

To consider

Improving Engagement

Issue

1. How to enhance our understanding of the views, perceptions and experiences of patients and the public, and doctors, as part of our wider engagement work with our key interests.

Recommendation

2. To agree to establish a Reference Community comprising around 25 members of the public and around 25 doctors (paragraphs 10-27).

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602

Background

4. We have identified four key interests – patients and the public; doctors; the NHS and other healthcare providers; and medical schools and medical Royal Colleges.
5. Broadly, we engage with key interests in four ways:
 - a. Involvement – establishing a relationship with an individual or organisation to the benefit of both parties. Involvement includes our work within specific external structures as well as more informal interactions.
 - b. Understanding – seeking views, and analysing behaviours and rationales, at an early stage within the policy-making process, by way of informal soundings and listening, horizon scanning, risk assessment, desk research, opinion polling or focus group research, or any related activity that might be described as ‘pre-consultation’.
 - c. Consultation – the formal process, sometimes required by legislation, of asking organisations and individuals their views on proposals or possibilities, using a range of methods.
 - d. Communication – the projection of our policies and messages using the media, website, publications, events, public affairs and other channels. This can include the securing of active ‘buy-in’ so that other individuals or organisations are willing to act as advocates for the GMC.

Patient and public involvement

6. In 1999 we established a group that later became the Patient and Public Reference Group. PPRG comprised Council members and representatives of patient organisations. PPRG was effective in ensuring that we considered the views and needs of a variety of groups and individuals when developing policy.
7. In 2006, we added six public members appointed through open competition. This enhanced PPRG’s effectiveness by enabling contributions that reflected the public at large.
8. We reviewed the role of PPRG in 2008 and concluded that its effectiveness was constrained by its role as a standing group with four meetings each year. Our policy development cycles were rarely synchronised with PPRG’s meeting schedule, and patient and public input into policy development was often needed when PPRG was unable to provide it.
9. On 18 September 2008 Council agreed to commend the principle of establishing a Reference Community, comprising around 25 patients and the public, and around 25 doctors, recruited by open competition. As a result PPRG concluded its work at the end of 2008.

Discussion

10. Improving engagement with patients and the public, and with doctors, has been identified as a high priority.

11. The NHS and other healthcare providers, and medical schools and medical Royal Colleges, are finite, readily identifiable, populations. We will continue to improve how we engage with them by doing better what we already do – contributing actively to their existing structures and processes, encouraging their involvement in our own structures and processes, and communicating effectively.

12. In contrast, patients and the public, and doctors, are large, diverse, populations. There are representative organisations but engaging exclusively through them does not meet our needs. The Reference Community would sit beside, and would not displace, continued engagement with representative organisations.

13. Equally, we would continue to enhance engagement in other ways. For example, on occasions it is desirable to seek the views of a larger group than can be satisfied by a 50-member Reference Community. We would use more conventional opinion survey or polling methods. We already use this approach in conducting with our tracking survey and PMETB also conduct regular surveys in this way.

Purpose of the Reference Community

14. The proposed Reference Community is designed to be used as:
- a. A sounding board on emerging policy possibilities.
 - b. A source of external input to provide a patient and public, or doctor, perspective on policy issues, primarily during 'pre-consultation' though possibly also as part of the formal consultation process.
 - c. A pool of potential members of working groups as and when the need arises.

Working methods

15. The aim would be to enable the Reference Community to work as flexibly as possible. We should be able to draw on the Reference Community in a variety of ways, including:
- a. All or a subset of members reviewing a policy document or other publication, or responding to a poll or questionnaire linked to an outline policy proposition.
 - b. A small group undertaking deliberative group work on a specific issue.
 - c. One or more individuals contributing as members of a working group.

16. The Reference Community would not normally meet as a group. To support a more flexible, responsive and inclusive approach, we would support members to enable them to work and communicate effectively with us.

Composition

17. We envisage that initially the Reference Community would comprise:

- a. Around 25 members of the public, representing a range of perspectives.
- b. Around 25 doctors working in a range of fields at different stages of their careers.

18. Within these two groups we would seek a broad cross-section of people, including those from a diverse range of locations, ages, faiths and beliefs, and ethnic and socio-economic backgrounds.

19. Increasing the number of public members to around 25 constitutes a significant enhancement of our current six-strong group and represents a practical number to recruit and service.

20. We will include within our plans for the Reference Community an opportunity to review its effectiveness and increase the numbers if necessary.

Recruitment

21. We would recruit the Reference Community by open competition and will seek to constitute it by the end of June 2009.

22. We are exploring the most efficient and cost-effective means of recruiting members of the Reference Community.

23. Essential attributes for all Reference Community members would include:

- a. An interest in a broad range of policy issues relevant to the patient safety agenda.
- b. A willingness to take a fair-minded approach, independent of any pre-existing personal affiliations.
- c. The ability to work as part of a team in a collaborative and flexible manner.

Next steps

24. As a first step towards establishing the Reference Community, we have invited the six public members of the former Patient and Public Reference Group, which concluded its work at the end of 2008, to continue to work with us during the

period before the Reference Community is established. This will provide continuity in the period before the public members transfer to the Reference Community.

25. Projects in which we may involve them include:

- a. Licensing as a first step towards revalidation.
- b. Lord Patel's Review of the regulatory framework for medical education.
- c. Development of our Equality Scheme for 2009.

26. In addition, public members will continue to serve on the *Confidentiality* Working Group and the *Tomorrow's Doctors* Review Group. One of the public members will be presenting at the *Tomorrow's Doctors* Consultative Conference on 2 March 2009.

27. We considered whether to convene a further meeting of the PPRG as part of the transition arrangements but, given the steps identified above, we do not propose to do so.

Recommendation: To agree to establish a Reference Community comprising around 25 members of the public and around 25 doctors.

Resource implications

28. There will be a set up cost for the recruitment and induction of the Reference Community. In addition there will be a small annual running cost broadly commensurate with that of running the PPRG in 2008. We have made provision for both these elements in the 2009 budget.

Equality implications

29. The recommendations for enhancing our engagement with patients and the public, and with doctors, are in line with our commitment to valuing diversity and promoting equality, not least in giving us access to a wider cross-section of people within an increasingly diverse society and changing healthcare environment. We will carry out an Equality Impact Assessment in advance of the recruitment exercise commencing.