

Hard to Reach Communities Nuala Conlan

Foundation Trust Network

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Is there such a thing as a hard to reach community?

- Yes and no.
- No list which defines the “hard to reach”
- Depends on local circumstances
- No decision making process can involve all the people it affects.
- Complex factors
- Need “good enough” processes to engage
- Reality of “rational apathy”

Who is hard to reach?

- Be clear who is hard to reach in your context
- Some factors that prevent engagement include:
- Age, gender, sexuality, ethnicity, income, faith, employment status, language, residential status, health, access to transport, lifestyle, time, ability, consultation overload, cynicism, motivation, etc
- Anything that creates a barrier between them and you

Active citizen / active patient?

- Dr Angela Coulter describes the active patient and the active citizen as being a key factor in the process of securing appropriate, effective, safe, responsive healthcare. the capacity for a person to make an active contribution to their care is not a choice they can enact alone. Rather it is a factor and consequence of the dynamic created by the way care is provided. For people to be more active in their care, we need clinicians, managers, services and systems that invite and enable an active role (previous policy and development director Kings Fund- now independent analyst)

Why engage?

- Macro and micro factors
- Requirement/obligation
- Desire – improved outcomes/good governance
- Reach /empowerment of ordinary people
- Reputation - legitimacy - long-term relationship/
accountability
- Recognition – more responsive and effective
services
- Reward

What supports good engagement?

- Strategic / senior management buy-in
- Systemic approach
- Excellent planning and teamwork
- Inter-agency working – building a joint profile
- Understand how communities are created – identity, geography, interest
- Tell why you are engaging – what's at stake
- Different methodologies - mix it up

Methodologies

- E-communication – email, text, facebook,
- Face to face – meetings, focus groups, forums, reference panels, conversations, discussion groups, expert patient groups, walkabouts
- Structured – think tanks, Listening posts, incentives, citizen panels, deliberative events
- 2nd tier – staff networks, vol orgs, community networks, stakeholder forums, piggy backing

Methodologies (2)

- Fun! – parties, playing, singing, art, dancing, events in the park
- Conduits – local leaders, gatekeepers, active citizens
- Always seek to use plain English - no jargon – no acronyms
- Take people with you and if you lose them on the way - go back and find them and try again.
- LINKS – relationship not prescribed but an important stakeholder

Issues

- Know why you are engaging
- People see themselves as individuals
- Horses for courses (level of engagement needed?)
- Be authentic and have integrity
- Support needed – build capacity of community and staff (resilience)
- Finance – secure a budget
- How will you decide? Mandate vs usual contributors?
- How will information be used?
- How will you evaluate the process and the outcome?

Top tips

- Build on what you've got
- Allocate the time and resources needed - "sell yourself"
- One size does not fit all – walk a mile in their shoes – go to them on their terms
- Prepare the ground – Be honest
- Water the ground (quick wins)
- Let relationship "flower" - establish trust. Be in it for the long term

Top tips (2)

- Never forget practicalities – FOOD! creche, elder care support, transport, access, expenses, timing, appropriate nature of events and publicity
- Reduce duplication – partnership working with other agencies – get strategic buy-in
- Trust and train your front-line staff (eyes and ears) - font of local knowledge
- Remember wider stakeholders – take them with you
- Remember – “you said, we did – always feed back