Taking Strategic Action for Engaging Communities (SAFEC)

A self-assessment resource for public sector organisations

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Part 1
Introduction

The first part of this resource pack outlines why public sector organisations need to find ways to work in equal partnership with the communities they serve, introduces the SAFEC approach and explains how to use this resource.

Section 1 Getting organisations and communities working together

Section 2 Is the SAFEC approach for us?

1 Getting organisations and communities working together

This section sets out why public sector agencies need to adopt an organisational development approach, such as that provided by SAFEC, to help them assess and improve the work they do on engaging with their local communities. It is aimed particularly at chief officers, members of governing bodies and senior managers.

Effective and more equal relationships between public sector organisations and the people and communities they serve must become part of the mainstream – 'the way we do things around here' – if the process of modernisation is to result in enduring improvements in public services. The public sector can no longer view local people as passive users of public services. Instead, it must include them in decision making at individual and strategic levels alike – engaging with them as partners in the processes of governance and active participants in service delivery and improvement.

The policy background

In recent years, the Government has introduced a number of initiatives that together will create a new system for involving local people and service users in the public sector:

- **The Health and Social Care Act.** One of the most important changes is the mandatory duty placed on all public agencies under Section 11 of the Health and Social Care Act (2001) to involve local people and formally consult them, where appropriate, on all planning and policy issues.
- **Baseline assessment.** All agencies are now required to carry out a baseline assessment of their activities aimed at user and/or public involvement and to develop strategic and annual plans for involvement against which their performance can be measured (Department of Health 2003).
- **Patient advice and liaison services.** All NHS trusts have set up patient advice and liaison services (PALS) to provide guidance and information. The service is intended to act in two ways: first, as a gateway to an independent complaints and advocacy service; and second, as a catalyst for improvement by monitoring and reporting concerns and feeding back themes to trust boards.
- **Patient and public involvement forums.** A national network of patient and public involvement forums (PPIFs), linked to every NHS trust in England, was set up by national legislation on 1 December 2003. These forums provide an independent voice for patients and the public. They monitor service quality from the perspective of service users and have powers to inspect premises, make reports and recommendations to trust boards and refer matters of concern to strategic health authorities, overview and scrutiny committees, the National Patient Safety Authority, the Healthcare Commission and the media. Forums can work outside the NHS, promoting public involvement in all matters that affect their health.

- **The emergence of the citizen governance agenda.** Most recently the concept of citizen governance has become more prominent in the policy discourse. The National Consumer Council defines this as the involvement of lay citizens in decision making and scrutiny roles in public services. With the Langlands Commission on public governance reporting in 2005, it is clear that there will be a growing emphasis in future national policy on citizen governance as a way of improving relationships between the state and the public.

To build this new system for engagement, the public sector needs to undergo major cultural and structural changes. To address this issue, in 2000, the Department of Health funded a programme of work called the Strategic Action Programme for Healthy Communities (SAPHC) - later renamed the Strategic Action for Engaging Communities (SAFEC). The findings of this programme turned the spotlight away from the traditional concern with community development and focused instead on the need for organisational development within the public sector that would promote the sustainable learning and change required for more effective partnerships with local communities.

Since that time, there has been growing recognition at local and national level that organisational development is pivotal to successfully involving the public and engaging local communities. Within the NHS, the Modernisation Agency, in particular, has taken a lead in this field. However, there is a long way to go before the cultural and structural changes that are needed are embedded in public sector organisations. This resource pack – the final output of the SAFEC project – is designed to help organisations through this process of change.

What is the SAFEC approach?

SAFEC was developed to change the way in which public sector organisations work with the people they serve. The SAFEC approach consists of four main elements:

- **A barrier model** highlighting the most common barriers operating within public sector organisations to constrain more effective partnership working with local people.
- **Four principles** providing a framework for activities aimed at helping public sector agencies to identify and act to reduce the barriers within their organisation that restrict their ability to work effectively with local communities.
- **Guidance** on implementing a programme of organisational development that reflects these principles and is designed to promote learning about organisational barriers to effective community engagement, and through this, cultural and structural change.
- **Resources** to support a programme of organisational development that can be tailored to the needs of particular organisations.

It *does not* include:

- **An audit or inspection process** that relies on a checklist of ‘good practice’ in community engagement.

- **A toolkit of techniques** dealing with how to involve patients and the public or undertake community development projects.

Many sources of information on these matters are available elsewhere. A good starting point is the NatPact Engaging Communities Learning Network (www.natpact.nhs.uk). The Health Development Agency, which merged with the National Institute for Clinical Excellence (NICE) in April 2005, has also established a national collaborating centre focusing on increasing the effectiveness of public sector efforts to engage their communities in action to reduce health inequalities. The National Collaborating Centre for Community Engagement can be contacted by emailing nccce@lancaster.ac.uk or, for further information, view the website: www.nccce.lancs.ac.uk.

How the SAFEC approach was developed

The SAFEC approach to organisational development is the product of an evaluated programme of research and development carried out in two phases. Phase One involved:

- **Reviewing** the research evidence on barriers within public sector agencies to involving the public.
- **Developing** an organisational development process and related resources that could be used to reduce these barriers.
- **Piloting** the process and related resources with a range of agencies, including primary care groups, health authorities, local authorities and regional development agencies.

A report on Phase One (when the programme was known as SAPHC) has been disseminated and further information is available on the National Collaborating Centre for Community Engagement website: www.nccce.lancs.ac.uk

In Phase Two, a modified programme of organisational development was tested in three pilot sites. This work focused on promoting change in Primary Care Trusts (PCTs), but in all three sites local authorities, voluntary and community sector agencies and local people were involved. The learning from these sites is incorporated into this resource pack.

We carried out an evaluation of both phases of the work. The results clearly indicate that SAFEC can make a significant contribution towards achieving the cultural and structural changes that are needed for service users and local communities to become more effectively involved in public sector decision making.

How the SAFEC approach can help

The SAFEC approach to organisational assessment and improvement is designed to provide public sector organisations and their staff with practical assistance to develop more effective ways of engaging with diverse communities. This in turn will help them achieve their organisational goals to provide more relevant, responsive and person-centred service through:

- giving local people real influence in public sector organisations;
- enhancing organisational purpose and direction;
- supporting quality improvements;
- linking strategy and implementation.

These activities are explained below.

- **Giving local people real influence in public sector organisations.** For many years, the NHS has wanted members of the public to act as expert advisers to service planners and care providers. This forms part of its modernisation process, enabling the NHS to provide a more appropriate and accessible service. However, traditional methods of engaging communities, such as using surveys, complaints procedures and consultation exercises, have not resulted in local people having any real and sustainable influence on decision making in the NHS. Arguably local authorities have made more progress than the NHS, but developing effective and sustainable relationships with local communities remains a major challenge for the public sector. The SAFEC approach is designed to help organisations to meet this challenge by explicitly focusing on the barriers that are blocking change and improvement.
- **Enhancing organisational purpose and direction.** It is increasingly recognised that meaningful engagement with service users and local people can offer enriched purpose and direction to local public agencies. The SAFEC approach accords with the desire of staff and patients to continuously improve services.
- **Supporting quality improvements.** User and public involvement and community engagement are increasingly being seen as major drivers for improving the quality of public service governance and decision making. Inspection and performance-management systems in the public sector are more frequently now focussing on the relationships between public sector agencies and the communities they serve, and central government is beginning to set formal standards for performance in this area.
- **Linking strategy and implementation.** Following recent national policy initiatives (see page 2)many public sector organisations are producing strategic plans and setting up new mechanisms for engaging with their local communities and service users. The SAFEC approach is designed to bridge the gap between the intentions of the strategic policies developed by NHS boards and local authorities and their implementation. Without cultural and structural changes, the good intentions behind these plans cannot become reality, and new relationships with local communities and opportunities for community governance will not be sustainable.

Evidence from our pilot sites shows that the SAFEC approach can improve both the governance and delivery of services by finding and harnessing the existing energy and enthusiasm among staff, service users and the public. We have witnessed a number of benefits from SAFEC from our pilot organisations. For example, SAFEC has been shown to build executive understanding of organisational and professional barriers to community engagement and to develop commitment and support for organisational change at all levels of an organisation. The SAFEC process also contributes to a deeper understanding of the expertise, time and resources needed to engage effectively with communities and highlights the shortcomings of traditional approaches. Perhaps most importantly, the SAFEC process of organisational learning appears to release new energy and capacity from service improvement amongst NHS staff. Resource 1 in Part 5 provides a comprehensive list of the benefits identified by those working with SAFEC in our pilot sites. You might find it useful to consider these before you embark on a SAFEC process for your organisation.

In this section we have covered:

- The policy context for engaging local communities and service users in assessing and developing public sector organisations;
- What the SAFEC approach is;
- How it was developed;
- How this approach can help to achieve more effective relationships between public sector organisations and the communities they serve and so support public sector organisations to achieve their goals.

2 Is the SAFEC approach for us?

This section is designed to help you decide whether SAFEC is the right approach for your organisation. SAFEC is an effective tool, but to work well it requires time and resources and can be extremely challenging. This section provides two checklists of questions that will help you assess whether you are ready for SAFEC.

Is SAFEC only for PCTs?

The resource pack is aimed primarily at NHS organisations, especially those in primary care. In developing SAFEC, we mainly focused on finding a method that matched the needs of the NHS in general and PCTs in particular.

We focused on primary care because the NHS PCT boards are uniquely placed to help create the environment within local health systems that will enable community engagement to flourish. They are also able to collaborate with their partner organisations and stakeholders in the local health and social care system to develop an overarching strategy. However, we also carried out some development work with local authorities and other public sector organisations *outside* the NHS - a wide range of organisations, community groups and local communities were involved in the PCT pilot sites and the research on which the approach is based is relevant to all public sector agencies, not only the NHS. We therefore believe that the SAFEC resource pack will be of relevance to all organisations within the public sector, not just PCTs.

Are you willing to change?

The answer to whether SAFEC is the right approach for you depends on whether you and your organisation are prepared to change. This resource pack contains a strategic programme for organisational assessment and improvement that requires commitment, time and resources to establish and mainstream. The programme will involve analysing, and possibly challenging, your organisation's leadership styles, cultures, structures and processes, and partnership working. The executives who sponsor the programme must be prepared for this, and they need to be supportive of actions that address challenges, even though the scale and nature of these actions will only come to light as the process unfolds.

The assessment process will raise the organisation's consciousness. Learning may cast new light on old issues and offer new insights into how the organisation is operating. It could reveal things about the organisation that managers did not previously know. These may be – initially at least – unpalatable. Revealing these 'blind spots' can offer great opportunities for further learning and development. However, the process of gaining insight can be a painful one for those in positions of authority – and for those carrying the message 'up' within organisations.

Research commissioned by the NHS Modernisation Agency identified six key steps that organisations must take in order to change. We advise you to review these steps before embarking on the SAFEC process.

Checklist: Six steps to change

Step 1: Recognise the external events or internal circumstances that require a change to take place – in this case the need to improve the organisation's effectiveness at engaging with local people.

Step 2: Take responsibility for starting a process in which the need for change is translated into an organisational desire for change; make a real commitment to taking action and to resource the process.

Step 3: Embark on a diagnosis – reviewing the current state and identifying the preferred future state.

Step 4: Prepare and plan for implementing change, taking action to reduce the barriers.

Step 5: Effect the desired change.

Step 6: Review the impact of the change.

Source: NHS Modernisation Agency (2003)

The role of leadership

Research by the NHS Modernisation Agency points to the vital role that leadership must play in any process aimed at organisational change and improvement. The SAFEC approach requires clear and strong leadership from chief executives, executive directors and non-executive and/or elected members to set the agenda for change and to generate and maintain momentum. Step one of the SAFEC process - described in more detail in Part 3 of the pack - involves the senior management teams and governing bodies considering whether they and their organisation are ready and able to provide this leadership by answering a series of questions provided in Resource 2 in Part 5. These questions focus on four areas:

- Leadership focused on the needs of local people and users;
- Multi-professional teams to lead the change process;
- Organisational structures that support change processes;
- Partnership working with local communities.

Weighing up the costs and benefits

As with any development process, SAFEC requires significant resources, and the challenges to be faced will only come to light as the process evolves. As the saying goes, 'you don't know what you don't know until somebody points it out to you.' Having the organisation's senior team give some thought to the questions in Resource 2 will at least alert you to the nature and scale of the endeavour to be embarked on.

The challenges will be significant, but over time, the overall objective is to help support your organisation to develop a culture that values, encourages and rewards the meaningful engagement of local people and service users. This engagement is the single most important way of achieving the 'prize' – which is running services that truly fulfil the requirements of users. Experience tells us that the benefits – the 'value added' - in terms of organisational performance, service quality improvement and fulfilling working lives for staff, can be considerable.

In this section we have covered:

- Whether SAFEC is only for PCTs;
- The importance of being willing to change;
- The role of leadership;
- Weighing up the costs and benefits.

Part 2
About the SAFEC approach

The second part of this resource pack introduces the SAFEC approach to organisational assessment and improvement, reviewing the research evidence that supports the approach, and then describes the four key principles that underpin the approach.

Section 3 Taking an organisational development approach to community engagement

Section 4 The four principles underpinning the SAFEC approach

3 Taking an organisational development approach to community engagement

The approach to organisational development described here is based on research conducted during 1999/2000 (Pickin *et al* 2001). The key message from this research was that although there were plenty of projects underway in the public sector that aimed to develop processes and mechanisms for involving service users and engaging communities in decision making at many levels, the work generally:

- was not integral to the organisation;
- was not an important way of addressing the organisation's vision and purpose;
- did not help the organisation 'do what it needs to do better'.

Too often, the task of involving service users and the public in decision making within public agencies is the responsibility of just one or two key individuals, and appears to be something that they have to carry out in order to 'tick a box'. Many statutory sector managers see involving service users and the public only as a means of achieving their goals rather than a vehicle for engaging in a long-term dialogue with services users and local people about how services should be run and developed. Predictably, this work is therefore done as a series of short-term projects rather than being part of the mainstream way of operating. Taken together the evidence suggests that the main problem is the lack of a strategic approach to working with local communities and service users.

Barriers to engaging communities in the public sector

Much is known about why public agencies find it difficult to improve their relationships with the people they serve. However, if we are to develop more effective ways of releasing and further developing the capacity of public sector organisations to engage with users and local people, we need to consolidate this evidence and bring it to bear on the practice of community engagement. This will help public sector organisations and their workers to develop a systematic understanding of what the main barriers to involving the public are, how they interact and what can be done to reduce them. The approach to organisational development described in this resource pack is based on a model that clearly identifies the organisational barriers that prevent services from effectively involving service users and the public and the relationships between these barriers.

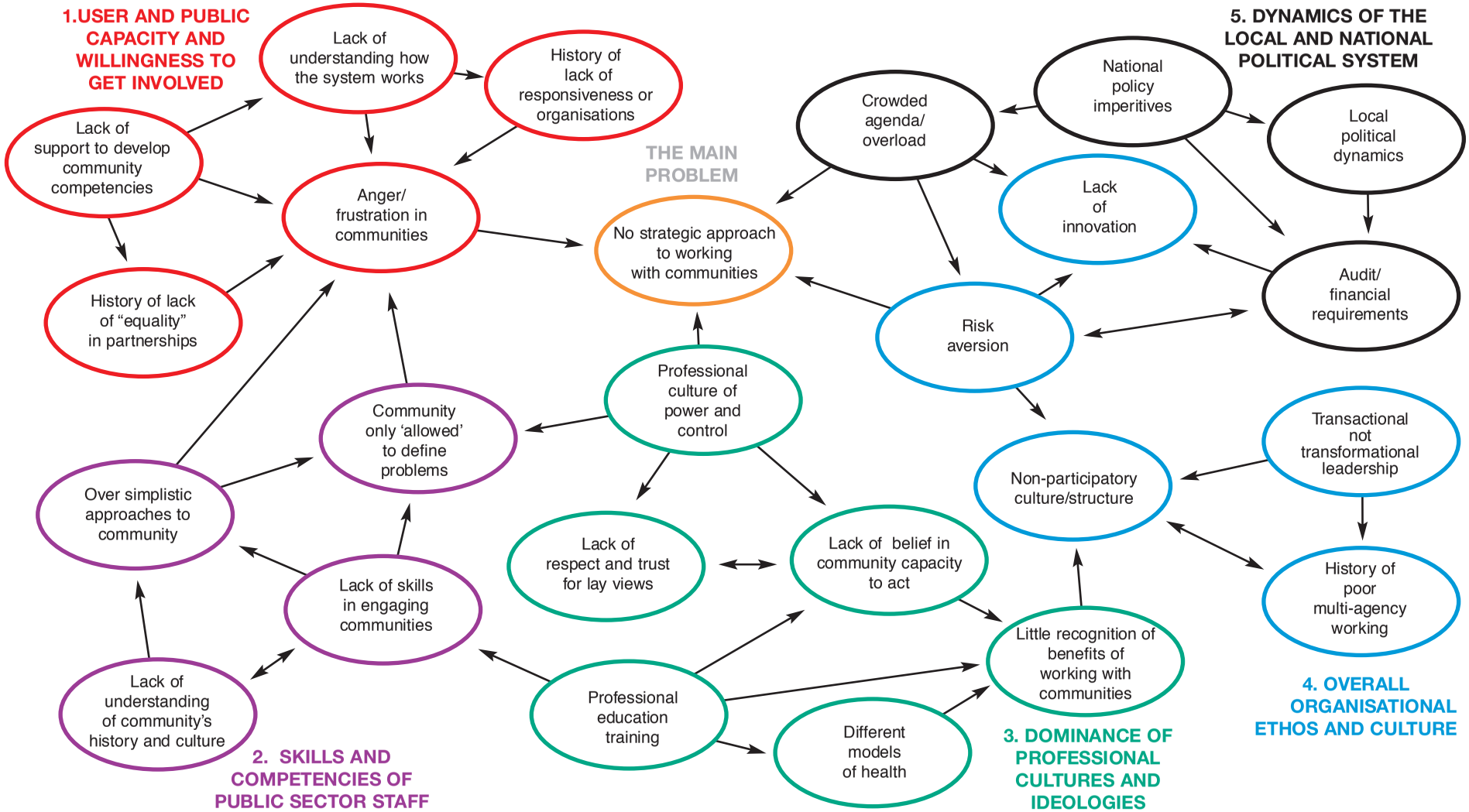
These barriers can be divided into five main groups:

- the capacity and willingness of service users and the public to get involved;
- the skills and competencies of public sector staff;
- the dominance of professional cultures and ideologies;
- the organisational ethos and culture;
- the dynamics of the local and national political system.

The barriers operating within each of these five groups, and the relationships between them, are shown in the diagram. These groups are briefly described below.

The Barrier Model

BARRIERS CONSTRAINING CAPACITY FOR PARTNERSHIP WORKING WITH COMMUNITIES



Group 1: The capacity and willingness of local people and service users to get involved

The barriers in this first group affect local people's capacity to engage in developing and implementing policy. For example, public sector workers trying to 'involve' local people in decision making are often faced with people who are angry or frustrated. This can lead to defensive responses from staff and make it more difficult to build relationships. The model suggests that this anger and frustration can be fuelled by the following factors:

- *an historical lack of responsiveness* on the part of the public sector, which causes members of the public and service users to feel that they have derived no benefit in the past from becoming involved in decision making at either an individual or a strategic level;
- *a lack of knowledge among service users and local people* of how the system works and, in particular, of how individuals or communities can get involved in the decision making processes of public sector organisations;
- *a lack of support from public agencies* for local people and service users to develop the skills and competencies they need if they are to be effectively involved in decision making;
- *unequal relationships*, which often make local people and service users feel that initiatives aimed at involving them lack genuine commitment to change things.

These barriers – including anger and frustration in local communities and a lack of respect and trust for lay views amongst service providers - affect the attitudes of local people and individual service users towards public services and their willingness to engage with them. Staff may sometimes assume that local people and/or users are passive or uninterested in being directly involved in decision-making, when in fact the opposite is true. However, anger or frustration within communities is not necessarily a hindrance to effective relationships. During the SAFEC research, one local authority senior manager explained: 'We used to get nobody along to the community forum until there was some conflict – and at the next meeting there were 100 people.' What is important is how public agencies and their workers respond to this anger and frustration, and their ability to channel that energy into positive action.

Group 2: The skills and competencies of public sector staff

Barriers in the second group are linked to the dominant beliefs within the public sector about what is an appropriate role for local people and service users in decision making processes. They reflect the fact that staff at all levels generally lack the necessary skills and competencies to engage more actively and equally with local people and users. The following situations are particularly common:

- *A lack of understanding* of, and respect for, the history and culture of particular communities, which may mean that staff are not sensitive to widely held beliefs, practices and styles of engaging among the people using their services;
- *Simplistic approaches* to working with local people and service users, which can frequently mean that initiatives to involve them cannot deal with the diversity of views and/or competing interests of different groups. There is a tendency to ignore the daily reality of people's lives, particularly in areas of multiple disadvantage. One activist involved in research for the SAFEC development said:

'You wouldn't look at a group of GPs and think they all think the same because they are GPs – I am a lot of other things besides being a resident of a poor community';

- *'Allowing' the public to only assess need or define problems* which results in a failure to make the most of the resourcefulness of local people and service users and the contributions they can make towards developing more appropriate solutions. In turn, many public sector workers believe that it is up to them alone to produce solutions to needs and problems that the community has identified. Having a sense of total responsibility for generating solutions can be overwhelming. One health service manager involved in the SAFEC research said: 'What can I do if I go into a room of 100 people who all want different things and I can't provide them?';
- *Frontline staff lacking the necessary skills***.** While most workers are aware of some of their skill deficiencies – for example, in appropriate language or listening skills - they may be unfamiliar with the techniques that they could adopt to engage in more meaningful discussions with local people and users. So lack of training is an important issue. As one public sector worker in our research noted: 'It's distressing to know you've got to do something but you don't know how'. Some of these skills are generic – for example, communication skills – and some vary according to role and possibly seniority.

Group 3: The dominance of professional cultures and ideologies

A third group of barriers to more effective and equal relationships between public sector agencies and the communities they serve arises from the cultures of health professionals. Research suggests that the following factors create these barriers:

- *Issues of power and control.* These dominate professional cultures in the health field. Professionals are trained to take responsibility for decision making so they find it difficult to share this responsibility with lay people;
- *An emphasis on the 'scientific' model of health care***.** Within professional cultures, scientific knowledge about health and illness is considered legitimate while the 'expert' lay knowledge, based on experience, is undervalued. One NHS manager involved in the SAFEC research commented: 'The lay views are listened to with interest, but they aren't given any weight in decision-making';
- *Underestimating the capacity of the community.* Professional cultures underestimate the capacity of local people to act collectively to improve health. Many communities, particularly those in disadvantaged neighbourhoods, are viewed as 'deficit' – lacking any skills and competencies that are of value to the communities themselves or to the public sector. So, instead of building on what is already there, statutory sector workers tend to impose their own structure and solutions. Community members can perceive this as disrespectful, as one community activist highlighted during our research when she declared: 'They think because you're poor you must be thick'. It is perhaps not surprising that statutory workers tend not to be aware of the benefits that can stem from more effective and equal relationships between public agencies, health professionals and lay people;
- *An elitist notion of expertise.* Professional education and training tends to reinforce and perpetuate an elitist notion of expertise rather than encouraging a

more inclusive view that respects and incorporates the perspectives of lay people while still valuing the technical expertise of professionals;

- *Professionals and lay people working with different models of health.* Professionals are more likely to work to a biomedical than a social model of health, so they are more likely to undervalue the benefits of community engagement in governance and decision making.

Groups 4 and 5: Organisational ethos and culture and the political context

The fourth and fifth groups of barriers relate to the organisational cultures of the public agencies and to the local and national systems within which they operate. Three of the barriers belonging to these two groups are particularly important: policy overload, aversion to risk and a transactional leadership style:

- *The policy overload***.** The public sector is faced with a very crowded agenda for implementing policy. This can lead to a 'siege mentality' by:
  - squeezing out structured time for thinking, and smothering innovation;
  - encouraging a reactive approach to partnership working, rather than a strategic, proactive one;
  - preferring to rely on ad hoc participation mechanisms because of the lack of staff, resources or energy to spend on developing and maintaining ongoing ways of engaging with communities.
- *Aversion to risk.* The public sector is generally too averse to risk. When the public sector develops collaborative work with the voluntary or community sectors, there is often conflict between the more entrepreneurial cultures of these last two and the public sector ethos of ensuring accountability for public money. For example, statutory-sector financial accountability mechanisms, such as tendering processes, can stifle innovation. The dominance of 'worst-case-scenario thinking' in the statutory sector may avoid some problems, but it has contributed to an over-regulated sector that can repress creativity and generates barriers to more effective relationships with local people;
- *A transactional leadership style.* The dominant public sector leadership style aims to get performance from others by offering rewards and sanctions ('transactional') rather than by inspiring others to excel and to think in new ways ('transformational').

Opportunities for organisational learning and change

As we have seen the SAFEC model identifies five groups of barriers to more effective relationships between public agencies and the communities they serve. It is likely that most - if not all - of these will exist in all public sector organisations and research has shown that the different groups of barriers interact in complex ways. For example, a simplistic approach that allows local people to define their needs and problems but not the solutions will exacerbate their anger and frustration about public services. Similarly, in the dominant professional culture of power and control, local people and service users tend to be seen as 'deficits' rather than 'assets'.

As a result, many professionals do not believe that 'lay people' have the capacity to contribute to decision making at an individual or collective level, so they do not recognise the benefits of involving them. Given this, it is not surprising that the culture within many public sector organisations is unsupportive of effective community engagement. Moreover, it can be difficult to find local people willing to spend the time to get involved in consultation initiatives.

Attempts to promote community and/or user engagement in decision making in the public sector must give more weight to building the capacity of statutory-sector organisations to develop more participatory and equal relationships with local people.

However, this will require a radical shift in how many organisations think and behave. Public agencies will have to recognise the complex barriers that affect their ability to develop and sustain relationships with local people and users and act to reduce these.

In the SAFEC approach, recognition of these barriers forms the basis for a process in which the organisation learns to identify where and how it needs to release and/or build its own capacity to engage effectively with communities.

In this section we have covered:

- The five groups of barriers to engaging communities in the public sector and the relationships between these. These groups are:
  – the capacity and willingness of service users and the public to get involved;
  – the skills and competencies of public sector staff;
  – the dominance of professional cultures and ideologies;
  – the organisational ethos and culture;
  – the dynamics of the local and national political system.
- Opportunities for organisational learning and change.

4 The four principles underpinning the SAFEC approach

This section outlines the four core principles underpinning the SAFEC approach to organisational development. It addresses the importance of sustaining and transferring what has been learnt from the SAFEC process throughout the organisation, the need to focus on barriers rather than successes and the importance of including a wide range of stakeholders in the process of organisational assessment and improvement. Finally it introduces the concept of 'facilitated dialogue' – the discussion method at the heart of the SAFEC process.

The SAFEC approach to organisational development rests on four core principles:

- **Principle 1**: Lead and plan for sustainability and spread;
- **Principle 2**: Focus on organisational barriers;
- **Principle 3**: Bring together internal and external perspectives;
- **Principle 4**: Learn through 'facilitated dialogue'.

Principle 1: Lead and plan for sustainability and spread

What is the principle about?

The SAFEC approach requires organisations to make effective arrangements for:

- leadership;
- project management;
- sustaining the learning and improvements achieved through SAFEC;
- spreading the learning throughout the organisation.

The organisation's efforts to sustain and spread what it has learnt from SAFEC are also known as 'mainstreaming'.

Why is it important?

The primary aim of the SAFEC approach is to support an organisation to come to understand the complex and inter-related barriers that prevent it from releasing and further developing the capacity of its staff to work more effectively with local communities. It also seeks to nurture the belief that more equitable 'community partnerships' are crucial if public services are to be modernised and health improvements are to be delivered. The SAFEC process offers a challenging but effective way for organisations to reflect on, and improve, how they engage with local people.

In Section 2 (page 8), we highlighted the pivotal role of effective leadership in any process of change. For SAFEC to deliver real benefits, the leadership arrangements for this organisational development work must include those people responsible for the values, culture and overall running of the organisation, including:

- non-executive board members;
- elected members of local authorities;

- the chief executive;
- executive directors;
- other members of the management team;
- (and in primary care trusts) the professional executive committee.

The arrangements must also fully engage middle managers with operational responsibility for service delivery.

Structured project management is an important way of engaging the organisation's leaders in the organisational development process, and can reduce the risk of some senior staff remaining unconvinced of the value of organisational self-assessment and challenge. However, if the focus is too narrowly on project management, this can create a short-term management environment. In this scenario, participants are expected to deliver a set of outcomes by a given date and there is little emphasis on making sure that the learning is spread throughout the organisation or that it is sustained.

While it is carrying out a SAFEC process, the organisation also needs to make a parallel effort to develop structures, processes and activities that ensure that the SAFEC approach will continue to evolve. Otherwise, the benefits of SAFEC – in terms of new ways of thinking, a commitment to removing barriers, and the potential for positively impacting on the services people receive – could simply fade away at the end of an initial cycle of learning and improvement. Sustaining SAFEC means making sure that new understandings and new ways of working become the norm for the organisation.

Principle 2: Focus on organisational barriers

What is the principle about?
The SAFEC approach involves an organisation assessing itself in order to identify which barriers are operating to constrain the development of more effective and equal relationships with local people and service users. It uses the findings as an opportunity to think creatively about how to reduce these barriers and hence to improve the way the organisation engages with local people and users. Its focus on barriers rather than strengths is unlike some other approaches to organisational development.

Why is it important?
Many people feel that focusing on barriers rather than strengths is a negative approach to learning. However, the organisational scientist Lewin (1947) produced a conceptual framework that supported this principle. Lewin argued that organisational change was shaped by the interaction between two sets of forces: those driving change, and those restraining or hindering change.

As we have seen in Section 1, there are many driving forces for positive change in involving the public and service users in decision making in the public sector. These include:

- new policy directives;
- political commitments;

- evidence of effectiveness for community engagement linked to policy initiatives such as Sure Start and New Deal for Communities;
- enthusiastic staff;
- active communities.

Yet, despite these driving forces, it is proving difficult to achieve any fundamental cultural change, and any change that has been achieved tends to be marginalised. Lewin explains this conundrum by arguing that a unilateral increase in driving forces always meets with an equal and opposite increase in restraining forces. So, according to Lewin, what is required for sustainable change is a conscious effort to reduce the barriers to change. As we have described earlier, the SAFEC research revealed a complex set of barriers to more effective working with local communities in public sector organisations. If Lewin's hypothesis is correct, agencies need to tackle these barriers before the policy-drivers can take effect. For long-term strategic change to occur in the way they engage with local communities, public agencies will need to:

- **cultivate** a more transformational leadership style;
- **change** the dominant professional cultures within their organisation;
- **recognise** the value of different types of knowledge – different 'ways of knowing about the world';
- **build** a more participatory culture, encouraging innovation and reducing risk aversion;
- **learn** to manage conflict more constructively;
- **develop** more sophisticated skills and techniques for engaging with local communities and service users.

The organisations themselves have direct control over many of the barriers that prevent them from having more effective relationships with the people they serve. They can also influence other barriers (such as those affecting local people's attitudes to getting involved in decision-making, and those affecting their relationships with other agencies) through the ways they and their staff behave. Other barriers arise from the way that organisations put national policies into practice. While individual professionals and organisations may have relatively little power to reduce this last type of barrier, they nevertheless can bring influence to bear upon them.

Principle 3: Bring together internal and external perspectives

What is the principle about?
In the SAFEC approach, the organisation needs to involve the whole system of stakeholders, including all parts of the organisational hierarchy – from board members to frontline and support staff – across the breadth of disciplines and services, as well as external stakeholders from other organisations, service users and members of the public.

Why is it important?
The health and social care system is made up of many parts. There is a current drive for ever more rapid and sustainable improvement in an increasingly changeable and uncertain environment. In response, public sector organisations are beginning to recognise that solving complex problems, and creating the flow of information needed to reach good decisions about how best to change the system, requires the knowledge and experience of staff and the public.

It is well documented that bringing internal and external influences and perspectives together creates a 'learning organisation' (Senge 1990). In fact, most public sector organisations already have most of the capacity they need to create and sustain the cultural and structural changes that are necessary to develop and sustain better relationships with local people. The problem is that the barriers identified by the SAFEC model constrain this capacity.

If an organisation is to release this capacity, then it must embark on a development process that brings together perspectives from across the whole system in which it operates to undertake a joint inquiry into what needs to change and then feeds the results back into the system. So it is the whole system that creates and analyses its own data and produces the solutions to the problems it identifies.

'Outside stakeholders' – in other words, members of local communities, service users and workers in other partner organisations – bring critically important information and relationships to this process. Given the diversity of perspectives involved, it is essential that equal value is attached to lay and professional expertise and to the expertise of different types of paid workers. Pooling this expertise and bringing together this diversity of perspective is an opportunity to challenge the different realities of each stakeholder group and to find a resolution. In the SAFEC process these perspectives are brought together as an Organisational Assessment and Improvement Team (the OAIT), the role of which is described more fully in Part 3 of the resource pack.

Principle 4: Learn through facilitated dialogue

What is the principle?
At the heart of the SAFEC approach is a process of 'facilitated dialogue' – a particular approach to learning through group discussion. The key elements of facilitated dialogue are:

- working within boundaries to maximise the creativity of the individuals involved;
- asking questions that cannot be answered with a 'yes' or 'no' answer;
- avoiding early consensus;
- bringing to the surface the underlying assumptions that individuals and groups hold about each other and about the way organisations 'work';
- challenging these underlying assumptions.

Why is it important?
Organisations and individuals learn and change only if they have opportunities to think and reflect with others. Providing these opportunities means challenging the goal-oriented approach that many managers (in the public and private sectors alike) take.

In a world of targets and performance management, most managers and practitioners feel they have little or no time for in-depth reflection on the nature of the problems facing their organisation, or on the range of possible options available to them to deal with these. People are pressured to use valuable learning time to move quickly to reach a consensus on the solutions to problems. They tend to adopt one strategy after another as they run into problems, without examining why the problems arise or clarifying what they hope to accomplish by switching strategy.

The world we live in is complex, and there are few 'quick fixes'. It is vital that public sector organisations carefully reflect on their barriers to change, and on the range of options for addressing these barriers. Without this reflection, they will not be able to deliver the many targets, and the strategic vision of services designed around users' needs, that the Government has set for them.

It is also important that reflection and learning about organisational barriers comes from a range of perspectives, and allows for the solutions to be considered collectively, as highlighted in Principle 2 (page 18). For this, people need to be involved in an organisational development process that provides 'protected' time and space for collaborative thinking and reflection. The process must also have clearly defined boundaries, on the premise that the more freedom of action (or dialogue) is constrained, the more creative it can become.

In this section we have covered the four principles that underpin the SAFEC approach:

- Lead and plan for sustainability and spread;
- Focus on organisational barriers;
- Bring together internal and external perspectives;
- Learn through 'facilitated dialogue' discussions.

Part 3
Step-by-step guide to implementing SAFEC

This is the main part of the resource pack. It gives you step-by-step guidance on how to implement the SAFEC process of organisational assessment and improvement underpinned by the principles detailed in Part 2. As you move through the steps you will find descriptions of a number of resources that we have produced to support the SAFEC process. These can be tailored to the needs of your individual organisation. They include sample documents, diagrams, templates, checklists and 'learning points' from the SAFEC pilot sites. All of these resources are included in numerical order in Part 5 so that you can readily access them for photocopying. In addition, some of them are also integrated into the main text where they help to clarify the points being made. A Powerpoint presentation providing an introduction to SAFEC is also available as a download from www.nccce.lancs.ac.uk. The next section provides a brief overview of steps needed to implement SAFEC before each of the steps are described in more detail.

Section 5 Overview of steps to implement SAFEC

Section 6 Are you ready for SAFEC?

Section 7 Getting started

Section 8 The SAFEC facilitators

Section 9 Establishing an organisational assessment and improvement team

Section 10 Planning and delivering team discussions

Section 11 Mainstreaming SAFEC

5 Overview of steps to implement SAFEC

This section gives you an overview of what to expect from the entire SAFEC process: from exploring whether your organisation is ready to start SAFEC, through the various elements of the assessment and learning process itself and, finally, to making use of the learning points that come out of the process.

The SAFEC approach requires a step-by-step implementation process in which you:

- Prepare yourself and others for learning about the barriers to effective community engagement operating within your organisation;
- Create a partnership group called the organisational assessment and improvement team (OAIT) – including staff from your own and other organisations and members of a local community - to discuss barriers to engaging local people and to explore ways of reducing those barriers;
- Mainstream learning throughout the organisation about the barriers found to exist and how they might be reduced.

The steps involved in the SAFEC processes and the related work tasks that are needed to implement SAFEC are detailed in a sample SAFEC plan (Resource 3) contained in Part 5. In summary the work involves:

- **Assessing whether SAFEC is the right approach for you**: undertaking activities aiming to help you establish whether your organisation is ready for SAFEC;
- **Getting started**: assuming you decide to proceed, you will need to put the management structures and processes in place to deliver the SAFEC process and to support the mainstreaming of the learning into the wider organisation;
- **Selecting and training your SAFEC facilitators**: the SAFEC process of assessment and improvement depends on the skills of experienced facilitators willing and able to develop some new approaches specific to SAFEC;
- **Establishing an OAIT**: it is through the OAIT that you will explore the barriers to community engagement operating in your organisation and explore ways in which these can be reduced;
- **Planning and delivering a process of facilitated dialogue**: this is the central element of the SAFEC process of learning and improvement;
- **Undertaking activities designed to mainstream** the learning from SAFEC.

Throughout the SAFEC process these different strands of work will need to be carefully planned and managed, processes for ensuring that learning is captured will need to be put in place and maintained and the senior members of the organisation will need to be kept informed about the work as it develops to maximise the likelihood that the learning will be acted upon. These on-going management tasks are described in more detail in the sections below and are also listed in the sample SAFEC plan included as Resource 3 in Part 5. It is important that you start planning early in the process in order to be confident you have the right resources and support to carry out the tasks involved. Using the sample plan may save you considerable time.

6 Are you ready for SAFEC?

This section explains how to explore whether your organisation is ready to begin SAFEC, and provides advice and a checklist to help you in this decision making.

The first step for any organisation thinking of adopting the SAFEC approach is for the senior management team and governing body to consider carefully whether they are ready to embark on a significant organisational development initiative. People considering using the SAFEC approach need to familiarise themselves with it, reflect on how ready they are for this type of organisational change process, and consider whether it is the right time for them to implement SAFEC. Some of these issues were highlighted in the introduction to this resource pack (page 7). This could be done as part of a private meeting of your board but you need to make sure there is enough time for people to consider the issues involved properly. The list of questions included in Resource 2 - 'Are we ready to lead SAFEC?' - is intended to support this process of assessment by taking the board through a series of questions which should help them ascertain whether your organisation is ready for SAFEC and understand the commitment required to make it work. The questions are set out under four headings:

- Leadership focused on the needs of local people and users;
- People to manage the change process;
- Organisational structures that support change processes;
- Partnership working with local communities.

The types of questions included in Resource 2 are illustrated in the box below.

- Are you convinced that community engagement and user involvement will benefit your organisation?
- How will an organisational development process contribute to your longer-term improvement strategies?
- Is this the right time for your organisation to focus on organisational development?
- Are you prepared to dedicate your best people to this work?
- Can you identify a really good project manager?

Another way to explore the organisation's readiness is to hold a half-day workshop that involves the board and perhaps other senior officers of the organisation. An introductory presentation to use on such occasions is available online at www.nccce.lancs.ac.uk, and a plan for a half-day event is presented in Resource 4. The questions included in Resource 2 and briefly described above could also be used to prompt discussions. This type of workshop can be very useful in helping the senior management team and the governing body decide whether to implement a SAFEC process of learning and change in your organisation. However, it is also important that the senior management and governing body realise that this is only the beginning - they will need to be involved at regular intervals throughout the SAFEC process, rather than just at the beginning and end.

Learning Point
Experience at the pilot sites confirmed that the senior management team, including non-executives and/or elected members, must stay actively engaged in the process if the learning is to be mainstreamed.

If your organisation decides to go ahead, the remainder of the resource pack will take you step-by-step through the process of implementing the SAFEC approach and help you to tailor it to suit your organisational needs.

In this section, we have looked at ways of assessing whether your organisation is ready to begin the SAFEC process, including suggestions for:

- A half-day event to familiarise senior staff with the SAFEC approach;
- Discussion topics to explore before going ahead with the process.

7 Getting started

This section looks at the first steps you need to take in preparing for SAFEC: deciding on the management approach you are going to use, putting the key elements of the management structure and process in place, and getting hold of the essential resources - senior managers, experienced facilitators and time.

Step 1: Deciding on a management approach

The first thing you need to do is to decide how your organisation will lead and manage the organisational development process. If you decide to use a formal project management approach to the SAFEC exercise, this will minimise the risk of it failing to deliver benefits for the organisation and used appropriately will maximise the learning about how best to run an initiative of this nature. One option is to use the PRINCE 2 structured project-management method (Office of Government Commerce 1996).

Whatever management approach you use, the individuals who will be responsible for managing the SAFEC initiative must be clear about:

- why they are doing it (what is the 'business case'?);
- who is sponsoring the initiative (who are its executive champions?);
- what outcomes and benefits are anticipated;
- what is involved in terms of tasks and activities;
- who will be involved, and in what roles;
- what resources are required (for example, expertise, time, rooms and equipment or money);
- how the work will be managed (what structures and roles are needed, and how these will link into the organisation's day-to-day management processes);
- what checks and controls can be put in place to constantly review the progress being made;
- how communication will be managed, and which parties will be communicating with each other.

Step 2: Put the SAFEC management structure and process in place

Many public sector organisations have access to formal project management expertise and experience, so this resource pack does not include details of any particular approach. However, you need to build a number of essential elements into your local SAFEC management structures and processes:

- **Draw up** a clear statement of the business case for carrying out the SAFEC process and the benefits that it can help your organisation realise – particularly in terms of the corporate and strategic objective of engaging local communities. See Resource 1 - 'Benefits of SAFEC'.
- **Make sure** you have executive and non-executive champions who are committed to addressing your organisation's barriers to engaging with local people. Their role is to support the project and enable it to meet its goals. At times, this could mean challenging the corporate management to reflect on the organisation's culture and its commitment to engaging local people.
- **Establish** a project management structure that has appropriate mechanisms for reporting to the senior management team and governing body, and that has other links, such as to the Patient and Public Involvement Forum in an NHS Trust, or the overview and scrutiny committees in local authorities. You may or may not require a project board, depending on your existing committee and project structures, but you will need an executive champion for SAFEC on the executive body of your organisation and a senior manager taking day-to-day responsibility for the work. A model SAFEC management structure is provided in Resource 5. The key roles to establish in the management process are described on the next page. For a full description of the key roles, see Resource 6 in Part 5.
- **Prepare** a plan, identifying major tasks and time scales, the resources needed for each major stage of the work, and an assessment of risks to the work and details of how to propose to manage them. For a planning framework, see Resource 3.
- **Draw up** a SAFEC proposal (see below). This needs to include a plan to mainstream SAFEC learning within the organisation, and details of how the management team will hand over to the mainstream management process within the organisation.

Contents of a SAFEC proposal

1. Purpose of this document;
2. Background and the business case for SAFEC;
3. Aim, objectives and deliverables or anticipated benefits;
4. Management structure and roles;
5. Selecting the reference community;
6. Plan/milestones;
7. Reporting;
8. Evaluation;
9. Resource Plan.

SAFEC roles

SAFEC board	It approves all major plans and authorises any major deviation from agreed stages. It makes sure the required resources are committed, and arbitrates on any conflicts or negotiates a solution to any problems between the SAFEC work and external bodies. It also approves the appointment and responsibilities of the SAFEC manager. It is made up of senior executives and can include lay representatives.
SAFEC director	The SAFEC board members should include an executive director, who is ultimately responsible for the work. Our pilot sites sometimes included a non-executive PCT board member in this role.
SAFEC manager	The SAFEC manager has the authority to run the SAFEC exercise on a day-to-day basis on behalf of the SAFEC board. The SAFEC manager's prime responsibility is to ensure that the work produces the required outputs to the required standard of quality, and within the specified constraints of time and cost. The SAFEC manager is also responsible for making sure SAFEC produces a result that is capable of achieving the benefits defined in the SAFEC plan.
SAFEC team	The SAFEC director and SAFEC manager need to review the size and complexity of the work plan and its areas of impact, and then create a management team with appropriate representation. The members of the team will have clear lines of responsibility for delivering their contribution to the work. They will know what their responsibilities are to be and will be clear about the lines of reporting and communication. In our pilot sites, the SAFEC teams included: • event facilitators; • senior service managers from the PCT and the local authority; • support for administration and technical advice. It might also be worth considering involving community activists, or people from: • patient advice and liaison services (PALS); • finance, human resources, organisational or training teams.

- **Establish** a series of control points throughout the work to check that corporate commitment is still in place, that there is still a requirement for the work and that progress is being made. You can do this by:

    - **Confirming** named executive and non-executive champions or sponsors, and making sure the senior management team signs off the work plan. You need to do this at the beginning of the initiative;
    - **Put arrangements in place** to make sure all the senior managers in the organisations are aware of the SAFEC initiative and the anticipated outcomes or impacts. This process formally launches the work, and starts to develop a shared and common understanding of what SAFEC is about. The managers' support is crucial when the going gets tough. To see a SAFEC introductory presentation for boards and senior managers, visit: www.nccce.lancs.ac.uk;
    - **Set up regular meetings** (for example, monthly) between the SAFEC team and the SAFEC director to take stock of progress and manage emerging issues, such as deciding what to do if a key member of staff leaves the organisation (e.g. the SAFEC manager). Preparing a regular progress report before each meeting can be useful for capturing the important matters that need to be managed and to communicate progress and any issues to the senior management team and other interested parties. For a template for this report see Resource 7.
    - **Give regular presentations** on progress and emerging issues to the senior management team and the wider governing body, and present a final report capturing the learning from the first SAFEC exercise, including the proposed mainstreaming plan for them to approve.

Learning point
Several of our pilot sites had a SAFEC board chaired by a non-executive champion, and a management team consisting of a director, a manager and the SAFEC facilitators. They found that having a formal project management structure in place helped them to keep on top of the process. All sites expressed difficulty gaining regular access to the senior management team and board members to help them develop their understanding of the SAFEC process and to manage the emergent issues arising from the initiative. Senior staff and board members had limited time to commit even when they were very enthusiastic. They had crowded agendas to manage and were sometimes challenged by the issues brought to the surface by the SAFEC process.

Step 3: Secure the three essential resources

To carry out the SAFEC process successfully, the following three resources are essential:

- **A senior manager** in the role of SAFEC manager. They must be confident communicators at an executive level, have the authority to direct the efforts of other staff, and be able to handle the complexity of issues that are raised;
- **Experienced group-work facilitators** with a proven track record in managing diverse views, polarity and conflict resolution. This issue is dealt with in detail in Section 8, 'The SAFEC facilitators';
- **Time** for SAFEC managers to manage, for management team members to support the organisational development process, and for facilitators to plan and deliver the discussion events that form part of the SAFEC process. Time must be made available to undertake SAFEC roles – they cannot simply be 'tagged on' to an existing portfolio of responsibilities.

Learning point
All the pilot site management teams needed to be released from some of their existing duties in order to contribute effectively. Because the process requires a range of skills, pilot site management teams varied in their make-up. Individuals within each team made varied and different time commitments depending on factors such as their expertise and availability, their role within the process, and what stage the SAFEC process was at. For example, SAFEC managers had to commit more time at the beginning of the process than in the middle, while facilitators made more contributions during the discussion sessions.

There is no definitive answer to how many hours a week, and what period of time, organisations need to commit to. However, as a rough guide, our pilot sites made an average commitment of between 70 and 80 hours per month, spread across the range of roles, for between 8 and 12 months.

In this section we have covered:
- Deciding on the management approach you are going to use;
- Putting the key elements of the management structure and process in place, including how to maintain control over the exercise;
- Obtaining the three essential resources: senior managers, experienced facilitators and time.

8 The SAFEC facilitators

This section looks at the importance of selecting experienced facilitators who have the capacity to develop the new skills that the SAFEC process requires. We then look at how to recruit them, and what training and support you will need to give them.

In Part 2 of the pack we explained the central place within the SAFEC process of facilitated dialogue amongst a diverse group of staff and local people. It is through this dialogue that the barriers to change operating in your organisations will be identified and ways of reducing them explored. The SAFEC facilitators therefore have a key role in the SAFEC learning process so getting the right people into these posts and supporting them in the work will be vital to your success. It is therefore important that you understand the unique features of the SAFEC facilitation process and the competencies required from the SAFEC facilitators.

The facilitation process and facilitators' competencies

Facilitated group work in most of our organisations is usually carried out following a 'consensus' model, aiming to find the common ground between participants. In SAFEC, however, the facilitation process has a rather different goal: to create an environment where differences are used to provoke learning. This means that rather than working to find what the participants have in common, facilitators have to work to reveal people's different perspectives. It is about:

- revealing areas for discussion and challenge rather than consensus;
- exposing individual and group assumptions;
- using these revelations to gain better insight into the values, judgements and behaviours of staff and the public.

The SAFEC facilitated dialogue is designed to help participants to identify which of the barriers in the SAFEC model are operating within your organisations and to understand how they are preventing service users and the public from being more effectively and extensively involved in organisational decision making at all levels. The facilitators' task is to find ways to stimulate discussion about the barriers so that the underlying assumptions held by participants are revealed. They also need to know how to stimulate thinking about how to verify the existence of the barriers that have been identified during discussions and help participants to explore ways in which these barriers could be reduced.

For these reasons, you need to select your facilitators carefully. Their role will determine the effectiveness of the group of people involved in the process of facilitated dialogue – the organisational assessment and improvement team (the OAIT) - and therefore the learning that this group generates. SAFEC facilitators need a range of competencies, including a track record in facilitated group work, skills in managing different perspectives and conflict, being comfortable in handling discussion and challenging the group participants. A full list of facilitator competencies is presented in Resource 8 in Part 5. An inexperienced facilitator may

struggle to master the basic techniques of group facilitation that the SAFEC dialogue approach demands, and could find it particularly difficult to carry out the crucial task of challenging the assumptions that emerge through the participants' dialogue.

Even experienced facilitators will need specific training and practice in the SAFEC approach. You can get more information on developing facilitators to take on the SAFEC role from the National Collaborating Centre for Community Engagement by emailing: nccce@lancaster.ac.uk.

The role of the SAFEC facilitator

The SAFEC facilitator is required to advise the project team on the design of the facilitated dialogue events - these are described in more detail on page 41 - to facilitate proceedings during these events and to manage activities between events. Typically the SAFEC manager and other members of the SAFEC project team take responsibility for overall project management but facilitators may also have responsibility for planning, monitoring, budgeting and reporting progress to the team relating to the discussion events. The precise allocation of responsibility to facilitators will therefore depend on the size and composition of your SAFEC project team.

As we have already explained, the discussion events require skilled facilitation of the OAIT. There are a number of issues concerning group dynamics in the OAIT and the design of the discussion events that are crucial to their success, so the SAFEC facilitator needs to be confident with managing the participants and the event process.

Managing participants

SAFEC facilitators need to be skilled in working with divergence in relation to both the membership of the OAIT and the viewpoints of members. Members of the OAIT are drawn from a local reference community - the process for selecting this community is described in more detail on page 37 - from your own employees and from people employed to work in other public and/or voluntary services related to the reference community. Here, as in many groups, there are a host of psycho-social issues to contend with, including control, power, trust, inclusion, tolerance of ambiguity and hierarchy – the latter referring not only to the hierarchies that exist within and between the professional workers, but also to the relationship between professionals, service users and members of the public.

There is the potential for frustration and sensitivities as a result of the invitation to disclose personal and professional experience of managing, delivering and receiving health care services, given the emotions that can accompany this type of experience. This requires well developed facilitation skills and insights into group dynamics.

Managing the event process

In addition to the core facilitation competencies, and the particular insight and skill in dealing with challenging group dynamics, SAFEC facilitators need a number of other attributes described in more detail below:

- **A thorough understanding of the barrier model and its component parts.** SAFEC facilitators need to introduce sections of the barrier model early in each discussion event in order to set the scene for the question under discussion. To give a confident presentation of the barrier model, they must have a sound knowledge of it. This knowledge can also help them to manage the dialogue in each event, signposting future events if issues arise prematurely. This requirement is not related solely to the event process but to the project as a whole – it is included in the list of key competencies for SAFEC facilitators detailed in Resource 8, but all members of the SAFEC project team will need to be very familiar with the SAFEC barrier model and general approach.

- **The ability to surface the assumptions underlying statements made by OAIT members.** The SAFEC facilitator is responsible for 'surfacing', or drawing out, assumptions embedded in statements made by participants during the facilitated dialogues. They therefore need to be equipped with an understanding of what assumptions are and to have had practice in drawing them out from statements people make. They must have the confidence to do this – reinterpreting people's statements in order to draw out the assumptions behind them for verification is not a natural function of facilitation.

  In SAFEC, the facilitator needs to make sure statements they highlight of particular relevance to the discussion are checked back with the participant who made them, in order to clarify their meaning and, where necessary, ask participants to acknowledge the assumptions embedded in these statements. This is the recommended way of working for the OAIT events. It allows the facilitator to focus primarily on process, and empowers participants to recognise their own assumptions and, over time, to help others to do this as well.

- **To facilitate a process over one or more events.** The facilitator needs to move the group through several key stages of the facilitated dialogue process, including:
  - introducing the barrier domain topics;
  - stimulating discussion;
  - drawing out assumptions relevant to the barriers under discussion;
  - deciding which of the assumptions identified to 'verify';
  - generating an action plan for verification.

  They then need to take responsibility for ensuring that the dialogue is linked from one event to another. Subsequent events will need to involve reporting back on verification activities, further exploration of the status of particular barriers within your organisation and discussion about possible ways of reducing these. This will ensure that the learning is developmental and cumulative as the events proceed;

- **The ability to bring closure on issues.** The SAFEC facilitator will help the OAIT to identify many assumptions about the barriers under discussion during the facilitated dialogues, but only some of these can be followed up with verification exercises and actions aimed at changing behaviour within the organisation. The facilitator needs to feel confident working through assumptions about barriers to explore how these assumptions might be checked out, "verified" or proven and, if found to exist, to determine with the OAIT what action might be taken to change the organisation to reduce or remove the barrier.

Learning Point
Feedback from our pilot sites indicates that facilitators prefer not to have a prescribed approach to delivering these elements of the SAFEC process. Instead, they like to draw on their own experience to design one or more events to deliver the SAFEC process within whatever time frame they decide is appropriate for the task in hand. This may be a half-day or full day event programme or a series of linked events. The key issue is that they should not feel they are fighting the clock, and need to have flexibility in how they design events and deliver the process. They will also need awareness of, and the ability to use, different facilitation styles. Facilitators also used different approaches to getting the group to decide which of the assumptions identified during a discussion they wished to focus on for verification and carry forward into the next event.

Step 4: Appoint the facilitators

You will probably need to appoint at least two facilitators for your SAFEC work. As we have already stressed, facilitators need to come to the role with a solid foundation in facilitation skills, based on the core competencies identified in Resource 8. Fran Rees, in '*The Facilitator Excellence Handbook*' published in 1998, offers a comprehensive framework for facilitation competencies and a tool for assessing facilitation skills that can be used when recruiting staff. These competencies could be used as the basis for a job description for a SAFEC facilitator.

Potential facilitators will need to demonstrate:
- an understanding of the role and fundamental skills of a facilitator;
- skills in designing and managing meetings to get results;
- experience in selecting and using a variety of tools to aid engagement and manage participation in groups;
- the ability to recognise and deal with difficult behaviours and group dynamics;
- the ability to use a variety of techniques to help groups work towards solutions that satisfy multiple needs;
- skills in helping groups to review progress and in giving feedback on group progress.

Even very good candidates are likely to need extra training to develop their ability to identify assumptions during discussions and all candidates will need to develop an understanding of the SAFEC barrier model and the process as a whole.

Competent facilitators are crucial to the SAFEC process. Ideally you should try and find a member of your own staff to fill these roles as this will bring added benefits to the organisation – as described below. However, in some circumstances you may find you have no internal candidates suitable for the roles and have to employ external consultants.

Learning point
The SAFEC pilot sites recruited senior managers from within their organisations to perform the facilitator roles. Some of the facilitators found their roles difficult or uncomfortable, particularly as they had to maintain long-term working relationships with colleagues who were members of the OAIT. They also found that it took time and practice to move away from the consensus model of facilitation to one that focused on exploiting differences. Mentoring and other support systems were felt to be very important in helping facilitators manage these pressures.

Step 5: Train and support the facilitators

Whether you appoint internal candidates or employ external people, and no matter how much facilitation experience they have had, SAFEC facilitators will need support to understand the SAFEC model and the process of facilitated dialogue. Personal development plans will enable them to develop their SAFEC facilitation skills, taking into account their existing skills, competencies and experience. Investing in a well thought-out training and development plan for your facilitators will help release your organisation's capacity to improve its relationships with users and your local communities, as well as enriching your workforce. Even if you have employed external consultants the first time around, developing training opportunities for SAFEC facilitators will provide you with valuable experience and skills that could be used to develop your own staff as SAFEC facilitators in the future. Our pilot site facilitators had a three-day residential training programme on the SAFEC approach, and on-the-job coaching and mentoring from experienced facilitators. Some of the less experienced facilitators also had facilitation skills training. Further advice on approaches to supporting facilitators is available from the pilot sites through the NCCCE website: www.nccce.lancs.ac.uk.

Learning point
All the dialogue facilitators from the pilot sites said they gained a high level of personal development and enrichment from their SAFEC experience and from the related training they received. They felt that the skills and competencies they had acquired through this training and experience could be transferred to other aspects of their working lives.

In this section we have covered:

- Why it is important to select facilitators with the specific skills required by the SAFEC process;
- How to select and appoint the facilitators;
- What training and support they will need.

9 Establishing an Organisational Assessment and Improvement Team

This section looks at how the SAFEC process is focused by the SAFEC Board choosing a reference community and how the SAFEC team can identify and recruit appropriate members for the OAIT from people living and working in this community. It is in the OAIT that the initial learning takes place through a process of carefully managed discussion known as 'facilitated dialogue'.

The process of assessment and learning about organisational barriers to effective community engagement that is at the heart of the SAFEC process takes place within the OAIT. To provide some shared perspective and coherence for the OAIT, the SAFEC board has to decide which community the discussions should be focused on. Once this is decided potential members of the OAIT can be identified from people connected in some way to this 'reference community'. Advice on how to identify a reference community (Step 6), and to identify and recruit members of the OAIT (Steps 7 and 8), is provided in this section.

Step 6: Choose your reference community

The SAFEC process is about helping organisations to work more closely with the communities that they serve. To do SAFEC requires your organisation to bring together local people and staff who have something in common to explore their different experiences and perspectives - that is, to identify a particular community to form the focus of the SAFEC learning experience.

The SAFEC approach places great value on people's life experiences, whether as service users, as members of a local community, or as employees of an organisation. Each individual holds a mental map of the world consisting of essential information not only about how an organisation works and their experience of it, but also about the individual's own values, expectations, prejudices, and assumptions.

These mental maps shape the way people interact with each other, and account for how two people can have very different perceptions of the same reality. During the SAFEC process, the OAIT - see page 42 - will meet up for 'facilitated dialogue' discussion sessions. It is important that these discussions are rooted in the experiences that people have had – in other words, in their own 'stories'. This can not be done unless the people involved are all focusing on the same community when they explore the issues through dialogue.

The SAFEC approach enables you to use whatever definition of 'community' you choose. Although we are all members of more than one 'community', the focus of the SAFEC dialogue will be a single 'reference community', which the SAFEC Board will identify and define at the outset. Having a clearly defined sense of the community in question keeps the discussion on track, and creates common ground between the OAIT team members.

You may decide to choose:

- a geographically defined community, such as an area of a town;
- a service-user group, such as those using general practice services;
- a disease-care group, such as people with diabetes;
- an age or gender group, such as young men;
- a group of people with some other homogenous characteristic, such as a school.

Learning point

Our three pilot sites chose the following reference communities:

- young people who were users or potential users of sexual health services in a given locality;
- users of primary care services;
- older people resident in a particular locality.

Step 7: Identify members of the OAIT

Once the SAFEC Board or team have agreed on the reference community, you can begin to identify staff and members of the public who have had experiences relevant to this community. You can then invite them to join the OAIT.

The OAIT team is not a 'representative' group in the formal sense of the word – it is created by making use of existing relationships between organisations, service users and/or local people from the reference community. It consists of between 10 and 20 people who are chosen to reflect the 'whole system' with which the organisational development process is concerned. They also need to be assertive enough to express their point of view and must have good listening skills.

The OAIT should include:

- staff from all levels within your organisational hierarchy, from executives to senior managers, frontline staff and support staff (which may include porters, cleaners, laboratory assistants or caretakers);
- a mix of professions, roles and functions;
- workers from other parts of the local health and social care system – public and private, voluntary and community sectors – relevant to the reference community;
- local people and/or service users from the reference community;
- one or more members of the SAFEC board, if you have one.

We have included a checklist to help you identify potential members of the OAIT, having an eye to the diversity that you need to reflect (Resource 9, Part 5). You may find it useful to develop this template as you gain experience of trying to recruit people to your OAIT.

At this stage, the SAFEC team will also need to prepare themselves to answer the questions that people are likely to ask when they are approached to join the OAIT. You will need to be prepared to answer questions about:

- what SAFEC is about and how the process will work;

- what being involved in the OAIT would entail;
- how much time will be involved;
- whether there will be any work outside of the facilitated dialogue events;
- arrangements for claiming for expenses such as travel or childcare.

The expenses issue may be one of the first barriers to engaging the community that you encounter. You need to have a clear policy and be ready with systems and processes for dealing with petty cash. You could produce a leaflet with answers to these and other questions you think potential OAIT members might have which you can give out during the recruitment process. For a sample background briefing, see Resource 10.

Learning points
The pilot sites began by approaching the networks of organisations and professionals related to their reference community. They identified individuals including, for example, care workers, service managers or support staff whom they knew, and who had a particular connection with the reference community. Then they drew up a list of possible participants. They also identified members of the reference community who could be approached to participate. The sites also produced background information leaflets to give to people who were being asked to join the OAIT which also sought to provide answers to 'frequently asked questions'.

Step 8: Recruit the team members

Once you have developed a list of potential members of the OAIT your next task is to agree on who should contact these people to invite them to join the OAIT. Someone will need to contact the potential members, either by phone or in person, and explain:

- what the OAIT is;
- why it is being set up;
- the importance of staff and local people from the reference community participating in it.

Potential members of the OAIT will also need the background information about the SAFEC approach that you will have prepared. You may find that during your first round of face-to-face approaches, the names of other potential members emerge. Follow them up too.

Learning point
The pilot sites found it was a good idea to hold a short initial meeting with the provisional OAIT members. This gave them the chance to explain more fully what was expected from them, the background to the SAFEC initiative, and how much time they would have to commit to it. It was also a good opportunity for people to get to know each other and develop their networks with others sharing a common interest in the chosen reference community.

In this section we have covered:

- Deciding on a reference community;
- Identifying members for the OAIT;
- Recruiting the team members.

10 Planning and delivering team discussions

This section explains how to prepare the OAIT's 'facilitated dialogue' discussions. This involves planning the discussion content, organising the programme, and managing the discussion process.

An exploration of the barriers to user and public involvement operating in your organisation is at the heart of the SAFEC process of organisational assessment and improvement. You will do this through a series of structured discussions between a diverse group of staff, local people and/or service users who are members of your reference community and other external stakeholders. This is known as the 'facilitated dialogue' process.

In this section we consider how the facilitated dialogue events might be organised and how the dialogue is managed during the events.

Step 9: Plan your event programme

The OAIT brings together a range of different perspectives and expertise. Each member has their own knowledge, the stories and experiences that underpin this knowledge, and the values and beliefs that give the knowledge shape. They also have some connection with the selected reference community (see page 37). The best way to draw out their knowledge is through carefully structured participative events that enable them to discuss and analyse the barriers to public involvement identified in the barrier model and decide whether they feel that a particular barrier is operating in the organisation. The programme of events for the OAIT should cover all five groups of barriers highlighted in the SAFEC model, but it doesn't matter what order you address these in or how many events you decide to have.

The SAFEC process allows you to arrange the programme of facilitated dialogue events flexibly to suit the circumstances, preferences and expertise of each project team and facilitator – though you may need to take into account any special needs relating to the potential members of the OAIT when you are deciding how to organise these events. Consider whether it would be better to:

- **organise a series of single-issue events** that discuss one particular barrier, such as the organisation's approach to risk management, or to tackle a number of barriers in the same session;
- **schedule a programme of events** in advance, to take place at regular intervals over a 6- or 12-month period, or to schedule events one by one, taking your time to fully exhaust discussion around each barrier or group of barriers before moving on to the next;
- **set a standard time for each event** (half- or full-day) or to hold events with varying lengths, such as alternating half and full days, or holding a two-day event with shorter follow-up events.

To get the maximum involvement of your team members, let them know what you are planning at a pre-meeting and listen to what they have to say about these

arrangements. It is really important that you make sure that OAIT members are happy with the timing of the events and know the dates for events well in advance.

The project team must plan each event carefully. There are many methods and techniques for facilitating small and large-group events that you can use to structure an event for your OAIT, and experienced facilitators will be able to tell you the methods they are familiar with. An example of an event plan for a facilitated dialogue is presented in Resource 11. If you decide to try something new, practise it first on a small group of colleagues who can give you constructive feedback before you take on a large group. It might also be useful to seek advice from specialist facilitation consultants.

Learning point
On occasions, facilitators at the pilot sites were anxious about using some of the facilitation techniques that the project team recommended. Instead, they preferred to adopt methods with which they were already familiar. Asking the dialogue facilitator to tell the project team which approaches they are familiar with, and which they feel confident to use, will avoid these difficulties.

Step 10: Manage the facilitated dialogue

As we have seen, the OAIT takes part in a series of facilitated dialogues – discussions about organisational barriers to involving service users and the public in decision making. This process has to be managed so that it provokes the greatest learning and mindset shift.

The SAFEC method for managing the dialogue involves four key elements:

- asking 'trigger questions' that cannot be answered with a simple 'yes' or 'no';
- avoiding early consensus;
- revealing assumptions underlying statements by participants;
- challenging these assumptions.

Ask trigger questions

The OAIT learning process begins with a presentation by the facilitator focusing on one or more of the barriers in the SAFEC barrier model. The facilitator then triggers group discussion using 'open' questions relating to the barriers highlighted. It is vital that these questions cannot be answered with a simple 'yes' or 'no'. Asking questions that have no easy answer can be disconcerting for those being asked the questions, particularly in the case of professionals who are used to being the experts – in other words, the ones who should know the answer. But it is exactly this 'unease' that creates space for the facilitator to encourage participants to think and reflect more widely and more deeply than they may be used to doing in their day-to-day lives. The facilitator needs to feel sufficiently confident about the overall process to not be distracted into a debate about the appropriateness of the question, but instead to use it as a framework for collaborative thinking. We have provided a list of possible trigger questions relating to each of the domains in the SAFEC barrier model in Resource 12 (see page 89 Part 5).

Learning point
Questions used by the pilot sites included:

- *What do workers believe are the benefits of working in equal partnership with user groups and communities?*
  This prompted people to reflect on what benefits there might be and for whom, and on the meaning of 'equal partnership'.
- *Who in this organisation holds power and controls the agenda?*
  This led to reflection on what 'power' means in this context, and whether that power is devolved, shared or centralised.
- *Who leads this organisation?*
  This led to a reflection on the meaning of 'leadership', what style of leadership predominates, and whether leadership is shared or devolved, or both.

Avoid early consensus
During facilitated dialogue people are likely to express differing and potentially conflicting views. This can be uncomfortable, since many of us try hard to avoid conflict. Because of this, the team members may begin to look for consensus before they have explored fully the nature of the problem. However, the reasons that public sector organisations find it hard to engage with the individuals, groups and communities they serve are complex and deep rooted.

There are no 'quick fixes' to these problems. The facilitator needs to steer the group away from an early focus on solutions and encourage them instead to explore in-depth the nature of the barriers that operate within the organisation that prevent it from having a more effective relationship with the communities it serves.

Reveal underlying assumptions
People working in public sector organisations have a range of assumptions about each other, about service users and about local people. Service users and local groups also make assumptions about public sector organisations and their workers. People do not make many of these assumptions explicit – they may not even consciously know that they hold them – but these assumptions shape the way we behave and can act as powerful barriers to true collaboration between members of local communities, service users and the public sector.

Examples of assumptions that can inhibit more effective community engagement and service users' involvement include the beliefs that:

- poor people are not very intelligent (rarely expressed outright);
- frontline staff do not engage more fully with local people because of lack of time and/or lack of skills;
- managers do not care about patients or clients.

Making these and other underlying assumptions explicit is an important step in learning and problem-solving. Organisational learning expert Chris Argyris has pointed out that learning can only occur when people are committed to examining assumptions and are open to challenge.

The facilitator needs to help individuals become aware of the assumptions that inhibit their learning, and challenge them, before the OAIT – and through them the organisation – can move towards a shared understanding of the complex and interrelated nature of barriers to community engagement that operate locally. This means that the facilitators must be aware of the presence of these 'inhibitory assumptions'. They must be able to spot them hidden in seemingly innocuous words and need the courage to reveal them (Argyris 1982).

We have provided some examples of the assumptions that emerged from the SAFEC process at the pilot sites in Resource 13 (page 90 Part 5). These included:

- Local people are not angry but may be apathetic;
- People have low expectations of services;
- People do not understand how the system works;
- NHS staff do not understand rural life;
- NHS staff work with stereotypes of service users;
- Staff listen to users but then do not take any action;
- The organisation does not have effective ways of involving people;
- Communication within the organisation is very poor;
- Service managers feel powerless to change things;
- Initiatives to involve people lack coordination;
- Politicians do not understand the complexity of engagement.

Challenge and verify the assumptions

Challenging people's assumptions while simultaneously creating a safe space for members of the OAIT to engage openly and honestly in the discussions is difficult to achieve and is not a task that comes naturally to anyone. It is here that the mixed nature of the OAIT is so useful. If the facilitator can make sure that the underlying assumptions in people's statements are clear to other team members then, as long as they all feel supported, the facilitator can encourage the team members themselves to begin to challenge each other's assumptions.

At this stage, a verification process is introduced. This process is designed to remind people that most of what we say is based on assumptions – that is, we do not know for sure that we are right. In the SAFEC process, once the facilitator or another member of the team reveals an assumption among the team members (for example, that frontline staff have the skills but do not have the time to fully engage with client), the team then has to devise a way of verifying the statement. In practice the dialogues resulted in far too many assumptions for the OAIT to verify them all so the facilitator had to help the team to decide which of the assumptions they had identified they wanted to verify – often the team worked on 2 or 3 assumptions from a longer list generated during each event.

In relation to the verification process it is important to distinguish between evidence-based practice (carrying out detailed research) and reflective practice (encouraging participants to seek further views on a particular assumption in order to help the team learn). The SAFEC verification process is an example of reflective practice – this is much less resource intensive and in depth than research would be but arguably no less enlightening. The case study provides an example of the process of facilitated dialogue and verification. More ideas about how assumptions could be verified are provided in Resource 14 (page 92, Part 5).

Case study: Revealing and challenging assumptions

In one pilot site, the OAIT took part in a discussion around the question: 'Do PCT staff working with patients have the necessary skills and abilities to engage with them?'. Having debated what skills were needed, and who in the PCT needed to have them, the frontline staff confidently said they felt that they and their colleagues had these skills. Through the facilitation, however, the service users and community members gradually expressed their views that, in their experience, frontline staff did not exhibit these skills in their dealings with them or their friends. The frontline staff retorted that they did have the skills, but they could not use them with patients because of pressure of time, and that if they had more time they would do so.

The team then started to address the question: 'Was it lack of time, lack of skills, or something else that was preventing frontline staff engaging well with patients?'. All the team members held the assumption that the predominant issue was that of time, and that solutions should focus on giving frontline staff more time with patients.

The facilitator then asked: 'How could we check this out?'. A manager of frontline staff from a range of disciplines agreed to develop a short questionnaire and circulate it among her team. The local patient advice and liaison service co-ordinator also agreed to raise the issue with some of their patients, and this became the agreed 'verification process' to check out this assumption.

The results of this process revealed that although many frontline staff perceived lack of time as important, it seemed to be only part of the problem. Two other issues emerged: first, some frontline staff felt it was not really worth trying to get patients more involved in their treatment because they believed the patients lacked the necessary skills and competencies to be actively involved; and second, some feared that if they did engage with patients in a more proactive way, they may be overwhelmed with issues they could not respond to.

This example highlights how sophisticated the process of identifying and reducing barriers needs to be. Relying on first impressions is not good enough. To reduce the barrier highlighted here, the organisation does not just need to make sure the employees have more time, it also needs to:

- **make sure** frontline staff have the skills to engage effectively and that these are maintained;
- **raise** awareness among frontline staff that patients can be actively involved in decisions about their treatment;
- **ensure** that patients are supported to engage effectively;
- **help** frontline staff to cope with feelings of being overwhelmed if patients raise issues that they do not feel confident to deal with;
- **develop** effective organisational processes to respond to issues raised by patients/users;
- **find** ways to allow frontline staff more time to spend with those patients who need it.

In this section we have covered:

- Planning the facilitated dialogue discussions;
- Organising a programme of discussions;
- Managing the facilitated dialogue using ‘trigger questions’;
- Thinking about the verification process.

11 Mainstreaming SAFEC

This section explains what is meant by ‘mainstreaming’. It describes some of the generic learning the SAFEC process can generate and suggests how you might begin to spread what has been learnt throughout your organisation, contributing to a gradual shift in your organisation’s mindset to help it work in more equal partnership with the local community.

‘Mainstreaming’ is the process of transferring the collective learning of all those closely involved in the SAFEC process throughout the organisation in order to promote a gradual mindset shift among staff. The Modernisation Agency’s ‘spread and sustainability’ principles can be helpful here (see ‘*The Improvement Leaders Guide to Sustainability and Spread*’, 2002).

Step 11: Transfer the learning throughout your organisation

To a large extent the learning points that you will need to mainstream will depend on each local SAFEC initiative. However, the checklist below highlights some common 'generic' elements of learning that any SAFEC initiative will deliver which you may feel are worth mainstreaming within your organisation:

Checklist: Generic learning from SAFEC that you can mainstream

Learning from the SAFEC principles and approach:

- the SAFEC 'barrier' model;
- the SAFEC process of organisational assessment using facilitated dialogue;
- forming a group made up of diverse perspectives and attracting local people to participate;
- the importance of valuing everyone as an 'expert'.

Learning from the facilitated dialogue workshops:

- the particular facilitation skills required for SAFEC;
- ingenious methods of keeping everyone interested;
- the importance of identifying and using local resources and businesses;
- new or untapped opportunities to engage with service users;
- the value of community engagement;
- the need for reflective 'space';
- the effort that engaging properly requires;
- opportunities to release capacity within the community and the workforce;
- the advantages of forming an OAIT versus conducting a service-user survey;
- the need for feedback and the responsibility to provide it;
- techniques for verifying whether assumptions about barriers to engagement are robust;
- how the organisation is perceived by people outside;
- how the organisation perceives its staff and service users;
- the barriers that inhibit community engagement;
- examples of action taken to address barriers.

Learning from managing an organisational development process:

- how to build executive commitment and support;
- how to manage work that challenges the existing culture and sometimes individuals in positions of authority and power;
- the benefits of evaluation at each stage of an organisational development process and of taking action to manage emergent issues;
- the benefits of 'expert' advice and support from internal and external coaches or mentors.

Step 12: Instigate a gradual mindset change among staff

The aim of the mainstreaming process is to begin to shift the 'mindset' of the majority of staff in an organisation by increasing their knowledge and experience of the SAFEC process. If the mainstreaming process is successful it should result in a gradual mindset change throughout the organisation and this will contribute to more effective engagement with local communities. It is important to emphasise however that this type of 'cultural change' takes time to come into effect. You should produce a mainstreaming plan at an early stage of the SAFEC process and keep returning to it to ensure that it takes account of the type of learning points highlighted in the OAIT discussions. An example of a mainstreaming plan is presented in Resource 15, Part 5.

Your approach to mainstreaming is likely to vary depending on the type of organisation involved. PCTs have a pyramid-shaped structure with few senior managers at the top of the organisation and many front-line staff at the base. If you are mainstreaming SAFEC learning in this type of organisation, you will need an approach that draws all grades and disciplines of staff into the SAFEC process. It is advisable to assign clear responsibility for mainstreaming at executive level and have a clear plan for how you hope to achieve a wider understanding of the barriers to community engagement identified during the OAIT discussions and how to overcome them.

In Part 4 we describe the learning that the pilot sites felt they had obtained from their SAFEC initiatives and two case studies which draw on the pilot site experience to give you a better idea of the nature and scale of the activities involved. Realistically one SAFEC initiative on the scale of those undertaken in the pilot sites is likely to have relatively limited impact on organisations the size and complexity of PCTs or Local Authorities. So one way of mainstreaming the SAFEC approach and sustaining and deepening learning about your organisation's barriers to engaging the public service users is therefore to run several SAFEC learning processes across the organisation over time, using different reference communities (see page 37). Running an annual programme of two or three initiatives will increase staff exposure to the concepts and practice of SAFEC. However, this type of programme needs to be sustained by a core team that understands the approach and can give support to any new practitioners.

Any attempt to mainstream learning from a SAFEC initiative will require a support structure that:

- maintains and develops the SAFEC knowledge base within the organisation;
- encourages a community of SAFEC practitioners to develop within the organisation;
- offers support to people setting up and running organisational assessment and improvement team workshops.

Staff and local people/service users who participate in OAITs can move in and out of these support roles, capitalising on the learning they have experienced. For an example of a structure that could be created to support mainstreaming, see Resource 16 in Part 5.

In this section we have covered:

- The generic learning SAFEC can generate that can be mainstreamed;
- How to instigate a gradual mindset shift among your staff.

Part 4
Sharing experience

This part looks at what lessons can be learned from previous experience. The first section lists some of the pilot sites' learning points by theme. The second section provides two scenarios based on a range of information consolidated from the pilot sites.

Section 12 What the pilot sites learned

Section 13 Building one experience: two scenarios

12 What the pilot sites learned

This section highlights some of the lessons to be learned from the experiences of the three pilot sites that we worked with to test and develop the SAFEC process. We have divided their learning into five different areas: organisational-level learning; benefits for team members; learning about mainstreaming; feeding back to the executives; and finally, spreading the message.

Learning at the organisational level

As part of the SAFEC process, each of our three pilot sites ran an OAIT. The learning that these teams generated about the organisation's relationship with local people proved to be a surprise and a challenge to the leadership of these organisations. For example:

- **Staff competency.** While staff believed they had the competency to engage with local people, local people reported that they thought the staff competence was very variable. In other words, our self-image can sometimes be very different from how the public see us. To understand an issue more completely, it is important to become aware of the range of different perspectives available;
- **Face-to-face contact.** Administrative and support staff often have the most frequent contact with the public out of any staff in the organisation, but they have little or no training in engaging or working with the public. They may be nervous or anxious about working with local people, with little support in managing these relationships. Some managers deal with this type of staff development need in a superficial way – for example, by booking them on to a course in 'customer care' - when what they really need is an exploration of more complex issues, such as their values, attitudes, fears and anxieties, and ongoing support needs. Making use of local people to deliver or participate in such staff development should be integral to any response, but managers may overlook this option;
- **Missed opportunities.** Public sector organisations and local people are missing opportunities to work together for mutual benefit. For example, a GCSE curriculum including topics on health and the health services was a great opportunity to engage young people in the development and design of new local treatment centres while, at the same time, contributing to their course work. The PCT responsible for developing the treatment centres took a consultative approach to obtain public input, delivering evening presentations in local community centres. But how much more discussion and debate could have taken place if this had been incorporated into a project with coursework?

Spin-offs for the OAIT

The OAIT at our pilot sites have dispersed for now, but many members of the public who participated said that they would be interested in supporting future initiatives that involved working to explore barriers and generating strategies for reducing them.

Organisations carrying out the SAFEC process need to manage the closure of the team carefully, and find ways of thanking members and acknowledging their contributions – particularly those from members of public. The organisation's leaders need to give the members feedback on the impact of their contributions and details of any actions that will be taken to address some of the barriers that they helped identify. Some of the pilot sites are proposing to involve former team members to support other OAITs that are set up in the future, to make sure the expertise that they had built up through their first experience is not lost.

One member of the public who became involved in OAIT process was interested in becoming more involved in helping develop the PCT and, with the encouragement of the SAFEC management team, has since become a non-executive member of the PCT board. This is an example of a very direct benefit that the SAFEC process has had on the NHS – and on the PCT in particular.

Learning about mainstreaming

All the pilot sites have sought to mainstream the learning from their SAFEC experience (see Section 11), particularly to incorporate it into their developing patient and public involvement strategies – a key outcome for SAFEC. At least one site is planning to repeat SAFEC initiatives in other parts of the organisation and with other communities, as a way of spreading exposure to the SAFEC principles - the barrier model and the value of facilitated dialogue involving staff and the public.

All the sites are working through some of the organisational improvement issues that emerged through their first SAFEC experience – for example, sharing the SAFEC experience with staff training departments and carrying out a deeper analysis of which competencies and support the staff need to improve relationships with local people. As a result of the OAIT learning, some have incorporated the SAFEC principles into local patient and public involvement strategies and have assigned director-level responsibility for promoting SAFEC approaches to reducing barriers to public engagement.

Feeding back to the executive teams

The first step taken by the pilot sites in their mainstreaming plan was to take the learning that the OAIT generated back to the executive teams for consideration and reflection. Executive teams at pilot sites were sometimes shocked by the feedback, as it gave them insight into a different reality – one directed by the perspectives of local people and frontline staff – and challenged their beliefs. Some had believed that they had a good track record in engaging their local community and were doing well in developing their approaches to patient and public involvement. The learning that the team work generated was sometimes very uncomfortable.

Spreading the message

At the end of the SAFEC experience, organisations can expect to have a small cohort of executives, middle managers, frontline staff and members of local communities whose thinking about community engagement will be very different from that of the rest of the organisation. The organisation needs to capitalise on this in its mainstreaming plans, to increase the proportion of staff who understand the need for a more strategic approach to reducing the barriers to engagement, and who are prepared to make the necessary changes to their own behaviour, and the systems and processes they deliver.

In this section we have covered:

- Learning at the organisational level;
- Spin-offs for the OAIT;
- Learning about mainstreaming;
- Feeding back to the executive teams;
- Spreading the message.

13 Building on experience: two scenarios

This section provides two scenarios that draw on insights and learning from across the organisations that helped test and develop the SAFEC process. They are designed to give you further insight into some of the challenges you may meet if you decide to adopt the SAFEC approach, and to suggest some ways of responding to these challenges.

We have constructed the scenarios in this section (both of which involve PCTs) to illustrate two contrasting situations. In the first, the organisational development process runs according to plan, and the organisation gains a great deal of learning, which it successfully mainstreams – at least in the short term. The second describes a more problematic experience, highlighting some of the attitudes and behaviours that can make the organisational development process less effective, and that you may need to deal with as part of the SAFEC process.

At the end of both scenarios, we summarise the key learning points to be drawn from them.

Scenario A: Uttlesworth Primary Care Trust

Committing to the SAFEC process

After reflecting on the proposal from his PALS co-ordinator, Geoff Read, chief executive of Uttlesworth Primary Care Trust, was keen to see his trust become involved in a SAFEC organisational development process. He had heard about SAFEC at a recent conference. He felt that after two years of more general organisational development activity, his PCT was now ready for this kind of in-depth, challenging look at how it could improve its approach to involving the public and its patients.

It was an area in which Geoff and his staff believed they had made some good progress. However, at a recent meeting local people had implied that they did not feel as though they were being treated as equal partners in decisions about the future shape of local services. In addition, his director of public health had informed him that Uttlesworth Council for Voluntary Services was rather critical of the PCT in respect of how much it involved local people.

Geoff thought the PCT was doing some good work in this field, and he would welcome the opportunity to share it with other organisations, but he was aware that most of it had been project-based and that it had focused on community development or capacity-building. He had not previously thought of organisational development approaches as being remotely relevant to work aimed at involving the public and/or engaging the local community. However, he was open to the possibility that his organisation and staff might have some blind spots about their abilities to engage with their communities effectively. He was also open to the idea of bringing new perspectives to bear on the issue.

Geoff could see how involvement in a SAFEC-type process could help him and his senior team to deliver more effectively on the patient and public involvement agenda. He sought advice from members of his senior team, who agreed that the process seemed to offer potential for the organisation to learn more about its weaknesses and strengths, and to view certain issues in a new light. They were aware that the process might raise difficult questions about the way they and their organisation worked. However, they were sufficiently confident about their relationship with each other, with their staff, and with other external stakeholders – including community, voluntary and other public sector organisations – to tackle these difficult issues and address any problems collaboratively.

The PCT's board had a strong desire for their organisation to excel, and board members were open to the idea of taking an organisational development approach to public and patient involvement, as a way of helping them to engage more effectively with local people and service users – and, thus, increase their trust's star rating. Gina, a local authority member of the board, was particularly keen to act as a champion for this work. However, before they fully committed to the process the board members agreed to contact other PCTs that had gone through the SAFEC process to see what the impact had been for them.

Setting up the SAFEC initiative

Geoff produced an outline proposal for a SAFEC organisational development initiative, which was discussed and agreed with the board. He then arranged for the issue to be discussed at the PCT's patient and public involvement forum. The senior management team agreed a budget for the project – a half-time senior manager for nine months, an administrator for two days a week, and an amount of cash (£5,000) for venue costs and participant expenses. They also agreed to establish a project team, which would include:

- the PALS co-ordinator;
- the PCT board non-executive champion;
- an executive director to lead the process;
- with their agreement, two members of the trust's patient and public involvement forum.

The project team would report primarily to the project board, but there would be clear lines of communication with the professional executive committee (PEC) of the primary care group, the patient and public involvement forum, and other local partnership groups, such as the local strategic partnership board. Dates for feedback to the committee and the board were fixed, and the issue would be made a substantive item at a board away-day.

The management team members also agreed that they needed to identify the best people to act as project manager and project facilitators. They used the SAFEC resource pack tools to produce role descriptions and competency frameworks, and then set about identifying the right people for the jobs. This involved internal discussions with managers as well as with partner organisations, including the local hospital trust and the local authority.

Next, the management team placed an advertisement in the internal staff newsletters of the partnership organisations, and posted an item detailing the initiative and the available positions on the PCT and local authority intranets. In the meantime, they presented a more detailed background paper on the rationale and outline of the SAFEC initiative to the PCT board, the PEC and the local strategic partnership board.

The management team identified five people as possible candidates for the posts of project manager and facilitators. Four put themselves forward, and one was put forward by their line manger because their current job was under threat. The board champion and two other senior managers who had agreed to be involved in the process assessed the candidates against the competency framework. Although each candidate had some of the competencies, the people on the selection panel did not feel that any possessed them all. However, they did feel that between them, three of the candidates (Aiden, Claire and Sarah) had most of the competencies that were required to make up the local project team.

After some discussion, the panel agreed that Claire (the manager who was 'at risk' due to organisational changes) would act as the project manager, as she had project management training and considerable experience in this area. Aiden was a physiotherapist manager and Sarah was a health promotion practitioner. The board champion interviewed their line managers, and reached an agreement on a way of releasing the staff from their existing duties without interrupting service delivery.

The national SAFEC practitioner network agreed to provide a mentor for Claire, Aiden and Sarah. Using the SAFEC resource pack, the mentor (James) helped to induct them into the background to the SAFEC process, the barrier model and the research underpinning it, and the tools available to help deliver the organisational development process locally. Aiden and Sarah worked with Claire and James to design their own personal development plans, and they agreed a process for regular mentoring. Claire set about producing a project initiation document and plan, both of which she took to the full project team, which helped to develop and ratify the two pieces of work.

Choosing the reference community

The project team identified a number of possible reference communities. They knew that the main purpose of the project was to diagnose the barriers that the organisation had to authentic engagement with communities, and that their reference community itself must be one that would highlight these effectively. The population of Uttlesworth was very diverse, and the team members wondered whether it would be appropriate to focus on a particular minority ethnic community. They also considered using older people as their reference community, as this would chime well with the priorities of Uttlesworth Borough Council.

In the end, however, they chose the geographical patch of Bowthorpe – a suburban area of considerable deprivation but which had many assets, including a vibrant community and voluntary sector. The project team felt that Bowthorpe would be home to a number of community activists who would be able to give an assertive account of their experience of the PCT.

Recruiting the OAIT

First, Aiden and Sarah met with members of the trust's patient and public involvement forum, who had agreed to join the project team to discuss its approach to finding members for an OAIT. The group agreed that the patient and public involvement forum would discuss the issue at their next meeting and come back to Aiden with any useful contacts identified.

Next, Aiden and Sarah met Barbara, the practice manager at the Bowthorpe General Practice, to discuss possible members of the OAIT. Barbara herself agreed to join. She had lived in Bowthorpe all her life. Through Barbara, the local project team identified a number of individuals, including some patients of the local group practice, who might be interested in helping the PCT explore its barriers to patient and public involvement, and who might be suitable members of the team. They included:

- two patients: a woman who was the main carer of her brain-injured husband, and a lone parent of a young child, who had been a member of the practice patient group in the past;
- the local Sure Start co-ordinator;
- the manager of the local day centre for older people;
- a district nurse;
- a health visitor.

Barbara agreed to ask the two patients on their next visits to the practice, which were expected during the next week or so. She also agreed to discuss the SAFEC initiative with the GPs at their next meeting and asked Aiden for a short background paper that she could show them. Aiden agreed to produce this, while Sarah took responsibility for contacting the local workers whom Barbara had identified as potential members of the OAIT.

Aiden called at the local pharmacy on the way home and discussed the initiative briefly with the pharmacist, who said she was interested in having more information, and might be willing to attend some of the meetings provided the project would pay for a locum. Aiden agreed to check whether the PCT had a policy on paying expenses for external people for attending meetings. Before going home, he dropped into the local community centre and discovered that it had a room that would be ideal as a venue and was cheap to hire. There were also crêche facilities.

When Sarah spoke to the local workers, not only were most of them keen to get involved, but they also identified further local people – including a local businesswoman – who might be interested if the venue and times were suitable. She then spoke to a friend at Uttlesworth Council for Voluntary Services who gave her a list of local community and voluntary sector groups operating in Bowthorpe, as well as details of social enterprises.

All the people Sarah spoke to said they would like to have more details of what they would be expected to do before they committed themselves to the project. She explained that the PCT was producing a short paper, which she would distribute as soon as possible. When the project team met to report progress, they agreed that they should hold a meeting at the local community centre to introduce the project and

give people the chance to find out what would be expected of them. They would advertise the meeting widely within the locality.

Six weeks later, this meeting went ahead. The team felt it was a success. Although some people decided they did not have the time to be a member of the OAIT, they were nevertheless interested in the initiative and said they would be keen to hear about the outcome. At the meeting, some local people forged new relationships with staff of local public and voluntary agencies that could bear fruit in future work.

As a result of this meeting, and Aiden and Sarah's personal communications with other individuals, the project team identified 18 people who had connections to Bowthorpe and were interested in joining the OAIT. They included:

- frontline NHS and local authority staff who worked at least part of the time in Bowthorpe;
- junior clinical managers;
- the GP practice manager;
- two community activists;
- a carer;
- two parents of young children;
- a local businesswoman;
- three voluntary-sector workers.

Claire also negotiated for the following individuals to join:

- two senior managers from the PCT;
- one member of the patient and public involvement forum;
- the non-executive board member champion.

The project team agreed a policy for expenses – and they were ready to begin.

Facilitating the dialogue

Aiden and Sarah realised that facilitating the dialogue within the OAIT about organisational barriers operating within the PCT would be very different from the kind of facilitation to which they were accustomed. Although they were both experienced in facilitating small groups, they had rarely worked with groups as large as 20. They were also aware that the role would involve bringing people's assumptions out into the open and challenging them, rather than looking for consensus or letting everyone have a say.

The pair spent a half-day with their mentor and someone from another PCT in the region who had already been a facilitator in the SAFEC process. The discussion was useful, but Aiden and Sarah realised how much they still needed to prepare before the OAIT first met. They decided to have a 'practice run', using board and executive team members as a mock OAIT, with the mentor and the former facilitator from the other PCT playing the role of local people. Aiden and Sarah agreed that this would be useful to hone their facilitation skills and learn a few new ones (a gap that they had identified in their personal development plans), and their mentor gave them a list of relevant training events in the region.

Before the first facilitated dialogue workshop, Aiden and Sarah organised an induction session with the OAIT members. During this session, they talked about the nature of the process they were about to embark on, what the goals were, how it was new to everyone involved and what each person should expect of the others. It was made clear that everyone attending was an 'expert', in one way or another, and everybody's 'expertise' was needed to identify the barriers to effective relationships with service users and local people that operated within the Uttlesworth PCT.

Claire talked about the PCT – who worked for it, how it was organised, what it was trying to achieve and how it would use the learning from the SAFEC initiative to change the way it worked with local people. She thanked everyone for giving up their precious time to help the PCT with this work and explained how the community members could claim expenses.

The following week, the first facilitated dialogue workshop took place. Everyone returned for this workshop except for one of the voluntary sector workers whose child was sick. She had sent her apologies, and Sarah had agreed to update her before the second workshop took place.

The first workshop focused on the community's capacity to work with the PCT. The discussion was thoughtful and reflective. The debate did not always flow, because it brought up questions that most of the participants had never really thought about before, and certainly not in relation to health care, such as: 'How are the people of Bowthorpe feeling?' and 'Are they angry, frustrated, vibrant or burnt out?'.

The participants felt that it was interesting to talk about these kinds of issues, and also wanted to talk about what Bowthorpe was like 50 years ago. Claire discovered that only 20 years ago Bowthorpe had been a very respectable part of Uttlesworth. The local people in the OAIT felt that the area had seemed to go into decline when the nearest out-of-town shopping centre was built. All the small shops went out of business, and the final blow was when the car factory closed.

Claire was surprised at the passion with which the local people spoke about Bowthorpe, and realised how little she knew of the area and its people. She didn't actually live in Uttlesworth, and in fact had never heard of it until she had come to work there two years ago.

Next, there was a discussion about the skills of frontline staff in engaging effectively with patients, and people were asked to describe a recent experience of being a patient, or a carer of a patient. Most of the women had recent experience as either a patient themselves (usually relating to childbearing) or as a carer – of their children or of a parent. Less than half the men had recent experience as a patient, but they could talk about experiences of friends and family members.

The general consensus seemed to be that the health service responded well to minor ailments but that when it came to chronic ailments, such as asthma and heart disease, or to social problems, such as caring for an elderly relative, they were sometimes not listened to and were generally unsupported. They felt that sometimes staff rushed through the consultation, almost trying to avoid discussing anything too

‘deep’. Of course, they knew how busy healthcare staff were, and most were grateful for the little support they did receive.

The frontline staff had mostly had better experiences as patients, but even they had to admit that when it came to issues of a more social nature, discovering how to get the support they needed was really hard.

With the help of skilful facilitation, the group reflected on what the reasons might be for this feeling of not being heard or supported as patients (although they all agreed that healthcare staff were trying to do their best). They came up with the following list:

- frontline staff not having the necessary communication skills;
- frontline staff not having the time to use their skills because of being under pressure;
- patients not being able to understand the information they are given (because of poor communication skills or the stress of the situation they were in);
- frontline staff being reluctant to allow the conversation to stray outside the clinician’s particular area of expertise, as they might feel powerless to help if the patient raised something they felt they could not respond to.

The last point was raised by a new district nurse, Chrissie, who felt this reluctance herself when she first started her job. The group agreed that it was probably worth checking whether any or all of the points they had listed were widespread issues. Between them, they worked out a way of verifying this within Bowthorpe, through the questionnaire mentioned below.

At the second meeting, all but one person – a clinical manager who was on holiday – returned, and the voluntary sector worker who missed the first meeting came to this one. Sarah, a project team member and facilitator, reviewed the issues that had been raised at the last meeting and reoriented the members of the OAIT towards the ‘barriers model’ by outlining how she thought the discussion so far might be pointing to certain barriers operating within Uttlesworth PCT. Aiden then asked for feedback from the people who had agreed to be part of the previous week’s verification exercise.

Chrissie, the district nurse, reported back on the results of a short questionnaire that she had given out to her fellow district nurses and health visitors. The response rate was 80 per cent. Of those replying:

- Fourteen said they thought pressure of work and shortage of time during the consultation contributed to their inability to really engage with and respond to their patients’ expressed needs;
- Eight felt that patients had unrealistic expectations of what they could do, and needed educating;
- Nine said they did not want to allow the patients’ agenda to dominate because they would feel powerless to respond. As one described it: ‘I don’t want to open a can of worms and then not be able to put the lid back on’.

The group agreed that while lack of time was clearly important, it was not the only issue.

One team member called Lucy, a local authority manager, mentioned a discussion she had facilitated with a carers' group in Bowthorpe. The carers had reported emphatically that the support they received from the health services was uncoordinated, unresponsive and were not always provided when they needed them. They felt that many frontline staff either did not have the skills to communicate effectively with them or did not have the necessary information.

The carers thought that local health service personnel knew less about services than they themselves did, and that while the clinicians had a lot of knowledge in their own areas of expertise, they seemed to know little about what else was available from health and social services and the independent sector. They also felt that the experience and skills they had developed as carers were not being utilised to help others – either staff or other patients in the area.

The OAIT reflected on these opinions. They felt that they raised important issues that pointed to certain unexpected 'barriers' that existed within the PCT and that had been created by the frontline staff. The team recorded these barrier issues and agreed that they should discuss them again at an event at the end of the dialogue process. The event would enable the team members to:

- debate all the issues and barriers that they had identified during the process;
- carry out a 'barrier diagnosis' of the PCT;
- suggest ideas for how the barriers could be removed.

The team also agreed to invite one of the Bowthorpe carers to join its ranks, as they clearly had an interesting perspective to share with the group. Sarah said she would thank the carers on the team's behalf for making their views available for discussion, and would invite one of them to join the OAIT.

Four further workshops were held to discuss aspects of the barrier model in relation to the PCT's work and services in Bowthorpe. What emerged from the discussions provided a rich source of data about the factors that were constraining improvements in relationships between the PCT and its staff and local people.

One example was a local consultation exercise being run by PCT staff on the development of new treatment centres. The staff involved in running these sessions had put great effort into organising a 'road show' of these events, but they had been attended only by a small number of retired people. It transpired that many of the community members of the OAIT had not been able to attend the sessions because they were held at 7pm, when many of them had to look after their children. The staff now had some clues as to why the turnout had been so low.

Similarly, frontline staff reported being fearful and suspicious of groups – large or small – of young people who came together to use the facilities of the local clinics. Conversely, the young people reported being treated in an undignified way by receptionists, who were wholly insensitive to the need to respect their privacy when they came to the clinic. The OAIT considered whether these two experiences could

be linked, and discussed whether dialogue between staff and young people about the clinic environment and how young people can access services would be beneficial to both groups.

On a number of occasions during the discussions, some staff said they felt powerless to adapt their service to the needs of their service users, and cited rules and regulations or their bosses as the reasons for this. In response, other staff challenged these individuals to be more assertive, to risk taking some responsibility for questioning their managers about why systems could not be modified to better meet the needs of local people.

For example, at the beginning of the SAFEC process the project team members had been told that there was no petty cash budget to reimburse OAIT members for out-of-pocket expenses incurred while attending the SAFEC workshops. However, after weeks of negotiations, the SAFEC project manager had secured a new financial system so that team members could be quickly reimbursed for their expenses while reassuring the organisation that its cash would be handled safely.

In the final session, the team diagnosed the following barriers as being in need of urgent attention in Bowthorpe PCT:

- over-simplistic approaches to engaging communities among frontline staff;
- the community being allowed only to define problems;
- lack of skills – among all staff – in engaging communities;
- the often unconscious use of power and control by many professional groups;
- management processes dominated by risk aversion;
- lack of innovation.

The spin-offs

At the end of the OAIT process, the project manager sent the members an evaluation form asking them what they had personally got out of being involved in the process. Generally, they felt that it had been worthwhile. Typical comments were:

> *It made me reflect a lot on how we as a PCT engage with local patients and communities – I realised how we have to think differently if we want to involve people in designing and contributing to our health service*.
>
> *I have many new contacts in Bowthorpe. I've been working there 20 years and did not realise there were so many other public sector workers managing the same patch. We have agreed to set up a Bowthorpe workers' forum – just an informal group that will meet monthly and share ideas for better co-ordination of our work*.
>
> *I have really learned more about facilitating groups*.
>
> *I have learned to reflect more on what the problems are and why things happen, rather than just leaping to conclusions without checking things out*.
>
> *I've learned that there are lots of different perspectives on the same issue, and that you need to understand all of them to really understand the issue*.

One of the local voluntary sector workers runs a youth club and was looking for someone to help with a course on sexual health. Through this process she met me and I was looking for ways of connecting with young people in the area – so it was a real win–win for both of us.

I realised that I wanted to help the PCT more, and applied for a non-executive appointment on the PCT board. I have just heard that I was successful.

What the organisation learned

Geoff was quite shocked when he first heard the presentation of findings from Claire and Aiden. He had thought that his PCT had a really good record of community-based projects. On reflection, he realised that that was still the case, but that what this project had done was to allow the organisation to look deeper at its 'institutional barriers' to engaging on a more equal footing with its communities. He described it as being 'akin to looking at institutional racism'. Claire had also sent a report and made a presentation to the patient and public involvement forum, which contacted the board.

The PCT board agreed to take some actions immediately, including:

- conducting a survey to explore further staff's views about leadership within the PCT;
- carrying out some development work on a communications strategy for the PCT;
- reviewing the training needed by frontline staff to develop their competence and confidence in engaging with the public (including a survey of the service users as well as service staff);
- implementing more detailed exit interviews for staff leaving the PCT;
- putting in place a policy to make paying local people's expenses easier.

In addition to these main points, the PCT felt that most of the issues raised in the workshops needed more exploration. Geoff and the board accepted that there would have to be some real mindset shifts among themselves, the PEC and frontline staff. They needed to explore this in the context of the organisation's public–patient involvement strategy.

They agreed to set up a group, made up of lay representatives as well as staff from different levels in the organisation, to review the existing public–patient involvement strategy in the light of the findings from the SAFEC process. Claire would continue working for the PCT to take this project forward. She would also run a number of 'road shows' within the organisation to share the findings from the OAIT, and to gather further views that would feed into this process.

Aiden was happy to go back to his physiotherapy manager post. He had learned a lot, and was sure he would use his insights in his management role, but he was not sure he wanted to do this again. Sarah was happy to repeat the process and agreed to join the SAFEC network and offer her support to other PCTs in the region that were thinking of embarking on the SAFEC process.

Scenario B: Thornfield Primary Care Trust

Gaining commitment to the SAFEC process

Jenny Smith, Communications Manager at Thornfield Primary Care Trust, looked quickly through the proposal for the trust to run a SAFEC-type organisational development process over the next 12 months. She'd never had much time for organisational development – all that navel-gazing when you could be getting on with delivering the goods. Still, it seemed to be about an important topic – public-patient involvement – and this was something the organisation had received some criticism about during the last star-rating assessment process, although she didn't know why, as they had set up lots of projects.

Anyway, it was clearly an area in which they had to be seen to be doing something to improve things. She had to think of some 'special project' to give to Peter – the senior manager who was displaced in the recent internal reorganisation – so this would do. She thought the board would probably like it, but she didn't like the idea of 'identifying barriers', which sounded a bit too negative for her liking, and she'd never seen the point of washing dirty linen in public. Hopefully it wouldn't be anything too risky – it was hard enough delivering the 'must dos' without opening up a can of worms around public-patient involvement. However, she thought there might be some money attached to the project and bringing extra money into the PCT was always useful.

Setting up the SAFEC initiative

Jenny took the project proposal to the senior executive team and identified a lead director for the project: the director of operations, Bob. He had no particular interest in organisational development or community engagement, but could see that it would look good on his CV if he had completed this project. He felt he could act as project manager in addition to his normal work.

Bob identified two members of staff to act as facilitators – Peter, of course, and Gita, a senior administrator. They had had no experience of process facilitation but they were assertive and could chair meetings well. Bob wasn't sure whether they would be interested in the project, but they were the only two people he could think of who had a bit of spare time. Another advantage was that as Gita was an administrator, he wouldn't need to find secretarial support for them. They didn't need a cash budget either, as he was sure they could use the PCT headquarters for meetings. Someone had mentioned expenses for the meetings, but he wasn't sure they would be needed.

Gita and Peter were not very clear what the project was about but, having been presented with an outline project plan and a few background papers (dug out from Bob's files), they sat down together to do their best to start organising these OAIT workshops – whatever that meant!

Choosing the reference community

Bob thought that the suburban ward of Owleton would be the best reference community for the project as it had just missed out on a Sure Start project, which had gone to a neighbouring community. This would mean he would have something to offer Owleton to deflect some of the community's anger at losing out on the other

scheme. He sent a memo to Jenny to that effect. She didn't reply so he assumed it was OK and informed Gita and Peter of the decision.

Recruiting the OAIT

Gita and Peter were very concerned that it was too much to ask local people to be involved in such a project, so they concentrated on identifying local managers. With Bob's help they identified six middle-grade managers who they thought would have time to offer to the project. Most of them had connections with Owleton. In addition, they asked the local authority community development worker for the area to get involved, as she could represent the views of local people. Bob said he would be able to attend most of the meetings, so all in all they had quickly identified eight people to attend.

As they had no cash budget for the project, they booked the meeting room in the PCT. It wasn't particularly easy to get to by public transport and there was no car parking but, with sufficient planning, most people should be able to get there and it would be easier for Gita, Peter and Bob. The eight people were sent formal invitations to join the team, together with a brief background paper on the project. Five replied positively – so with these five on board, Gita, Peter and Bob were ready to start.

Facilitating the dialogue

All eight people – the five respondents, plus Gita, Peter and Bob – turned up at the first meeting. Gita and Peter had worked hard to put together a presentation about the SAFEC barrier model but, to be honest, they weren't sure they fully understood where the model had come from and what was important about identifying barriers – why focus on the negative? Having done the presentation they felt a bit silly, as the more they talked the more they realised how much they didn't know. What would Bob think of them? Luckily, he didn't seem to be listening anyway – he clearly had other, more urgent things on his mind.

At the end of the presentation, the other members of the group asked some very interesting questions. The community development worker, Sîan, asked if she could bring along a couple of local people that she knew to the next meeting. That was a surprise, as Gita had been worried that local people might feel overwhelmed by the process, but Sîan felt that the two people she had in mind would be fine. One of the physiotherapy managers, Clive, asked how the project would contribute to the review of the PCT's public-patient involvement strategy. Peter said he wasn't sure and deflected the question to Bob, who agreed to try to make the links between the outcome of the project and how the public-patient involvement strategy should develop.

Gita and Peter asked the group some of the SAFEC trigger questions, but everyone found them really odd. No one knew the answers, or sometimes even what the questions meant. Gita and Peter looked embarrassed and Bob looked irritated, but eventually they found a question that seemed straightforward: 'Do the frontline staff have the skills to engage with patients and the public effectively?'. All the managers agreed that the answer was 'yes' – they had been engaging with patients for 60 years between them, so they ought to know how to do it. Only Sîan looked a little uncomfortable. Then Gita recalled that the previous day she had taken her mother to

see her GP. She had come away with a prescription for anti-arthritis tablets when all she really wanted was to discuss her mother's options in terms of housing, because her mother was struggling to get to the upstairs toilet. Gita found the courage to talk about this to the group. The response from the managers was that doctors were hopeless at communicating with patients and carers, but that nurses and other health professionals were much better.

Then Sîan found she was able to say: 'That sounds a bit of a assumption to me – do we know that's right?'. Peter remembered that as a facilitator he was meant to be 'surfacing and challenging assumptions' so he leapt in and said: 'Yes – perhaps we should be asking patients what their experience is? Do they feel the healthcare staff they see have the skills to engage with them effectively?'. After some further discussion, Sîan agreed to discuss the issue with her residents' association group and Jackie, a dietician manager, said she would discuss it with her departmental patients' group, which was due to meet the following week.

After this, the conversation was a bit stilted – the clinical managers were not used to having their opinions challenged – but the group managed to get through the first meeting without anyone feeling too cross, and they all agreed to reconvene in three weeks' time.

At the next meeting, Sîan reported that the two local people she had identified were really keen to get involved, but that they would need travel expenses as the PCT was so far out of town. The team could not ask Bob whether this would be possible, as he had had to pull out of the meeting at the last minute – an urgent briefing to be produced for the strategic health authority.

Then Sîan reported back from her residents' association. Most people felt that frontline health staff had listened to them appropriately and met their needs, especially when they were attending for routine matters, such as coughs and infections. However, all of those who experienced chronic health problems or were carers of disabled or elderly people felt that their issues and concerns were not heard nor responded to well. They felt unsupported, and that the services were designed to meet the needs of the professionals more than those of the patients. Sîan stressed that the people she had talked to had all expressed their understanding of the pressures that healthservice staff were under and their gratitude for the little support they did receive.

Next, Jackie reported on the feedback from her patients' group, with very similar findings. In particular, she noted that the services were available at the wrong time and in the wrong place, and that they failed to take into account the realities of the lives of the people living in Owleton. 'Why do you think people report their experiences in this way?' asked Gita. 'Well, it's because we are so overloaded,' said Philippa, a district nurse. 'It doesn't mean we don't have the skills – it's just that we don't have the time.' Everyone seemed to agree – even Sîan. Gita felt uncomfortable. She was not sure they had fully explored this issue, but she didn't feel sufficiently confident to challenge everyone again, and they certainly had lots more work to do, so she concurred that the issue was clearly one of pressure of time, and moved on.

The OAIT met on three further occasions to discuss different aspects of the barrier model. Peter and Gita became more confident at facilitating the discussions, particularly as they decided to modify the trigger questions so that the group would have less difficulty in finding answers as a result of their discussions. They continued to try to identify assumptions underlying the things that people said, but this wasn't always possible and in any event it wasn't clear what the purpose of this was. They both felt that the group had raised some important but difficult issues, including problems with leadership and communication within the PCT.

At a final session, the team members tried to consolidate the things they had learned overall. They agreed that the main barriers to more effective patient and public involvement operating within the PCT were:

- frontline staff lacking the time to spend talking to patients and carers;
- too many competing priorities for the PCT and their staff;
- not enough education and training in how to involve patients and carers;
- a lack of participative structures and processes within the PCT;
- unclear leadership and communication within the PCT about public-patient involvement.

The spin-offs

At the end of the OAIT process, the members were sent an evaluation form asking them what they personally had got out of being involved in the process. Generally, the members felt it had been a positive experience for them individually, but they were unclear about the overall purpose of the process they had been involved in. Typical comments were:

> *It was interesting but I'm not sure how it is going to help*.
>
> *It was useful to hear the carer's views – I wish we could have heard more*.
>
> *It raised some important issues, but there was not really the time to explore them in any depth*.
>
> *I realised how little influence the PCT has over the national policy agenda – really we can't do anything while the Government continues to force us to deliver hundreds of targets*.

What the organisation learned

Jenny was quite shocked when she first heard the presentation of findings from Bob and Gita. She had thought that the PCT had a really good record of community-based projects. She had received Gita's report and, to be honest, didn't think it was very good. The evidence on which the 'findings' were based seemed very thin and, apparently, even her leadership style had been questioned. She would have to handle any report to the PCT board very carefully, or this thing could get out of hand.

She decided to take the report off the board agenda, saying that more work would need to be done before it was in a fit state to take to the board. She did, however, discuss the draft report with Bob and a few members of the executive team. They agreed that as it stood, the report was not particularly helpful. They needed to

respond somehow, to allay the OAIT and also Gita, who seemed to have developed a bias towards the service users' views. They decided to put on a customer care course for staff, and to review sickness and holiday cover arrangements, as these were reported as affecting the amount of time frontline staff had for engaging with their patients. That, together with a leaflet entitled, '*What you can expect from the PCT '*, should show that Thornfield PCT takes public-patient involvement seriously.

Meanwhile, Gita applied for a job as a patient advice and liaison service co-ordinator in a neighbouring PCT. She had learned a lot from the SAFEC process and wanted to use what she had learned. Her new colleagues were impressed with her experience of the process and her enthusiasm to look more deeply into the issues. She wasn't sorry to leave Thornfield PCT.

In this section we have covered:
In this section we have looked at two very different scenarios of organisations taking on the SAFEC process:

- **Scenario A**, where the SAFEC process runs according to plan, and the organisation gains a great deal of learning and successfully mainstreams it;
- **Scenario B**, which is more problematic experience, highlighting some of the attitudes and behaviours that can make the organisational development process less effective.

These two scenarios are illustrative to prompt you to make your own judgements about why different approaches produce different results, and to decide for yourself what are the important circumstances to establish and maintain when implementing your own SAFEC initiative.

Part 5
Resources

This section is made up of:

Section 14 Resources

Section 15 References

Section 16 Glossary

14 Resources

Resource 1: Benefits of SAFEC

SAFEC…

- places on everyone's agenda the issue of organisational improvement to deliver better community engagement;
- builds executive understanding of the barriers to community engagement and develops commitment and support for organisational change;
- raises awareness of the barriers to community engagement and stimulates a response to address them;
- develops a deeper understanding of the expertise, time and resources needed to engage effectively with the community;
- structures a self-assessment of the barriers in the organisation;
- exposes the shortcomings of traditional approaches to community engagement;
- develops competencies in engaging the public in organisational development;
- re-positions and heightens the influence of local people's perspectives on how the organisation operates;
- creates reflective space for a meaningful dialogue between staff and the public about the organisation's performance;
- releases energy and capacity from service improvement by:
    - generating new insights into the public's experience of NHS services and working with them to address shortcomings;
    - revealing new or untapped opportunities to engage with service users that can benefit the public and the service alike;
    - using local resources and businesses to support organisational development;
    - taking action with local people to develop services;
    - creating a network of public perspectives that can be drawn on to advise on the development of services;
- can be used to engage local communities that are marginalised or disempowered;
- can develop services so they meet local needs;
- can contribute towards a baseline assessment of user and public involvement;
- provides public sector organisations and their staff with practical assistance to achieve authentic patient and public involvement in their organisations, and to use this to promote sustainable cultural and structural change;
- provides tools and guidance to support a programme of facilitated organisational development tailored to the needs of particular organisational contexts.

Strategically, SAFEC can contribute towards:

- developing a deeper understanding of community engagement in the workforce and identifying for every member of staff what they can do to overcome the barriers to engagement to which they are party, and their role in overcoming the barriers to engagement;
- changing the culture of the organisation so that it comes to value the public as expert advisers and integrates their perspective into all aspects of service development;
- developing more relevant public involvement plans against which performance can be measured;
- developing local patient advice and liaison services and support for local patient and public involvement forums (PPIFs);
- providing a network of communities that can be easily accessed by staff.

Resource 2: Are we ready to lead SAFEC?

Leadership focused on the needs of local people and service users:

- Are you convinced that community engagement and user involvement will benefit your organisation?
- How will an organisational development process contribute to your longer-term improvement strategies?
- Is this the right time for your organisation to focus on organisational development?

People to manage the change process:

- Are you prepared to dedicate your best people to this work?
- Can you identify a really good project manager?
- Which director will champion this initiative and why?
- Will SAFEC become part of your performance review agenda?

Organisational structures that support change:

- What support are you prepared to offer to those responsible for leading the process – for example, in:

  - investing in developing their skills?
  - external mentoring?
  - access to the chief executive or chair?
  - secondment to the role?
  - temporary arrangements to fill the posts they vacate?
  - administrative support?
  - a budget?

- How much staff time are you willing to commit? Our pilot sites seconded people to the SAFEC process for a minimum of 12 months. When you take project management, group facilitation and administration into account, the total staff time required could amount to a half-time post.
- Are you prepared to secure protected time for your key SAFEC staff members to give them space to analyse the current situation and develop their vision for a desired future? This may include back-filling roles or reducing their workload in some other way.
- How will you ensure that the SAFEC initiative is well governed, that members of the governing body and senior management team are kept in touch with the process as it develops, and that they are prepared to support the learning from the process as it becomes available?
- Are you and your governing body or board prepared to commit time to reflect on SAFEC and the learning it is generating?
- Are you prepared to encourage and resource staff to develop a SAFEC practitioner network within your organisation, as well as links with others relevant networks across the country? Examples could include forum meetings, putting up a web page, or compiling a practitioner mailing list.
- Are you prepared to encourage and resource staff to develop SAFEC communication mechanisms to sustain momentum and share learning?

Partnership working

- Have you considered what working in more equal partnerships with local people might mean for your organisation?
- Are you prepared to back the perspectives of local communities if necessary?
- Are you ready for users and the public to become involved in assessing your organisation, raising issues and suggesting solutions?
- Are you ready to consider community governance of local services?

Resource 3: Outline plan for SAFEC implementation

Stage/task		Start date	End date	% done	Lead	Notes
1	**Are you ready for SAFEC?**					
1.1	Preliminary meeting of senior officers to discuss SAFEC and whether to explore further with leaders					Consider involving previous pilot site expertise
1.2	Plan preliminary briefing of executive team					Use material in this resource pack. Decide whether or not to proceed
1.3	Present to executive team and decide whether to undertake the exercise 'Are we ready to lead SAFEC?' with board and professional executive committee (PEC)					Decide whether or not to proceed
1.4	Plan half-day session with board and PEC for briefing about SAFEC and to undertake 'preparatory reflection'					Apply SAFEC principles in the approach to this event
1.5	Hold half-day board/PEC session					Decide whether or not to proceed If to proceed, confirm executive and non-executive SAFEC champions and reporting procedures
1.6	Executive team to confirm whether or not SAFEC project is to proceed to next stage				Chief executive	
2	**Getting started**					
2.1	Assign responsibility for the project director and project manager roles				Chief executive	Make arrangements to back-fill the project manager's day job for about 18 hours per week for 12 months

Stage/task		Start date	End date	% done	Lead	Notes
2.2	Establish a small project team				Project director	Mixed professions to support the planning and management of the project
2.3	Establish a SAFEC project board, or assign responsibility for the role to an existing body				Project director	
2.4	Establish administrative support				Project director	Make arrangements to back-fill any existing admin input
2.5	Plan and hold a joint first meeting of project board and project team				Project director/ project manager	Produce briefing about SAFEC and outcome of PCT board/PEC's response to Resource 2 'Are we ready to lead SAFEC?' Outline plan and roles Identify the reference community
2.6	Draft a project proposal and plan including points at which SAFEC will return to the executive team, board and PEC agendas in the future				Project manager	Use expertise from project team to consider elements before drafting Refer to this outline project plan as a checklist of tasks
2.7	Project board approval of plan				Project board	Decide whether or not to proceed
2.8	Establish project budget and project office				Project manager	
3	**Selecting and Training Facilitators**					
3.1	Draft a role description and person specification for the event facilitator for the OAIT				Project manager with team	Consider the skills, experience and expertise needed to understand and deliver SAFEC principles
3.2	Decide method of recruitment or selection				Project manager with project team	

Stage/task		Start date	End date	% done	Lead	Notes
3.3	Implement recruitment to make an appointment				Project manager with project team	Facilitators to join your project team
3.4	Explore with the appointee their individual training or learning requirements to deliver SAFEC facilitation				Project manager	
3.5	Develop a facilitator's development plan and secure any resources required				Project manager	
3.6	Implement facilitator development plan (including a SAFEC induction)				Project manager	Network with previous or other SAFEC site facilitators
4	**Establishing an organisational assessment improvement team (OAIT)**					
4.1	Plan and implement a trial OAIT event for project board and project team members				Project team	Purpose: to develop understanding about how principles 1–4 will be put into practice and give facilitators a chance to practise Use the reference community identified by the leaders and one or two 'trigger questions' from the case study
4.2	Draw up a list of potential OAIT participants relevant to the selected reference community				Project team	Use Resource 9
4.3	Prepare recruitment papers for OAIT participants				Project team	See guidance on Principle 2 for ideas (page 18)
4.4	Plan and implement a recruitment plan for OAIT participants				Project team	See guidance on Principle 2 for ideas (page 18)
4.5	Plan and implement a first meeting of OAIT participants with project team				Project team	Purpose: to explain what SAFEC is about, plan for events and build relationships

Stage/task		Start date	End date	% done	Lead	Notes
5	**Planning and delivering team discussions**					
5.1	Decide overall approach to event – for example, whether half-day events over several months or full-day events over a few weeks				Project team	
5.2	Plan Event 1				Project team	
5.3	Deliver Event 1 – identify assumptions				Facilitator	Decide and document assumptions and verification action
5.4	Conduct verification exercises emerging from Event 1				OAIT	
5.5	Feed back outcome from verification to OAIT and decide whether barriers exist or what further investigations are required				OAIT	More consideration of issues may be needed at future events. Don't jump to early conclusions or action, but take time to explore issues deeply
5.6	Capture and summarise learning				Project team	
5.7	Take action to address barriers				As appropriate	
5.8	Plan Event 2				Project team	
5.9	Deliver Event 2 – identify assumptions				Facilitator	Document assumptions and decide on verification action
5.10	Conduct verification exercises emerging from Event 2				OAIT	
5.11	Feed back outcome from verification to OAIT and decide whether barriers exist or what further investigations are required				OAIT	More consideration of issues may be needed at future events. Don't jump to early conclusions or action, but take time to explore issues deeply
5.12	Capture and summarise learning				Project team	
5.13	Take action to address barriers				As appropriate	
5.14	Repeat for however many events you have decided on, to deal with all domains of the barrier model (see p 12)					

Stage/task		Start date	End date	% done	Lead	Notes
6	**Mainstreaming SAFEC**					
6.1	Draft plan for SAFEC sustainability and spread					See Resource 15
6.2	Secure approval from the project board before presenting to the PCT leadership					
6.3	Implement plan					
6.4	Continually review the impact of SAFEC and the changes in organisational behaviour delivered					
6.5	Evaluate whether changes are real improvements, and whether they are affecting the performance of the organisation in engaging the community					
7	**Project management**					
7.1	Continually reflect on issues and learning emerging from OAIT events regarding barriers, from verification exercises, and on ideas for change					
7.2	Establish meeting plan for project board					Take learning back to the project board on a regular basis
7.3	Establish meeting plan for project team					
7.4	Establish meeting plan for PCT board and PEC to consider SAFEC progress, outputs and impact					Do this at key milestones when there is learning of significance to share, and when organisational-change issues have emerged
7.5	Plan and implement a communication strategy to share the SAFEC experience within your organisation, and with key stakeholders					
7.6	Prepare monthly progress reports					See Resource 7

Stage/task		Start date	End date	% done	Lead	Notes
7.7	Network with other SAFEC sites					
7.8	Maintain the project structure and roles					Personnel will move out of the project organisation and you will need to replace them
7.9	Draft end of project report for project board consideration					Evaluate whether the project management processes have been successful or not – if not, how could they be improved for the future?

Resource 4: Half-day event plan for PCT boards and executive teams

8.45 Arrival and coffee

9.00 Welcome and objectives of the session

9.10 Introduction to SAFEC (online presentation available at www.nccce.lancs.ac.uk)

- Introduction – what's it all about?
- The SAFEC approach
- Are we ready for SAFEC?
- Getting started
- Selecting and training facilitators
- Establishing an organisational assessment and improvement team (OAIT)
- Planning and delivering team discussions
- Mainstreaming SAFEC
- Organisational learning
- Questions

9.45 Practise a facilitated discussion

- Run one or more mock facilitated discussions using one of the trigger questions (see Resource 12) and a pre-determined reference community.
- SAFEC team members could role-play members of the community or frontline staff
- Draw out assumptions
- Explore possible verification options.

10.45 Summarise the key elements of the OAIT learning process

- Mixed perspectives
- Root discussion in experience of a reference community
- Trigger questions that can't be answered 'yes' or 'no'
- Identifying and challenging assumptions
- Verification.

11.00 Coffee

11.15 Group work – board and executive team preparatory reflection

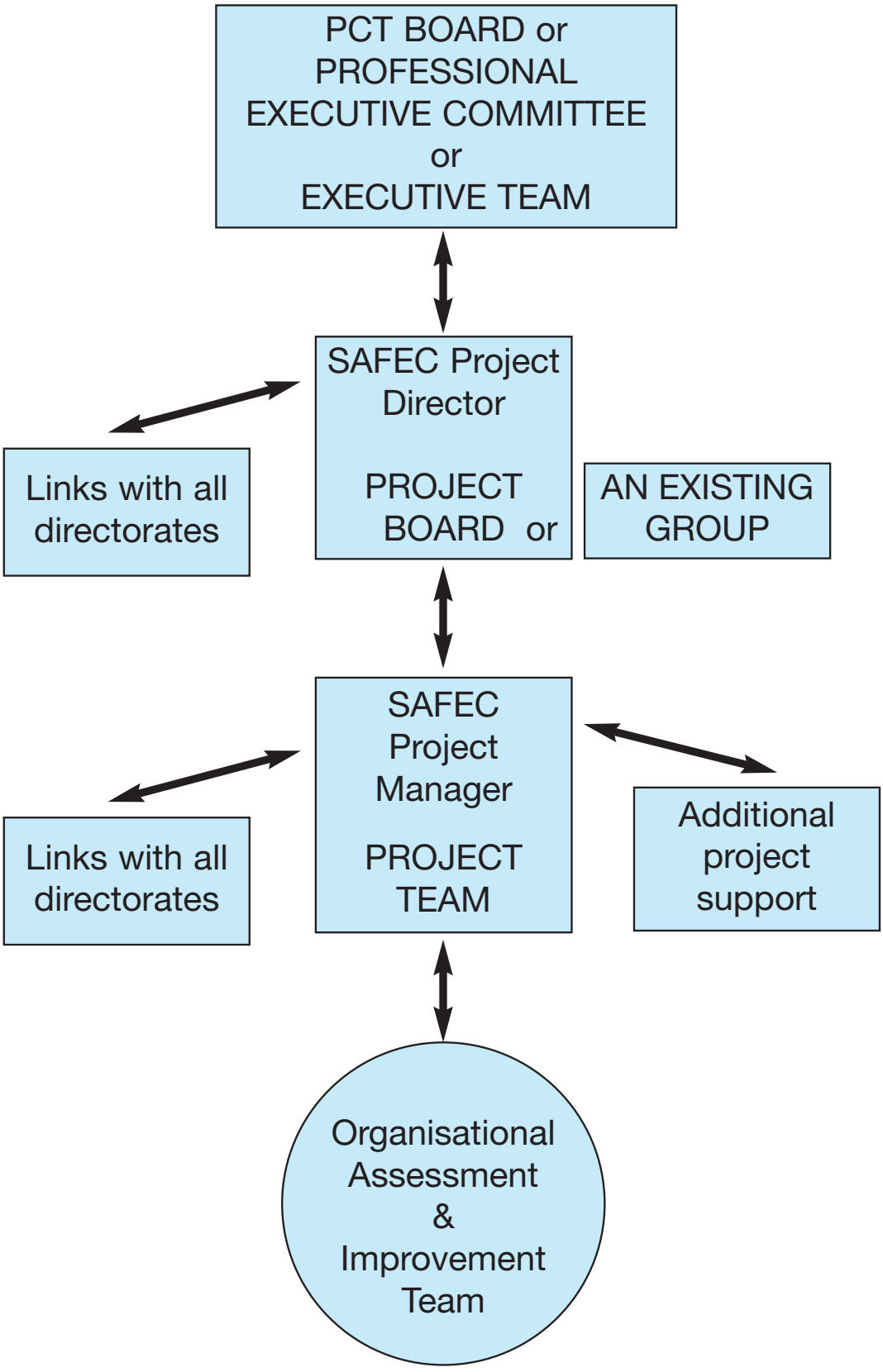
- Groups discuss all questions, or take selected questions from the list in Resource 2 "Are we ready to lead SAFEC"

12.15 Are we ready for SAFEC?

- Feed back from group work
- Are the board, executive team and professional executive committee (PEC) ready to commit to SAFEC?
- Next steps.

13.15 Close

Resource 5: Model SAFEC management structure



Resource 6: SAFEC roles

SAFEC board	The board is appointed by the organisation's executive team to provide overall direction and management of the work. It is accountable for the success of the SAFEC exercise and has responsibility and authority for the work within the remit set by the executive team. It approves all major plans and authorises any major deviation from agreed stages. It makes sure the required resources are committed, and arbitrates on any conflicts or negotiates a solution to any problems between the SAFEC work and external bodies. It also approves the appointment and responsibilities of the SAFEC manager. The number of SAFEC board members is low. Members should include an executive director, a service user, and a senior service provider, such as a senior officer from a local patient and public involvement forum (PPIF).
SAFEC director	The board members should include an executive director, who is ultimately responsible for the work. Our pilot sites sometimes included a non-executive PCT board member in this role.
SAFEC manager	The SAFEC manager has the authority to run the SAFEC exercise on a day-to-day basis on behalf of the SAFEC board. The SAFEC manager's prime responsibility is to ensure that the work produces the required outputs to the required standard of quality, and within the specified constraints of time and cost. The SAFEC manager is also responsible for making sure SAFEC produces a result that is capable of achieving the benefits defined in the SAFEC plan. Specific responsibilities are to: • manage the production of the required outputs, such as plans, workshop administration, event reports, and verification exercises; • direct and motivate the SAFEC team; • plan and monitor the work; • produce the 'project initiation document'. This describes the need for SAFEC, what will be achieved (including benefits to the organisation and the public), how it will be delivered, by whom, and within what timeframe; • manage risks; • liaise with the board and other related work streams to ensure that the SAFEC work is neither overlooked nor duplicated; • report to the SAFEC board and liaise with it to maintain the overall direction and integrity of the work; • manage one or more SAFEC teams, either directly or through a team manager. The SAFEC manager is accountable to the SAFEC board and is not a member of the board.

SAFEC team	The SAFEC director and SAFEC manager need to review the size and complexity of the work plan and its areas of impact, and then create a management team with appropriate representation. The members of the team will have clear lines of responsibility for delivering their contribution to the work. They will know what their responsibilities are to be and will be clear about the lines of reporting and communication. In our pilot sites, the SAFEC teams included: • event facilitators; • senior service managers from the PCT and the local authority; • support for administration and technical advice. It might also be worth considering involving community activists, or people from: • patient advice and liaison services (PALS) • finance, human resources, organisational or training teams.
Dialogue facilitator	An essential component of the SAFEC approach is to deliver 'facilitated dialogue' discussions about the barriers to community engagement that involve staff and people from the local community. This requires at least two experienced group-work facilitators, trained in the SAFEC approach, to design and deliver workshop events for the OAIT. The facilitators are members of the project team. See also Section 8 – The SAFEC Facilitators [page 31]
Support	Support – organised on a formal basis with, for example, a SAFEC office – is optional. It can take the form of advising on SAFEC, facilitation and management or administration. Experience from the SAFEC pilot sites suggests that this advice is vital to the development of SAFEC competencies, helping the management team to act as a repository for lessons learned and a central source of expertise in the use of the SAFEC. Administrative support is also required for the management processes. Specific support responsibilities are: • to provide advice, and access to SAFEC-related specialist knowledge on issues such as the barrier model, the SAFEC approach to facilitated dialogue, workshop design, and project management tools and techniques. The people who can provide this advice may not be employed by your local organisations but instead may be available for advice by phone or email; • relating to administration, to set up and maintain project files, establish document control procedures, establish relevant mailing lists, compile and distribute papers, administer the SAFEC board meetings, assist in the compilation of reports, and update plans.

Resource 7: Monthly report template

SAFEC Monthly report			
Author		Date	
Reports to		Month covered	
Copies (for info) to			
Things completed this month (refer to tasks from the local plan)			
Things that have gone well this month			
Actual or potential issues and problems			
Action planned to address issues and problems			
Key learning points this month			
Things planned for completion next month			

Resource 8: Facilitator competencies

A Attitude

'I am willing to initiate and manage change within my organisation.'
'I remain neutral when facilitating a group.'

B Role understanding

'I can clearly explain the role of a facilitator to a group of people.'

C Listening

'I am able to listen actively to others, regardless of my personal feelings towards them or whether I agree with them or not.'

D Managing meetings

'I am effective at co-ordinating pre- and post-meeting logistics and coaching others to do so.'

E Designing meetings

'I am skilled at writing clear, results-oriented objectives for a meeting.'
'I am able to select appropriate tools and processes to help a group accomplish its meeting objectives.'

F Tools and methods

'I have experience using a variety of tools and methods for group work, such as brainstorming, affinity diagrams, 'fishbone' multi-voting.'

G Group dynamics

'When leading a meeting, I offer the group an opportunity to set its own guidelines for meeting behaviour.'
'I recognise group thinking and challenge groups to avoid hasty solutions.'

H Participation

'I can obtain balanced participation from people in a meeting, even when there are quiet, outspoken or dominant people present.'

I Group memory

'I am experienced at using flipcharts to post meeting objectives, agendas, decisions and action items.'

J Decision-making

'I am comfortable at using open-ended and closed questions and recording techniques to bring a group to agreement during a meeting.'

K Feedback

'I regularly solicit feedback from groups and people I work with, including those in the meetings I lead.'

Other competencies: understanding of the SAFEC model and ability to steer people away from early consensus

Unlike the other competencies which are general to the facilitation process, these two competencies are unique to SAFEC facilitation and may need to be learnt by even the most experienced facilitator.

Resource 9: Recruiting to an OAIT

Reference community chosen: _____

Checklist	Names of people to approach	Who will contact them	Confirmed participant? (tick if yes)
Members of your chosen reference community			
Community groups			
Known community activists			
Community centres, such as bingo halls, local clubs, pubs			
Public meeting places, such as day centres, play schemes, supermarkets, sports centres			
Community projects or schemes			
Religious leaders			
Schools and colleges			
Council for Voluntary Services			
Care groups, such as people with diabetes			
Service-user groups, such as users of a clinic			
Members of your PCT leadership			
Non-executive board members			
Executive team			
Professional executive committee			
Other committee members			
Senior managers			
Heads of services			
PCT staff			
Clinicians			
Support staff, especially receptionists, porters, building maintenance, care assistants			
Finance			
Commissioning			

Checklist	Names of people to approach	Who will contact them	Confirmed participant? (tick if yes)
Public health			
Human resources			
Modernisation			
Estates and facilities			
Primary care staff			
Clinicians			
Support staff			
Local authority staff			
Social services			
Housing			
Regeneration			
Education			
Waste management			
Transport			
Other public-sector staff			
Ambulance service			
NHS acute trusts			
NHS children's trusts			
NHS mental health trusts			
Police			
Benefits agency			
Job centres			
Criminal justice systems			
Independent and not-for-profit sector staff			
Private care providers			
Housing associations			
Business parks and trade organisations			
Private sports clubs			
Citizens advice			
Solicitors			

Resource 10: Introductory briefing paper for OAIT recruits

What is SAFEC (Strategic Action for Engaging Communities)?
SAFEC is an approach to organisational learning and change that is being used by the primary care trust (PCT) to help it improve the way it works with local people. The SAFEC process aims to explore the barriers to co-working between service users, local communities and the NHS and to use the information gained to change the organisation and improve the influence that local people have on our services. The work brings together local people and staff to discuss a wide range of issues about the way the PCT works. The group of people we bring together is called the 'organisational assessment and improvement team' (OAIT), and we will focus our discussion on the experiences of local people and staff connected with [insert your reference community definition here].

What is the OAIT?
The OAIT is a group of 10–20 people who are able to discuss barriers to co-working and explore possible solutions that can be tried out locally. The OAIT will consist of local people, staff from the PCT, and other health and social care professionals who have a common interest in [insert your reference community definition here]. Members of the OAIT group are not asked to represent any group or organisation. They contribute their own personal experiences and opinions. However, they may be asked to 'check these out' with colleagues and friends in their workplace or community, or to find evidence to support their opinions if this is available.

What is the time commitment?
OAIT members will need to be available to attend discussion groups at the following times: [insert your chosen programme of events here]
A small amount of time in between events might be required, on a voluntary basis, to verify information that has been discussed during the events.
The OAIT members may also be invited to attend PCT board or executive meetings, on a voluntary basis.

Claiming expenses
[Insert details of your policy on members of the public claiming expenses.]

If you are an NHS or local authority worker, or an employee of a voluntary organisation, will your line manager allow you to attend?
The PCT board and executive team have already given their support to staff being released from their normal duties to attend OAIT events and to support follow-up activities, so your line manager should support your involvement. If you have any difficulty securing time out, we suggest you discuss it with your line manager in the first instance, and let us know. We recognise that in some circumstances, individuals may not be released from their normal duties, and we are keen to be advised of any problems so that we can try to find ways round them.
Joining the OAIT is an opportunity to influence how your own PCT and other PCTs work with the communities they serve, and a chance to share experiences of patient partnership work.

For further information, contact [insert SAFEC manager contact details].

Resource 11: Facilitated dialogue event plan

Strategic Action Programme for Healthy Communities
Event 2

What do you know about the capacity of young people in Longway to engage with the PCT?

Longway Steel Works Social Club, Longway Road, Longway
Wednesday 20 November 2002
12.00–4.30 pm

Programme

12.00–12.30	Welcome and introduction Review of the SAFEC model
12.30–1.00	Lunch
1.00–1.30	Feedback of verification from Event 1 Ideas and actions for improvement
1.30–1.50	Experience of the area (ice-breaker)
1.50–2.50	Discussion period
2.50–3.10	Review and confirmation of assumptions
3.10–3.20	Feedback
3.20–3.40	Tea/coffee and comfort break
3.40–3.50	Deciding which assumptions to verify – voting
3.50–4.30	The next verification – generating ideas

Resource 12: Trigger questions for each barrier domain discussion

Domain 1: Capacity and willingness of local people and service users to get involved

- Is this community feeling angry, frustrated, burnt out or vibrant?
- Does this community understand how the primary care trust's (PCT's) current system of involvement works?
- How does the PCT encourage this community to come up with solutions for itself and the PCT, rather than just discussing their own needs and problems?

Domain 2: The skills and competencies of public sector staff

- What skills and competencies are needed to engage with your selected reference community?
- Who needs to have these skills?
- Do PCT staff working with this community have the necessary skills and abilities to engage local people?
- Do the staff of your PCT understand the culture and history of this community?
- How does your PCT deal with different views from this community relating to the same issue?

Domain 3: Professional cultures and ideology

- Are there differing views about the definition of health, and what causes it, within the PCT and between the PCT and this community?
- What do the staff believe are the benefits of working in equal partnership with this community?
- Do the people working in the PCT believe that this community has the capacity to act to improve their own health and well being?
- Who in the PCT holds power and controls the agenda?

Domain 4: Organisational ethos and culture

- What is the dominant style of leadership in this PCT?
- If I had a great new idea, would the PCT encourage and support me to take it forward?
- Are staff given appropriate time to support the process of, or to respond to the results of, community engagement?
- Are there routine ways in which the community can engage with the PCT's regular business?

Domain 5: National context

- Does the national policy agenda support the PCT in putting effort into community engagement?

Resource 13: Assumptions that can emerge from SAFEC events

Domain 1: The capacity and willingness of local people and service users to get involved:

- People aren't angry but may be apathetic;
- Patients are angry and frustrated;
- People have low expectations of services and therefore they 'make do';
- People will engage only with services, organisations or individuals directly relevant to their concerns;
- People lack understanding about the PCT;
- People don't understand how the system works;
- There is a high proportion of socially isolated people, who are invisible to the service, don't know where to go for help and support, or don't want to 'bother the doctor';
- Service users feel that staff judge them;
- Systems and procedures are made easy for staff, not for service users
- Staff lack the skills and training to engage service users;
- Service users want someone to talk to instead of written information;
- Service users are not educated about how to get access to health services or to put across their views about the services;
- The PCT is frightened to ask people what they want in case they cannot deliver;
- Some PCT staff fear large groups of young people.

Domain 2: Skills and competence of public sector staff:

- PCT staff have the skills to engage with the community but do not have the time to use them;
- Staff may have skills but are unable to put them into practice;
- The environment does not allow staff to engage with or work in partnership with service users;
- Service providers do not have enough time to spend on personal care;
- Staff lack understanding of rural/small-town life;
- There is a lack of knowledge about local resources and about what other services can provide;
- Staff are leaving the NHS as they aren't getting the opportunity to use a social model of health and engage with communities;
- Frontline staff are good at dealing with differing views but as they move up the organisation they tend to rationalise the views of individuals, reducing them to a few general points;
- The PCT stereotypes service users, bracketing them together in groups.

Domain 3: Dominance of professional cultures and ideologies:

- Staff are listening to service users but then take no action, because of problems within the PCT (bureaucracy);
- The PCT does not have partnerships with service users;
- The public has no power in relation to the PCT – the real customer is the Government;
- Services present 'doctors' as the primary contacts and this reinforces people's reluctance to ask for help and support;

- The organisation does not have effective mechanisms for listening to staff/community or for harvesting knowledge/expertise from staff/community;

Domain 4: Organisational ethos and culture:

- Communication within the PCT is poor;
- People do not like change and are comfortable with the status quo;
- The organisation is too complex and there is no overall control of all elements within it;
- Service managers have a sense of powerlessness;
- Differing management cultures within the organisation affect service delivery;
- The current plethora of partnership working methods is good in theory, but does not work in practice.

Domain 5: The national context:

- There is a general lack of co-ordination regarding community involvement initiatives;
- Government ministers and the Department of Health sign up to the principles of partnership working, but have no real understanding of the practicalities;
- There is so much of a national focus that the potential for local innovation is overlooked;
- The NHS has developed a ‘can’t do’ mentality.

Resource 14: Ideas for verification exercises

Assumption to be verified	Verification process	Tasks involved
Are people leaving the NHS to practise the social model of health?	Checking with personnel department about reasons for leaving	Contact personnel department to request breakdown of 'reasons for staff leaving' in the previous year, and benchmark with other local trusts
Does current training for health professionals prepare them to deliver a social model of health?	Checking with colleagues	Discuss at staff meetings. Clarify colleagues' definitions of 'health'
Staff are resistant to ideas from patients	Presenting various members of staff with a scenario and asking what the staff response would be	Letter to GP practices. Explore issues with colleagues at staff meetings. Check with carers' project on responses from GPs to approach regarding involvement
Primary care staff have the skills to engage with the community but do not have the time to use them	Distributing a questionnaire	Ask a mother to ask a group of parents whether they think that PCT staff have the skills to engage Ask a member of a patient liaison group to ask a group of patients whether they think that PCT staff have the skills to engage
Patients have difficulty navigating the PCT system	Using scenarios	Ask a parent and a carer to try out a couple of scenarios (specifically designed to discover how they would navigate the system) in their parent and carer groups
Patients are angry and frustrated	Distributing a questionnaire	A member of staff offered to check some questionnaires that had recently been filled in by carers, which might help to confirm that patients are feeling angry and frustrated by their attempts to engage with the PCT

Assumption to be verified	Verification process	Tasks involved
Service providers have insufficient time to spend on the personal care part of their role (the 'human' side of care)	Knocking on doors! Checking with others	Ask colleagues and local people
There is a high proportion of socially isolated people - who are invisible to service - and do not know where to go for help and support, or do not want to 'bother the doctor'	GP data review	Look at the percentage of older people in the population visiting GP in the previous month, compared with other sites Discuss with local colleagues and contacts at meetings and, as appropriate, some of the following: older people, Age Concern, the local community, voluntary groups, local religious leaders.
The PCT has a hierarchical structure to control power, but there are ways of getting through that structure to increase influence	Emailing survey to all staff Contacting members of the professional executive committee, PCT board and the chair of the PCT Contacting director of finance	Executive discussions Letter to all staff to check this assumption. Human resources staff to progress this
The current plethora of partnership working is good in theory, but in practice it is too extensive, problematic and counter-productive	Checking this assumption with members of local groups and partnerships	
PCT staff fear large groups of young people	Distributing a questionnaire to staff delivering services Discussing with, and distributing a questionnaire to, young people at local high school	Prepare questionnaire. Distribute, collect and analyse

Assumption to be verified	Verification process	Tasks involved
Young people have changed, but staff training and skills have not been updated to keep up	Surveying staff to profile their training and skills specifically related to working with young people	
Young people do not take responsibility for their own health	Holding focus group discussions at the local school	Liaise with school head teacher to set up discussion Use trigger questions for discussion

Resource 15: Mainstreaming plan

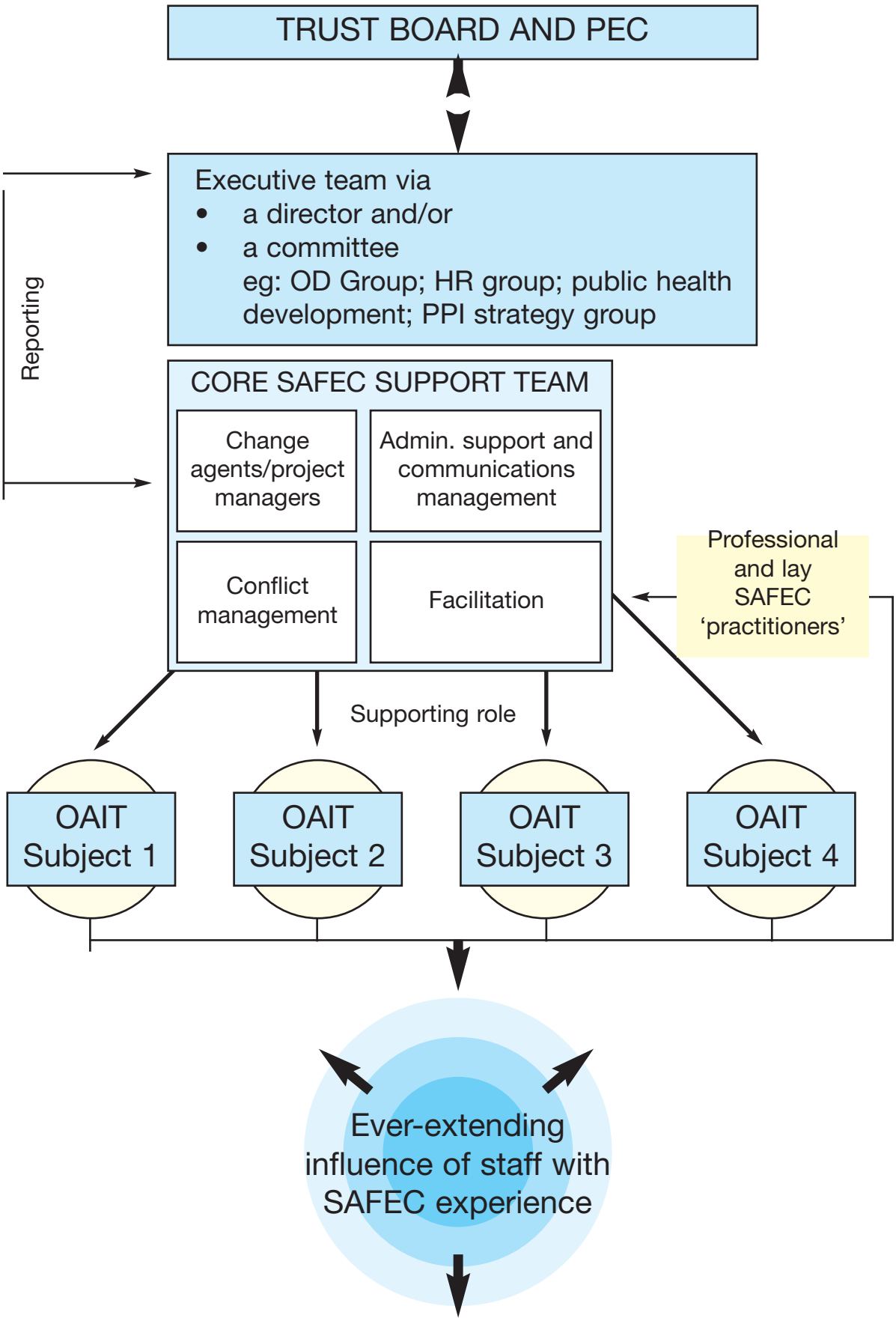
Stage	Objective	Target group	Rationale	Possible processes	Outcome measure
1	Trust board and professional executive community (PEC) support for SAFEC process	Trust board and PEC	Organisational leaders need to reflect on their first SAFEC experience and re-commit themselves to continuing with SAFEC. The trust board and PEC need to be reminded of the SAFEC process, its challenges and values, and the demonstrable benefits or drawbacks of the first experience need to be reported and considered.	Present outcome and impact from first SAFEC experience to board and PEC and reflect on whether the benefits have been worthwhile for the organisation and whether further SAFEC initiatives should be planned to sustain and spread the benefits within the organisation.	Further develop understanding and 'buy-in' of SAFEC process by all executive and non-executives and PEC Number of SAFEC champions identified

Stage	Objective	Target group	Rationale	Possible processes	Outcome measure
2	Establish core SAFEC support team	Executive and management champions	The SAFEC process works best when supported by robust systems within the PCT. The SAFEC process works best when it is experienced, understood and supported by key senior personnel. The SAFEC process works best when networked into the local PPI strategy.	Establish a SAFEC support team with dedicated projects manager, change agents and administrative capability to support a number of concurrent organisational assessment and improvement team (OAIT) processes Support could be provided in consultative capacity by the initial SAFEC team. Identify external facilitator to support and challenge SAFEC process within PCT. Key senior personnel (not executive or PEC, such as directors of operations or service design) should be taken through one event. Participation manager and other relevant staff with defined engagement and effective partnership roles should be networked with core team.	Administrative support available to each OAIT group Integration of SAFEC within local public and patient involvement (PPI) strategy Projects managed and changes implemented Reporting mechanism to executive team

Stage	Objective	Target group	Rationale	Possible processes	Outcome measure
3	Identify initial topic areas	PEC and senior locality managers	To target SAFEC process in appropriate areas To establish support for SAFEC process among senior management	Link SAFEC process to local development plans, national service frameworks, new locality developments and buildings where community engagement is integral part of the way forward.	Three or four topics identified with PEC and senior manager champions
4	Establish OAIT for each topic area	All tiers of PCT staff	To provide experience of SAFEC process to a wide cross-section of staff and disciplines	Supported by the core team, use some or all of the SAFEC tools and processes to engage with the community in chosen service and area.	Barriers to engagement verified Reporting mechanism to core SAFEC team 'Change' projects developed and supported

Stage	Objective	Target group	Rationale	Possible processes	Outcome measure
5	Build and support a community of SAFEC practitioners	SAFEC practitioners	To help spread the skill and experience required to deliver SAFEC and spread the learning from SAFEC initiatives	Integrate a skills development programme for new SAFEC practitioners (project managers and facilitators in particular) into leadership development programmes. Individual learning resources would have to be set aside to fund any formal training/development inputs. PCT intranet development should include a SAFEC site for practitioners, including elements such as a bulletin board, story board, practitioner lists.	An electronic learning network An annual event to share experiences and take stock of impact of SAFEC An internal 'buddying' scheme for new practitioners Increasing numbers of staff who have experienced SAFEC and are capable of running their own initiative

Resource 16: Structure to support mainstreaming SAFEC



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16 Glossary

Facilitated dialogue. A style of managed discussion at the core of the SAFEC process. The organisational assessment and improvement team members meet to discuss and challenge their perceptions of health and social care issues, with the support of a staff member who helps the team work effectively and draws out the key issues.

Independent complaints and advocacy services (ICAS). Organisations working to provide a voice for those service users who, for whatever reason, cannot speak up for themselves, to help them access better quality services.

NCCCE. The National Collaborating Centre for Community Engagement established by the HDA in 2004 and based at Lancaster University. For further information see the website at www.nccce.lancs.ac.uk or telephone 01524 593377.

Organisational assessment and improvement team. The team that works at the heart of the SAFEC process. Made up of 10–20 health and social care staff, service users and local communities, the team meets periodically to discuss health care services through facilitated dialogue (see above).

Patient advice and liaison service (PALS). An organisation working within each NHS trust to signpost patients to ICAS (see below) and to monitor patients' concerns and providing feed back to trusts.

Patient and public involvement forums (PPIFs). Groups linked to each NHS trust in England which monitor service quality and provide an independent voice for patients and members of the public.

Project team. A team made up of staff of the organisations carrying out the SAFEC process, which oversees and manages the smooth running of the SAFEC project. Within the SAFEC process, the project team is made up of a project director, a project manager, and SAFEC dialogue facilitators.

Reference community. A clearly defined group of service users or local people that the project team agrees on as the focus for the facilitated dialogue. Examples could include: older Asian women, people with HIV, users of family planning services, young men from a particular area of town, or pupils at a particular school.

SAFEC. The acronym for Strategic Action For Engaging Communities, a Department of Health-funded model devised by the Health Development Agency's National Collaborating Centre for Community Engagement, based at Lancaster University, to find ways to engage communities in public sector decision-making. It was formerly known as SAPHC (see below).

SAFEC approach. The method described in this resource pack of changing the way in which public sector organisations work, to overcome barriers to involving their service users and local communities.

SAFEC process. The series of steps that organisations need to take in order to learn about their barriers to engaging local people and changing the way they work.

SAPHC. The acronym for Strategic Action Programme for Healthy Communities, since renamed as SAFEC (see above).