the LINk acting as the 'agent' of the commissioner at one end (Option 1), to separate and parallel working at the other (Option 6). Some of their potential strengths and drawbacks for both PCTs and the LINk itself are summarised in Table 2 overleaf.

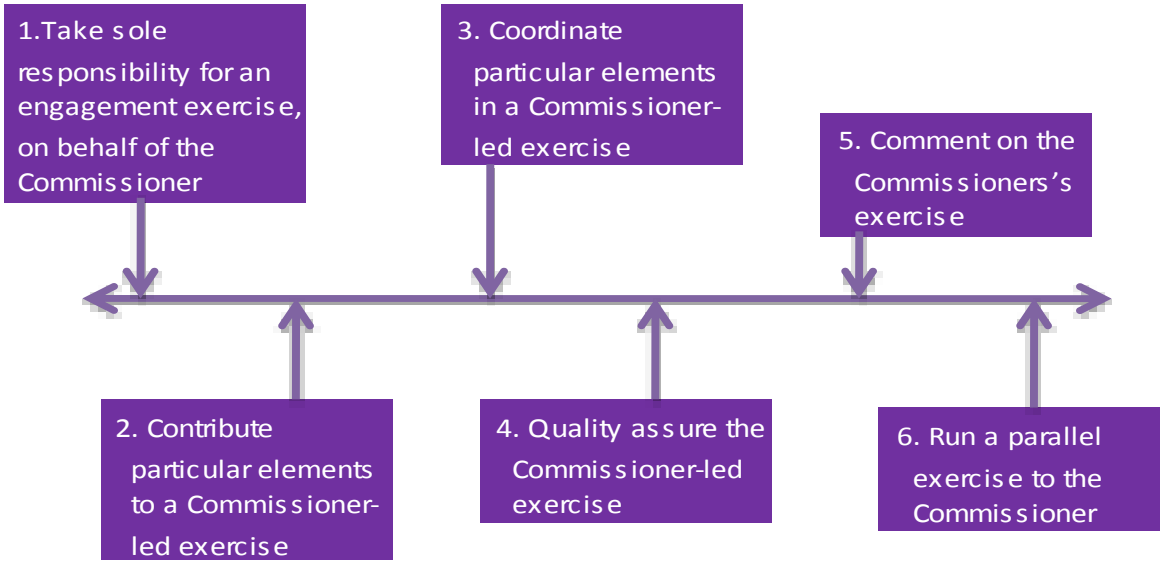


Figure 3 | LINk and Commissioners' joint working – a spectrum

In Option 1, the LINk agrees to conduct the entire engagement exercise on the Commissioner's behalf. This would require a clear agreement from the outset about respective responsibilities, and a high measure of mutual confidence and understanding. The risks for both parties are high, but where this option is appropriate, it offers good value for money for the public purse. Also, perhaps somewhat paradoxically, it can safeguard the independence of the LINk, since the pre-agreement will be clear about the level and extent of the authority delegated from the commissioner to the LINk. It also offers the potential, in certain circumstances, for income generation by the LINk. In this context, the LINk may eventually decide to establish an arms-length organisation (perhaps a social enterprise) which could conduct public engagement work of various kinds on behalf of a variety of public agencies.

What the LINk could do	**How** it could do it	Potential Strengths	Potential Drawbacks
1. Take sole responsibility for an engagement exercise, on behalf of the Commissioner	Engage directly with individuals and interest groups; coordinate the views of established groups; commission research; review the literature	• Coherence • Clarity • Prestige for the LINk • Develops LINk's networks for future • Potential for income generation • Preserves LINk independence	• Loss of Commissioner's direct contact • Contractual relationship with Commissioner
2. Contribute particular elements to a Commissioner-led exercise	Engage directly with particular communities which the Commissioners' find 'hard to reach', using the LINk's own connections	• Draws on respective strengths • Multiple resources • Commissioner gains direct understanding • Development of mutual understanding	• Confusion • Incoherence • Perceived/assumed compromise of LINk independence
3. Coordinate particular elements in an Commissioner-led exercise	Similar to 2., but coordinating the views of LINk members and organisations, and not carrying out original work	As 2. above, plus: • Minimise time commitment for LINk • Confirms the benefits of LINk membership	As 2. above, plus: • Limited spectrum of views • Influence of established groups over 'new voices'
4. Quality assure the Commissioner-led exercise	Contribute to the design of the engagement work, agree quality measures and monitor their achievement. Involves an element of shared responsibility	• Improved method • Independent 'seal of approval' • Preserves Commissioner's direct contact with public • Maintains LINk's independence	• Minimal influence for LINk • No development of LINk's own networks
5. Comment on the Commissioner's exercise	Monitor what the Commissioner is doing and provide a public assessment, without sharing responsibility	• Maintains LINk's independence	• Minimal Influence
6. Run a parallel exercise to the Commissioner	Seek views of LINk members (individual and group) and conduct direct engagement with the public, with little or no attempt to coordinate with the Commissioner's own work	• Maintains LINk independence • Develops LINk networks • Highlight missed areas • Independent scrutiny • Different evidence base should the LINk wish to respond itself	• Duplication • LINk and Commissioner antagonise each other

Table 2 | Joint working – implications

In Option 2, similar principles apply as in Option 1, but the extent of the LINk's responsibility is circumscribed to specific elements of the overall exercise. This may well be more palatable than Option 1, since it allows the commissioner to retain clear responsibility for the overall work and those aspects they choose to keep 'in house', while bringing in the unique strengths of the LINk where they are most appropriate.

In Option 3, the LINk adopts a more internally-focused role. As in 2, it is responsible for particular elements of the engagement; but unlike 2, it does not conduct original work with citizens and service users. Rather it relies on gathering, coordinating and synthesising the views of its own members (individual and group) on the Commissioners' consultation.

Thus it operates as an effective spokesperson for its own membership. This is not necessarily a reactive or passive role – indeed, the LINk may wish proactively to encourage thinking and contribution from its membership. In general, this will be a less time-consuming option for the LINk than 1 and 2.

In Options 4-6 the LINk remains essentially outside the engagement work of the commissioner, whilst contributing in different ways to the effective design and implementation of that work. In Option 4 the LINk would have an active 'quality assurance' role, commenting on the broad outline and detail of the commissioners' proposed approach, and perhaps even scrutinising aspects of its execution. The commissioners get an independent 'seal of quality' from the LINk, and thereby greater legitimacy; the LINk gains influence without having to expend large amounts of time and effort; and the people of Birmingham get better engagement. Option 5 is similar, but the LINk confines itself to comment, rather than contributing actively to better design.

Finally, Option 6 represents parallel working. The commissioners do their engagement, as does the LINk, and their respective results are fed into the decision-making process. For the LINk, this offers the simplicity and freedom of movement that comes with independence. The price may be relative marginalisation, duplication, and some waste of public resource.

None of these options is 'better' than any other – each has its merits, depending on the circumstances of the case. In effect, these six examples (and there are many other variations on a theme) constitute a menu of options from which the LINk and commissioners, hopefully working together, can choose. Which will be appropriate in different cases will depend upon the circumstances of that case. They are presented here for discussion: the LINk and commissioners may wish to further refine the options, and to explore other strengths and drawbacks. The options may not always be mutually exclusive, and certainly the LINk may choose to employ different options in different cases.

The LINk will also wish to consider whether it might be best in some circumstances to use the existing network of engagement activity, sponsored by the statutory and third sectors, rather than develop its own mechanisms. Such an approach can offer efficiency gains, as it draws on existing infrastructure, and also can help to cement the working relationship between the LINk and the statutory/third sectors.

3.1.3 Be Birmingham Local Strategic Partnership

The LSP is responsible for developing and driving local community strategies. Be Birmingham is the LSP for Birmingham, which brings together various partners, in a non executive and non statutory organisation. Its aim is for the partners to work together to deliver a better quality of life within Birmingham, 'bringing together local plans and partner initiatives to provide a forum through which mainstream public service providers work effectively together to meet local needs'.[2]

Be Birmingham is responsible for the development of the three year Local Area Agreement (LAA), which sets out local priorities and subsequent action plans, which are agreed with central government. The LAA encourages partnership working and pooling of resources – working on the principle that 'developing services collectively is more effective than in isolation'.[3]

There are over 30 delivery plans in Birmingham to take forward the LAA. These are being taken forward through Be Birmingham and its family of thematic partnerships, including the Health and Wellbeing Partnership (BHWP), which is of central importance to the LINk. The Joint Strategic Needs Assessment (JSNA) determines its priorities and targets, and requires cooperation from PCTs and the Council, making the JSNA key to commissioning decisions. There are five stages to the delivery planning process, demonstrated in Figure 4 below.

In terms of influence, therefore, the relationship between the LINk and the BHWP is crucial. The Birmingham LINk actually has a lot to offer the Partnership:

- Geography – both organisations cover the whole of the city (unlike the PCTs);
- Health and Social Care – like the Partnership itself, the LINk crosses the divide between health and social care;
- Efficiency – the Partnership is committed to engaging the public and actual/potential service users in its work, but the only way it could do this to date has been to engage with a large variety of other groups who, despite their number, still do not necessarily represent the full diversity of interests.

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[2] Be Birmingham (2009) *What is an LSP?* www.bebirmingham.org.uk Accessed 28/9/09

[3] NHS Centre for Involvement, *Guide 18: Local Involvement Networks - Health and Social Care Structures* (www.nhscentreforinvolvement.nhs.uk accessed on 28/9/09) p.16

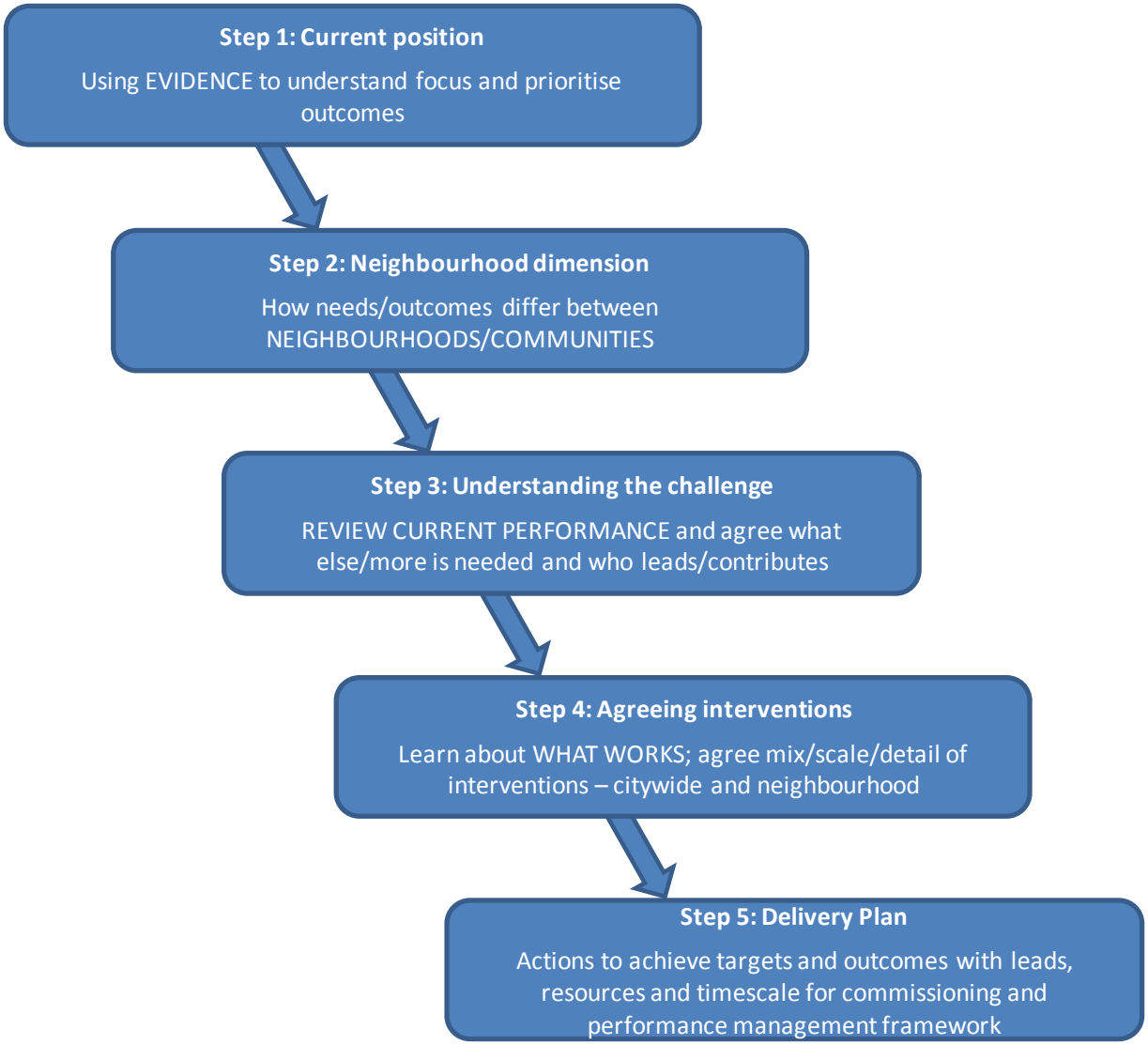

Figure 4 | The LAA Delivery Planning Process[4]

Interviewees from the BHWP stressed the importance to their work of what they termed the 'triangulation' of three sets of intelligence and perspective:

- Public health – e.g. largely objective data on needs and interventions: epidemiological data on health needs, including projections of future need, allied with the evidence base on effective service interventions and models;
- Commissioners – e.g an understanding of the resource constraints and opportunities, and how services might best fit together;
- Public – e.g. rich data on what people really experience, want and need, and what would mean a better outcome for them.

[4] Be Birmingham (2008) *Birmingham Local Area Agreement 2008/11 Working together for a better Birmingham* (www.bebirmingham.org.uk accessed on 28/09/09) p.7

Each of the three sets is vital, and each provides a somewhat different view of what is needed, and what is possible/desirable. The 'triangulation' is a process which involves understanding what each has to say; exploring the implications of the different views; and working out an approach for the future which maximises the beneficial impact, from all three perspectives. For example (and simplifying for the sake of illustration), public health data on HIV/AIDS will help understand the future needs of the population, and the proven ways of addressing them; commissioners will contribute an understanding of how such needs can best be met in the context of existing services and plans; and the public perspective will reveal something of the 'reality behind the figures', the strengths, weaknesses and gaps in services as experienced by their users, together with their hopes and fears for the future.

The Partnership is keen for the LINk to contribute the public perspective in particular, and to be part of the process of 'triangulation'.

3.1.4 Primary Care Trusts

A second key set of relationships for the LINk is with the three PCTs. While the BHWP will increasingly take the lead on pan-Birmingham health and social care issues, the majority of commissioning and many strategic decisions about health care provision will remain with the PCTs. These will include the strategic direction of primary and community health services and the commissioning of most of the secondary care for the city.

The potential merger of the PCTs may ultimately simplify working relationships, by reducing the number of points of contact and different policies, procedures and mechanisms. But in other respects, the issues highlighted in this report generally relate to the nature of the relationships between commissioner and the LINk, regardless of how many commissioners there are.

NHS Commissioning and Public Engagement

The development of the concept of 'World Class Commissioning' (described in Section 1.2.2) is key to understanding what PCTs are trying to achieve. There is a range of tasks to consider when commissioning services, including assessing the needs of the local population, prioritising health and social care outcomes, procuring products and services, and then performance managing providers. The LINk needs to understand this commissioning cycle and be prepared to engage at each point – planning, contracting, monitoring and revising.[5]

The LINk may carry out the following work to influence the planning, delivery and operation of services:[6]

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[5] NHS Centre for Involvement (2008) *Guide 10: Local Involvement Network – Starting a Work Programme* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.5

[6] NHS Centre for Involvement (2008) *Guide 10: Local Involvement Network – Starting a Work Programme* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.5

- Find out what local people think (in creative and innovative ways);
- Ask for information from commissioners and providers;
- 'Enter and view' premises where care is being provided to observe and gather peoples' views about services;
- Praise good services and consider recommendations for improvements and write reports to commissioners and providers; and
- Review the outcomes of its work and keep local communities informed about its activities impact.

NHS organisations are required by the Health and Social Care Act 2008 to involve local people in the planning, delivery and operation of health services. *Real Involvement: working with people to improve services* is a useful tool for the LINk – for use when considering how far a local NHS organisation has fulfilled its duty to engage with the public, and secondly for guidance and advice on LINk involvement activities.[7]

So PCTs will need to continue to engage with their public in order to discharge their statutory responsibilities. A key issue for the LINk, therefore, is to create an approach which best complements what the PCTs are doing. As one PCT interviewee expressed it:

> *'PCTs will want to maintain their own direct route to patients, so LINks will not substitute entirely for that'.*

Because they are new, PCTs will have to learn how to relate to LINks. In some of the interviews, there was a measure of concern among some PCT staff about how the LINk would relate to the PCTs' current and future engagement work, based in part on the need to be assured that the LINk would do a 'good' job at engagement (see Section 2 for how they define 'good'). After all, there is real merit in the PCTs maintaining their own *direct* line with their public and patients:

> *'The PCT's first instinct is to go directly to patients and cut out the middle man – they're our patients'*

Although the LINk has certain statutory powers, and there are clear expectations in DH guidance and elsewhere that LINks will have a key role in public engagement in the NHS, nevertheless in reality it will be quite difficult for LINks to *insist* on involvement if PCTs are not convinced of their value. As one PCT interviewee expressed it:

> *'Very little about working with the LINk is compulsory: if times get tough, PCTs can revert to just consulting with the easy to reach'*

[7] NHS Centre for Involvement, *Guide 18: Local Involvement Networks - Health and Social Care Structures* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.3

Nevertheless, all of the PCT interviewees could see real benefits to working with the LINk and – subject to the *caveats* set out in Section 2 – wanted to do so. In addition to the improvements in the quality and efficiency of their public engagement which such cooperation offered, there was a recognition of the need to be seen to be doing engagement properly:

> *'The PCTs are hungry for the LINk to have legitimacy because that makes their own engagement task easier'*

Practice Based Commissioning

The way in which PCTs discharge their responsibilities is changing and the LINk will need to consider the implications of this. The development of practice based commissioning (PBC), through the creation of clusters of practices, is now unfolding.

PBC is designed to place primary health care professionals in a prime position to translate their clinical expertise and knowledge of patient needs into the redesign of local services, placing practices at the heart of commissioning. Patient groups and networks are being set up in Birmingham, aligned with GP practices and practice-based commissioning clusters in order to provide feedback on patient experience in the primary health setting and to act as a sounding board for commissioners at a practice level. For further information see Appendix 3.

Whilst the full implications of this change have yet to become clear, discussions with PCT staff have highlighted at least two key impacts for the LINk to consider:

- The creation of multiple 'decision points' in the NHS locally, moving from three PCTs to perhaps several dozen clusters of GPs. The LINk will need to consider how it responds to the logistical challenges this poses;
- A change in the way in which health commissioners engage with their public, with the creation of more, locally-focused engagement forums of various sorts. This is likely to increase the influence of smaller communities on the decision-making process, and may well lead to greater diversity of provision. This further highlights the need for the LINk to be clear about its own balance between city-wide and local work (discussed in Section 3.2.1 below).

Three PCTs working together

There are some areas where the three PCTs already work jointly on commissioning and public engagement. There are several services where one PCT commissions on behalf of all three. The discussion above on the relationship between the LINk and individual PCTs applies equally to this arrangement, and this will of course become the norm if the PCTs merge.

There are also aspects of public engagement work where the PCTs are coordinating their activities. A recent example is the development of a shared approach to remunerating participants. PCTs would welcome the LINk's engagement in this, with obvious gains in terms of

efficiency (one voice representing the interests of all participants) and effectiveness (improved chance of the outcome being acceptable and implemented by all).

3.1.5 Adults and Communities Directorate of Birmingham City Council

Adults and Communities has developed quite an extensive set of engagement mechanisms over the past few years, which provide both intelligence, and a set of structures for engaging with older adults, people with learning disabilities, with physical disabilities and mental health needs. There are also well-established arrangements for engaging with carers. These are outlined in Appendix 3. The mechanisms are supported by a variety of routine and other 'data streams', including the user feedback regularly collected as part of contractual arrangements with providers, as well as the arrangements for responding to complaints.

This work has been given added impetus recently as the Council seeks to re-engineer services to meet the differing aspirations of individual service users, and to make a reality of the devolution of budgets to individual clients. All of this builds to provide a relatively detailed view of the strengths and weaknesses of current service provision, as experienced by those directly supported or funded by BCC. The system is not perfect, of course, and the LINk could potentially provide 'added value' here through its independence – both a real and perceived lack of conflicting interests – and perhaps by accessing client groups who do not take part in the mechanisms provided.

There is not a comparable system for engaging with people who may have similar needs but who are not recipients of council-funded services: so-called 'self-funders'. Figure 5 illustrates the case. This example represents large numbers of people, who are only distinguishable from social care service recipients because their disposable means exceed the current means-related thresholds; and yet their needs for support, information and 'care' may be as great, but are not necessarily easily purchased. As a proportion of the total population, their numbers are likely to increase in the future. In comparison with those who do receive services from Adults and Communities, their needs and wishes are in fact relatively poorly understood. These are people, of course, who are considerable users of the (non-means-tested) NHS. This is a section of the population which the LINk might choose to address.

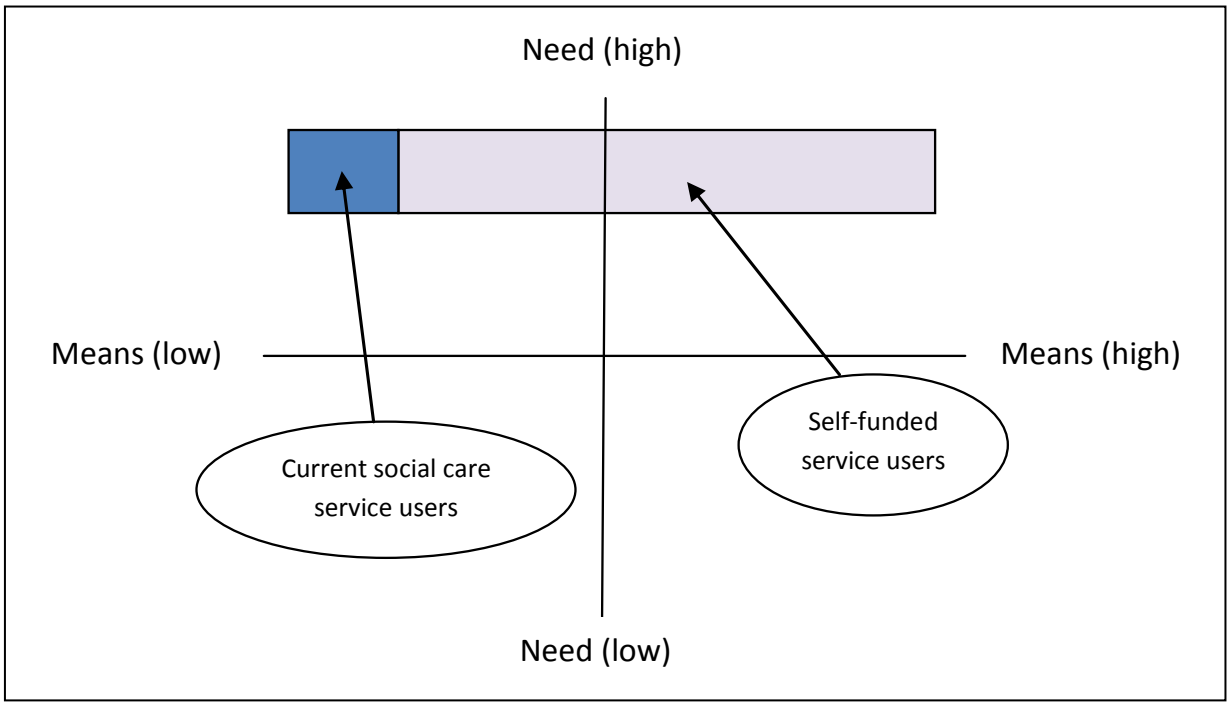

Figure 5 | Engagement with BCC service users and non-service users

3.1.6 The constituency structure within BCC

Another potentially fruitful relationship for the LINk is with the constituency structure of the Council (see Appendix 3):

> *'[It's a] big city, but increasingly planning is taking place at a neighbourhood level and the LINk could operate at the ten constituencies'*

Based on the ten geographical patches of the Parliamentary constituencies, this structure represents the attempt of the Council (and increasingly of other agencies) to ensure that the synergies between its functional departments are realised at the local level. At the local level, the network of Constituency Strategic Partnerships work out a shared vision for their area, for their local people.[8] Each Constituency Strategic Partnership also produces an Annual Constituency Community Plan, and often sets up sub groups to deal with specific groups. Most constituencies' strategic partnerships have a sub group for Health and Wellbeing. Be Birmingham, the LSP, is developing a Neighbourhood strategy (see Figure 6) which involves:[9]

- A clear assessment of need – based on classifying neighbourhoods into three groups,

[8] Consultation Team, Birmingham City Council (2009) *Be Involved: A Guide to Consultation Forums in Birmingham* Birmingham City Council p.15

[9] Be Birmingham (2008) *Birmingham Local Area Agreement 2008/11 Working together for a better Birmingham* (www.bebirmingham.org.uk accessed on 28/09/09) p.9

"priority", "at risk" and "stable";

- A clear delivery focus – with priority outcomes for each "at risk" or "priority" neighbourhoods linked to the Local Area Agreement;
- The neighbourhood dimension built into Local Area Agreement delivery plans.

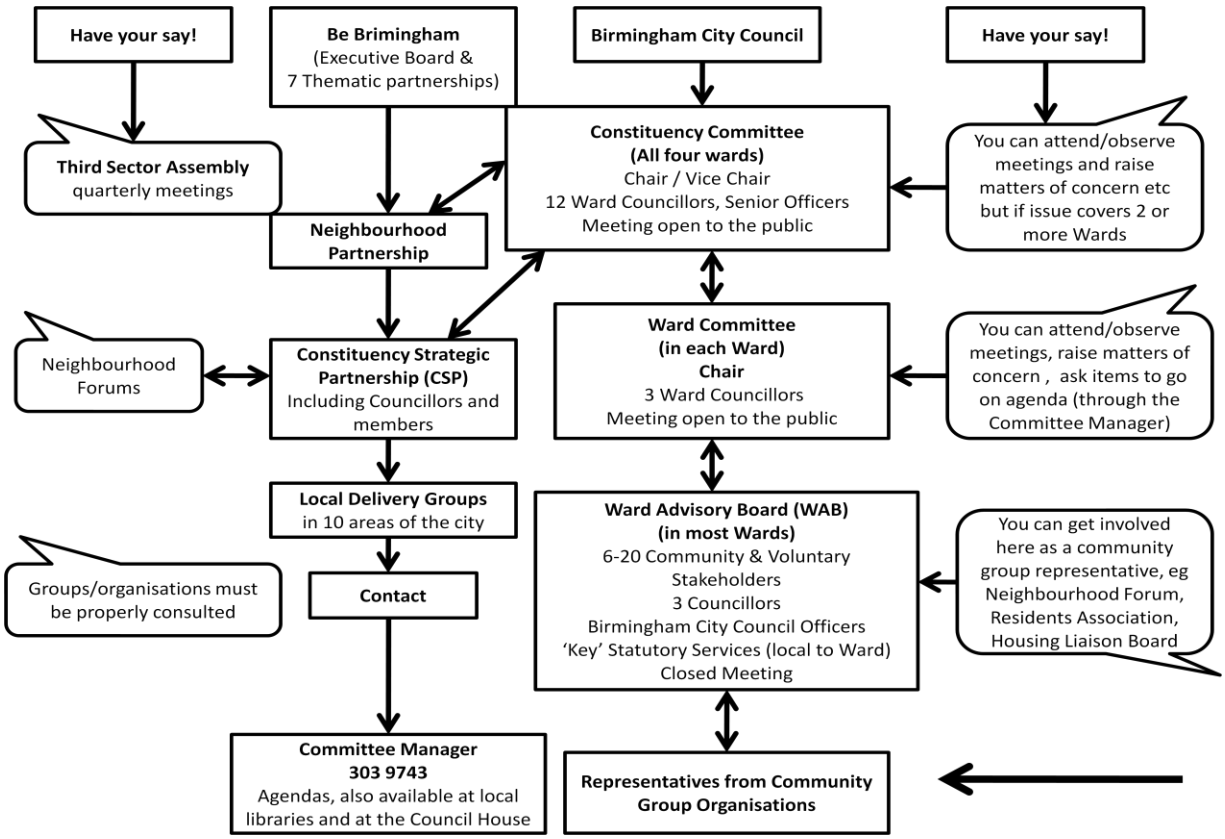

Figure 6 | Decision Making at a Local Level in Birmingham

The constituency structure therefore provides a managerial and professional mechanism for 'joining up' different departments to meet the totality of need, and is a rich source of intelligence about the need (amongst others) for health and social care. It also provides a forum for identifying approaches for improved 'well-being'. To this extent, the LINk could relate to the constituencies as the local counterparts of Be Birmingham, both informing its local debates, and using that intelligence to inform its pan-Birmingham work. Relating to all ten constituencies clearly has logistical implications for the LINk.

3.1.7 Overview and Scrutiny Committee

Both the OSC and the LINk have an important role in 'delivering the new approach of person-centred services by holding health and social care services to account and influencing service

development in the public interest'.[10] The two have very distinct but complementary powers (Figure 7).

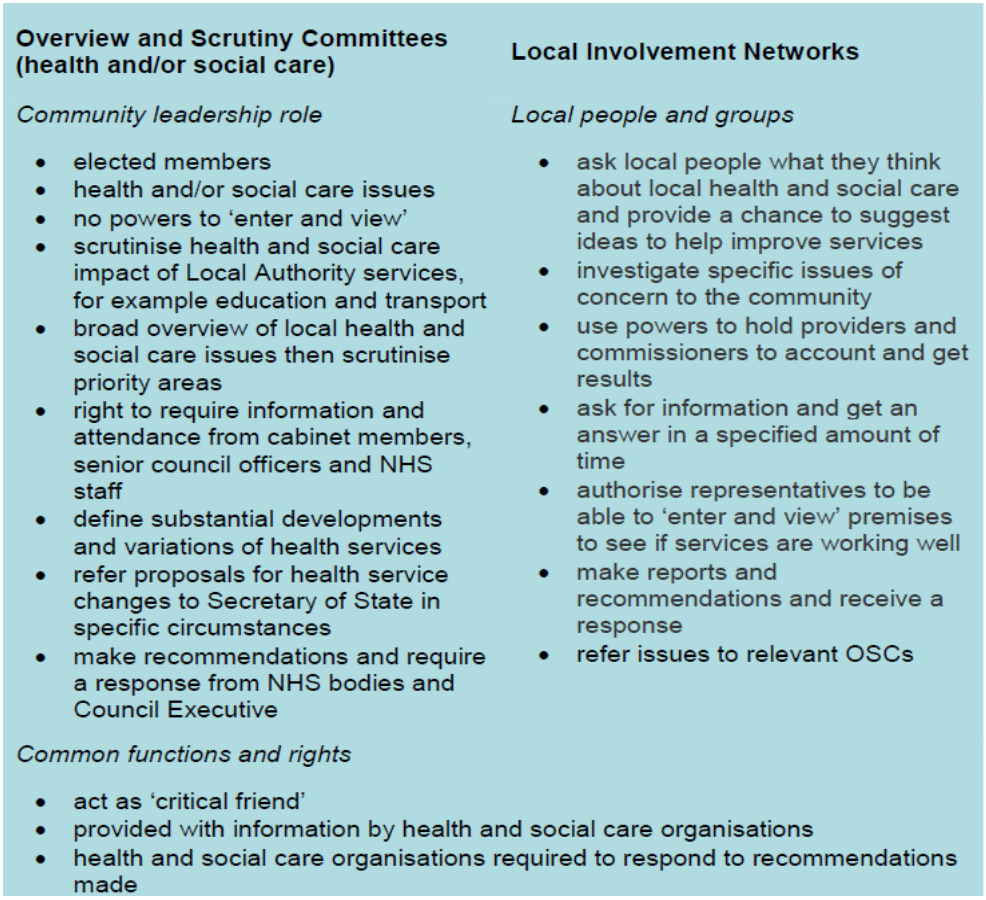

Figure 7 | Summary of roles[11]

LINks and OSCs are encouraged to work together as 'both have a responsibility for engaging with local people and by developing a relationship based on joint working, both can become more effective'.[12]

In working together, LINks and OSCs can avoid duplication, and can focus on shared priorities. The following are identified as opportunities for joint working:[13]

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[10] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09) p.5

[11] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09)) p.6

[12] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09) p.1

[13] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09) p.13-17

- LINks and OSCs can work together to build local relationships with service providers and commissioners;
- LINks and OSCs can jointly communicate with local people;
- LINks and OSCs can work closely with Health and Social Care bodies, to help them fulfil their duties to engage with the citizen, and ensure that responses to Health and Social Care bodies are reflective of the views and diversity of local people;
- LINks and OSCs can have a good working relationship with providers and commissioners to ensure that if a formal consultation[14] is occurring, it complements, and is in addition of any ongoing involvement taking place;
- LINks can provide OSCs with local evidence and data to help them make an assessment about whether a proposal from the Health Service should be considered 'substantial' and therefore, should undergo formal consultation;
- LINks can refer health and social care issues to the OSC, and OSCs must acknowledge referrals within 20 working days, and keep the LINk informed about any actions they are going to take
- LINks and OSCs intelligence can make a coordinated contribution to CQC assessment activity, and use the Commission's assessments as baseline information for their own work;
- LINk and OSCs can explore how they can contribute to the Comprehensive Area Assessment and work with the outcomes.

LINks and OSCs may want to develop a set of agreed protocols for joint working, in order to clarify each role and responsibility (see Box 2).

Interviewees from the OSC in Birmingham expressed considerable willingness to work with LINk, for all the reasons set out above. Joint themed reviews were suggested as one way of coordinating the work of the two bodies, and it was suggested that the LINk could ask for items to be put on the OSC agenda where it had failed to get an adequate response from health or social care organisations. OSC interviewees were also interested to see if the LINk could exercise more influence over Foundation Trusts (FTs) than they had been able to.

[14] 'Formal Consultation' is a term to describe the statutory duty on NHS bodies to consult with OSCs when they are considering a proposal for a substantial development of Health Services in the area of the local authority (ref 11 pg 16).

BOX 2 | LINk and OSC protocol

Sutton LINk and Sutton Health and Wellbeing OSC have agreed on the following terms, which may have relevance in Birmingham:

- For a LINk representative to sit on the OSC and report back regularly to the steering group and members
- To share and coordinate LINk and OSC work plans and relevant areas of work
- For LINk to attend the OSC agenda planning meetings in order to coordinate work
- For the OSC Chair and Vice-Chair to attend LINk meetings when appropriate
- For LINk to provide community input into to the work of the OSC as agreed (LINk facilitated the involvement of service users in the review of long term conditions, and the involvement of users of Mental Health Services in the OSC investigation of mental health services)
- To work together informally in the interests of the community wherever possible, rather than through formal referrals.

Source: Sutton Local Involvement Network (2009) *Sutton LINk Annual Report 2008-09*, (www.suttonlink.org.uk accessed on 13/8/09) p.17

The OSC will, of course, draw its intelligence from a variety of sources, and will operate in a political environment, with all the competing influences that that implies. This may present challenges for both the LINk and the OSC. For example, there was concern that political allegiances might undermine the willingness to cooperate with the (Labour government-created) LINk; and the LINk will need to ensure that it understands the remit and aspirations of the OSC as a body of democratically-elected local politicians. However, interviewees were clear that it should be possible for the LINk and the OSC to cooperate, bringing their different perspectives to bear, and their combined influence would be greater than either of them working alone. The relationship may require some discussion and mutual reflection as it develops.

Several interviewees from commissioner organisations said that they hoped that the LINk – often working in conjunction with the OSC – would jointly hold them to account. They felt that this would be an important lever for ensuring more joint working across the city, in three dimensions:

- Health and social care – they felt it would be useful if the LINk/OSC chose some early studies where joint working between health and social care was particularly critical for service users;

- Health commissioning – the three PCTs could be encouraged to share good practice if the LINk/OSC jointly asked them to explain differences in service provision across the city;
- Commissioners and providers – a joint scrutiny which focused on both PCTs and FTs, or commissioners and third/independent sector providers, would also emphasise the need for whole systems planning and delivery.

3.1.8 NHS Foundation Trusts

The number of Foundation Trusts – already significant in Birmingham – will shortly increase further as the PCTs are encouraged to split into separate provider and commissioner entities. Foundation Trusts (FTs) are independent, with their own systems of accountability to local people, who can become members and governors. The board of governors acts as a communication link between the Trust and the local community.[15]

The relationship between the LINk and NHS provider organisations is necessarily a somewhat ambiguous one. The LINk is charged with influencing commissioning, and therefore at one level does not need a direct relationship with providers: it should influence their work via the commissioners. But many of the interviewees questioned the practicality of this, since the public will often be concerned about issues which are largely 'operational' in nature - they result from the way in which the provider has chosen to deliver their contract with the commissioner. The most frequently quoted examples were hospital car parking charges and ward cleanliness. Although such matters could be addressed through the commissioning process, the more direct route would often be to raise them directly with the provider in question. Some sort of relationship between the LINk and FTs is therefore necessary:

> *'it's hard to recruit people on the mantra of "commissioning" as most people don't know what it is'*

The LINk Early Adopter Programme (EAP) highlighted areas for concerns around working with health providers. In response, a document has been produced called *LINks – Relationships with Health Providers*, which aims to address some of the issues. The EAP highlighted concerns about how LINks would work with FTs – how they would consult with its members and governors. In response a number of options have emerged:[16]

- The 'membership' of the FT in its entirety becomes a LINk member organisation. Communication with the members could be through web-based means or could develop in synergy with the FTs own communication channels;

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[15] The NHS Centre for Involvement, *LINks Relationship with Health Providers* (www.nhscentreforinvolvement.nhs.uk accessed on 28/09/09) p.2

[16] The NHS Centre for Involvement, *LINks Relationship with Health Providers* (www.nhscentreforinvolvement.nhs.uk accessed on 28/09/09) p.3

- A sub-group of the membership could be formed to become a LINk organisational member;
- Individual members of the FT could be actively encouraged to become members of the LINk and take some responsibility for communicating with the wider FT membership;
- The Board of Governors (elected by the members) could be engaged e.g. given a place on a LINk Board, considered as a member organisation;
- The LINk could play a secondary role in FTs and develop a relationship with them to enable them to signpost people and to pass on information that it collects as part of its day-to-day work;
- The LINk could, in the case of specialist FTs e.g. mental health FTs, treat the members as a specialist sub-group of the LINk;
- There could be a combination of the above depending on the purpose of the engagement.

Birmingham LINk may wish to consider which of these might be appropriate to the different Trusts with which they will relate. Three sets of issues might form the basis for early discussion with the FTs in Birmingham:

- Shared intelligence – protocols for ensuring that each body has timely and appropriate access to the other's intelligence. One example might be to facilitate the LINk's access to information collected via the work of the Patient Advice and Liaison Service (PALS);
- Relationship with Members and Governors – there are potential overlaps in membership and conflicts of accountability which need to be resolved; there also needs to be a practical set of guidelines on who talks to whom, about what, and when; and
- Lines of communication between staff – as with Adults and Communities and the PCTs, there needs to be a clear set of direct relationships between the LINk/host and staff in the FTs responsible for particular aspects of service provision and policy, so that information can be easily shared, and issues of disagreement resolved at the lowest possible level.

One other immediate issue will be how the LINk designs its own internal 'architecture' to ensure that it relates effectively to FTs. If it chooses to have direct relationships with these providers (and the nature of those relationships is a key early question for the LINk), and not work solely through the commissioners, there will be a need to maintain some element within the LINk which cultivates that relationship, to ensure the sort of mutual understanding that was identified in the earlier part of this report as a key element of a successful relationship. This may echo previous structures (for example, the PPI Forums), which has the advantage of

familiarity, but may also raise concerns about the continuing dominance of elements from those previous structures, and the risk of continuing an agenda which may no longer be entirely appropriate. The LINk will probably wish to reflect carefully on this issue before deciding on how it wishes to pursue this element in its external relationships.

3.1.9 Birmingham Voluntary Services Council

The potential relationship between the LINk and BVSC is rather different from that with the statutory sector providers, given the very different remit of BVSC.

The BVSC – and in particular the Third Sector Assembly – expressed great willingness to work with the LINk in our discussions with its members, although many Third Sector representatives felt that they did not yet know enough about the constitution and remit of the LINk. A clear advantage for the LINk in relating to BVSC and the Assembly is that it provides a channel of communication to this very large and diverse set of organisations.

In our interviews with various Third Sector organisations with an interest in health and social care, a spectrum of views emerged on their relationships with commissioners, and therefore on what they might expect from the LINk. Some organisations had well-developed relationships with health and social care, which were crucial to their future role, knew of the remit of the LINk, and felt little need for the LINk to act as an intermediary in this.

Others felt that their relationships with commissioners were less well-developed, and struggled to understand the commissioning and strategic context and how to influence it. Perhaps not surprisingly, they also felt less secure in their knowledge of the LINk, but were potentially interested in its help: *'LINk needs to raise its profile and reach out to smaller, poorly resourced organisations like [us]'.*

Given this diversity of circumstances within the Third Sector, and the large number of bodies involved, the LINk will need to develop an approach which responds to different needs. BVSC and the Assembly should be crucial partners in this endeavour, to mutual benefit. Three particular roles were identified in the interviews and discussions with BVSC/Assembly, which the LINk and BVSC could perform together, and which would help in the LINk's relationship with commissioners:

- Providing a 'front door' to the Third Sector – this was a frequent plea from commissioners, who reported that they too had great difficulty in understanding which third sector organisations were their potential partners, and what would be required (in terms of resources, understanding, culture) to cement such a relationship. In practical terms, if the LINk were to be such a 'front door' it would be able rapidly, efficiently and authoritatively to put commissioners in touch with the organisations relevant to their needs;

- Support Third Sector organisations in their involvement with commissioners – commissioners themselves recognised that many of the smaller and younger organisations lacked the knowledge and resources to engage with them in discussions on current and future service provision and saw the LINk as having a role in facilitating this engagement. Their best outcome would be a direct conversation between commissioners and organisations with a good understanding of the needs of particular communities or groups, which the LINk could enable by providing information to the organisations, and working with them to present its understanding of people's needs in the most effective manner. The reciprocal of this relationship would be a recognition by commissioners of the ways in which they might need to adapt their own engagement processes to meet the needs of the third sector. The LINk could also have a role in this;
- Encourage Third Sector organisations to work together – several interviewees from the Third Sector regretted the level of competition which sometimes exists between organisations serving the same communities. This is variously fuelled by the funding policies of public bodies - which sometimes encourage competition for scarce resources, and often do not require bodies they fund to work together as a condition of the grant – and sometimes by the inherently competitive and independent-minded nature of the Third Sector organisations themselves. This is a difficult set of problems to resolve, but the LINk could work with BVSC and others to reduce the sort of isolation of bodies which is not conducive to the common good.

Practical issues for early discussion between BVSC and LINk will include mutual representation on each other's structures, a statement of principle relating to areas and ways of joint working, and hopefully an agreement on specific issues for joint working.

3.1.10 Care Quality Commission

The new Care Quality Commission (CQC), brings together the regulation of health and of social care. There is an opportunity for the LINk to feed into the regulator's work plan. CQC Assessments include an annual 'health check' on NHS bodies, and an annual performance assessment of local councils' social services functions. The health check assesses NHS organisations against core standards, to assess whether a good standard of care is provided across a range of areas, 'it aims to measure what matters to patients and to provide a fuller picture of how local services are doing'[17]. The performance assessment is based upon how well council services serve their communities. Additionally, the CQC undertakes periodic reviews of

[17] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.20

specific services, across various localities, and inspects independent healthcare providers to check services are compliant with registration requirements[18].

The CQC is keen for LINks and OSCs to tell them how they think their trusts and councils are performing against the standards set by government based on the views and experiences gathered from their local communities', and it will also 'check on how well the trust or council is working with LINks, and how well they are involving local people in service developments'[19]. LINks and OSCs are not expected to be experts on all services and assessment standards; 'the aim of their involvement is to provide a reality check on the self assessment and to demonstrate the links between services and the experiences of local people'.[20]

Our interviews with CQC representatives echo these official statements. In particular, there was a desire to capitalise on what was seen as the key strengths of the LINk in relation to the CQC's role:

- Access to the 'authentic' views of service users, including the most vulnerable;
- No conflict of interest – the LINk can genuinely put the client at the heart of its work;
- Informed understanding of the objectives and constraints of the statutory sector and others.

3.2 DETERMINING A WORK PROGRAMME

Once established, effective working relationships will need to be augmented by a balanced work programme within LINk. It is the responsibility of the LINk to determine such a work programme, but there are a series of important considerations and choices that should be made in order to optimise the influence that LINk is able to exert. The balance between these factors is demonstrated in Figure 8 below and detailed in the following text.

[18] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.20

[19] NHS Centre for Involvement, *Guide 18: Local Involvement Networks - Health and Social Care Structures* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.12

[20] NHS Centre for Involvement (2009) *Guide 17: Local Involvement Networks and Overview and Scrutiny Committees working together* (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.20

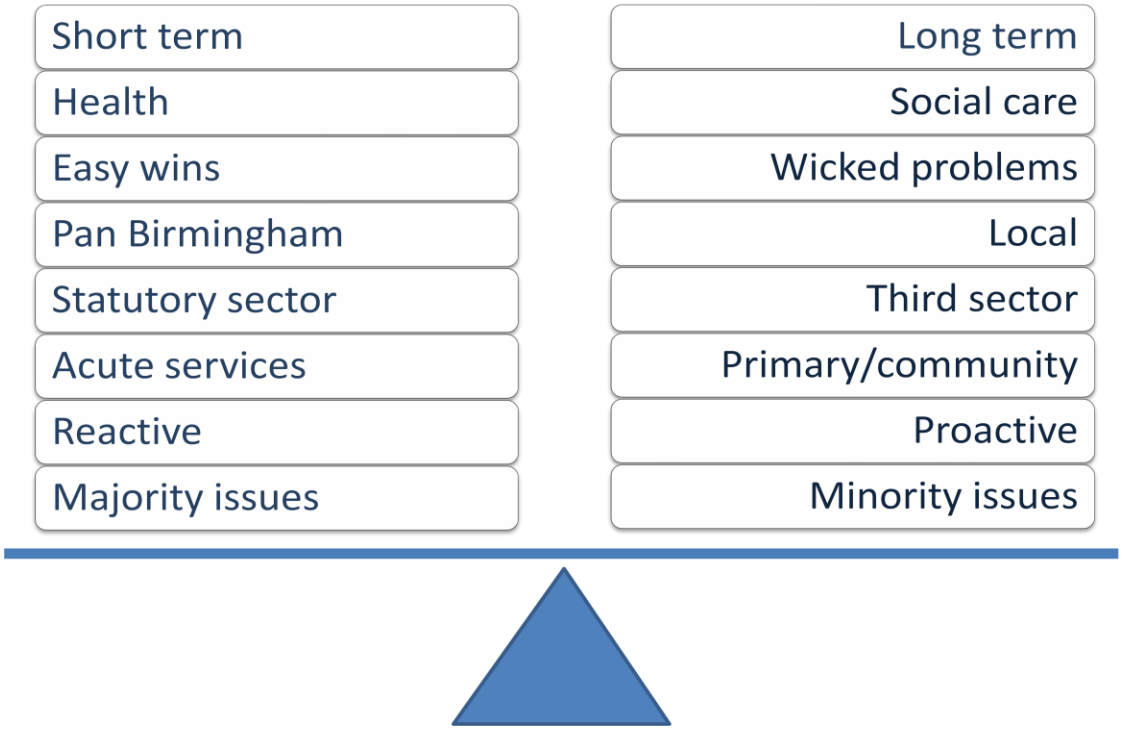

Figure 8 | Striking an effective balance in the LINk's work programme

3.2.1 Key domains

The list of the domains that follows is not intended in any way to be deterministic, but is an indication of what people said and of the key factors to be borne in mind when the LINk determines its work programme. There are, of course, other considerations and choices to be made when that process of prioritisation begins. These issues emerged in conversation with respondents and the rather neat balance indicated by the diagram above is unsettled somewhat when further consideration is taken of respondents' views on exactly what needs to do in its work programme.

Short term | Long term

Perhaps most self-evidently, the LINk needs to strike an effective balance between short term and long term issues for consideration. These factors do not operate in isolation, and in many ways the extent to which the LINk is able to determine this balance will depend upon other choices. Most closely related to the short term / long term axis are, for example, how proactive or reactive the LINk chooses to be, and the extent to which the LINk strives to establish quick wins or tackle 'wicked problems'.[21] Striking an effective balance between short term and long term objectives will allow the LINk to prioritise the immediate and deal efficiently with the important issues.

[21] Rittel, H and Webber, M (1973) 'Dilemmas in a General Theory of Planning' *Policy Sciences*, Vol. 4 pp.155-169; and Conklin, J (2005) *Dialogue Mapping: Building Shared Understanding of Wicked Problems* Wiley: London

Health | Social care | Health and social care

As discussed extensively in the previous Section, one of the LINk's key strengths is its remit over both health and social care. Striking the right balance between these two factors will be a real challenge – partly because the LINk is a direct descendent from other health-focused organisations (Community Health Councils and Patient and Public Involvement Forums) and partly because of the fact that healthcare is universally available, whilst social care is both means and needs dependent. An important further consideration is that there is a third configuration – health and social care – which is not represented in the diagram. In many ways the interface of health and social care is where the LINk may be able to provide a unique perspective, and add value when compared with CHCs and PPI forums. Participants commented that patients and the public often see health and social care services in a more joined up way, than perhaps commissioners or 'decision makers'. Therefore, the LINk's viewpoint could prove invaluable in encouraging joint working between health and social care.

Easy wins | 'Wicked problems'

When asked about the nature of the impact that the LINk should look to have, one of the respondents noted that in the short term, achievable goals were vital to building trust with its partners in Birmingham: *'because of short term funding for the LINk itself, people will wonder – will they still be around? They need to establish measurable, achievable goals'*. Another respondent indicated that: *'for every one big thing, LINk needs to have two quick wins'*.

Getting the right balance between these competing forces may not always be as easy as this simple arithmetic implies, but the LINk is advised to consider how it will be able to show impact in the short term (an important function in generating momentum and possible new members), and that it is dealing with the intractable problems that have besieged health and social care for a long time. Being effective in both of these spheres will prove to be important in showing the LINk as a positive force for change.

Pan Birmingham | Local

The tensions between the LINk's pan-Birmingham brief and its need to remain close to hundreds of different communities in the city is not a challenge to be underestimated. The obvious links with statutory and Third Sector partners is described above, but an effective balance is important. If the LINk is perceived to be too local (and therefore without a city-wide agenda) it risks becoming irrelevant to pan-Birmingham commissioners, and vice-versa. Participants highlighted that pan-Birmingham issues would often need to be addressed and investigated locally. For example, infant mortality, although a concern across different communities within Birmingham, cannot be addressed on a city-wide basis. Having a distinctly geographical element within its structure is both an advantage and a disadvantage for the LINk,

and it will need to work hard in order to maintain a presence at the point where both local and city-wide commissioning decisions are taken.

Statutory sector | Third sector

Connected to the point made above, the LINk must be seen to work effectively across both the statutory and third sectors, albeit for different purposes and for different reasons. The nature of this work will fluctuate – and will be located at some point along the continuum indicated in Section 2 above – but must be based in on an effective partnership. In some ways in its work programme the LINk may be less able to dictate the balance between these two sectors, than for the other issues described here. Suffice to say that good relationships with both sectors – whether in respect of gathering information or influencing decision-making – are central to the LINk being a well positioned and credible partner.

Acute services | Community/primary

In healthcare, there is a choice to be made between how much time the LINk spends on acute health issues and community/primary services. In this respect, it is important for the LINk to determine what weight it wishes to place upon its functions – like 'enter and view' – and where those might be most effectively deployed. The alignment of the LINk with commissioning services rather than providing services brings with it a series of opportunities, and one of these may be to recalibrate LINk activity towards communities and away from hospitals, and in so doing make linkages with the social services provided therein. An effective balance in this domain, therefore, could be one of the ways in which the LINk is able to find a way into debates around both health *and* social care.

Reactive | Proactive

In more ways than for most, the balance to be struck between a reactive LINk and a proactive LINk is a function of the qualities and values that the LINk embodies. A strong line of argument in the interviews related to the LINk acting in a positive and hands-on manner:

> *'The LINk needs to be proactive: going out and getting the views of vulnerable people…the LINk needs to make it easy for these people to give their views. The LINk can achieve this by working with voluntary organisations that work with these groups'*

That is not to say that a proactive LINk cannot, and should not, also be reactive – making quick and informed responses when needed. Indeed this was also a quality espoused in the interviews. What is up for debate is the extent to which the LINk wishes to 'wait and see' how priorities emerge for health and social care organisations over the coming years, and how much it actively wishes to help shape that agenda (information on how this could be achieved is contained within Box 3). Again, striking the correct balance between these poles will mean that the LINk is seen to be a serious and long-term contributor to the ongoing discussion about

health and social care in Birmingham, but also as a network with community information and intelligence close to hand that can respond effectively when it decides to act.

BOX 3 | Prioritising the LINk work programme

Many LINks identify priorities under consultation and then set up working groups or task and finish groups for a period of time to address and take forward emerging issues. Kent's Local Involvement Network has a decision making and priority setting process of a reactive nature. This process begins when a referral or issue is made by the community. Each issue or topic works through the following system:

- The host discusses the issue with the referrer
- Wider LINk participants and interest groups are consulted with
- Host prepares a business case for the moderating panel
- Moderating panel make a decision to take no action, refer on to the provider or commissioner, carry out further consultation, work with another organisation, or initiate a LINk project
- Feedback to wider LINk participants and referrer

Source: Kent Local Involvement Network (2008) *Appendix 4 to Governance Framework – Decision Making and Priority Setting* (www.thekentlink.co.uk accessed on 4/11/09)

Majority issues | Minority issues

The final dimension in this list centres on the degree to which the LINk balances issues which may be of concern to the vast majority of its constituency (whether defined on a pan-Birmingham or more local basis), or which affect a much smaller number of people (and therefore can be considered to be minority issues). There is a potential trade-off for the LINk in terms of breadth and depth when it comes to such matters. It is possible to argue that within its given resource, the LINk has the capability to deal with only a small number of large-scale majority issues, whilst it would be possible to engage on a much larger number of more minority issues, and in so-doing give a voice to those more seldom heard across the involvement landscape in Birmingham. An opposite view would be that city-wide exposure on an issue affecting the majority could give the LINk a good deal of effective publicity. There's no right or wrong in any of this – again the choice lies with the LINk. What has emerged however, as highlighted in Section 2, is a plurality of views:

> *"LINks should not always try to speak with one voice…there are several perspectives which cannot be reduced to one"*

> *"politicians will become suspicious of the LINk if it always condenses issues to one response"*

This must be considered by the LINk, whether tackling minority or majority issues. The series of issues for consideration that follow will need to be reconciled in the choices that the LINk makes. In places they are seemingly contradictory, and it will be for the LINk to exercise its judgement in prioritising the right activities. The importance of the Section here is in allowing an insight into the perceptions of commissioners and stakeholders before such prioritisation takes place.

3.2.2 Issues for consideration

There were three issues in particular which emerged through the interviews which are important for the LINk to be aware of.

Within the LINk's work programme, it was felt that a role as 'watchdog' was important. This came up in relation to activities like 'enter and view', but respondents also noted that the LINk should have access to complaints data, including the information collected by Patient Advice and Liaison Services across Birmingham. It was noted that in concluding the review of the Mid Staffordshire incident, had an organisation like the LINk seen the data, it might have been possible to identify earlier the problems being experienced. So whilst on the one hand respondents advocated that the LINk should comment, influence, provide a fresh pair of eyes and a different perspective, at the same time they also advised the LINk to use such powers sparingly. The cautious nature of such comments centred on the fact that LINk is a fresh start and for it uncritically to adopt old positions and attitudes would be problematic. Further, some respondents argued that the LINk has a role to play in shaping and changing citizens' behaviours, for example by informing them hospital wards are not as dirty as they may think. They believe that, if a more mature engagement dialogue is required, then this needs to be based on genuine and honest communication with the public – the LINk has, they feel, a role to play in this.

Secondly, in considering its work programme, the LINk was exhorted to ensure that it reaches into the right communities and demographic groups. The immediate question which follows is: which *are* the right communities? From a commissioner's perspective, the work of the LINk should be seen to add value to their existing mechanisms. Acknowledging that the engagement spectrum includes the newly arrived and seldom heard is a useful starting point for such exploration, as this would ensure that the LINk moves past only dealing with well-known communities. At the same time however, respondents acknowledged that in order to be effective the LINk needs to pay heed to existing groupings and boundaries, for example the parliamentary constituencies and neighbourhood forums. Such activity, of course, runs the risk of engaging with those already engaged and not reaching those who are seldom heard – for by definition they could not be represented in such meetings.

Finally, service redesign and prioritisation is a harsh reality for many health and social care commissioners in Birmingham. This will only become more acute as budgets constrict over the coming years. Inevitably, then, the LINk will need to engage with the decommissioning of services in the city. Again from a commissioner's point of view, patients and service users are uniquely well-placed to identify inefficient services which could be improved, and to comment on services that are no longer needed in their current guise. As such the LINk could be a huge ally in providing information and intelligence to commissioners to help the process of service redesign and prioritisation. However in order to create momentum, obtain more members, and get the statutory sector to take notice, a number of participants acknowledged that the LINk needs early and significant successes – and such successes may well be at the expense of those organisations who were interested in working with the LINk to identify priorities.

3.3 QUALITIES AND VALUES

Thinking finally about how the LINk works, and what choices are open to the LINk, are a series of considerations on the qualities and values represented by the LINk. These speak to two different things: qualities and values in the relationships that the LINk has with its partners; and the qualities and values represented by the LINk itself. Both of these domains – extra-LINk and intra-LINk relationships – have three dimensions:

Extra-LINk relationships	Intra-LINk relationships
Trust and maturity	Attitudes to membership
Respect *status quo*	Expectation management
Informed dialogue	Groups' autonomy within the LINk

3.3.1 Extra-LINk relationships

Trust and maturity

There is an expressed need for relationships between the LINk and its partners to be based on trust and maturity. As part of that, respondents noted that a robust exchange of views was to be sought and respected in discussion with the LINk. An important aspect of this relationship was that whilst a robust exchange is good, such challenges should focus on systems and circumstance, but not on people and personalities. Similarly constructive criticism and being a critical friend of the statutory sector is a positive quality for the LINk to exhibit, but commissioners in particular would rather not be 'ambushed' by the LINk, and relationships

should not be defined by aggression. If relationships were thus constructed, it was felt to be an expression of their immaturity. The LINk may or may not wish to accede to the wishes of the Commissioners in these cases, but it is important to consider carefully the positive and negative consequences that would follow each course of action.

A further dimension of trust and maturity will be realised as the LINk becomes seen as a credible and trusted partner to stakeholder organisations, much of which has been discussed in Chapter 2 above. One respondent noted that this credibility might be expressed if:

> *'LINk is aware before others what the issues are and should be in a position to respond'*

It is acknowledged that the LINk represents a plethora of potentially contradictory views. However respondents noted that despite this, the LINk has a duty to ensure that it treats all views equally – it would be illegitimate for the LINk to make decisions about which views are 'authentic' and which are not. Importantly though, in terms of the qualities and values to be exhibited, the LINk must justify its logic, be serious and professional in its outlook and transparent about where data has emerged from. Reflecting this and the discussion in Section 2 above, respondents emphasised the importance of providing new knowledge as the basis for a trusted and mature relationship, drawing on new contributors:

> *'Success also in getting beyond those currently actively interested – they are important but it is important to broaden the base'*

They recognise that the LINk is a 'fresh' organisation, and in many ways that gives it a distinct advantage. Accordingly there is a premium on new faces, but respondents do note that they should not be sought to the exclusion of all others – old faces must not be disregarded uncritically.

The final aspect of this trusted and mature relationship centres on the nature of the LINk's interaction with the statutory sector. There was a feeling expressed that some statutory sector partners can be a little disrespectful at times – either by rarely turning up for meetings, or by leaving early. The counterpoint to this is that the LINk needs to be realistic about attendance at meetings – giving statutory sector organisations enough advance notice, and being clear about their aims and objectives.

These three facets speak very clearly to the need to have some memorandum of understanding, or concordat between partners in order to clarify respective roles and to ensure that the grounds for misinformation are minimised.

Respect *status quo*

Whilst a premium was placed by many respondents on the LINk collecting new information from new people, it was equally important for the LINk to build on existing structures and

results of previous engagement work. Taking the 'Year 0' approach to public engagement would, many believed, undermine much of the very good work that has been done. In this way, one potential role for the LINk would be to act *'as a data warehouse'*, augmenting (but not duplicating) current efforts to provide a comprehensive portal for engagement activity in the form of BCC's 'Be Heard' consultation database.

Respecting what has been undertaken was also evident in people's comments about existing groups and bodies across Birmingham. A number of individuals currently involved in engagement activity with communities perceived that the LINk might not only duplicate function, but be a real threat to them given the resource base that it has. As such they advocated a degree of resource sharing across the engagement landscape (and not necessarily in financial terms) which would go some significant way to allaying fears that the LINk is only interested in empire building and thus impairing its ability to effect change. Therefore in respecting the *status quo* the LINk needs to be aware of these sensitivities, whether based in fact or solely in perception, and to recognise the credibility and power of others. The LINk could reduce these anxieties by exhibiting values and qualities – like respect for what has gone before – commensurate with those who have been doing engagement work in Birmingham for many years.

Informed dialogue

The most straightforward way in which the LINk can demonstrate its commitment to the values and qualities of openness and honesty is in communicating what it is doing. Whether this is through a series of techniques – e-bulletins, mailings, web updates – or in relation to effective sharing of information and intelligence, the LINk was exhorted to ensure that relationships were based on mutual understanding. Respondents fully acknowledged that this was a joint venture and could not be achieved by the LINk on its own – it would only come about on the basis of a mature and responsible attitude towards dialogue between partners. If these values and qualities could underpin the relationships, it was felt that this would minimise the possibility of miscommunication and a gap emerging between the LINk and those stakeholder organisations with whom it needs to work in order to be effective.

BOX 4 | Relationships between the LINk and the PCT

Cornwall's Local Involvement Network held a meeting with its local PCT to explore the establishment of open, positive, timely and practical inter-relationships between the LINk and the PCT. They discussed the following issues:

- How can we determine which routine committees/groups it would be appropriate for LINk members to sit on, and vice versa?
- How will we communicate on a regular basis and at what level should that communication be?
- How might LINks exercise their right to view premises? Are any premises unsuitable?
- What training/briefings could be offered to help the LINk develop an in-depth understanding of health services?

Source: Cornwall Local Involvement Network (2008) *Local Involvement Network in Cornwall Annual Report 2008-2009* (www.cornwallrcc.co.uk accessed on 13/08/09) p.24

3.3.2 Intra-LINk relationships

It may well be that much of what is reported below will be perceived by the LINk as somewhat meddlesome – how is it that those external to the LINk should have a view on how we do our business? It is important therefore to read the following Section in context. Respondents were never directly asked about the values and qualities that they think should be found in the LINk. However, and inevitably, issues emerged *en passant* that may be useful for the LINk in understanding how others see it. The following passages should therefore be read as holding up a mirror to respondents' perceptions of how the LINk *should* and *shouldn't* behave, and not necessarily as an accurate *current* assessment of how the LINk *actually* behaves.

Attitudes to membership

With all of the caveats above understood, there is a fear among respondents that LINk members will repeat what are considered to be the mistakes of previous organisations, principally the CHCs and PPI forums. Chief among these fears is that single issues and a few personalities will come to dominate the work of the LINk and its agenda. If this were to happen, participants perceived that it would be increasingly difficult to maintain the motivation of members.

Another issue which was raised in this context concerned engaging with those who don't want to become 'members'. It was, of course, recognised by respondents that members are important but they also noted that the LINk has a specific role in ensuring that it is 'user

friendly' so that non-members feel they can make an approach should they want or need to. The LINk therefore needs to find a way to involve the wider public and to build capacity within communities so that such information can be forthcoming:

> *'LINk's reputation needs to be built on skilling up ordinary members of the public – developing capacity within the public to be engaged is their primary activity'*

There were some concerns raised, however, about whether the LINk could identify the right skills within its existing membership in order to be able to do this: *'To work effectively the LINk needs the right people to gather intelligence – is there an appropriate skill set?'*

It is apparent therefore that there needs to be a 'variable geometry'[22] within the LINk membership. This would mean that the LINk has a number of membership 'constituencies', each of which would have different types and levels of involvement in the LINk's activities. These constituencies could be drawn upon for different purposes on different occasions as was relevant. In order to engage with such people, the LINk may need to refine its 'offer' – concern was expressed that there may not be enough of a unique selling point to persuade groups to become involved with the LINk: *'Why should we join – is it just another group offering us stuff? What it can offer?'*

BOX 5 | **Different levels of involvement**

Kent's Local Involvement Network defines four levels of involvement, offering flexible ways that its communities can engage;

INFORM – Information giving

CONSULT – Market Research

INVOLVE – Participation/deciding together, partnership/acting together

DEVOLVE – Supporting independent community initiatives

Source: Kent Local Involvement Network (2008) *Kent LINk Community Engagement Strategy* (www.thekentlink.co.uk accessed on 13/08/09) p.12

[22] Variable geometry is most commonly associated with the European Union and applies to the politics of regional integration. The EU's enlargement since 2004 has presented particular challenges for European integration, many of them associated with differences in size, political maturity, economic development, language and culture. Different countries will therefore meet the criteria for deeper integration at different speeds. Variable geometry acknowledges that not every member-state will take part in every EU policy area to an equal degree, and that some will not take part in certain areas at all.

Expectation management

A second set of issues raised by respondents related to the expectation management of members. Interviewees recommended that the LINk works to ensure that its members are educated about their role in relation to commissioning, and accordingly that they are realistic about what may and may not be achieved:

> *'LINk can't pretend that things can always be resolved as communities would like – but by working differently and being more engaged, solutions that were not envisaged can be found'*

Consequently, respondents felt that it was important for the LINk to manage the expectations of members to guard against four specific problems:

1. Special interest groups and lobbying;
2. Inappropriately using the LINk's voice on behalf of others;
3. Immature comments about de-commissioning and service cuts;
4. Not being briefed adequately before meetings, and misunderstanding key issues.

If this 'wish-list' is to be part of an open two-way dialogue, it is very important that LINk members feel that there is clarity about exactly what is on, and what is off, the table at the meetings they attend. Expectation management is therefore not a function that the LINk can effectively discharge on its own.

Autonomy of groups within the LINk

The final substantive issue concerned the nature of the relationship between different parts of the network. Effective governance structures will clarify much of this in the medium term, but respondents did note that they were unclear about two specific things in the short term.

The first of these related to the characteristics of the network and how far it is top-down or bottom-up. Respondents were unsure of the internal working of the LINk, so that when asked about how the network functions, they could not point to a structure very readily. It is important for those wishing to engage effectively with the LINk to know how much power has been devolved from the LINk to other groups in order to gauge whether they are speaking to the right people at the right time.

Very much connected to this, is the second issue which concerns who speaks for the LINk, and with what voice. This has two dimensions. Firstly, there was concern raised by some members that they were unable to make the statements they wanted to in their capacity as LINk members. Secondly, it was perceived to be difficult for stakeholders to ascertain who has the right to speak for the LINk, and if people are speaking for the LINk, on whose authority do they

do so? There are clear political overtones to much of this, and in some ways, the LINk is perceived to be a threat to established systems and structures:

> *'Local politicians and MPs stick their oar in – LINks need a bit of savvy in their LINk about who and what speaks for the LINk. Need relationship and alliance building, particularly around what OSC is doing'*

Clarity about who speaks, and on what, is central to minimising miscommunication between partners, echoing the issues noted above.

BOX 6 | Who speaks for the LINk?

Manchester Local Involvement Network has agreed a number of procedures with its partner organisations including:

- People representing the LINk in a formal capacity to external organisations are to be appointed by the steering group and these individuals will report back to the steering group;
- All LINk related enquiries will have to go through the LINk support organisation to the steering group or chair;
- Only the chair and vice chair of the working groups may speak on behalf of the LINk to outside agencies. In the absence of the chair or vice chair the LINk support organisation will endeavour to identify an appropriate member of the steering group.

Source: Manchester Local Involvement Network, *Manchester LINk's Communication and Engagement Strategy* (www.communityvoices.org/LINKs accessed on 13/08/09) p.7

SECTION 4 | DECISIONS

The overwhelming majority of interviewees from the statutory sector thought it fairly or highly likely that the LINk would make a significant impact in improving services for people in Birmingham in the next five years. The advent of the Local Involvement Network in Birmingham provides a great opportunity to effect a step change in the engagement of local people in their health and social care. The creation of a well-resourced new body, with a pan-city remit, statutory powers, and an interest in both health and social care, should result in more effective engagement, but such an outcome is not automatic. It requires the LINk to make decisions on a number of key aspects of its ways of working, and to follow-through in implementing those decisions; and it requires the commissioners and other bodies to work with the LINk in ways which enable it to do its job. Essentially, what is required is a partnership, which recognises the distinctive remit of the different bodies, but finds the synergies of effective collaboration. Both parties need to embrace a step change in their relationship.

This report has focused on two key issues. First, where should the LINk and its partners be heading: what would an influential LINk look like, and how should commissioners behave in response? Second, what are the steps which the LINk and commissioners should now start to take in that direction?

This final section summarises the key areas where decisions are now required, by the LINk itself, by the LINk working with commissioners, and by commissioners alone. It is brief, and is intended as a checklist: it does not repeat the material set out earlier in the report.

4.1 DEFINING SUCCESS

'There isn't a panacea for engagement'

The various defining aspects of an influential LINk and its supportive commissioners were discussed in Section 2. In full recognition of the complexities of this issue, we set out below two lists of success criteria, and how they might be assessed. The first relates to the LINk itself, and draws on the perspectives of commissioners in Birmingham. The second relates to the commissioners themselves, in relation to their responsibilities in helping the LINk to achieve success.

There are, of course, a host of factors which could be described here, at great length. This would perhaps not be helpful, however. Rather what we have done is to flag up twelve issues which clearly relate to the immediate concerns in Birmingham, and they are presented here as a means for stimulating the sorts of conversation which need to take place between the LINk,

commissioners and others as they jointly reflect on the quality and productiveness of their relationships.

4.1.1 Assessing the LINk

The following are specific criteria which define a reasonable set of aspirations for the LINk, in order to maximise its influence on health and social care in Birmingham. They are derived from the research conducted for this project, and further detail on each is contained in Section 2.1:

Success Criterion	How would you assess it
1. New faces	Some unfamiliar participants, speaking for themselves
2. New communities	Groups and issues that are hitherto relatively unknown by commissioners
3. New information	Perspectives not already available; new levels of understanding
4. New thinking	Evidence-based, independent-minded, new solutions
5. Broad 'membership'	Reasonably numerous and representative; different ways of engaging
6. Reliable	Reasonably rigorous in research and presentation
7. Constructive	Often suggesting solutions or ways forward
8. Coordinated	Efficient approaches to engagement
9. Good feedback	Groups and individuals reporting positively about the LINk
10. Aligned with timetables	Often just ahead of commissioners' agendas
11. Big issues	Focusing on issues of serious detriment
12. Savvy	Using levers effectively

Table 3 | LINk success criteria

4.1.2 Assessing the Commissioners

The following criteria set out a reasonable set of expectations for commissioners, if they are to play their part in maximising the influence of the LINk. These, too, are drawn from the research and further information on each can be found in Section 2:

Success Criterion	How would you assess it
1. Transparency	Share and agree decision-making processes with the LINk; agree timescales in advance
2. Honesty	Inform the LINk about real objectives and (formal and informal) constraints; invite challenge
3. Approachability	Provide the LINk with easy access to relevant decision-makers; provide alternative methods of interaction (verbal, written etc)
4. Respect	Ensure 'organisational body language' shows respect; be clear about mutual expectations
5. Corporate unity	Ensure that all decision-makers share respect for/understand the LINk; invite LINk feedback on commissioners' performance
6. Timing	Explain constraints; flexible response to LINk's own agenda/timescales
7. Listening	Understand the LINk's perspectives, needs and priorities; ensure that decision-makers interact directly with the LINk
8. Sharing	Assume all information should be provided to the LINk; proactively explain systems/data etc
9. Coordinating	Look for synergies with the work of the LINk; design joint/shared approaches where appropriate
10. Feedback	Keep the LINk informed about how their views were used; explain why LINk input is not accepted (where applicable)
11. Behaviours	Agree parameters of behaviour in advance; void unnecessary antagonisms; reflect jointly on behaviours
12. Shared wins	Find issues/areas which can address commissioners' and the LINk's priorities

Table 4 | Commissioner success criteria

Recommendation 1

The LINk and commissioners separately should reflect on the criteria set out above, and decide:

a. Are these a fair and reasonable set of criteria to which we would wish to subscribe?

b. What are the implications of each for our organisation?

Recommendation 2

The LINk and commissioners together should reflect on those criteria by which they wish to be assessed, and agree a shared Concordat. This should set out in some detail how each party will act in order to ensure that the criteria are met

Recommendation 3

The LINk and the commissioners should agree a process for reflecting on their performance against the criteria, and learning from that reflection. The process should include participation by the most senior staff, be informed by the views of services users, patients, carers and the public, and report publicly on progress against clear performance criteria.

4.2 THE WAY FORWARD

In moving towards the outcomes described above, there are some issues on which the LINk needs to reflect and make decisions, and there are other areas where decisions need to be made in conjunction with commissioners.

4.2.1 Choices for the LINk

The research suggests that there are six key strategic choices for the LINk as it builds up its own priorities, work plans and structures. Further detail is provided in Section 2. There are several points along the various spectra set out here:

Issue	Choice: the balance between…
a. City-wide vs local	… issues which have clear relevance across the city, and those which really only concern one locality or group
b. Health, social care, or both	… issues which only relate to either health or social care, and those where both services are inextricably connected
c. Multiple agendas vs. limited resources	… addressing all significant issues, and choosing those where the LINk could make the greatest impact
d. Proactive vs. reactive	… responding to all issues raised with the LINk, and deliberately choosing issues to pursue against an objective set of criteria
e. Independent/scrutiny vs. cooperative/co-production	… scrutinising and maintaining strong independence, and working collaboratively with agencies to make improvements
f. Network vs independent	… facilitating the work of the network of affiliated bodies, and doing independent work with the public as 'the LINk'

Table 5 | Choices for the LINk

Recommendation 4

The LINk should reflect on the issues represented by the issues/choices set out above, and use these as a basis for setting its own strategic direction. The material presented in Section 2 of this report can inform this discussion.

Recommendation 5

Based on this discussion, the LINk should agree a practical set of criteria for determining its own work priorities.

4.2.2 Choices for the LINk and Commissioners together

There are several aspects of the practical working relationships between the LINk and commissioners which require early discussion and mutual agreement. These are discussed in Section 3 above. As a checklist for action, the key areas include:

What	Who	See Sections
a. Agree annual timetable for joint working	LINk, Be Birmingham, BHWP, Primary Care Trusts, BCC Adults and Communities, Overview and Scrutiny Committee, BCC Constituencies, Foundation Trusts, BVSC, CQC. (See Section 3.1.1)	3.1.3-3.1.10
b. Agree annual work plan		3.1.3-3.1.10, 3.2
c. Agree approaches to joint working		3.1.2
d. Develop understanding on behaviours		2, 3.3
e. Agree lines of routine communication		2, 3.3
f. Agree information sharing protocols		2, 3.3

Table 6 | Choices for the LINk and Commissioners together

Recommendation 6

The LINk and the relevant bodies should discuss and agree the various issues set out above, using the material presented in this report. A joint forum should be created for the purpose, linked to the arrangements outlined in Recommendation 3.

4.3 CONCLUSION

Whilst there have been clear successes from public engagement during the past few years in Birmingham, all parties need now to focus on the step change which is required if engagement is really to deliver the improved services which people should expect.

The future success of public and patient/client/carer engagement depends in large part on the success of the partnership which is forged between the LINk and the statutory agencies. Everyone accepts that the partnership should be robust and – when necessary – constructively critical. For this to happen, the LINk needs to maintain its independence, and to develop a way of working which adds value to the efforts of the NHS and the Council. The statutory agencies, too, need to develop their own ways of working, to support the LINk and to embody the principles of good engagement. This will require effort from both partners, and movement away from some of the ways of working which have characterised the recent past.

These recommendations are not intended to be too prescriptive. The recent election of the LINk's Core Group represents an excellent opportunity to determine and prioritise an effective

work programme. Our aim has been to provide the LINk with enough information to make that process easier, and for the LINk and commissioners to work out what they need to focus on jointly to make their partnership a success. This report represents the beginning of the process and the detailed action planning that will follow.

Looking ahead, public services in Birmingham – and by extension, the relationship between the LINk and commissioners – will be hit by several potentially destabilising external factors. These may include:

- A general election, with the possibility of new priorities and policies
- Significant budget pressures
- Extension of the personalisation agenda in social care
- Development of mico-commissioning in health
- Organisational change: the 'business transformation' of Adults and Communities, and the possibility of the merger of PCTs

All of these changes have the potential to distract senior staff from focusing on public engagement and the LINk, and several of them (e.g. a change of government) may demand some changes in the nature of the relationship with the LINk. Despite this, it is important that all concerned believe in the value of the relationship between the LINk and commissioners, and continue to pay attention to the issues identified in this report.

4.3.1 Strengths of LINks

This section highlights some of the important strengths that all LINks possess.

Early Adopter Lessons

The Early Adopter Programme (EAP) ran from January to September 2007, across nine sites, to test out the new model of public involvement in health and social care. The aim of the EAPs was to 'provide valuable learning, in depth insight and evidence… to inform the wider implementation process and support an approach that secures local ownership of, and credibility for, LINks as a robust involvement mechanism'.[23] The experiences across the sites have contributed to a wealth of guidance to support the development of other LINks.

[23] Taylor. J, Tritter. J, and Dimov. M (2007) *Local Involvement Networks – Learning from the Early Adopter Programme – Final Report.* NHS, The National Centre for Involvement (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.9

Locally Determined Networks

Since the EAP, there have been a number of publications to support and guide LINks in their development and the choices they make. However, the guidance places a great emphasis on the LINk as a locally determined, and locally owned network, allowing each LINk to be shaped by local communities. LINks will adopt appropriate models based on the local geographical and cultural context, to ensure they meet the engagement and involvement needs of local people and stakeholders. A Local Involvement Network will demonstrate transparency and be accountable to its community, involving them in development and review processes.[24]

Health and Social Care

Unlike previous patient and public involvement within the NHS, LINks have a statutory duty to include social care services as well as the NHS in their work. LINks can follow a typical patient pathway which crosses traditional boundaries. It follows other policy and practice trends, which bring the health and social care sectors together.

The Host

Each LINk has a contracted host organisation, to support and facilitate their development. The role of the host includes the following:[25]

- Undertake the initial set up of the LINk;
- Provide advice and support for the LINk;
- Have a strong commitment to forming strategic partnerships and effective working relationships with other organisations, and support the LINk to develop such partnerships;
- Support the LINk in the development and promotion of its priorities and work plan activities;
- Build on and where necessary, develop local networks to support ongoing sustainable recruitment activity;
- Operate within the agreed performance frameworks laid down in its contract with the local authority.

A Network of Networks

The LINk is a network, a system of interconnected people and groups. Any member of the public, individuals and groups or organisations can be members of a LINk, or participate in LINk

[24] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.41

[25] Department of Health (2007) *Getting Ready for LINks - Contracting a host organisation for your Local Involvement Network* (www.dh.gov.uk accessed on 28/9/09) p.4-7

activity. LINks will be inclusive and enable involvement from all sections of the local population: 'It is important to remember that LINks are not merely groups of individuals, but are primarily networks that will bring together diverse groups in the area, and representatives of other networks'.[26] A 'network of networks' enables people who may already be active with a particular area or issue, to link into new initiatives, but avoiding a duplication of efforts.[27]

LINk Powers and Partner Duties

LINks can exercise certain powers within their communities, which are set out in legislation, enabling them to have an impact on local services. One of which is the power to 'enter and view' health and social care service. This empowers LINk participants and provides an insightful method of monitoring the nature and quality of services. The government has introduced duties on certain commissioners and providers of health and social care services to allow authorised representatives of the LINk to enter and view premises to see and hear for themselves how those services are provided.[28] LINks have the power to request information from local health and social care organisations; LINks can produce reports and recommendations for local services and expect a response; and LINks can refer matters to the relevant Overview and Scrutiny Committees (OSC), who must acknowledge this referral within 20 working days.

[26] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.4

[27] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.18

[28] The NHS Centre for Involvement (2008) *Code of Conduct Relating to Local Involvement Networks' visits to enter and view services* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09) p.3

APPENDIX 1 | TERMS OF REFERENCE AND LIST OF PARTICIPANTS

Terms of Reference

To investigate the attitudes and practices of commissioners and strategic decision makers in health and social care concerning public, patient and service user and carer involvement in determining commissioning priorities.

The purpose of the research was to explore the connections and accountabilities between the LINk and other patient and public involvement activities and the people who make decisions and commission (and de-commission) services. It was designed to help the LINk during its early stages of development by providing practical evidence of how it can have an impact on the commissioning and de-commissioning of health and social care services in Birmingham.

List of Participants

Voluntary
Abdirahman Ali, Coordinator, Afro British Support Services "IMPACT"
John Rexford Coleman, E Square Community Network
Cheryl Garvey, British Association of Youth Clubs
Mango Hoto, Chair, Aston & North Nechells Patient Network
Candy Passmore, Policy and Communications Manager, BVSC
Heather Patterson, Lisieux Trust
Dr Rob Rijkborst, Insulin Dependant Diabetes Trust
Paul Slatter, Director, Chamberlain Forum
Jean Templeton, St Basils Young People and Support
Jean Tompkins, Head of Health and Social Care, Ashram Housing
Hannah Wilson, SIFA Fireside
Quesdues Zafar, Stechford Youth Network
LINk Children and Young Peoples Working Group *(focus group)*

Political
Cllr Deidre Alden, Chair Health Overview and Scrutiny Committee
Cllr Sue Anderson, Cabinet Member for Adults and Communities
Cllr Paulette Hamilton, Lead for Health
Cllr Paul Tisley, Deputy Leader, Birmingham City Council

Be Birmingham Local Strategic Partnership
Simon Bennett, Manager, Birmingham Cultural Partnership, Be Birmingham
Rachel Ginnely, Senior Policy Officer, Be Birmingham Strategic Partnership
Lucy McDonald, Experience and Engagement Programme, Birmingham Health and Wellbeing Partnership

Darren Wright, Life Expectancy Lead, Birmingham Health and Wellbeing Partnership

Health

Rehana Ahmed, PPI Manager, Heart of Birmingham teaching PCT (HoB tPCT)
Olivia Amartey, Outpatient Care Project Manager, HoB tPCT
Stephanie Belgeonne, Head of Communication, NHS South Birmingham (SB)
Sandy Bradbrook, Chief Executive, HoB tPCT
Elizabeth Buggins, Chair, West Midlands Strategic Health Authority (SHA)
Sam Davies, Head of NHS Continuing Healthcare
Simon Foster, Carers and LINks Lead, Department of Health (West Midlands)
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Jonathan Hill, Engagement Specialist, NHS SB
Julia Holding, Programme Specialist – Consultation Regulation, West Midlands SHA
Professor Deirdre Kelly, Care Quality Commission (cover health and social care)
Sohaib Khalid, Associate Director of Commissioning, Strategy and Redesign, HoB tPCT
Alison Last, PPE Lead, NHS SB Provider
Louise Pritchard, Director of Performance and Organisational Development, NHS BEN
Adrian Reedman, Interim Director of Commissioning, NHS BEN
Martin Samuels, Director of Strategy, Service Transformation and Planning, HOB tPCT
Ranjit Sondhi, Chair, HOB tPCT
Rita Symmons, Director Commissioning, NHS SB
David Walker, Pan Birmingham Sexual Health Commissioner, Host – NHS BEN
Sheila Wrotchford, Associate Director of Transformation, Outpatient and Diagnostic Lead, HoB tPCT

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Janti Champaneri, Operations Manager Older Adults
Karen Cheney, Community Empowerment Lead
Pam Dixon, Consultation Programme Manager
Belinda Dooley, Joint Commissioning Lead for Learning Disabilities
Mike Ewins, Service User and Carer Involvement Officer, Adults and Communities
Harry Fowler, Head of Youth Service
Maria Gavin, Head of Service, Design Authority, Adults and Communities, Business Transformation
Chris Glyn, Children, Young People and Families Commissioning Team
Kate Griffiths, User Involvement and Carers Unit, Adults and Communities
John Hagans, Customer Relations Manager, Adults and Communities
Peter Hay, Strategic Director for Adults and Communities
Satpal Hira, Equality and Diversity Manager
Jagwant Johal, Constituency Director, Lead for Consultation, Adults and Communities
Nargis Kapasi, User and Carer Involvement Mental Health
David Mason, Service Director Policy and Strategy and Commissioning

Jim McManus, Joint Director of Public Health
Georgina Owen, Consultant, iMPOWER Consulting Ltd
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Barbara Perryman, Head of Service, Modernising and Day Services (LD), Adults and Communities
Bret Willers, Constituency Director, Lead for Social Care
Steve Wise, Services Director Business Transformation, Adults and Communities

APPENDIX 2 | WORLD CLASS COMMISSIONING COMPETENCIES

World Class Commissioners competencies[29] are described by a series of 11 headlines, requiring commissioners to:

1. Are recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission service that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money

[29] Department of Health (2007) *World Class Commissioning: Competencies* (www.dh.gov.uk accessed on 12/10/09)

APPENDIX 3 | BACKGROUND TO THE DEVELOPMENT OF LINKs

Changing policy

Over the past few years, we have seen several changes in patient and public involvement within health and social care.

Following the abolition of Community Health Councils (CHCs), Patient and Public Involvement (PPI) Forums were established in 2003, marking a new era of public involvement.[30] There was one forum for each NHS trust, Foundation Trust, and PCT in England. They sought to bring the views of patients, service users and families into service improvement. However, in 2004 and 2005, a consultation took place which claimed that the forums were not fitting to typical patient pathways, and that their boundaries were too artificial. There was also a growing awareness of the developing relationship between the health sector and the social care sector: 'It was recognised that the typical patient pathway would involve not only primary and secondary care but social care services as well'.[31]

This prompted the Department of Health to review patient, user and public involvement. In January 2006, the White Paper, *Our Health, Our Care, Our Say: a new direction for community services* was published, outlining a strategy which would put people in control and make services more responsive to people's needs. The public had prioritised convenient access to social and primary care, that they could choose and influence,[32] and the paper led the way for reforms within the health and the adult social care system in England.

Later in 2006, *A Stronger Local Voice* was published, setting the proposals for the establishment of Local Involvement Networks. The role of the LINk was to provide 'a flexible way for local people and communities to engage with health and social care organisations; support and strengthen open and transparent communication between people, commissioners and

[30] Taylor. J, Tritter. J, and Dimov. M (2007) *Local Involvement Networks – Learning from the Early Adopter Programme – Final Report.* NHS, The National Centre for Involvement (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.7

[31] Taylor. J, Tritter. J, and Dimov. M (2007) *Local Involvement Networks – Learning from the Early Adopter Programme – Final Report.* NHS, The National Centre for Involvement (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.7-8

[32] Department of Health (2006) *Our Health, our care, our say: a new direction for community services – health and social care working in partnership* (www.dh.gov.uk accessed on 14/8/09) p.6

providers; and make sure organisations that commission and provide health and social care services are more accountable to the public and build positive relationships with them'.[33]

The Local Government and Public Involvement in Health Bill proposed that PPI Forums were to be abolished and LINks to be established in each local authority area with social services responsibilities. In October 2007, the Bill received Royal Assent and Local Involvement Networks were launched on 1 April 2008.[34]

LINks and commissioning

The World Class Commissioning (WCC) programme was launched by the Department of Health and the NHS, to transform the traditional models of commissioning. The programme is to meet the needs of a changing landscape, where people's aspirations and lifestyles are changing, and the nature of public heath is evolving.[35] The publication of *Commissioning A Patient-Led NHS in 2005*, defined the shift from spending on services to investing in health and wellbeing outcomes.[36]

WCC aims to deliver better health and wellbeing for all, better care for all, and better value for all. Central to delivering better care for all, is that services will be evidence-based, and of the best quality, and people will have choice and control over the services that they use, so they become more personalised.[37]

For local organisations to become more effective and capable commissioners, they must aspire to certain skills and behaviours. A platform of commissioning competencies has been developed, to assist PCTs in achieving WCC, locally (See Appendix 2). One of the Commissioning Competencies refers directly to the importance of public engagement:[38]

[33] Department of Health Patient and Public Involvement Team (2006) *A Stronger Local Voice: a framework for creating a stronger local voice in the development of health and social care services* (www.dh.gov.uk/publications accessed on 14/8/09) p.14

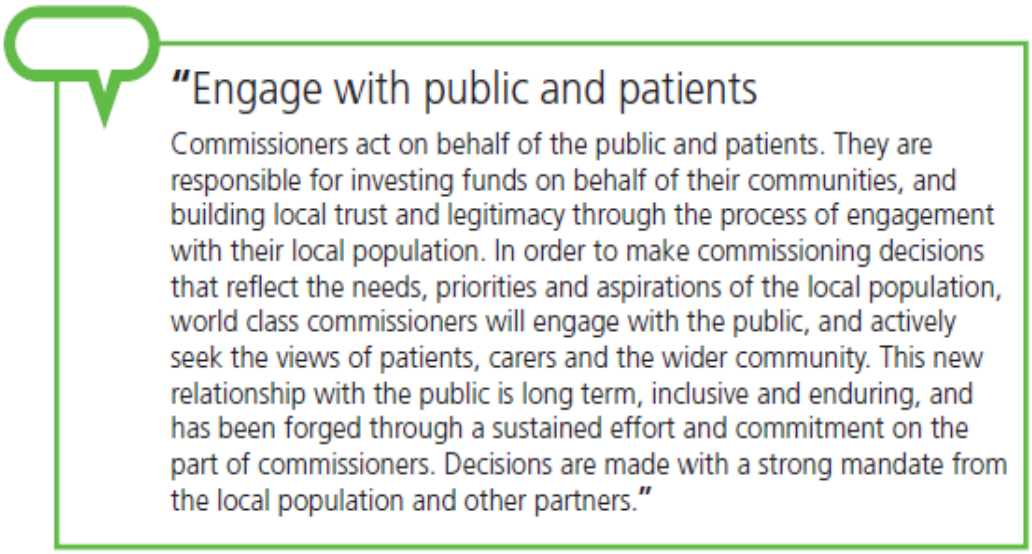
[34] Taylor. J, Tritter. J, and Dimov. M (2007) *Local Involvement Networks – Learning from the Early Adopter Programme – Final Report.* NHS, The National Centre for Involvement (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.8

[35] Department of Health (2008) *Real Involvement – Working with people to improve services* (accessed on www.dh.gov.uk) p.13

[36] Department of Health (2007) *World Class Commissioning: Vision* (accessed on www.dh.gov.uk) p.3

[37] Department of Health (2007) *World Class Commissioning: Vision* (accessed on www.dh.gov.uk) p.4

[38] Department of Health (2008) *Real Involvement – Working with people to improve services* (accessed on www.dh.gov.uk). p.14



The WCC Engagement Cycle (Figure A), considers ways to involve patients and the public in WCC:[39]

- Engaging communities to identify health needs and aspirations;
- Engaging the public in decisions about priorities and strategies;
- Engaging patients in service design and improvement;
- Patient centred procurement and contracting;
- Patient centred monitoring and performance management.

[39] NHS Centre for Involvement (2009) *Guide 19: Local Involvement Networks - Working With LINks.* (www.nhscentreforinvolvement.nhs.uk accessed on 28/9/09) p.7

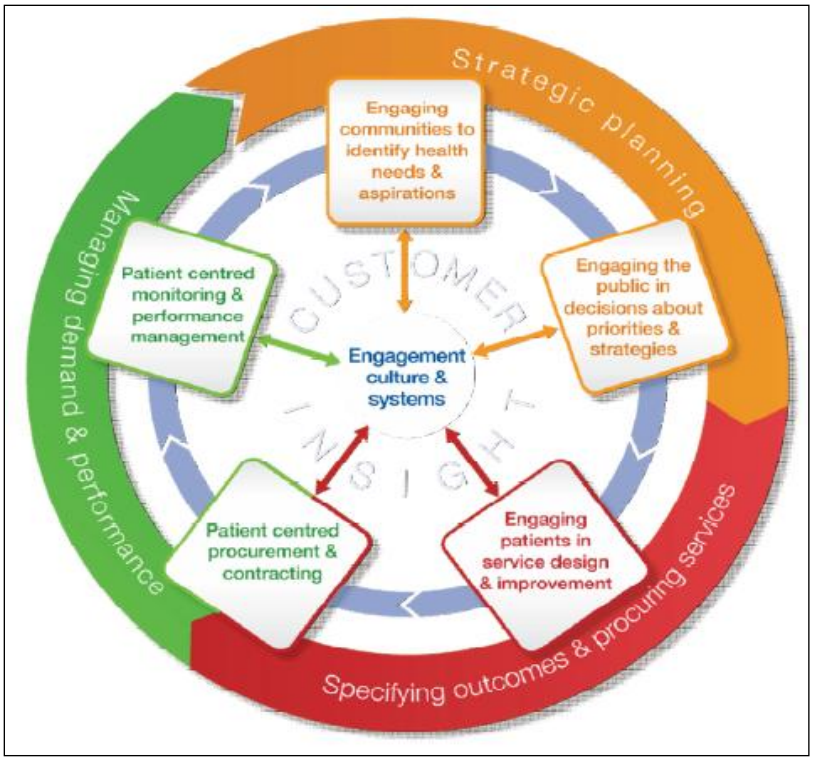


Figure A | WCC Engagement Cycle[40]

A shift to WCC cannot be achieved in isolation, and new and innovative partnerships will need to emerge, to consider the wider determinants of health and the role of other partners in improving the health outcome of their local population:

> *Commissioning Competency Two – work with community partners to commission services that optimise health gains and reductions in health inequalities*[41]

Greater discretion for councils, places 'governing' back with local government: 'not just administering services, but thinking strategically about what people want and need'.[42]

Central to this is the Local Government Public Involvement in Health Act (2007), which introduces a new settlement between central and local government, its partners and citizens.

LSPs and their thematic partnerships will be key in shaping and steering strategic commissioning of local services across their localities, listening to the Joint Strategic Needs

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[40] NHS Centre for Involvement (2009) *Guide 19: Local Involvement Networks - Working With LINks.* (www.nhscentreforinvolvement.nhs.uk accessed on 28/9/09) p.7

[41] Department of Health (2007) *World Class Commissioning: Competencies* (www.dh.gov.uk accessed on 12/10/09) p.8

[42] HM Government (2008) *Creating Strong, Safe and Prosperous Communities – Statutory Guidance* Communities and Local Government, London (www.communities.gov.uk accessed on 12/10/09) p.6

Assessments (JSNA), and turning the visions of the Local Area Agreement and Community Strategy into reality. The partners of the LSP aim to deliver positive outcomes by:[43]

- Cooperation taking place through the LSP framework as part of a continuous process of planned engagement rather than a one-off event;
- Establishing a shared understanding of the totality of recourses that local partners bring to bear with a view to increasing the efficient and effective use of those resources;
- Sharing information and identifying what works and what does not in terms of service provision;
- Exploiting opportunities for the joint strategic commissioning of services, economies of scale, and bringing together different services.

Figure B below cements the approach in a local performance framework, where partners and local people work together to improve wellbeing.[44]

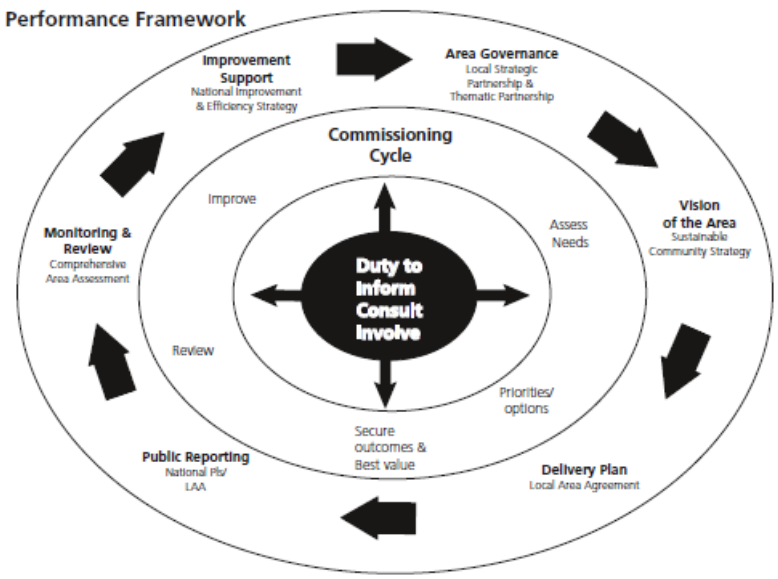


Figure B | Relationship between Community Strategy and statutory local and regional plans[45]

[43] HM Government (2008) *Creating Strong, Safe and Prosperous Communities – Statutory Guidance* Communities and Local Government, London (www.communities.gov.uk accessed on 12/10/09). p.46

[44] HM Government (2008) *Creating Strong, Safe and Prosperous Communities – Statutory Guidance* Communities and Local Government, London (www.communities.gov.uk accessed on 12/10/09). p.14

[45] HM Government (2008) *Creating Strong, Safe and Prosperous Communities – Statutory Guidance* Communities and Local Government, London (www.communities.gov.uk accessed on 12/10/09). p.14

Strengths of LINks

This section highlights some of the important strengths that all LINks possess.

Early Adopter Lessons

The Early Adopter Programme (EAP) ran from January to September 2007, across nine sites, to test out the new model of public involvement in health and social care. The aim of the EAPs was to 'provide valuable learning, in depth insight and evidence… to inform the wider implementation process and support an approach that secures local ownership of, and credibility for, LINks as a robust involvement mechanism'.[46] The experiences across the sites have contributed to a wealth of guidance to support the development of other LINks.

Locally Determined Networks

Since the EAP, there have been a number of publications to support and guide LINks in their development and the choices they make. However, the guidance places a great emphasis on the LINk as a locally determined, and locally owned network, allowing each LINk to be shaped by local communities. LINks will adopt appropriate models based on the local geographical and cultural context, to ensure they meet the engagement and involvement needs of local people and stakeholders. A Local Involvement Network will demonstrate transparency and be accountable to its community, involving them in development and review processes.[47]

Health and Social Care

Unlike previous patient and public involvement within the NHS, LINks have a statutory duty to include social care services as well as the NHS in their work. LINks can follow a typical patient pathway which crosses traditional boundaries. It follows other policy and practice trends, which bring the health and social care sectors together.

The Host

Each LINk has a contracted host organisation, to support and facilitate their development. The role of the host includes the following:[48]

- Undertake the initial set up of the LINk;
- Provide advice and support for the LINk;

[46] Taylor. J, Tritter. J, and Dimov. M (2007) *Local Involvement Networks – Learning from the Early Adopter Programme – Final Report.* NHS, The National Centre for Involvement (www.nhscentreforinvolvement.nhs.uk accessed on 13/8/09) p.9

[47] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.41

[48] Department of Health (2007) *Getting Ready for LINks - Contracting a host organisation for your Local Involvement Network* (www.dh.gov.uk accessed on 28/9/09) p.4-7

- Have a strong commitment to forming strategic partnerships and effective working relationships with other organisations, and support the LINk to develop such partnerships;
- Support the LINk in the development and promotion of its priorities and work plan activities;
- Build on and where necessary, develop local networks to support ongoing sustainable recruitment activity;
- Operate within the agreed performance frameworks laid down in its contract with the local authority.

A Network of Networks

The LINk is a network, a system of interconnected people and groups. Any member of the public, individuals and groups or organisations can be members of a LINk, or participate in LINk activity. LINks will be inclusive and enable involvement from all sections of the local population: 'It is important to remember that LINks are not merely groups of individuals, but are primarily networks that will bring together diverse groups in the area, and representatives of other networks'.[49] A 'network of networks' enables people who may already be active with a particular area or issue, to link into new initiatives, but avoiding a duplication of efforts.[50]

LINk Powers and Partner Duties

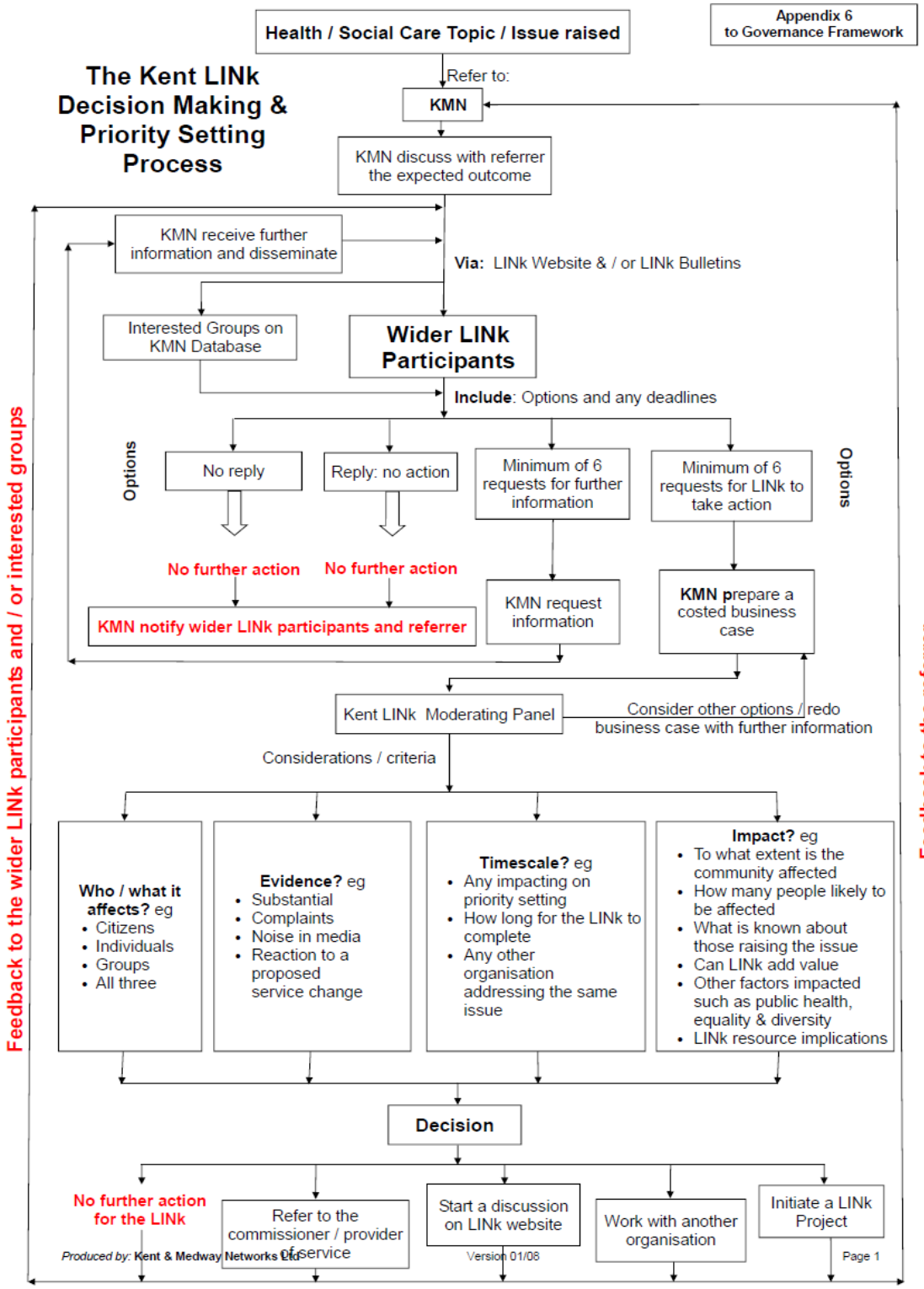
LINks can exercise certain powers within their communities, which are set out in legislation, enabling them to have an impact on local services. One of which is the power to 'enter and view' health and social care service. This empowers LINk participants and provides an insightful method of monitoring the nature and quality of services. The government has introduced duties on certain commissioners and providers of health and social care services to allow authorised representatives of the LINk to enter and view premises to see and hear for themselves how those services are provided.[51] LINks have the power to request information from local health and social care organisations; LINks can produce reports and recommendations for local services and expect a response; and LINks can refer matters to the relevant Overview and Scrutiny Committees (OSC), who must acknowledge this referral within 20 working days.

[49] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.4

[50] Department of Health (2007) *Getting Ready for LINks - Planning Your Local Involvement Network* (www.dh.gov.uk accessed on 13/8/09) p.18

[51] The NHS Centre for Involvement (2008) *Code of Conduct Relating to Local Involvement Networks' visits to enter and view services* (www.nhscentreforinvolvement.nhs.uk accessed on 12/10/09) p.3

APPENDIX 4 | KENT DECISION MAKING AND PRIORITY SETTING



Source: Kent Local Involvement Network (2008) *Appendix 6 to Governance Framework – Decision Making and Priority Setting* (www.thekentlink.co.uk accessed on 4/11/09)

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