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Your Ref:
Our Ref:
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Circular: HSC (SQSD) 29/07

For action:

Chief Executive Designate, HSC Authority
Chief Executives, HSS Boards
Regional Director of Public Health and Care Standards Designate, HSC Authority
Chief Executives, HSC Trusts
- for cascade to relevant staff, including CSCG leads
Chief Executives, Special Agencies
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices.

For information:

Chief Officers, HSC Councils
Directors of Public Health, HSS Boards
Directors of Social Services, Dentistry, Pharmacy, Nursing, Primary Care in HSS Boards and HSC Trusts
Director of Social Care & Children's Services Designate, HSC Authority
Regional Director of Commissioning Designate, HSC Authority
Medical Directors, HSC Trusts
Chief Executive, Regulation & Quality Improvement Authority
NI Children's Commissioner
NI Commissioner for Complaints
Equality Unit, OFMDFM
Professor R Hay, Head of School of Medicine and Dentistry, QUB
Professor James McElnay, Dean of Life and Health Science, QUB
Professor Hugh Mc Kenna, Dean of Life and Health Science, UU
Professor Jean Orr CBE, Head of School of Nursing and Midwifery, QUB
Professor Sean Gorman, Head of School of Pharmacy, QUB
Dr Carol Curran, Head of School of Nursing, UU
Professor Geraldine Macdonald, School of Sociology, Social Policy and Social Work
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Director, Northern Ireland Clinical and Social Care Governance Support Team

Dear Colleague

GUIDANCE ON STRENGTHENING PERSONAL AND PUBLIC INVOLVEMENT IN HEALTH AND SOCIAL CARE

1. INTRODUCTION

- 1.1 This guidance is intended to assist Health and Social Care (HSC) organisations improve the quality and effectiveness of user and public involvement as an integral part of good governance arrangements and to support the development of a more patient and user-centred HSC envisaged by the reform programme.
- 1.2 It does not place new requirements on the HSC, rather it seeks to clarify and standardise good practice in implementing existing policy requirements and statutory responsibilities. As such, the guidance provides explicit, strategic direction about what the Department means and expects of HSC organisations in terms of implementing user and public involvement and seeks to build on what already exists. It sets out principles of good practice and provides a framework of self-evaluation to assist HSC organisations integrate PPI into the organisation's governance arrangements.
- 1.3 Effective service user and public involvement is central to the delivery of safe, high quality services and as such is a key element of clinical and social care governance which provides the framework for quality improvement and assurance of the quality of services commissioned or provided by HSC organisations¹.
- 1.4 Statutory requirements to consult and involve people are already enshrined in Equality² and Disability³ legislation. The proposed new statutory duty of public involvement and consultation in the draft Health and Social Services (Reform) (Northern Ireland) Order 2007 (draft Reform Order⁴) will place a new requirement on all HSC organisations. It is therefore timely for the DHSSPS (the Department) to provide guidance to support HSC organisations to maintain and strengthen the voice of service users and carers in the new arrangements for the commissioning and delivery of services under the Reform of Public Administration (RPA).
- 1.5 This circular provides HSC organisations with guidance to strengthen and improve service user and public involvement in the planning, commissioning, delivery and

¹ The following are the Health and Social Care organisations: -□

- (a) the 4 HSS Boards (and in time, the appropriate regional structure(s));
- (b) HSC Trusts;
- (c) HSC Councils (and in time, the appropriate regional structure(s));
- (d) Family Practitioner Services; and
- (e) Special Agencies.

² Section 75 of the Northern Ireland Act 1998

³ Section 49A of the Disability Discrimination Act 1995 (as amended by the Disability Discrimination (Northern Ireland) Order 2006)

⁴ Now the HSS (Reform) Bill

evaluation of services as part of their clinical and social care governance arrangements. It has been developed in collaboration with service users, carers, local communities and service providers (See Annex 1 for summary of methodology).

This circular should be read in the context of guidance already issued on the implementation of clinical and social care governance ([HSS \(PPM\) 10/2002](#)) and the associated *Quality Standards for Health and Social Care – Supporting Good Governance and Best Practice in the HPSS* (DHSSPS, March 2006) ([the Quality Standards](#)).

It should also be noted that The Health & Social Care Authority Designate is working with a wide range of people, organisations and representative groups to establish a 'Stakeholder Involvement Network' for Northern Ireland. This will include individuals, organisations and groups not directly involved in the provision of health and social care services, but who may represent those who use the service or who make a contribution in fields that impact on broader determinants of Health and Wellbeing, for example the Northern Ireland Housing Executive, District Councils or Department of Social Development.

The network is expected to be formally established in late autumn 2007, and the Department will work with them to ensure there is a consistent and transparent approach to stakeholder involvement at the regional level.

- 1.6 The Department recognises that many HSC organisations already have excellent systems and processes in place and are effectively involving people in plans and decisions about service provision. However, it is also recognised that more can always be done to improve the uniformity of approaches and to enhance the commitment to involve people in the planning, commissioning and delivery of services.
- 1.7 The purpose of this circular is to:
 - strengthen personal and public involvement (PPI) in every HSC organisation;
 - promote greater uniformity and consistency in PPI activity across HSC organisations;
 - improve the quality of the individual's experience of HSC services by involving people in plans and decisions about their own care or treatment and learning from their experiences to improve service delivery;
 - ensure HSC organisations take the public's views into account in the planning, commissioning, delivery and evaluation of services; and
 - support the integration of PPI into individual and organisational clinical and social care governance arrangements within HSC organisations.
- 1.8 This guidance is intended to help HSC organisations improve their current practice of involvement through a process of self-evaluation against principles of good practice. It is for each organisation, together with service users, carers, staff and local communities to determine how best to involve people in the planning, commissioning,

delivery and evaluation of services using the principles set out in this paper as a framework for good practice. The core aim is to strengthen PPI in HSC organisations as a means of improving the quality of services.

- 1.9 This guidance is intended for use by all HSC organisations including policymakers, planners, commissioners, service providers (including primary, community and tertiary care), inspectors and regulators. Therefore, it applies to all HSC staff and requires their commitment to effect change. As such, the guidance should be circulated widely throughout the organisation.
- 1.10 The guidance is not intended to cover relationships between different professions or services within HSC organisations or relationships between HSC organisations and other external health or social care agencies.

2. PERSONAL AND PUBLIC INVOLVEMENT (PPI) – A WORKING DEFINITION

- 2.1 People have a wide variety of relationships with HSC organisations. Most obviously when they are users of these services. They can also be relatives, friends or neighbours of service users. They can be voluntary workers, members of community groups or employees of voluntary organisations. In short, there is already significant involvement by people and the public in relation to HSC services.
- 2.2 There is no consensus on the use of terms or definitions for these people and public. Therefore, for the purpose of this guidance ‘*Personal and Public Involvement*’ is used as an umbrella term to encompass the many different terms in use.
- 2.3 “*Personal*” refers to service users, patients, carers, consumers, customers, relations, advocates or any other term used to describe people who use HSC services as individuals or as part of a group, e.g. a family. “*Personal*” is the preferred term for anyone who uses the service because:
 - there is no consensus among people who use services about how they wish to be described;
 - it is a generic term that is inclusive of persons in receipt of a health service or a social care service;
 - it reflects the personal nature of the care or treatment people receive from our services.
- 2.4 “*Public*” refers to the general population and includes locality, community⁵ and voluntary groups and other collective organisations. Individuals who use health and social care services are also members of the general public.
- 2.5 “*Involvement*” means more than consulting and informing. It includes engagement, active participation and partnership-working. “*Involvement*” is the preferred term

⁵ A community may define itself by geography, by affiliation or by interest, as for example a community affected by a specific disease, disability or chronic condition.

because it is the term used in the proposed new statutory duty of public involvement and consultation in the draft Reform Order.

- 2.6 PPI should be part of everyday working practice, underpinning communications and decisions regarding care or treatment. It should be an integral part of service planning, commissioning and delivery. It means discussing with those who use our services and the public: their ideas, your plans; their experiences, your experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.
- 2.7 Involving individuals, who use your services, in plans and decisions about their specific care or treatment needs is an integral part of PPI. PPI is also about involving local communities or the general population where the issues are of broad public concern or interest, such as, the location or nature of local services. PPI is about empowering people and communities to give them more confidence and more opportunities to influence the planning, commissioning and delivery of services in ways that are relevant and meaningful to them.

3. REFORM AND MODERNISATION OF HSC SERVICES

- 3.1 The reform and modernisation of HSC services under RPA aims to put in place structures which are person-centred and responsive. Structures, where individuals and local communities are actively engaged in their own health and wellbeing and in improving and shaping local services.
- 3.2 The Department’s commitment to strengthening the voice of those who use the services and ensuring the public has a stronger voice in priority setting and decisions is reflected in the proposed new statutory duty of public involvement and consultation in the draft Reform Order. This will require all organisations to embed PPI as part of organisational activity.
- 3.3 This guidance sets out the principles of good practice in PPI which will provide a benchmark of good practice for involvement activity.

4. THE CASE FOR PERSONAL AND PUBLIC INVOLVEMENT

- 4.1 High quality PPI can really change things for people who use services, both in their experience of services and the quality and safety of care. PPI can also increase service responsiveness and accountability to local communities and the wider population by involving them in the debates and decisions about service provision. Staff morale and satisfaction can also improve when staff know they are providing a responsive service that is valued by individuals and appreciated by the wider public.
- 4.2 The reasons for involving individuals who use services are different but complementary to those for involving the wider public in plans about services as set out in the table below.

The case for personal involvement	The case for public involvement
To ensure appropriate care or treatment.	To improve service design.
To improve individual outcomes and	To improve population health and social

improve the patient and user experiences of care.	wellbeing. To determine priorities for commissioning and to ensure access to safe, quality services for people living and working in Northern Ireland based on need, evidence of effectiveness and available resources.
To reduce risk factors, promote health and social wellbeing, prevent disease or harm and encourage self-help/care.	To raise population awareness of risk factors, promote positive health and social wellbeing, and prevent disease or harm. To manage demand.
To improve safety and quality of treatment and care for the individual and their family.	To improve safety and quality of treatment and care at community and population levels. To discuss public expectations and agree how these can best be met, taking account of local and regional needs, the evidence of effectiveness and the availability of resources.
To understand how, when and why care goes wrong, and to ensure an apology and redress are made, where appropriate To reduce complaints and litigation.	To strengthen local decision making and accountability for the safety and quality of services. To promote social inclusion.

5. VALUES AND PRINCIPLES OF PERSONAL AND PUBLIC INVOLVEMENT

5.1 The values and principles of PPI set out below complement the *Quality Standards for Health and Social Care*. “Public and service user involvement” is one of the principles underpinning the Quality Standards and this is reflected in the criteria for all of the standards. The principles of PPI can be used as a benchmark of good practice to assess the quality of involvement activity as specified in the criteria for each of the Quality Standards.

5.2 There are 3 key premises which underpin PPI. They are that:

- people in receipt of services should be actively involved in decisions affecting their lives and should fully contribute to any planning, decisions and feedback about their own care or treatment;
- the wider public has a legitimate entitlement to have opportunities to influence health and social care services policy and priorities;
- PPI is part of everyday practice within HSC organisations and should lead to improvements in an individual’s personal experience of the service and the overall quality and safety of service provision.

6. CORE VALUES

6.1 The quality and effectiveness of PPI is dependent on the values underpinning the interaction and relationships between staff, people who use the services and the public. The following values are recommended as the core values underpinning the behaviour and attitude of HSC staff in their interactions with individuals and the public. These core values can be built upon by the mutual agreement of participants in public involvement activities.

DIGNITY AND RESPECT	Each person is treated with dignity and respect. This includes individual responsibility to respect the views of all participants be they individuals, communities or HSC staff.
INCLUSIVITY, EQUITY AND DIVERSITY	The PPI process should facilitate the inclusion of all those who need to be involved and who chose to do so. It must be sensitive to the needs and abilities of each individual. Each person’s background, culture, language, skills, knowledge and experience will be valued, accommodated and respected.
COLLABORATION AND PARTNERSHIP	The PPI process is based on collaboration and partnership working. Each person has a responsibility to build constructive relationships with others involved in the process.
TRANSPARENCY AND OPENNESS	The PPI process should be open and transparent and each person has a responsibility to be open and honest in their interactions and relationships with others.

7. PRINCIPLES

7.1 The following principles provide a framework that should underpin PPI across HSC organisations. The principles are applicable to the whole of HSC, including those services, which are commissioned or provided by HSC organisations and Family Practitioner Services. These are underpinned by the statutory duty of quality placed on HSS Boards and HSC Trusts in the 2003 Order⁶.

7.2 The 12 principles are set out under three themes reflecting:

- the organisational context – an attitude of mind, a way of working;
- implementation – do what you do, do well; and
- outcomes – making a difference.

An attitude of mind, a way of working

1. Leadership and accountability
2. Part of the job
3. Supporting involvement
4. Everyone's an expert
5. Creating opportunity

Do what you do, do well

6. Clarity of purpose
7. Doing it the right way
8. Information and communication
9. Accessible and responsive

Making a difference

10. Developing understanding and accountability
11. Building capacity
12. Improving safety and quality.

⁶ The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

8. WHAT DO THE PRINCIPLES MEAN?

AN ATTITUDE OF MIND, A WAY OF WORKING

Principle 1: Leadership and accountability

The commitment to PPI will be reflected in the leadership and accountability arrangements in HSC organisations.

The leadership for PPI within organisations will be the key to creating the culture and environment whereby organisations can show they are accountable to the populations they serve.

This requires establishing and maintaining clear lines of responsibility and accountability for the planning, implementation, monitoring and evaluation of PPI activity as part of corporate governance arrangements within the organisation.

Principle 2: Part of the job

PPI is the responsibility of everyone in HSC organisations.

PPI needs to be seen as the job of all involved in HSC organisations, integral and not incidental to their daily work. PPI should be part of staff development and appraisal.

PPI has significant implications for the way staff carry out their roles and responsibilities and their attitudes to the people who use the service. Recognising and seeking to minimise the power differential between those who provide the services and those who use the services is the first step.

PPI requires staff to be confident and competent in engaging with individuals and the public in ways that respect them as active partners with a right to be involved and voice their views about services.

Principle 3: Supporting involvement

Appropriate assistance is required to support and sustain effective PPI.

Successful PPI requires building the capacity of people to get involved as well as building the capacity of staff to involve individuals who use the services and the wider public.

The process of PPI needs to be supported by the organisation with dedicated time and resources to make it happen. Resources may include staff time, training and development and practical or financial support.

This requires PPI to be part of organisational planning and management processes including budgets, workloads and training plans to ensure the organisation's commitment to PPI can be sustained.

Principle 4: Everyone's an expert

Everyone is an expert in their own right, whether by experience, by profession or through training.

The experiences and views of all participants are valid and should be respected.

It should be recognised that people may have different viewpoints. Understanding different, and at times, competing viewpoints and recognising that decision-making is complex and may involve hard choices is part of involvement. Decisions should take account of the views and opinions of individuals, the public and professionals.

This requires information sharing and dialogue between individuals, communities, and those planning, commissioning and delivering services including policy makers.

Principle 5: Creating opportunity

Opportunities should be created to enable people to be involved at the level at which they choose.

PPI can occur at different levels:

- **Personal Level** – being involved in plans, decisions or giving feedback about the individual care or treatment plan for themselves or for someone they are caring for;
- **Commissioning Level** – being involved in the planning and commissioning of services to meet agreed local and/or regional needs;
- **Delivery Level** – being involved in plans, decisions and giving feedback about the ways in which the services are run;
- **Monitoring & Review Level** – being involved in monitoring and review of the quality and effectiveness of services; and
- **Policy Level** – being involved in developing local regional policies

The number of people who volunteer to give substantial amounts of time to PPI will always be limited and as such is a valuable resource. They may not, however, be fully representative of the population profile. Opportunities, therefore, need to be created to enable a wide range of people to be involved who are representative and have a legitimate interest in the work. Opportunities also need to be created to promote engagement with under-represented or unrepresented groups, including those who do not normally get involved or who may find it hard to give their views, for example because of age or ability. PPI needs to be flexible enough to adapt to the needs of those who need to be and wish to be involved. Some people may choose not to be involved and this choice should be respected.

DO WHAT YOU DO, DO WELL

Principle 6: Clarity of purpose

The purpose and expectations of PPI are clearly understood.

Each PPI activity needs to have clear objectives, realistic timeframes and a shared sense of purpose communicated to all participants from the outset. Clear, succinct and understandable information needs to be available at the point of invitation to enable participants to make an informed decision about being involved, to be clear about expectations of involvement and to contribute meaningfully. People's right to confidentiality and/or anonymity should be made explicit from the outset.

The purpose of the PPI activity will inform who should be involved. Decisions about who needs to be involved will depend on what you are asking people to be involved in and why. The aim is to gain the best representative spread of views from those who are affected or may be affected by the service or issue under discussion. Other individuals or groups (or representatives of these) who have a legitimate interest in the work should also be involved.

Decisions about the right time to involve people will depend on the purpose. If people are expected to contribute to planning they need to be involved from the start. However, if the purpose is to consult on proposals for implementation which have already been developed, involvement may come at a later stage. Involvement at an early stage can help prevent misunderstandings or accusations of tokenism at a later stage.

Principle 7: Doing it the right way

Different forms of PPI need to be used to achieve the required outcomes and to meet the needs of the people involved.

No single method or approach can be taken to constitute PPI. There are many different ways and methods of involving people from staff showing respect, listening actively and responding to what people say to more formal and explicit methods such as focus groups, citizen's panels, surveys and community development.

PPI may be a one-off event or a longer term arrangement involving regular dialogue between the organisation and the people involved.

There are a range of targeting methods which can be employed to ensure appropriate representation and a range of voices from self-selection to specific invitation. The choice of method will depend on the earlier decision about who to involve.

Doing it the right way requires practical advice and guidance on the range of methods and approaches including training and development for those responsible for implementing them and learning from good practice both locally and internationally. Partnerships with community groups, voluntary organisation or self-help groups provide an excellent channel to involve a diversity of local voices.

Principle 8: Information and Communication

Timely, accurate, user-friendly information and effective two-way communication are key to the success of PPI activities.

People need timely information to be able to be involved meaningfully; information needs to be presented in ways that can be understood by the target audience; people need to know how to make their views known, including how to make a complaint; and they need to be informed of outcomes and decisions.

This requires appropriate systems and mechanisms to be in place to facilitate ongoing dialogue and information exchange between participants before, during and after the PPI process.

BEFORE

- *The need for advance information which is clear and focused on the purpose and topic for discussion with sufficient background information to support understanding and meaningful involvement.*

DURING

- *The need for participants to feel they are being actively listened to;*

AFTER

- *The need for timely feedback from the involvement activity; and*
- *The need for follow-up communication on the impact of the involvement on decisions.*

Principle 9: Accessible and responsive

The organisation's commitment to PPI will be demonstrated through its recognition of the right of people to initiate engagement with it.

Traditionally, PPI has been shaped around the organisational priorities, rather than the concerns those in a local community identify as important. Organisations need to be prepared to listen to the issues and concerns of individuals, groups or communities.

This requires a more open culture and a willingness to listen to what is important to people.

MAKING A DIFFERENCE

Principle 10: Developing understanding and accountability

People's understanding of HSC services and the reasons for decisions are improved through PPI activity.

Making decisions about service provision can involve hard choices. The PPI process itself will not necessarily lead to a consensus about what should happen. However, the opportunity to register a viewpoint in a transparent and open process and to hear other viewpoints can foster a greater appreciation of the issues and competing perspectives involved and clarify the choices policy makers, commissioners and service providers face.

This in turn can lead to a greater understanding of the reasons for decisions and accountability of the decision-makers to make explicit the reasons for their decisions based on evidence.

Principle 11: Building capacity

People's capacity to get involved is increased and the PPI processes are improved through learning from experience.

The experience and learning from being involved should help build the capacity of individuals, communities and staff to be more confident and effective in engaging with and listening to each other. Being involved should help people to better understand the issues and the business of health and social care and to make an informed contribution.

This requires appropriate mechanisms for reviewing and learning from the involvement process and the outcomes of each PPI activity.

Principle 12: Improving safety and quality

Learning from PPI should lead to improvements in the safety, quality and effectiveness of service provision in HSC organisations.

PPI should support the clinical and social care governance agenda of developing an open culture that promotes and safeguards high standards and improvements in the safety and quality of services delivered to individuals and communities.

This requires a culture of openness, transparency, listening to the views of individuals, communities and staff, learning from feedback, where appropriate learning from an analysis of complaints, sharing information and working in partnership.

Through a partnership approach with people and communities, HSC organisations can improve the safety, quality and effectiveness of services and make them more accountable to the public. The difference PPI makes to the safety and quality of services should be communicated throughout the organisation to share and encourage good practice.

This requires appropriate mechanisms for evaluating the impact of PPI in improving the safety, quality and effectiveness of health and social care services.

9. THE CHALLENGE

- 9.1 PPI needs a genuine commitment from senior managers and all staff to make it happen. This requires developing a culture of openness, respect, listening and a willingness to change within the workplace. Genuine PPI takes time and commitment to achieve. It challenges the way organisations and staff go about their daily work. Developing the right culture is perhaps one of the biggest challenges in ensuring PPI is both meaningful and effective.
- 9.2 The leadership provided within HSC organisations will be the key to creating a culture and environment where PPI is accepted as everyone's responsibility within the organisation.

10. STRENGTHENING PPI - A PROCESS OF SELF-EVALUATION

- 10.1 In order to strengthen PPI, a systematic process of self-evaluation should be adopted. Four basic questions lie at the heart of self-evaluation:

- *How are we doing?*
- *What are our strengths, what do we need to do better?*
- *What action do we need to take to bring about improvement?*
- *How will we know if improvements are being made?*

- 10.2 In the first year, this guidance provides a basis within new HSC Trusts (and other HSC/HSS organisations) to recognise the importance of PPI and to take account of it in their evolving governance work programmes.

- 10.3 Thereafter, from 2008/09 the following steps should be taken by all HSC organisations as part of the self-evaluation process to strengthen and improve PPI.

Step 1: Confirm or establish leadership and accountability arrangements for PPI;

Step 2: Using the principles in this guidance as a framework, review current PPI work to establish the baseline from which improvements can be made;

Step 3: Prioritise the areas for improvement;

Step 4: Develop and implement an action plan with clearly defined targets to strengthen and improve PPI securing agreement and support for this plan across the organisation;

Step 5: Clarify reporting arrangements for PPI as part of organisational management and clinical and social care governance. Arrange for the inclusion of PPI as part of the organisation's annual report on what has been achieved and agree the priorities and targets for the subsequent year.

The following paragraphs set out guidance in relation to each of the 5 steps.

STEP 1: LEADERSHIP AND ACCOUNTABILITY ARRANGEMENTS

The Head⁷ of each organisation is accountable to his/her board for the availability, quality and effectiveness of services.

The Head of each organisation will designate a senior professional at board level to provide leadership in relation to PPI throughout the organisation. He/she will support and encourage good practice and compliance with the 12 principles in this guidance and ensure that where problems are identified, appropriate action is taken.

The senior professional will be expected to put in place mechanisms for ensuring the production of PPI reports (see Step 5 below). The senior professional will look to other key professionals and staff groups to provide support.

STEP 2: REVIEW/BASELINE ASSESSMENT

For those organisations which have already established a policy and PPI systems, a review of current arrangements should be taken in light of this guidance. The review should include a report on the progress made towards complying with the principles set out in this guidance.

For those organisations which do not have a policy or systems for PPI, a baseline assessment should be carried out.

The review/baseline assessment should provide the basis for a strategy and associated action plan to strengthen and improve PPI. Agreement should be reached by the organisation regarding the resources required and available to implement the plan.

STEP 3: PRIORITISE THE AREAS FOR IMPROVEMENT

Decisions will have to be made about priorities for improvement and timescales so there is a realistic and feasible plan to strengthen PPI.

STEP 4: STRATEGIC AND ACTION PLANNING

The strategy should provide a clear vision in respect of improving PPI throughout the organisation. This should be a shared vision which people who use the services, the wider public and staff should contribute to, support and endorse. The strategy should provide the long-term (3 year) plan for PPI work and draw upon and incorporate the findings from the baseline assessment. The strategy should specify how the organisation will provide support and resources for the implementation of the strategy. The PPI strategy should be reflected in the organisation's strategic plan.

The action plan (1 year) will set out short-term priorities and targets to support the achievement of the longer-term strategy. In larger organisations action plans may need to be developed for different parts of the organisation to ensure work can build on existing good practice and strengthen and improve what already exists. This may vary throughout large organisations. The PPI action plan should be reflected in the organisation's annual business plan.

⁷ Head of organisation denotes Chief Executive or equivalent senior officer.

STEP 5: REPORTING ARRANGEMENTS

Organisations will be expected to include an up-date on progress against action plans for PPI in their organisational Annual Reports for 2008-09. Thereafter, they will be expected to devote a specific section in subsequent Annual Reports, giving a full account of their PPI work related to clinical and social care governance, what has been achieved and what is planned for subsequent years.

In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine updates to their board on progress and outcomes from PPI work in the organisation.

PPI reports should answer 3 broad sets of questions.

- *What have we done?* – overview of PPI activities with feedback and learning from the process.
- *What difference has it made?* – feedback from people and communities who have been involved and learning about the outcomes in terms of people’s experiences of care and decisions about safety, quality and delivery of services.
- *What do we need to do next?* – action planning for following year.

11. MONITORING PERFORMANCE

11.1 Monitoring of PPI will take several forms.

- (a) **Internal monitoring.** Each organisation should monitor the impact of PPI work through their clinical and social care governance arrangements with routine updates to their board and the inclusion of PPI in their Annual Report.
- (b) **External monitoring.** The 4 Boards (and in time the appropriate regional structure(s)) will monitor PPI activity for all HSC commissioning and provider organisations. The Department through its accountability arrangements through the 4 Boards (and in time through the appropriate regional structure(s)) will monitor the impact of PPI work.
- (c) **Independent monitoring.** The Regulation and Quality Improvement Authority (RQIA) will monitor PPI as part of its review of clinical and social care governance arrangements. The principles contained in this guidance will contribute to the framework for PPI monitoring /or a thematic review of the specific requirements for public and service user involvement as outlined in the Quality Standards. The principles set out here are seen to complement those set out in the Quality Standards.

12. FURTHER GUIDANCE

This circular will be supplemented by further guidance as necessary.

Yours sincerely

A handwritten signature in black ink that reads "Maura Briscoe". The signature is written in a cursive style with a large initial 'M'.

DR MAURA BRISCOE
Safety, Quality & Standards Directorate

GUIDANCE ON STRENGTHENING PERSONAL AND PUBLIC INVOLVEMENT

SUMMARY OF DEVELOPMENT PROCESS

This work was commissioned by the Clinical and Social Care Governance Sub-Group.

The process of developing the guidance and associated values and principles was managed by a small project team, chaired by Christine Smyth (Office of Social Services, DHSSPS). Membership included a service user and representation from Medicine, Nursing, Pharmacy, Performance Management, HSS Council and the NI Clinical and Social Care Governance Support Team.

Following two planning meetings, an inclusive and reiterative process of involvement was agreed and implemented. This involved a variety of involvement activities and methodologies including:

- (i) Departmental Board endorsement for work;
- (ii) focus groups with expert users and carers, and HSC staff involved in PPI activities;
- (iii) engagement with relevant Department Directorates in policy trawl and quality assurance;
- (iv) individual meetings with experts and key stakeholders including David Sissling;
- (v) a regional workshop of service users, carers and other key stakeholders organised by the HSS Councils to inform the development of the values and principles;
- (vi) redrafted principles were circulated to all regional workshop participants following the above event for further comment;
- (vii) an independent evaluation of the draft values and principles with participants involved in a Departmental public consultation activity;
- (viii) values and principles were redrafted in light of recommendations from the independent evaluation and circulated to all those who had contributed for further comment;
- (ix) a 'virtual' quality assurance process involving key shake holders and all those who were involved in the development of the values and principles and final draft of guidance;
- (x) final draft presented for endorsement by Departmental Board.

PERSONAL AND PUBLIC INVOLVEMENT DEVELOPMENT PROCESS

