

**Western Health and Social Care Trust
(WHSCT)
Personal and Public Involvement (PPI)
Monitoring Report
April 2015**

Prepared by Martin Quinn and Claire Fordyce, PHA



Contents

Introduction	2
Rationale for PPI	2
PPI Standards, Monitoring and Performance Management.....	3
Methodology.....	3
Findings and Recommendations	5
Standard 1 – Leadership.....	6
Standard 2 – Governance.....	8
Standard 3 - Opportunities and Support for Involvement.....	11
Standard 4 – Knowledge and Skills.....	13
Standard 5 – Measuring Outcomes.....	15
Conclusion.....	17
PPI in Practice – Cancer Services across the Trusts.....	18
Background.....	18
Methodology.....	18
Findings	18
Suggested Areas to Enhance Practice through PPI.....	21
Acknowledgements / Thanks	22
Appendix 1: Personal and Public Involvement (PPI) Standards and Key Performance Indicators	23
Appendix 2: PPI Monitoring Process with HSC Organisations.....	26

Introduction

Personal and Public Involvement (PPI) is a process whereby service users, carers and the public are empowered and enabled to inform and influence the commissioning, planning, delivery and evaluation of services in ways that are relevant and meaningful to them. People have a right to be involved and increasingly they expect to be actively involved in decisions that affect them.

PPI is a statutory responsibility as detailed in the HSC (Reform) Act (NI) 2009 through the Statutory Duty to Involve and Consult. Each Health and Social Care organisation, to which the legislation applies, is required to involve individuals in the planning and delivery of Health and Social Care (HSC) Services. Specifically, sections 19 and 20 of the above legislation require that service users and carers are involved in and consulted on:

1. The planning of the provision of care
2. The development and consideration of proposals for change in the way that care is provided
3. Decisions that affect the provision of care.

Rationale for PPI

PPI is underpinned by a set of values and principles, but at its core, is the drive to achieve truly person centred services, where service users, the carers and the public are fully engaged in a partnership based approach to health and wellbeing, whether that is at the strategic, or individual level of care planning and provision.

The impact of PPI has been demonstrated in a range of areas from efficiency, and effectiveness, where services have been tailored to need, reducing wastage and duplication, to improvements in quality and safety, to increased levels of self-responsibility for one's own health and wellbeing.

PPI Standards, Monitoring and Performance Management

The Public Health Agency (PHA) has responsibility for leading the implementation of PPI policy across HSC organisations. This is outlined in the Department of Health Social Services and Public Safety (DHSSPS), PPI policy circular (2012). The PHA has a responsibility for monitoring PPI across the HSC system, but has particular responsibility for providing assurances to the DHSSPS in relation to the compliance with and progress of PPI in HSC Trusts.

As part of its leadership role for HSC, the PHA has for the first time in Northern Ireland, established a set of standards for involvement, helping to embed PPI into HSC culture and practice, supporting the drive towards a truly person centred system. The five PPI Standards and associated Key Performance Indicators (KPIs) were formally launched in March 2015 (appendix 1) and provide the basis for the structure of the monitoring and performance arrangements, which have been developed by the PHA.

A pilot monitoring exercise for PPI was conducted at the end of 2013/14. The results of this were used to inform the development of the first formal PPI monitoring arrangements with Trusts. This was initiated in late 2014/15, with a view to having reports completed and available for the Accountability meetings with the DHSSPS in May / June 2015.

Methodology

The monitoring process has used the PPI Standards and associated KPIs as a framework to gather information to help assess Trust progress against compliance with PPI. A direct assessment has not however been made against all KPIs for this report as the PPI Standards were only recently endorsed in March 2015.

The monitoring mechanisms and arrangements were developed in partnership with members of the Regional HSC PPI Forum including service users and carers.

Further discussion and input from the Health and Social Care Board (HSCB), the Patient and Client Council (PCC) and in particular, Regional Quality Improvement Authority (RQIA) helped shaped the final format of these arrangements. They were then shared with and agreed by the DHSSPS.

The key components of the monitoring process are outlined below, with the associated timeline detailed in appendix 2.

- i. An initial baseline self-assessment questionnaire is completed by Trusts in partnership with their PPI Panel (or equivalent) which helps inform assessment of progress in embedding PPI into the culture and practice of the organisation.
- ii. The self-assessment report is considered and approved by the Trust Clinical and Social Care Governance Committee (or equivalent), representing formal sign off by the Trust on their submission.
- iii. The reports are reviewed and analysed by the PHA working with in conjunction with service user and carer members of the Regional HSC PPI Forum Monitoring sub group.
- iv. A verification visit is undertaken with each Trust, probing the responses and evidence provided as part of the self-assessment.
- v. All information is then reviewed and a final report produced for the DHSSPS as part of the accountability arrangements.

Findings and Recommendations

The report is based on evidence gathered through:

1. The Trust PPI self-assessment monitoring return.
2. Information collated during the verification monitoring visit.
3. Additional evidence supplied by the Trust.

The report sets out the findings against the five PPI Standards and recommendations are provided for each area.



Standard 1 – Leadership

HSC Organisations will have in place, clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.

Findings

- The Trust has named executive and non-executive PPI leads at Board level.
- The Trust has a named PPI operational lead, however a limited proportion of this post is dedicated to PPI.
- The Trust has changed its Directorate leadership arrangements for PPI. Each of the service Directorates are represented on the PPI Forum. The Directorate PPI named contact, is there to provide advice and guidance to colleagues on matters of PPI and act as a link person for any PPI matters within their Directorate. As we understand it, this individual is not responsible for providing leadership in PPI in the Directorate, or holding others to account in respect of their compliance with their PPI responsibilities.
- PPI is a standing item on some of the Directorate SMT meetings.
- The extent and nature of engagement and involvement with service users/carers is diverse across the Directorates, with the Trust acknowledging that some service areas are stronger than others, some of which is due to the nature of the service being provided.

Recommendations

1. In terms of the PPI named contact system that the Trust has introduced, it would be important to:
 - Ensure that the individual PPI named contact has capacity (protected time) to provide the advice and guidance in PPI to their Directorate

colleagues. The Trust also needs to monitor the levels of demand on their time.

- Ensure that the PPI contact has the appropriate level of knowledge, expertise and skill in PPI to be in a position to perform their role.
 - Have a clear role description for the named contact, setting out what they are expected to do and also ensure that others in the Directorate are aware of who the contact is and what support is available through them.
2. The Trust should consider how it ensures that PPI Leadership in each Directorate is strengthened, in order to ensure that staff and teams are able to deliver against their PPI responsibilities, both at an individual patient care level and also at a more generic service development / change level.
 3. Consideration needs to be given to the resources that have been assigned to fulfil the PPI responsibilities and Statutory Duty of Involvement.



Standard 2 – Governance

HSC Organisations will have in place, clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

Findings

- The Trust has a PPI Strategy and Action Plan 2012-2015 in place. The Trust has advised that PPI is a corporate priority in the organisation.
- The Trust acknowledges that progress on delivery against the Action Plan has been slow, with a number of actions not met in the current plan. The Trust has attributed this to the level of pressures and competing priorities that face HSC organisations, a lack of momentum for PPI and a key factor being the lack of PPI staffing resources to implement actions within the plan¹.
- Individual Directorates are required to have Directorate specific PPI Plans as outlined in the Western Trusts PPI Strategy and Action Plan 2012-2015. However, the development of these individual Directorate Plans has not been universal.
- An Annual PPI Progress Report is produced and is available on the website demonstrating PPI in action across the Trust.
- The Trust operates a PPI Forum which is a sub-committee of the Trust Governance Committee, which in turn reports to the Trust Board on PPI.
- The PPI Forum is currently comprised of community and voluntary sector representatives and six Directorate PPI named contacts, with only one service user/carer represented. The Trust advised that they have faced challenges in trying to encourage service users / carers to join the Forum to discuss strategic PPI matters, but have recently adopted a new Terms of Reference, and will seek to support additional service user representation and also are

¹ WHSCT, 2 April 2015, Personal and Public Involvement correspondence – Proposal for additional resource to support the implementation of PPI standards throughout the WHSCT.

considering the development of a Service User Led Panel for Western HSCT within 2015/16.

- The Chair of the PPI Forum is a non-executive Director who also sits on the Trust Governance Committee.
- The Trust PPI Forum focus on working to drive forward the PPI agenda across the Trust and consider progress against the PPI Strategy. The PPI Forum is not however, routinely informed about the Trust investments, service development / withdrawal plans, nor asked for their input or guidance. However, these matters are subject to the normal consultation requirements in accordance with Section 75 duties and the Trusts Consultation Scheme and are made available on Trust website and subject to public consultation as required.
- Trust representatives identified that plans are in the development stage as part of the new PPI Strategy and Action Plan, to strengthen corporate and governance arrangements overall for PPI across the organisation.

Recommendations

1. In terms of corporate governance arrangements, the Trust should consider how it can ensure that PPI is regularly placed on the agenda of Executive and Board meetings. There is a potential risk that PPI is only considered when the scheduled updates on the PPI are brought forth through the Trust Governance Committee reports. Having PPI as a standing item on the agenda as it pertains to the on-going and daily business of the Trust, would help ensure that it is embedded into the culture and practice of the organisation.
2. The Trust should review and formally record the mechanisms that operate in each Directorate, to ensure that there are clear and transparent arrangements for involvement of service users and carers. The mechanisms and processes for involvement should be checked out with service users and carers to

ensure that they are accessible, purposeful and encouraging for service users and carers

3. In respect of the Trust PPI Forum the Trust should:

- Consider how the advised mechanism to refresh membership could be made more robust, to ensure that service users and carers from across the Trust area of operations are recruited onto the Forum to share good practice and to ensure consistency of approach to meaningful involvement in service developments etc.
- Consider how to strengthen the influence of the Forum in the work of the Trust Governance committee, including representation, agenda setting etc.



Standard 3 - Opportunities and Support for Involvement

HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Findings

- The Trust does not currently maintain a formal register of existing and future opportunities for involvement, but individual Directorates hold information at source on groups relating to their own particular area.
- The Trust has a number of informal and formal mechanisms to raise awareness about existing and future opportunities for involvement. This has been identified as a key action area for the new PPI Strategy.
- The Trust described a number of internal support processes, materials and resources for service teams and staff, to support them to facilitate the involvement of service users/ carers and the public which included:
 - Ad hoc support, advice and guidance made available to service teams when engaging with service users/carers or the public, upon request.
 - Range of training and support available to facilitate engagement e.g. equality and human rights training and a number of support resources, particularly when engaging with Section 75 groups.
 - Range of communication techniques promoted.
 - Reimbursement guidance disseminated across the Trust.
- In respect of feedback, the Equality & Involvement team encourage staff to build this in as an integral element of any engagement or involvement, be that at individual care, or service planning and development level. The Trust acknowledged however, that it may not always take place and that they do not have any way of assessing whether or not, staff did provide feedback to those they engaged with.

- The Trust Equality & Involvement team advise that there should always be a named point of contact for each engagement exercise, but could not confirm that this always happens in practice.
- The Trust robustly argued that the lack of a dedicated PPI resource was compromising their ability to enable them to deliver on their PPI responsibilities and plans as fully as they would otherwise wish to. They set out the magnitude of the task required and detailed the limit to the resources that they currently have available to meet the need.

Recommendations

1. The Trust should in accordance with their new draft strategy proposals, develop a central register of opportunities for involvement that is updated across all Directorates and is readily accessible by the public.
2. The Trust should consider how to most effectively communicate and make accessible the range of its current training materials / resources which support the active involvement of service users / carers.
3. The Trust should ensure that there is an appropriate level of materials and support made available directly to service users and carers who may wish to become involved, be that at an individual level, or in respect of service developments. This could include things such as information on the standards service users can expect from services, how to become involved, what your role could be etc.
4. Feedback must be embedded as standard practice at all levels across the organisation. The Trust also need to consider how they can ascertain if this is being done and to a satisfactory level.

Standard 4 – Knowledge and Skills

HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.

Findings

- The Trust's Corporate Induction Programme references the PPI Forum and User Views, however given the nature of Induction training and the necessity to cover a large range of issues, specific attention is not given to PPI in practice as part of your individual role.
- Provision and access to PPI training is provided on an ad hoc basis. The Trust did however undertake a programme of awareness raising and training on PPI in partnership with a 3rd sector voluntary organisation in the northwest. (35 staff members availed of this)
- The Trust has also creatively integrated PPI training into Equality Screening Training which has resulted in 130 people accessing specific knowledge about elements of PPI between 2012/14.
- The Trust has also accessed regional training opportunities hosted in 2014/15 which resulted in a small number of staff attending the generic training and 17 staff attending the PPI Team Briefing training which was held locally.
- The Trust advised that there has been limited input of service users/carers in PPI training due to lack of locally developed programmes, but believe that this will change when the new Regional PPI Training resources and programmes are made available.
- In 2015/16, the Trust aim to avail of the Regional PPI awareness raising and training programme which is currently being developed.
- It was noted by the Trust that the majority of the pilot regional training programme development and meetings, with the exception of one briefing session, was delivered in Antrim/Belfast and due to travel restrictions, this

limited Trust ability to participate fully in the development of the regionally agreed PPI awareness raising pilot programme.

- The Trust also mentioned the need for the Engage Website to be operational and the need for roll out of an eLearning programme for PPI to support the face to face provision under development.

Recommendations

1. The Trust should ensure that in the corporate induction and in individual job inductions, that staff are clearly made aware of what PPI is and their responsibilities at a general level. Direction to further sources of information / training as appropriate should also be provided.
2. The Trust should consider how it records uptake of current and future PPI training, including training which incorporates elements / aspects which may be relevant to responsibilities associated with PPI.
3. The Trust should consider how it plans to take forward the dissemination and roll out of the Regional PPI training programme (once available) across its organisation and how it intends to record uptake.
4. The Trust should build PPI into future job descriptions as a key responsibility and also into staff development plans and appraisals as appropriate to their role.

Standard 5 – Measuring Outcomes

HSC organisations will measure the impact and evaluate outcome of PPI activity.

Findings

- The Trust has previously mapped PPI work across the organisation during 2012/13 & 2013/14 and has produced Directorate reports which provided a baseline for Directorate Action Plans. The Trust advised during the verification visit that Directorate level PPI Plans are not in place. PPI information is captured via annual up-date requests, which is collated by the PPI Lead.
- The Trust collates progress across all Directorates and develops an Annual Progress Report on PPI, which highlights a wide range of examples of good PPI practice.
- The Trust advised that it seeks to involve service users, carers and the public at an early stage, in all significant service developments, changes, investments. It cannot guarantee that this always takes place. The Trust cited a number of reasons why this may occasionally be the case, including time pressures by commissioners, the diverse and ever-changing nature of pressures and demands being faced by Trusts, the pace and scale of reform, but above all, the lack of a dedicated PPI resource to support and ensure delivery against the Statutory Duty to Involve and Consult.
- The Trust were able to evidence a number of good practice examples of PPI across the organisation which have resulted in tangible benefits for service users, carers and indeed staff and the Trust itself. A number of these have potential for replication and transferability both within the organisation itself and indeed across the region.

Recommendations

1. The Trust should ensure that the mechanisms that it employs to record and capture evidence of PPI in practice across the organisation, includes the use of PPI indicators, helping to ensure that good practice is recognised and lessons transferred if appropriate. It should also highlight areas for possible improvement.
2. Any PPI monitoring mechanism utilised by the Trust needs a verification element from the recipients of services to be built into it, to ensure that the perspective of the service user / carer and public feedback is fully integrated.
3. Trust senior management should regularly reinforce the need for PPI considerations to be regarded an integral element of the responsibilities of staff and the organisation, whether operating at the individual care or strategic planning level.
4. The Trust needs to ensure that PPI is clearly built in as a formal key step in respect of the planning and delivery of care for individuals and also for changes to services, with appropriate checks and balances built in to ensure compliance with the statutory responsibility.



Conclusion

PPI is being progressed by the WHSCT on a number of fronts. Corporately, the Trust has taken a number of key steps in respect of compliance with its responsibilities under the Statutory Duty to Involve and Consult. This is reflected in the fact that a PPI strategy is in place, a PPI Forum has been established and an Officer with PPI responsibility assigned to them is in post.

The Trust has also been able to evidence a range of good PPI practice from throughout the organisation, which has really made a positive difference to service users and carers. These have the potential for replication and transferability both within the organisation and across the region.

There are however a number of areas which the Trust needs to consider. The Trust has accepted their need to do more in this area and recently submitted a proposal seeking resources to address recognised deficiencies. Consistency of approach and compliance with both the spirit and the letter of the Statutory Duty of Involvement and Consultation is a huge challenge for a large and complex organisation such as a Trust but is one which needs to be addressed robustly and comprehensively across the organisation.

The recommendations set out in the report are aimed at helping the Trust to progress towards a position where PPI is fully embraced and embedded into culture and practice.

The PHA will work with the Trust in its endeavours to address the recommendations in this report, in particular, where it is clear that there would be merit in a collective approach across HSC organisations.

PPI in Practice – Cancer Services across the Trusts

Background

As part of the PPI monitoring process, it was agreed to engage with a service area to examine the outworking of PPI in practice. Cancer services was selected by the review team as the first area for review, as there was a recognition that there was already a focus on this service area through the Cancer Services Experience Survey.

The following section provides an overview of the responses and reports on findings of PPI practice within cancer services to support the sharing of information and good practice. A wealth of work is currently being undertaken in cancer services to involve service users / carers and this report, provides only a small snapshot of the activity at a point in time. We also recognise that regional cancer service meetings happen on a regular basis and encourage this report to be discussed at such meetings to share findings.

Methodology

After the corporate PPI monitoring verification visit in each Trust area, a separate meeting took place with representatives from cancer services. Each Trust was asked to secure a senior staff member responsible for the service area and if possible, a service user / carer from that area. A series of questions in relation to how PPI operated and was implemented in cancer services, was then addressed to the interviewees in a discussion type arrangement. Service user / carer representatives (where they were in attendance) were also asked about their experiences in relation to their involvement in regards to cancer services in that Trust area.

Findings

In relation to leadership and governance, all Trusts reported a named PPI lead was appointed.

Governance arrangements were not uniform across cancer services in the Trusts; however it was clear that PPI was a core element of the culture of all cancer services. Some Trusts had PPI Action Plans specifically for cancer services, whilst others attempt to build PPI in as an integral element to their Directorate / Service plan.

In terms of service user / carer involvement in the planning and delivery of cancer services, a variety of mechanisms were employed. The SHSCT and SEHSCT have a Service User Cancer Group in place and a PPI group for each tumour site, whilst WHSCT has a Cancer Services Locality Group and BHSCT are informally working to embed PPI into all activity. The NHSCT were the only area without a cancer services PPI group, but evidenced a range of work which engaged with service users either at a one-to-one level, or via involvement in regional work. This is in line with our findings from a corporate PPI perspective, as not one model of engagement suits all areas.

No specific budget is outlined for PPI work in cancer services, but all Trusts reported that reimbursement for out of pocket expenses is provided and some support for involvement activity is also provided via cancer charities.

At an individual care level, the role of the Clinical Nurse Specialist (CNS) in involving all service users was referred to by most Trusts. This role provides the opportunity for service users to discuss their needs and provides guidance and support before and after consultations, to involve patients in their own care. This role was also recognised as key to getting service users and carers involved in cancer specific PPI groups, either at a local or regional level. In the NHSCT, good practice was noted in that the CNS job description and job plan includes involvement as a key role which helps to embed PPI into practice in cancer services.

Given the increasing demand for care, people living longer and surviving cancer, the matter of providing appropriate support for people post treatment was raised by all Trusts. At a service improvement level, the Transforming Cancer Follow Up (TCFU) initiative was noted by all Trusts as providing a structure to facilitate and encourage

involvement. The Holistic Needs Assessment (HNA) process engages service users to review their own needs, which then empowers patients to drive forward their own care and deal with recovery. Health and Wellbeing events were noted again in all Trusts, which provide an opportunity to involve service users and carers in self-care, but some Trusts had also involved service users in developing and evaluating the events.

A wide range of examples were provided to demonstrate the involvement of service users/carers in a range of Trust developments. In the WHSCT, service users were involved in the campaign for the development of the radiotherapy unit for Altnagelvin. In SHSCT, service users and carers helped to plan and design the new Macmillan Information Unit in Craigavon Hospital. Service users and carers have also been recruited as volunteers to support the dissemination of cancer information. In BHSCT regional radiotherapy unit, the service evaluations conducted in partnership with service users / carers are reviewed and categorised into the top 5 things that are going well and the top 5 areas which could do better. As a result of this work, a number of practical changes to the way in which services were delivered and the adaptations to the physical surroundings for those availing of treatment, were identified and are being actioned. In the SEHSCT, a Results Clinic was established to provide a quieter area for patients away from the Outpatient Clinic. In NHSCT, Consultants attend advanced communications training to support the consultation process and this has been reported to be very beneficial and supports the involvement of patients in treatment.

Across all the Trust areas, feedback to service users/carers on service improvements / changes was not strong. Feedback is as an essential component of PPI, enabling information to be shared, to show how people the difference their involvement has made. This is an area which needs to be strengthened.

All Trusts provided the opportunity for carers or family members to be involved in consultations. Further support for carers was noted including accessing information or being involved in discharge care plans. The approach to the involvement of carers

however across cancer services, was neither standard, nor robust and could be strengthened.

Suggested Areas to Enhance Practice through PPI

- Trust cancer services are encouraged to have in place or to develop a PPI Action Plan and to monitor progress.
- The opportunities for involvement are clearly and regularly communicated e.g. have your say posters, websites, and opportunities raised at clinical/patient and carer interactions.
- Trusts should ensure that staff know who the responsible PPI lead is in cancer services.
- Trusts should ensure that there is a named point of contact for individual care and also for involvement in any wider PPI projects.
- It is important to ensure that there is a structured plan / mechanism to facilitate the voice of the service user/carers being heard. Where recruitment to groups is proving problematic consideration should be given to the use of surveys, social media and partnership arrangements with advocacy organisations in a planned manner.
- Trusts should ensure that there are clear mechanisms for staff to share and use knowledge gained from involvement with feedback from service users/carers.
- In developing, delivering and evaluating programmes, Trusts should always seek to identify opportunities to utilise service users / carers' knowledge and expertise.

- Trusts should assess the aspects of PPI knowledge/skills/training required by staff as appropriate to their post and build that into the service action plan.
- A more systematic approach to consider carers needs and how they can be involved would be beneficial. Linking this to the work with the Carers Co-ordinators which was noted by a few of the Trusts, may help in this regard.
- Trusts should capture/record how PPI approaches have impacted on outcomes for service users/carers, to inform learning and future practice.
- Feedback to service users/carers should be adopted as standard practice.

Acknowledgements / Thanks

The PHA would like to acknowledge the work of the service users and carers from the Regional Forum who helped co-design the PPI monitoring mechanisms and who participated in the verification visits and contributed to the assessment of the findings. The PHA also appreciate the work of Trust staff, in particular those with responsibility for PPI who led on the completion of the Trust self-assessment returns and for their contribution and time given during their participation in the monitoring verification visits. Finally, sincere thanks to the service users and carers in the respective Trust areas, who participated in the monitoring verification visits, sharing generously of their time, stories and personal experiences of Involvement.

Appendix 1: Personal and Public Involvement (PPI) Standards and Key Performance Indicators

Standard One – Leadership

Health and Social Care (HSC) Organisations will have in place, clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- PPI Leadership structure in place across the organisation to include:
 - Named Executive and Non-Executive PPI lead at Board Level, with clear role descriptions and objectives;
 - PPI Operational Lead;
 - PPI leadership structure throughout the organisation.

Standard Two – Governance

HSC Organisations will have in place, clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

Key Performance Indicators:

- Governance and corporate reporting structures are in place for PPI.
- Action plan with defined outcomes developed to demonstrate the impact of PPI.
- Annual PPI report produced, demonstrating evidence of compliance with PPI responsibilities and work undertaken to address challenges in this area.

Standard Three – Opportunities and Support for Involvement

HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.

Key Performance Indicators:

- Maintain an up-to-date register of existing and future opportunities for involvement at all levels across the organisation, which is accessible by the public.
- Support the involvement of service users, carers and the public to include:
 1. Provision of clarity on roles/responsibilities for those who are participating.
 2. Provision of training/support.
 - Advocacy support provided if required.
 3. Use of accessible/user friendly communications, mechanisms/procedures. E.g. use of plain English, easy read, jargon free etc.
 4. Good meeting etiquette.
 5. Application of Interim Service User, Carer and Stakeholder Reimbursement Guidelines and Procedures for HSC Organisations.
- Named HSC points of contact for each individual engagement exercise.
- Provide feedback to those involved on each engagement as standard practice.
- As part of your Action Plan, identify barriers to involvement and develop actions to overcome these.

Standard Four – Knowledge and Skills

HSC organisations will provide PPI awareness raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.

Key Performance Indicators:

- Integrate basic PPI awareness raising into induction arrangements for all new staff.
- Evidence compliance with any annually agreed regional targets for the provision of/access to PPI training.
- Ensure a mechanism is in place to capture information on the up-take of PPI training.
- Demonstrate service user and carer involvement in the design, delivery or evaluation of PPI training.

Standard Five – Measuring Outcomes

HSC organisations will measure the impact and evaluate outcome of PPI activity.

Key Performance Indicators:

- Evidence service user and carer involvement in the monitoring and evaluation of PPI activity.
- Demonstrate through the Annual Report:
 - How the needs and values of individuals and their families have been taken into account, in the development and delivery of care;
 - The outcomes/impact (positive/neutral/negative) achieved by using PPI approaches in respect of policy, investments, decisions and service delivery across the organisation.

Appendix 2: PPI Monitoring Process with HSC Organisations

