Making integrated care a reality – collaboration to reduce demand

"We need to create a culture of cooperation and coordination between health, social care, public health, other local services and the third sector.
Working in silos is no longer acceptable"
(National Voices)

Developed by Susan Ritchie, MutualGain, on behalf of the

South East Commissioning Support Unit

Background

This resource guide will provide you with additional information on the theory and practice of working with the voluntary and community sector (VCS) to develop integrated care. The contents build on the work of Greenwich CCG and other research and pilots focused on integration.

When preparing this guide, commissioners asked the CSU to compile a snapshot of material that covered integration: they wanted the materials to provide the starting point for having a shared peer dialogue which could encourage exploration and learning together. This document provides the pre and post reading for the accompanying masterclass session.

Introduction/policy context

NHS England's 'Transforming Participation' Guidance (2013) has provided renewed focus on Patient and Public Participation for CCGs and NHS Area Teams. The Guidance provides clear and practical support for healthcare commissioners to:

- Provide a wide range of opportunities for the *public* to influence commissioning decisions
- Achieve better outcomes for *patients* by listening and responding to their needs
- Offer a range of *participation* methods that encourage dialogues within diverse populations

To successfully achieve these aims, there is recognition that integrated working practices must be implemented effectively. It is useful to utilise the voluntary sector for some aspects of integration, as has been demonstrated well by some of the CCGs who put forward case studies used in this resource guide. They have demonstrated the positive outcomes that can be achieved through partnerships with the Community and Voluntary Sector to develop and deliver their programmes.

Engaging with the voluntary and community sector (VCS) as an integrated partner can enhance the opportunities to connect with the wide range of opportunities for social prescribing within the normal working day of a GP/Clinicians, and our population is living longer with co-morbidities. Individuals and families are challenged by a healthcare system that is not easily navigated by some, and overused by many: by making efforts to reduce demand and redirect patients to appropriate services that better meet their needs, they are averting the growing trend to use acute services by patients who are already known to primary care services.

The following resources provide further information on key aspects of how deliberate and focused engagement with a broad range of partners can perform a key role in developing

the integration agenda with the VCS as a key partner. It provides the reader with links to further information if required, and should be seen as a starting point in directing you to key organisations, texts and themes that are present.

If you are thinking of replicating the examples referred to, we recommend that you familiarise yourself with the theory and practice that underpins them.

NB. *This resource guide differs from the others in this series in that it focuses on engagement and collaboration of partners rather than the public: it focuses on the role that the VCS can play in helping to shape a new way of thinking about the integration of services. It will also provide you with useful information on key themes emerging from the Greenwich case study and wider integration learning which draws on a variety of resources.*

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Masterclass case study

The Greenwich case study included the following partners: Greenwich Clinical Commissioning Group, Greenwich and Lewisham NHS Trust, Greenwich RBC, Oxleas NHS Foundation Trust, all the borough's GP practices, Greenwich Action for Voluntary Service and the local Healthwatch

What is it?

The work in this case study is part of a bigger integrated whole system change which started in 2009 when the Greenwich CCG worked with partners to develop their planning.

Aims

The Joint Emergency Team (JET) has a clear remit to prevent A&E attendance by working with GPs, the London Ambulance Service and other community staff as well as to prevent admission once a person has reached A & E.

How they did it?

In 2011 the Royal Borough of Greenwich and Oxleas NHS Foundation Trust re-organised their rapid response and intermediate care services into integrated health and social care teams. A clear pathway with shared aims and outcomes was established which involved pooling resources and bringing together teams of therapists, other health care professionals and social care staff into one service, with shared management arrangements

They created clusters of GP services called Communities of Practice and adopted a 'test and learn' approach to their work

Patients are referred to the Greenwich Navigator by their own GP. The Navigators:

- Understand the complexity and simplicity of the 'problem' associated with repeat attendance and usage of care through the use of I Statements
- Once agreed the navigator shares the information with a multidisciplinary team who agree an action plan
- The types of action taken can involve: referral to employment advice; housing improvements; support for weight loss; referral into voluntary work; alcohol support

Outcomes

The cost of packages of care and number of referrals to residential care was reduced by £900k in the first year of operation. As a result, these initiatives were awarded a HSJ Award for Efficiency in 2011.

The critical success factors were: a commitment to a shared vision, a willingness to change the culture of both health and social care organisations, excellent clinical engagement which led to shared values and approaches, excellent leadership, good governance and risk management, and integrated performance management

Context for this resource guide

There is no one model of integrated care: it has been an evolving and iterative process of development for many years. In the recent Five Year Forward view, leaders of the NHS in England created the Forward View into Action programme which encourages the development of these new models of care as:

- Multispecialty community providers (MCPs);
- Integrated primary and acute care systems (PACS);
- Additional approaches to creating smaller viable hospitals; and
- Models of enhanced health in care homes.

The website has a variety of information from technical definitions to financial templates and resources to support organisations in developing new models of care. The Vanguard sites are yet to be announced (at the time of writing this guidance) but will be found on the website, using the link above.

Leaders of local and national health and care services are required to take action on five fronts. The guidance:

- Sets outs seven approaches to a radical upgrade in prevention of illness with England becoming the first country to implement a national evidence-based diabetes prevention programme
- Explains how £480 million of the £1.98 billion additional investment will be used to support transformation in primary care, mental health and local health economies;
- Makes clear the local NHS must work together to ensure patients receive the standards guaranteed by the NHS Constitution
- Underlines the NHS's commitment to giving doctors, nurses and carers access to all the data, information and knowledge they need to deliver the best possible care
- Details how the NHS will accelerate innovation to become a world-leader in genomic and genetic testing, medicine optimisation and testing and evaluating new ideas and techniques.

If you are in the early stages of implementing new models of care or integrating services, there is a range of information and learning which has informed the Integrated Care agenda over the past few years: it might be helpful in getting you to the stage of offering radical new models of care.

Integrated care is a much spoken about concept across the NHS and Care services, but putting it in to practice can be more complex and challenging than it sounds. This animation from the Kings Fund outlines the basics of what is expected from integrated care.

In 2008 Lord Darzi spoke of the need for more Integrated Care Organisations to ensure the patient experience stays at the heart of the NHS. In the Nuffield Report: Where Next for Integrated Care Organisations, the findings show that **aligned teams and professionals around a detailed shared care plan,** as a form of integration, can be particularly useful for people with less predictable, variable, multiple and/or complex conditions such as those with long-term mental health problems. Greenwich CCG share their learning from this in the accompanying masterclass.

Post Darzi, the Nuffield Trust produced the "What is Integrated Care?" report where they set out the differences between integration and integrated care (p.7). On page 8 they provide a useful description of the five main types of integration and their allied integrative processes (systemic to clinical). Page 11 provides a useful set of prompts which you can use to help you think through the development of an integrated approach. Page 19 provides some examples of which methods pilot sites have used to measure the impact of their work, before finally concluding with four key lessons which include:

1. Integrated care is best understood as a strategy for improving patient care (a reminder that integrated care, in terms of better patient outcomes, is unlikely to happen if the focus is solely on bringing organisations together for better shared systems and processes)
2. The service user is the organising principle of integrated care (shared vision which puts the service user at the centre)
3. One form of integrated care does not fit all (no one model suits all contexts, settings and service users)

4. It is only possible to improve what you measure (evidence on what works is still evolving, but generally focuses on structures and processes rather than costs and outcomes. Evaluation can influence the refinement of integration)

What this work shows is that commissioners and practitioners must go beyond the systems and processes to genuinely put the patient at the heart of both. National Voices developed a set of principles to help ensure that patients stay at the heart of integration.

Principles of integration

They state that integrated care must:

- Be organised around the needs of individuals (person-centred)
- Focus always on the goal of benefiting service users
- Be evaluated by its outcomes, especially those which service users themselves report
- Include community and voluntary sector contributions
- Be fully inclusive of all communities in the locality
- Be designed together with the users of services and their carers
- Deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for
- Be driven forwards
- Be encouraged through incentives
- Aim to achieve public and social value, not just to save money
- Last over time and be allowed to experiment

I statements

In doing so you may wish to use i-statements to help ensure that the patient is involved in the process. The following I statements are put forward by NAVCO as an example set which can be used when specifically thinking about integration:

- *All my needs as a person are assessed*
- *I am supported to understand my choices and to set and achieve my goals*
- *I work with my team to agree a care and support plan*
- *I have systems in place to get help at an early stage to avoid a crisis*
- *I always know who is coordinating my care.*
- *I have one first point of contact. They understand both my condition(s) and me. I can go to them with questions at any time.*
- *When I move between services or settings, there is a plan in place for what happens next.*

Greenwich CCG encourages patients to develop their own statements which are shared in a multidisciplinary to fully understand the context of the patient and their behaviours.

With the number of people with more than one long term condition such as diabetes, asthma or dementia set to rise from 1.9 million in 2008 to 2.9 million in 2018 and increasing pressures on A&E departments, the need to deliver better joined-up care which puts the patient at the centre will ensure a more sustainable NHS can be realised.

Pilot programmes

The government has invested in 14 pilot integration sites across the UK, with many of those in London. The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

Results from these approaches in the pioneer areas include:

- 2,000 fewer patient admissions over a two and a half year period, achieved through teams of nurses, social workers, occupational therapists and physiotherapists working together to prevent crises
- Reducing waiting times from eight weeks to 48 hours at physiotherapy services by making professionals work closer together
- Setting up a crisis house where people who suffer mental health problems can get intensive support

Greenwich is one of the integrated care pilot areas: they have helped cut social care spend by £900,000. To read the report they produced for the House of Commons Select Committee, click here. For an overview of the other pioneer sites click here.

On 7th November 2014, the NHS Improving Quality service received joint applications from areas that could demonstrate partnership working between one or more clinical commissioning group, local authorities, and at least one voluntary sector partner. Local partners are expected to make a clear commitment to implementing new integrated funding models, making information and support available to their target population, and embedding personalisation in their organisations. You can read more about the programme here. To follow progress on this work click here.

Successful integrated working requires:

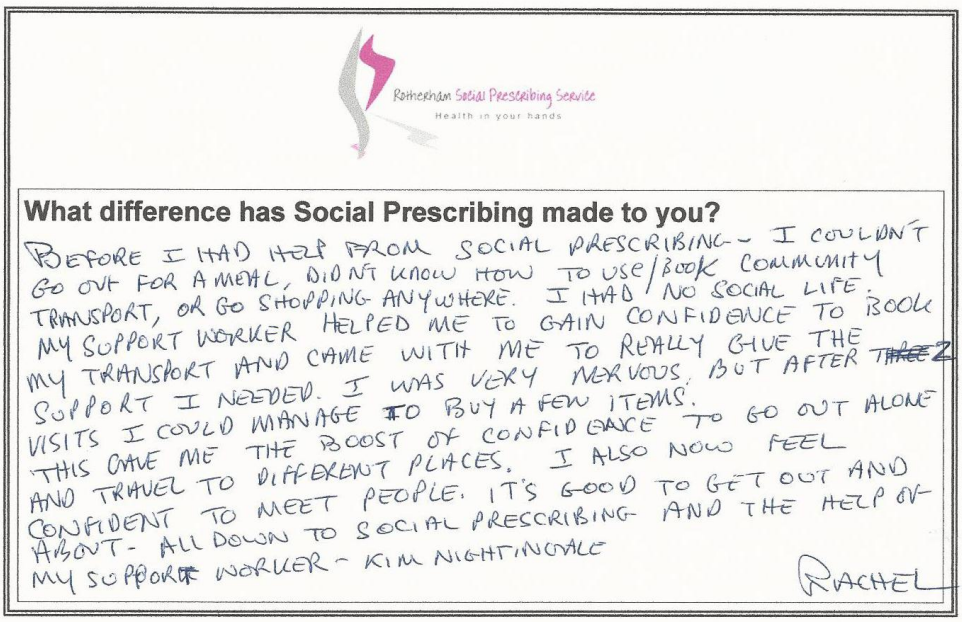
- Commitment to a shared vision (reimagine how you provide care)
- Pooled resources (beyond money)
- Multiprofessional teams, with a single point of contact
- Collaboration and integration, not just joined up working
- Create the systems that make the above work

Emerging learning from Islington Clinical Commissioning Group, who recently embarked on a collaborative care project shows:

- It takes **time and resources**
- There is a need for **strong clinical leadership** at executive and clinical level to change systems and cultures
- Need for **flexibility of delivery** models
- **Need to Integrate concurrent initiatives** - putting self management at the heart of Islington's integration work increased its profile
- Working from the **ground up** – co-production workshops meant all the relevant people were in the same room.
- Year of Care steering group – having **commissioners and providers in the same room** is important.
- Recognising that the journey people are on is not linear – approach is '*what can we do to help take people on that journey'* through shared agenda setting, collaborative goal setting, timely follow up.
- **Belief**!

Learn more about others

Rotherham is one of the leading lights for social prescribing. This note from a patient summarises the potential that social prescribing has on improving the quality of life for many:


Rotherham Social Prescribing Service
Health in your hands

What difference has Social Prescribing made to you?

BEFORE I HAD HELP FROM SOCIAL PRESCRIBING - I COULDN'T GO OUT FOR A MEAL, DIDN'T KNOW HOW TO USE/BOOK COMMUNITY TRANSPORT, OR GO SHOPPING ANYWHERE. I HAD NO SOCIAL LIFE. MY SUPPORT WORKER HELPED ME TO GAIN CONFIDENCE TO BOOK MY TRANSPORT AND CAME WITH ME TO REALLY GIVE THE SUPPORT I NEEDED. I WAS VERY NERVOUS, BUT AFTER ~~THREE~~ 2 VISITS I COULD MANAGE ~~TO~~ TO BUY A FEW ITEMS. THIS GAVE ME THE BOOST OF CONFIDENCE TO GO OUT ALONE AND TRAVEL TO DIFFERENT PLACES. I ALSO NOW FEEL CONFIDENT TO MEET PEOPLE. IT'S GOOD TO GET OUT AND ABOUT - ALL DOWN TO SOCIAL PRESCRIBING AND THE HELP OF MY SUPPORT WORKER - KIM NIGHTINGALE

RACHEL

Their work was evaluated by Sheffield Hallam University – the learning can be found here

To watch a film about the Greenwich Coordinated Care click here

Listen to Paul Corrigan talk about the move from mass production to co production through the People Powered Health NESTA programme here

This film looks at different ways to integrate and promote community-based services into health and social care – lots on social prescribing

To see some films about how others across the country are tackling integrated care go to the NHS Improving Quality website

OPM worked with the CSU to develop a range of support for commissioners. In doing so they created this table of resources which focuses on person centred care as a central theme of integration:

Health Foundation	**Person-centred care resources** http://personcentredcare.health.org.uk/person-centred-care/commissioning A directory of resources for supporting clinicians to deliver person centred care. Commissioning section under development but includes questions to ask at each stage of the commissioning cycle.
NHS Commissioning Assembly	**Community of leaders for NHS commissioners.** http://www.commissioningassembly.nhs.uk/pg/dashboard Learning Environment site where you can search for case studies and support offers under different themes
NHS England	Extensive list of **general resources** to support CCG commissioning, direct commissioning and a specific section on shared decision making. http://www.england.nhs.uk/resources/resources-for-ccgs/ Signposting to available resources on shared decision making: http://www.england.nhs.uk/ourwork/pe/sdm/
NHS Clinical Commissioners	**Membership organisation for CCGs.** http://www.nhscc.org/ Resources and tools to help CCGs – need membership to access
Royal College of	**Commissioning hub**. Online resource for commissioning secondary care services in England, service planners and clinicians. Includes a section on

Physicians	SDM. https://www.rcplondon.ac.uk/projects/clinical-commissioning-hub
Nuffield Trust	**Ongoing programme of work** to share best practice around commissioning. http://www.nuffieldtrust.org.uk/our-work/projects/supporting-development-clinical-commissioning-groups-and-nhs-england Includes learning from commissioning personal health budgets
Royal College of GPs	http://www.rcgp.org.uk/policy/centre-for-commissioning.aspx **Centre for Commissioning.** Includes guidance on working with and developing communities

Wandsworth and Islington CCGs provide additional examples of putting the patient in control of their care, within an integrated system:

Wandsworth CCG Self management **Case study area:** Proactive care to avoid emergency and unscheduled care	Wandsworth have two programmes which might be of interest in putting the patient at the centre of their care offer: 1. Planning All Care Together a programme of activity to re-design primary and community services to better coordinate how patients with LTC are managed. The aim is for patients and service users to feel better and more able to live independent lives – the vision is that community health and adult social care services will work as one service, and help patients remain in their own home and prevent trips to hospital. Patients will: • be supported to manage their condition • get help to recover their independence after illness or injury • benefit from a comprehensive, coordinated plan of care that is communicated across health and social care • feel their care has been well coordinated with smooth transitions between professionals or services • experience fewer steps in their journey across health and social care services. The CCG plan describes Planning All Care Together as a philosophy for how out of hours hospital care for adults is delivered. The PACT contract involves delivering a comprehensive self management

	framework as part of 5 year plan for out of hospital care. In 2013/14 the Planning All Care Together Programme served as one of the key vehicles through which Wandsworth CCG delivered significant change in the way that care for patients with LTCs is provided in the Borough. 2. Wandsworth self-management service consists of: Wandsworth CCG – 5 year plan for out of hospital care for adults Wandsworth Self Management Service • a range of free self-management courses for people living with any long term health condition(s) and their carers • a database of activities or opportunities and information for people living with a long term health condition. The main delivery partner for the self-management service is Lifetimes – the CVS in Wandsworth. The main programme is The Expert Patients Programme (EPP) that offers a tool-kit of techniques and skills to enable participants to manage their condition better on a daily basis, increase confidence and take control of their condition and its impact on their quality of life. People who have attended the programme have reported that it has helped them to: • feel confident and more in control of their life • manage their condition and treatment together with healthcare professionals • be realistic about the impact of their condition on themselves and their family • use their new skills and knowledge to improve their quality of life.
Islington CCG **Approach to integrated care using the House of Care model and Patient Activation Measures**	Islington is part of the national Integrated Care and Support Pioneer Programme. The integrated care programme priorities (London wide) - New ways of commissioning and delivering healthcare so that care is planned and managed close to home. - Focus through commissioning on intensive users and health

Case study area: Proactive care to avoid emergency and unscheduled care AND Improving post-acute care and reducing readmissions	and wellbeing of the broader population - Focus on self care, personalisation, patient activation and mobilisation of community assets In Islington it is governed by an Integrated Care Board and aims to bring together different provider projects to provide support and coordination; provide feedback on the overall impact of improving the quality and cost of care for adults with LTCs; provide an overarching commissioning process to drive integrated care. The commissioning foundation in Islington's House of Care model includes patient involvement; good collaborative working across the borough and a move from a disease specific approach to generic Long Term Conditions approve via commissioned services in general practice. From October 2014 Islington will start collecting The Patient Activation Measure score for all patients registered with a LTC. This is a validated tool that helps to understand and link patient activation (skills, knowledge, confidence), subsequent behaviour and graded need for support to achieve better outcomes. This may help to inform commissioning decisions in Islington in the future so that self management support initiatives are commissioned according to a co-produced implementation plan. In April 2014 – vcs orgs through Age UK were commissioned to deliver local service navigators who will use the tool.

You may also find it useful to learn more about the use of IT for integration. In **North West London** staff share information using an IT tool which allows for the identification of patients needing intensive case management, while multidisciplinary groups of local care providers meet on a regular basis to review and plan people's care. The full evaluation can be read here. They identify that '*International evidence points to the fact that integrated care takes years to develop, and a minimum of three to five years is needed for such initiatives to show impact in relation to activity, patient experience and outcomes. Key areas for future work for the pilot should include: embedding governance systems and support so that they can survive in a different financial climate; improving the quality of care planning ; ensuring consistency among the multidisciplinary groups; refining the IT tool; and working with patients to improve their involvement in their own care*.

This masterclass is focused on the way in which Greenwich worked together with others to streamline the coordination and integration of health and care for 'over users' of GP and acute care services. There are aspects of the other masterclasses which might also be worth looking at when thinking about an integrated approach, which are set out below:

Cross referencing to other masterclasses

- ### Patient education for self-management

Self-management is an increasingly important aspect to achieving good health outcomes. Sometimes referred to as self-care, self-management aims to enable patients to take active ownership in managing their health condition in a preventative way; one that avoids healthcare crisis and the need to use critical healthcare services.

Most healthcare professionals support self-management programmes that teach patients how to recognise signs and symptoms of worsening conditions, avoidance of accelerating conditions and general health and lifestyle advice. There are a number of different self-management methods and tools used to support the management of long-term conditions as set out above, and you will also find more on the SECSU Participation website: http://participation.southeastcsu.nhs.uk/

Methods include:

- Structured education
- Motivational interview
- On-line applications – with developed guides and instructions for the user
- There is also an additional range of self-management techniques 'self-management support' that includes:
- Peer to peer support
- Informal education
- Education for healthcare professional on self-efficacy

The Case Study example utilises a range of self-management support approaches – moving away from the traditional 'patient education' model to an approach that uses empowerment, self-direction and personal ability to raise the patient's confidence and self-belief that they can manage themselves, and links them to the relevant statutory and non statutory agencies to help change their personal experiences and circumstances.

- ### Tackling isolation

Increasingly healthcare commissioners are looking to the community to undertake local activities through volunteering, which makes a vital difference to people living in isolation: connecting them with peers and recognising the value that they add to society.

Isolation in the health and wellbeing context describes the reduced level of social contacts and interactions people have. It is often assumed to affect 'older people', but in fact it

affects many younger people too. Isolation affects groups of people at different stages in their lives, for example carers, young mothers, older married women, new communities, and older people living with adult children. Isolation also affects specific groups with other social/health needs, such as the homeless and substance users who face difficult daily lives, often without experiencing trusting relationships.

The effects of isolation are varied, for some people their isolated living is temporary and may not lead to long term negative impacts; for others the effects can be wearing and lead to worsening physical and mental health, compounded by reduced knowledge and understanding of how to gain support from health, care and other support available in the community. Common across isolated groups are factors around poverty and education and can be seen in both rural and urban communities.

The case study examples in the Improving the Health of Isolated Groups masterclass focus on key challenges facing healthcare commissioners nationally:

1. how to improve well-being as a preventative measure to avoid crisis health needs
2. how to encourage communities to contribute to and maintain 'health resilience'

There is a renewed focus on isolation across all age groups, based on current understanding of how isolation leads to reduced mortality and costly health and care services at the crisis end of the health spectrum. When thinking about integrating care, techniques used for reducing isolation could be useful.

- ## Harnessing the assets in your community

Asset based working is an approach used to deliver sustainable community-driven development. It differs from many other approaches because it seeks out the existing strengths within communities and builds on the premise that communities have the resources and the solutions to change their lives and communities.

The strengths in individuals and communities are frequently overlooked or taken for granted in the usual service provider/service consumer relationship. By looking for strengths you can support the changing relationship taking place across public health and care services as it strives to put 'patients in control': this method enables communities to self-identify the assets they hold, and in doing so enables communities to recognise the power within them. Integrated care might include and/or compliment many of those assets, when done well: the community can be a key component of integrated care. Assets they have can consist of the following, and more:

- Skills of local residents
- Power of local associations

- Resources of public, private and non-profit institutions
- Physical infrastructure and space in a community
- Economic resources and potential of local places
- Local history and culture of a neighbourhood

These assets are common to most communities and form the basis of utilising the existing community 'pool' of resources to begin a process of change, including changing the level of recognition awarded to those assets by others such as service providers.

If you are a service provider working with a 'community deficit' approach, you can begin to facilitate a change process by changing the way you view communities, and giving the time and space to them to realise their own strengths and mobilise to positive end. In changing this dynamic, services are better placed to work positively and constructively with communities to accelerate benefits to both service provider and service user, through improved ownership, leadership and outcomes.

Working with the voluntary sector and volunteers

NAVCA – National Council for Voluntary and Community Action
The national umbrella organisation for almost 200,000 support and development organisations in the UK. Provides clear policy guidance to its members and useful resources for commissioners, including:

Social Value Act

Voice and Influence

Working with communities

NAVCA follows health and public policy changes: it can provide a useful temperature check on how new policies impact on the sector, and how they share their areas of concern with Central government.

LVSC is a central resource for knowledge and policy for the London voluntary and community sector. They hold a list of all the Directors of CVS organisations across London. To find yours open the link on this page. You may also find it useful to access their databases of who's who in the NHS – local lists of contacts to help locate the right peers.

Local Healthwatch

Every local borough (or rural area) has a local Healthwatch organisation. The role of Local Healthwatch is to be the consumer champion for patients – seeking patient experience and opportunities for patient involvement.

Healthwatch was established in 2013. Many Local Healthwatch organisations hold positions on Health and Well Being Boards, CCG Committees and Quality Review Groups. Your local Healthwatch is a statutory independent organisation that reports to Healthwatch England the national body that provides guidance and national influence for the local Healthwatch groups.

Local Healthwatch organisations are contracted by the local authority.

Working with volunteers

The Institute for Volunteering Research provides national evidence, research, guidance and statistics on volunteers. There are useful resources to support commissioners, including barriers to volunteering and volunteer management.

Most local boroughs and areas will have a Volunteer Centre. Generally, these organisations will provide best practice advice, volunteer recruitment and management for local authorities.

Commissioning the voluntary sector

To commission the voluntary sector successfully, you should have some understanding of the voluntary and community sector structures and best practice principles for working with them.

The National Council of Voluntary Organisations provides useful guides for community organisations on commissioning. Their guide to commissioning and procurement can be read here.

It also produces a Guide to Commissioning for Maximum Value, which brings together an outline of Social Return on Investment (SROI) and the Social Value Act.

The Nuffield Trust have produced a report on the Role of the Voluntary Sector in providing Commissioning Support. The Report identifies the opportunities and challenges in commissioning the voluntary sector and gives useful advice for CCGs, CSUs and NHSE on how the VCS role can be better defined.

The Kings Fund have a Commissioning Reading Room – packed full of reading resources and links to useful information for commissioners

Watch the video…..

The Centre for Social Justice discusses the voluntary sector in its Breakthrough Britain 2015 programme.

The Rainbow Haven in Manchester has produced a video of service providers and service users talking about 'What happens when voluntary groups are listened to'

The Voluntary Sector role in Commissioning is explained by a service provider to a service user from the Refugee Council

You can read more about successful partnership working with the voluntary sector in the Kings Fund Publication 'Working Together to deliver the Mandate', 2013.

Equality and diversity

Before commissioning a programme of work, you will need to consider and include the equalities and health inequalities needs of your borough or area. You may have to work with your VCS organisations and Healthwatch first to identify which groups are most affected by either, or both.

Much has been written about barriers to participation, particularly among groups known not to engage in traditional methods. BMC Health Services Research conducted a qualitative study with the VCS to explore the notion of 'hard to reach'. They found:

> *"the 'hard to reach' may include drug users, people living with HIV, people from sexual minority communities, asylum seekers, refugees, people from black and ethnic minority communities, and homeless people although defining the notion of the 'hard to reach' is not straight forward. It may be that certain groups resist engaging in treatment services and are deemed hard to reach by a particular service or from a societal stance. There are a number of potential barriers for people who may try and access services, including people having bad experiences in the past; location and opening times of services and how services are funded and managed"*

By working with your local voluntary and community sector partners, you can strengthen your knowledge and practice on how to engage those groups who appear to be 'hard to reach' or those who you 'aspire to engage'. If you don't know of any training in this area you may want to contact your regional Council of Voluntary and Community Organisations for signposting.

There are many publications and training courses about accessing seldom heard groups. As a method of engagement and recruitment we recommend that you consider 'snowballing' as a recruitment methodology.

You will also need to ensure that there are steps in place to meet additional needs – such as communication and access for individuals. Healthcare Standards are being introduced in Wales to ensure that the communication needs of hearing and visually impaired patients and the public needs are met by health and care services. There are also discussions taking place for such standards in England.

The EDS is an NHS England tool first developed by the Department of Health in 2011. In November 2013, a refreshed and streamlined 'EDS2' was formally launched.

The EDS2 is an assessment framework which allows NHS commissioning and provider organisations to:

- Understand their performance against equality and diversity standards
- Collect robust evidence and good practice examples to inform service and workforce developments
- Support the development of accessible and equitable services, which promote higher levels of patient experience
- Develop patient and public and staff engagement mechanisms, and utilise the patient voice in service improvements
- Supports the reduction of health inequalities and positive outcomes for protected groups
- Demonstrates compliance and mainstreaming around the Equality Act 2010

The four Goals of the EDS:

The nine steps used to implement the EDS are:

1. Governance and partnership working
2. Identify local interests
3. Assemble evidence
4. Agree roles with the local authority
5. Analyse performance
6. Agree grades jointly
7. Prepare equality objectives
8. Integrate equality objectives in mainstream business planning
9. Publish grades and equality objectives