Career focus

Developing skills in consulting with the public

Have we forgotten somebody? Diana Jakubowska and Paul Crossley discuss sharpening your skills to take decision making into the public arena

The issue of involving the public in healthcare decision making has a complex history. Debates have raged about challenges to professional judgment and the weighting given to public views.¹ Questions of whom to consult and when can be equally perplexing.

There are clear expectations that each layer of the NHS will seek the views of the public on the services it provides. A number of documents explain the rationale behind involving the public and the applicability of different methods.²⁻⁴ What has not been explored is the role that medical practitioners must play in this exercise given their background, knowledge, and professional experience, and what sort of skills might be needed.

What the papers say

The relaunch of the Patient Partnership Strategy earlier this year with its announcement of £2.5m being earmarked for research into public involvement methods has signalled the government's intentions. This is not about political sensitivity but an acknowledgement that the quality of services can be improved by gaining the experience of patients. Every PCG member will need skills in involving the public.⁵ NHS professionals will need to know how to participate in such exercises and how to understand the processes adopted. But underpinning this is the need for a change in attitude. As the NHS accepts the reality that it is only part of the health equation so it will not be enough to assume that doctors have the sum total of knowledge where a patient's treatment is concerned. Other parties such as the voluntary sector, carers, and users of the service have valuable roles to play and expertise to bring.⁶

The skills that are needed in such situations are those that emphasise cooperation and finding shared solutions, and willingness to overcome defensiveness. There will be a need to step back and discover the range of con-

Questions to ask before beginning

- What do we want to find out?
- Who do we need to talk to?
- How much time have we got?
- Can we change things if we do consult?
- Is everyone included?
- Have we got a good plan? Does everyone have a copy?
- Is the plan written in plain English?
- Which methods will we use? Are they suitable?
- What resources can we put into this?

cerns that different people have. Group skills rather than those of the consulting room come to the fore. The doctor is likely to be one player in such a scene, and perhaps not the star turn.⁷ But it may not be easy: "GPs are professional autonomous healthcare workers who are assertive about their clinical freedom and in consequence 'have a tendency to resist change.'"⁸

What's in it for you

The gains for doctors are a more realistic sense by all parties of how care is best delivered; what works and what doesn't and who else is giving support. Recognising the validity of others' knowledge and contribution can give you a perspective that takes in the whole patient experience. Involving the public implicitly recognises that medical expertise cannot provide all the answers in all situations. Learning about the range of relevant groups in your

community can be valuable and stimulating. Work by Neve and Taylor shows the advantages that GPs can gain from working alongside those in community development.⁹ The gain in personal skills, understanding group dynamics and shaping new services is vital for the new NHS.

The important skills for public consultation reflect the necessity for new attitudes, and include time management, project planning, the use of plain English, media skills, and public relations awareness. The skills of running a group—providing context, listening, questioning, facilitation, building consensus, suspending judgment, sharing the agenda, and knowing your audience—are all useful. A perspective that recognises the whole patient experience is essential.

It may also be helpful to unlearn some skills and attitudes: speaking in jargon, using scientific and medical language, assum-

ing that expert knowledge can answer every problem, and automatic presumptions that the doctor should be in control can be counterproductive. Instead, behave as an equal member of the group, and recognise the validity of others' knowledge and contribution.

Consultation is resource intensive. There is no quick and dirty option, or at least not a meaningful one. Time is essential in order to work with people, to amend the process, and assess the agenda for discussion in light of others' issues. Consultation documents should be prepared without jargon and science; facts and figures should be presented in a non-technical way. And you will have to attend and run meetings, workshops, and forums with many different groups. Media training would also come in very useful.

In many consultation exercises we have come to realise that people understand the constraints within the system well; they do not expect change overnight, or even at all. One significant benefit of consultation is the fact that people, patients, users, need to be heard properly and seriously. Process is important, as is the need to have the patient's experience recognised. It is worth remembering from the outset that the rapid cycle of decision making within the NHS often runs counter to its desire to involve the public in its work.

Consultation may be a waste of everyone's time. It certainly will be if the process is ill defined, inadequately planned, or poorly targeted. Avoid tokenism: if a decision has already been made then it is not consultation; rather an exercise in giving information. Rushed public involvement destroys goodwill and public credibility; people need sufficient time to grasp the issues and be able to make a positive contribution. But consultation that poses real choices will invite public involvement.

Your local population makes up lots of different publics; there

A case study

One of our consultations on the future of adult mental health services in Cambridge resulted in consultants, community psychiatric nurses, managers, members of the community health council, and users and their families returning to the same issue again and again over two years. The process had been planned to take six months. We could not reach agreement and therefore no valid decision could be taken. The mental health groups worked together and created a coherent view that drew on the views of mental health users and carers across the community. The result was a new type of service, which was welcomed by providers and users alike. A key player in this process was a consultant in public health who was able to work within the range of views. This intense process of management of change doesn't fit neatly into NHS planning timetables.

is the local population, the people who live in a certain area, the people who use a specific service and the people who have particular needs. Your consultation topic will determine with whom you should consult. It can range from how you allocate your total budget between the various services to talking to the local mums and toddlers group about family planning services, or the role of health visitors.

You may wish to talk to both the patient and their family and friends about how accessible the community mental health support service should be. This could be termed single focus experience and is most likely to generate commitment to the process from consultees. The essential point to realise is that there are many groups with different needs and agendas and that involving them needs to be properly planned and resourced.

So what about training?

Training for consultation would include three broad areas. Firstly, the background and historical perspective of public involvement would look at changes in attitudes to professionals and public institutions by the public and how their perceptions have changed. Critical to this is the change from "doctor knows best" to working partnerships with users, and the current views of the doctor and their changing relationship with the patient.

The second area would examine the dilemmas and problems likely to be encountered. An understanding of the real value of public involvement and consulting the public is important if the work is to be undertaken in a meaningful way. There are lots of

ideas about how we should communicate and provide information. Is absolute medical clarity important if it clouds understanding? When is "nearly right" better than wholly accurate? Public involvement has its own set of jargon, and a working knowledge of the terms is important. Understanding who they are and where you can find the public and stakeholders is a worthwhile exercise. The public is an umbrella term used to describe everyone who is not part of the organisation or the professional team. However, it is an empty phrase: the public does not exist as an entity.

You may wish to talk to both the patient and their family and friends about how accessible the community mental health support service should be. This could be termed single focus experience and is most likely to generate commitment to the process from the people who are consulted. The essential point is that there are vast numbers of groups with different needs and agendas. To complicate things further, some people will be in several groups and may have a different view in each.

The final section would discuss the new NHS and opportunities for public involvement; it would evaluate comparative methods and dissect case studies. Looking at the many new and evolving approaches to consultation, and planning how to build a good process and prepare the ground, will be of immense practical value. There are constant new initiatives in different spheres of the NHS and partnership working with stakeholders, particularly those organisations with an interest in health care and whose services often merge

with our own, will assist the process of health improvement. These types of involvement can assume a greater knowledge of the factors included, but equally each party must be able to stand back to see a different view of the world.

Given the pressures that doctors face, coupled with a plethora of initiatives, we do not underestimate the problems that active participation in public involvement will entail. Our view, based on working alongside doctors in consulting over health service changes and policy decisions, however, is that there is a need for a more active engagement from the profession not only to satisfy the system, but above all to improve the quality of service to the patient.

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1 McIver S. Public involvement in the NHS. In Spurgeon P, ed. *The new face of the NHS*. London: Royal Society of Medicine Press, 1998.

2 Barker J, Bullen M, de Ville J. *Reference manual for public involvement*. London: Bromley Health, West Kent Health Authority, Lambeth, Southwark & Lewisham Health Authority, 1996.

3 Kelson M. *User involvement: a guide to developing effective user involvement strategies in the NHS*. London: College Of Health, 1997.

4 NHS Executive, IHSM, NHS Confederation. *In the public interest: developing a strategy for public participation in the NHS*. Leeds: NHS Executive, 1998.

5 Wilson T, Butler F, Watson M. A view to a skill. *Health Serv J* 1998;24 September:24-5.

6 Sang B. The customer is sometimes right. *Health Serv J* 1999;19 August:22-3.

7 Williamson C. Rise of doctor-patient working groups. *BMJ* 1999;317:1374-7.

8 Lawrence D. Doctors in management: theory and practice. *Clinician in Management* 1999;8:76-80.

9 Neve H, Taylor P. Working with the community. *BMJ* 1995;311:524-5.

Briefing

● An EU directive gives parents of preschool children the right to up to 13 weeks of unpaid leave, and the government is currently consulting on its implementation. Its model scheme proposes that leave should be taken in blocks of one week, with four weeks' notice given to the employer, who will have the right to postpone it for up to six months if things are busy. Not much help if your child is viral then, but the act also gives employees the right to reasonable amounts of (unpaid) time off to care for any dependant to cover unexpected situations. Maternity rights will also be strengthened: all women will be entitled to 18 weeks of leave regardless of length of service, for example. More information is available from <http://www.dti.gov.uk/IR/fairness/index.htm>

● The professional bodies who accredit specialists must move very carefully and with due process—for after all, their decisions affect careers and continuing livelihoods. Mistakes can happen, and the latest newsletter of the body responsible for accrediting general practitioners—the Joint Committee on Postgraduate Training in General Practice—suggests that its officers are feeling exposed. They have received advice that the Department of Health would not indemnify them against possible litigation. The Specialist Training Authority is not so vulnerable. Its chief executive, Lesley Hawksworth said, "We have been independently funded (and insured) since our inception."

● Career focus is now integrated with the rest of the *eBMJ*, which enables customised @lerts (<http://www.bmj.com>), textword searches, and themed collections of articles. Content will continue to appear through the Synergy site (<http://classified.bmj.com>) for the time being.

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