Information, Insight and Interaction:

An engagement strategy for a 21st century health and social care service

Final report – March 2009

The brief

Tim Kelsey and Hilary Rowell were commissioned by Hugh Taylor, Permanent Secretary, Mark Britnell, Director General of Commissioning and System Management, and Richard Gleave, Director of Patient Experience and Planning, to provide input to the direction of the Department's plans around:

- Supporting PCTs to meet competency 3 of World Class Commissioning.
- Refocusing the strategic role and structure of the Department's PPE division.
- Providing insight on communication and engagement with the public using digital technologies.

Competency 3 states that World Class Commissioners should: "Proactively seek and build continuous and meaningful engagement with the public and patients to shape services and improve health."

The primary focus of this piece of work has been to explore the views of local NHS leaders on these issues. Fifty interviews have taken place with SHA and PCT leaders, as well as interviews with ministers, senior officials and other key stakeholders locally and nationally. Workshops have also been held to shape the direction and test the findings with relevant DH officials.

Who we are

Tim Kelsey established Dr Foster in 2000 and is Chair of the Executive Board of Dr Foster Intelligence, the joint venture between Dr Foster and the Information Centre for health and social care. His commitment to improving the use of information to galvanise service improvement in health and social care is reflected in the range of Dr Foster's work, including the annual publication of the Hospital Guide and client relationships with three quarters of NHS trusts and around half of all PCTs. He was responsible for designing, launching and overseeing the NHS Choices service in its first 18 months of operation. He was awarded 'Outstanding Contribution in Healthcare 2008' by Health Investor magazine. In 2007, he received the annual award for Innovation by Laing and Buisson. He is a trustee of the Nuffield Trust and the 2020 Public Services Trust.

Hilary Rowell is an independent consultant specialising in health policy and strategy. As head of strategy for Dr Foster, she was responsible for the influential Intelligent Board series as well as a series of thought leadership papers on commissioning and personalisation. As head of strategic development for NHS Choices, she developed the vision for NHS Choices as the digital wing of the NHS (published April 2008) and oversaw a programme of multichannel development projects with PCTs. Her consultancy clients have included a number of regulatory bodies and third sector organisations. She is a trustee of Turning Point.

Contents

Executive summary

- Our contention is that the quickest and most effective route towards an NHS with which patients and the public actively want to engage is the offer of personalised information and interactive services. Other important issues need to be addressed, but we believe this offer is central to the achievement of world class engagement.

- A radical improvement in the availability, quality and use of basic local information about health and social care is a precondition for this.

- It also requires a 21st century digital NHS, capable of creating personalised information and interactive services and reaching a mass audience in a cost-effective way.

- There has been a sea change in the local NHS's commitment to public engagement as a business fundamental. This, together with the arrival of the NHS Constitution and the frameworks offered by World Class Commissioning and High Quality Care For All, offers an unprecedented transformational opportunity.

- The appetite to deliver this transformation exists in the local NHS, but capacity and skills are limited. There is an acknowledged need for action at national level to support local solutions.

- PCTs need to position themselves as commissioners of information for their communities. They should, as a minimum, be required to provide detailed, accurate and timely information about local health and social care services – and demonstrate that this is disseminated in ways that help patients and the public to navigate the system. This is no small task.

- A national digital services agency should be established. Its role would be to stimulate the local generation of authoritative high quality digital content, information and services in health and social care, through setting minimum standards and facilitating access to support services.

- The proposed agency would also take responsibility for managing and developing an integrated national multichannel platform giving access to: a national choice information service, powered in large part by local content; and locally developed interactive services that have proved successful at local level.

Illustrating the information challenge

Comments from Hartlepool residents, Connected Care Audit 2006, Turning Point et al:

"You need to know what is on offer and how to get it."

"My parents needed help and information to cope with my drug use. But none of us have got a clue where to get it." DRUG USER

"People will get information from many different sources. You need to be able to get the information wherever you are." PARENT OF CHILDREN WITH LEARNING DISABILITIES

"A single point of access for advice and guidance."

"There should be an NHS directory where you can phone them up and tell them your needs and they will provide you with advice on where to go." CARER

"It is no longer acceptable that service providers tell us what they can deliver. It's up to them to deliver services that we need at a time and location that fits our needs."

1. A radical vision

People power is the engine of sustainable quality in health and social care

The 21st century demands nothing less than a reinvention of the relationships between the local NHS and all the local communities, partner organisations and individuals that it serves – a real shift towards harnessing patient and citizen power by enabling and promoting choice and personalisation. The impact of the quality agenda, inspired by the Darzi review, will not be sustained unless the people who use and pay for the NHS are also enabled to exert their power to take control of their own health and care and to drive service transformation. The NHS must also harness the power of its own people, supporting and developing staff and clinicians to play their central role in making this reinvention of relationships happen.

Information, insight and interaction are the keys to engaging people and enabling them to exert their power to shape services and improve health

Information, insight and interaction are the cornerstones of choice, patient power and the achievement of Wanless's fully engaged scenario. Our central proposition is that the key to revolutionising the relationships between the local NHS and local communities and individuals lies in the creation of sustainable, inclusive networks of engagement. This, we believe, should be at the forefront of tackling the multifaceted challenge of public engagement as defined by competency 3 – not the whole answer but an important

and achievable starting point. The demand is for a move away from formalised or mandated structures towards locally relevant and locally determined networks connected by high quality information. These are transactional networks: the local NHS offers something people really want in return for their ongoing engagement with its plans.

The best, most useful incentive the NHS can offer to citizens is the development of first-class personalised information resources that can be used with confidence to determine how and when they can access services, alongside quality information on health improvement and self-care. The reason for this is to empower people to make informed choices about their health and wellbeing and about the health and social care services they need. These will reflect the reality of the 21st century patient, carer or service user who wants to be seen as a 'valued customer' not a 'grateful recipient'. We believe that such moves will spearhead other necessary changes, particularly in terms of the skills and culture within the NHS.

This is not an NHS-specific vision: the NHS will work with its partners to meet people's information needs and create feedback loops so as to hear what people have to say about those services. It will back this up with sophisticated customer insight, and have the skills to balance conflicts between evidence, insight and feedback.

The 21st century NHS: the world's finest digital public service

Digital technology offers the means to maximise the reach of information, insight and interaction in a continuous and cost-effective way, one that is consistent with the way people live their lives today. Providers and commissioners will exploit the potential of digital technology to personalise information and care, inspiring and enabling people to exert their power to drive sustained improvement in services.

This vision does not require everyone to have access to a computer, nor to have advanced technical skills. Digitised information and digital infrastructures provide the core foundation for the local NHS to employ a range of channels for two-way communication with local people, not only through web, phone and other digital channels but also through key 'intermediaries' such as frontline health workers, pharmacies, libraries and other community-based services.

2. A unique transformational opportunity

This is a pivot point. World Class Commissioning, the Next Stage Review, the NHS Constitution and Choice have created the conditions for a unique transformational opportunity in 2009 – the development of a new engagement strategy in public services: NHS 2.0.

"This is a completely new challenge – there is no analogy for it." SHA INTERVIEW

Nationally and internationally there are no real precedents for this ambition – the creation of sustainable and inclusive dialogue with users and non-users in order to drive service transformation. This is the moment at which the NHS has to learn how to listen and engage. Successful execution of such a concept would be a model for other public services. For many NHS organisations it presents a huge challenge, but it can be done.

"We will only crack this thing (Choice) if we persuade people to be active and informed consumers of healthcare." MINISTER

Transformation does not require 'one big leap'; it will be achieved through a number of gradual but significant steps towards the vision. This report makes recommendations as to these initial steps, with a particular focus on what needs to happen at national level (as required by our brief). Our conclusion is that the centre needs both to provide leadership and to reorient itself towards supporting, empowering and serving the local NHS. We have tested these recommendations with a range of key players and are confident that the ground is fertile for progress to be made.

3. Supporting local action

The main thrust of this work has been to explore with local NHS leaders their perspectives on the challenges of public engagement, and the need for action to support and enable excellence. We have undertaken 50 chief executive and director interviews in six SHAs and 16 PCTs, as well as senior figures in the Department, national bodies and the private sector. Our thinking has also been shaped and tested through two workshops with relevant Department officials.

We found:

- A significant and positive shift towards a customer-focused mindset among commissioners and awareness of the fundamental importance of engaging their whole community of patients and the public.
- Many admit that, while there is a renewed understanding of this as a priority, they do not necessarily have clear and coherent strategies for tackling it yet. Customer insight and engagement efforts are often felt to be one-off and limited in their reach – not yet sustained or systematic in driving service transformation.
- A recognition of the potential value of digital tools and infrastructure, but many PCTs feel that their access to the vision, skills and capacity to realise that potential is currently limited.
- Almost every PCT acknowledged the need for some direct support and there was enthusiasm for co-producing solutions.

"The game has changed – information and knowledge management are the core required to enable effective local engagement and leadership." PCT CHIEF EXECUTIVE

Informing and engaging the public is rapidly becoming the central job of PCTs, the foundation for becoming World Class Commissioners – and PCT leaders are telling us that they are increasingly aware of this as a business necessity, as well as what could be called a moral imperative. The business necessity is to gain the insight and evidence base to ensure that health and care services respond effectively to need. The moral imperative is to connect with people in a way that demonstrates the accountability of the local NHS for the decisions it makes and the public money it spends. The language is also changing – PCTs are thinking of local people as customers, members, owners, 'insured souls' – and this in turn is influencing their approach to public engagement. They are looking for this kind of thinking to inform and transform the traditional concepts underpinning PPI and PPE.

"We now need to see equipping the public with information as fundamental to commissioning and to bridging the gap between health and social care – not just a 'nice to have' extra." COMMENT IN DH WORKSHOP

In essence, PCTs tend to feel they are quite good at 'pushing' out information across their communities through an increasing variety of channels but struggle to 'pull' enough people in to new kinds of relationships that are as active, inclusive and continuous as competency 3 demands – and, most importantly, which are 'productive' in terms of increasing understanding and influencing commissioning decisions.

"We are doing a lot of good engagement work, but I'm not sure I can put my hand on my heart and say that it is truly systematic or embedded." PCT CHIEF EXECUTIVE

There is strong evidence of often extensive and creative engagement activity designed to address particular needs – social marketing initiatives to address key public health priorities, market research to inform joint strategic needs assessments, consultation mechanisms to support service reconfigurations – but what is not clear is that this activity is taking place within a coherent and strategic framework. SHAs and PCTs do see a role for national leadership and innovation to support and give direction to their efforts – indeed, in some cases, they are concerned that local success in engagement depends explicitly on more active national support. However, they do not want prescribed solutions nor do they want local creativity to be controlled.

"Some of our PCTs think they are doing lots of engagement and that they will score level 3 on competency 3. They won't." SHA INTERVIEW

There is an acknowledged need to build capacity and skills among staff and clinicians. Developing or acquiring improved marketing and engagement skills is a priority, and

many PCTs are also reorganising to strengthen and reorient teams concerned with public health, communications and engagement and to bring them closer to the commissioning function. PCTs also feel they have a way to go to become truly intelligent clients for external providers of engagement services. At a wider level, they are concerned to ensure that staff and clinicians embrace their own role in transforming the way the NHS engages with the public and patients – not only embedding a customer care culture but empowering them to listen and respond to people's views and enable people to influence and, where appropriate, co-create services.

"NHS staff are our most powerful and credible channel for engaging people." MINISTER

On a similar theme, PCTs are also thinking about how to build the capacity for engagement within the local community. The identified challenge is to reach out to all sections of the community and ensure that people are supported and informed enough to engage productively. Most are working hard to make existing structures work, but some are pursuing interesting initiatives – from exploring community development approaches through to offering training and qualifications to people as an incentive to get involved and exert real influence.

The following give a flavour of people's comments – a fuller summary is provided in Appendix 1 and a list of interviewees and workshop participants in Appendix 2:

- "Our PCTs see the future but they don't have the capacity to deliver it."
- "We are the headquarters of the local NHS – working for you and with you."
- "We have 20 people working on engagement. They are well intentioned. But we scored 1 on competency 3."
- "We still need to bring together our public health, commissioning and engagement teams."
- "We are only scratching the surface – this is where national help can come in."
- "I went to a LINks meeting last week and all the usual suspects were there. We are ticking the box as we are required to do, but LINks are not the answer."
- "Some boost to our ambition and existing plans would be welcome."
- "This is a perfect opportunity to show co-production and subsidiarity."
- "No PCT is proud of its website. You can't rely on all 150 PCTs to consistently deliver a high end online service."

4. The new narrative: high quality personalised information and care

A new narrative is required – one that illustrates for commissioners how population-wide engagement is the essential foundation for service transformation and local accountability, and highlights the role of customer insight and personalised information services as key drivers and enablers. This narrative needs to resonate with clinical staff

and stimulate them to improve the delivery of healthcare. It also needs to make sense to the public, engaging them on issues that matter to them rather than those which the NHS sees as strategically important.

"People cannot choose their commissioners – but what would they be looking for if they could? That's what we should be aiming for." DH INTERVIEW

Position PCTs as information hubs, networked into the local community

According to our proposed new narrative – and reflecting the requirements of the NHS Constitution – PCTs will see themselves as commissioners of information as much as commissioners of services. They will deliver useful personalised information services to people, enabling choice and motivating them to close the loop by giving their feedback. Using multiple channels, PCTs will create self-sustaining networks by enabling people to see that the local NHS uses the information they give to make real decisions. At present, in many if not most PCTs, sufficiently detailed, accurate, timely and reliable information about services is simply neither currently available nor easy to access.

PCTs will not work alone on this. They will need to create or tap in to other information resources and form local partnerships, especially NHS, independent sector and third sector providers, local authorities and local strategic partnerships. It is particularly important that engagement and the sharing of information does not become an area of dispute between PCTs and providers. The emphasis should be on the availability of local primary and community services, ideally covering social care services too – not just information to support choice of elective care. This aspiration resonated with the PCTs we spoke to, but they recognised the resourcing challenge it would present. They were also clear that this is not a task that can or should be 'nationalised'.

"Information is powerful – it can not only empower people to make choices but is also a health service in its own right." DH INTERVIEW

Explicitly link engagement, powered by customer insight, information and interaction, with service transformation

Engagement will not be an end in itself. Engagement will be driven by sophisticated customer insight, underpinned by proper segmentation of local communities and understanding of the places and ways in which people prefer to give and receive information. It will enable proactive and targeted provision of relevant information services and opportunities to interact. Engagement will drive service transformation at every level – from specific experience feedback that informs service improvement to opportunities to inform service redesign to wider conversations that shape commissioning strategies.

Mean that PCTs are held to account for the reputation of the local NHS

PCTs will position themselves as the local headquarters of the NHS, and shape their engagement strategies accordingly. PCTs will take responsibility for narrowing the apparent distance

between people's experiences of local NHS care and their perceptions of the local NHS as a whole. Again, this is a demanding task but one which many PCTs are keen to embrace.

"We take responsibility for building local relationships with local people." PCT CHIEF EXECUTIVE

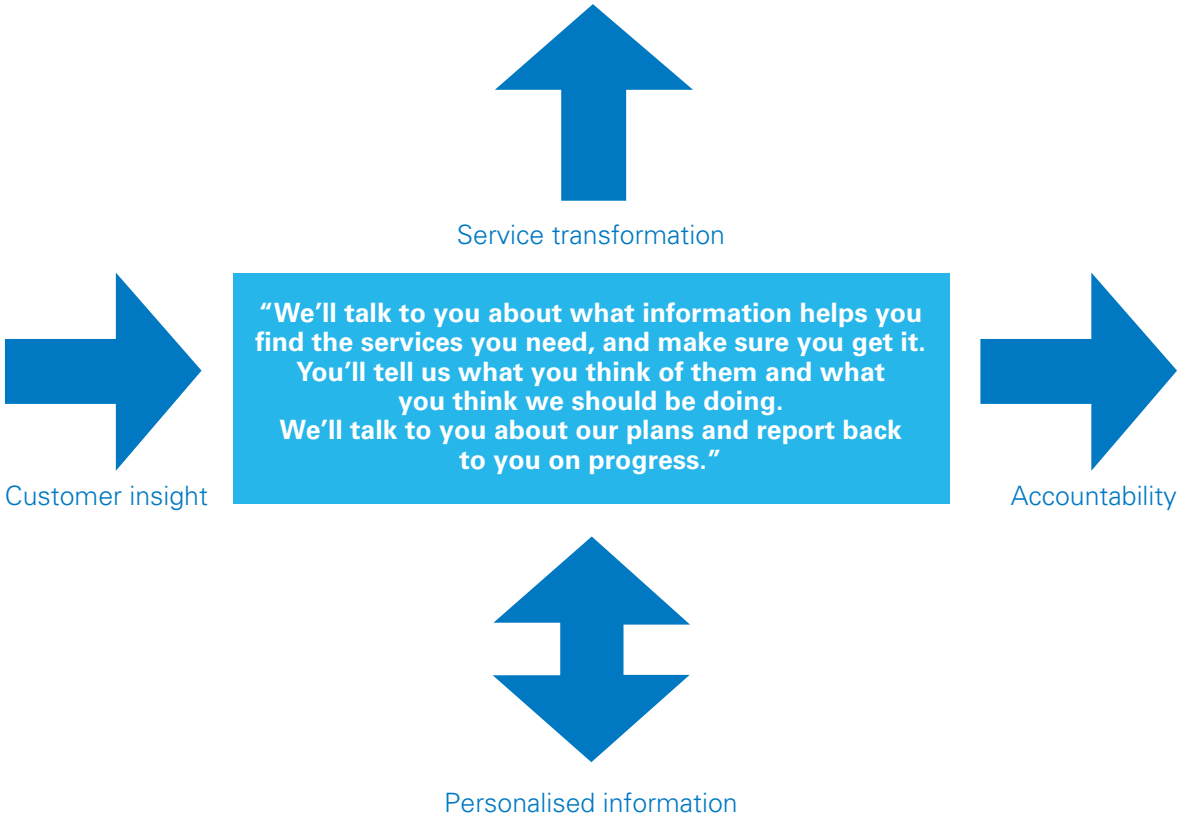
A new engagement narrative: the first step

The graphic below sets out the key elements of the new narrative. At its centre is the concept of this simple public statement from PCTs to local individuals and communities. It is simple and specific but nonetheless powerful. Delivering on this statement would, we believe, represent a significant but achievable first step towards the radical vision described earlier. It would also give prominence and reality to the new duties placed on PCTs within the NHS Constitution.

"What we need is a simple public statement – the PCT's commitment to local people." DH WORKSHOP

By taking action to deliver on this commitment, PCTs will:

- Harness their powers of customer insight.
- Not only deliver personalised information but receive it too.
- Use this insight and personalised information to drive service transformation – from setting strategic priorities down to service redesign and co-design.
- Demonstrate how they have used this insight and information, along with other evidence, to deliver improved health and healthcare.



5. What does the Department need to do?

Consensus emerged as to the key national tasks:

A. Define what world class looks like.
B. Decide how to hold the NHS to account.
C. Promote Choice and the NHS Constitution – boldly and at scale.
D. Create a digital services agency that is accountable to the local NHS.

There is also a common view that the Department should stop doing some things, especially prescribing formal structures at local level and (for some) mandating national patient surveys.

"We don't yet have a shared vision of what world class engagement looks – and feels – like." PCT INTERVIEW

A. Define what world class looks like

A key task for the Department is to develop a clearer and more coherent picture, with the NHS, of what world class engagement looks like, and to place it more clearly within the context of service transformation. This should include, as a starting point:

- The vision, the key elements of which are proposed at the start of this paper.
- The narrative for PCTs. Again the key elements are proposed above, building on the new duties placed on PCTs under the NHS Constitution. One of the key challenges is to bring coherence to the varied types and purposes of engagement into a coherent whole.
- Reviewing the criteria for competency 3 to describe in clear, practical terms what counts as world class at each level.
- Defining core roles at every level of the NHS.

"The legitimate role for the Department is to set the policy, define the minimum requirements and tell us how much leeway there is." SHA INTERVIEW

The picture of what world class looks like will need to be developed and constantly refreshed in partnership with the local NHS. We propose a series of 'co-production projects' later in this report.

B. Decide how to hold the NHS to account

Building on its work to 'define what world class looks like', the Department also needs to set out the arrangements for holding the NHS to account for world class engagement. This needs to be considered at a number of levels:

- How the public hold PCTs to account for listening and explaining how they have acted on feedback – especially in the absence of people being able to choose their commissioner.
- How SHAs hold PCTs to account through the assurance and performance management regimes.
- How the Department holds SHAs to account, and whether there is a role for metrics in relation to engagement. (More than one interviewee argued that the focus should be on overall health and healthcare outcomes, rather than attempting to measure engagement per se.)
- How all this dovetails with the role of CQC.

"The truth is that significant progress won't be made until we are held to account for this – at the moment, it doesn't figure in my performance appraisals (unless a media storm breaks out)." SHA CHIEF EXECUTIVE

What is clear is that PCTs' performance in the provision of useful and used information for patients and the public should be built into the World Class Commissioning assurance process, led by the SHAs. SHAs should also embed this into their own assurance frameworks for system management. Feedback from PCTs suggests there is room for reviewing the criteria underpinning competency 3 and providing more detail to guide them. In addition, future panels should include people with specific expertise in information and engagement so as to provide greater challenge.

C. Promote Choice and the NHS Constitution – boldly and at scale

There is felt to be an important role for the centre in actively promoting key national messages to the public in general, setting the national strategic context (or "shaping social mores" as one put it) and leaving the way clear for the local NHS both to respond to local challenges and to tailor and target messages to local communities. There was a general view that the Department should specifically do more to promote concepts of choice through national marketing. It was felt that the public was not sufficiently aware of choice, particularly in long-term conditions, and often perceive choice as a threat to local services rather than an empowering opportunity. A shift in focus towards personalisation was felt to be important. There is a view that this can only be achieved through sustained above-the-line promotion to the general population. This should be allied with an ongoing campaign to promote the NHS Constitution and what people should expect of their local NHS, especially given the new duties placed on PCTs to provide information to enable choice.

"The Department can really help us by pushing out generic national messages more strongly, especially about choice and what people can and should expect from the NHS. Our job is then to tailor those messages locally and respond to people's expectations."
PCT CHIEF EXECUTIVE

D. Create a digital services agency that is accountable to the local NHS

We recommend that the Department takes bold action to create an integrated digital services agency. We immediately want to acknowledge that alarm bells may ring for some at what sounds like a 'national solution'. We also want to be clear that we intend quite the opposite. Its success will be judged by the extent to which it promotes and supports, rather than constrains, local creativity and initiative.

The primary role of such an agency would be to stimulate the local generation of authoritative high quality digital content, information and services in health and social care, through setting minimum standards and requirements and facilitating access to support services. It would also take responsibility for managing and developing an integrated national multichannel platform for delivering information and interactive services to the public.

The collective aim for this agency and the wider NHS must be to ensure that people have access to – and are supported to use – an authoritative, relevant and rich suite of information resources along with opportunities for personalised and interactive services through their preferred channel. This is key to the achievement of world class engagement.

"The Department has a leadership responsibility here – it cannot take a passive role."
DH INTERVIEW

The case for national initiative here is clear-cut:

- The market is currently deficient. The challenge of achieving world class engagement for the NHS is unique. Solutions from other countries, other sectors and other public services are potentially useful but they are also partial. We do not believe there are any other services where the requirement is: to be inclusive across the whole population from cradle to grave; to find ways of engaging people who are in a number of possibly simultaneous roles – as customers, beneficiaries, co-producers and 'shareholders'; and to engage them on issues as core to life as health and wellbeing. What this means is that there are no full-service off-the-shelf solutions on which to draw – they need to be cultivated and created. In other words, there is a need to make the market for engagement support and services, digital and otherwise. Moreover, many PCTs do not yet represent a sophisticated client for such services and there is a need to provide 'intelligent client support'.

"In the private sector, the purpose of increasingly sophisticated segmentation systems is not only to understand and target specific demographics, but to exclude them too. The NHS cannot exclude any group in society. We need different solutions to Tesco."
DH WORKSHOP

- Choice is a national issue. Effective choice (and voice) demands an infrastructure and information to enable comparison between health and care services across local health economies. There is therefore a core of public information to support and enable choice which needs to be nationally organised. This includes, as a minimum, standardised comparative performance information and clinically approved information on health, wellbeing, conditions and treatments (as several interviewees pointed out, there is no need or justification for 150 answers to the questions 'what is diabetes?' or 'what is cognitive behavioural therapy and when is it appropriate?'). Currently, NHS Choices is responsible for compiling this information, from sources including the Information Centre for health and social care and what will be NHS Evidence.

"We do need a national choice machine to drive choice and access." SHA INTERVIEW

- Consensus on the need for a national multichannel 'front door' to the NHS, both because this is more cost-effective than myriad regional 'shop windows' but also to simplify and facilitate access for people. Currently, there are a number of front doors, including NHS Choices, NHS Direct, HealthSpace and Choose & Book.

"NHS Choices is great but we haven't made enough of it within the NHS." DH INTERVIEW

The digital services agency we propose would have the following functions:

- Creating an integrated NHS consumer information portal.
- Using its digital platform to give wider access to locally developed content and interactive services.
- Providing support services to the local NHS.

Creating an integrated NHS consumer information portal

People need easy access to authoritative and relevant information that helps them to make decisions about how they live and the services they need. The agency should integrate the existing web and phone portals to create a national multichannel 'front door' to this information. It will compile and present the core set of national information described above – but local content will provide the real engine for this 'national choice machine'. PCTs should, as a minimum, be required to supply accurate and timely information about available local health services, and work with partners to supply information on social care services.

"Of course we need a piece of national infrastructure – a recognised, credible portal the public understand is the NHS channel." SHA INTERVIEW

Using its digital platform to give wider access to locally developed content and interactive services

The proposed digital services agency would use its multichannel platform to deliver a

wide range of digital information and services to the public. This national multichannel platform cannot and should not have a monopoly on the creation of digital or NHS 2.0 services. The promise of digital media is one of individual and local initiative, and this must be maximised. As one SHA pointed out: "This is the time for fast experimentation, with local NHS leaders in 'hothouse' dialogue with software designers and local NHS 2.0 enthusiasts. Better for the centre to offer an open platform onto which large numbers of digital/NHS 2.0 services can be placed, once they have proved to be valuable to customers and communities at a local level." The range of digital services should extend not only to information but also to transactional services (such as appointment booking or test results) and clinically approved therapeutic services.

This approach preserves the freedom of SHAs and PCTs to innovate in the creation of digital services, while creating a mechanism for showcasing and sharing successful services. It also implies that the agency should have a role in 'talent spotting', scouring the NHS (and elsewhere) for proven innovations, and setting standards for migration to the national platform (an NHS 2.0 kitemark perhaps). It might also be empowered to intervene to protect the integrity of the NHS brand if a local service is significantly below standard.

Providing support services to the local NHS

The proposed agency should provide support in the following three areas.

Minimum standards and requirements

It should play a role in defining minimum standards and requirements for the local NHS, whether advising the Department or setting them in its own right. These should include:

- Minimum standards for the quality and nature of information that needs to be compiled locally (such as accurate, detailed and up-to-date information on the availability of services, in particular).
- A requirement for PCTs to have effective mechanisms in place (without prescribing those mechanisms) for supporting and enabling people to access and use that information to navigate the system.
- Minimum standards for the quality and utility of digital services, wherever they are developed.

"The system needs to be really local, but credibility, information and standards have to come nationally to be trusted." SHA INTERVIEW

Making the market for services to support the NHS in achieving world class engagement

PCTs would value access to services which help them to procure appropriate support for public engagement and support to become intelligent clients. At the least, this would entail approved supplier lists or an enhanced FESC focusing on this area.

However, it is also recognised that there are currently few off-the-shelf solutions to the particular challenges of inclusive engagement faced by the NHS. The proposed agency should play a role in making this market and in facilitating access to advisory and support services for local PCTs and their SHAs (including procurement frameworks) so as to improve the quality of information and to optimise their use of digital services to achieve world class engagement.

"I want to buy not make. There is a role for someone at the centre to signpost us to relevant or approved sources of support and expertise." PCT CHIEF EXECUTIVE

Direct support

The agency should be in a position to offer direct support services to the local NHS on a client basis. In some cases, individual SHAs will be able to provide such support to their PCTs and, as the market develops, sources of external support will become increasingly available and fit for purpose. Where neither are available, the NHS should be able to commission services to support the development of information and interactive services directly from the agency.

Issues and implications

Exploring the options and feasibility of creating the proposed agency demands more detailed work than is possible within the scope of this project. Our recommendation is based on ideas that emerged from several interviews – particularly relating to the perceived fragmentation of existing national digital initiatives – which included a fairly strong view that any such agency should be managed at arm's length from the Department.

In creating the proposed integrated support service, it is also important to emphasise the range of functions proposed. Any such service would not (only) be a technology provider, it would be a multimedia engagement service to support World Class Commissioning – a centre of excellence delivering valued services both at national and local level. Beyond a core of national public-facing services, its success would be measured by its ability to respond to the needs of the local NHS in achieving world class engagement and to stimulate the generation of excellent local digital content and services. Some health economies are further ahead on the digital agenda (such as the North West and West Midlands) – a national infrastructure would not seek to restrain such initiative but to ensure it is supported.

"The opportunity exists for health to be the first public service to create a bespoke digital engagement agency." SENIOR OFFICIAL

In considering options for organisational form, the Department should address the following principles:

- Coherence – the core elements of the digital infrastructure and information described above currently reside in a number of organisations and projects, and are governed through a variety of different channels, reporting into the Department through different routes and at different levels. In considering the creation of a digital services agency, the following should be considered: NHS Choices, NHS Direct, HealthSpace, Choose & Book, elements of NHS Evidence and the public-facing information functions of the Information Centre.
- Accountability – while there is agreement on the need for national infrastructure and services, it is also clear that there is (to a large extent) unrealised potential for them to deliver important and relevant services to the local NHS to support engagement. This would demand a radical reorientation of the current services towards a client relationship with the local NHS. Neither NHS Choices nor NHS Direct are currently seen as being configured to support the NHS in this way. Future delivery should be organised on the principle that they are, in some degree, responsive and accountable to the local NHS.
- Local ownership of local content – we believe the principle that the local NHS should own its relationships with local people is a strong one. Detailed and up-to-date information on available services can only be generated and maintained at local level and through local partnerships – and feedback from patients and the public must be channelled locally for a local response. Work is required to draw the boundaries and describe the routines that will facilitate appropriate integration of national and local information.

"National doesn't have to mean the Department." DH INTERVIEW

A number of other 'conundrums' were raised with us, which demand some comment:

- Transformational Government – this cross-government agenda clearly provides important context and drivers for the work on the digital strategy. It aims to put a stop to the proliferation of websites and channels set up from the centre. The proposals made in this piece of work are consistent with that aim – in essence, promoting a more coherent national infrastructure which should support and facilitate locally responsive engagement solutions. From a local point of view, it is important that Transformational Government is not interpreted in a way which unnecessarily restricts their options for engaging local people.
- Health AND social care – greater integration between health and social care is becoming and must become a reality at local level. What we found was that each PCT is seeking local solutions in local partnerships. It appears that there is often more anxiety about this at the centre than there is in the field – there is certainly little appetite for new or different structures or governance to be imposed.

- Branding – we have regarded branding as largely out of the scope of this piece of work, although there will be issues to be addressed if our recommendations are taken forward, largely at national level. There may also be issues to explore further around the freedom available to the local NHS around branding in relation to their local engagement initiatives.

6. Co-production now: inspiring an engagement revolution in the local NHS

Alongside work to create the proposed digital services agency, we believe the Department should move quickly to work with SHAs on initiating a series of 'co-production projects' with groups of PCTs. These exemplars should inform the national tasks described above but do not, in our view, need to wait for them to be completed. There is considerable enthusiasm among those we interviewed to participate in such projects.

We recommend four groups of projects.

A. Engagement driving commissioning: the NHS 2.0 Prospectus, making a reality of the Constitution

There is an opportunity to radically redefine the concept of the PCT Prospectus as a core engagement tool in the context of the new duties placed on PCTs in the Constitution. The concept needs to be reinvented around the information needs of the local population – and, crucially, as a tool for building sustainable local networks. An NHS 2.0 PCT Prospectus would be continuously available and updated, providing people with far richer and deeper information and directories of available services.

This entails NHS Choices and NHS Direct working directly with PCTs (as their clients) to create:

- Comprehensive, detailed and constantly updated interactive catalogues of local services (especially primary, community and social care), with feedback loops on those services. One obvious place to start, given the introduction of information prescriptions and the patients' prospectus, would be services for people with long-term conditions and self-carers.
- Opportunities and incentives for service providers to add and update their own service profiles.
- Interactive 'neighbourhood health profiles' which explain and illustrate the health challenges that exist in neighbourhoods, invite comment and opinion, and allow the PCT to explain how they are addressing those challenges and discuss commissioning options and decisions.

- This service being available online and through a variety of other channels (eg by phone and through community-based workers).

While the seeds of this concept already exist, none come close to the truly revolutionary opportunity to move them from fairly pedestrian sources of information towards active networks that close the feedback loop and sustain world class engagement.

While PCTs would use the profiles to publish strategic plans and annual reports, the defining feature would be that they permit a continuous public conversation. As several PCT chief executives observed to us, opening themselves up to hold transparent and honest conversations about priorities, which include 'saying no and this is why', is both necessary and challenging. Exposing the evidence that underpins decisions and allowing people to see comments and responses, the profiles could play an important role here.

This kind of resource will become essential as personal budgets are rolled out. The emphasis, in the first instance at least, should be on information about the services available, more than on performance information. These projects will also help to clarify the distinction between national and local responsibilities for information. They will also provide impetus to the task for PCTs of establishing how to respond, and demonstrate their response, to local feedback.

B. Experience driving commissioning: patient feedback and public insight

Momentum has already been put behind the goal of ensuring that providers gather patient experience feedback as a matter of routine. The opportunity here is to work with commissioners on three key challenges:

- Demonstrating how they will use patient experience feedback to drive commissioning decisions – including looking at how they access feedback gathered by providers and the extent to which they should gather experience feedback directly.
- Developing ways of enabling people to use patient experience feedback to compare services across regions, thus supporting choice.
- Looking at options to extend the concept of routine patient feedback to gather broader insights from the public about the NHS both in pimary care settings and beyond – and assessing the value of doing so.

C. Capacity building for world class engagement: standards and incentives

NHS staff are a powerful resource for public engagement, both as members of the public themselves and frontline representatives of the NHS. Clinicians in particular have a crucial role to play in enabling patients to become participants in their care rather than recipients. This project would explore how to build commitment and capacity among staff and clinicians – from equipping them to be informal ambassadors through to formal leadership development.

One specific area worth exploring is NHS Apprenticeships. In order to meet the aspirations of rich local information described in this report, many PCTs will need to build up their capacity for collecting and managing directories of local services. The NHS Apprenticeship scheme could provide the ideal route for creating this workforce and establishing standards of professional competence.

The second area for capacity building is within the community itself. The task is to develop and test incentives for people to engage with the NHS, and how those incentives can be supported through training and qualifications. A number of PCTs have in place or are exploring innovative approaches to community-led commissioning which actively and directly engage ordinary people (eg community researchers trained by Turning Point in a number of PCTs to engage locally and support commissioning). Others are considering NVQs or other 'something for the CV' options to draw people in to working with the PCT.

The outputs from these projects would be a framework and good practice guidance on building capacity among staff and local communities.

D. Locally determined exemplars driven by local priorities

Many SHAs and PCTs are already advancing the engagement agenda and exploring particular challenges and innovations. This programme should include space for supporting (and shaping) some of these under a national banner, enabling learning to be shared more widely. Some of the issues these might cover include the following:

- The role of digital technology in directly delivering healthcare services.
- Bringing together customer insight and segmentation services with call centre and web capability to support personalisation of information and care.
- Online/phone occupational health services for employers, as a means of engaging with the employed population.
- Targeted networks, eg schools/children (Healthy Schools).
- Exploring information and engagement in partnership with local authorities.

Tim Kelsey
Hilary Rowell

March 2009

Appendix 1: Summary of findings from interviews with NHS leaders

Fifty interviews have been carried out with chief executives and key directors in 16 PCTs and eight SHAs, as well as a number of senior officials and national stakeholders, through December 2008 and February 2009. It is notable that these leaders were generous with their time and keen to contribute their thoughts. Most interviews were face to face with a number being held by telephone. Two workshops were also held with Department officials. A full list of contributors is attached in Appendix 2.

The SHA perspective

The SHAs we spoke to were unanimous in identifying competency 3 as one where they were seeing significant underperformance among their PCTs. They were concerned at some PCTs scoring themselves highly, without necessarily demonstrating a real grasp of the step change demanded by competency 3. Others clearly do recognise the need for change but are limited in their ability to deliver that change.

Without necessarily claiming to have the answers themselves, they observed deficiencies in:

- The vision for world class engagement.
- Both awareness and availability of the tools and infrastructure required.
- Skills and capacity.

While some SHAs are clear that PCT development is very clearly their territory – not the Department's – the scale of the challenge specifically in relation to competency 3 means there is a degree of openness to national action. There is recognition, in particular, that choice is a national matter and that it is a job for the Department to ensure the availability of standardised comparative performance information to enable choice as well as clinically approved information about conditions and treatments (as a minimum). One interviewee described this as the "national choice machine"; another emphasised the need for a "common library for patients".

A significant shift in PCT mindset

Over the past 12 to 18 months, there is strong evidence that the mindsets and aspirations of PCTs have changed, in large part driven by the ambitions of World Class Commissioning.

"Under the old rules, we were quite good at public engagement. However, the game has now changed." PCT CHIEF EXECUTIVE

Another was clear about the centrality of public engagement to the 21st century PCT and the underpinning necessity of sophisticated knowledge management – "knowledge and

information are the core required to enable effective local engagement and leadership". PCTs are increasingly approaching the public as their customers, and beginning to establish their own profile as the "local headquarters of the NHS". Some are thinking of themselves as insurers – "I feel privileged to be responsible for buying and providing services for the insured souls of this parish" – and therefore responsible for managing risk across the entire population, whether active customers (patients) or inactive (public), and for demonstrating that the PCT is doing a good job on their behalf. As a consequence, PCTs are fiercely protective of their local space – "there must be local ownership of relationships with local people".

Another described the PCT's role as advocacy for the local community. We found that such PCTs are not afraid to stimulate people's expectations of the NHS. However, they are not always confident of their abilities to achieve population-wide engagement and sufficiently deep understanding of needs.

"We spend £330m of your money, you deserve better." PCT CHIEF EXECUTIVE

A long way from the aspirations of competency 3

Most PCTs describe engagement efforts that tend towards the one-off and are limited in their reach – insufficiently strategic, sustained or systematic in terms of driving commissioning.

Every PCT was able to cite a range of positive and often creative examples of engagement activity, typically relating to: the development of strategic plans; major consultations around service reconfigurations, such as the introduction of GP-led health centres; Facebook; segmented focus groups; surveys; and the use of citizens' panels and locality partnership boards, for example, often in partnership with the local authority. Social marketing campaigns focusing on particular public health priorities are also well-established.

However, most acknowledged that:

- Too much of their engagement effort is focused around specific events or issues.
- Questions of reach and cost-effectiveness are on their minds.
- They tend to be better at 'pushing' information out than creating ongoing feedback loops – and convincing people that "they can influence the system".
- There is a big challenge to embed such feedback into decision-making processes, and to manage the tension between 'evidence' and 'popular views' in making key decisions.

"We are doing a lot of good engagement work, but I'm not sure I can put my hand on my heart and say that it is truly systematic or embedded." PCT CHIEF EXECUTIVE

The challenge is to create a more systematic and sustainable approach to engaging individuals and communities, reaching "real people not just the usual suspects" (some local LINks came in for particular criticism in this regard), getting beyond series of market research exercises, and finding more cost-effective ways of doing so.

Other issues frequently cited by PCTs include:

- How best to achieve a join-up with local authorities in the face of conflicting timetables and requirements, often driven by national and regional processes.
- How best to manage the conflicts between expressed local views and needs, on the one hand, and nationally or regionally set priorities.

A helpful note of caution was made by one interviewee – to paraphrase: "We may now be talking the right language and describing the right aspirations, but that doesn't mean it will happen!"

Lack of a common coherent narrative driving engagement

There is emerging recognition that delivering service change and transformation, as well as improved health and wellbeing, will be founded on strong and sustained relationships across local communities. Information, in terms of customer insight, securing feedback and disseminating information to the public, is seen as key but there is a lack of coherence, sophistication and ambition in the various ways that PCTs are approaching the challenge.

Some see public engagement within the context of choice – as one put it, "persuading people to be more choosy". A few paint a more ambitious overarching picture of personalisation and service transformation. In one PCT, this is described in terms of individual risk profiling and proactive targeted health promotion, as well as individual case management from diagnosis through to treatment and aftercare (essentially a US-insurer model). Founded on sophisticated information and knowledge management, and supported by an expert nurse-led call centre service, the vision is that this kind of personalised information and care will deliver both improved outcomes and an engaged population. Others may not have such a developed vision, but share the view that maximising access to services and 'trading' useful and relevant information with patients is in large part the answer.

"How do I get my population to agree that my spending priorities are the right ones?"

PCT CHIEF EXECUTIVE

Others remain more concerned with the role of engagement in demonstrating accountability – the challenge of demonstrating that the PCT's decisions are founded on a proper understanding of local needs and preferences, and that people have an early stake in decisions on spending priorities. Many PCTs feel they fall short of the

challenge of engaging people in "rich" discussions of local priorities and plans – and then demonstrating how those conversations have had an impact on decisions and outcomes. There is concern in some quarters about their ability to manage the tensions that can arise from inviting opinion – on the one hand, "we can't and shouldn't always do what the public tell us they want"; on the other hand, "given people can't choose their commissioner, how do they hold us to account if we don't adequately listen to their views?"

Most agree that there are plenty of opportunities to engage the 'sick' – and they need to better exploit those opportunities – but the real challenge is to engage the 'well' who only occasionally come into contact with the NHS.

There are differing degrees of confidence as to the scope for getting and keeping people engaged. For a few, they feel they have made significant strides forward through a variety of channels and created an appetite and expectation of involvement within their local communities – their challenge is capitalising on and sustaining that level of interest. At the other end of the spectrum, there are some who are sceptical as to the scope for really engaging many of those who are not regular users of NHS services.

Many have experimented successfully with using cash or shopping voucher incentives for people to attend events or roadshows – and in the process uncovered unexpected levels of interest. Other popular draws include offering blood pressure or cholesterol testing. In general, they are looking for ways to move beyond one-off cash incentives for participation to more transactional (and therefore sustainable and cost-effective) relationships.

"Once I have information that is relevant to me and my health interest then I will start getting interested in being more involved in commissioning." PATIENT REPRESENTATIVE

A number of PCTs have started or are considering membership schemes, including exploring the option of linking up with a local FT scheme. As an example, one of these is on target for 1 per cent of the population by April 2009. The thinking about how to 'use' members is, however, at an early stage. Others dismiss membership, arguing that "our starting point must be that every member of the local community is already a member of the PCT". No one felt that membership or other such structures should be mandated.

"Different mechanisms will work in different places." PCT CHIEF EXECUTIVE

We had some interesting discussions about the role for GPs in public engagement. While recognising the crucial frontline role of GPs, and the importance of supporting them in that role, PCTs also noted that GPs are just one of many channels. They noted that there can be divergence between the interests of GPs and those of the wider health economy (GP campaigns against GP-led health centres often cited here) and that, in

a multi-provider environment, GPs are no longer the sole front door to the NHS. The challenge is to ensure that GPs, often among the most IT literate of groups within the NHS, feel assisted and supported by digital technologies in meeting the needs of their populations, not undermined.

Finally, we found that PCTs are also exploring innovative ways of engaging people actively and directly in more detailed commissioning work, ie community-led commissioning. The idea of offering training and 'something for the CV' is being tested as a way of drawing people in to such relationships. For example, Turning Point's connected care service works in a number of localities to identify, recruit and train community researchers to map local services, audit local needs, and then work with the PCT and local authority to design services. The 'pull' factor here is the opportunity to play a community leadership role and to acquire qualifications – in Bolton, some 30 community researchers are currently active and working with the PCT and local authority. We came across a similar principle in Oxfordshire, where efforts to engage people in service reconfiguration have floundered and they are exploring the potential to develop NVQ or similar qualifications to help draw people in. In Southampton, the appointment of community liaison staff has reaped rewards.

PCTs as information commissioners

The role of two-way exchanges of information in drawing people into more engaged relationships with the local NHS is key. The idea of PCTs as commissioners of information for individuals and local communities resonated with many. There is scope for developing better information services to create the kind of transactions that can 'pull' people in to more engaged relationships. As one chief executive emphasised, the task is to be opportunistic, to 'grab' people at every point where they come into contact with the NHS – or to create such opportunities. Thinking about how to approach this task varies:

- Creating call centres to provide information on services (eg NHS dentists), or book appointments (Choose & Book) or services (eg patient transport).
- Working more closely with local authorities, who have more routine and regular contacts with people and "because we are all fishing in the same pool", or put another way, "we need one 'database' for the place not one for each agency".
- Focusing on the places where the 'well' who only occasionally use the NHS are to be found (GPs, A&E, Maternity).
- "People are fascinated by their own health, yet the last place they come to is the NHS – our goal is to position NHS xxxxx as the local health brand."
- Starting where people are, eg creating Facebook entries.
- Community development approaches, such as investing in community liaison officers.
- More generally, focusing on staff both as 'members' in their own right and as conduits for soft intelligence from customers.

"You have to invite people to offer up their information on their own terms."

PCT CHIEF EXECUTIVE

Interviewees suggested various important aspects of transactional information services:

- A detailed and interactive catalogue of local services – with the option (and encouragement) to provide feedback on those services.
- Comparative information on the quality of local services, especially other people's feedback.
- Personalised information, risk assessment tools – especially to appeal to the 'browsers'.
- A one stop shop on health and healthcare (and social care, ideally) delivered through a combination of web, phone and face-to-face channels. One PCT is, for example, already looking at introducing a single 'in hours' local NHS number.
- The ability to make transactions not just get information online.

National (or regional) infrastructure support is welcome, not least to facilitate access through a single front door, but the local NHS must take control of local content. The resource implications of this may be reasonably substantial, though requiring providers to maintain up-to-date information as a condition of contract would play a part.

Patchy awareness of digital opportunities

While some health economies are moving further ahead on the digital agenda (eg West Midlands, North West), more generally, there is limited awareness or understanding of digital technologies and the opportunities they offer – both to enable personalised interaction and to achieve widespread engagement cost-effectively. There is increasing interest in using digital channels, in part through recognition of the opportunity to create networks and reach far larger numbers of the community – but many feel they lack the competence to drive such initiatives.

It is also recognised that there are real economies of scale to be found in relation to establishing or supporting an infrastructure to enable greater use of digital or interactive media. Our interviews confirmed that NHS Choices has yet to register as a resource for PCTs. The need for NHS Choices as a national choice portal is not disputed, providing consistent sets of comparative data on services and quality-assured content on conditions and treatments. However, the common view is that NHS Choices does not yet have sufficient buy-in within the NHS and is not set up to deliver real value for PCTs, for example:

- Allowing PCTs to take control of their own local content within sets of standard templates or designs.
- Providing highly segmented sites or networks, tailored to the needs of particular demographic groups – again with the facility for the local NHS to add locally specific content.

There is little if any awareness of HealthSpace. However, it is clear that there is interest in the engagement value of some of the functionality that HealthSpace is intended to allow. Indeed there are instances of local initiatives which are effectively bypassing HealthSpace. In other cases, PCTs feel constrained from making things happen by the existence of national initiatives. For example, one PCT had to suspend work on an interactive personal health risk assessment tool because the Department is piloting LifeCheck, yet she is still waiting for the national one to emerge.

A number are in the process of redesigning their websites, and some examples of web and phone plans are given above. Several also highlighted that they felt that some of the least engaged are in the 18 to 25 and 25 to 45 brackets (especially men) and that online channels could be better used to reach them. Linking up with schools, where all children have online access, and also employers, is also seen as a priority. Of course, digital channels would not replace the need for more targeted and face-to-face efforts to reach particular communities.

In relation to NHS Direct, PCTs again see a set of skills located there which they would like to be able to harness to support local priorities, eg: "Could NHS Direct help me deliver individual case management services? They have the skills and infrastructure but I don't think they are set up to help me." NHS Direct is also perceived to be expensive and some PCTs have or are planning to set up their own call centres.

In short, there is both recognition of the value of national digital services, but also a view that there should be a way of harnessing those skills to deliver support services directly to the local NHS on a client basis.

Competence and capacity is limited

In almost every case, PCTs are 'capacity building' and reorganising themselves to become more customer-focused organisations. Typically, they are in the process of bringing together teams which have hitherto been in distinct silos and aligning them with the commissioning task, eg engagement, communications, social marketing. Traditional approaches to PPI and PPE are seen as "well-intentioned but not connected with strategic agenda". Another commented on the need to "forge a new path between the soft-edged PPE crowd and the hard-edged comms people".

"The competence and capacity required to become world class on competency 3 is some way where from where we are now – and I think that is true across most PCTs."

PCT CHIEF EXECUTIVE

Examples of key gaps include:

- Customer insight skills and resources, in particular to undertake more sophisticated segmentation and risk profiling of populations.

- The ability to consistently deliver high quality online/digital resources and services (some more confident and active than others).

More generally, PCTs are also looking at ways of empowering their own staff to play their own part in the patient and public engagement challenge. This entails both cultural change and new skills.

Enthusiasm for co-producing solutions

There is unsurprising scepticism about centrally led initiatives – on the one hand as being too slow and getting bogged down in the pursuit of perfection, and on the other hand, sometimes generating such a volume of ideas and initiatives that it is hard to keep up.

Transforming public engagement is seen as an ideal co-production opportunity – as one chief executive commented: "We will be working on this anyway but there would be value in doing it under a national banner." There is a significant appetite to work collaboratively with other PCTs and providers, and to work with the Department to create exemplars of 'world class engagement'. There was also a plea for any national support to need to earn its keep in some degree according to how well used it is by the local NHS.

"I don't want to be developed but some boosters to our ambitions and existing plans would be welcome." PCT CHIEF EXECUTIVE

Other comments on roles for the Department

Information issues

There are a couple of issues which PCTs feel present an obstacle to advancing their engagement plans, and which can only be resolved through national channels:

- Those with more developed ambitions around population segmentation and personalisation have been frustrated in their attempts to access the Exeter data, which one described as "my membership database but I'm not allowed to access it". It would also be of great value if it included fields that routinely request mobile numbers and email addresses.
- Clarifying and simplifying the rules around confidentiality and consent to use personal data to support their public engagement efforts – some feel caught between the two conflicting pressures of personalisation and information governance.

Knowledge repository

In principle, people feel the Department ought to be well-placed to act as a hub for best practice, new techniques and customer insight. However, the SHAs in particular argue that these are areas now firmly within their remit – and that the SHAs need to figure out how to collaborate with each other to deliver on it.

Stop doing some things

There was a plea from several to:

- Stop prescribing structures, but require PCTs to put in place locally appropriate and effective mechanisms.
- Stop or scale down annual patient surveys, which were described as of little or no use and poorly executed.

Appendix 2: List of interviews conducted

The following gave their time to meet with us or were interviewed by phone. Their views have been invaluable in informing our thinking.

PCTs

Kevin Barton, Chief Executive, Lambeth PCT
Sophia Christie, Chief Executive, Birmingham East and North PCT
Sheena Cumiskey, Chief Executive, and Mike Barker, Director of Corporate Affairs and Partnership Strategy, Trafford PCT
Bob Deans, Chief Executive, Southampton City PCT
Jeremy Gardner, Head of Communications, Tower Hamlets PCT
Sally Gorham, Chief Executive, Waltham Forest PCT
Leigh Griffin, Chief Executive, Sefton PCT
Stephen Jones, Chief Executive, Coventry PCT
Christopher Long, Chief Executive, Hull PCT
John Parkes, Chief Executive, Northants Teaching PCT
Joe Rafferty, Chief Executive, Central Lancashire PCT
Tim Riley, Chief Executive, Tameside and Glossop PCT
Mike Scott, Chief Executive, Westminster PCT
Dr Kevin Snee, Chief Executive, Devon PCT
Ian Tipney, Chief Executive, and Jan Hull, Deputy Chief Executive and Director of Strategic Health Development and Partnerships, Somerset PCT
Rob Whiteman, Chief Executive, Barking and Dagenham Council

SHAs

John Bewick, Director of Strategic Development, NHS South West
Sir Ian Carruthers, Chief Executive, NHS South West
Jane Cummings, Director of Nursing, Performance and Quality, NHS North West
Jim Easton, Chief Executive, NHS South Central

Margaret Edwards, Chief Executive, NHS Yorkshire and Humberside
Mike Farrar, Chief Executive, NHS North West
Neil McKay, Chief Executive, NHS East of England
Karl Milner, Communications Director, NHS Yorkshire and Humberside
Andrew Millward, Communications Director, NHS South West
Candy Morris, Chief Executive, NHS South East Coast
Peter Spilsbury, Director of Strategy and Regulation, and Steve Coneys,
Director of Communications and Public Affairs, NHS West Midlands
Stephen Webb, Director of Communications, NHS London
Lee Whitehead, Director of Communications, NHS East of England

National bodies and others

Lord Victor Adebowale, Chief Executive, Turning Point
Dr Alf Collins, Clinical lead, Health Foundation's Co-Creating Health Programme
John Coulthard, Director of Healthcare, Microsoft UK
Dr Jennifer Dixon, Director, Nuffield Trust
Mark Duman, Patient Information Forum
David Stout, PCT Network Lead, NHS Confederation
Tim Straughan, Chief Executive, Information Centre for health and social care
Matt Tee, Permanent Secretary, Government Communications, and former Chief
Executive, NHS Direct
Baroness Young of Old Scone, Shadow Chair of Care Quality Commission

Department of Health

David Behan, Director General of Social Care
Gary Belfield, Director of Commissioning
Ben Bradshaw MP, Minister of State for Health Services
Mark Britnell, Director General of Commissioning and System Management
Christine Connelly, Chief Information Officer for Health
Prof. The Lord Darzi of Denham KBE, Parliamentary Under Secretary of State (Lords)
Sian Jarvis, Director General of Communications
Prof. Sir Bruce Keogh, NHS Medical Director
Jo Lenaghan, Chief Advisor to David Nicholson
David Nicholson, Chief Executive, NHS
Jo Revill, Strategic Communications Advisor
Bob Ricketts, Director of System Management and New Enterprise
Hugh Taylor CB, Permanent Secretary

The following also participated in workshops to support this project:

Gary Ashby, Programme Director, NHS Choices
Bob Gann, Head of Strategy, NHS Choices
Chris Heffer, Head of Customer Insight and Deputy Director, Strategy Unit
Ronnette Lucraft, Commercial Director, NHS Direct
Rachel Neaman, Deputy Director, Corporate Communications
Bernard Quinn, Head of Strategy and Planning, NHS Direct
Graham Reid, Information for Choice, Project Manager
Joan Saddler, National Director of Patient and Public Affairs
Mary Simpson, Acting Deputy Director Market Research,
Patient and Public Empowerment

Richard Gleave, Director of Patient Experience and Planning, has worked closely with us throughout this project.