Department of Health

Feedback Report:

Evaluation of Health Link Training for Patient and Public Engagement

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Date: 16th August 2011

Executive Summary

This report is comprised of a summative evaluation of Patient and Public Engagement (PPE) training that was delivered by Health Link to staff from two Primary Care Trusts (PCTs). The aim of this evaluation is to understand how the training intervention embedded PPE in the PCT and how it influenced commissioning and practice. The training and evaluation was conducted prior to the announcement of the intended abolition of the PCTs (Equity and Excellence: Liberating the NHS, 2010). The evaluation findings may inform the future training requirements for PPE in GP Consortia, Local Authorities and local HealthWatch. PPE is also referred to as Patient and Public Involvement (PPI) in some communities. The report also contains the views of community organisations in the PCT area about how PPE consultation works in practice and views from Local Authority staff involved in Local Authority Involvement Networks (LINKs).

The Executive Summary is based on the findings that emerged from the: views of NHS staff who participated in the PPE training designed and delivered by Health Link; views from staff in Voluntary Organisations relating to how they are engage with PPE within the PCT area; views from the trainers, views from LINKs representatives; and views from the PCT's senior managers who did not participate in the training.

Findings

The PPE training has contributed towards embedding PPE into some areas of the PCT: Middle managers who attended the training strongly endorsed the PPE training and they were able to provide examples of how they incorporate PPE into their service delivery i.e. how it assisted them in their practice and involvement with the local community. However, there are no such examples from senior managers to show how this is working in their practice.

One type of PPE training does not fit all: The training is appropriate for middle managers, and staff, who have no previous experience of PPE training but not appropriate for Senior Managers who have an extensive understanding of PPE. Senior manager attendees strongly recommend the training for other staff and confirmed that the training in its current format is appropriate for new staff or middle management staff with less PPE knowledge.

Develop a menu of training: Senior Managers attendees suggest a menu of training designed to meet different knowledge expertise. The menu would include a much shorter refresher course for senior management, focussed on updates to legislation and policy issues of PPE.

PCT Senior Management verbally support PPE Training but believe it is hard to involve patients: The two PCT Senior Managers who did not attend the training spoke of how they supported PPE training. However they were unaware of the content of the training and unable to provide examples of how PPE influenced commissioning or how PPE is systematised in the Trust. They were also of the opinion that it is hard to involve patients.

PCT Training Sessions Communication: Attendees suggested that time constraints through work load made it very difficult to attend day-long sessions. Suggestions include: to change the format to half-day sessions; to find ways of reducing required time at the course – e.g. reducing the length of each session by reducing some activities or even non-educational activities such as lunch; to have the training on-site; to have on the job training. However, the PCT instructed Health Link to hold the sessions off site to accommodate the two PCTs. Furthermore, the training was actually delivered through half day sessions. This raised an unanswered question about how the training brief had been delivered to the staff.

Timing Schedule: The training sessions schedule design (over a period of eight months) caused issues for some respondents who had forgotten the earlier sessions. A more concentrated training time schedule was recommended.

Practice and Commissioning: Middle manager respondents were able to provide examples of how training influenced practice but unable to provide examples of how PPE influenced commissioning. Senior Manager respondents' acknowledged the importance of PPE in influencing commissioning but did not provide any examples.

System: There was no evidence from middle management to show that PPE was systematised in the PCT, however, senior managers identified PPE as part of staff briefings with a clear PPE Policy and a designated PPE lead in the PCT. It is therefore unclear about the extent to which staff were briefed about the existence of the training after it was commissioned.

Poor Attendance of the Training Course: Of the 45 members enrolled on the training only an average of 18 attended each session, with no session attracting all 45 attendees. All of those that did attend recommended that middle managers attend PPE Training. To improve attendance in the future it may be beneficial to engage with staff prior to the training to hear their views and advise

them of the benefits that this training has to offer. Some respondents were concerned that they had been told to attend by the PCT and not asked to attend. The PPE lead in the trust did not attend the training and was unable to comment on the low participation. When asked, Health Link provided a training benefits outline to all potential attendees that was distributed by the PPE lead to all potential attendees.

Develop a post-training strategy and training for Local Authorities staff: It was highlighted that there did not appear to be a strategy to ensure that there was an on-going future commitment to the knowledge imparted or feedback given to the PCT. The Local Authority respondents also identified the need for PPE training for their staff involved in the future HealthWatch organisation.

PCT Collaboration: Whilst the PCTs' attempt to bring staff from two PCTs together in the training had strong potential, this appeared to be limited in realisation. There were significantly more members from one PCT than the other. This created a perception that it was an event for one PCT with a few interested bystanders from another PCT coming to sessions. Only staff from the lead PCT agreed to take part in the interviews. On the basis that no PCT staff or management agreed to be interviewed in PCT 2, it is not possible to comment on the reason why their participation in the training was poor.

Training materials: The supplementary training materials – the white document file and the website – were praised, however, they were not being used by all staff. The reason for the web based material not being used appeared to be limited IT ability and confidence in using the internet from some staff. The white folder containing the DoH statutory guidance was not used in some instances on the basis it could add to potential information overload.

In-house staff training: Respondents felts there was appropriate content and depth in the training materials and that they could be used to train other staff. It may be useful to create two sets of supplementary course materials. One set could be much more concise, providing the key points from the training where staff can easily find the required information. The other set could remain in its current form, to provide the level of depth when needed – to enable training other staff members in PPE.

Established PPE Engagement with Community Groups: The PCT Acute Hospital, Mental Health Trust, local LINks (Local Involvement Networks) and the PCT have developed a strong network of PPE

engagement with Voluntary Groups in the area but less so with Church Groups. The Community groups gave examples of how their PPE engagement worked with the Acute Hospital, Mental Health Trust and LINks. They also spoke of the feedback mechanism, however were less able to provide examples of their PPE work with the PCT. This information was reported by the voluntary groups after the training had been delivered.

Strong Commitment of the Third Sector Organisations to PPE: In general, third sector organisations responded to the initiatives put forward by the PCT or other NHS organisations. It is apparent that they wanted to increase healthcare service quality for the members of their organisation. This demonstrates the willingness of members of the senior management of these organisations to be involved in health care management decisions.

Develop existing PCT-community group communication channels: The community groups that reported that they worked with the PCTs or other NHS organisations had good communication channels. These were used to monitor and feedback whether there were any particular healthcare services that patients desired that were not currently available.

Develop new PCT-community group communication channels: Despite some community groups not being involved with PCTs (particularly religious groups), and not finding out whether there are any particular health care services that need to be provided, some community groups had feedback mechanisms in place that could be used for this purpose. For example, the residents association were shown to have a wide-array of extensive formal and informal feedback mechanisms that could be harnessed to create greater PPE.

Community Groups are heavily involved in social care and tend to talk about social care as health care: There is a grey area in the community groups about the boundaries between social care and health care. As such they tend to talk about the social care and health care interchangeably and would benefit by clearer information about the state responsibility for PPE.

Trainers concern about the poor attendance: The independent trainers spoke candidly about the attendance rate. It was their view that the number of attendees diminished because of the behaviour of senior management. They were confident about the content of the session but surprised by the senior management learning approach to some of the sessions.

Introduction

Health Link was commissioned to design and deliver PPE training to over 40 staff employed by two PCTs (PCT1 andPCT2). Subsequently, the Department of Health commissioned Health Link to procure and manage an independent evaluation of the training as an intervention to embed PPE in a PCT. This report summarises the findings of that evaluation.

The first stage of the evaluation was conducted with 8 staff in PCT 1 and 10 voluntary organisations in the area around PCT 1. The evaluation also further analysed the three surveys that had been conducted by Health Link with the attendees during the training. The second stage of the evaluation comprised of interviews with two of the Health Link trainers, two Local Authorities' staff involved with LINKS and two PCT 1 senior management staff who had not participated in the training. The original design of the research methodology incorporated eight stages of analysis: the content of the training sessions, including the quality of the material being taught and the appropriateness of the content for the trainees; the impact on the trainees, including reflections on the quality of the training session and how trainees have changed their practice as a result of the training session; the impact on the Community, including the trainees changed practice in the community and the sustainability of the learning; and the impact on trainers, including reflections from trainers on the training session and the involvement of trainees.

This design was modified to incorporate the second stage for two reasons:

1) The attendance at training sessions was lower than anticipated. From a target group of 45 only 15 staff attended half or more of the training sessions. This number significantly lowered our target group and raised questions as to why the attendance was so poor.
2) Within the target group the number of respondents who agreed to be interviewed was very low, with staff and managers from only PCT 1 agreeing to take part in the evaluation. The refusal of staff to participate in the study followed them being sent a personal letter explaining the evaluation and follow up emails and phone calls. The poor response rate also raised questions as to why there was a resistance to be interviewed. Where possible, and without bias, we have tried to address this issue in stage two.

PCT 1 has a population in the region of 225,000, which is estimated to grow by 6.6% to approximately 240,000 by 2029. The local population demographics are hugely diverse in terms of backgrounds, levels of deprivation and health needs. Just under 50% of the population come from ethnic minorities, and PCT1 is socio-economically classified as one of the most deprived boroughs in

the country (NHS: Commissioning Compendium, January 2010). Patient and Public Engagement (PPE) is a mandatory requirement in the National Health Service (NHS), referred to as Patient and Public Involvement (PPI) in much of the literature.

This report meets the key objectives of the study. The main objective is to evaluate the PPE training which was provided by Health Link for staff to see how PPE is embedded in the PCT and how it influences commissioning and changes in working practice. The findings from the attendees provide useful insights as to how this training influences PPE integration in the PCT (in practice) and the themed views of staff about the need for training and support material. The second is to formatively evaluate the responsiveness of third sector organisations to PPE initiatives in the area around PCT 1. This shows that the community is very responsive to PPE. The trainers' reflections also shed light on the diminishing numbers of training attendees. In the light of current changes in the NHS including the establishment of GP Consortia and additional Local Authorities (LAs) responsibility, staff from two Local Authorities were interviewed to explore their views on PPE training. Finally, two PCT senior management staff who did not participate in the training contributed their views about PPE training.

This report is divided into 4 sections. First, the context of PPE will be discussed by providing an overview of policy. The results of the data analysis will then be presented in respect of the objectives highlighted above of this study in Sections Two (finding from interviews with training attendees), Three (findings from interviews with community groups) and Four (findings from other interviews e.g. Local Authorities, trainers). The Literature Review is located in Appendix 1 and the interview schedules are located in Appendix 2.

Section 1 - Policy Overview: Current and Forthcoming Patient and Public Engagement Policy

Engaging with Local Communities

The need for appropriate training and the importance of knowledge transfer from the PCTs for the training already established in PPE is also of pressing importance to the future GP Consortia and for the commissioning and care provision of patients. Following the forthcoming abolition of the PCTs (in 2013), Local Authorities (LAs) will take interest in PPE, as outlined in the Government White Paper: (2010), Equity and Excellence: Liberating the NHS. The White Paper proposes that, by April 2012, a local Health Watch will be established and will be accountable to National Health Watch. Responsibility includes providing evidence to show that feedback from patients and service users is reflected in commissioning plans. It is proposed that new Health and Wellbeing Boards will enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

NHS organisations have always been expected to engage with their local community to improve health and well-being. Hence PCT experience of the training and statutory requirements of PPE (REAL INVOLVEMENT, DoH 2008) can inform the new role that has been proposed for GP Consortia. The newly emerging GP Consortia remit of responsibility for public health includes working closely with the patients and local communities, including Local Involvement Networks (LINks) and patient participation groups, and with community partners. The White Paper proposes that HealthWatch becomes operational from April 2012.

In addition, the DoH paper: Governance Responsibility of Patient Choice – A Revolution for Patients (October 2010) explains that the intention is to give people more information and control and greater choice about their care. DoH is setting out their proposed next steps towards this revolution for patients in the forthcoming Health and Social Care Bill.

Aims indicate that patients and the public:

- will have the opportunity to be involved in planning local health and social care services through an enhanced role for LAs, in feedback on services through local HealthWatch and in their local provider through Foundation Trust governance arrangements.

- will be engaged with and listened to in order to understand what other changes are needed to enable a truly patient and service user led health and social care system.

It is the responsibility of GP consortia for HealthWatch and Public Health to ensure that these aims have been met and how the NHS workforce involve patients and the public is a key plank of this policy.

Background policy to PPE and the influence on commissioning

Governments of all political parties have sought ways to improve patient and public involvement in health care. A number of initiatives have been introduced that aim to help achieve a stronger voice for individuals and communities. Initiatives have been introduced and subsequently abolished, such as the Community Health Councils (1974) and, more recently, Patient Forums (2007). Nonetheless there is an ongoing statutory duty in the NHS to involve people and communities to play a greater role in shaping health and social care services. A Consortium will not be approved by the NHS Commissioning Board unless its PPE arrangements are acceptable.

The Local Government and Public Involvement in Health Act 2007, introduced a number of measures relating to the involvement of local communities. The Act abolished Patient Forums and the Commission for Patient and Public Involvement in Health. The Act also introduced LINks and strengthened the NHS duty to involve and put in place a new NHS duty to report progress. Within this remit the NHS has also produced guidelines for PCTs. The Department of Health (DoH) also noted that increasing emphasis on primary care and the increase in commissioning carried out directly by PCTs means that public involvement at this level is more important now than when PPE was first introduced. The Health Committee (2007) suggested that, "*the commissioning of services without public and patient involvement is commissioning with one hand tied behind the commissioners back – statistics can be used to determine what services are required but the way they should be provided will be largely guess work by commissioners without patient involvement*" *(Health Committee Patient and Public Involvement in the NHS Third Report of Session 2006–07 Volume I Report, together with formal minutes Ordered by The House of Commons to be printed 22 March 2007).*

There is an importance of involvement at each stage of the commissioning cycle at an individual and collective level in order to create localised, personalised and effective health and social care services. The process moves from information, to feedback, to influence and can be done at each stage of the

commissioning cycle. Hence PPE becomes integral to needs assessment, decisions about priorities and strategies, service improvement, procurement, contracting, monitoring and performance management. Part 5 of the Health Act 2007 seeks to improve co-operation between LAs and "*local partners*", including "*persons from the voluntary and community sector and local businesses*". Together they are expected to form Local Area agreements, which include local improvement targets, and agree community improvement strategies. Thus, greater public engagement in local government is proposed to complement the changes to PPE arrangements within the NHS

Section 2 - <u>Findings from training attendees</u>

PPE Training Evaluation

In total there were 6 PPE training sessions over an eight month period. One member of the research team observed three of the six training sessions. (See appendix 4 for training commissioning spec)

Prior to the sessions the 45 potential attendees, who had been recruited by the PCTs, were sent e-mails with the location time and dates of the training. The research team were provides copies of numerous e-mails that were sent to the potential attendees, detailing time and venues, and strongly encouraging staff to attend.

The table below shows that the attendance rate was 40%. Of the 45 invited attendees the average attendance rate was 18 attendees. The PCTs ambition to recruit 45 staff was never achieved. Of these, 8 attendees from PCT 1 agreed to be interviewed and none from PCT 2. This followed introductory letters, e-mails and phone calls to request an interview. The evaluation questions were also sent to the potential respondent group so that they could see the questions that were being asked. The majority of attendees refused outright saying sorry but they were too busy with a busy work schedule. A minority did not want to be interviewed because they said they could not recall all of the training sessions because they had not attended many, and four had left PCT 1. The research team requested an interview with the Chief Executive in PCT 1, the organisation that had initiated the training, to see if there was any possibility that this low number of respondents could be increased by some gentle encouragement from the Trust. However, although initially this interview was arranged it was subsequently cancelled because the Chief Executive left the PCT. The PPE lead in the PCT agreed to be interviewed and was most helpful in explaining the importance of PPE to the PCT, however, this person had not attended the trainings sessions and was unaware of the training content. At that point the research team decided it was not ethical to further pursue the staff who had attended the training sessions for an interview as they had made it clear they did not want to be interviewed. Hence the summative aspect of the evaluation is limited by the lack of respondent group participation. The findings from the formative and summative stages have been compared with this methodological consideration.

In addition to the attendees, interviews were conducted with a range of people who had not attended the training but were involved in PPE with the aim of finding out more about how others did PPE. These included community groups, two local authorities and a senior management member of PCT 1. The trainers were also invited to give their views.

Attendees

A significant number of attendees completed evaluation forms at the end of each session and a short survey tool was completed. These were distributed by the Health Link trainers and comprise the formative part of the evaluation. The results from these are shown in Table 1 and Figure 1.

Session Number	1	2	3	4	5	6	Total
Number of expected	45	45	45	44	44	44	
Number of attendees	23	20	14	22	19	9	
Percentage attended	51%	44%	31%	50%	43%	20%	40%

Table 1

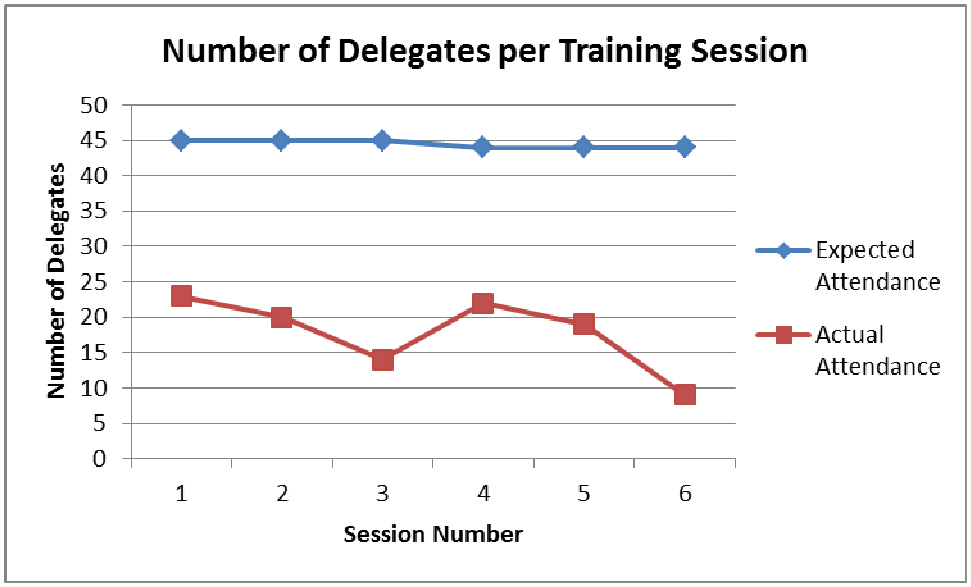

Figure 1

As Table 1 and Figure 1 show, actual attendance rates were significantly lower than the expected attendance rates. Figure 1 also shows there was a general declining trend in the number of delegates attending each session. To help understand the reasons behind this and to capture a richer understanding of how delegates felt about the training sessions, feedback was captured from delegates using two different methods. The first method was through the use of a Health Link Exercise survey as part of their QA. This has provided a more extensive respondent view on the content of the training.

Health Link surveys were conducted at the following three training sessions:

- Survey 1 – 4th June Training Session

- Survey 2 – 10th July Training Session
- Survey 3 – 8th September Training Session

Each delegate at the training session was given a survey questionnaire to complete, with 11 criteria that delegates were asked to rate on a scale of 1-6. These criteria were:

1. Stimulating → Boring
2. Useful for my work → Useless
3. Relevant to my work → Irrelevant
4. Good discussions → Limited discussions
5. Flexible structure → Rigid structure
6. Well conducted → Poorly conducted
7. Demanding → Undemanding
8. Challenging → Patronising
9. Good use of time → Poor use of time
10. Good level of activity → Poor level of activity
11. My objectives achieved → My objectives not achieved

These surveys further asked delegates if they would recommend this PPE course. The results from these surveys are provided below in Tables 2-13 and the results are discussed extensively in Themes 1-7 of this section.

	Stimulating →					Boring
	6	5	4	3	2	1
Survey 1	0.0%	11.8%	64.7%	23.5%	0.0%	0.0%
Survey 2	8.3%	41.7%	41.7%	8.3%	0.0%	0.0%
Survey 3	8.3%	41.7%	50.0%	0.0%	0.0%	0.0%
Average	**5.6%**	**31.7%**	**52.1%**	**10.6%**	**0.0%**	**0.0%**

Table 2

	Useful to my Work →					Useless
	6	5	4	3	2	1
Survey 1	17.6%	52.9%	23.5%	5.9%	0.0%	0.0%
Survey 2	25.0%	50.0%	0.0%	25.0%	0.0%	0.0%
Survey 3	8.3%	75.0%	16.7%	0.0%	0.0%	0.0%
Average	**17.0%**	**59.3%**	**13.4%**	**10.3%**	**0.0%**	**0.0%**

Table 3

	Relevant to my Work →					Irrelevant
	6	5	4	3	2	1
Survey 1	56.3%	31.3%	12.5%	0.0%	0.0%	0.0%
Survey 2	23.1%	53.8%	15.4%	7.7%	0.0%	0.0%
Survey 3	25.0%	58.3%	16.7%	0.0%	0.0%	0.0%
Average	**34.8%**	**47.8%**	**14.9%**	**2.6%**	**0.0%**	**0.0%**

Table 4

	Good Discussions →					Limited Discussions
	6	5	4	3	2	1
Survey 1	25.0%	25.0%	50.0%	0.0%	0.0%	0.0%
Survey 2	0.0%	75.0%	25.0%	0.0%	0.0%	0.0%
Survey 3	25.0%	33.3%	41.7%	0.0%	0.0%	0.0%
Average	**16.7%**	**44.4%**	**38.9%**	**0.0%**	**0.0%**	**0.0%**

Table 5

	Flexible Structure →					Rigid Structure
	6	5	4	3	2	1
Survey 1	17.6%	23.5%	41.2%	11.8%	5.9%	0.0%
Survey 2	8.3%	66.7%	8.3%	16.7%	0.0%	0.0%
Survey 3	8.3%	58.3%	25.0%	8.3%	0.0%	0.0%
Average	**11.4%**	**49.5%**	**24.8%**	**12.3%**	**2.0%**	**0.0%**

Table 6

	Well Conducted →					Poorly Conducted
	6	5	4	3	2	1
Survey 1	17.6%	47.1%	35.3%	0.0%	0.0%	0.0%
Survey 2	33.3%	41.7%	25.0%	0.0%	0.0%	0.0%
Survey 3	33.3%	41.7%	16.7%	8.3%	0.0%	0.0%
Average	**28.1%**	**43.5%**	**25.7%**	**2.8%**	**0.0%**	**0.0%**

Table 7

	Demanding →					Undemanding
	6	5	4	3	2	1
Survey 1	0.0%	6.3%	37.5%	50.0%	6.3%	0.0%
Survey 2	0.0%	41.7%	33.3%	25.0%	0.0%	0.0%
Survey 3	0.0%	16.7%	33.3%	41.7%	8.3%	0.0%
Average	**0.0%**	**21.5%**	**34.7%**	**38.9%**	**4.9%**	**0.0%**

Table 8

	Challenging →					Patronising
	6	5	4	3	2	1
Survey 1	0.0%	13.3%	86.7%	0.0%	0.0%	0.0%
Survey 2	0.0%	41.7%	41.7%	16.7%	0.0%	0.0%
Survey 3	0.0%	16.7%	66.7%	16.7%	0.0%	0.0%
Average	**0.0%**	**23.9%**	**65.0%**	**11.1%**	**0.0%**	**0.0%**

Table 9

	Good use of Time →					Poor use of Time
	6	5	4	3	2	1
Survey 1	6.7%	33.3%	26.7%	26.7%	6.7%	0.0%
Survey 2	0.0%	41.7%	25.0%	33.3%	0.0%	0.0%
Survey 3	0.0%	66.7%	33.3%	0.0%	0.0%	0.0%
Average	**2.2%**	**47.2%**	**28.3%**	**20.0%**	**2.2%**	**0.0%**

Table 10

	Good Level of Activity →					Poor Level of Activity
	6	5	4	3	2	1
Survey 1	13.3%	26.7%	33.3%	26.7%	0.0%	0.0%
Survey 2	8.3%	41.7%	41.7%	8.3%	0.0%	0.0%
Survey 3	8.3%	66.7%	25.0%	0.0%	0.0%	0.0%
Average	**10.0%**	**45.0%**	**33.3%**	**11.7%**	**0.0%**	**0.0%**

Table 11

	My Objectives Achieved →					My Objectives Not Achieved
	6	5	4	3	2	1
Survey 1	7.7%	30.8%	30.8%	30.8%	0.0%	0.0%
Survey 2	0.0%	50.0%	33.3%	16.7%	0.0%	0.0%
Survey 3	8.3%	41.7%	50.0%	0.0%	0.0%	0.0%
Average	**5.3%**	**40.8%**	**38.0%**	**15.8%**	**0.0%**	**0.0%**

Table 12

	Recommend Course	Not Recommend Course
Survey 1	100.0%	0.0%
Survey 2	100.0%	0.0%
Survey 3	100.0%	0.0%
Average	**100.0%**	**0.0%**

Table 13

All attendees were invited to be interviewed by the Aston Research team for the summative stage of the evaluation, however only 8 agreed. These interviews explored in detail their views on PPE in their organisation, their views about the PPE training and how it was working in practice. The questionnaire designed for these interviews is located in Appendix 2. The following themes were identified through the analysis of these interviews and compared to an analysis of the survey data provided:

1. Training Content
2. Training Scheduling
3. Training Delivery
4. PCT Collaboration
5. Training Materials
6. Impact of the Training on Practice and Commissioning
7. Overall View of the Training Course

These themes are discussed in detail in the following sections. In terms of referencing, quotes are coded to provide anonymity.

Theme 1: Training Content

The training content was viewed as very good and appropriate for middle management by the interviewees (I1-I8). Below we also present interpretation of results from the surveys (S1-S3). As noted by (I1) "*some people I know I talked to who haven't done much at all on it thought it was absolutely great because they learnt a lot*" and one respondent in (S2) stated that they "*came away with more info and understanding of PPE*". The newness of the topic to some of the respondents may explain the contradictory results from some of the survey questions. Table 2 shows that most participants found the course stimulating, with overall only 10.6% of the delegates rating the stimulation aspect of the course 3/6 or less. Similar results are shown in Table 3, with overall only 10.3% of the delegates rating the usefulness to my work aspect of the course 3/6 or less. (I3) also saw a benefit for themselves in lower level staff/PPE novices taking the course, "*it was good to try and bring quite a significant number of colleagues all up to a same understanding and level which therefore helps you yourself in terms of pushing it, because they're more likely to be supportive having had the training than they were before*".

Notably PPE was new to all except one of the middle managers (I4,I5,I6,I7) whereas (I8) related it closely to Patient Choice. Those in the 'new to PPE' group pointed out that he/she, '*was loosely aware of PPE but not very involved or understood regulations and not aware of formal process'*. Another suggested that he/she would recommend the training to PCT colleagues and another '*had, no previous experience of PPE Training'.*

However there was a general feeling amongst the senior staff that the course had been pitched below their level (I1, I2). (I1) stated "*it was not at the right level for us*" and that during PPE training "*people were perhaps beginning to switch off – they weren't responding, not because it was outside their sphere, it was just too simple*". (I2) highlighted that "*I think there were times when I felt I was sitting there listening to things that I had heard before or practicing skills that I'd had the opportunity to practice*". This stance is further supported from comments in (S1) that the course was "*too slow but may be because I have a lot of prior knowledge*" and in (S2) that it "*needs to be a bit more challenging*". This viewpoint, however, seems to be contradicted to an extent by Table 9, where overall only 11.1% of delegates found the course less challenging than average. Indeed, one respondent in (S1) viewed going back to basics as a positive, "*it was good to go back to basics – I actually was surprised how much I did know and where my gaps of knowledge are*".

One possible explanation for the difference in these results might be that different levels of staff were all put in to the training together. As explained by one respondent in (S3) there were "*different staff group[s] with differing needs*" at the training and (I2) noted that "*there were bits where I thought "c'mon I know this, I can move on a bit now" but other people obviously don't*" in the training. If there were more people of a lower level who attended this training, this may explain the contradiction described in the Table 9 results.

This divide between senior staff and middle management created a different experience of the course content for these two groups. Senior staff generally appear to have had prior training and experience in elements of PPE. (I1) said "*I did quite a bit of PPE training before this… [although] they wouldn't have been necessarily called Patient Public Involvement [training]*" and "*stakeholder engagement to me is just part and parcel of our work and I think the reason I tend to think of that is because I've been doing it or been involved at some point for so long*". (I2) said they had done "*day [courses] here and there, scattered through working life really*" and "*I'm reasonably experienced in the field*". Furthermore a respondent in (S1) said "*I have a lot of prior knowledge*" and a respondent in (S3) said "*similar training ha[s] been done before*". This group of delegates viewed the learning

experience more as a refresher course. For example (I1) attended the "*equality and opportunity legislation*" session, and, although "*we cover equalities in our mandatory training*", found the session "*interesting, I did attend that and that was sort of a refresher, it was good just to remind ourselves and [update ourselves on] the changes that were forthcoming*". (I2) said "*a lot of it wasn't new stuff for me, it was refresher*", explaining that on a course, you can "*have that real 'light bulb moment' and you go WOW! That's fantastic, and that's really changed how I do things. It wasn't like that for me… [it was] a good reminder*".

Of particular relevance for this group was the session that included material on policy and legislation with (I1), (I2) and (I3) all highlighting they felt they had benefitted from being refreshed in this aspect. (I2) suggested that "*the ones [sessions] that were most useful to me were the context and policy ones*" and (I3) said "*I think I attended for a number of reasons, one was purely [a] personal one in terms of feeling like I needed some refreshment in terms of being up to date with policies and laws and all of those sorts of issues*".

However middle managers found the legislation training session as the one that was most difficult to grasp: *'references to legal jargon confusing' (I7).* Whilst it had raised awareness for (I4, I5,I6) for those, *'Initially not aware of PPE processes or legal framework'* it also led to some confusion because, *Session no 1 on the legal framework of PPE had no clarity about what needs to be done in consultation. Session 2 was better because that was related to the NHS Constitution' (I5).*

The sessions identified as most useful for middle managers were, *"Session no 5 on case studies very good as we discussed how to set up case studies such as providing out of hours services for low income families" (14)* and the *"useful experience working with---PCT about PPE and hard to reach groups and about how to tackle aggression. The mock scenario on how to handle aggression was a very useful exercise*" (I6).

Consequently, (I1) summed up the general feeling about the course content when they said "*I wouldn't recommend it [PPE training] to anybody who is a senior manager, I would recommend it [to]… new members of staff*" and that "*if this course is run again it [should be made] very clear at which level of staff that you're putting in*".

Theme 2: Training Scheduling

One of the issues highlighted by some attendees was that they felt they had been asked to attend the training with little consideration of their own schedules (I1-I8). Comments included "*there was an expectation that we should attend, we were basically told [that we] needed to attend [by managers]*" and highlighted that "*it was a three line whip, which isn't to say that I didn't want to attend the sessions, but it was one of those 'these sessions have been put on, these are the dates, you will attend as many as you possibly can'*". It was also stated that "*to a certain extent it was expectation that we would do the training*" and that "*there was, in some people's cases, this sense that they'd been effectively told to attend by others that weren't attending*". However, despite this training being seen as necessary, another complained that "*dates were given very late for us*" and that also they "*basically got an email saying that we needed to go and as far as we were aware at the time… we just had to attend one session and it was on PPE*" but then "*all of a sudden after that found out that it was actually… not one day*". These issues made it more difficult for them to schedule time in for the PPE sessions.

This difficulty in scheduling time meant that some sessions were missed by staff. One highlighted "*it was just not possible to give that time commitment at my level because of current workload, and I think that might be the case for quite a few other senior managers because it's something we discussed*" and so "*unfortunately I had meetings to go to which had a priority setting on them, and they were one's that I couldn't not go to*" and so missed training sessions when these meetings were on. Another also commented that "*unfortunately working life gets in the way"* which stopped them from going to some sessions. However, one respondent in mentioned how their director had supported them to schedule the training session in amongst competing tasks, "*I am glad I came and I'm glad my director supported me to be here today; I had a difficult choice to make and I made the correct one*". This appeared to influence a lack of commitment to attend future sessions, with "*people being called away and missing a session and then perhaps feeling like they didn't want to then reengage*".

These scheduling issues perhaps explain why overall 20.0% of respondents in the surveys rated the use of time only 3/6 in Table 10, and a further 2.2% rated the use of time as only 2/6. Respondents highlighted some different ways in which scheduling issues could have been improved. (I3) suggested that "*a number of us were of the opinion that it might have been better to have done it in half-day slots just in terms of diary management*", to enable delegates to maintain other commitments alongside the training on the day. The training location was also criticised, as it meant that respondents lost time whilst travelling to the training venue and two respondents suggested

they "*could manage without lunch and end earlier*". However despite this request the evidence showed that all the training sessions did indeed last only half a day. This suggests that some of the respondents were unaware of the timing schedule or they may just have been making excuses.

However, it was the refresher aspect of the senior manager group discussed in 'Theme 1: Course Content' section above that provided the biggest opportunity to overcome scheduling issues. As this group were shown in the above section to view the training as a refresher course, they were very keen for the majority of the training (which they felt they were already familiar with) to be taken out to condense the course content and therefore its length. (I1) suggested that "*for [senior] people like myself, they need not 6 sessions, they need 1 session quite focussed*" on new legislation and future Department of Health changes "*a quick update… something quite concentrated*". (I2) suggested "*it was very lengthy training, I think it worked out at nearly 6 days… the course could have been done perhaps over 3 days*" and (I3) stated "*it [the course] did start to feel a bit like a marathon rather than a sprint*". One respondent in (S3) also highlighted that this could improve commitment, saying "*the length of the programme may need to be reviewed/adjusted in order to achieve a greater commitment*".

(I3) summed up, "*I think I would have them [the training sessions] closer together, not lasting as long, and trying to ensure as far as is possible that everybody that enrolled on it was there at the end that started at the beginning*".

Theme 3: Training Delivery

The way in which the material was delivered during training sessions appears to have been seen positively overall. This is supported by Table 7, which demonstrates that only 2.8% of respondents overall rated the delivery of the course as being 3/6 or less.

Both senior managers and middle managers praised the delivery of the training. The trainers delivering the content were consistently praised, with comments being made such as "*facilitator good*", "*knowledgeable presenter*", "*good facilitator*", and "*trainers were clear and concise*". The only criticism of the trainers was made by one respondent in (S1), "*I found it hard to hear the end of your sentences as sometimes the voice trailed off and you spoke very fast!*". A respondent in also put this difficulty in hearing down to the way the room was set up, "*room is set out in a way that makes it difficult to hear what is being said*". Further issues with hearing were highlighted by a respondent

in, who struggled to hear a video during the course, saying "*having the video at lunch was not useful, we could have had a slot to listen to it more carefully*".

In terms of interactivity, this was also seen as positive. Table 5 highlights that overall, all delegates felt that the discussions during the course were rated 4/6 or higher. This is supported by comments, such as "*very interactive, time to explore thinking*" (S1), "*opportunity to think and discuss useful and welcome*" (S1), "*good mix of discussion and slides*" (S1) and "*especially enjoyed getting out of the seat for the exercise on communities*". However, 11.7% of delegates overall did rate the level of activity at only 3/6 in Table 11. On this, one respondent in (S2) felt there should be a reduction, "*level of activity could have been condensed*", whilst (I3) wanted an increase, "*some of it did feel a little bit like going back to school, whereas I think an even more interactive approach would have been better*". (I3) suggested that discussing the agenda for the session at the beginning of each training session would have been welcome. However, this perceived lack of flexibility did not seem to be heavily prevalent across delegates – being highlighted by 12.3% rating flexibility of structure overall as 3/6 and 2.0% overall rating it 2/6 in Table 6.

Theme 4: PCT Collaboration

The training was delivered to members of staff from two PCTs at the same time. There were mixed views on this. (I2) was critical that it meant having to travel to a location that was not on-site, which increased travel time as noted in the 'Theme 2: Scheduling' section above. (I3) felt it did not feel at all like an equal collaboration, saying "*there was significantly less commitment to it from [PCT1] and essentially, as it went on, it predominantly just felt like a [PCT2] event with one or possibly two people from [PCT1] as interested bystanders rather than it being a joint thing really*".

Despite these negative views, (I1) was much more positive about the experience, saying "*it's good meeting with other PCTs*" and that "*it's very refreshing to be with other PCTs, because it gives you an opportunity to network and it also gives you an opportunity to see if you're wrestling with the same problems*". (I2) mentioned that "*it is always good to hear other people's experiences*". (I1) also stressed the future benefits of this collaborative element, as its "*easier then to ring them [the PCT] up… [and] talk to them about other issues because you already met them on the course*". (I6) spoke of it as "*useful experience working with---PCT about PPE and hard to reach groups and about how to tackle aggression. The mock scenario on how to handle aggression was a very useful exercise.*"

Theme 5: Training Materials

There were mixed views on the usefulness of the supplementary training materials – the white document file and the website – provided to delegates on the course. Information overload was cited as a barrier to use by (I1) who commented that they already received lots of "*hefty documents*" in their day-to-day work. It was highlighted that if they needed information, the materials would be a final port of call following first consultation with their colleagues or the documents more immediately available. (I1) went on to note that the situation where these two have failed causing the need to use the supplementary course materials instead has not yet occurred. Time pressures also had prevented the use of this material for some delegates and induced comments such a "*doing the day job has been what I've been getting on with*".

As well as time pressure, technology was another reason for not using the website supplementary course material, "*two reasons – one, just pressure of work and second, I'm slightly technology challenged*". This lack of confidence/being less used to technology also restricted another in using the website, "*I do use the folder more than the website – that's because of my age I think*" and stated that they had not looked at the website since training.

However, others found the white document file useful, "*I used the file, the white file, I use that quite a lot because I find that really useful*" for "*just checking and referencing, there's an awful lot of information in there*". It also noted that they used the course materials to provide PPE education to other less experienced members of staff, "*it's a really good resource to be able to use with a less experienced member of the team*".

Theme 6: Impact of the training on practice and commissioning

Impact of the course was evident at three levels – the organisational level and the individual delegate level and in practice. However there were no examples of commissioning in health care provided in the interviews. At the organisational level, one respondent highlighted the commissioning of the training as commitment from the organisation, "*some challenge in the course but actually the commitment of PCT (to the training at least!) is more stimulating/empowering*". (I3) supported this, saying "*I think I attended for a number of reasons… [one was] in terms of wanting to demonstrate commitment to other members of staff who were attending… to show that there was a commitment from senior management to it*". A respondent in (S2) also felt that the PPE training was "*very relevant to current projects*".

(I1) felt PPE was "*viewed as part and parcel of our business*" and that "*it's actually I think quite ingrained within the organisation itself*". However, (I1) did concede that "*that doesn't mean we may be best at doing it… it's doubtful we get it right all the time but the expectation is we will have it as part and parcel of our work*". In terms of the impact the course had on the organisation, (I1) highlighted that "*if the objectives of the training was to ensure that everybody had a basic knowledge of patient public involvement training then I think it probably did [meet those objectives]*".

One respondent recalled that PPE was not ingrained in their organisation in the past, "*when I first came to [this PCT] I think there had been a number of negative experiences, there was a sort of sense that PPE was necessary but kind of always in a slightly too difficult or ok we have to do it or we'll grit our teeth and get on with it and do it*". (I2) suggested that more recently "*I think we're increasingly positive about PPE*". In terms of the impact the course had on the organisation, for (I2), they felt that previously in "*my early experience of PPE in [this PCT] was that it was quite adversarial, with meetings… sometimes quite aggressive in response*" and that "*PPE perhaps was seen as a bit of an add-on, I think it was something we weren't particularly trained as a PCT to do very well*". (I2) highlighted that the PPE training had helped the organisation overcome this adversarial and 'add-on' nature of PPE, commenting that "*having the structure and having the training from Health Link it feels like we've got a better understanding… it feels more like a conversation*".

(I3) stated that "*it felt like there was a very mixed response to it [PPE] here*" but *"in terms of directors and non-executive directors I think there's a good understanding of it and a commitment to it*". In terms of the training it was noted (in the 'Theme 1: Course Content' section above) that the training enabled middle management colleagues to gain the "*same understanding and level which therefore helps you yourself in terms of pushing it, because they're more likely to be supportive having had the training than they were before*". One respondent did however comment that, to their knowledge, there was currently a lack of necessary on-going commitment to ensure the organisational impact from the training was not just short-term, "*I haven't seen anything about our own sort of internal evaluation of it and our thoughts in terms of how we take it forward in terms of thinking about refresher training and the like for the future. Because I always think with these things, it was good at the time but you [have to have] that on-going commitment to it*".

However the observations from the sessions showed there was concern from middle managers about how they could validate views through PPE, and whether or not the evidence that was being

collected was collected in way that was robust enough to influence commissioning. Whilst senior managers declared their knowledge of PPE, middle managers were more sceptical about which tools they needed to engage with communities. For example, there was discussion about the use and value of surveys and about individual consultation.

In terms of impact at an individual level, (I1) noted that individual views on PPE "*highly depends on what type of job you're doing*". Nevertheless, the relevance of the course to individuals' work was identified as being extremely high in Table 4, where overall 47.8% rated the course as 5/6 relevant to their work and 34.8% rated it 6/6. Even where PPE did not currently influence an individual's role, (I2) pointed out that it should, saying "*how does PPE influence my role? Not as much as it should, because it never does*". However despite being ranked highly at the senior manager level there were no examples of how it had influenced commissioning services.

The examples of PPE practice came from the middle managers. One explained, *'we conducted an --- assessment and invited groups and managers of care homes and did a population survey for ---- services. We shared the outcomes with all of the stakeholders that participated and sent the final document for formal scrutiny".* Another spoke of how it was, *"essential that the organisation has a high standard of formal PPE for polyclinics"*. In the sessions the researcher also observed middle managers giving practice examples, including setting up a day centre for young mental health patients who suffered from early dementia. Furthermore the training session where attendees went out into the community to ask people about their health needs had yielded some fruitful ideas including some information that was, *"useful for community pharmacy to understand it better"*. This had also influenced one respondent so that in practice he/she*, "asked all GPs to do a patient experience survey".*

In terms of how useful individuals found the course to their work, Table 3 shows the vast majority of delegates at the course found it useful (as previously highlighted in the 'Theme 1: Course Content' section). (I3) felt the course had had a significant impact on their working, saying "*those of us that attended, I think it's made us feel more confident when we're in the situation where we're meeting and presenting to members of the public and the community*" and that the training had given them more "*options [for] when you're talking to people about issues*". One respondent supported this increase in options, saying the course was "*very useful; will definitely think about doing more face to face surveys*". Another had more structure to PPE in their working practice through the course materials (discussed in the 'Theme 5: Course Materials' section) and felt that they benefited

individually from the course through sharing experiences with peers outside of the actual teaching time.

Theme 7: Overall View of the Training

Despite the issues highlighted in the previous sections above, Table 13 shows that 100.0% of delegates would recommend the course to other people. Indeed, whilst the 'Theme 1: Course Content' section highlighted that senior managers) were disappointed at the level the course was aimed at for them, they were still prepared to recommend the course to middle manager level staff. (I3) stated that "*I would encourage all of those people where it would be of use to them to undergo the [PPE] training because I think 1) the organisation needs to give it that importance and 2) it needs to ensure that all members of staff for whom it's appropriate in the work that they're doing ought to be on it just as we have mandatory training for other issues*". Middle managers endorsed that view with one suggesting that the PCT,' *could set up PPE training as staff induction'* and another pointing out the importance of*, 'with a new service PPE can change a way of working - so important'*

Table 12 shows that the majority of delegates felt that overall their objectives had been achieved, with only 15.8% rating their level of objectives being achieved as 3/6 or less. Even those, who felt that the training had been below their level, said the course had achieved the objective of providing staff with a basic knowledge of PPE. It appears that the overall view, as highlighted in the 'Theme 1: Course Content' section, was that senior staff supported the full course for middle managers and wanted much shorter refresher training for themselves – especially in legislation and policy updates.

Section 3 - <u>Findings from Community Groups</u>

The third sector around the PCT 1 is enriched by a broad spectrum of dynamic organisations that are value driven. They include grassroots based groups, such as faith-led bodies and medium-sized voluntary organisations. Apart from the underlying ethos of non-profit making – what these organisations also have in common is their unique relationship with local people – which is achieved by responding to the needs of specific communities, providing a voice for under-represented groups, campaigning for change, building cohesive communities and promoting innovative ways to transform public services. (FINAL REPORT- MAPPENG THIRD SECTOR-STRATEGIC PARTNERSHIP (HSP), January 2010.

In total 10 community groups were interviewed by telephone. The types of different community groups were:

- Two Churches (CG1 and CG4)
- Four Community Associations (CG2 , CG8,CG9, CG10)
- One Residents Association (CG3)
- One Advice Centre for a Foreign Community (CG5)
- One Health Support Charity (CG6)
- One Preschool Provider (CG7)

The questions asked in the interviews were based around social care service provision as experienced by community groups, information available about healthcare services, use of healthcare service information, community group involvement in PPE and working with PCTs. The analysis of these interviews led to 3 key themes being identified from the data and supplementary evidence on four core themes that were explored.

1. Community group and social care provision
2. Community group knowledge on PPE
3. Community group involvement in PPE

These themes are discussed in detail in the following sections.

Theme 1: Community group and social care provision

There was a range in the levels of social care provision offered by three different community groups as well as healthcare information. One of these was the community association for a minority community (CG2). (CG2) was heavily involved in the community, working with other individuals and organisations to deliver "*after school support*" to youngsters, to "*get people back into work and also*

provide them with some training" and also offering art and stress management classes. (CG2) "*also have a kitchen… [where] we have a luncheon club on a Wednesday where our elderly visits*" and offer an "*advice surgery*" which occurs "*once a week*" where they "*give advice on welfare rights, housing… basic form filling, reading [and] telephone call making*". This advice surgery also provided healthcare information on "*access to medical services*". Other social care provision offered by (CG2) was in the form of them providing care for elderly and disabled people, including "*helping people get out of bed, wash, dress, preparing breakfast, assistance for medication… supporting our service users [to attend] GP appointments or hospital appointments… [and a] befriending service*". They also offer respite provision for family carers. Another community group offering some level of social care provision was (CG5) which, like (CG2) offered some educational classes and provided "*advice and guidance*". Similar to the breadth of advice and guidance offered by (CG2), advice was offered by (CG5) to "*help people get into jobs… help with benefit, welfare… housing… youth programs, old age programs*". In terms of specific healthcare provision, (CG5) offered advice on "*health*" and also provided "*healthy eating programs*". The other community association for a minority ethnic community (CG8) also said they offered some social care service provision in the form of a "*dance session… improving on their healthy lifestyle, etc.*" for the elderly. (CG8) also offered "*football coaching… training to become football coaches, they actually get qualifications for that as well*" and a project "*helping young people… train them and get them in to employment or even education*" for the community.

One community group was heavily involved in offering both health and social care provision. This was the health support charity (CG6) which "*is a charity which supports… stroke survivors*". (CG6) provide "*exercise class[es]*", "*massage therapy*", "*speech and language therapy*", "*talks by outside speakers on topics such as stroke research, diet and exercise or talks by other stroke survivors*", produce a "*newsletter*", are "*involved in stroke research*", carry out "*campaigning to raise awareness of stroke*" and organise "*social events*".

Another two community groups that did get involved in social care service provision were the residents association (CG3) and the preschool provider (CG7). (CG3) "*promotes a sense of community in the area*" as it "*organises events*" and has also "*in the past been a pressure group*" that represents the views of the community on various issues. (CG3) engages with the community through "*a monthly meeting*", "*a quarterly newsletter*" and "*a web group… providing a forum for debate and comment*". However, none of this community engagement was said to involve

healthcare provision. (CG7) offered "*early years preschool for children from 2 ½ to 4 year[s] old*" and "*a parents and toddler group*" but said "*we don't provide healthcare services*".

Similarly the churches/faith groups were not involved as organisations in health/social care provision but they did provide information through an informal route. (CG1) commented that healthcare information may occur at an individual level, "*members of our church need healthcare and if there is somebody who is uncertain how to obtain these services, we will endeavour to help them but that is just on a personal level – it's not the church doing it*".

Theme 2: Community group knowledge on PPE

The level of involvement in community group social care provision discussed in the above section appears to correlate to some extent with their level of engagement with PPE and their subsequent knowledge of the opportunities available As shown above, the two churches had little to do with healthcare provision. Both churches also had little knowledge on PPE, with (CG1) commenting that in terms of PPE "*I know very little about it*" and (CG4) said "*I know absolutely nothing about this [community involvement in healthcare] at all*". In contrast, (CG6) was shown above to be involved extensively in social care service provision and also appeared to have the strongest knowledge on PPE. (CG6) had attended meetings which have informed them about PPE through the "*stroke research network*" and "*cardiac and stroke network*". (CG6) had also received "*lots and lots of information*" on PPE and has a "*huge file of stuff on my email*" about it. This included information on "*lots of meetings*", "*PPE workshops*" and "*newsletter[s]*".

However, this correlation between the level of involvement in community group social care provision with the level of knowledge they had received on PPE did not always hold for some community organisations. For example, (CG3) was shown above to have no real involvement in social care provision, however, they had received written information on PPE which they described as "*useful information*".

Whilst (CG6) was shown above to have acquired knowledge on PPE-related matters through meetings, none of the other community groups had received information on PPE in this way. The more common way of community groups receiving PPE information had been through receiving it in written form through email or post. (CG3) and (CG6) were shown above to receive information in this way, and (CG7, CG9. CG10) reported that the local authority had sent some information last year about a new hospital opening, "*sending us information about if we wanted to go to the meeting*

about this new hospital". Whilst these three community groups all remembered receiving written information on PPE, the number of community groups receiving this information may have been higher as some found it hard to remember. (CG2) said they "*don't recollect*" receiving any information on PPE by email or post and (CG4) said "*I can't put my hand on my heart and say yes or no*" and cited the reason for this was "*I get sent lots and lots of information, most of the emails I get I skim read and delete and most of the stuff I get through the post gets put in the bin*".

The faith groups/churches were two community groups that did not really get involved in PPE, with (CG1) commenting that "*we're a church, what would we have to do with patient involvement?*". However, the churches both seek "*to engage with its community*" (CG4). (CG1) did this through providing its church "*hall which is let out to community groups*", "*we hold public worship on Sundays*" and "*we're involved with other churches*". (CG4) engaged with the community through a "*soup kitchen, which provides hot meals for about 40-45 people*", "*an older people's group which meet [weekly] and they also have meals together and they have day trips away*" and a "*primary school after school [club]*". (CG4) also provides its building for use for community activities that "*haven't got direct input from the church*", such as a playgroup and after-school club. (CG4) also works with other organisations to deliver community services on an ad-hoc basis. For example, the church worked with another organisation in an attempt to tackle violent weapon crime in the local area.

Theme 3: Community group involvement in PPE

There was a range of levels of involvement between PCTs and the community groups. (CG2) said they work with a PCT and are on their "*approved list of providers*". (CG5) said in terms of working with PCTs, "*we have a health program that we refer people to GPs or hospitals or specialised services*". (CG6) said they work with PCTs, "*we are part of a strokes strategy implementation group and we do a lot of work there*". (CG8) said in terms of supporting PCTs, "*during these [dance] sessions, we're always promoting a healthy lifestyle and the dance instructor is always giving them [participants] information about the local health centres they can visit, etc.*", although this support appeared to not be a strong information based one, "*we don't really have much information to give them [the community] but from what we do know, we're able to provide them [the community] with that*". However, (CG1), (CG3), (CG4) and (CG7) said they did not work with PCTs, although (CG7) did highlight that they do sometimes work with the early years inclusion team, "*if we have a child with special needs we refer that child to the [early years] inclusion team… and we work with the inclusion team… supporting that child but we don't do referrals to doctors*".

Due to working with the PCTs, this appeared to open up a communication channel between PCTs to (CG5) and (CG6). (CG5) appeared to use this communication channel for PPE purposes through monitoring and feeding back whether there were any particular health care services that patients desired to be provided that were not currently available for patients. On this, (CG5) said where "*we notice a trend in certain services that are not available, we do contact the PCT*". (CG6) also had "*quite close relations with the people that provide them [healthcare services]*", which enabled them to monitor healthcare provision, which they felt that "*at the moment the healthcare services which are being provided are very good*". However, working with the PCT did not always mean this communication channel was used by a community group to monitor and feedback service provision requirements from patients. (CG2), who worked with a PCT, highlighted they had not attempted to find out whether there are any particular health care services that need to be provided because "*we specialise in care, the most we'd get involved in that type of thing is maybe administering medication*". (CG8) also commented that they work with an elderly persons charity and so receive information about services available for older people; however (CG8) were more proactive in providing missing social care services rather than feeding this information back to PCTs – e.g. the elderly community wanted a dance session and (CG8) took it upon themselves to provide it.

Despite none of the other community groups getting involved in finding out whether there are any particular health/social care services that need to be provided, some community groups had feedback mechanisms in place that could be used for this purpose (CG3, CG7). (CG3) was particularly well set up to do this, saying that they engage with the community through "*a monthly meeting*", "*a quarterly newsletter*" and "*a web group… providing a forum for debate and comment*", the community notice board and also through posters on "*various points around the area where we can display material*". (CG3) also had a more informal network they could use to engage with the community too. In terms of this, (CG3) were involved with the local library, local church and local school, and highlighted "*we have our fingers in lots of pies in the area, which is a way of spreading information*". Other ways of engaging with the community involved (CG7) using a "*questionnaire*".

However, (CG7) highlighted that even when such feedback mechanisms were used for spreading information, the community may not necessarily be particularly interested or want to get involved. Referring to the information on the meeting about the new hospital discussed by (CG7) above, (CG7) highlighted that "*we did show the parents [the information] but they didn't really show any interest*". Nevertheless, if the right community is targeted, community group feedback mechanisms can be

harnessed to provide positive outcomes. As (CG6) highlighted, in terms of community feedback, "*every three months we have meetings where these things are discussed and debated*" and that is where "*people are very interested*" in this feedback. Equally positive was (CG5) who provided "*lots of forums and we have open days and access to service days… we have leaflets and put it in our newsletter and any publications that we have*", which was seen as being a positive feedback mechanism by the community.

Two issues emerged about the use of community group feedback mechanisms, to their own community .. One was that some community groups do not have any such mechanism at all. Both (CG1) and (CG4) were in this category, with (CG4) highlighting that "*there's no formal way that was set up to engage with the community*". The other issue is that process failure can result in this feedback mechanism failing. One instance of this occurred for (CG3), who said "*if something comes to me, either as an individual or as the Chair of the organisation, and I think it is something which should be passed on to residents, then I will do that*". However, this reliance on a single person had created an issue on one occasion, "*I did have some information... which I should have put out to the group and I was very busy at the time personally, and it was one of those things that went in a pile and by the time I discovered it I'd gone past the deadline*'. However, this was due to a personal difficulty at the time and was a one-off occurrence.

Supporting Evidence on Community Groups

The supporting evidence presented below shows that the PPE involvement was mainly with LINks, the Acute Trust and the Mental Health Trust. Examples include: willingness of the voluntary organisations to be involved in PPE, and opinions on initiatives put forward by the LINks, and the Mental Health Trust.

1: To determine whether third sector organisations have been consulted about PPE

In all the health–related community organisations, it is apparent that there was a substantial amount of engagement through PPE, however this was mainly associated with LINks and the Mental Health Trust. This was also the case with the age-related community organisations.

Within the general community organisations there seemed to be a moderate amount of consultation and this is demonstrated by the following quotations: *"I attended a meeting at the local health centre about services."* and *"They weren't specifically LINk meetings, I've been involved in a number of meetings to do with health issues".*

One of the managers also stated: *"We are very concerned currently about that situation anyway, particularly now with the changes in the health service etc."*

This demonstrates that health, age and general third sector organisations had shown some response to the PPE initiatives put forward by these other organisations but do not provide specific examples with respect to the PCT. It is apparent that the community organisations want to increase healthcare service quality for their members and have demonstrated the willingness their senior management to be involved in PPE/health care management decisions. As stated by Perry (1993) impulse to be involved by these managers may have been "reflected through the public's desire to be involved in the NHS which, as a publicly funded institution, is perceived to be owned by the citizens as a whole."

In ethnic and religious organisations, it can be seen that PPE consultation was not viewed as relevant:

- *"no, I don't think our members are interested"*
- *"Healthcare has nothing to do with what we do"*
- *"We aren't involved in any way"*

This demonstrates that these groups have less interest in being consulted about PPE and perhaps explains why these organisations have not responded to any of the initiatives put forward by the PCT. This may be due to the fact that the management do not see themselves as part of the healthcare decision-making process, either because they feel that healthcare has no relevance to what they do or because they feel that the members of their organisation would not be interested in being involved with the process. However, it must be noted that the managers of these groups may not necessarily have asked members of the organisation whether they would like to be involved which could be a lack of communication.

However one manager stated: *"We've had invitations to become involved and unfortunately because I'm the only paid worker we haven't got the facilities to be able to send people to proper consultation"*. This demonstrates a willingness to be involved, however due to finance and staff restraints; this manager was unable to get involved.

To summarise, the age, health and general organisations were afforded opportunities to be involved in NHS decision-making.

2: Opinions on PPE initiatives

There were many positive opinions about the PPE meetings from the managers of third sector organisations who were willing to be involved. These are demonstrated by the following quotations:

- *"People attending, talking to each other and also the useful material distributed by health campaigners."*
- The best part of the meetings was: *"meeting people and finding out what's happening."*
- *"I think they were fine and quite relaxed for one. No doubt I'll have my two pennies worth if I can think of any way of improving them."*
- *"I think their helpful to everybody who goes and I think also their quite supportive and they are enabling in the sense that people don't seem so isolated having to deal with things on their own etc. You feel that there are other people there who are concerned too."*
- *"A lot of people there said that they'd learnt things they didn't know about."*

It is evident that by attending the PPE meetings, the managers of these third sector organisations were able to interact with others that are also willing to be involved in the healthcare decision-making process. According to Martin (2002) many initiatives attempt to achieve empowerment through increasing individuals' involvement. As Rappaport (1987) presented, empowerment refers to "a mechanism by which people, organisations and communities gain mastery over their affairs". As Zimmerman summarised, "psychological empowerment includes beliefs about one's competence and efficacy, and a willingness to become involved in activities to exert control in the social and political environment." As noted by Burgess (2003) people who participate in community organisations often feel more empowered than non-participants.

Managers also recognised that there were also other managers who have concerns about the healthcare services that are currently being provided by Area XXX by speaking to them. This is a form of networking.

Also, as a result of these initiatives, managers were able to find out more about the healthcare issues within the community hence increasing their knowledge. This is reinforced by Carlsson et al. (1996) who state that knowledge can be viewed as a capability with the potential for influencing future action. Watson (1999) builds upon the capability view by suggesting that knowledge is the capacity to use information; learning and experience result in an ability to interpret information and to ascertain what information is necessary in decision making.

Although there were many positive opinions about the initiatives, there were also a significant number of negative views which are evidenced below:

- *"none of what people said in the meetings seemed to make any difference whatsoever to the predetermined decisions of the PCT"*
- *"the views of those participating conflicted with the strategic views of the PCT and the government were completely ignored."*
- *"When is it going to move from being a ticked box exercise to a form of empowerment over government policies?"*
- *"Guarantees should have been provided that the views of the public would carry most weight in any future decision making regarding local health services."*

It can be seen that the management of these third sector organisations (the public) who have been consulted about policy choices later found out that their views have been ignored, which led them to conclude that their input was not valued, thus causing anger and cynicism. They believed that there was no point in expressing their views as they felt that they were not heard. It can also be seen that they clearly wanted some guarantee that their contributions to the healthcare decision making process would be heard.

It is evident that these managers felt that their involvement would not change decisions. This demonstrates a lack of trust in the PCT as the managers of these organisations clearly feel that the PCT does not consider the community's interests a priority. According to Robbins and Judge, trust is a "positive expectation that another will not-through words, actions or decisions act opportunistically." They also note that trust takes times to form, building incrementally and accumulating and is based on the behavioural predictability. It is clear to see that the PCT has shown that the managers views are not taken on board which in turn has decreased the managers confidence of trustworthiness in the PCT. It has also been noted that a climate of mistrust tends to make it difficult for people to visualise common goals, stimulates dysfunctional forms of conflict and reduces co-operation.

3: Partnership Work

With regard to partnerships, it was clear that there has been a substantial amount of communication between the general, health and age organisations and the PCT which is evidenced below:

- *"We have to provide monitoring information to our funders, the PCT and the council."*
- *"We have a good relationship with Area XXX PCT and are in regular contact."*

- *"We work very closely with the PCT"*
- *"Yes, we have always supported them"*
- *"The PCT has been asking about what we do and taken an interest in what we do locally."*
- *"Yes, it is important to us to support the health service through the work that we do."*

This demonstrates that strong relationships exist between these organisations and the local PCT. It can also be assumed that there has been a substantial amount of communication between the two which has resulted in a collaborative partnership.

However, some managers expressed negative views on their partnership with the PCT.

- *"…there's a problem because we're not allowed to be political per se by constitution."*
- *"We have worked hard to protect and improve local health services and the problem is that the PCT is clearly carrying out government policy to make huge cuts and force privatisation on our local health services."*

This demonstrates that although partnerships have been established, these managers clearly perceive an intimidating power imbalance between them and clinician and policymaking experts, which according to can undermine the legitimacy and fairness of the priority-setting process. A perceived imbalance of power between partners is a frequently cited destabilizing factor for those undertaking collaborative activities. It has also been noted by Goldman (2004) that involvement does not necessarily result in more influence or control. If a partnership starts out on a basis of unequal power then the most powerful partner will get the greatest benefits and the least powerful will incur a larger burden of costs.

4: Degree of healthcare engagement in third sector organisations and the community

The findings demonstrate that the health, general and age third sector groups engaged with the local community. This is evidenced below:

- *"We carry out monitoring on a regular basis."*
- *"We send out newsletters."*
- *"We get a lot of positive support, I think especially around here people know that there's a handful of us who do all the work and their very grateful for that."*
- *"We do that as a matter of cause anyway, we also have a newsletter which we will be sending out very shortly."*

- *"We provide information advice and guidance and involve young people in the community in that process."*
- *"We publish monthly newsletters."*

It is apparent that strong relationships have been formed between the community and these organisations. There is also a high level of feedback about healthcare given back to the community. It is also evident that there is appreciation from the community towards the third sector groups. It can clearly be seen that there is a significant amount of engagement between these groups and the wider community with regard to healthcare.

In the religious and ethnic groups, it was evidenced that there was no engagement with the local community with regard to healthcare. This was due to the fact that they have no interest in involving themselves in the healthcare decision-making process; therefore there would not have been any feedback to give to the community.

Section 4 – Findings from interviews with Local Authorities, trainers and Senior Managers

Final interviews were conducted with: senior management representatives from PCT 1, LINks council staff from two councils, and two of the Health Link trainers. In terms of the council staff, they represented Council 1 (which worked with PCT 1) and Council 3 (which worked with, so as to not confuse it with PCT 2's council).

The purpose of these interviews was: to explore views of support for PPE training; identify what, if any, training schemes were in place beyond that provided by Health Link; ask for general reflections from the trainers.

Overview of Findings

- PCT senior management leadership support PPE training but believe it is hard to involve patients.
- Trainers identified the behaviour of senior managers as a contributing factor to the diminishing number of attendees.
- Local Authorities have aspirations for PPE training in HealthWatch.

Leadership Support

The PCT respondent was aware that PPE training had taken place in the PCT but did not have knowledge about the content of training and did not have any view that the training had been supported by senior management in the PCT. The respondent had not participated in PPE training directly but was aware that it was taking place. This was explained as a benefit, "*from the patients point of view how it would affect the patients and in some meetings that are set up patients are invited."* When asked about the trust's leadership commitment to PPE the respondent commented that the PCT is, *"wholly committed because we are encouraged to invite patients to committees that are set up."* It was also reported how senior management viewed PPE, *"as necessary, it's necessary to get patients involved but it's very difficult getting patients involved."* Hence, senior leadership in the PCT 1, *"put importance on it but I think it's felt generally that it's difficult to get patients involved in decision making."*

Nonetheless a point was made about how the training was initially communicated in the PCT : *"I would, if it was offered to me, I would have taken it [PPE training] so I would have definitely recommended it to my colleague. I don't know how it was recruited. I don't know if we were invited, I can't remember, whether I missed it or not, you know."*

Trainers views on the behaviour of Senior Managers

The two trainers interviewed believed that the behaviour of some senior managers who attended the training sessions contributed towards the diminishing attendance rate. This was explained as, '*protectionism going on',* whereby some senior managers, '*dominated either vociferously or by their presence'* and were, '*motivated for some things but turned up with negative views about learning*'. A most disappointing session for some was the senior managers' negative view of a service user (ex - alcoholic) who volunteered to explain his history of addiction. In contrast, the conflict management session was well received by all attendees. It was pointed out that it is, '*difficult to provide training where learners choose not to engage'*. The Director of Health Link was not included in the trainer interviews.

Future PPE Training Aspirations for the Local Authorities

The important issue raised by the council respondents focussed on what PPE training is supposed to achieve. Council 1 respondent noted that, *"you need to be quite clear about what you mean by PPE cause it's banded around a lot. It takes many forms you know…"* Both PCT 1 and Council 3 respondents believe that training should be more focused. Council 1 respondent suggested it was

important to, *"make sure that, you know, wherever they're recruiting it's relevant to the area they're interested in".* When asked if they would recommend PPE training to a colleague, Council 3 respondent suggested that would depend, *"…on the colleague, whether it falls within their work area or specific interest or a specific project at that time or their level of expertise as it is and whether they needed it."* Also the point was made that currently, '*the achievements of the LINks are possibly not known or at least understood at the levels of senior management*'. The success stories on PPE were more localised, "…*I would say that my colleagues are generally more aware of the successes perhaps more on a personal level. Some of the success stories have been linked to where it has had an impact… Some aspects of the LINks are performing exceptionally well and are supported very well and other aspects aren't delivering what we had hoped they would"*

However, it was acknowledged that overall current communication between the LINks and their Council worked well. For example, the Council 1 respondent explained how informal means of communication, such as meetings and e-mail, is established in the Council-LINk relationship. *"…they are able to refer things to the Overview and Scrutiny Committee and we use them to share information and intelligence …we talk to them and they give us information about the uses patients roughly and the process works the other way – we will relay particular concerns our Scrutiny Councillors have to them and suggest that they may wish to follow them up and so on and so on."* In a similar way the Council 3 respondent reported several communication mechanisms, "*We've got a LINks advisory group that's got that representatives from the PCTs as well as the council so that's got scrutiny representation. As well there is a senior in adults and community as well as managing the contract. My director will have updates with the deputy leader and also his manager so the corporate director and that is updated there.. We also have a presentation to scrutiny on a 6 monthly basis. So twice a year."*

Both respondents were keen to learn how to improve PPE. The Council 1 respondent explained how, *"when the committees are considering health issues it tries to involve patient groups and local interest groups, etc. it depends on the issue. I mean for instance if we were talking about a mental health issue came to the committee we would try and get a view from patient groups."* The Council 3 respondent also explained how *"We're developing a plan within HealthWatch early next week to look at what different group supported is offered within the PCT and how they can be supported and included within Healthwatch. But actually at the moment, as with most things, most areas, the PPE within the PCT has continued separately to the LINk. So there are some crossovers. So the PPE lead for the PCTs attend LINk meetings and take things back to the PCT and vice versa but really the groups have essentially remained separate."*

Conclusion

This report helps us to understand how PPE can become better systematised and the relevance of PPE training to national policy and legislation on PPE It does this through meeting two objectives – evaluating PPE training which was provided by Health Link to assess how it has been embedded in the PCT and formatively evaluating the responsiveness of third sector organisations to engagement initiatives. This section will summarise the findings of this research in relation to these two objectives, highlighting areas where further consideration can be given to increase PPE integration.

In terms of the PPE training provided by Health Link, there were a range of positives identified, as well as areas where the course could potentially be further enhanced. In terms of positives, attendees overall felt the training had achieved its objectives and raised staff knowledge on PPE to a certain level. Furthermore, the delivery of the course was seen as well run and the materials provided appear to have been comprehensive. However the views of the senior managers and middle managers differed in response to the use value of the training, with middle managers viewing it as an essential aspect of their role and senior managers commenting that some of the training was not appropriate for them. For this reason they suggested a menu of training modules in the future. However the behaviour of the senior managers who attended the course was viewed as a factor that contributed towards the decreasing number of attendees by the trainees. The content of the course was praised by the middle managers. The additional interviews with Local Authority LINks staff showed that there is a need for PPE training in the forthcoming HealthWatch organisations.

In terms of the responsiveness of third sector organisations to engagement initiatives on PPE there was a good response towards PPE involvement, which may suggest they value it. This appears to manifest where there was a range in the levels of involvement in social care provision in the community and minimal level of involvement in healthcare. The faith-based organisations, the residents association and pre-school education provider were less interested in healthcare services. However, the community groups for ethnic minority communities did all offer some level of social care and, as may well be expected, the health support charity was involved in healthcare which naturally brought them closer to the topic of PPE. These groups gave examples of working on PPE with the Mental Health Trust, The Acute Trust and the LINks. They also identified the PCT as an organisation that they worked with but offered more examples with the other organisations. The questions were phrased around their PPE work with the PCT, however, it may be that the term PCT was too narrow and that these organisations view PPE as their association with a range of organisations.

Interestingly, the level of involvement in social and health care did not always translate to the level of knowledge community groups had on PPE. For example the residents association (shown above to have no real involvement in healthcare) had received written information on PPE, which is more than some of the more active healthcare community groups for foreign communities had received. PPE meeting attendance appeared to be the least common method for acquiring PPE knowledge, with only the health support charity involved in PPE meetings. The more common way of community groups receiving PPE information appears to have been through receiving it in written form through email or post.

In conclusion, the aim of the evaluation was to understand how the training intervention embedded PPE in the PCT and how it influenced commissioning and practice. As discussed in more detail in the Executive Summary, the main findings were:

- The training sessions themselves:
    - **Training materials** were praised.
    - **Appropriate content/depth** in the training for in-house staff training, but develop supplements.
    - **One type of PPE training does not fit all** as Senior Managers may already have an extensive understanding of PPE.
    - At the request of the PCT the training sessions were held over a period of **eight months,** however, some respondents had forgotten earlier sessions.
    - Senior Management verbally support PPE Training but **believe it is hard to involve patients.**
    - **Poor Attendance** of the Training Course – average attendance of 18 out of 45 enrolled members.
    - The attempt to **bring staff from two PCTs together** in the training had potential, but this was not realised.
    - Trainers were concerned about the **poor attendance** and how this diminished due to the behaviour of senior management.
    - Attendees suggested that **time constraints** through work load made it very difficult to attend day-long sessions.
- The impact of the training sessions:
    - **The PPE training has contributed** towards embedding PPE into some areas of the PCT, especially middle management.

  - **Develop a menu of training, including** shorter refresher courses e.g. updates to legislation, PPE policy issues.
  - Examples are available of how the training **influenced practice and commissioning.**
  - **Develop a post-training strategy** and training for Local Authorities staff.
- Existing PPE practices:
  - **Strong networks for PPE Engagement exist** with Community Groups, less so with church groups.
  - **Strong commitment of the Third Sector Organisations to PPE** as they respond positively to initiatives.
- Work still to do on PPE:
  - Some Community Groups are involved in **social care and may talk about this as if it were health care** as the definitions/boundaries are unclear. May benefit from clearer information about the state's responsibility for PPE.
  - No evidence from middle management to show that PPE was **systematised** in the PCT. senior managers identified some attempts e.g. staff briefings, a designated PPE lead.
  - **Further develop existing PCT-community group communication channels** to monitor and feedback particular healthcare needs.
  - **Develop new PCT-community group communication channels** to access untapped views from willing groups.

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Appendix 1: Literature Review

Involvement and Partnership are two key aspects of a PPE initiative. This section will examine the literature surrounding these two important issues.

Involvement

Involvement can be defined as ''*taking part in the process of formulation, passage, and implementation of public policies [through] action by citizens which is aimed at influencing decisions which are, in most cases, ultimately taken by public representatives and officials*'' (Parry et al. 1992, p. 16). Arnstein (1969) proposed a model of involvement consisting of a ladder with eight rungs representing different degrees of involvement. The first two rungs are seen as non-participatory, with 'manipulation' being the persuasion of citizens to support existing plans and 'therapy' the diversion of citizens from the real issues. A second set of rungs consists of modest degrees of involvement: informing citizens; consulting simply in terms of conforming with statutory legislation but without obligation to act or take notice of citizens' views; and placation, where there is a guarantee that citizens' views will be heard but no guarantee that they will be heeded. The higher rungs on the ladder identify forms of participatory activity in which the public has increasing power and where there is a commitment to ongoing integration of the views of the participants fully within the wider decision-making process (Arnstein, 1969).

It has been noted that public involvement in decision making can "*promote goals, bind individuals or groups together, impart a sense of competence and responsibility and help express political or civic identity*" (Brady, 1995,). In this study the common interests of PCT and health care services is linked to PPE in commissioning by the PCT, with the assumption that the expertise of the public should lead to more appropriate provision of local health services (Department of Health, 1999). According to Bruni et al. (2008), there are at least 4 reasons for believing that public engagement in setting health care priorities has value. First, is the desire for local accountability which stems largely from the fact that the NHS is a publicly funded service and that managers and health professionals should therefore be accountable to actual and potential consumers; patients and local people (Calnan, 1997). As patients and members of the public are becoming more knowledgeable about health care and expecting more from it, it has been suggested that decisions should be made more explicit and open to public scrutiny (Doyal, 1997). Second, greater involvement of the public in policy-making is in keeping with the principles of democracy. This is also reinforced by Calnan (1997) who noted that there is a need to develop citizen senses of competence and responsibility, and the concern to enhance democracy by encouraging citizens to reach their full potential. Third, empowering people

to provide input in decisions that affect their lives encourages support for those decisions, which in turn improves the public's trust and confidence in the health care system. Fourth, public involvement provides a crucial perspective about the values and priorities of the community, which should lead to higher quality of priority-setting decisions.

Conversely, Goldman (2004) states that various barriers have frequently been cited in the literature as reasons not to pursue greater public involvement. It has frequently been noted that members of the public are not objective as they have an inherent personal bias and cannot represent interests other than their own. However, according to Bruni et al. (2008, p. 15) "*this concern is applicable to all participants currently sitting at the priority-setting table, including health care professionals, administrators and researchers. Therefore there is no reason to believe that members of the public are less objective than any other type of participant*". Others assert that the public is not well enough informed about the complicated scientific, clinical and administrative aspects of health care to contribute meaningfully to priority setting. However, members of the public have real-life experience as users of the health care system and can offer insight into the values and beliefs of the public at large. In genuine public engagement, members of the public are not expected to be scientific experts, but rather to provide their perspectives (Burgess, 2003).

Callaghan and Wistow (2006) suggest that insufficient attention has been given to the impact of the shift to governance on public involvement in the NHS. Jessop defines governance as "*the reflexive self-organisation of independent actors involved in complex relations of reciprocal interdependence, with such self-organisation being based on continuing dialogue and resource- sharing to develop mutually beneficial joint projects and to manage the contradictions and dilemmas inevitably involved in such situations*" (Jessop, 2003, p. 101).

Partnership

Within the public, private and voluntary sectors, the need for partnership working, often cross-sectoral working or working beyond the boundaries, is recognized as a vital component of success. In the UK, partnership working is a key component of the government's modernisation agenda, particularly in the health field (Wildridge et al., 2004).

A collaborative partnership is an alliance among people and organisations from multiple sectors, such as schools and businesses, working together to achieve a common purpose (Roussos and Fawcett, 2000). Three phases are identified in the collaborative process:

- **Phase 1: problem setting** – defining the problem; committing to collaboration as a method of addressing the problem; identifying appropriate stakeholders; establishing the level of participation of individual stakeholders; identifying the convenor (who will bring the stakeholders together); identifying resources.
- **Phase 2: direction setting** – establishing ground rules of openness and mutual respect; setting the agenda of what is to be done; organising the process of collaboration; obtaining information; exploring options; reaching agreement.
- **Phase 3: implementation** – obtaining agreement of the constituents within each stakeholder organisation; obtaining external support; setting up the necessary structures and any required changes; monitoring activities and obtaining compliance.

In addition, according to (Wildridge et al., 2004) several assumptions underlie the strategy of collaborative partnership: (a) the goal cannot be reached by any one individual or group working alone; (b) participants should include a diversity of individuals and groups who represent the concern and/or geographic area or population; and (c) shared interests make consensus among the prospective partners possible.

We note that some collaborative partnerships may reinforce and strengthen an institutional architecture, while others may undermine and challenge it. Also, an organisation such as a local authority has its own constituency, culture and formal obligation. When it enters a partnership, this will require it to do some things differently, or in addition, or even instead of its existing activities. However, a partnership is unlikely to bring together partners who have no prior knowledge of each other. He also recognised that the maturity of these relationships, and the history of past encounters, will colour the development of the partnership. This partnership may also have more or less legitimacy. For example, senior management in the partner organisations might be enthusiastic but the project might lack legitimacy among the wider constituencies of the organisations. Similarly, resources for the partnership may come from a variety of sources. It might be funded from central government, from one of the public sector partners or from the private sector. In addition to financial resources are the knowledge, local linkages and trust which organisations can bring (Roussos and Fawcett, 2000).

In public health, collaborative partnerships attempt to improve conditions and outcomes related to the health and well-being of entire communities. According to Roussos and Fawcett (2000, p.370), the distinguishing feature of collaborative partnership for community health is "*broad community*

engagement in creating and sustaining conditions that promote and maintain behaviours associated with widespread health and well-being". Working in this partnership may help the organisations involved to: get a better picture of what is happening in an area; identify and work to fill the gaps; and make more imaginative use of resources. In a guidance report published by the DoH, (REAL INVOLVEMENT 2008), it was noted that to secure the greatest potential benefits NHS organisations, along with their partners in other agencies both in the public and voluntary sector should work together to: maximise the potential gains of undertaking involvement in a more coherent, co-ordinated and integrated way; and minimise the prospect of ignorance, misunderstanding and confusion on all sides which may waste resources and result in missed opportunities. However, only limited empirical evidence exists on the effectiveness of these partnerships in improving community-level outcomes. Working effectively in a partnership has major potential benefits for health and health care, including: reductions in health inequality, better outcomes of individual care and better health for the community and a better understanding by all concerned of why and how local services need to be changed and developed. Therefore, working in partnership with third sector providers may help NHS organisations to achieve better outcomes from their involvement activity. This is also reinforced by Black (1988) who states that voluntary organisations can complement the NHS by responding to local needs such as those of the minority ethnic groups and provide a channel of communication for consumers' views to the health authority (Black, 1988).

Appendix 2: Questionnaires

Questionnaire 1 – PPE Training Attendees

Experience of PPE prior to training

1. What is your role in the organisation?
2. How long have you worked in the organisation?
3. What does PPE mean to you?
4. How does PPE influence your role?
5. Are there any other types of PPE training that you took part in before the Health Link Training
6. Can you explain how you were recruited onto the PPE Training course?
7. Can you describe your knowledge of PPE prior to the training course?
8. Can you describe how PPE is viewed by your colleagues?
9. Can you describe how PPE is viewed in the organisation as a whole?
10. Can you think of any initiative that would improve PPE in your PCT,
11. Can you describe how PPE is formalised in your trust? For example:
    a. Is there a PPE office? Is it included in team briefings? Who leads on PPE? Does the trust have a written policy on PPE? If so, how is that applied in practice?
    b. How is PPE represented on the Trust Board?
    c. How would you describe the trust's commitment to PPE?

Training Course

12. Why did you attend the training sessions?
13. Are there any reasons why you were not able to attend some of the training sessions?
14. Did the training sessions that you attended have the right objectives?
15. Did the training sessions that you attended meet these objectives?
16. To what extent has the information in the training session informed your working practice?
17. Do you think that combining with another PCT had any effect on your learning? If so why?
18. Which of the training sessions most influenced your **understanding** of PPE ? Can you recall any examples?
19. Which of the trainings sessions most influenced your PPE **practice**? Can you recall any examples?
20. Which of the training sessions least influenced your **understanding** of PPE Can you recall any examples?

21. Which of the training session least influenced your PPE **practice**? Can you recall any examples?
22. Are there any ways in which you would change the training sessions for future participants?

Post Training

23. Since the training finished, have you ever looked at the website or materials from the training? Why?
    a. What have you done with those materials?
    b. Do you have any examples of how you been able to make use of any of the material and websites provided in the training?
24. Can you explain how you have been able to influence your working colleagues about the value of PPE.
25. To what extent would you recommend the PPE training to your colleagues?
26. Is there anything about PPE training that I should have asked you that I have not asked you?
27. Is there anything about PPE in your trust that I should have asked you about that I have not asked you?

Questionnaire 2 - Third sector organisations

Name of Organisation:…… Date:……

Address:……..

Telephone:……..

1) What does your organisation do?
2) What community services do you currently provide for the members of your organisation?
3) Have you attended meetings which have informed you about PPE? Yes No
4) Can you talk me through these meetings
5) Did you find these meetings useful?
6) What was the best part of the meeting?
7) What was the worst part of the meeting?
8) What could have been done differently at these meetings?
9) Have you been sent information (via email or post) to inform you about PPE? Yes No
10) If Yes, what information was sent and was it useful?
11) Have you received phone calls to inform you about PPE? Yes No
12) If Yes, what was said and has this information been useful?
13) Have you used this information (from the meetings/ emails/post /calls) to provide healthcare services in your organisation? Yes No
14) Does your organisation play a role in supporting PCTs to identify and to meet the needs of individuals? Yes No
15) Has an effort been made by your organisation to find out whether particular healthcare services need to be provided? Yes No
16) If Yes, what was done
17) In what way did you manage to feedback to the community after obtaining their views
18) How was this received by the community (positive/negative)
19) Is there anything about PPE that I should have asked you that I have not asked you

Questionnaire 3 – Local Authorities

1. What is your role in the organisation?
2. How long have you worked at this role in the organisation?
3. Who has responsibility for training in general?
4. How are you planning to incorporate Patient and Public Involvement (PPE) In LINKS
5. Who has responsibility for Local Involvement Networks (LINks)Training?
6. How does that work on Practice?
7. What is your knowledge of PPE training?
8. How will PPE impact on your role?
9. Are there any types of PPE/ LINks training that you have taken part in?
10. Can you describe how PPE/LINks is viewed by senior management?
11. Can you describe how PPE /LINks is viewed by your colleagues?
12. How do you feedback LINks to the Local Authority management
13. Can you give any examples of how commissioning has been influenced by LINKs?
14. What sort of training do you think is most appropriate for PPE /LINksS
15. To what extent would you recommend the PPE training to your colleagues?
16. Is there anything about PPE/ LINks training that I should have asked you that I have not asked you?
17. Are there any recommendations you would give to other Local Authorities about taking over responsibility for PPE and PPE training?

Questionnaire 4 - Senior Management

1. What is your role in the organisation?
2. How long have you worked in the organisation?
3. Who has responsibility for training in general?
4. Who has responsibility for PPE Training?
    a. Can you describe how PPE is formalised in your trust? For example:
    b. Is there a PPE office? Is it included in team briefings? Who leads on PPE? Does the trust have a written policy on PPE? If so, how is that applied in practice?
    c. How is PPE represented on the Trust Board?
    d. How would you describe the trust's commitment to PPE?
5. What does PPE mean to you?
6. How does PPE influence your role?
7. Are there any types of PPE training that you have taken part in?
8. Can you describe how PPE is viewed by senior management?
9. Can you describe how PPE is viewed by your colleagues?
10. Can you describe how PPE is viewed in the organisation as a whole.
11. How were the staff who attended the PPE Training recruited?
12. Can you give any examples of how commissioning has been influenced by PPE?
13. Can you explain how staff who attended the training fed back the information about the training?
14. To what extent would you recommend the PPE training to your colleagues?
15. Is there anything about PPE training that I should have asked you that I have not asked you?
16. Is there anything about PPE in your trust that I should have asked you about that I have not asked you?
17. Are there any recommendations you would give to the Local Authorities about taking over responsibility for PPE training?

Appendix 4 Commissioning Document

Haringey NHS
Teaching Primary Care Trust

Consultation and stakeholder engagement
Training programme

Invitation to tender

5th November 2008

Introduction

A World Class Primary Care Strategy was launched on 28th June 2007, as an underpinning strategy to the Barnet, Enfield and Haringey (BEH) Clinical Strategy. Both documents compliment a Framework for Action – the London wide review of health services by Professor Ara Darzi, which was published 2 weeks after the launch of the BEH Clinical Strategy and the Primary Care Strategy. A 16 week period of consultation was undertaken during June – October 2007, with more than 50 events organised to engage with stakeholders, patients and the public on the proposal to modernise primary care services.

The Primary Care Strategy provides a framework for modernising primary care, which will provide the best and highest quality health services for all of Haringey's population. We set out our case for change within the strategy and focused on integrated services and care pathways which would bring clinicians and health workers together to provide a diverse range of services in community settings. Better and modern facilities would be offered as well as extended opening hours so that people can access health services outside normal working hours. There will also be opportunities for innovative joint working with other community services including those provided by the voluntary sector. We aspire to create environments in which general practitioners and healthcare professionals will want to work and where patients will want to be treated

Our strategy has been revised and updated to reflect the feedback we received from local residents, voluntary and community groups as well as other stakeholders such as our local authority partners. We acknowledge that the right service model for Haringey is a lengthy and evolving process. The valuable feedback we received during the 16 week consultation period has been used to develop a new model of care which describes how we can best deliver more local health services. The resulting 'hub' and 'spoke' model will essentially see a range of key primary, community and other services currently only available in hospital brought together under one roof in dedicated Neighbourhood Health Centres or 'hubs'. These 'hubs' will be linked to a range of GP practice 'spokes', which will provide more localised services. Under the proposals set out in the Primary Care Strategy, there will be four Neighbourhood Health Centres located in Haringey. These will be developed about existing or planned new developments including:

- Hornsey Central
- Lordship Lane
- The Laurels and Tynemouth Road
- A new development in central Haringey, most likely near Wood Green or Turnpike Lane. The location of this facility will depend on the availability of appropriate sites and making the best use of the good transport links in those locations.

Importantly we want to gain the views of local residents and patients about what high quality, accessible and responsive primary care service would look like and how services should be delivered. Thereby creating a lively and stimulate debate that will inform the next stages of the improvements in primary care. For this reason we have supplemented our consultation and feedback mechanisms by conducting a community survey – asking 1,000 Haringey residents their views on primary and community services. The results of this survey will be available in the autumn 2008. This information along with other patient survey data including Patient Advice and Liaison Service issues and complaints will be considered by the locality groups which are developing the primary care locality plans. These groups will be clinically led by local GPs working alongside clinicians, stakeholders and patient representatives to shape future primary care services.

We undertook stage one of the consultation process on the primary care strategy in 2007 which involved presentations, deliberative events and round table discussions at a series of public meetings, local partnerships, local area assemblies and community forums. We obtained a great deal of feedback from local people about our proposals. We have learnt a great deal from the consultation process and the feedback we received, particularly about engaging with communities whose voices are rarely heard.

We are committed to involving a diversity of people across the borough in our primary care plans and actively engage local people in shaping the health services of the future. To this end we are seeking a suitably qualified organisation / agency with experience and expertise

of working with a broad range of stakeholders including 'hard to reach' communities on engagement and involvement. In view of the feedback we received from local people and stakeholders around consultation / engagement in decision making; we want to ensure that there is broad engagement from all sections of the community

Part 3

Commission a training programme for stakeholder engagement

We want to skill up our own Communications / Patient and Public Involvement teams and senior management so that they are trained in a variety of techniques that will enhance the way in which we engage with stakeholders in the commissioning agenda of Haringey and Enfield PCTs, and in particular key strategic plans such as the Primary Care Strategy and the BEH Clinical Strategy. Additionally, we want to train in-house staff and volunteers on the methods and mechanisms that can be used to consult 'hard to reach' groups, especially on key plans contained within Healthcare for London and our own local strategic plans.

We are conscious that PCTs really need to produce a comprehensive strategy for engaging stakeholders not least as under the NHS Next Stage review[1], Lord Darzi required the NHS to 'raise the standard of evidence we expect before service change takes place', such that change is always:

- 'For the benefit of patients and, where appropriate, their carers';
- 'Clinically driven;
- 'Locally-led

We hope that devising a framework for engaging stakeholders and providing training that will skill up our staff and volunteers; we will be better placed to engage local people, voluntary and community groups as well as statutory agencies in our commissioning agenda. This work should commence in January with an end of March completion date.

Objectives	**Outcome**
Produce training programme in consultation with TPCT representatives	Customised training programme

1

Deliver 4 / 5 training events to Haringey / Enfield staff Jan – March 2009	Staff, senior managers and volunteers in Enfield and Haringey attend one of 5 training dates
To develop an operational understanding of consultation and involvement requirements on PCTs and SHAs To acquire an overview of different consultation methods and when they could be used. To become familiar with the resources available for conveying complex information simply. To develop understanding of equality opportunities in involvement, the different target groups for consultation and involvement and how their varying needs may be met To learn techniques to absorb aggression and make it productive in contentious consultation and involvement.	Staff, senior managers and volunteers will obtain an understanding of consultation and involvement understand and can apply different consultation methods become familiar with conveying complex information in an accessible way to different audiences develop an understanding of equality of opportunity in engaging and involving diverse communities, and understand how their needs may be met learn and apply different techniques and methods to absorb aggression and confrontation during consultation and involvement events and meetings.
To learn from other organizations including PCTs that have successful stakeholder engagement strategies and methods	Staff, senior managers and volunteers will: Learn 'good practice' techniques and methodologies in other organisations.
To discuss and share with colleagues 'fears' and concerns about facing patients and the public	To share concerns and fears about public meetings / partnership forums and other meetings These meetings can be

	confrontational and adversarial.

The following questions should be answered by organisation that wishes to secure a contract for the training programme:

- **Experience and expertise in stakeholder engagement in particular: demonstrable evidence from previous work undertaken at a local or national level; testimonials from clients and outcome measures (critical success factors that have been achieved)**
- **Understanding of the local population and diverse communities within Haringey and Enfield, particularly the diverse nature of the population of Haringey and knowledge and understanding of the Enfield population**
- **Creative and innovative training techniques around engaging hard to reach communities / diffusing potential and 'real' aggression and confrontation – what works and what does not**
- **Capacity to run at least 4-5 workshops across two boroughs and train up to 45 staff over a period of 3 months**
- **Outline of the training programme and method of evaluating the training delivered**
- **Outline of how key activities, products and outcomes that would be delivered as set against the objectives and outcomes under each of the three areas**
- **Infrastructure and capacity to fulfil the requirements of the work – number and type of staff dedicated to this work, demonstrable financial competence**
- **Ability to meet the timescale as prescribed within each piece of work**
- **Details of two references**
- **Quote of costs including any additional expenses.**

Timescale for this work are as follows:

- **5th November 2008 – Invitation to organisations (competitive quotes)**
- **1st December 2008 – Tender return deadline**
- **5th December 2008 – Short listed organisations**
- **12th December 2008 -Sign contract and initial meeting with organisation**
- **January 2009 Organisation commences work**

- **March 2009 - Organisation completes training and provides a brief evaluation of the training provided.**

Submissions should be sent to:

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Director of Corporate Services & Partnerships
Haringey Teaching PCT
St Ann's Hospital
St Ann's Road
London N15 3TH

Tel: 0208 442 6181
Email: Christina.gradowski@haringey.nhs.uk