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# Community Participation in Health Improvement Programmes: A case study of tensions between policy and practice.

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# ABSTRACT

This thesis explores the tensions between policy and practice in community participation in Health Improvement Programmes (HImPs). The HImP is used as a vehicle through which partnership working and public participation in health planning in the 'new NHS' may be examined.

The literature review discusses key theories and models of community participation, power and policy implementation which informed the development of my key research questions and strategy. A review of the global, national and local influences upon community participation in health planning is supplemented with primary research in the form of a detailed case study of one locality's response to the national requirement to involve the public in the development of their HImP. A multi-method case study was employed using the following methods of data collection: observation, interviews, questionnaires and documentary analysis.

The research presented identifies a number of issues as significant in affecting a locality's approach to public participation, including: power; the organisational culture(s) within the HImP partnership; the attitudes and capacity of those charged with developing participatory activities; and the impact of national priorities on local flexibility to respond to community identified priorities.

The application of Alford's (1975) structural interests theory to the findings provides a useful framework for assessing power relations and understanding why the HImP fails to represent community interests in the way that had been hoped.

A number of recommendations are made to facilitate participation in health planning in the future, including: the need to address the national culture of risk avoidance; the need for better training in public participation skills for personnel charged with developing participatory opportunities; and the need for a mandatory performance framework related to community participation as a mechanism to ensure that participation issues are given the same attention as other nationally monitored issues.

# KEY TO ABBREVIATIONS

CHCs – Community Health Councils

D.A.T. – Drugs Action Team

DoH – Department of Health

HAA – Health Action Area

HAGs – Health Action Groups

HAZs – Health Action Zones

HDGs – HImP Development Groups

HImP – Health Improvement Programme

HIMP – Health Improvement and Modernisation Plan

HSG – HImP Steering Group

JCG – Joint Commissioning Group

JIP – Joint Investment Programme

LIT – Local Implementation Team

PALS – Patient Advice and Liaison Services

PCG – Primary Care Group

PCT – Primary Care Trust

SaFF – Service and Financial Framework

WHO – World Health Organization

# CHAPTER ONE

# HEALTH IMPROVEMENT PROGRAMMES: AN OPPORTUNITY TO EAXMINE COMMUNITY PARTICIPATION IN HEALTH PLANNING

## Introduction

In this thesis I will examine the response in one locality to a national government requirement to involve the public in the development and implementation of Health Improvement Programmes (HImPs). Community participation features heavily within 'New Labour' policies, but turning this political imperative into a reality is fraught with numerous practical difficulties which hinder implementation. Therefore this thesis set out to present a detailed examination of the tensions and problems involved in such attempts to include communities in health planning. The overarching question this study sought to examine was: What can we learn about community participation in health planning in the 'new NHS' through an examination of a local Health Improvement Programme?

In addressing this question the study provides a critical review of participation in planning and decision-making processes, and examines the opportunities and challenges for local public involvement presented by the introduction of HImPs. Therefore, HImPs provide a vehicle within which to examine how partnership working and public participation works in practice, and to identify both the opportunities for participation and the tensions between policy and practice.

The issue of community participation in HImPs is considered in the context of theoretical debates about community; participation, power and policy implementation. A brief examination of the global health policy context demonstrates that participation is a term which has had increased currency internationally during the past twenty five years. The study also includes an analysis of the national policy context within which HImPs were developed in order to situate the findings.

## Health Improvement Programmes and community participation

The Health Improvement Programme, introduced in the 1997 White Paper *The New NHS,* was one of the first radically reforming health policies to be introduced by the Labour government (Grant, 2000). The HImP recognised the wider determinants of health and placed health promotion, prevention and tackling health inequalities firmly on the agenda. As a policy it may be regarded as embodying the 'New Public Health' approach (Ashton and Seymour, 1988). Whilst this approach draws on the World Health Organisation's 'Health For All' programme of 1978 and is therefore not a new approach, it is the first time it has been so prominent and articulated so explicitly in English health policy.

Health Improvement Programmes had two main functions: firstly, to tackle inequalities in health and secondly, to engage a wide variety of organisations and individuals to work together as partners to improve health generally (Hunter, 1999). The focus on partnership working, and particularly the recognition of the importance of involving the public, was in sharp contrast to the managerialist reforms and the introduction of an internal market brought in under the previous Conservative administrations (Ham, 1999).

### Research strategy

A detailed case study in one locality (Coventry, England) was chosen as the research strategy for demonstrating both the possibilities and the many tensions inherent in local efforts to implement a national top-down policy that sought to promote local public involvement. The case study examines the processes adopted at the local level by statutory agency employees with the responsibility for developing the HImP in order to highlight the tensions faced by those charged with developing public participation in the HImP. The research also seeks to identify and examine the critical enabling and inhibiting factors in involving the public in health planning through the medium of the HImP. It is important to highlight here that this study is therefore an examination of a top-down model of participation. The aim of this research is to consider the strategies employed to involve the public by those charged with implementing this policy and the rationale behind the choice of these strategies. The focus is not on measuring the extent of participation, the outcomes of participation nor is it an examination of the experiences of participation by members of the public. Rather, it concentrates on the *process* of developing community participation and the tensions between policy and practice. The case study includes a description of the social, economic and political context in which this policy was being implemented. The case study was not predicated on a specific hypothesis but used key issues (for example the impact of context, power relations and attitudes towards participation) identified from the literature review as the basis for enquiry and for informing the research questions considered within the study.

**Why study community participation?**

The work for this thesis began in October 1998 with the clarification of the topic to be researched. I had spent the previous year (1997/8) examining *Pals in Pregnancy*, a local project which trained women living in the six most socio-economically disadvantaged areas of Coventry to provide social support to other pregnant women in the locality who did not have alternative social support networks to draw on. The overall aim of this project was to reduce the high levels of low-birth weight babies born to women in these six areas of the City by supporting the mothers. Whilst I was fascinated by the proposed impact of this social intervention on a health issue, I found myself particularly interested in the experiences of the women who were trained to offer social support. Many of these women went on to find further work, re-entered education and reported feelings of increased value. In short, they experienced a degree of empowerment as a result of their involvement in this project. They felt that their experiences were valued and their knowledge respected.

Furthermore, in my role as a full-time contract researcher with the University of Warwick I had been jointly responsible for conducting the Coventry Health Authority commissioned evaluation of *Coventry Community Research Project.* This project sought to train members of the public living in the city's six Health Action Areas as researchers to carry out a health needs assessment exercise across these six geographical areas. The term 'Health Action Area' is used to refer to the six most deprived areas of the city and not surprisingly, the areas where health status was identified as the worst in the city. The project involved the 'Community Researchers' administering a questionnaire verbally and conducting focus groups in local community venues. A number of participants trained as Community Researchers again reported positive feelings and some went on to gain employment within the health authority or local authority whilst others expressed an interest in receiving formal research methods training from the university.

My involvement in these projects sparked my interest in the issue of lay involvement in health service planning and provision. It occurred to me that Health Improvement Programmes, which demanded public participation in order to increase accountability and ensure the development of appropriate services, would serve as an ideal policy within which to examine the issue of public involvement. Furthermore, the HImP was a Coventry wide plan and therefore allowed me to examine participation on a larger scale than my previous enquiry into a discrete service for pregnant women experiencing socio-economic deprivation. I wanted to learn more about the factors which facilitated and inhibited participation, how those in charge of top-down programmes such as HImPs went about transforming policy into practice and whether the opportunities for empowerment I witnessed within the small scale *Pals in Pregnancy* programme would exist within larger programmes of activity like HImPs.

Furthermore, I have a strong personal and political commitment to broad public involvement in policy making and the promotion of health improvement in general, as well as for the citizens of Coventry specifically. Here I will borrow from Harding's account of feminist 'standpoint' research which asserts that "the adoption of this standpoint is fundamentally a moral and political act of commitment [...] not merely intellectual" (Harding, 1986: 149). Consequently, I have approached this research from the standpoint that community participation in health planning is a desirable objective as it has the potential to (i) provide opportunities for local people to get involved in planning and decision-making, thereby allowing for the development of more accountable and appropriate services which are effectively targeted, and (ii) through their participation individuals have the opportunity to gain knowledge and skills, which may empower them personally and as members of communities. The focus within this research is on the first of these two aspects of participation.

The examination of HImPs, as one of the first health policies to place public involvement at the heart of its work is therefore of considerable interest. The examination of one HImP in detail demonstrates the importance of context and of recognising existing structures and capabilities in examining the rationales behind the approaches adopted to facilitate community participation. This research examines the literature around community participation highlighting in particular the competing models of participation found in the literature, notably Arnstein's (1969) 'ladder of citizen participation' which was developed as a tool with which to classify participation activity and the two key theories of participation – *consumerism* and *citizenship* (Klein, 1984). This study examines concepts which are highly contested and the next chapter will discuss in detail competing definitions and understandings of 'community' and 'participation'. It is worth noting here that within this study 'community' is being used to refer to the general pubic and does not assume any homogeneity. Indeed, Coventry as a whole, and the six Health Action Areas which receive special attention within the thesis *vis à vis* community participation efforts, are highly differentiated, incorporating social divisions such as class, 'race' and gender which reflect the stratified nature of British society.

The research for this thesis considers the implementation of policy into practice in order to highlight the difficulties of translating such policy directives and to problematise the assumption within government rhetoric that public involvement is straightforward and necessarily empowering for members of the public (DoH, 1998c). The study draws on the literature around policy implementation highlighting the different models of implementation which have been put forward (Pressman & Wildavsky, 1973; Barrett and Fudge, 1981; Sabatier and Jenkins-Smith, 1993), the notion of 'policy windows' (Kingdon, 1995), the important role of 'street-level' discretion (Lipsky, 1980) and the potential for an 'implementation gap' (Dunsire, 1978) to arise.

A discussion of the power differentials amongst 'partners' in the HImP demonstrates the dynamics inhibiting this policy's achievement of its goals of inclusiveness and ownership by local communities. Indeed, power is demonstrated to be a key concept within any study of community participation and different ways of categorising and theorising power are discussed. The thesis does not subscribe to any particular grand or meta-theory but rather draws on a range of 'middle range' theories to inform the key issues and help to answer the key research questions.

By examining the issues relevant to the implementation of this policy, this research provides an example of one locality's endeavour to make 'New Labour's' intersectoral and partnership-based approach a reality. This demonstrates the salience of issues such as power and accountability within partnerships. Whilst it is not possible to generalise from all areas of the case study, many of the issues arising have wider significance given that partnership and participation strategies are central to a broad range of government policies.

### HImPs no more

The Health Improvement Programme (HImP) turned out to be a relatively short-lived policy. Announced in the 1997 White Paper the first HImPs were to be in place by April 1999. However, two-thirds of the way through my field work, in April 2001, it was announced that HImPs were to be restructured into Health Improvement and Modernisation Plans (HIMPs). More detail on what this meant for those working on HImPs and for this study are provided in Chapter Five. Policy succession must be regarded as a typical hazard of undertaking policy research examining a fast-moving, ever-changing policy environment. Moreover, the rapid pace of policy and organisational change within the NHS is itself an important contextual factor for this research and the implications of this for community participation and partnership working more generally are considered in Chapters Two and Six. A drawback of the short life of the HImP is the paucity of published research on this policy. However, community participation is an even stronger theme in national policy now than it was when I began this research. Consequently, the findings from this study are of relevance to a wide variety of individuals and organisations working to implement policies which include partnership relationships and public involvement as key elements.

### Coventry Health Improvement Programme

Coventry Health Improvement Programme was chosen as a case study on the basis of both accessibility and interest. Accessibility is considered to be a legitimate criterion on which to select a site. As Stake (1995: 4) suggests:

> The first criterion should be to maximise what we can learn. [...] Our time and access for fieldwork are almost always limited. If we can, we need to pick cases which are easy to get to and hospitable to our inquiry...

Furthermore, as a Coventry citizen I was particularly interested in identifying the local conditions which enhanced and inhibited the capacity of key stakeholders to involve local people in health planning. I was committed to feeding back my findings to interested personnel within the city to facilitate and enhance local decision-making processes.

As a policy student I also found Coventry interesting politically, economically and socially. Traditionally an industrial working-class city with a powerful traditional 'old-Labour' style local authority (i.e. committed to public ownership and trade unionism, state planning and equality of outcome (Page, 2001)), the local authority had recently re-positioned and restructured itself such that the key politicians and managers within the city may be regarded as subscribing to New Labour principles. The material reason for this shift in philosophy within Coventry is arguably the sudden shock to the city's prosperity in the 1980s resulting from the crash experienced within the manufacturing industry which was the traditional employment-base for a large proportion of Coventry citizens. Consequently, the traditionally powerful unions representing employees within this sector lost much of their power and influence within the local authority. The health authority, though not an elected body, nevertheless followed these principles and at the time of conducting this research may also be regarded as having subscribed to a New Labour philosophy. The local political context and implications of this are discussed in more detail in Chapter Five.

Page (2001: 513) notes that New Labour have an "ideological commitment to the free market not shared by previous Labour administrations" and have a shift of emphasis to equality of opportunity, as opposed to outcome. For Driver and Martell (1998: 3) the New Labour agenda is about balancing "economic success and 'social inclusion', the free market and the community". A more detailed discussion of New Labour philosophy and its impact upon health policy is provided in Chapter Four.

Coventry Health Authority may also be regarded as having subscribed to a New Labour philosophy, espousing their commitment to social inclusion, citizen involvement and local partnerships as strategies for improving health (Coventry Health Authority, 1998). Therefore the case study is of a city in which it was anticipated that the key strategic level personnel within the city would embrace the HImP and the partnership/public involvement agenda promoted by the HImP. Coventry was therefore felt to provide a good test site in which to examine the implementation of this policy. A more detailed examination of the features of Coventry is provided in Chapter Five.

### Wider significance of this case study

This research may be specifically focused on one short-lived policy. However, it has a broader relevance. First, community participation has been identified as central to the *new NHS* modernisation agenda, the tackling of inequalities, increasing accountability within the health service and the delivery of appropriate services (Murray and Greer, 2002). Second, HImPs encouraged community participation on a larger scale than had been seen previously within UK health policy (Strobl and Bruce, 2000). Third, communities have been identified as key partners in the stakeholder approach which is endorsed in a wide range of New Labour policies, as shall be demonstrated in Chapter Four.

There is an increasing interest in community participation in health in the UK, as well as internationally. Indeed, public participation is recognised as a key principle of a modern health system (Meads and Iwami, 2003) and features in health policy across the globe. The literature review for this research highlights the many different methods used to involve the public and examines the theoretical literature underpinning these different approaches. The case study demonstrates how one locality attempted to realise its responsibilities for community participation in the HImP and identifies the practical barriers faced by those seeking to involve the public as well as the factors which helped to facilitate the process. In addition, attention is given to the mechanisms employed to involve socially excluded and disenfranchised communities.

The findings are of relevance to Primary Care Trusts (PCTs). PCTs are the new organisations with responsibility for involving patients and the public in decision making processes about service planning, development and delivery. Furthermore, the Government has announced a whole raft of additional policies and initiatives which advocate community participation since this research was conducted. Consequently, a broader range of individuals and organisations now have to consider issues such as who should be involved, in what decisions, how, and in what capacity. This demonstrates the contemporary relevance of the findings of this thesis.

Finally, there is currently a paucity of literature examining participation in health since the political context has changed with the election of a Labour government in 1997. This thesis adds to the literature available.

### Alford's 'structural interests' framework

Alford's (1975) study of the role of interests and interest groups in health care decision-making examines the dominant role of health care providers, including health professionals and health service managers and officers, relative to the power and influence of the public. This therefore proves a useful framework for this study. Despite Alford's (1975) case study of health system reform in the United States being nearly 30 years old, the structural interests typology utilised in his study are still highly relevant today as a basis for examining the extent to which lay interests may be becoming more prominent. Alford's framework will be examined in more detail in the next chapter. This framework will be applied to the study of community participation in Health Improvement Programmes where statutory sector organisations may be likened to Alford's 'corporate rationalizers' (the *challenging interest*) and the community to *repressed interests*. This research will examine whether the structures introduced in order to involve the public and represent their interests as part of HImPs allowed the repressed interests of the 'community population' to be given a greater influence.

### Key research questions

The key research questions for this study reflect my interest in the impact of the attitudes and values of those responsible for developing the HImP on the participation strategies employed. I was also keen to identify the barriers to participation and the strategies employed to overcome these. The literature review helped me to devise these questions and highlighted the importance of context. I was eager to investigate these contextual influences further and adapted Mohan's (1996) macro-, meso- and micro-level framework to consider the global, national and local pressures for and on public participation. I have concentrated on citizen, rather than user participation. I recognise that this is a continuum but want to focus on citizen, referred to as 'community' and 'public' participation within this thesis, because this is regarded as more difficult to do (Harrison *et al.*, 2002). Within the literature bottom-up participation is strongly contrasted with top-down approaches (Nelson & Wright, 1995), with the former promoted as empowering and the latter often defined in terms of co-optation (Arnstein, 1969). Since HImPs represent a top-down approach to participation I was keen to examine whether such an approach could in fact create the kind of conditions within which participation may be experienced as empowering by members of the public. My research questions span the four categories of questions Ritchie and Spencer (1994) argue that it is necessary to ask within policy research. They define these four categories as:

- Contextual: identifying the form and nature of what exists;
- Diagnostic: examining the reasons for, or causes of, what exists;
- Evaluative: appraising the effectiveness of what exists, and
- Strategic: identifying new theories, policies, plans or actions.

Box 1 below presents the key research questions to be addressed by this research.

**Box 1: Key research questions**

| **Research Questions for the Case Study of Community Involvement in Coventry's Health Improvement Programme** | **Question type** |
|---|---|
| How do those with a responsibility for HImP development and delivery feel about community participation in health planning and delivery? | Evaluative & Contextual |
| What different approaches are adopted within the HImP to involve the wider community? | Contextual |
| What approaches will be used within the future to improve community involvement in Coventry's HImP? | Strategic |
| Why were these strategies adopted/advocated and what do their proponents expect them to achieve? | Diagnostic |
| What factors facilitate efforts to involve the community in the HImP? | Diagnostic |
| What factors impede efforts to involve the community in the HImP? | Diagnostic |
| How important are contextual factors in shaping the form and approach adopted to involve communities in the HImP? | Evaluative & Contextual |
| To what extent can different styles of community involvement across a HImP be identified? | Contextual |
| Can top-down, Government initiated programmes such as HImPs cultivate an environment within which public participation may be experienced as empowering? | Evaluative & Strategic |

## Structure of the thesis

Having introduced the subject area and set out the key research questions to be examined within this thesis the next chapter will review the literature around community participation, power and the implementation of policy in order to ascertain what is known about this topic already and to identify the key issues, problems and ideas requiring further examination. This includes the identification and discussion of the key theories and models underpinning this study.

In Chapter Three I outline the research strategy and methods adopted in order to examine the key research questions. Chapter Four examines the macro and meso policy context within which HImPs were developed in order to describe and assess the place of Health Improvement Programmes within national health and social policy, identify the driving factors behind the introduction of this policy and consider how it fitted into a broader global agenda for health improvement.

Chapter Five examines the local context within which the case study was undertaken, describing the social, economic, political and cultural characteristics of Coventry, the organisation of the HImP within Coventry and the priorities the HImP sought to address. This chapter also describes the political, policy and organisational changes which occurred during the period in which the case study was conducted. This contextual information is considered to be crucial for understanding why and how participation is developed within the locality and for the interpretations drawn from the case study findings. Chapter Six presents the findings to the nine research questions set out in this chapter, drawing on evidence collected within the case study.

Chapter Seven synthesises the findings from the case study with the material from the literature review in order to crystallise the learning from this thesis. Chapter Eight then presents the conclusions with reference to community participation within

Coventry's HImP; participation within HImPs more generally; and implications from these findings for participation within health planning, principally within the NHS.

# CHAPTER TWO

# COMMUNITY PARTICIPATION, POWER AND POLICY IMPLEMENTATION: A LITERATURE REVIEW

## Introduction

In the previous chapter I provided a general overview of the issues to be examined and presented the specific research questions to be addressed in this thesis. In this chapter I review the literature around the three key topics I have identified as relevant for this research: (i) community participation, (ii) power and (iii) the implementation of policy. This literature will be examined in order to illustrate what is already known that is of relevance to the study of community participation in HImPs, determine the theoretical frameworks of significance and identify gaps in the current knowledge.

### *Searching the literature*

I began by undertaking a literature search to try to identify the existing literature of relevance to this study. Five key words/phrases were used to search BIDS and Medline computerised databases. These were: **community development, community participation, citizen participation, empowerment, and Health Improvement Programmes (or HImPs).** Whilst this search found zero publications concerning Health Improvement Programmes the literature around community development, participation and empowerment was vast. I was, therefore, able to revise these initial search terms and concentrate on the literature around **community participation/community development** initiatives relating to

**health**. The University of Warwick library electronic listing was also searched using these terms and a number of key journals identified which were hand searched for relevant articles.

*Critique of search strategy*

It must be recognised that database searching is not an exact science. Carrying out a search necessitates the specification of a set of key words or phrases. In order to make the search relevant it is essential to be specific about the words and phrases used. I began with a range of keywords and selected that these key words were mapped to include all other appropriate thesaurus terms. This search strategy retrieved far too many records covering a wide range of topics and it was obvious that I needed to refine the search terms to narrow the focus to community participation in health initiatives/programmes. This strategy helped me to obtain more relevant information for my research needs. I then used a 'snowballing' technique to identify further references, examining the papers found in the search and identifying other useful sources of information.

Therefore, the types of references included within the literature review were predetermined to a large extent by the search terms I chose and the databases I chose to search. In particular the sheer volume of references I obtained using my initial search terms forced me to narrow my focus which may mean that certain key references, or indeed whole bodies of literature are missed.

Reliance on databases as the key search strategy may also mean that recently published material is not found because of delays in indexing articles.

My first search through the literature highlighted that I had chosen a contentious issue to research and that debates around levels of participation and what constitutes 'community' had been taking place for 20 years.

*The use of electronic sources*

Given the recency of HImPs as a policy (announced in 1997 but with the first HImPs not beginning until April 1999) and the time it takes for authors to get work published it was not surprising that published literature on HImPs was not yet available. Consequently, I decided that a different strategy was required in order to obtain information about HImPs. Policy documentation and planning guidance issued by the Department of Health (DoH) on the development and implementation of HImPs was examined on an iterative basis as and when it was published. Some of this material was gathered from printed policy documentation, but the majority of this information was collected from DoH circulars distributed on the internet. These circulars were accessed through the COIN database: (www.info.doh.gov.uk/doh/coin4.nsf/circulars).

A number of weaknesses have been highlighted in relation to the use of the internet as a research tool. In particular it has been argued that pages used by researchers can disappear within months or even weeks of being referred to and the lack of editorial authority over the contents of many internet sites means that information presented can be misleading, fictitious and may have no date of publication (Newland and Dauppe, 2003). Given that my internet source was an official government website, this research was able to avoid all of these problems.

### *The incorporation of 'grey' material*

As the research progressed, literature on HImPs became available and this was incorporated into my review. In addition this review incorporated unpublished or 'grey' literature, such as individual health authority's HImPs, conference material, information from websites and documentation obtained as a result of attendance at Health Development Agency research meetings for researchers undertaking work related to Health Improvement Programmes.

The main part of my literature review was completed by December 1999 and the key questions for my empirical research, as set out in Chapter One, were identified. Additional relevant literature was reviewed and incorporated into my study as it became available.

## Community participation

As a first stage of reviewing the literature around such a contested area as community participation it is necessary to set out exactly what is understood by these terms. Various explanations of the meanings of the concepts 'community' and 'participation' have been put forward and these will be examined in turn.

### ***Community***

Attempts to define 'community' are not new. Bell and Newby (1971) note that sociologists have been attempting to define community for over two hundred years. However, according to the Penguin Dictionary of Sociology (Abercrombie *et al.*, 1994: 75) the term 'community' is used to mean so many different things that it is "now largely without specific meaning". Indeed, Spicker (1996: 230) suggests that "[t]he idea of community is ambiguous". Taylor (1999: 2) argues that we should not "accept the language of community unreservedly", noting "scratch the surface of community and there are all sorts of contradictions and tensions".

Community can refer to a network of social relationships, a group of people in a specific geographical area, or a group of individuals with a shared agenda, perspective or experience – a 'community of interest'. However it is defined there is usually an assumption that members of the 'community' will feel "a sense of belonging or community spirit" (Abercrombie *et al.*, 1994: 75). Yet, as Smithies and Webster (1998: 79) point out, this is not necessarily the case and those people who are defined as belonging to a particular community "may, or may not, acknowledge membership".

Moreover, in the field of health, Rifkin *et al.* (2000) note that a community is usually defined by outsiders aiming to introduce initiatives/services for a particular group of people, rather than by people themselves. Labyrinth Training and Consultancy (1993) have identified four different ways in which health authorities, the organisation responsible for developing HImPs, use the word community. These are:

i. Communities of interest, for example black and minority ethnic people, carers, older people;

ii. Users of services, for example mental health service users, users of maternity services, patients;
iii. Localities, for example neighbourhoods, patches, estates, villages,
iv. The general public.

(quoted in Smithies and Webster, 1998: 80).

I will be using 'community' in its broadest sense to mean the general public as 'citizens', as opposed to users/patients/carers, who are also to be partners in the HImP. I recognise that within this definition there will be numerous discrete and overlapping 'communities', both geographical and of interest and that 'the public' is a heterogeneous grouping. However, within this study my focus is on the mechanisms developed by those charged with planning and delivering health services to involve all members of the public. Furthermore, this broad definition of community mirrors that found in government documentation on HImPs, the policy which forms the focus of this research. However, as Light (2001) notes, in industrialised nations, participation is most frequently enacted by the better educated and more affluent members of society. Given the Health Improvement Programme's focus on tackling health inequalities particular attention will be given to efforts to involve those most (negatively) affected by these inequalities in health. Social divisions affect the possibilities for participation and special measures may be needed to ensure the participation of socio-economically disadvantaged groups.

### *Participation, Involvement, Consultation*

The word 'participation' is often used interchangeably with words such as 'involvement' or 'consultation'. Participation was chosen as the preferred term for this research as I will refer regularly to Arnstein's (1969) *ladder of citizen participation*, which uses levels of participation as a means of categorising the extent to which activities provide an opportunity for increasing citizen power. As Lupton *et al.* (1998: 46) note: "Arnstein prefers the term 'participation' to 'involvement' precisely because of its emphasis on interaction".

Parry *et al.* offer the following definition of participation 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: 16).

This definition seems too narrow since it excludes direct democracy as a form of participation. However, Gilbert (1987) suggests that there will never be a universally accepted definition of participation. Rather, the meaning alters depending upon the agents involved, the purpose of the participation and the context within which it is taking place. Parry *et al.*'s definition does, however, seem appropriate in relation to participation in Health Improvement Programmes since in this context it refers to the engagement of the public in a programme within which officials have overall control of the decision-making process.

Morgan (2001) suggests that two different perspectives have led to the development of two competing definitions of community participation. The first of these sees "participation as a *means*" (Nelson & Wright, 1995: 1). Participation is this sense is defined by powerful organisations, such as governments or statutory agencies, seeking involvement in top-down initiatives as a way of using community resources (for example labour or local knowledge) to increase effectiveness or efficiency. Alternatively, Morgan (2001) notes that participation may be defined as communities identifying local issues and needs and developing their own solutions to these. Nelson and Wright (1995: 1) describe this as "participation as an *end*", arguing that participation in and control over issues defined by communities themselves may be viewed as a tool for empowering community members who get involved. However, I would suggest that these two perspectives are not necessarily mutually exclusive. As noted in Chapter One, my previous experience of evaluating a health authority initiated project, *Pals in Pregnancy*, found that whilst the women providing support were recruited for their local knowledge and personal experience, (participation as a means), their participation was also recognised as an end in itself and health authority employees sought to support the women in using their participation experience to further their own individual needs and desires, such as to gain employment.

The language of participation is used by a variety of different bodies and has a range of different meanings, from information giving to consultation to substantial support for community-led initiatives. This spectrum of activities classified as community participation has been widely acknowledged (Arnstein, 1969; Smithies and Webster, 1998; Brown, 2000). One of the ways in which commentators have sought to classify these activities is through the development of 'ladders of participation'. A number of variations of the ladder of participation exist with varying degrees of complexity. Arnstein's original ladder developed in 1969 had eight rungs (manipulation, therapy, informing, consulting, placation, partnership, delegated power and citizen control), whilst Charles and De Maio's (1993) ladder only featured three rungs (consultation, partnership and lay domination) and a number of other versions of ladders exist. I have chosen to use Arnstein's ladder as this is the best known and most frequently referred to within the literature. Arnstein's (1969) ladder of citizen participation is presented below:

**Figure 1: Arnstein's ladder of citizen participation**

| **DEGREES OF CITIZEN POWER** |
|---|
| 8. Citizen control |
| 7. Delegated power |
| 6. Partnership |
| **DEGREES OF TOKENISM** |
| 5. Placation |
| 4. Consultation |
| 3. Informing |
| **NON-PARTICIPATION** |
| 2. Therapy |
| 1. Manipulation |

Each rung of the ladder represents different degrees of participation. The higher up the ladder the greater the extent of participatory activity. At the two lowest levels on this ladder, participation (or non-participation according to Arnstein) may take the form of giving approval to decisions already taken by those with power. The three degrees of tokenism include inviting participation and views from members of the public but not guaranteeing that their views will be acted upon. Palfrey (2000) notes that this includes the co-optation of members of the public or user groups to act as representatives within arenas where their views will be marginal and it is unlikely that they will have much chance of affecting decisions. Here participation becomes nothing more than, in Balloch and Taylor's words (2001: 285) "a tool of the established system for incorporation..." Partnership, delegated power and citizen control all refer to degrees of citizen power in which members of the public are able to really influence decision making.

Smithies and Webster (1998) argue that the ladder model demonstrates how different levels are appropriate for different situations and interests. However, from my own personal standpoint, as outlined in Chapter One, I would argue that a higher degree of participation is to be desired. As Morgan (2001: 222) notes, essentially "participation is about power" and it is clear that participants have increasing degrees of power with each rung of the ladder. Indeed, for Lupton *et al.* (1998) a major strength of the ladder model is the fact that it suggests the conceptualisation of participation as a process of development whereby the aim is to keep progressing up the ladder. This frames participation as a long-term course of action, requiring comprehension and commitment.

Burns, Hambleton and Hogget (1994) argue that Arnstein's ladder does not recognise the fact that individuals will be differently placed on the ladder and have differing amounts of power as a result of their participation in different arenas. Consequently, they argue that the single ladder model over generalises in its assessment of the degree of community participation. Furthermore, Palfrey (2000: 28) notes a more general criticism of the use of such analytic tools to classify and evaluate community participation as "prone to adopting a paternalistic approach by imposing on others its own ideological assumptions". Despite these criticisms I feel that the ladder is a valuable tool for classifying participation activities and preferable to the alternative horizontal view of participation as a continuum, from informal, bottom-up participation to coercive, compulsory participation suggested by Morgan (1993).

Jewkes (1995) points out that with 'community' itself so difficult to define, the notion of what constitutes community participation is far from clear. It is these competing definitions and their very different implications which has led Morgan (1993) to argue that participation is 'used' differently by a variety of actors or organisations to advance very different goals. Muller (1991: 26) notes that participation "cannot be defined outside of a social context", with Morgan (2001: 225) continuing that each context has a different meaning in terms of the "social relations and matrices of power through which participation must be effected". I would agree with Muller's emphasis on the necessity of defining participation within a social context. Indeed, this is one of the reasons why I considered a case study to be the most appropriate research strategy as it provides an opportunity to examine participation processes within a specific context.

Dudley (1993) refers to the increasing co-optation of the concept of participation internationally:

> Participation used to be the rallying call of radicals; its presence is now effectively obligatory in all policy documents and project proposals from the international donors and implementing agencies.
>
> (Dudley, 1993: 7).

The same could now be said about national policy in England. Moreover, Murray and Greer (2002: 193) conclude that: "Participation is no longer a radical idea, but is part of a vocabulary which embraces collaboration and cooperation in the drive for a more pluralist polity". Milewa *et al.* (2002) support this claim, arguing that participation is institutionalised in the vocabulary of policy makers who use it in a variety of different ways to suit their purpose. For this reason Murray and Greer (2002) caution against the unquestioning acceptance by some that an increase in public participation activities necessarily indicates an increase in democracy. Since Government rhetoric emphasised the increased accountability and democratisation of the health service resulting from wide participation and ownership of the HImP Murray and Greer's point is significant for this study.

### *The objectives of community participation*

Litva *et al.* (2002: 1826) suggest that public participation 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". Parry *et al.* (1992: 6-16) have identified four reasons for the impulse towards participation: instrumentalist, communitarian, educative and expressive.

- Instrumentalist: participation as a form of promoting or defending the interests of those who participate (e.g. user group involvement);

- Communitarian: participation as a means of advancing the interests of a community (e.g. public involvement in the commissioning of services in a particular locality);
- Educative: participation as a means of developing citizen competence and responsibility,
- Expressive: participation as a means to enhance democracy and allow participants to express their feelings and political identities.

It could be argued that New Labour policies around participation encompass all of these impulses and that the incorporation of public participation is expected to fulfil several objectives, from giving citizens and users a voice in the health care services they receive to building capacity and promoting social inclusion.

A number of objectives of involving communities in health planning have been suggested by Judge *et al.* (1999: 107). These include participation to achieve:

- improved responsiveness to local health needs;
- more sensitive and person-centred health services;
- capacity building within communities;
- more accountable systems of decision-making;
- the reduction of social exclusion,
- the reduction of health inequalities.

Different techniques are employed dependant upon the aims and objectives of involving communities.

The objectives presented thus far have all been positive and set out the potential gains from participation for all involved. However, not all participation is benevolent. As Light (2001: 9) notes: "Public involvement can be democratic, counter-revolutionary, or manipulative". Furthermore, Harrison and Mort (1998: 60) note that public and user participation may be employed as "technologies of legitimation", used by managers to legitimate the decisions taken in what they regard as an "increasingly pluralistic policy agenda". Taylor (1999) suggests that whilst community members are used to add legitimacy to partnerships, they are often excluded from the arenas in which the important decisions are made.

Zakus (1998) notes how participation can be used by governments as a means of providing services without the requirement of additional resources. He notes that this 'resource dependency model' was employed in Mexico during the 1980s. He argues that communities were co-opted to provide services for a resource-lacking government, yet were not given any power to make decisions about how to provide these services. Participation as a form of co-optation is something which could happen anywhere in the world. Indeed, as noted earlier, Palfrey (2000) regards co-optation as occupying a position in the middle of Arnstein's (1969) ladder of citizen participation, within the three degrees of tokenism. Since it is noted in the literature (North and Werko, 2002) that many participation activities never make it any higher up the ladder than the mid-way point, it could be that much participatory activity is little more than co-optation.

## Theories of community participation

The two key approaches to community participation used here are referred to as *consumerist* and citizenship (also called the democratic approach) (Harrison *et al.* 2002; Pickard and Smith, 2001; Klein, 1984).

### *Consumerism*

Consumerism, as the name suggests, conceptualises participation in terms of the rights and duties of individual consumers and is essentially based on the logic of market principles. Within the consumerist framework participation is about ensuring that health care consumers have information, choice and the ability to complain. Examples of consumerist approaches to participation include "the Patient's Charter, Complaints procedures, Consumer Audit and Patients' Participation Groups centred around general practice" (Pickard and Smith, 2001: 171). Consumerism represents an attempt to individualise arguments around the involvement of user groups and the public (Ward and Mullender, 1991), focussing on the individual patient or user group member, rather than on patients and users collectively. The consumerist approach is criticised for not acknowledging the significance of power. As Lupton *et al.* (1998) argue, such individualistic arguments rely on all citizens having equal opportunities to make 'choices' and act as healthcare consumers. This, they argue, does not recognise the wider social, economic and political context within which citizen participation takes place.

### *Citizenship*

Citizenship (or the *democratic* approach) conceptualises participation as a right of all citizens to have an input into decisions which affect their lives. For Pickard and Smith citizenship:

> emphasises the importance of equity and empowerment, with participation being seen as a key concept, and shared decision-making in which citizens are formally engaged with the processes whereby decisions are made.
> (Pickard and Smith, 2001: 171).

Approaches to participation that may be regarded as reflecting the citizenship approach include health panels and citizens' juries.

Harrison *et al.* (2002) note the need to distinguish between public and user participation arguing that public participation is harder to achieve than user participation. Moreover, Klein (1984) argues that participation by consumers (users) is fundamentally different to participation by citizens (the public). It is for this reason that this research is focussing primarily upon efforts to involve members of the public as citizens, as noted earlier. However, Pickard and Smith (2001) warn against regarding the two approaches as mutually exclusive, noting that methods adopted to involve the public can span both approaches. The theory of community participation adopted by an organisation has implications for the practicalities of involving communities. These two theories will be considered in relation to approaches to participation employed within Coventry Health Improvement Programme.

## Models of participation

A number of competing models of participation have been put forward which will be summarised below:

### *The 'community development' ideal type*

Participation approaches characterised by the 'community development' ideal type seek to involve the public but within existing social and economic structures. Areas of work within which participation is sought are pre-defined and participation mechanisms professionally led. It is argued that the myopic focus upon community participation as a means to an end, rather than as an end in itself, characterised by this model is likely to prevent the mechanisms for participation employed leading to the empowerment of those who participate. Within this model participation may be sought as an attempt to satisfy national and/or local requirements (Rifkin *et al.*, 2000).

### *The 'people's participation' and 'empowerment' ideal types*

The 'people's participation' and 'empowerment' ideal types describe community participation strategies which are "concerned with the transformation of oppressive structures in order to achieve equity" (Rifkin *et al.*, 2000: 3) and seek to provide the less equal members of society with the ability, expertise and conviction necessary to tackle these oppressive structures themselves. Within these models participation is conceptualised as an end as well as a means to an end.

### *The 'action research' ideal type*

According to Rifkin *et al.* (2000: 3) the 'action research' ideal type characterises "the application of the more theoretical notions of 'people's participation' and 'empowerment'". Within this model local people are involved in defining what the issues are, who should participate and how to take things forward in partnership with professionals. 'Action research' approaches regard participation as an empowerment process in which individuals develop the solutions, with the support of other organisations, to change their circumstances.

These models may be regarded as representing steps on Arnstein's (1969) ladder of citizen participation, with the action research model representing the upper rungs of the ladder and the community development model representing the lower rungs.

### ***Participation in health care decision making***

As the above demonstrates, participation is a complex concept. In theory at least, participation in health care decision making is clearly encouraged in the UK, although in practice the degree of influence that citizens have upon the final decisions taken is considered patchy (Light, 2001). There are numerous factors affecting the practice of participation including the purpose, the degree to which the senior management teams and front line officers are disposed towards participation as a desirable thing to do and the extent to which they feel capable of implementing and managing public participation. Whilst the need to empower community members and build their capacity to participate has been noted, very little attention has been given to the need for training by managers and staff who work with and seek to encourage participation from communities.

Kahssay and Oakley (1999) point out that in the past community involvement has too often been about involvement in discrete projects. If community involvement in health is to be sustainable, rather than a one-off initiative or programme, participation needs to be developed at the level of local policy-making and planning. In principle, community involvement at the level of Health Improvement Programmes offers this potential.

Participation is often regarded as a means of increasing the democratic accountability of local health services (Litva *et al.*, 2002; Light, 2001, Milewa *et al.*, 1998). As a publicly funded service the NHS should serve and be accountable to all users and potential users. It has been argued that the historical lack of accountability is a primary reason for formalising public participation in decision making (Langton, 1978) and indeed, increased accountability and legitimacy are reasons put forward by government for public participation being a key feature of HImPs.

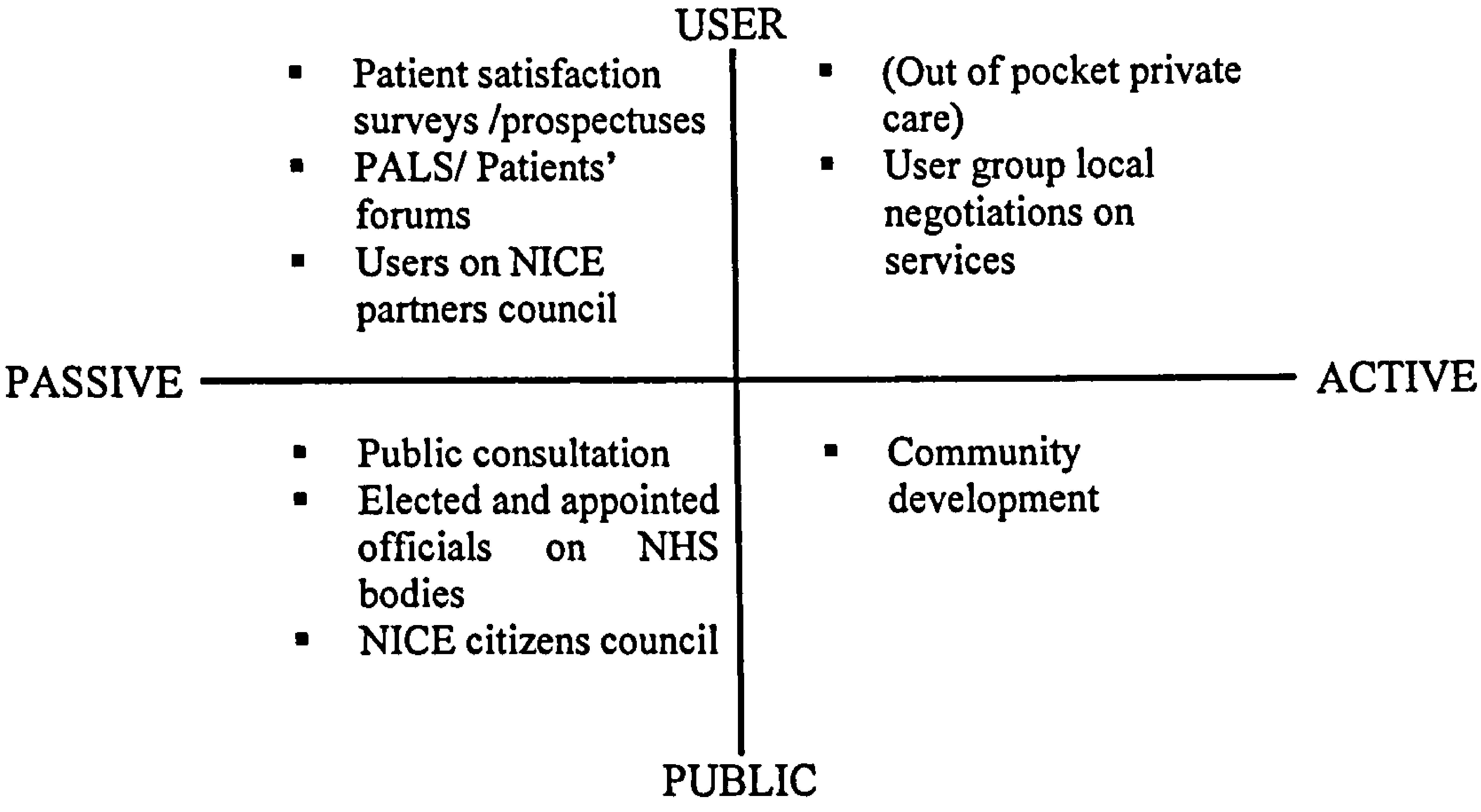
The problem of representation is often discussed in relation to involvement of the general public in health care planning (North and Werko, 2002) and will be considered in my case study by an examination of whose participation is being sought.

### *Participation mechanisms*

The literature concerning community participation discusses a wide range of participation mechanisms, their application for varying purposes and their strengths and weaknesses. A brief summary of this literature will be presented here in order to highlight the range of participation techniques available. This will help to situate the findings from my case study, highlighting and explicating the potential approaches to participation available for use.

It is widely recognised (Harrison *et al.*, 2002; Milewa *et al.*, 1999; Mort *et al.*, 1998) that involvement mechanisms can be split into two categories, what Harrison *et al.* (2002: 64) have termed 'active' and 'passive'. Active involvement requires direct involvement from the public or user groups in making decisions. Passive involvement may take the form of advocacy or involvement through an elected representative. These may also be referred to as direct and indirect participation. Harrison *et al.* (2002) have taken the four categories *public, user, active* and *passive* to develop a 'typology of involvement' as demonstrated below:

**Figure 2** **A typology of involvement (Harrison *et al.*, 2002: 65)**



The emphasis within HImP policy is supposed to be on active involvement in decision making. The type of participation which takes place within HImPs will therefore be examined in order to compare the approaches adopted with the rhetoric around the type of participation which will take place within HImPs.

Murray and Greer (2002: 192) note the range of different techniques employed to involve the community in policy formulation from what they refer to as "traditional" modes of participation such as consultation documents and public meetings, to "customer oriented" techniques such as complaints/suggestions schemes and surveys of satisfaction, through to what they term "innovative" techniques like citizen's panels and community needs assessments. These different methodologies and approaches to involving the wider public are all endorsed by Government in policy documents such as the National Strategy for Neighbourhood Renewal, the New NHS, and the NHS Plan.

Health authorities use a range of participatory mechanisms including consultations and surveys (Strobl and Bruce, 2000), citizen's juries, focus groups and rapid appraisal techniques (Milewa *et al.*, 1998) , so called 'mass' approaches (Mullen, 1999) such as telephone hot-lines, advertisements in newspapers or self completion questionnaires, and citizen's (or standing) panels, to name but a few. Since the purpose of this thesis is to identify the processes involved in enacting community participation in the HImP, rather than to evaluate the outcomes of participatory activity, the strengths and weaknesses of these different approaches is of less interest than the 'political' and organisational decisions the choice to use these mechanisms represents. Consequently, I shall not evaluate the approaches here[1].

Strobl and Bruce (2000) note that health authorities are not always clear and honest about how the information they collect will be used and what degree of influence will be assigned to the views provided by the public should they contradict those held by professionals. If participants often find that their views are not accorded significance in the overall decision making, or if it has not been explained that they are one of many stakeholders whose views are being sought on an issue, then participants will deem their involvement worthless and will not participate in the future.

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[1] The work of Penelope Mullen is excellent in this regard for those seeking a more detailed discussion of the different approaches (see for example Mullen, 1995, 1999).

Furthermore, despite the vast array of methodologies for involving the public which exist, or perhaps paradoxically because of them, many local bureaucrats charged with implementing community participation feel lost and/or overwhelmed. This can be related to my earlier point about the lack of recognition of the need for training for those with responsibility for taking forward participation.

A number of participation 'toolkits' (for example, Burns and Taylor, 2000), frameworks for benchmarking participation (such as that produced by Yorkshire Forward, 2000), and good practice guidelines (for example, HEA, 2000) have been produced during recent years in response to the increased demand for initiatives to involve the public. Whilst these may prove useful in providing examples of 'how to do' participation and serve as a useful checklist of factors to consider it is argued that participation 'blueprints' are unlikely to be successful (Krishna *et al.*, 1997). Rather, the form participation may take is highly dependent upon the local context within which initiatives are developed.

### *Constraints to participation*

Dobbs and Moore (2002) note a number of constraints to community participation. These include:

- the constraints of national policy;
- tensions in partnership structures;
- commitment to community involvement, and
- the capacity of the community to get involved.

In particular they note that the necessary time and resources required to support a bottom-up approach to community participation does not exist within statutory public sector agencies, even where the will exists. Indeed, HImPs will not adopt a bottom-up approach to participation. As a government initiated programme, led by statutory agencies, HImPs are an example of a top-down approach to involving the public. This research will therefore concentrate on identifying the constraints faced by those seeking to involve the local community in the development of the HImP.

Morgan (2001: 222) notes that many are uncomfortable with the fact that community participation is rarely a spontaneous effort by disadvantaged communities and often requires "outside prompting". Moreover, she argues that "marginalized or disenfranchised communities are powerless to effect participation precisely because they have no power..." (Morgan, 2001: 222). This is in sharp contrast to the argument put forward by Muller (1991: 16) that participation requires no prompting. Rather, he suggests that participation is a reaction against the state by marginalised citizens and that community-based initiatives are manifestations of the unequal power held by certain sections of society and may be regarded as forming part of a survival strategy. HImPs clearly reflect the argument put forward by Morgan. They are based on national government logic that assumes that state organisations need to take responsibility for ensuring their work incorporates the views of and is accountable to local people.

The literature reviewed has demonstrated the contested nature of concepts such as 'community', 'participation' and other concepts underpinning HImPs as well as other contemporary policy initiatives that prioritise the active engagement of community groups as a means of achieving policy objectives. The literature has also highlighted the overwhelming support for community participation in principle. Indeed, Harrison and Mort (1998: 66) conclude that: "Being in favour of public participation is rather like being against sin; [...] it is hard to find disagreement". My case study will examine the practice of community participation and compare this to the rhetoric outlined in relevant national policy documents, supporting guidance documents and local HImP documentation.

### Power

As the above discussion has demonstrated, any examination of community participation inevitably has to address the issue of power. Indeed, Atkinson and Cope argue that:

> Community participation involves forms of community power. Consequently, understanding community participation requires an understanding of power relations between a state agency and its 'publics'.
> (Atkinson and Cope, 1997: 207).

Power amongst citizens is also differentially distributed as a result of the social stratification of 'the public'. Class, gender, 'race', disability, sexuality, language, age and religion are just a few of the many factors which determine, to a certain degree, the amount of power held by citizens. An individual's power also varies depending upon the forum within which they participate.

HImPs start from the premise that participation is not only desirable for public agencies in terms of making services more appropriate and more accountable, but that the public will also *want* to participate in its development and delivery. However, this simplifies participation and does not take into account the differences in power amongst the many stakeholders forming the HImP partnership. An acknowledgement of the power relations and development of strategies to overcome power differentials are essential elements in efforts to ensure effective public participation. The type of participation strategies employed within HImPs directly relates to the amount of power the HImP partnership is allowing the public to have over HImP decisions. The impact of power relations and the amount of power devolved to citizens within the planning and delivery of the HImP will be examined in more detail within the case study. As Arnstein's (1969) *ladder of citizen participation* demonstrated, the higher up the ladder participants go in terms of degrees of involvement the more power they have within decision-making. Moreover, she argued that:

> Citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have-not citizens [...] to be deliberately included in the future.
>
> (Arnstein, 1969: 216).

It is a paradoxical fact that community participation is often recommended as a means of bringing the most marginalised members of society back into the mainstream (Taylor, 1999; Klein, 1984).

**Models of power**

Within partnership based policies such as Health Improvement Programmes a number of different organisations work together to develop and deliver the policy.

However, power is not distributed equally amongst the participating organisations and individuals within the partnership in terms of their relationship to that policy. In order to consider the impact of this differential distribution of power it is important to briefly examine the key models of power found in the literature: the pluralist model, Marxist approach (including elite theory) and the structuralist approach.

### *Pluralism*

The *pluralist* model of power argues that power is widely distributed across society, but not equally. Pluralists argue that there is no one dominant group which holds all of the power and no group is totally devoid of power (Barker, 1996). Pluralists argue that all groups have the opportunity at some point to influence decision making (Ham, 1999). Clegg argues that:

> It is not that pluralists deny the existence of elites: they simply see them as more dispersed, more specialized and less co-ordinated than would elite theorists.
>
> (Clegg, 1989: 9).

This position has been widely criticised as not recognising the relative strength of certain groups in comparison to others and for being naïve in believing that all have equal opportunities to exert power. Furthermore, Bachrach and Baratz (1970) critiqued the pluralist approach for ignoring the manifestation of power through deliberate attempts at keeping issues off the agenda. This concept of 'non-decision-making' (Bachrach and Baratz, 1970) refers to the extent to which powerful organisations, for example nationally the government or locally the health authority, are able to "limit the scope of actual decision-making to 'safe' issues" by, for example, setting the agenda within which community participation is sought (Frederickson and Schluter O'Leary, 1973: 10).

### *The Marxist approach*

The *Marxist* approach to power may be regarded as directly responding to criticisms of the pluralist approach. Marxists recognise the vast differences in power between interest groups. For Marxists, power is held by the economically dominant class within society (Ham, 1999), in effect those who own the means of production. Marxists argue that the "dominant social classes [hold] the ultimate power to serve their own interests and suppress less powerful social classes" (Palfrey, 2000: 17). The *elitist* model may be regarded as drawing on the Marxist approach. However, elitists believe that the ruling class is made up not only of owners of the means of production but also includes a political elite as well as members of the aristocracy, military, business and bureaucratic elites (Barker, 1996). Ham (1999: 204) criticises Marxist approaches to power for their inability "to explain the processes of policy-making and implementation".

### *The structuralist approach*

Alford's (1975) *structuralist* approach identifies three sets of structural interests: dominant, challenging and repressed. *Dominant interests* are groups whose interests are served by current social, economic and political structures and who seek to preserve the status quo (Barker, 1996). *Challenging interests* are groups who seek to challenge current structures, recognising that their interests may be better served by changing the existing structures (Ham, 1999). *Repressed interests* are those whose interests are not being well served (Alford, 1975: 15). Struggles between these structural interests reflect efforts to influence decision-making, thereby exercising power. Ham (1999) argues that the structuralist approach incorporates some of the strengths of pluralism, for example by acknowledging the range and multiplicity of pressure groups activities and power, as well as encompassing Marxist observations on the way in which interests may be kept off the agenda and fundamental conflicts between interests concealed. However, a deficiency within this theory is that Alford's *repressed interests*, who within his 1975 study of the role of interests and interests groups in health care decision-making in New York represent those of the 'community population', are recognised as being heterogeneous, Alford does not discuss in detail the power differences amongst community members. Ham suggests these theories of power should not be regarded as alternatives, rather as complementary theories, each of which provides useful insights. However, he concludes than none of these theories can provide a complete account of power.

For my study of community participation in HImPs Alford's structural interests theory, which suggests that interests in health care can be classified into three major groupings: dominant, challenging and repressed, provides a useful framework for analysing the different interests involved in decision-making related to the HImP, their aims and objectives and the way in which their power is structured. Structural interest theory also appealed since it was developed using the findings from a local case study of the role of interests and interest groups in health care decision-making in one locality - New York, a similar methodology to that employed for this research. That Alford identified 'the community population' as a repressed interest, competing for power and influence against health service managers and health care practitioners, also has parallels with my own research area and approach.

Walton (1968) identifies four categories of power relating to styles of leadership:

**Box 2: Categories of power**

(i) Pyramidal - a monolithic, monopolistic, or single cohesive leadership group;

(ii) Factional – at least two durable factions compete for advantages;

(iii) Coalitional – leadership varies with issues and is made up of fluid coalitions of interested persons and groups,

(iv) Amorphous – no persistent pattern of leadership or power exercised on the local level.

(Source: Frederickson and Schluter O'Leary, 1973: 9).

This categorisation will be considered in relation to HImPs. I would speculate that partnership-based programmes such as HImPs will either rely on negotiations amongst all partners leading to a consensus (i.e. coalitional or amorphous styles of leadership), or on the dominant powerful elites advocating a particular position and other partners agreeing to this view on what and how outcomes should be delivered (a pyramidal style of leadership). This will be examined within the case study. Whichever style of leadership is adopted the result is that policy is redefined in line with the interests of those who deliver it.

Two key concepts of relevance for this study are those of *strategic power* and *operational power* (Hart *et al.*, 1997: 189). These refer to the ability to influence long-term, policy-level decisions (strategic), as opposed to power to influence day-to-day service level decisions (operational). What type of participation is encouraged within the HImP and how this equates to the level of power participants are able to exert within the decision-making process will be examined closely within the case study.

As this discussion has demonstrated, the issue of power is fundamental to any examination of community participation. Explanations for the differential distribution of power have included the pluralist, Marxist and structuralist approaches as well as Walton's categorisation of power based on different leadership styles. Of particular relevance to participation are the concepts of strategic and operational power. These refer to the arena within which participation is sought and the influence each arena allows participants to exert over the decision-making process. All of these explanations will be considered in relation to community participation in Health Improvement Programmes.

Having reviewed the literature around community participation and power it is necessary to consider another issue of importance to this research - policy implementation. This thesis, by examining a policy in practice is fundamentally examining the issue of policy implementation. Consequently, a brief, selective overview of the literature appertaining to the concepts paramount to the study of policy implementation will now be provided.

## Policy Implementation

Policy implementation literature tends to categorise implementation into three models: (i) top down models, in which policy is made in one place and implemented in another (Pressman & Wildavsky, 1973); (ii) bottom-up models, which regard policy as being implemented by individuals within organisations who often have considerable discretion as to the manner in which the policy gets implemented (Lipsky, 1980); and (iii) models which integrate the top-down and bottom-up arguments (Sabatier and Jenkins-Smith, 1993).

These three models will be examined for their applicability and usefulness in illuminating and providing an understanding of the problems of implementing community involvement in the HImP.

*(i) Top down models*

Top down models of policy implementation have tended to regard implementation of policy as separate from policy making (Pressman and Wildavsky, 1973). The emphasis has tended to be on describing the conditions for 'perfect implementation' through the development of ideal-type models and then examining the constraints which lead to deviations from this ideal-typical model. For example, Hood (1976) sets out 10 preconditions which would need to be satisfied if perfect implementation were to be achieved. These have been summarised by Hogwood and Gunn (1984) and are set out in Box 3 below:

**Box 3: Preconditions for perfect implementation**

1. Circumstances external to the implementing agency do not impose crippling constraints.
2. Adequate time and sufficient resources are made available to the programme.
3. Also at each stage in the implementation process the required combination of resources is actually available.
4. The policy to be implemented is based on a valid theory of cause and effect.
5. The relationship between cause and effect is direct and there are few, if any intervening links.
6. There is a single implementation agency which need not depend upon other agencies for success.
7. There is complete understanding of and agreement upon the objectives to be achieved.
8. In moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant.
9. There is perfect communication among, and co-ordination of, the various elements or agencies involved in the programme.
10. Those in authority can demand and obtain perfect obedience.

(Abstracted 'headlines' from Hogwood and Gunn's (1984) detailed discussion of pre-conditions for perfect implementation spanning pages 199-206)

Top-down models assume that if these conditions are met then the policy will be successful. HImP policy, promoting public participation in the planning of health services, would never meet these criteria, relying as it does on interagency working, flexibility and iterative developments required to respond to a continually changing local and national policy context. However, it is widely accepted that 'perfect implementation' is not possible (Hogwood and Gunn, 1984; Barrett and Fudge, 1981; Exworthy *et al.*, 2002) and that the reality of implementation will never mirror ideal-typical models.

The top-down model is criticised for assuming that if the pre-conditions for perfect implementation are met the policy will automatically be successful. It does not recognise the influence of those delivering the policy (Palfrey, 2000) or the fact that the logic underpinning a policy may be flawed. The latter is referred to by Hogwood and Gunn (1984) as '*unsuccessful implementation*':

> Unsuccessful implementation [...] occurs when a policy is carried out in full, and external circumstances are not unfavourable but, none the less, the policy fails to produce the intended results (or outcomes).
> (Hogwood and Gunn, 1984: 197).

### *(ii) Bottom-up models*

Critics of the top down approach in which implementers are conceptualised as 'agents' of policy *makers* (Barrett and Fudge, 1981) have developed bottom-up theories of policy implementation. These theories challenge the view that policy is formulated by politicians (and political bureaucrats) and implemented by other bureaucrats and acknowledge the important role played by those involved in policy implementation. For bottom-up theorists policy is implemented by a number of actors and agencies, rather than being the domain of one organisation. They argue that as a result, it is essential to examine the interactions between the various actors as well as the interorganisational relationships necessary if agencies are to work together.

Bottom-up theorists have also noted the fact that frontline staff often have considerable discretion in how they apply policy. In effect policy is remade in the process of delivery (Lipsky, 1980). Lipsky argues that public sector organisations, which would include health authorities and local authorities, the two major organisations with a role to play in HImP development, can be labelled as 'street-level bureaucracies', with a large proportion of their workforce being made up of 'street-level bureaucrats'. He defines street-level bureaucrats as public service workers with discretion over the implementation of policy and notes how policies become reshaped at the point of delivery as a result of the discretionary activities of these street-level bureaucrats, often struggling to balance competing pressures such as limited resources (Palfrey, 2000). Thus the distinction between policy making and implementation can be artificial. Barrett and Fudge (1981) state that policy making and implementation are intricately linked in an iterative process involving negotiations and deals in order to find a compromise and reach agreement. Indeed, as Hogwood and Gunn note:

> there is no sharp divide between (a) formulating a policy and (b) implementing that policy. What happens at the so-called 'implementation' stage will influence the actual policy outcome.
>
> (Hogwood and Gunn, 1984: 197).

According to Lipsky (1980: 25) those who wish to understand policy implementation should focus upon the actions of policy deliverers, rather than formal policy makers.

*(iii) Integrated models*

Neither the top-down nor the bottom-up approaches are considered sufficient to explain policy implementation (Palfrey, 2000; Sabatier 1986), focussing primarily on the important role of the policy makers (top-down) or alternatively on the important role played by those who delver policy (bottom-up). Recognition that both national policy makers and local policy deliverers have influence upon the shape of the final policy which gets implemented has led to attempts to produce an integrated approach (Sabatier 1986; Sabatier and Jenkins-Smith 1993). One such example is the Advocacy Coalition Framework developed by Sabatier and Jenkins-Smith (1993) which strives to understand policy change. An advocacy coalition may comprise actors from any sector - statutory, voluntary, community, private, political and academic – whom:

> Share a set of basic beliefs (policy goals plus causal models and other perceptions) and who seek to manipulate the rules, budgets, and personnel of institutions in order to achieve goals over time.
>
> (Butler Flora *et al.*, 2003: 48).

The Advocacy Coalition Framework recognises that policy formation is not a linear process. In contrast policy formation is regarded as cyclical and interactive, and as being influenced by actors involved at all points in its development and delivery.

Powell *et al* (2001) suggest that for a policy to be successful it must have "clear objectives, mechanisms which achieve those objectives, and resources to finance these objectives", and use Kingdon's (1995) model of 'policy windows' to demonstrate the importance of connecting these three issues. According to

Kingdon the first barrier to be overcome is getting the issues recognised as important enough to warrant tackling.

### ‘Policy windows’ and the implications for participation

Crucially, Morgan notes that:

> Participation can be sustainable only as long as the relevant actors remain committed, and the socio-political and economic environments remain conducive, to the process.
>
> (Morgan, 2001: 223).

This is a factor not only relevant to participation. All forms of policy have a limited life and the opportunity to act upon these policy interests occurs, according to Kingdon (1995), in discrete policy windows. Kingdon’s model is based upon three streams: problem, policy and politics which, he argues, need to accord and coincide in order to create change and allow a policy window to open.

For the participation policy window to open community participation would need to be recognised by both government and local agencies as a problem, needing further development, or as a solution to another problem, for example to tackle inequalities in health, accountability issues or service responsiveness. Participation must be viewed as a viable and feasible policy initiative to introduce to address the identified problems and must accord with the values of the government and local agencies. Finally, participation must be seen as a politically viable policy to introduce. However, as Exworthy *et al.* (2002: 80) note, “once issues are on the agenda, an ‘implementation gap’ between national objectives and local action is likely”.

### The 'Implementation Gap'

Milewa *et al.* (1999) highlight the difference between policy as discourse and as reality. This 'implementation gap' (Dunsire, 1978) and reasons for its existence has been the subject of research since the late 1970s. One explanation is that policy implementation at the local level is the outcome of negotiation between national policy makers and those charged with delivering policy at the local level (Barrett and Fudge, 1981).

The existence of 'street-level bureaucrats' (Lipsky, 1980) and their possible influence upon policy implementation is an important issue for this study. For example, national policy dictates that the public are to be involved in HImPs but leaves the determination of appropriate strategies for ensuring public participation to the discretion of local actors. Ham (1999) notes that this is typical of New Labour health policy which takes the form of a framework, rather than a blueprint for implementation, thus allowing local discretion in how policies are implemented.

Exworthy *et al.* (2002) note that the discretion held by local agencies in reinterpreting national policy directives according to local organisational and individual priorities and attitudes, leads to the difference known as the 'implementation gap'. For them, this serves to demonstrate the fact that 'perfect implementation' is not possible.

Hogwood and Gunn (1984) document two facets of the implementation process which may be cited as causing an implementation gap. These are non-implementation of policy and unsuccessful implementation of policy. Unsuccessful implementation, as described earlier, refers to policies which despite being implemented by highly competent people in favourable circumstances do not produce the desired outcomes. Non-implementation, however, is described as resulting from uncooperative or inefficient individuals being in charge of the implementation process, or when these individual's "best efforts could not overcome obstacles to effective implementation..." (Hogwood & Gunn, 1984: 197).

John (1998) also highlights the difficulties associated with policy implementation, especially policies which require the management of complex interorganisational relationships. He notes that:

> What appears to be a neutral and straightforward mechanism to translate intentions into reality is in fact a complex matrix of public, quasi-public and private decision-making bodies, all of which are involved in the policy process but which have their own autonomy, interest and values.
>
> (John, 1998: 27).

As a result, John suggests that policy making and implementation involves a series of trials, adaptations and retrials. This is an interesting point in relation to the shift of policy around HImPs and will be examined in detail within my discussion of the case study findings.

The nature of policy implementation may also be regarded as reflecting the balance of power between central government and local agencies, thus representing a response to the policy making climate. With regards to the implementation of New Labour health policies Lee (2001) suggests that a recentralisation of political authority under New Labour means that central prescription has replaced negotiation around implementation. I would suggest that this central prescription and political authority over health policy favoured by New Labour is a paradox. For all New Labour's central prescription of objectives and targets there remains considerable autonomy and discretion as to how these get translated locally. Despite the fact that New Labour's push for universality has led to the development of a number of national standards, for example government floor targets and National Service Frameworks in specific areas of health policy, this will not automatically preclude discretion in local implementation.

### *The notion of interdependence*

Each partner in the HImP is likely to have at least some discretion over implementation and some bargaining power in its relationship with the others. Hogwood and Gunn (1984) note that where more than two organisations are involved, the scope for discretion may be higher because, for example, alliances and understandings can be used as levers on others. HImPs all have numerous partners representing a diverse range of organisations. Whilst it is recognised that each partner organisation has different resources and differing levels of power, this does not exclude the likelihood that each organisation is dependent on the other partner organisations for key aspects of implementation. This is referred to as 'interdependence'.

It is also worth considering the concepts of 'policy termination' and 'policy succession' (Hogwood and Gunn, 1984). It is rare that policies continue unchanged. Policies may be terminated as a result of their success in tackling the problem they were introduced to correct or if it is felt that they increase the problem (de Leon, 1978). However, as Hogwood and Gunn (1984) note, complete termination of a policy is very uncommon. Rather, policy refinement is the more typical response, in which policies are adjusted to be more appropriate to tackling the problem or to make them more relevant if the problem or context changes.

According to May and Wildavsky (1978), a major problem is the fact that policy makers advocate a particular policy alternative as though success were certain. It could be argued that this is what New Labour has done with community participation, given the inclusion of this concept in a wide range of health and social policies. However, public involvement is a feature of policy in many countries throughout the world that are seeking to modernise their health care systems (Meads and Iwami, 2003). Moreover, its promotion by the World Health Organisation as an important feature of health service planning and delivery indicates that participation is more than a whim of New Labour. Nevertheless, May and Wildavsky's (1978) argument that the language of policy success is employed, often without the evidence to back up the claims made by policy makers is an important one. This can lead to what Edelman (1977) described as 'rhetorical policies' – "words that succeed and policies that fail" (Powell and Exworthy, 2001: 21). Whether community participation in the HImP could potentially be such a 'rhetorical policy' is of considerable interest. However, the impact of community participation upon the HImP and whether it has the potential to match the government's claims that participation will lead to increased accountability, more appropriate services et cetera is not the focus of this study. This is an important question warranting its own research study.

## Conclusion

This chapter has considered three key areas of relevance to the study of community participation in Health Improvement Programmes: community participation, power and the implementation of policy. I have set out the main theoretical debates around these topics and sought to relate these to the concerns of the current study. The importance of understanding debates around power for any study of participation has been established and the many ways in which policy may be affected and reshaped by those involved in its design and delivery illustrated. This review of the literature provides the context within which to review my own findings on the challenges and dilemmas faced by those seeking to develop community participation in Health Improvement Programmes. Furthermore, this literature review helped to inform the direction of my empirical research and helped me to clarify and refine the questions I was keen to ask within the case study. The next chapter will describe the case study research strategy adopted and discuss the methods employed within the case study.

# CHAPTER THREE

# CASE STUDY RESEARCH STRATEGY

## Introduction

In this chapter I will set out the case study research strategy employed and provide a reflexive account of the research process. Chapter One included a discussion of how my interest in community involvement in HImPs developed, my prior experience of community involvement in health and how this impacted upon the type of questions I wished to pose. Chapter Two subsequently provided an overview of the literature utilised to help identify and/or refine my key research questions. This chapter deals with the empirical research undertaken in order to investigate those questions. However, it is important that my personal interest in the subject, political commitment to public involvement in policy making and the promotion of health improvement in general, as well as for the citizens of Coventry specifically, as set out in Chapter One, are re-iterated here. These personal factors may be regarded as influencing my approach to conducting this research and to the type of questions for which answers were sought. As Stanley and Wise state "the researcher is also a subject in her research and [...] her personal history is part of the process through which 'understanding' and 'conclusions' are reached." (Stanley & Wise, 1993, cited in Maynard, 1994: 16).

## Case study research strategy

I decided that the most appropriate way of examining the issue of community participation in HImPs was to undertake a case study. The emphasis of my research is on examining process issues in order to understand how community participation within Health Improvement Programmes works in practice. HImPs are complex partnership arrangements which incorporate many different individual and organisational stakeholders and have a wide remit of addressing both national and local priorities. My focus on processes in what Bowling (2002: 404) defines as a "complex social setting" means that a case study approach is the most appropriate research strategy to investigate these issues (Bowling, 2002). Moreover, both Robson (1995) and Yin (1994) state that the case study is the most suitable strategy for undertaking studies of contemporary 'real life' events in which multiple sources of evidence will be collected. As this thesis investigates real life implementation of community participation this lends further weight to my choice of using a case study approach.

Within the case study I aimed to identify the factors that facilitated and inhibited community participation given that there was a formal requirement to involve the public. I also sought to describe how the presence or absence of these factors shaped community participation. I examined the mechanisms and strategies employed to involve the community and the rationales behind the use of these strategies. The conditions within which the programme was being implemented and the dynamics and power relations between the actors involved were also key elements of this study.

Consequently, this research does not follow the pattern of many of the previous studies discussed within the literature, which seek to identify an 'ideal type' model or participation mechanism which is then promoted as the most appropriate strategy to be utilised by others. Rather, it seeks to identify the various factors which influence how participation is developed locally and examine how these contextual factors may lead to tensions between national policy and local practice.

A single case study approach was adopted as HImPs are implemented in each health authority area and are all qualitatively different. Whilst each HImP is to include the four national priorities set out in *Our Healthier Nation* (Department of Health, 1998c) of Coronary Heart Disease and Stroke, Cancer, Mental Health and Accidents, they were also to reflect local needs and priorities. Furthermore, HImPs were to be partnership based, drawing on key local stakeholders from statutory, voluntary, business and community organisations in the locality. Accordingly, the development and implementation of each local HImP and the strategies adopted to promote the involvement of local communities in each HImP was also expected to vary. Moreover, in a study examining processes and rationales context is very important and will impact upon the strategies employed in a locality (Brown, 2001; Taylor, 1999; Beresford and Croft, 1993). Therefore a single case design was utilised.

Furthermore, as HImPs were continually being refined, an in-depth examination of one locality provided me with the opportunity to engage closely with the case study site and key stakeholders within the locality. This proved to be essential for me to keep abreast of developments within the site. Conducting a single site case study allowed me to examine the many contextual factors that influenced the implementation of this policy, providing rich data with which to answer my research questions.

The case study was based on the examination of issues (for example, factors affecting participation possibilities, strategies employed to involve the public and the rationale behind them, power within organisations and partnerships and its impact upon participation) and these issues were used to inform the research questions considered within the study. Such an approach is also favoured by Stake who argues that:

> I choose to use *issues* as conceptual structure – and issue questions as my primary research questions – in order to force attention to complexity and contextuality.
>
> (Stake, 1995: 16).

The purpose of case studies is to examine a single case in great detail. Stake (1995: 1) argues that: "We are interested in [case studies] both for their uniqueness and commonality". It is argued that by getting to understand a single case well we can begin to develop a more widespread comprehension of the issue under examination (Bowling, 2002), in this case, community participation in Health Improvement Programmes. This is not to argue that case study findings are easily generalisable. However, as Stake (1995: 85) notes "people can learn much that is general from single cases". In attempting to gain a more general understanding of this issue the case study presented here may be regarded as what Stake (1995: 3) refers to as an "instrumental case study".

Using Alford's (1975) structural interests framework, within this case study I sought to examine whether the mechanisms and/or structures developed to facilitate community participation in the HImP allow members of the public, particularly those who have traditionally been marginalised (Alford's 'repressed community interests') to be taken into account. I therefore examine whether the structures put in place are adequate to incorporate these interests. The community is just one focus influencing HImPs. There are many other factors influencing health planning which may prevent community involvement.

To summarise, the ***aims of the case study*** were to:

**Box 4: Aims of the case study**

- Explore the processes of developing community involvement in the local HImP
- Identify the strategies employed to involve communities in the development of the local HImP
- Explore the rationales behind the choice of community involvement strategy
- Consider the different perspectives of partners in the development of community involvement in the HImP
- Identify and share the difficulties partners face in involving the community in the development of the HImP

My key research questions for this study were set out in Chapter One. These questions formed my case study questions, for which answers were sought through primary data collection within the case study site. These research questions were selected to reflect my interest in the decision-making processes and practicalities of attempting to implement community involvement in a HImP. They should provide an insight into the relevance of context, both in terms of the wider national policy arena and local characteristics which impact upon community involvement, the significance of local attitudes and expectations around community involvement. It is also hoped that the answers to these questions will highlight the macro and micro opportunities and constraints facing those charged with involving 'the community' in HImPs and the resource implications of policies requiring public involvement.

## Conducting the case study

The empirical research for the case study in this thesis was undertaken within Coventry between January 2000 and February 2002.

### *Field Procedures*

Gaining access to key organisations and interviewees

A meeting was held on 26th January 2000 with the Director of Health Development in charge of Coventry's HImP and after a preliminary discussion about my research she stated that she would be willing for Coventry to become my case study site. She felt that being open and transparent about the HImP process would be good and that having an independent person observing may actually make those responsible for Coventry's HImP take the process more seriously and work harder at it (thereby introducing a positive observer effect). She explained how the HImP priorities were taken forward and how those in charge of implementing each chapter of the HImP met together quarterly at HImP Steering Group meetings. The names of those leading on each area of the HImP were given to me along with the details of the organisation they worked for. A copy of the topic guide for the meeting can be found in the appendices (Appendix A).

The Director of Health Development invited me to attend the next Steering Group meeting in March and present my research plan to the rest of the Steering Group members in order to gain their collective consent and identify and recruit any potential interviewees. I wrote a brief description of the aims and objectives of my study along with my contact details in case anyone had any queries about the proposed research and this was circulated prior to the March 2000 meeting along with the agenda and other official Steering Group documentation. I then gave a brief presentation on my research at the Steering Group meeting and asked if all partners were happy to support the Director of Health Development's decision that I should be allowed to make a case study of Coventry's efforts to involve the community in the HImP. All partners consented. I arranged with the Director of Health Development's secretary to add my name to the circulation list for all documentation to be dispatched to members of the HImP Steering Group and to ensure I was notified of all Steering Group meetings. This worked at times. I received notification via this route of approximately 60% of the meetings that I attended. At other times, particularly if I had not received any communication for a month, I took it upon myself to phone the secretary and find out when the next meeting was to be held. She would then make sure that I received all of the information for the meeting on the day. Steering Group meetings were held approximately every 3 months throughout the period March 2000 to February 2001.

### Data collection strategies

I carried out a multi-method case study employing a number of methods of data collection: observation, interviews, questionnaires and documentary analysis. A description of whom and what was studied using each of these methods as well as the advantages and disadvantages of each method will now be examined.

#### Observation

Observation was used to obtain qualitative data on the general policy and political context within which the HImP was developed, to provide an understanding of the issues involved in partnership working and to examine the HImP decision-making process 'in action'.

Bowling notes that observation can be a key method used as part of a case study because:

> Observation of behaviours, actions, activities and interactions is a tool for understanding *more* than what people say about (complex) situations, and can help to understand these complex situations more fully.
>
> (Bowling, 2002: 358).

My observation of meetings relevant to the Health Improvement Programme included a number of different forums. A total of five HImP Steering Group meetings were observed during a one-year period between March 2000 and February 2001, whilst three different HImP Development Groups meetings were observed between November 2000 and January 2001.

I adopted an 'informal information gathering' (Robson, 1995: 194) approach to my observation, recording all information that I felt was of relevance to this study exactly as it occurred. In reality this amounted to at least 95% of all activity being observed. The only information which I deemed not relevant was one-off presentations to the HImP Steering Group such as a presentation on health in the workplace. I found that almost everything that occurred within the Steering Group and Development Groups had relevance to this study. Although only a very small percentage of this was directly related to community participation I found that my observations of the relationships between partners, manifestations of power, the representation of different organisational cultures and so forth all had relevance and all impacted upon the way in which community participation in the HImP was implemented.

Bowling (2002) suggests that one of the strengths of observation as a method of data collection is that it is not dependent upon the agreement of participants to be interviewed, complete questionnaires or upon reliable documentation on the subject of interest existing. Moreover, observation can be used to supplement data collected using other methods. As Robson suggests, the directness of observation:

> contrasts with, and can often usefully complement, information obtained by virtually any other technique. Interview and questionnaire responses are notorious for discrepancies between what people say that they have done, or will do, and what they actually did or will do.
>
> (Robson, 1995: 191).

As my findings and discussion chapters will demonstrate, observation proved to be a particularly successful method within this study for precisely this reason. Furthermore, using a multi-method approach meant that I was able to analyse the findings from my observations in light of my findings from the interviews, documentary analysis and questionnaires.

However, observation has its limitations. The first of these is the reactive or 'Hawthorne' effect. This is where the observer's presence affects the behaviour of the individuals or groups being studied, thereby introducing 'observer bias' into the study (Bowling, 2002; Robson, 1995). Second, the very nature of observation, which requires considerable amounts of time in the observational setting and negotiated access to events and situations means that it is limited to use on a small number of cases (Bowling, 2002).

## Interviews

The strategies being employed to involve the public in the HImP in the case study site were identified through semi-structured interviews with members of the HImP Steering Group with responsibility for leading the development of the local HImP. Following my presentation about my research at the HImP Steering Group meeting in March 2000 I wrote to each member of the Steering Group individually asking them if I may interview them to discover what, if any, mechanisms they were employing to ensure the involvement of the public in the development of the HImP. 15 of the 17 members of the Steering Group agreed. One voluntary sector and one local authority member declined saying that they had had a minimal role with the HImP to date and did not feel that they would be able to answer my questions. Of the 15 HImP Steering Group members interviewed all 13 of the HImP Development Group (implementation) leads were included. Where possible I carried out the interviews face-to-face at the interviewees' place of work (12 out of 15). Robson (1995: 229) notes that: "Face-to-face interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives" and as such are preferable to telephone interviews. However, if the respondent preferred to be interviewed over the telephone this approach was used instead (3 out of 15). All of the interviews with members of the Steering Group were conducted between July and December 2000. Those interviewed represented the following organisations:

- Health Authority;
- Local Authority;

- Community Health Council;
- Voluntary Service Council,
- Race Equality Council.

The value of interviews for researching complex issues which may need to be explored in detail is noted by Petchey (2000). I chose to use semi-structured interviews to gain a more detailed understanding of the experiences, feelings and aspirations of those involved with the HImP. An interview schedule was drawn up setting out the key topics to be covered with each participant. This schedule listed questions but the order in which the questions and issues were covered was not fixed. This flexibility is a major advantage of semi-structured interviews. Robson (1995) notes that when conducting semi-structured interviews and thus using an interview guide as opposed to a rigid set of questions the interviewer is:

> free to modify their orders based upon her perception of what seems most appropriate in the context of the 'conversation', can change the way they are worded, give explanations, leave out particular questions which seem inappropriate with a particular interviewee or include additional ones.
>
> (Robson, 1995: 231).

Using the topic guide meant that I was able to follow up on interesting points made by interviewees and ask them to elaborate. Indeed, May (1997: 111) notes that an advantage of semi-structured interviews is that the interviewer is able to "seek both *clarification* and *elaboration* on the answers given". Interview topic guides were developed which varied only slightly between respondents, depending upon whether they led a Development Group or not. These interview guides can be found in

Appendix B (Development Group leaders) and Appendix C (Steering Group members only). Briefly, interviews covered the respondents:

- Role within the HImP Steering Group;
- Views on community participation;
- Views on the impact of partnership working on community participation efforts;
- Perceptions of the successes and shortfalls of existing efforts and strategies to involve the public;
- Difficulties experienced in trying to involve members of the public, and
- Future intentions around community participation.

I did not define the terms 'community' or 'participation' within the interviews as I was very interested in what respondents understood by these concepts and their own definitions.

A major advantage of the face-to-face interviews for me was that it was possible to audiotape them. Permission was sought from each respondent interviewed face-to-face and was granted by all of them. This allowed me to concentrate on the answers given to my questions and pick up on interesting points, rather than concentrating on recording information. Bowling (2002: 262) advocates this approach and argues that: "Respondents quickly forget the recorder is turned on and the reactive effects are believed to be minimal". Nevertheless, Petchey (2000: 39) suggests that there is a danger with all interviews that: "Interpersonal interaction is likely to generate interviewer effect". As with observation this is something which I bore in mind throughout and I used a triangulated research methodology to look for consistencies and inconsistencies in my data. Triangulation is where more than one method of data collection is used as a means of "testing one source of information against other sources" in order to ensure the validity of the information collected (Robson, 1993: 383).

Another disadvantage of interviews is that it is a time-consuming method to employ and, as Bowling (2002: 358) notes, interviews rely on the "memory or knowledge of interviewees, or their reporting of attitudes and behaviour – all of which can be subject to bias".

### Questionnaires

These interviews were supplemented with the views of officers charged with delivering the HImP, obtained via a questionnaire. The questionnaire was developed to cover how the HImP Development Groups, each of which address different issues within the HImP (e.g. Environment, Older People etc), had sought to involve the public in their area of the HImP. It also asked respondents to rate the success of their group in this task. The questionnaire sought to gain an insight into members' level of commitment to the issue of public participation and discover more about approaches utilised within these groups, their perceived success and to identify the factors which were regarded as facilitating and inhibiting participation in the HImP. A covering letter was included with the questionnaires setting out the purpose and guaranteeing anonymity in the reporting of the findings (See Appendix D).

The questionnaire included a number of my own questions as well as six adaptations of questions used in an evaluation questionnaire for participants in the David Thompson Health Region (Canada) Healthy Communities Initiative. The Healthy Communities Initiative had as one of its aims "broad and meaningful public participation in key decisions that affect a community's health" (David Thompson Health Region, 1999: 47). Consequently, a number of the questions they asked of participants were similar to those I was seeking an answer to from members of Coventry's HImP Development Groups, hence my decision to incorporate these questions, adapted in order to make them locally relevant, within my own questionnaire (Appendix E).

Permission was sought from each of the HImP Development Group leads (one person led two different groups) to distribute the questionnaire to their members who were responsible for developing and implementing strategies to tackle the 14 priority areas of Coventry's HImP. Three of the HImP Development Group leads agreed to distribute the covering letter and questionnaire on my behalf with their usual circulation material that goes to all group members. This meant that I only had to know how many members were on each group rather than their identities. Two HImP Development Group leads, whilst not agreeing to the distribution of the questionnaire agreed to my observation of their group. One of those agreeing to distribute the questionnaire also welcomed my presence as an observer at their group's meetings. Questionnaires were distributed throughout the period October 2000 – April 2001.

The questionnaire was despatched to 55 people and was completed by 32 HImP Development Group members representing the following agencies:

- Health Authority;
- National Energy Action;
- Local Authority;
- The three Primary Care Group(s) in the city;
- Community NHS Trust,
- Acute NHS Trust.

The following groups agreed to circulate the questionnaire and the response rates were as set out in table 1:

**Table 1: HImP Development Group questionnaire responses**

| HImP Development Group | Number in group receiving questionnaires | Number of respondents | Percentage of group responding |
|---|---|---|---|
| Environment | 23 | 10 | 43% |
| Health Inequalities | 12 | 6 | 50% |
| Older People | 20 | 16 | 80% |

It was felt to be important to ask those involved with the day-to-day practicalities of developing and delivering the HImP their opinions on the community involvement strategies employed to date and/or in development rather than to rely on the information provided by those at managerial level within the interviews I conducted with members of the HImP Steering Group. As Lipsky (1980) notes, it is often those operating at officer level who have considerable discretion over implementation. Consequently, the values and attitudes of the group were considered to be crucial to understand, as was their opinions on the strategies employed to date to foster community participation.

Although HImP Development Groups were responsible for the implementation of the HImP, this was not to the same extent as the HImP Development Group leads I interviewed who were also HImP Steering Group members. Therefore, I felt that the Development Group members were likely to have different opinions and be less protective about progress, or lack of it, around public participation. It was also felt that members of these groups would be more aware of problems and/or difficulties in trying to involve the public and may have useful information about strategies employed to overcome such barriers that could be shared with other HImP Development Groups.

The use of a self-completion questionnaire is a time-efficient and non-obtrusive method of data collection (May, 1997). May (1997: 89) suggests that self-completion questionnaires "provide people with a medium for the anonymous expression of beliefs". Self-completion questionnaires have also been praised for eradicating the bias which may result from interviews and observation as a result of the presence of the data collector (Petchey, 2000). Furthermore, the fact that people can complete the questionnaire at a time of convenience to them may mean that they provide carefully considered replies (May, 1997).

However, self-completion questionnaires have a number of disadvantages. As May (1997) notes, people only usually take the time to complete and return postal questionnaires when there is a) an incentive to do so, or b) they have an interest in the subject. Since I was not offering any form of reward for participating it is likely that those people completing my questionnaire had an interest in community involvement in the HImP and/or recognised it as an important issue. Consequently the replies could reflect this

In addition, lack of incentive can lead to low response rates. I encountered this problem with a response rate of only 43% from one of the HImP Development Groups the questionnaire was despatched to. When the questionnaires were aggregated the overall response rate was 58%, which is quite acceptable for self-completion questionnaires. May (1997) suggests that a 40% response rate is not uncommon for self-completion questionnaires whilst Petchey (2000) suggests questionnaires often only achieve a 30-40% completion rate.

A second disadvantage of self-completion questionnaires is the inability to clarify what respondents mean, follow-up on interesting comments and ask for further information (May, 1997; Petchey, 2000). I attempted to overcome this disadvantage in two ways. Firstly, I included a comments section under every question for people to provide more detailed information relating to that particular answer. The responses provided by respondents in the "comments" section provided under each closed question were all read in order to provide a more detailed understanding of the answer provided and grouped by theme.

Secondly, at the end of the questionnaire I asked if it would be possible to re-contact the respondent if any further clarification was needed. Where people ticked yes I asked them to provide their name and telephone number. The number of people agreeing to this request was 28 (87.5%). Whilst this may mean that the above noted advantage of respondent anonymity is reduced I felt it was worth doing in order to increase the clarity of my findings. As the questionnaire was not dealing with a sensitive issue I felt that this did not compromise the research in any way and the high proportion of people agreeing to this request suggests that respondents also felt that this was not a highly sensitive issue and indeed were happy to be contacted.

Robson (1995: 243) argues that a major disadvantage of the self-completion questionnaire is that: "There is little or no check on the honesty or seriousness of responses". This is where my decision to use a multi-method approach was valuable as I was able to check the validity and reliability of much of the information provided against other information sources utilised.

Documents

Documentation relating to the HImP produced between January 2000 and March 2002 by the HImP Programme leader for circulation to the Steering Group, Development Groups and Health Action Groups was examined. This included minutes of meetings, copies of Coventry Health Authority reports on any aspect relating to the HImP (e.g. "NHS Plan Implementation Programme and the HImP"), targets and milestones to be met by each HImP Development Group, Service and Financial Framework (SaFF) information, arrangements for involving the local Community Health Council (CHC) and Voluntary Service Council (CVSC) in the HImP, and findings from the Citizen's Panel Health Survey. This meant that I was privy to information which would not otherwise be available to me in the public domain. My access to this information was facilitated at the same time as my access to the Steering Group meetings since most of this information was circulated prior to or following on from a Steering Group meeting. Bowling (2002: 418) notes that:

> It is important for the investigator to be aware of the authenticity, completeness and representativeness of documents and the meanings of words and classification schemes used in their compilation.

Indeed, because much of the documentation I was utilising was not for public consumption, for example minutes of HImP Steering Group meetings or consultation documents for HImP partners, they incorporated all of the jargon and acronyms used within the health service and would be difficult for someone who is not able to familiarise themselves with the terminology to understand.

Furthermore, Bowling notes that the material to be included within documents is often selected and much material discarded. Indeed, it is essential to bear in mind who these documents were written by and for. May (1997: 174) notes that the researcher should "consider how the document represents the events which it describes and closes off potential contrary interpretation by the reader". He notes that documents might seek to characterise "events and people in particular ways according to certain interests" (May, 1997: 175). This was found in the HImP documentation where final decisions taken by the Steering Group were recorded but heated debates leading to this decision and the fact that many individuals within the group did not in fact concur with this decision, as witnessed by my observation of Steering Group meetings, omitted. Consequently, these documents became a useful resource in verifying that I had understood discussions and their outcomes, but provided very little insight into the process of arriving at decisions.

However, a major advantage of document research is that it is not subject to reactive effect (Bowling, 2002). The use of documents as a form of data has, however, been criticised because, "documents reflect society's biases and are simply social constructions of reality" (Bowling, 2002: 417). The purpose of the documentation collected was always clear – to raise awareness of issues, describe thinking on an issue, and to stimulate interest and request feedback on issues. In this way I would suggest that these documents were "representative of the practical requirements for which they were constructed" (May, 1997: 163). Therefore, it is not assumed that these documents are neutral artefacts, rather, that they are located within a wider social and political context and are therefore involved in the production of a desired social reality. Indeed, my research found that if I had used documents alone I would have received a very different impression about the extent of community participation in the HImP.

As with the data collected from all other sources it was recognised that these documents represented the views and ideas of a few individuals charged with leading on HImP development and implementation. Alongside my observation of Steering Group meetings this documentation allowed me to feel immersed in the local HImP and gain a better understanding of the decisions people made and upon what sort of information and 'evidence' they were basing these decisions. The thought-processes being followed became clearer through the use of these two sources of information. Yin (1994) notes that observation can provide useful additional information about the topic and the context within which the subject matter is studied. May suggests that observation allows researchers to:

> witness the 'reflexive rationalization' of conduct, that is the continual interpretation and application of new knowledge by people [...] in their social environments as an ongoing process.
>
> (May, 1997: 138).

### Additional interviews and observations

From my initial reading around HImPs and discussion with the Director of Health Development before beginning my fieldwork I had identified the need to collect data from members of the HImP Steering Group as well as examine the role of the HImP Development Groups they led with respect to community involvement. However, at this stage the thinking around the devolvement of HImP monies to Health Action Groups (HAGs) was not sufficiently developed and as a consequence I had not envisaged HAGs playing an important role in my research. The realisation as I spent more time at Steering Group meetings and examined the documentation being produced by those leading on HImP development that HAGs would become a key vehicle through which community involvement efforts would be fostered meant that I had to build in an additional period of data collection. I had envisaged the collection of information from the HImP Development Groups via a questionnaire, as my final piece of data collection (bar the ongoing collection and analysis of HImP documentation). However, once these questionnaires had been returned and analysed I then embarked upon an additional six-month period of data collection from HAGs between September 2001 and February 2002. Documentation on HAGs had been circulated to all Steering Group members and so I did not need to collect additional documentation.

HAGs were health planning groups operating at the neighbourhood level within the six most deprived areas of the city. As my research progressed HAGs were identified by the HImP Steering Group as the key forum within which community involvement in the HImP would take place. Data was collected from Health Action Groups via observation of HAG meetings and interviews with HAG members.

This is what Parlett and Hamilton (1976) refer to as 'progressive focussing' and is a recognised aspect of case study research which allows for flexibility to amend the design of the research as it progresses if new issues come to the fore.

Interviews were conducted with three members of Health Action Groups between November 2001 and February 2002. The purpose of these interviews was to elicit the views of HAG members about the devolution of HImP monies to Health Action Groups. Interviewees were asked their opinions on the appropriateness of this as a strategy to involve the community in health planning and delivery decisions in their locality on behalf of the HImP. They were asked questions about how the money devolved from the HImP had been or was to be used and who got to decide how this money was spent. The interview schedule used can be found in Appendix F. Two of these interviews were carried out face-to-face at the interviewee's place of work and one was conducted over the telephone.

Observation of the meetings of two different HAGs took place between September 2001 and January 2002. Within these meetings I was particularly interested in who attended, the amount of influence each had, the power relations between different individuals and different organisations and how they operationalised aspects of the HImP.

*Benefits of using a multi-method approach*

The use of a number of different data collection strategies, defined earlier in this chapter as 'triangulation', helped me to make better sense of the data. As Whyte and Whyte suggest:

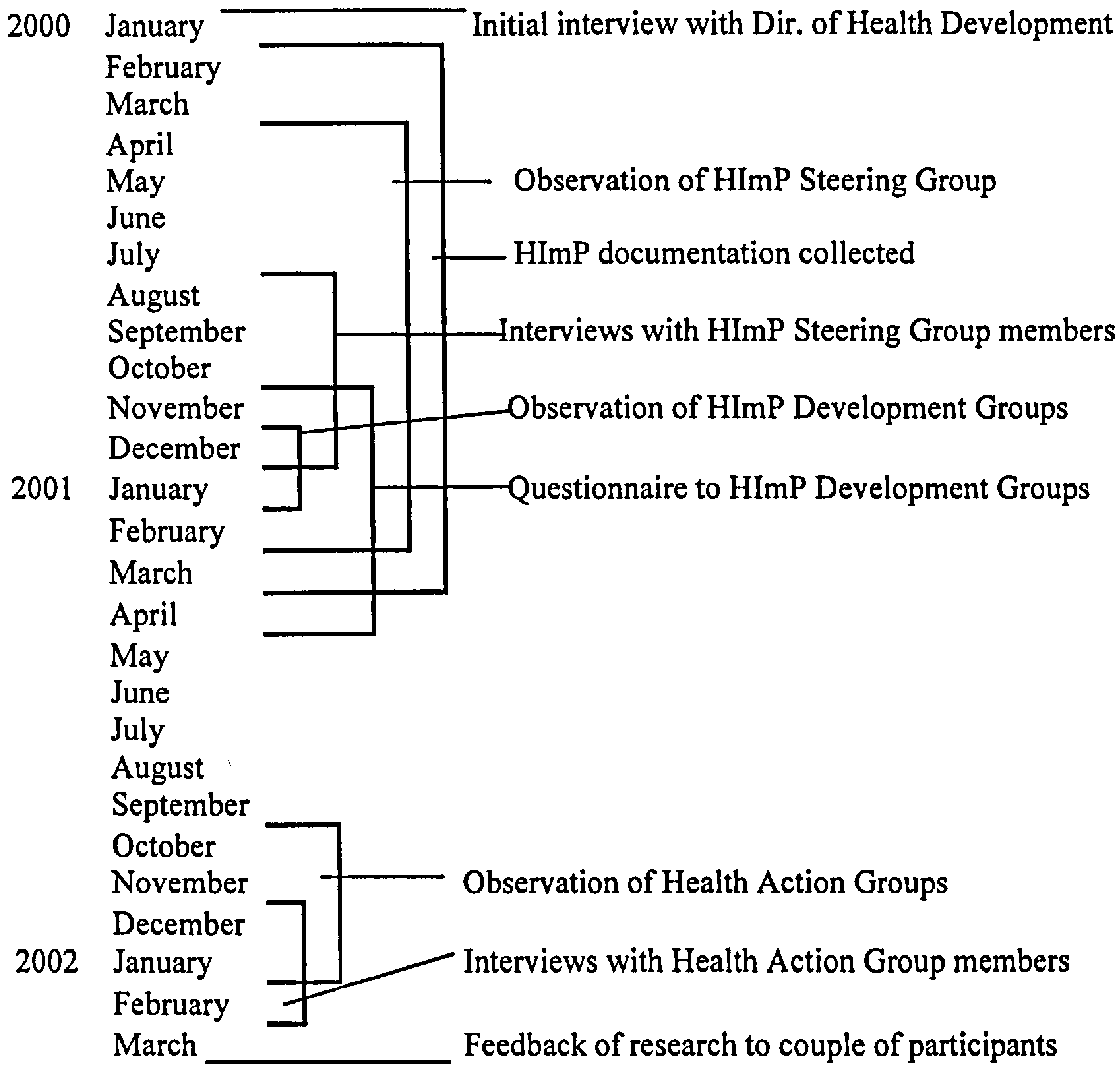
> Observation guides us to some of the important questions we want to ask the respondent, and interviewing helps us to interpret the significance of what we are observing.
>
> (Whyte and Whyte, 1984: 96).

Indeed, my observations proved useful for understanding the rationale behind certain decisions taken and for providing evidence which reiterated or contradicted what respondents had told me in interviews. Documents and questionnaire responses served to further enrich this pool of data.

My decision to use multiple research methods also helped facilitate my recognition of the biases and pitfalls of each individual method of data collection as well as validating my findings. Multiple methods were considered useful as much for the fact that they can often produce quite different findings, as for an attempt to triangulate my findings. Indeed, whilst any convergence in findings from different data sources and methods helped me to clarify and refine the themes emerging from my data, the use of different methods also highlighted any inconsistencies in my findings. This helped me identify areas where further data collection was required and, with regard to some issues, where differences in views and opinions would not be overcome.

Once the fieldwork had been completed (February 2002) my initial findings were fed back to a couple of the participants from the case study site in order to check for inaccuracies and get their reaction to my findings. This took place in March 2002. The following diagram shows my time in the field and the different methods of data collection and participants groups within this time.

**Figure 3: Time in the field**



Throughout the case study period Coventry's HImP, like all other HImPs nationally, was continually changing and reviewing performance in response to the changing national agenda and to other local priorities. Therefore this case study provides 'snapshots' of the processes and policy developments within a particular period in time. As the case study began at the end of the first year of Coventry's HImP it was conducted at a time which those charged with developing the HImP regarded as early days in the life of this policy. However, in July 2000 the NHS Plan was published which shifted the direction of HImPs and in April 2001 the succession of HImPs with HIMPs, to be in place by November 2001 was announced. Retrospectively, therefore, the case study may be regarded as beginning half way through the policy and following it until its succession by HIMPs.

### *Data Analysis*

My case study analysis was based on what Robson (1995: 378) refers to as a "Descriptive Framework". Where this approach to analysis is adopted Robson states that a researcher is not starting within a particular theoretical framework, rather:

> You are looking for a set of themes or areas, linked to the research question [... which are subsequently used to inform an] *issues analysis*, where the issues can be used as a means of organizing and selecting material.
> (Robson, 1995: 378).

My research adopted an interpretative approach to the data, studying the processes involved in HImP development and delivery and seeking to identify the factors which enhanced and/or inhibited attempts to involve the public in this policy. The data collected in the case study site was analysed in an attempt to gain a more general understanding of the tensions between policy and practice with regards to community participation, both within HImPs and within other policies and programmes advocating broad public participation. The analysis used an iterative process of reviewing data, categorising by themes and applying all themes to all sets of data. Each set of data collected within the case study was initially analysed separately (i.e. observation of the HImP Steering Group, HImP Development Group meetings and Health Action Group meetings, interviews with members of the HImP Steering Group and Health Action Groups, questionnaires to members of the HImP Development Groups and documentary evidence).

All interviews were transcribed and themes identified from these transcripts using simple content analysis (Krippendorff, 1980). As an interview schedule was used in all cases all respondents worked through the same set of issues, making thematic analysis an appropriate form of analysis. The completed questionnaires were analysed using SPSS (Statistical Package for the Social Sciences), and the answers to closed questions tabulated. A thematic analysis was carried out on all responses to the open questions. Each of these data sets is an embedded unit of analysis within the case (de Vaus, 2001). Once each of these data sets had been analysed separately they were brought together to build up a picture of the whole case and allow an overall case analysis. This led to the development of interpretations and conclusions, which will be outlined in the discussion chapter (Chapter Seven).

The empirical data for this research was collected over a two-year period. The observation of all HImP Steering Group meetings over a one-year period in particular allowed me to develop a detailed understanding of the working of the HImP in this locality, including the decision-making processes and where the locus of power lay. Being closely involved with the site for a relatively long period of time also provided me with the opportunity to familiarise myself with the language used. As anyone who has worked with public sector organisations, and particularly the NHS, will know the use of acronyms is extremely common. To the uninitiated this can be quite daunting at first.

The period during which I observed Steering Group meetings (March 2000 – February 2001) almost coincided with the financial year the health authority was working to (April 2000 – March 2001). This gave me a good insight and understanding of the timetables those charged with co-ordinating the HImP were working to. The need to report back to the Regional Office of the NHS Executive at certain points in the year, and to have the plans drawn up for next years HImP and all associated targets had a considerable impact upon which elements of the HImP were focussed upon and, of interest to me, how much attention was paid to the issue of community participation. Attending the Steering Group meetings enabled me to understand the working of the whole HImP, not just my area of interest within the HImP (i.e. community involvement).

### Limitations of the research

Whilst gaining access to the site and research participants within the site had been relatively easy and facilitated through the desire of the Director of Health Development to make the HImP as transparent and open as possible, a shift in policy nationally, and accompanying re-shuffle of key personnel locally had dramatic effects on my ability to continue accessing the site. The shift in government priorities towards the implementation of the NHS Plan was reflected in the development in

April 2001 of NHS Plan Modernisation Boards charged with the implementation of the 'national plan'. Existing Health Improvement Programmes (HImPs) joined together with the newly established NHS Plan Modernisation Boards to become 'Health Improvement and Modernisation Programmes' (HIMPs).

In Coventry what this effectively amounted to was a re-shuffle of those already on the HImP Steering Group with many of these taking on key roles within the new HIMP Project Board. This change took place at a similar time to the arrangements for establishing a Primary Care Trust (PCT) in Coventry and other members of the original HImP Steering Group moved on to strategic positions within the new PCT. This and other changes impacting upon this research are discussed in Chapter Five in which I outline the impact of policy and organisational changes on the local HImP.

In February 2001 the HImP Steering Group was operating as normal and my presence at meetings accepted as standard. By the time of the next scheduled meeting in May 2001 HImP Steering Group meetings had been cancelled until further notice whilst arrangements for the new HIMP Boards were established.

This signified a major shift in my close involvement within the site. In particular, a shift in the lead person with overall responsibility for the HIMP resulted in a closure of the door opened for me by the Director of Health Development. The result of this was that I was unable to attend and observe the HIMP Project Board meetings. It is difficult to know exactly why my access was no longer facilitated as I was unable to discuss the matter with the new HIMP lead. I tried telephoning on numerous occasions and left many messages for her to call me but never heard back. After numerous unsuccessful telephone calls, her secretary, who vaguely knew me from my attendance at HImP Steering Group meetings, suggested that many changes were taking place and my observation of the settling down of a new and different initiative was probably not regarded as suitable.

By April 2001 all of my observations of the Steering Group and Development Groups, interviews with members of the Steering Group (including Development Group leads) and questionnaires to Development Group members had been completed. Consequently, the impact of this change in policy and personnel locally on my research was minimised. My fieldwork with the Health Action Groups (HAGs) took place during the period September 2001 and February 2002. However, the HAGs were still to be utilised in the same way by the new HIMPs as the key vehicles through which community participation would be developed. Therefore, whilst changes had taken place at managerial level, HAGs, which existed separately to the HImP, were still to perform the same function. Consequently the observations of HAG meetings and interviews with HAG members were still considered to be an important part of this research.

### Reflections on the research

Initially I was concerned that by stating from the outset that my research was particularly focussing on community involvement in the HImP, rather than just presenting it as research on the HImP more generally, that this may produce a change in the way community involvement was addressed. Indeed, de Vaus (2001: 136) notes that participation in a longitudinal study may produce change "because it alerts participants to matters they would otherwise not think about". Whilst I never doubted that community involvement as an issue would be addressed, indeed it was a formal requirement of the HImP, an initial comment by the Director of Health Development in charge of the HImP that my observation may make people take the issue of community involvement more seriously, further added to my concerns that I would have an influence. It must be acknowledged that on a personal level, as someone both professionally and politically in support of increased participation, especially within Coventry as my home city, I would have been pleased if my presence did have a positive influence on the development of community involvement strategies. However, as a researcher I was only too aware of the problems which may occur if I did influence outcomes in this area and how this would reduce the possibility of arguing that my findings had more general implications. In reality this was not a tension I have had to deal with. As the research progressed I reached the conclusion that my presence was having no, or very little impact upon processes. The need to meet government targets and follow national directives was considerably more powerful than the presence of a research student. Moreover, since very little could be said to have happened with regards to community involvement in the HImP it is hard to believe that I had any influence on the process at all. However, the possibility must be considered by readers of this research study.

### *The ethics and politics of research*

In keeping with my commitment to participation in health planning I wanted to present my overall findings from this research to the Steering Group but no longer had access to do this. I contacted the interviewees offering this information. One person asked me to give a presentation to the Development Group they led whilst another asked for a brief summary of my findings. However, I am still keen to feed back my results and aim to contact Coventry Primary Care Trust's new 'Public Involvement and Diversity Facilitator' and will seek to meet with her in order to discuss the implications from this research for her future work.

## Conclusion

In this chapter I have set out the research strategy adopted to undertake this study. This has included a consideration of the strengths and weaknesses of the methods employed and a discussion of my rationale for using these methods as well as my personal standpoint on the issues to be considered within this research study. I have attempted to be open about my own epistemological position and acknowledge where I may have influenced the research process as much as possible, as endorsed by Holland and Ramazanoglu (1994).

Public involvement is a key element of much New Labour health and social policy. By combining knowledge gained through a review of the literature with a detailed examination of policy in practice it is hoped that this research will help to provide an increased understanding of the issues and complexities surrounding the actual 'doing' of community involvement.

Before moving on to describe the case study findings the next chapter will examine the macro and meso influences on community participation in health planning and delivery. This will be followed in Chapter Five by an examination of the micro level contextual factors at play in Coventry. These two contextual chapters, in which an analysis of global, national and local policy drivers and influences upon community participation will be conducted, form a substantive element of the research for this thesis alongside the data collected within the case study.

# CHAPTER FOUR

# HEALTH IMPROVEMENT PROGRAMMES AND THE WIDER HEALTH POLICY CONTEXT

## Introduction

In order to understand the findings from my case study of community participation in Health Improvement Programmes it is necessary to examine the political and policy environment within which HImPs were being developed and implemented at the time of my case study being conducted. Therefore this chapter will examine the macro- and meso-level influences upon policies and programmes for enhanced participation, drawing upon the model developed by Mohan (1996) for examining both global and local influences within national health care systems.

Mohan (1996: 675) applies "three interrelated scales of analysis": macro, meso and micro, to describe and explain the British health care reforms of the 1990s, drawing attention to the fact that developments taking place at each of these levels – global, national and local – are interconnected. Within this chapter health policy and its impact upon community participation at the macro and meso levels will be examined, whilst the next chapter will consider the micro level influences upon community participation. I will begin by describing the global context and identifying international drivers for participation. This will be followed by an analysis of the national context, including the state level rationale behind the promotion of participation; an exploration of the principles and objectives of New

Labour, the concept of the 'third way' and the vision for a *new* NHS. This chapter will then examine the HImP as a policy which seeks to translate many of these principles into practice.

## The Global Context (Macro-level analysis)

The UK government does not exist in a political or policy vacuum. All nation states are increasingly influenced by international legislation, Charter's, declarations and other globalising forces. Many powerful institutions, for example the World Bank and the World Health Organization (WHO), seek to influence the direction of policy across the world, either by encouraging individual nations to sign up to Charters or through the use of sticks and carrots (e.g. World Bank funding for development projects which include certain provisos and obligations). Mohan (1996) argues that a global perspective is essential in understanding and explaining external pressures on individual nation-states. Consequently, any study examining policy must recognise the impact of global forces (Deacon *et al.*, 2003).

World Health Organization documents have routinely included the values and philosophy of community participation and multi-sectoral working since this approach was first advocated by the WHO in the *Health for All* programme launched at the Alma-Ata Conference in 1978 (Strobl & Bruce, 2000). Community participation has become a key issue for health policy makers internationally. The principles of empowerment and participation underpinned the *Ottawa Charter for Health Promotion* (WHO, 1986) and inform the approach adopted by the 'New Public Health' movement (Petersen and Lupton, 1996). The 'New Public Health' movement, established in the 1980s, is:

> a movement of public health professionals and others who have sought to re-emphasise the crucial role that social and environmental factors play in affecting the public's health; and therefore the importance of building alliances between the public and the public health profession in taking action to influence these factors.
>
> (Smithies and Webster, 1998: 11).

According to Morgan (2001), participation achieved global currency in the 1990s. Nevertheless, she notes that key organisations such as the World Health Organization are still involved in promoting the concept internationally. Indeed, the endorsement of community participation as an appropriate and effectual means of making health systems accountable and suitable can be seen in contemporary health policies and declarations internationally (Wiseman *et al.*, 2003). It is argued that this represents an international shift in philosophy about who has the right to participate in health care decision making (Higgins, 1999; Kneeshaw, 1997). Therefore the shift towards greater participation of the public in health care planning and delivery seen nationally, as embodied by HImPs, may be regarded as part of a global trend.

The inclusion of the concept of participation by the World Bank (Bhatnagar *et al.*, 1996) is cited by Morgan (2001) as an example of the institutionalisation of participation into mainstream discourse internationally. Rather than regarding community participation as institutionalised, Light (2001) suggests that participation has become an 'international fashion'. Whilst this sort of attention has been craved by user movements and individuals convinced of the efficacy of community participation since the 1960s, Light (2001) concedes that participation as a 'fashion' within policy carries with it the inevitable downside of having a limited timeframe within which to achieve. This suggests that current national policies promoting participation may be short-lived. This argument may be related to Kingdon's (1995) model of discrete 'policy windows' which suggests that all forms of policy have a limited life and the opportunity to act upon these policy interests occurs only when the policy is recognised as necessary, feasible and politically viable, as discussed in Chapter Two.

### The National Context (Meso-level analysis)

O'Keefe and Hogg (1999) suggest that nationally as well as internationally public and user participation in decision making is acknowledged as an important mechanism for ensuring the legitimacy of health service planning and provision. This can be seen within national health policy where the emphasis placed on the health service working in partnership with other local stakeholders including local authorities, the voluntary sector, local businesses and the general public may be regarded as a key element of the reforms introduced in *The New NHS* White Paper. Whilst the 1992 *Health of the Nation* White Paper (Department of Health, 1992) represented the first shift towards a New Public Health framework, according to Pickard and Smith:

> Post-1997, developments in the NHS are taking place within a new political and philosophical environment which has become known as the 'third way'. It has been suggested that within this framework 'community' and 'partnership' are the new buzz words replacing 'markets' and 'contracts' and in this context *partnership* means not only interagency co-operation but also partnership with lay people in decision-making.
>
> (Pickard and Smith, 2001: 172).

This may be seen as representing a shift in health policy towards that promoted by the World Health Organization in *Health for All* (WHO, 1978).

*The New NHS: Modern, Dependable* White Paper (Department of Health, 1997) was the first health policy document to be published following the election of the Labour government to power in 1997. *The New NHS* introduced a number of reforms which the Government described as building on the successful elements of Conservative health policy by extending GP fundholding to cover all General Practitioners through the formation of Primary Care Groups (PCGs) whilst replacing the fragmentation of the internal market introduced by the Conservatives in 1989 in the *Working for Patients* White Paper (Department of Health, 1997). This was to be achieved by inviting PCGs to work towards becoming Primary Care Trusts (PCTs) with both purchasing and providing roles.

Emphasis within *The New NHS*, as within many other government policy documents produced since, was on 'modernisation'. Modernisation of health care services, or the "'third way' of running the NHS" (Department of Health, 1997: para 2.2) claimed to build on previous successes and discard previous failures in an effort to:

> link a continued search for economic efficiency with greater social justice by combining the best attributes of market preference and state intervention.
>
> (Murray and Greer, 2002: 193).

However, the existence of a distinct 'third way' has been widely debated. Driver and Martell (1998) discuss the creation of a new brand of 'post-Thatcherite politics', fashioned by the principles of Thatcherism whilst simultaneously seeking to reject them. However, Smith (2001: 267) defines New Labour as "reflecting the often contradictory and conflicting demands of social democracy, social conservatism, Thatcherism and Pragmatism" (quoted in Lister, 2001: 426) rather than as representing a discrete approach.

Lister (2001) discusses the contradictions and tensions in New Labour politics. In particular she identifies two characteristics of New Labour: "A populist tendency to woo rather than to lead the electorate and a pragmatic 'what works' approach, which avoids a direct assault on structural inequalities" (Lister, 2001: 425). Lister argues that this leads the government to see the solution to tackling inequalities as "managerial rather than political: the breaking down of departmental boundaries rather than of structural divisions, when both are needed" (Lister, 2001: 433). She postulates that the rationale behind the 'what works' approach is that it is less threatening than trying to bring about structural change. The HImP may be regarded as a policy which incorporates all of the elements of the 'third way' and modernisation and which seeks local solutions to problems, rather than national structural changes. These are issues emphasised by the New Public Health and the World Health Organization's promotion of participation and intersectoral working.

The prominence of joined-up working within *The New NHS* White Paper was underpinned by a new statutory duty of partnership for NHS bodies and local authorities to work together introduced by the Health Act in 1999. These collaborative arrangements have been underpinned by duties of partnership. The Health and Social Care Act (2001) placed a duty of partnership on health and social care organisations, building on measures such as the integration of service provision, pooled budgets for health and social care services and lead commissioning arrangements introduced in the Health Act (1999) to facilitate integrated working.

This emphasis on partnership working, or what Clarence and Painter (1998) have called the 'collaborative discourse' is a feature of much New Labour health and social policy. A far from exhaustive number of examples are given below in Box 5 as an indication of the breadth of policy areas now requiring joint working.

**Box 5: Examples of New Labour policies which place an emphasis upon partnership working**

- *Local Strategic Partnerships* (LSPs) as set out in *The NHS Plan* (2000) are partnerships at the local authority level with a remit of encouraging core public services to work together in conjunction with the voluntary sector, private sector and communities to help shape the delivery of services in the future.

- *Education Action Zones* were established in 1998 to bring local education authorities, voluntary organisations, businesses and schools together in order to improve educational achievements in areas with low performance levels in education.

- The *National Strategy for Neighbourhood Renewal* launched in 2001 aims to harness the support of all sectors within deprived areas and get them to work in partnership with local residents and community groups and support them in turning their neighbourhoods around.

- *Employment Action* Zones were introduced to bring private and public sector partners together in areas with long-term levels of high unemployment.

- The *Saving Lives: Our Healthier Nation* White Paper (1999) set out how coordinated action is being taken across Government.

- The introduction of *Primary Care Groups/Trusts* is another initiative which introduces partnership structures at the local level.

- The Department of the Environment Transport and the Region's (1998) *Modern Local Government: In Touch with the People* sets out the need for all parts of government to work together better if services provided at the local level are to be improved.

- *Local Compacts* were introduced in July 2000 by the DETR to improve relations between local statutory bodies and voluntary agencies. They provide guidelines on how to establish agreed ways of working across multiple agencies.

- *Care Trusts*, announced in the NHS Plan (2000) are vehicles for the integration of health and social services and allow the delivery of all health and social services by a single organisation where locally this model is considered most appropriate.

- *Health Action Zones* were established to bring together all agencies who can make a difference in terms of health, i.e. NHS bodies, police force, educational bodies, local authorities, private business, voluntary organisations, community organisations etc, in order to highlight the interdependence of all of these different agencies and the importance of working together.

- *Crime and Disorder Partnerships* were established as a result of the *Crime and Disorder Act* (1998) which required the police and local authorities to work together to reduce crime and the fear of crime.

Partnership working has been extended to include Whitehall with joined-up government at the centre of collaboration efforts (Exworthy and Powell, 2000) and the Office for Public Services Reform established with a remit of coordinating activities across Government departments.

The rationale behind the government's push towards joint working is set out in the National Strategy for Neighbourhood Renewal's Policy Action Team 17 report *Joining It Up Locally* (DETR, 2000b). Here it is argued that because problems like high levels of crime, low levels of educational attainment and poor health are related, or 'joined up', that solutions to overcome these problems should also involve multi-agency and interprofessional collaboration. This inevitably necessitates the joining up, or working together of the different agencies traditionally responsible for issues such as health or crime. The report argues:

> no single organisation holds the key to addressing these problems. A combination of public, private, voluntary and community sector effort will be needed to crack them.
>
> (DETR, 2000b: 9).

A total of 18 Policy Action Teams (PATs) were established to examine issues related to neighbourhood renewal in 1998, to inform the future work of the Social Exclusion Unit. The HImP typifies this broader determinants of health agenda and embraces the principles of partnership working, seeking collaboration and co-operation on issues from many different organisations within a locality.

Whilst recognising that in many areas efforts have been made to develop joint-working in the past, and that through initiatives like SRB and City Challenge some progress had been made towards integrated working, PAT 17 suggest that many previous attempts at joint working have failed. They suggest that this is the result of: previous government policies not creating the environment in which joint working efforts could prosper; because strategies developed had often been based around centrally identified priorities and did not include locally identified priorities, and because many had not adequately involved local communities. It is argued (DETR, 2000b) that these imbalances have started to be addressed through the health and social policies introduced by New Labour. Indeed, in relation to health policy a key element of the reforms set out in *The New NHS* White paper was the importance placed on involving both users and the general public in health care planning and delivery.

Whilst previous initiatives such as *Local Voices* (NHS Management Executive, 1992) had highlighted the importance of involving citizens in the identification of health care needs it is suggested that the political rationale underpinning the support for public participation is fundamentally different between New Labour and the Conservative administrations of 1979-1997 (Milewa *et al.* 1999). According to Milewa *et al.* (1999) a 'consumerist' approach to participation, which as described in Chapter Two conceptualises participation in terms of information and choice for health care consumers, was favoured by the Conservatives. In contrast they argue that New Labour subscribe to a more 'democratic' model of participation (described in Chapter Two as the 'citizenship' model) as advocated by the World Health Organization. However, a number of the initiatives introduced by the Conservatives, such as the *Patient Partnership* Strategy (NHS Executive, 1996), which cast patients as partners involved in the decisions around their care, have been built upon by New Labour. An example of this is the *Expert Patients Programme* (DoH, 2001d) which helps people living with chronic conditions maintain their health and improve their quality of life through their participation in self management. This consumerist/democratic distinction will therefore be considered within my case study of participation in HImPs.

The promotion of partnership, in contrast to competition is exemplified within Health Improvement Programmes. HImPs are also prime examples of the new weight placed on the importance of making the health service more accountable to the public. In particular, the promotion of public involvement as a means of both enhancing accountability and making the NHS more responsive to the needs of the public, as seen in HImPs, was a core element of New Labour health policy.

Ham (1999) notes that New Labour's vision for the new NHS was clearer in setting out the principles which should underpin the vision than about how these should be achieved. This suggests that Lipsky's (1980) notion of 'street level bureaucrats' as officers with discretion over the implementation of policy may have significance and will require further investigation within the case study.

I will now examine the HImP in more detail in order to demonstrate how many of these features of New Labour and the New Public Health strategy are embedded into a specific policy.

## The Health Improvement Programme

Health Improvement Programmes (HImPs) were a central part of *The New NHS* modernisation agenda introduced by the Labour government in 1997. They have been described as the cornerstone of the 1997 White Paper (Gallagher, 2000). The White Paper set three broad strategic objectives for HImPs:

i. to identify and address the "health needs of the local population";
ii. to develop ways of more effectively meeting "the main healthcare requirements of local people" through working in partnership with other relevant organisations;
iii. to cover "the range, location and investment required in health services to meet the needs of local people." (Department of Health, 1997: para 4.9).

It was stated that HImPs would "replace the fragmentation of the NHS internal market with a coherent planning process within the local health care system and with Local Authorities and other partner organisations" (NHSE, 1998: 1). HImPs were defined as the principal strategic planning vehicle through which all statutory and voluntary agencies involved in the planning and delivery of health care must work together and with the local communities to improve health and reduce health inequalities (Grant, 2000). According to the government, working together in partnership to develop and implement the HImP would be the key to its effectiveness: "Ultimately, improvements in health will be delivered through the performance of all local partners" (DoH, 1999: 3). Furthermore, it was argued that the partnerships demanded by the HImP would lead to increased integration across the health and social care interface and help providers move towards offering a seamless service for users.

> A fragmented NHS has been poorly placed to tackle the crucial issues of better integration across health and social care. [...] To overcome this fragmentation, in the new NHS all those charged with planning and providing health and social care services for patients will work to a jointly agreed local Health Improvement Programme.
>
> (Department of Health, 1997: Paras 2.10 and 2.11).

HImPs were three-year programmes within which priorities were reviewed on a yearly basis. HImP development was to be led by health authorities.

**HImP functions**

Health Improvement Programmes had two main functions: firstly, to tackle inequalities in health and secondly, to engage a wide variety of organisations and individuals to work together as partners to improve health (Hunter, 1999).

*(i) Tackling inequalities in health*

This emphasis on tackling inequalities may be regarded as representing a sea-change within the UK. As Exworthy and Powell (2000: 46) note:

> During the years of the Conservative governments of 1979-1997, the 'I' word – inequalities – was little mentioned in government circles, with the preferred term being health variations.

The articulation of a 'health gap' (Shaw *et al.*, 1999) and acknowledgment of the significant widening of this gap over the last 25 years by the Labour government (DoH, 2001e) therefore represents a paradigm shift from previous health policy, although somewhat anticipated by the 1992 *Health of the Nation* White Paper which introduced many of the concepts and a recognition of health 'variations', if not inequalities.

Shaw *et al.* (1999) also point to the fact that geographical location is now a much higher indicator of mortality than before and recognition of this fact has led to a two-pronged approach by government in an effort to reduce health inequalities. Health Improvement Programmes (HImPs) were to be the mainstream planning mechanisms and Health Action Zones (HAZs) the innovative area-based approaches which would both have the reduction of health inequalities as one of their key aims.

The New Labour Government appear to accept the need to tackle the wider determinants of health in order to try and reduce inequalities and recognise the importance of involving the public in deciding how to tackle these issues. At least in the rhetorical sense, health inequalities are given a higher priority than under previous Conservatives administrations.

The importance *The New NHS* White paper and guidance related to HImP development placed upon addressing the determinants of health and the emphasis upon working in partnership to tackle inequalities and improve the health of the population may be regarded as addressing many of the factors highlighted within the Black Report of 1980 around class and regional inequalities in health, and pre-empted many of the issues accentuated as requiring joint-agency action within the Acheson Report on inequalities in health published in 1998 (Acheson, 1998). This report adopted a socio-economic approach to the explanation of health inequalities, arguing that poor health was the result not only of individuals' biological and behavioural differences but also related to socio-economic status, living conditions, employment status, educational level, transport and other structural factors. Consequently, the report stressed that health should not be the responsibility of the NHS alone and highlighted the need for agencies to work together to tackle the wider determinants of health.

### *(ii) Working in partnership*

The HImP was to belong to the whole of the local community and was to have the widest possible involvement from health agencies, local authorities, voluntary sector bodies, community groups, the private sector and others in the locality. In the statutory sector this was underpinned by duties of partnership and all public sector agencies were expected formally to sign up to delivering their contribution to the HImP. The Chief Medical Officer's *Project to Strengthen the Public Health Function* report stressed the role of local authorities as equal partners with the NHS in delivering better health and wellbeing for their residents. According to the report equal partners:

> means the development of joint ownership at all stages, even though the NHS has been accorded the lead role in Health Improvement Programmes, otherwise little will change in practice.
>
> (DoH, 2001f: 16).

### The community as key partners in the HImP

Involvement of the community is one of the underlying principles of HImPs. Public involvement and public empowerment have thus been seen from the start to be central to the success of the HImP (Rawaf and Orton, 2000). But the range of objectives implied by these exhortations to include both community and voluntary organisations perspectives within the HImP also indicate the need for clarity about the different ways in which groups and individuals might be involved in the HImP and what different objectives might be achieved as a result.

A national review of Health Improvement Programmes carried out by the Health Development Agency (Hamer, 2000: 2) found a: "Lack of community involvement and development strategies in most HImPs." A number of consultation mechanisms and information provision strategies were recorded but proactive approaches to broader community participation were found to be scarce and the report concluded that this was an area requiring substantial improvement. Similar conclusions were drawn by another research team (Carruthers *et al.*, 1999) examining seven separate HImPs as they were being established. This research found that: "The level of engagement with the public and the wider body of health professionals [in developing the HImP] had been minimal" (Carruthers *et al.*, 1999: 1). Research into the views of Directors of Public Health on the HImP (Geller, 2001) also found that public participation, as well as a greater role for PCGs, voluntary organisations, Trusts and clinicians was an issue which was regarded as requiring considerably more attention in the future. Furthermore, a King's Fund commissioned research project examining the first year of HImPs in London concluded that: "Opportunities for involving the public as citizens, rather than just as service users, remain inadequate" (Arora *et al.*, 1999: summary).

These studies therefore suggest that community participation is either difficult to achieve or it has not been given adequate attention and resources to make it happen. They also point to a lack of creativity in the approaches adopted to involve the public in HImP and a perception of consultation on the HImP as being equal to participation in the process of HImP development. This is despite the fact that government guidance stresses:

> the need to achieve an inclusive process with the accent on the widest possible local involvement from the outset, rather than consultation on a near-final product. [...] local communities need to have a real opportunity to shape the HImP so they feel ownership of its objectives and are committed to its implementation.
>
> (Department of Health, 1998b: 2).

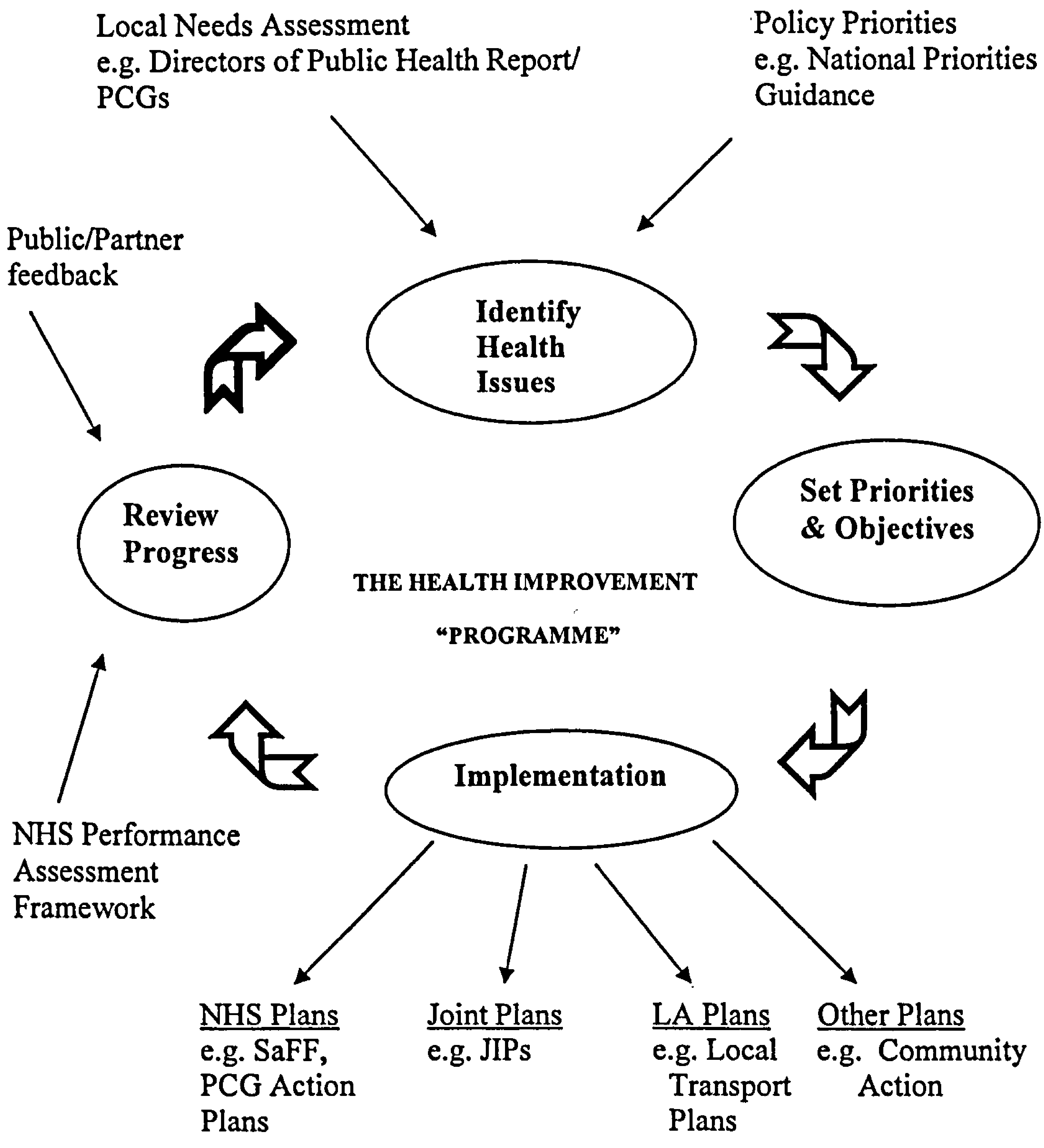
### *HImP development and the planning cycle*

HImPs placed more emphasis on preventive, rather than curative health. They attempted to shift thinking around health away from the biomedical model and to encourage those planning for health to recognise the importance of tackling the wider determinants of poor health, such as inadequate housing, low levels of education, and factors affecting psychological well-being, for example fear of crime. However, all HImPs had to include local strategies for addressing the four government identified priority areas as set out in *Our Healthier Nation: A Contract for Health* (1998). These were Heart Disease and Stroke, Accidents, Cancer and Mental Health. Consequently, all HImPs shared many common characteristics. However, HImPs also included a number of locally defined health improvement priorities. These local priorities were continually being refined in response to local health needs assessment work being carried out (Arora *et al.*, 1999).

The diagram below illustrates the continuous process of identifying issues to be tackled, setting objectives, implementation and review of progress HImPs demanded. Each of these four stages was to be carried out in partnership.

**Figure 4 – The Health Improvement Programme 'Cycle'**

(Source: Department of Health, 1998b: 2)



The first stage of the cycle is the **identification of health needs**. The health information held by all partner agencies is pooled in order to develop a comprehensive picture of local health needs. This local data, along with nationally identified priority areas, is used to determine the **priorities for action** within the

HImP each year. This must include objectives and targets for measurable improvements for each of the priority areas. The **implementation** of these action plans is the responsibility of all of the partners in the HImP and different agencies are likely to lead on the different priority areas. All areas of the HImP are **reviewed** against the targets and milestones for improvement set with at least one area of the HImP being subjected to a detailed review annually. The review process is to incorporate the views of all partners, including the wider community.

HImPs were widely regarded as signalling a partial shift in health policy away from the competition of the internal market introduced in 1990 by the Conservatives towards a more holistic multi-agency collaborative approach to health care (Rawaf & Orton, 2000; Gallagher, 2000). Furthermore, HImPs placed an emphasis on the importance of health improvement and the public health function (Ham, 1999).

### Community participation as a feature of New Labour policy

North and Werko (2002) note that following the exhortation that health authorities must involve the public in their local health plans through the HImP a number of subsequent policy documents set out further details on the subject including *A First Class Service* (DoH, 1998), *Patient and Public Involvement in the NHS* (DoH, 1999) and *The NHS Plan* (DoH, 2000). Furthermore, *The Health and Social Care Act* 2001 enshrined in law "a new duty on the NHS to involve the public in the planning and development of services, and in major decisions" (DoH, 2001c: 6). Indeed, Murray and Greer (2002: 194) suggest that: "Enhancing public participation can be regarded as a cross-cutting theme of *The Third Way* agenda".

The Labour Government from 1997 has increasingly regarded community participation as fundamental to the delivery of public policy objectives (Strobl and Bruce, 2000) and participation has been promoted nationally through a number of different government policies. The prominence of public participation and the recognition of the importance of communities having power and influence within the decision-making processes can be seen in the following extract from one of New Labour's key strategies for tackling social exclusion, the *National Strategy for Neighbourhood Renewal*:

> Communities need to be consulted and listened to, and the most effective interventions are often those where communities are actively involved in their design and delivery, and where possible in the driving seat.
> (Social Exclusion Unit, 2001: 19).

Participation of the kind advanced in the National Strategy for Neighbourhood Renewal requires that communities have influence, resources and the skills to exploit these opportunities fully. Such participation would feature very highly on Arnstein's (1969) ladder of citizen participation and would certainly be categorised as a degree of citizen power. However, positive as it may be to have government strategies and policies which promote public involvement, the inclusion of community participation in government policies should not replace the macro interventions necessary to overcome the structural inequalities within society. As Rifkin (1996: 79) notes, community participation is often conceived as "a magic bullet to solve problems rooted both in health and political power".

Indeed, Ferguson (1990) notes that technical solutions, such as community involvement, are often proffered for problems which require political solutions.

Furthermore, despite the inclusion of community participation in government policy documents, Lister (2001) and Holman (2001) both note that community involvement in the design of *national* policies and strategies is extremely limited.

Prior to the 1990s, it has been suggested that the highly centralised planning and political control over healthcare, along with the power and influence of the medical profession, meant that with regards to the NHS citizens were "merely recipients of technocratic and medical expertise delivered in accordance with central planning and clinical judgement" (Milewa *et al.*, 1998: 508). It is acknowledged that public and user involvement have received increasing political attention of one form or another in the UK for the last 10 years (Milewa *et al.*, 2002; Tovey *et al.*, 2001). However, it is recognised that this political exhortation to involve the public and users in health care has been cemented since the election of the Labour government in 1997 and that 'participation' is now a key element of health policy (Harrison *et al.*, 2002; Exworthy and Powell, 2000; Milewa *et al.*, 1999).

Furthermore, the decentralisation of power which has occurred within the NHS since 1997, as set out in *Shifting the Balance of Power* (DoH, 2001b), and exemplified in the transfer of £45 billion directly to PCTs (75% of the entire NHS budget) by 2004 may be regarded as providing enhanced opportunities for communities to influence health care planning in their locality (DoH, 2001b: 13).

A number of official bodies have been established by the government to facilitate and oversee public involvement in health care planning and delivery. These include *Patient Advice and Liaison Services* (PALS), established to provide information to patients, help resolve patients concerns and if necessary, support patients and carers in accessing Independent Complaints Advocacy Services (ICAS).

Additionally, each Primary Care Trust and NHS Trust had to establish its own *Patient and Public Involvement Forum* (PPIF) as the arena within which local patients may participate and these have become operational within the last month. PPIFs were established to monitor the standards of care received and the effectiveness of the local PALS service, and have powers to inspect all aspects of the work of trusts (DoH, 2001c). PPIFs provide the local authority Overview and Scrutiny Committees (OSCs), established in January 2003, with reports on the local patient experience. OSCs have the power to scrutinise health services as part of their wider remit of contributing to the health and well-being of local residents.

At the national level the *Commission for Patient and Public Involvement in Health* (CPPIH) exists to support and facilitate the co-ordination of PPIFs. The government also established a *Citizens Council*, to provide guidance to the National Institute for Clinical Excellence (NICE) in its decisions on treatments.

However, whilst consultation documents about each of these new public and patient participation bodies was in circulation and guidelines issued as to the requirements for each during my time in the field none of these new bodies was yet in place. The only impact the proposals to establish these new bodies had upon my research was to create anxiety amongst the Community Health Council (CHC) staff who were heavily involved in the HImP. This anxiety was created by the announcement in *The NHS Plan* (Department of Health, 2000) that CHCs, the traditional patient and public advocacy organisation within the NHS, should be phased out and replaced by PALS by April 2002. The implications of this are discussed in more detail in the next chapter. In reality, CHCs continued until December 2003 when they were finally abolished by Government.

These new formal mechanisms for involvement represent a shift in the relationship between the NHS and the public. As Klein (1984) notes, CHCs, whilst representing anyone with a complaint or query about health services, deliberately sought to ensure that the voices of the most marginalised sections of society were heard.

> By ensuring the presence of members representing pressure groups for the mentally ill and handicapped, among others, the constitution of CHCs gives a voice to those citizens least able to participate in political processes: that is, the most vulnerable.
>
> (Klein, 1984: 30).

Furthermore, CHCs were independent bodies, whereas PALS are part of the health service and located within hospitals. The abolition of CHCs was strongly contested, including by Peers in the House of Lords, and the new arrangements criticised as "a pointless fragmentation of powerful community champions in the NHS" (Wintour, 2002: 2), which would leave no single organisation with an overview and powerful critical voice.

However, the policies and organisations introduced by the Labour government are argued to place more recognition on the role that citizens may have in healthcare, facilitating their participation in planning and decision making, rather than simply reacting to pre-determined plans through CHCs and formal consultations (Milewa *et al.*, 1999). For Tovey *et al.* (2001: 156), the perception of citizens as:

> passive recipient[s] of services (planned and delivered by almost omniscient and implicitly benign technocratic and medical experts) appears to have given way to a more proactive, informed and perhaps combative 'patient-consumer'.

Exworthy and Powell (2000) note that the goals the NHS pursues are multiple and often conflict. For example, two key strands of current government health policy are the promotion of public involvement in health planning and the assertion that policy initiatives should be evidence-based practice. As Harrison *et al.* (2002: 63) state, "giving people what they want may not be compatible with what the evidence says they should have." Weatherly *et al.*, in their examination of the use of economic evidence in the design of HImPs found that local constraints including:

> time limitations, lack of certain expertise and the need for political acceptability [...] often restricted the extent of the search for, interpretation and use of economic evidence.
>
> (Weatherly *et al.*, 2002: 4).

Moreover, they found that the main form of evidence those developing the HImP relied upon was national guidelines emanating from institutions such as the National Institute for Clinical Excellence (NICE) and from National Service frameworks (NSFs). Consequently, for participation to become sustainable and to ensure that it is compatible with other guidance being disseminated, it may be necessary to ensure that the national guidelines incorporate evidence relating to good practice in community participation.

There is also growing commitment to the value of community participation amongst local policy makers and service deliverers (Carruthers *et al.*, 1999). However, uncertainty exists about the multiplicity of initiatives that call for community participation (Judge *et al.*, 1999). There is also concern that communities will be 'over consulted' and become cynical about frequent consultation if this does not lead to positive outcomes. As Arora *et al.* (1999: 64) note in their report on the first year of developing HImPs, with the "plethora of emerging models for public involvement [...] the issue of 'user fatigue' is becoming very real".

## Conclusion

In this chapter I have identified the global trend towards increased participation which, I would suggest, established an environment within which it was conducive to promote public and patient participation nationally. The rationale behind the current government push for increased participation has been examined and contrasted with the underlying principles of participation held by the Conservative administrations of the 1990s. This chapter has discussed the philosophy and approach of 'New Labour' focussing particularly on the modernisation of the NHS agenda. The implications, and indeed the existence of a 'third way' have been discussed and examples of policies which encompass the 'joined-up working' approach presented. The Health Improvement Programme itself has been described and its key functions of tackling health inequalities and working in partnership, with communities identified as key partners, examined. Finally the chapter examines the growing import of community participation in government policy since the advent of the HImP.

The examination of the macro- and meso-level influences upon community participation in health care planning and delivery has provided a broader knowledge-base which serves as important contextual information for the next chapter which presets an analysis of the micro-level influences upon community participation in Coventry's HImP and the case study findings, presented in Chapter Six. This chapter has helped to highlight the issues of relevance to my research question: "How important are contextual factors in shaping the form and approach adopted to involve communities in the HImP?" I have shown how the opportunities and challenges faced by those seeking to implement community participation in HImPs at the local level are influenced, and thus may be better explained, by their relation to the national context and culture, which in turn reflects and mediates wider global trends in health policy.

# CHAPTER FIVE

# BACKGROUND TO THE CASE STUDY

## Introduction

The previous chapter set out the macro and meso level influences upon community participation in health service planning and delivery. This chapter describes the micro level social, economic, political, cultural and institutional framework within which those charged with engaging the community in Coventry's HImP were operating in order to contextualise the findings. The chapter provides background contextual material on Coventry and provides a brief sketch of the population health status within the city. A description of the aims of Coventry's HImP and the structure for the local development and delivery of the HImP follow in order to facilitate the readers understanding of the different strategies and operational levels within Coventry's HImP. This chapter will then provide an account of developments within the case study site during the research period which have significance for and an impact upon the research findings. Through this analysis of the micro-level I will demonstrate how the macro and meso-level influences described in the previous chapter shaped the local response to policy implementation, including the influence upon the environment within which local actors were seeking to develop community participation.

## Coventry – health, social and economic characteristics

It is necessary to consider the economic, social, cultural and political environment of Coventry as this will create both opportunities and barriers for community participation in the HImP. The following discussion therefore serves as valuable background information to the case study findings.

At the point at which I began the empirical data collection for this research in January 2000, Coventry Health Authority was responsible for a population of 331,788. The City had three Primary Care Groups (PCGs) with populations as follows[1]:

| | |
|---|---|
| East | 102,829 |
| North | 88,734 |
| West | 140,225 |

The joint health and local authority submission for the HImP Performance Award in January 2000 noted that Coventry Health Authority was the 13th most deprived nationally, as reflected through the Jarman index[2]. It also reported that according to 1998 Index of Local Deprivation[3] statistics 11 enumeration districts fell within the worst 1% nationally and 21 enumeration districts fell within the worst 1% of lowest earners. Index of Local Deprivation statistics measure deprivation at three different levels and are thus useful in providing different pictures of the geography of deprivation within an area depending upon the scale at which it is analysed.

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[1] The south of the city was covered by the East and West Primary Care Groups.

[2] The Jarman index is a measure of deprivation which comprises eight variables: unemployment; overcrowding; lone pensioners; single parents; residents born in the New Commonwealth; children aged under five; low social class, and one year migrants.

[3] The 1998 Index of Local Deprivation was made up of four different measures based on three different spatial scales - local authority district, wards and enumeration districts.

Deprivation and ill-health were primarily concentrated in six areas within the city, the majority of these being in the north and east, with one area in the west. However, small pockets of deprivation may also be found within more affluent areas of the city. Figure 5, which presents a map of deprivation in Coventry, as defined by the Townsend[1] score, illustrates these geographical concentrations (Source: Coventry Health Authority, 1998). Both the Townsend and the Jarman index were regularly used by Coventry Health Authority, depending on the level of detail required and the data available.

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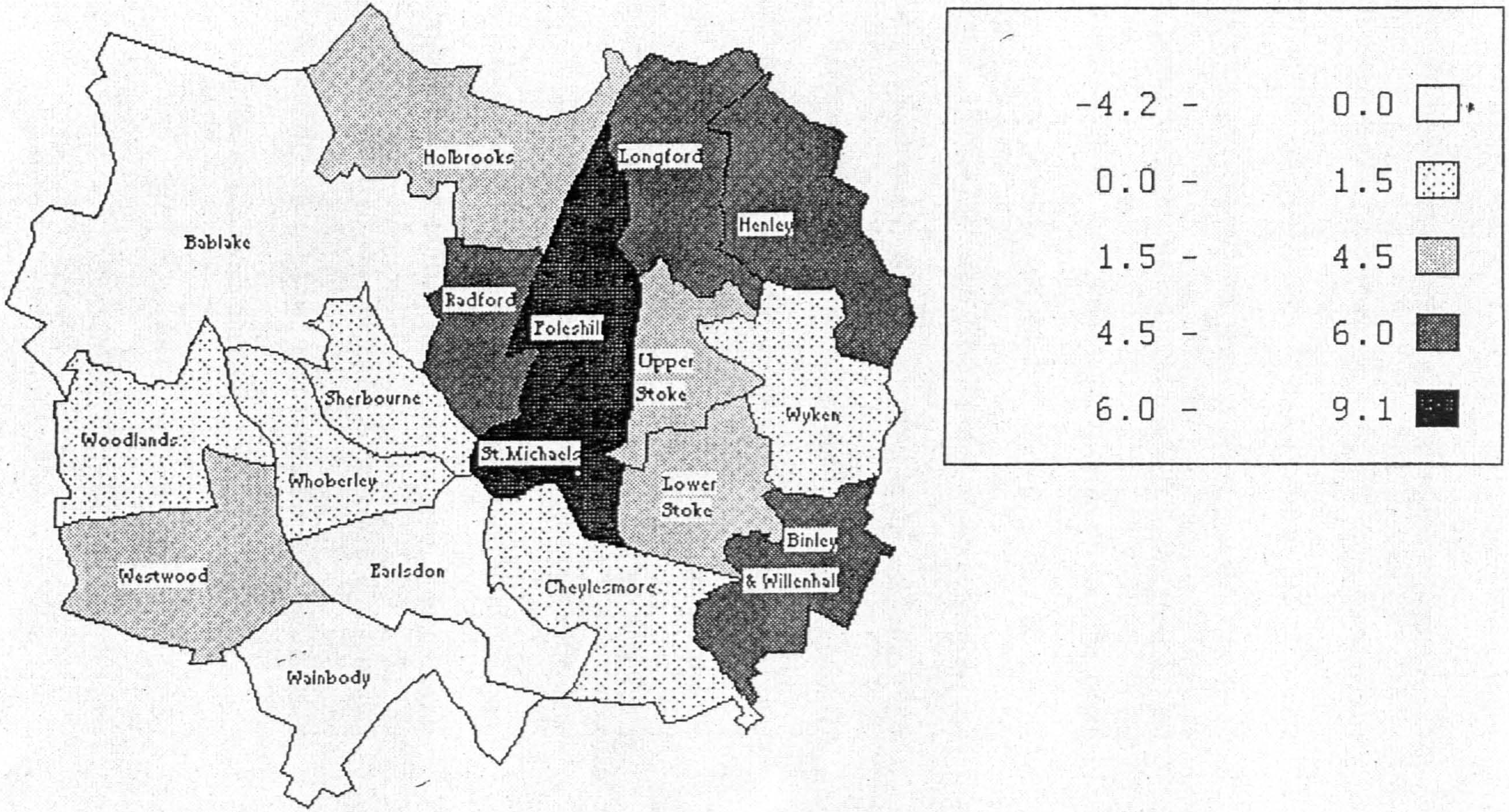
[1] The Townsend index comprises four variables: unemployment; overcrowding, non car ownership and non house ownership.



TOWNSEND SCORE BY COVENTRY WARD

Through its Area Co-ordination structure Coventry City Council had a strong focus on regeneration and had received Single Regeneration Budget money for 7 years, as well as European Social Fund monies to work with socio-economically disadvantaged communities within the city. Area Co-ordination served as a mechanism for integrating and co-ordinating service delivery at the local level. Area Co-ordination Teams actively involved local residents in the planning and delivery of local policy in the six most disadvantaged areas of the city, which between them covered approximately one third of the city's total population (Coventry City Council, 1999). The Area Co-ordination structure had existed since 1994 and involved a team of officers from a number of the local authority's service departments working together with other agencies and community representatives in each of the six areas. It was a multi-agency partnership between all the major strategic public agencies, the private and voluntary sectors and the community. Each of the local authority's six 'Priority Areas' had an Area Team comprising a full-time neighbourhood-based area co-ordinator (an officer from the local authority Chief Executive's department) and an administrative officer. Additional team members included officers from Council service departments, other agencies (e.g. health, police, and voluntary agencies) and community representatives. Each Priority Area was supported through ward-based councillors. A profile of Coventry is provided in Table 2.

**Table 2: Profile of Coventry**
(Source: Adapted from the 'Community Profiles' categories suggested in Abelson *et al*, 2001: 781).

| | COVENTRY |
|---|---|
| Population | Medium-sized city. Population approx. 330,000 |
| Socio-economic characteristics | The city as a whole has an average socio-economic status (i.e. typical in terms of unemployment levels, average earnings etc) and average educational attainment level for England. However, concentrated pockets of severe deprivation exist within the city. |
| Employment characteristics | Traditionally an industrial working-class city, Coventry was hit hard by the decline in manufacturing during the late 1970s and experienced widespread recession. Re-positioning itself at the heart of the growing telecommunications industry in the late 1980s, the local authority attracted substantial investment, creating over 20,000 new jobs. However, 21 of the city's enumeration districts still fall within the worst 1% of lowest earners nationally. |
| Geographic and administrative characteristics | Deprivation levels and ill-health are concentrated in six geographical areas. The local authority has a strong focus on regeneration and has received Single Regeneration Budget money for 7 years, as well as European Social Fund monies to work with socio-economically deprived communities within the city. |
| Cultural characteristics | Coventry has an ethnically diverse population with 9% of the population of Asian origin, 2.3% of African/Caribbean origin and 0.2% of Chinese origin. 88.5% of the City's population are defined as White which includes a significant percentage of peoples of Irish decent, a Polish community and during the last decade an increasing number of refugees and asylum seekers especially from the Balkan region. |
| Political characteristics | Traditionally a powerful 'old-Labour' style local authority with the decline in the traditional manufacturing industrial bases to the City's wealth and power the Council has experienced restructuring and has moved towards a New Labour agenda. |
| Health characteristics | The Coventry Standardized Mortality Ratio (SMR) for Coronary Heart Disease (CHD) is 11% above the national average and 3% above the regional average. Death rates from CHD are 34% higher than the Coventry average in Indian men and 17% higher in women. Teenage conceptions are higher than the national average as is the perinatal mortality rate. There are also significant inequalities within Coventry linked to deprivation. |

Coventry was one of the country's major industrial cities. The city and surrounding areas were hit hard by the decline in manufacturing, particularly in the British car industry, during the late 1970s and early 80s, and has experienced widespread recession (at it's worst with an unemployment rate of 20%) and a subsequent restructuring. Re-positioning itself at the heart of the growing telecommunications industry and the service sector in the late 1980s, the city experienced a revival, but has since been hit once more by the downturn in the telecommunications industry in the late 1990s. However, the local authority has been relatively successful in attracting investment - £2.4 billion in 2000 (DETR, 2000) and creating over 20,000 new jobs. Despite this, 21 of the city's enumeration districts still fall within the worst 1% of lowest earners nationally.

The local authority itself has also experienced restructuring and has moved towards a New Labour agenda, as described in Chapter One. The health authority, as it was during the period in which field work for this research was undertaken, may also be regarded as having subscribed to a New Labour philosophy, endorsing the principles of intersectoral working; partnerships, and citizen and user participation. Political context is thought to be important because as Doran and Whitehead (2003) found in their multi-case study research of local authorities in England, political context impacts upon health. This is proffered to be a result of the types of policies and programmes of action favoured under particular political conditions. However, Doran and Whitehead's research is continuing in an attempt to further examine the differences in health profile found in different political contexts.

### Coventry's Health Improvement Programme

The Coventry HImP set out two specific aims for the second phase period from April 2000 - March 2003. These were:

- To improve everyone's health, and
- To reduce inequalities in health.

These two aims reflect those of the consultative document *Our Healthier Nation* (Department of Health, 1998c) and are common aims for most HImPs (Powell *et al,* 2001). However, the mechanisms employed to meet these aims, and the priorities and health needs identified as those most urgent to tackle if these aims are to be met, vary by locality. The key issues to be addressed in Coventry, as identified in the 2000-2003 HImP were:

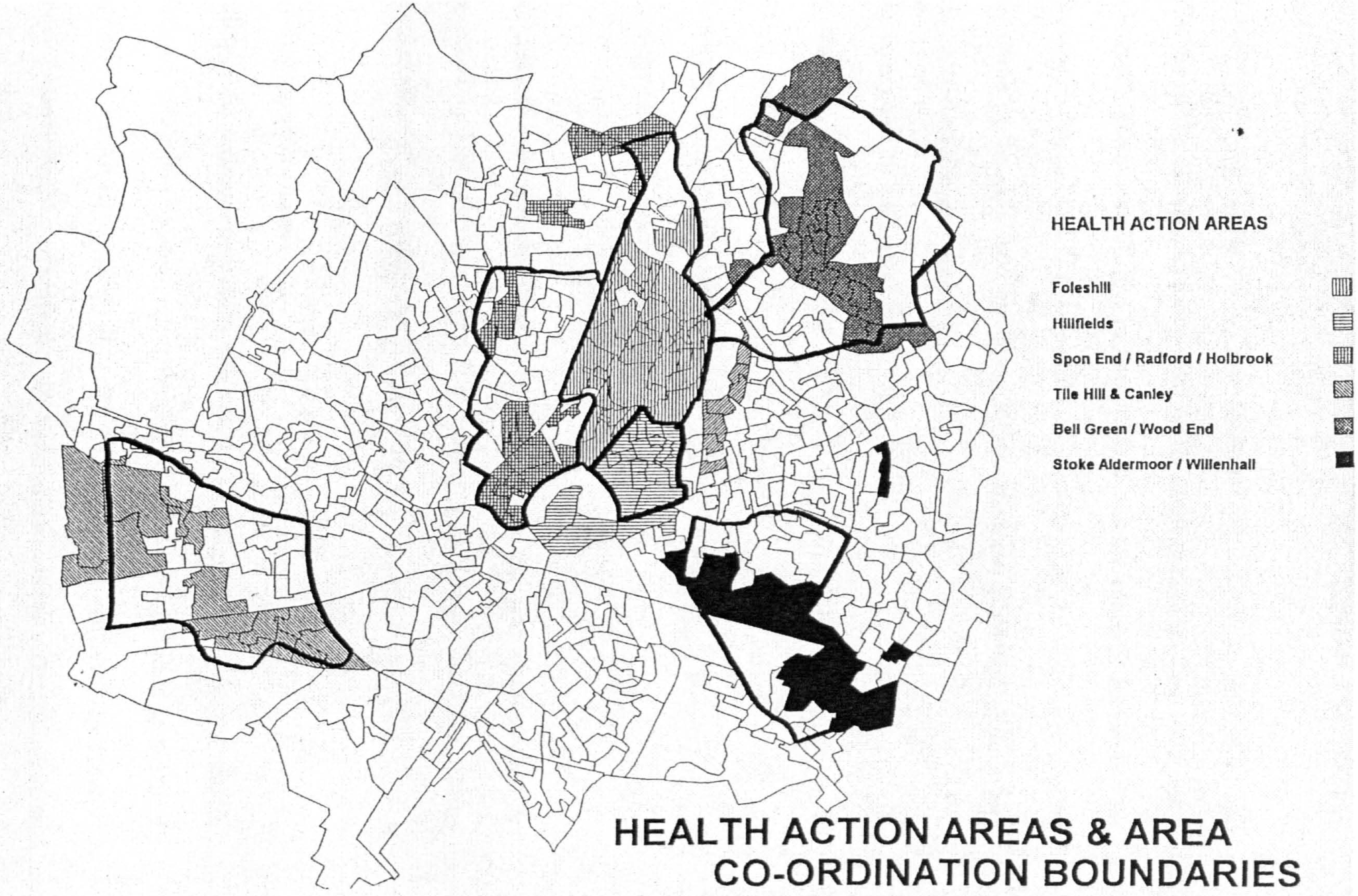
- Social Exclusion;
- Health Inequalities;
- Accidents;
- Cancer;
- Children in need;
- Coronary Heart Disease and Stroke;
- Diabetes;
- Drugs Misuse;
- Environment;
- Learning Difficulties;
- Mental Health;
- Older People;
- Sexual Health,

- Modernising Health Services.

Some of these priority areas, i.e. Coronary Heart Disease and Stroke, Cancer, Mental Health and Accidents, were national priority areas set out in *Our Healthier Nation* (Department of Health, 1998c) and were to be incorporated into every HImP in the country. The remainder of Coventry HImPs priorities were informed by local needs assessments, public health information for the area and issues identified as needing to be tackled by Coventry's citizens.

*Tackling health inequalities*

Coventry HImP stated that reducing health inequalities was one of its two core aims. One of the key ways in which this aim was to be tackled was through the health authority's designation of the most deprived areas within the city as Health Action Areas (HAAs). These HAAs were co-terminous with the six local authority Area Co-ordination Priority Areas, allowing greater opportunities for collaboration between the two agencies as well as with other organisations to deliver interventions which aimed to reduce health inequalities and tackle their root causes. By working in partnership with the local authority the health authority was able to draw on the experience Coventry City Council had of working in and with communities living in these six 'Health Action' or 'Priority' areas. Each of the six areas had a Health Action Group (HAG) which was a jointly managed health and local authority initiative in which key organisations working in the area met together with community members to discuss priorities for action and possible strategies for dealing with these priorities. Figure 6 illustrates the location of the six Health Action Areas within the city (Source: Coventry Health Authority, 1998):



HEALTH ACTION AREAS & AREA CO-ORDINATION BOUNDARIES

## Structure for the development and delivery of the HImP

### *The HImP Steering Group*

The HImP Steering Group (HSG) had responsibility for the co-ordination and production of the HImP and for overseeing its implementation. The HSG was a multi-agency group, established in June 1999 to set the strategic framework for improving health and tackling inequalities in Coventry. At the time of presenting my research to the HSG and recruiting interviewees the HSG had 17 members representing the following organisations:

- Coventry Health Authority;
- Community Health Council;
- Coventry City Council;
- Coventry Voluntary Services Council,
- Coventry Racial Equality Council.

A representative from each of the three PCGs in the city was also recruited as members of the HSG during my period of observing the group's activities, taking the total number of individuals on the HSG to 20.

### *HImP Development Groups*

For each of the priority programme areas within the HImP a multi-agency, multi-disciplinary group had been, or was in the process of being established by the time of my exit from the field in February 2002. These groups were to include, as a minimum, representatives of voluntary organisations as well as statutory agencies and a broader range of representatives was encouraged (See Appendix G for 'model' membership). Referred to as HImP Development Groups (HDGs) they were responsible for agreeing:

- The priorities within their programme area;
- The targets to be achieved;
- An evidence based action plan, and
- The monitoring arrangements.

Coventry's HImP was divided into 14 priority programme areas, 13 of which had HImP Development Groups to take the area of work forward.[1] HDGs were to "lead policy, identify priorities for action, specify city-wide targets and provide guidance on the interventions known to be effective" for their particular area of work (Coventry Health Authority, 2000a: 4). As well as being responsible for compiling action plans, HDGs were to ensure that they linked with other programmes of action related to the issue and that all of the plans sought to reduce inequalities. A copy of the key terms of reference for HDGs, produced in October 2000, can be found in Appendix H. The Modernising Health Services programme of work incorporated the mainstream strategic and operational health service issues required to meet the government's modernising agenda. This programme spanned the whole spectrum of activities undertaken by the health authority and consequently this particular area of the HImPs work did not have a designated HDG to take the work forward. Rather, it was managed through mainstream health authority, PCG and Trust business processes.

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[1] HImP Development Groups were each led by a member of the HImP Steering Group.

Interestingly, of the four Steering Group members who were not HImP Development Group leads this included all three representatives from the voluntary sector. I interviewed two of these three voluntary sector organisation representatives as part of the fifteen interviews carried out. Rather than being perceived as a tactic employed to ensure that power remained within the statutory sector, both of these individuals suggested that this was due to the fact that the voluntary sector did not have the capacity to take on the role of leading on a specific area of the HImP. Unlike statutory sector employees, for whom the HImP formed a major part of their role and directly related to their other responsibilities, voluntary sector employees could not dedicate the amount of time needed to coordinate a HImP Development Group, stating that their roles were both wide-ranging and multi-faceted. The following table illustrates the variety of agencies included on each of the HImP Development Groups:

**Table 3: Agencies represented on each of the thirteen HImP Development Groups**

| HImP Priority Programme Areas with an HDG | Agencies represented on the HImP Development Group |
|---|---|
| Health Inequalities | Area Co-ordination, Coventry North & West PCGs, Health Authority, Social Services, Acute Trust, Community Trust, Citizens Advice Bureau, Coventry City Council. |
| Older People | Age Concern, Coventry City Council – Corporate Policy Team, Better Government for Older People Pilot, Health Authority, NHS Trust (Mental Health – Older People's Services), Social Services, Social Services – Finance, Social Services – New Homes for Old Project, University Hospitals Coventry & Warwickshire NHS Trust, PCG. |
| Learning Difficulties | Old Joint Commissioning Group used as HDG. This included representatives from the Health Authority, Community Education and Local Authority. Membership has been widened to include the Community Trust and additional staff from Social Services. |
| Environment | Agenda 21,. City Council – Housing Services, City Development (Transport), Action Against Crime, Environmental Services, National Energy Action, Health Authority – Public Health, City Council – Leisure Services, City Council – Education, Health Authority – Health Promotion, City Council – Area Co-ordination. |
| Mental Health | Old Joint Commissioning Group used as the HDG. Included local Trusts, Social Services, Voluntary Agencies, User Groups, PCGs, CHC and the Health Authority – Public Health. Intention is to broaden membership in the future. |
| Drugs Misuse | Chief Execs and/or people at organisational level from the Police, Probation Service, Education and Social Services. Also CHC, Area Co-ordination, PCGs, Local Authority Health Development Unit, Coventry Healthcare NHS Trust – Community Drugs Team, Young People's Substance Misuse Service, Action Against Crime Partnership, Coventry Health Authority, Youth Service. |
| Social Exclusion | Health Agencies, Voluntary Sector, Coventry University, University of Warwick, Local Authority. |
| Accidents | No group in existence at point of interview in 2000. The HImP chapter had been written in conjunction with a number of different agencies, who, I was advised "may or may not eventually be on the HDG". It was hoped that the group would include representatives of all service providers and a number of voluntary sector organisations including: City Council, NHS Trusts, Primary Care Groups, voluntary sector (e.g. Age Concern,) local universities, health authority and the private sector. |

| **HImP Priority Programme Areas with an HDG** | **Agencies represented on the HImP Development Group** |
|---|---|
| Children in need | Not established at point of interview in 2000. *Quality Protects* Management Action Group used to ratify HImP (includes local authority - Social Services, Education, Housing, Leisure Services - and health authority). Intention was to build upon this group and broaden the membership |
| Cancer | Coventry Health Authority, Warwickshire Health Authority, Primary Care Groups, Health Promotion Services, User Group representative. In negotiation with voluntary sector to discuss their involvement at point of interview in 2000. HImP Development Group was part of a wider group, *Coventry and Warwickshire Cancer Network* required by Quality programme - involved with setting priorities and planning. |
| Sexual Health | Teenage Pregnancy National Strategy Local Implementation Team used as HDG. This included Family Planning, G.U. Medicine, HIV Voluntary Services, Terence Higgins Trust, Community Trust, Public Health, Health Promotion, Youth Service, CHC, PCGs, Local Authority Health Development Unit, Education, and the Health Authority. |
| Diabetes | *Local Diabetic Services Advisory Group* used as the HDG. This group included UK Diabetes, Consultant Physicians, Specialist Diabetes Nurses, Dieticians, Chiropodists, Paediatrician, CHC rep, and 1 PCG rep, Health Authority – Public Health, Health Authority – Health Promotion, PCG Nurse, Ophthalmologist and an Optometrist. |
| CHD | Local Implementation Team for CHD National Service Framework used as HDG. This group included: Health Promotion, Local Authority Health Development Unit, 3 GPs (PCG CHD reps), CHD Nurse, Voluntary Sector (Heart Save), Consultant Cardiologist, NSF Nurse, Cardiac Rehab Nurse, Trusts and the Health Authority. |

Many of the groups designated as HImP Development Groups were already in existence as a Joint Commissioning Groups (JCG) or as specific targeted partnerships, such as the *Quality Protects* Management Action Group working on child protection issues and the Drugs Action Team looking at drugs misuse. Many of these groups remained the same but were rebadged as HImP Development Groups (HDG). Others experienced a slight change of membership, widening or reducing numbers as was felt appropriate to the area covered by the HDG.

> The Drugs Action Team (D.A.T.) includes people at Senior Officer or Chief Executive level within organisations such as the Police, Probation Service, Education and Social Services. The D.A.T. was used as the HImP Development Group initially but it has now been broadened to include members of the Drugs Reference Group. This group includes people working at operational level in these same services and also includes user representation and representation from the Community Health Council.
> (Drugs Misuse HImP Development Group lead, Interview, 07/08/00).

Such an approach makes sense in so far as developing new partnerships is time consuming, requires a long period within which to build trust and effective working arrangements and for the simple fact that there are only a limited number of people within the City with a specific interest in, for example, learning difficulties. Since a new group would probably draw on these same individuals for yet another purpose it seems logical to incorporate the work of the HImP into a pre-existing group's workload. However, the danger with this is that it means the group was not established with HImP priorities in mind. This may lead to lack of enthusiasm for taking HImP priorities forward, an overburdening of a few key individuals, and/or the possibility that some of the people on the group are not appropriate to this work and that individuals who may be more appropriate are left out of the HImP planning and delivery process.

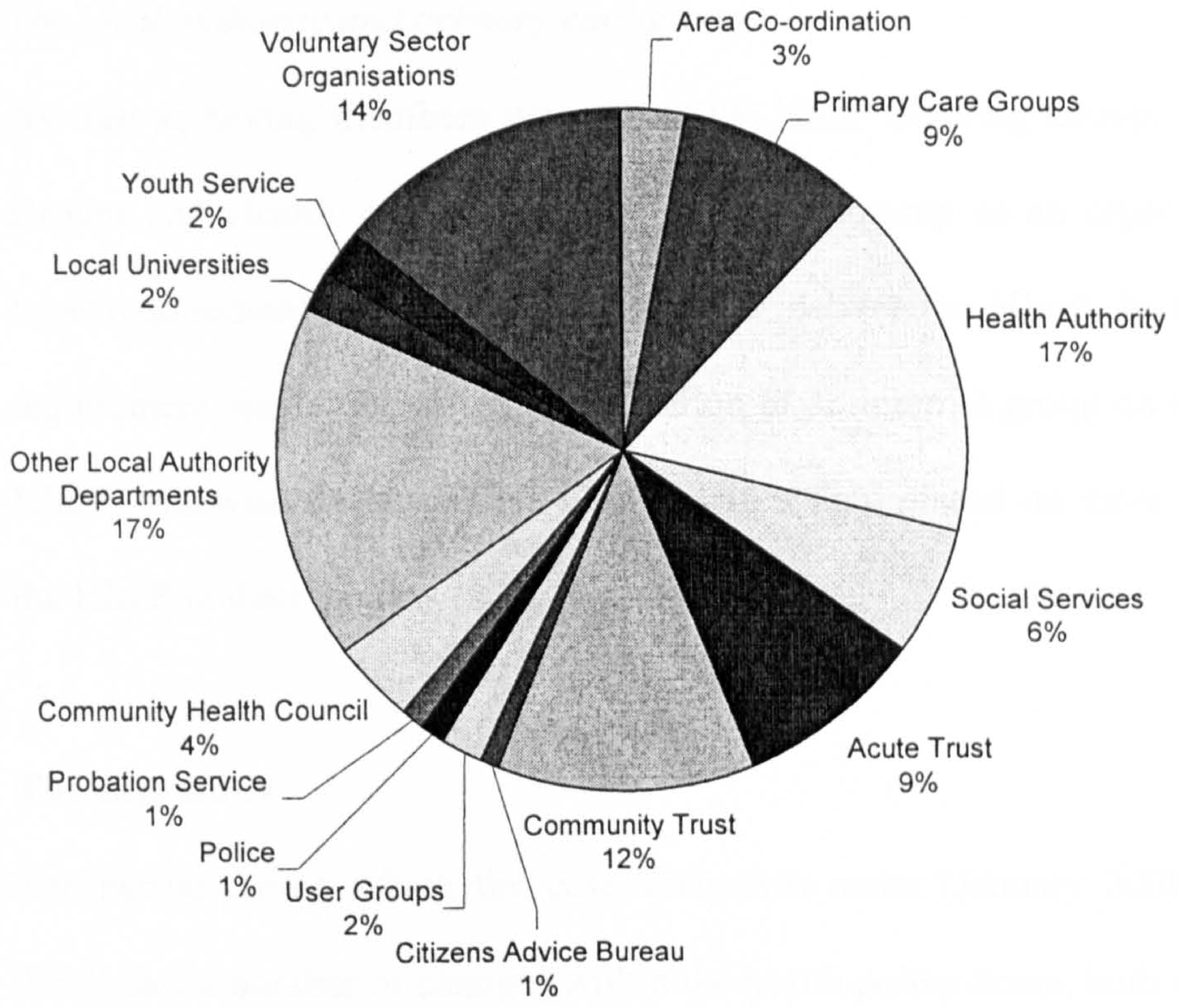
The health authority took the lead for developing a new group to function as the Health Inequalities HDG whilst the local authority developed new groups to lead on Environment, Accidents and Social Exclusion issues. Existing joint working arrangements were extended to incorporate a HImP remit for the following HImP priority programmes: Older People, Learning Difficulties, Children in need, Mental Health, Drugs Misuse, CHD and stroke, Cancer, Sexual Health and Diabetes.

By appointing HImP Development Group leads who represented senior health and local authority staff, in charge of groups consisting of individuals from a wide range of organisations - statutory, voluntary, charities and local universities - ownership of the HImP was widely dispersed across a range of organisations within the city, even if overall responsibility for the HDGs lay with the health and local authorities. One of the HImP Development Group lead posts was a joint post, working across the health and local authorities. The person holding this particular post felt that this was a strategy which would be used significantly more in the future in an effort to promote collaborative practice.

HImP Development Groups have the responsibility for disseminating their priorities to a wide range of stakeholders for consultation. This structure for and process of involvement of stakeholder groups is displayed in appendix I.

An analysis of the organisations involved in the HImP Development Group revealed that 77% of all agencies represented on these groups were from the statutory sector, 19% from the voluntary sector, 2% represented user groups and 2% were from the higher education sector.

**Figure 7: Agencies represented on HImP Development Groups**



*Health Action Groups*

Health Action Groups (HAGs) existed in each of Coventry's six Health Action Areas. These areas were recognised as being the most socio-economically disadvantaged areas of the city in which residents typically experienced worse health than citizens residing in other areas of the city. HAGs were jointly managed health and local authority initiatives that provided a forum in which stakeholders from the local authority, health authority, PCG and Community Trust could work together and in partnership with voluntary organisations and community members to discuss and take forward health development priorities within the area. Appendix J sets out the key terms of reference for a Health Action Group.

### *The local authority and primary care groups*

As well as having members who sat on the HImP Steering Group, Development Groups and Health Action Groups, the local authority as an organisation had a legal requirement to work in partnership to deliver the HImP. In Coventry this requirement was satisfied by the formation of an internal group on delivering the HImP. Likewise, Primary Care Groups had a duty placed on them to implement the HImP in their locality (S28, Health Act, 1999).

## The case study

The period during which the case study was made (January 2000 to February 2002) saw a number of changes within the health policy arena, both nationally and locally, a number of which had a significant impact upon the institutional and policy context of the research. When the research was originally being planned I was interested in examining the issue of community participation in health, having worked on the evaluation of the *Coventry Community Research Project*, a needs assessment exercise which trained local people living in disadvantaged areas of the city to carry out the needs assessment in their area. As discussed in Chapter One, whilst undertaking this evaluation I became interested in the way in which some of those participating benefited from this experience and the obvious potential for empowerment through participation in such exercises. I became keen to explore the issue of participation further.

At this point in time the Health Improvement Programme was a relatively recent initiative in its first year of development. Having examined the *New NHS* White Paper, the emphasis placed upon HImPs as three-year programmes which must work in partnership with all local stakeholders, including the public, made it an obvious choice. The HImP was a critical element of the NHS modernisation project. It was claimed that the HImP would be the key local strategy for improving healthcare and the vehicle by which national targets were to be delivered locally (DoH, 1997). Consequently I felt that the implementation of the community participation element of the HImP would constitute an interesting research topic.

### *Political changes*

A number of significant changes occurred from the outset of this research. In particular, the replacement of Frank Dobson as Secretary of State for Health in October 1999 by Alan Milburn bought with it a shift in the rhetoric relating to the health service. An increased emphasis was placed on 'delivering' on traditional NHS concerns and targets, such as waiting lists, and less prominence given to the wider determinants of health agenda embodied by HImPs. I was concerned that this may signify an end to Health Improvement Programmes. However, after spending a couple of months familiarising myself with the literature around community participation, no new developments had occurred within health policy and so I decided to proceed with my research idea and approached the person in charge of the HImP in Coventry about becoming my case study site. Permission was granted and all the necessary access arrangements made.[1]

### *Policy changes*

I began to gather data on Coventry's HImP from January 2000 and during my first year of closely observing processes (March 2000 to February 2001) a number of changes occurred. As the findings will reveal the structure for the development and delivery of Coventry's HImP was still very much in the process of evolution during this period.

One factor inhibiting wider involvement from the voluntary sector was the uncertainty surrounding the future of Community Health Councils (CHCs). *The NHS Plan*, published in July 2000, stated that CHCs should be phased out by April 2002 and be replaced by PALS (Patient Advice and Liaison Services)[2]. Coventry HImP was quite heavily reliant on the involvement of the local Voluntary Services Council and the Community Health Council. However, the proposed abolition of CHCs and ensuing dispute about its replacement by an NHS-run service (PALS) meant that the CHC, who were already understaffed, were unable to recruit any new personnel. As a result responsibility fell to the same CHC member to attend all HImP meetings and participate in all HImP related events. Whilst understaffing would most likely have been an issue

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[1] More detailed information on access to the case study site and key personnel was presented in chapter three.

[2] A more detailed discussion of the differences between CHCs and PALS was provided in chapter four.

regardless, the uncertain future of this patient and public advocacy service clearly exacerbated these problems.

The shift in government priorities towards the implementation of the NHS Plan following its publication in July 2000 is reflected in the development of NHS Plan Modernisation Boards charged with implementation. In April 2001 it was announced that Health Improvement Programmes (HImPs) were to join together with the newly established NHS Plan Modernisation Boards to become 'Health Improvement and Modernisation Plans' (HIMPs). The wider determinants of health agenda was given less prominence within the remit of the HIMP, and was regarded locally as falling under the auspices of the National Strategy for Neighbourhood Renewal and hence to be addressed by Local Strategic Partnerships (LSPs) and the New Deal for Communities (NDC) programme. The main remit of the HIMP became the implementation of the NHS Plan. In brief, the key objectives of the NHS Plan were to ensure that there was:

- More staff, equipment and facilities;
- Patient focussed services;
- Patient and public involvement;
- More national standards; and
- Improved health, reduced inequalities.

The publication of the NHS Plan was regarded by all Steering Group members as having a number of implications for the HImP. In particular, the NHS Plan Implementation Programme, published in December 2000, set out the priorities for reform and specified the targets and planning milestones which had to be achieved during 2001/2. These targets had repercussions for the following HImP priority areas:

- Modernising Health Services;
- Cancer;
- Children in Need;
- CHD & Stroke;
- Mental Health;
- Older People;
- Health Inequalities;
- Sexual Health, and
- Drugs Misuse.

However, five of Coventry's priority areas were not NHS Plan priorities. These were:

- Accidents;
- Diabetes;
- The Environment;
- Learning Difficulties, and
- Social Exclusion.

It was recognised within the Steering Group that non-NHS Plan priorities would take a back seat and this was reflected in the financial allocation to each of the HImP priority areas. However, Accidents, as an *Our Healthier Nation* priority and Diabetes and Learning Difficulties, both of which were anticipating National

Service Frameworks, were operating to tighter national control than the Environment and Social Exclusion. As a result of the change to HImPs Coventry's HImP Development Groups changed to become HIMP 'Programme Areas' and the Steering Group incorporated into a Project Board charged with implementing the HIMP. The HIMP itself fed into Coventry's Local Strategic Partnership.

With regards to the tackling of inequalities in health two national health inequalities targets were published in February 2001. These were:

- "Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole;
- Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole" (DoH, 2001a: 13).

These 'headline' targets were followed by the production of a consultation document in August 2001 and a series of regional workshops throughout the autumn on the action needed to deliver on these targets. Whilst I was encouraged that health inequalities remained a priority, the agenda set by the introduction of these targets was different to that of the Health Inequalities HImP Development Group. The focus of the HDG had been broader than narrowing the gap in mortality within the city seeking also to improve access to health services in the city. The wider determinants of health agenda, i.e. unemployment, poor skills, housing, education, crime etc, being tackled by the Social Exclusion HImP

Development Group was not touched upon at all by the introduction of these targets.

### *Organisational changes*

As discussed in Chapter Three a number of changes occurred which impacted upon my fieldwork. In April 2001 Coventry Primary Care Trust replaced Coventry Health Authority as the principal organisation with commissioning responsibilities (alongside PCGs) within the city. As described in Chapter Three, a number of the key personnel from the health authority who had important development roles within the HImP and who had been members of the HImP Steering Group moved positions to join the new leaders of Coventry's PCT and this impacted upon my fieldwork. April 2001 also saw the shift from Health Improvement Programmes (HImPs) to Health Improvement and Modernisation Plans (HIMPs). These changes meant a period of considerable uncertainty for many of those involved with the HImP as well as amounting to an end to my facilitated access to observe Steering Group (now known as Project Board) meetings.

Throughout the period during which empirical data was collected there were plans to expand the Area Co-ordination structure to cover the whole city. Within this new structure there would be 31 'priority neighbourhoods' instead of the six Health Action Areas. Quite what the impact of this on mechanisms to engage community members would be is unknown. The existing six priority areas each covered a range of neighbourhoods and the shift to 'priority neighbourhoods' was defined as an attempt to identify 'real' neighbourhoods as a basis for locality planning. This could mean that the new structure would further facilitate participation by marginalised groups outside of the original Health Action Areas. However, as the following discussions will demonstrate, the Health Action Groups, one of which exists in each of the six Health Action Areas, were still being championed as the most appropriate way in which to involve the public. No plans had yet been drawn up to detail what would happen to these groups and how the 31 priority neighbourhoods would feed into them. Removing this forum and replacing it with even smaller groups could be detrimental in that it may not produce the critical mass needed to make decisions and act upon them.

The ever changing policy context and its impact upon organisational structures and responsibilities is something which NHS employees have to deal with constantly. Furthermore, it impacts upon all of the organisations and groups who form partnerships with NHS organisations. This feeling of being in a state of flux perhaps partly accounts for why elements of the New Labour modernisation agenda for health, which were regarded by some within the case study site as 'fashionable' rather than enduring priorities, (for example community involvement and tackling inequalities), were taken less seriously than the ever-present agendas around waiting times and reducing winter pressures.

These changes caused me some problems in that the focus of the work being carried out in the case study site changed slightly, along with a change in a number of the key personnel who had facilitated my access to the site. However, in consultation with my supervisor I decided that the central purpose of the case study, i.e. to investigate the implementation process surrounding community involvement remained a viable topic of examination.

## Conclusion

In this chapter I have presented an analysis of the micro-level contextual influences upon community participation in the HImP including: the local characteristics of the case study site; the local structure for the development and delivery of the HImP; and the political, policy and organisational changes which occurred during the two year period within which the fieldwork was undertaken. These micro-level factors may be regarded as interrelated to the meso and macro-level influences on public participation in health planning presented in the previous chapter. Together these two chapters provide a contextual analysis which help to explain the case study findings presented in the following chapter.

# CHAPTER SIX

# CASE STUDY FINDINGS

## Findings from the fieldwork

Having set out the important contextual considerations in Chapter Five this chapter will present the findings to the nine key research questions this thesis set out to examine, drawing on material collected within the case study site. These findings and their implications are discussed in detail in Chapter Seven.

As outlined in the introductory chapter, this research set out to examine a set of nine key research questions. These were to be explored through an examination of the literature, supplemented with a detailed case study of the processes employed by those agencies charged with involving the public in the planning and delivery of a HImP. The purpose of the case study was to examine how the responsible agencies were attempting to implement the community participation element of HImP policy and to identify those factors which impact upon their ability and desire to work with a broad range of partners, including communities. Eight of these nine questions were examined in detail within the case study. These were:

- How do those with a responsibility for HImP development and delivery feel about community participation in health planning and delivery?
- What different approaches are adopted within the HImP to involve the wider community?
- What approaches will be used within the future to improve community involvement in Coventry's HImP?

- Why were these strategies adopted/advocated and what do their proponents expect them to achieve?
- What factors facilitate efforts to involve the community in the HImP?
- What factors impede efforts to involve the community in the HImP?
- How important are contextual factors in shaping the form and approach adopted to involve communities in the HImP?
- To what extent can different styles of community involvement across a HImP be identified?

In addition, a ninth question was examined within the case study, but also requires an appreciation of the literature around community involvement in health initiatives. This question could not therefore be answered through material gathered within the case study alone. This question was:

- Can top-down, Government-initiated programmes such as HImPs cultivate an environment within which public participation may be experienced as empowering?

Coventry was not chosen as a representative HImP and has not been presented as such within this thesis. Consequently it would be unfair to pass judgement on the ability of the Health Improvement Programme *per se* to empower communities through their involvement in the programme based upon the case study findings alone. Whilst evidence from the case study relating to this question will be presented within this chapter, it will be given a more detailed examination within the next chapter which draws on a wider range of sources.

Each of the key research questions shall now be examined in turn and material gathered from all sources within the case study[1] which can be drawn upon to answer each question presented.

---

[1] Those included in the case study comprise members of the HImP Steering Group, HImP Development Groups and Health Action Groups.

### *How do those with a responsibility for HImP development and delivery feel about community participation in health planning and delivery?*

Broadly, the promotion of community participation in the planning and delivery of local health policy within New Labour's key policy and delivery documents was welcomed by the majority of individuals within the case study site. It was noted that the push towards greater involvement of patients and the public within healthcare was not a new idea. However, whilst increased participation was advanced by the preceding Conservative Government it was never centre stage in the way it was within New Labour policy documents published during this period in time. A few individuals within the case study site had long been involved in projects involving community members or in community development programmes. For them, the blanket endorsement of community participation in policy documents served to legitimise the work they had been involved in and arguments they had been putting forward for some time. As one local authority employee on the HImP Steering Group observed:

> The Health Development Unit[1] has been actively working to encourage community participation in health for the last ten years. We need to share our experience with the health authority and help them get to the same position we are now in with regards to community involvement without travelling the same route we did to get here. We need the health authority to trust us and recognise our much greater experience in this field.
>
> (Interview with HImP Steering Group member, 14/08/00).

One interviewee expressed caution over the broad use of terms like 'participation' and 'involvement', recognising that these can be used to represent a whole

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[1] The Health Development Unit is a unit within the local authority set up to tackle inequalities in health.

spectrum of activities from asking the public for their opinions and then ignoring them if they don't neatly fit with pre-determined priorities through to encouraging communities to define their priorities and develop action plans around these priorities. This represents an awareness of the different levels of participation as conceptualised by Arnstein (1969) as the 'ladder of citizen participation'. Whilst this interviewee stressed their support for approaches which give more control to the public over priority setting and the design of solutions to identified problems they stated that: "organisations don't always allow us to work in this way. The necessary culture of risk taking doesn't really exist" (Interview with HImP Steering Group member, 04/09/00). This point was reiterated by another member of the Steering Group who argued that:

> The government's commitment to allowing local people to make planning decisions does not sit comfortably with their other commitment to quality standards. The reduced flexibility this leaves us with makes us less able to take some of the risks associated with other people having a decision making role with our money.
>
> (Interview with HImP Steering Group member, 31/08/00).

Many of those within the case study noted the importance of community participation in the HImP but also recognised their own lack of skills and confidence in how to facilitate such activities. It was acknowledged that most of the Steering Group members represented middle-management and consequently had very little contact with community members. A number of individuals suggested that training was needed for both professionals seeking to involve lay members and for lay members on how to effectively participate. As one interviewee noted: "It's not just that the people attending the HAG meetings need training, rather all of us involved in this process need our capacity building" (Interview with Health Action Group member, 18/02/02).

Despite the evident lack of confidence there was no shortage of explanations given as to why community involvement was perceived as so critical. The specialist knowledge many service users have and the local knowledge among community members about difficulties with access to services, locally identified health problems and ways to reach out to community groups were all highly valued. In addition it was frequently suggested that community involvement in the planning process could result in more appropriate, more culturally sensitive and more accountable systems of health care. Shared ownership and improved services which respond to currently unaddressed needs were both cited as an aim of increased community participation in planning. Where the community had been involved in decision-making, at whatever level from consultation to developing proposals for new services, it was perceived that these decisions had increased legitimacy. As one member of the HImP Steering Group noted:

> Getting the community involved in identifying the gaps and developing a shared vision means that there is shared ownership of better and more appropriate services.
>
> (Interview with member of HImP Steering Group, 26/01/01).

In addition it was suggested that community participation served to facilitate good relationships with voluntary and community groups in the area and was a way of ensuring that the plans and work of the voluntary, community and statutory sectors were integrated and supportive of each other wherever possible.

Furthermore, a number of interviewees stressed that working with members of the public helped them to 'get in tune' with community groups and 'hear' their messages. As one person noted: "Working with members of the public also provides an opportunity for us to disseminate *our* message so that communities understand our priorities" (Interview with HImP Development Group member, 07/08/00). A couple of HImP Steering Group members noted that many of the issues the HImP was seeking to tackle had been defined by community members. Consequently their continued involvement was considered highly relevant and necessary.

However, the responses received by some individuals demonstrated a less overtly committed approach to community involvement. For example, a few interviewees stated that community participation was necessary because it was encouraged by government whilst others stated that there was pressure from local citizens on certain issues which meant that they must involve them.

Whilst data collected around this issue through the observation of meetings and analysis of documentation provided an indication as to the importance placed on this topic and time dedicated to discussing it, the most illuminating findings were gained through interviews. In addition, responses to the questionnaire demonstrated how those at officer level, who have the responsibility for implementing community participation, feel about the role of the community in their area of work. As detailed in Chapter Three the questionnaire was circulated to three of the thirteen HImP Development Groups for completion by all members of the group. Within the questionnaire participants were asked how well they felt their group had been able to obtain the views of the public. Some of the comments given in response to this question help to reveal feelings about community participation in the planning and delivery of the HImP. The responses to the closed question were as follows:

**Table 4: Success in obtaining community views on the HImP**

| Success in obtaining community views | Frequency | Percent |
|---|---|---|
| Very poor | 2 | 6.3 |
| Poor | 4 | 12.5 |
| Ok | 10 | 31.3 |
| Well | 12 | 37.5 |
| No answer given | 4 | 12.5 |
| Total | 32 | 100.0 |

Four respondents (12.5%) did not provide an answer to this question. Two of these explained their inability to comment by noting that they had not yet been able to attend any of the HDG meetings and therefore felt unable to comment. One respondent did not provide an answer for this question but noted underneath that community involvement in the HImP was not part of the remit of the group. This individual argued that it was: "Not our place to obtain the populations views. We provide expert advice on the implications of decisions and situations on the public's health". This view was only expressed by this one individual with the most common answer to this question, given by 37.5% of respondents, being that the HDGs had done well in obtaining the views of community members. One of the respondents stated that there was:

> relevant representation from all of the key agencies at the strategic level whilst more appropriate consultative mechanisms are used for other groups and individuals.
>
> (Comment from questionnaire).

This demonstrates an awareness of the different approaches which may be employed to canvass views. A number of interesting points were made in response to this question. One person completing the questionnaire noted that: "The invitation to join and participate in the group has been circulated widely. However, attendance at the first two meetings has been erratic", whilst another respondent stated that: "This section of the HImP has been developed mainly on professional opinions and existing strategies, programme & policies", adding as a caveat: "BUT, the community will have been involved in developing these existing strategies". These replies may be regarded as indicating the types of involvement regarded as satisfactory by many of the respondents.

Many more comments were provided by those who felt that their group's success in obtaining community views had been poor (12.5%) or very poor (6.3%). For example, four people noted that much more needed to be done around involving the voluntary and community sectors, two specifically mentioned the need to find ways of involving black and minority ethnic communities and groups in the HImP and one respondent stated that existing community-based structures, such as the local authority's Area Co-ordination teams should be much more involved than they were. One individual argued that: "The Group is populated by professionals from a range of partners but there is no community-based representation", whilst another noted that their group had gained:

> some input from community members but when they have attended meetings or consultation sessions these didn't tend to enable them to contribute as much as they might.
>
> (Comment from questionnaire).

Some of those interviewed, along with respondents to the questionnaire, argued that whilst their group had not been successful in involving certain groups within the community that this was not through lack of trying. It was argued that they had attempted to target certain groups which they defined as "hard-to-reach" on a number of occasions but that, in their opinion, these groups did not *want* to participate in the HImP. When asked to explain who they were referring to as 'hard-to-reach' those listed included "marginalised groups", "those most socially excluded" and "refugees".

A number of people (n = 6) raised particular concerns they had about community involvement in the HImP, particularly when in a one-to-one interview with me. Many of these concerns were around representation and how to ensure that those community members and organisations who participated were representative of the general public in Coventry. One respondent queried: "Can anyone really represent the views of anybody else – or do we all actually only represent our own views?" (Interview with HImP Steering Group member, 07/08/00). Representation issues seemed almost paralysing for some individuals who were unable to get past this need for 'proper' representation. For individuals with this mindset the only mechanism for community participation which they felt was appropriate was the Citizen's Panel, which was drawn from a representative sample of Coventry citizens. The Citizen's Panel is described in more detail in the data provided to answer my next research question: "What different approaches are adopted within the HImP to involve the wider community?"

One interviewee noted the tension that exists in seeking community participation but within pre-circumscribed limits. It was noted that an agenda for what priorities were to be tackled was given to those charged with implementing the HImP by central government. This was particularly the case for government identified priority areas and areas covered by a National Service Framework (NSF). As a result, it was argued that: "Community involvement becomes more like working with the community to get endorsement for what you are already doing" (Interview with members of HImP Steering Group, 14/08/00). This issue was discussed by another interviewee who had a different take on the situation arguing that:

> There is a dilemma in inviting people to participate and then not being able to address the issues they raise. There is no point trying to involve people if we are going to ignore what they say and carry on making decisions for them.
>
> (Interview with member of HImP Steering Group, 07/08/00).

This respondent did not see the point in attempting to involve the community at all until it was possible for the community to have a strong input into priority setting.

A number of people expressed a feeling of bewilderment as to how they should set about involving the general public. It was suggested that identifying user groups and special interest groups to work with was a considerably easier task than attempting to work with the general public.

One individual suggested that there was a danger that the number of different policies calling for community participation introduced by what they regarded as a well-intentioned government would lead to cynicism amongst both those charged with implementing these policies and the public themselves. For this individual the sort of consultation fatigue often found in areas of extreme deprivation spreading to the public *en masse* was a distinct possibility.

**Key messages**

- Community participation in health planning and delivery was broadly welcomed.
- The importance of wide public participation was generally accepted as leading to more appropriate and accountable services.
- However, a number of interviewees, both at HImP Steering Group and Health Action Group level noted their lack of knowledge and skills in developing community participation and reported poor performance in involving the public in the HImP to date.
- A number of interviewees expressed anxiety about the representativeness of those members of the public they managed to engage and concerns about representativeness severely constrained the approaches adopted by some towards the promotion of public participation.
- It was noted that participation was encouraged but within pre-circumscribed limits, reflecting the top-down model of HImPs which were to contribute towards meeting a number of government priorities.

### *What different approaches are adopted within the HImP to involve the wider community?*

Not surprisingly, given the concerns expressed about how to involve the general public, the number of different community participation strategies being employed within Coventry HImP was nominal. Whilst some of the HImP priority areas had considerably more in the way of community involvement in the activities of the associated HImP Development Group than others, in general emphasis was placed much more on developing strategies which would facilitate the involvement of the voluntary sector.

#### *Strategies employed to involve the voluntary sector*

Most of the HImP Steering Group members interviewed openly admitted that they were concentrating their efforts on establishing robust methods for involving users, and in some cases carers. How to involve the wider community was something they intended to think about in the future and was widely regarded as more difficult than securing user involvement. However, statutory sector HSG members representing both the health and local authority felt that they had made significant attempts to involve the voluntary sector in the work of the HImP. Examples given included the commissioning of Coventry Voluntary Services Council (CVSC) to undertake a mapping exercise to identify and chart the various different ways in which voluntary organisations were communicating with and contributing to the work of the health and local authority. The aim of this research was not only to map these various communication channels but also to highlight where further links and strategies were needed (Head, 2000). The report from this mapping exercise concluded that the relationship between the voluntary and statutory sectors within the city was very patchy. The report stated that very few permanent opportunities existed for the voluntary sector to influence planning processes. Furthermore, it argued that people in the voluntary sector wanted to get more involved.

As a result of this mapping exercise the HImP as a whole, as opposed to individual HImP Development Groups covering specific areas of work, agreed to the report's recommendation to recruit a Networking Officer to be based within CVSC. This post, funded primarily by the health authority with a contribution by the local authority and three PCGs was created in Spring 2000. The Networking Officer was employed to develop greater networking opportunities and partnerships between health and social care voluntary and community organisations (VCOs), HImP Development Groups, Health Action Groups and PCGs through the development of regular networks and forums. One of the objectives of the establishment of this post was to enable greater ownership of the HImP by social and geographic communities, especially marginalised communities outside of mainstream channels. One of the ways in which the Networking Officer sought to achieve this was by convening a series of seminars around each of the HImP Development Group areas for all voluntary sector groups interested in which priorities were discussed and opportunities for involvement outlined. These seminars were attended by the HDG lead for each programme area who outlined the current work happening around this topic as part of the HImP.

Other strategies employed to build more robust relationships between the statutory and voluntary sectors included recruiting representatives from Coventry Voluntary Service Council, Coventry Community Health Council and Coventry Racial Equality Council to sit on the HImP Steering Group.

The following table sets out those strategies listed by each of the HDG leads as those they were currently using to involve the community in the work of their group.

**Table 5: Community participation strategies employed within Coventry HImP**

| HImP Area | Community involvement strategies being employed |
|---|---|
| Health Inequalities | Person from Citizens Advice Bureau on the HDG to represent the views of the wider community. |
| Older People | (i) Voluntary sector represented on HImP Development Group.<br>(ii) Main strategy for getting more agencies and community members involved was to have a number of sub-groups working on specific pieces of work. Each sub-group was asked to involve the wider community. |
| Learning Difficulties | No direct representation of users, carers or wider community on HDG at this point in time. But a number of other user and carer groups fed into the HDG. |
| Environment | No community members directly sat on the HDG. Main community input was through Agenda 21 which had city-wide multi-agency and community group conferences. Also Area Co-ordination's Environment Action Groups involved people from those localities. Had not gone out to seek a 'representative' community view. But issues being tackled by the HDG, apart from those that which were nationally defined had all been identified by the community through consultation and surveys. |

| **HImP Area** | **Community involvement strategies being employed** |
|---|---|
| Mental Health | 2 users and 1 carer represented on the Group. 1 user sat on a number of other regional fora and the other was a member of a users group. The carer chaired a users and carers group in the city. They were expected to disseminate info from the HDG within the other groups they were involved with and feed back opinions from these groups to the HDG. No involvement by wider community as yet. |
| Drugs Misuse | DAT & DRG groups used to inform HImP rather than a new Drugs HImP Development Group. No direct community or user representation on either of these groups. CHC involved in linked work around prevention with young people. Area Co-ordination and Health Development Unit were on HDG to ensure the community issues identified were addressed. Person from SRB drugs education project involved to act as voice for community. |
| Social Exclusion | No community involvement, either directly or through representatives. |
| Accidents | Service providers involved but HDG lead struggling to think how to involve the community in planning around accidents. |
| Children in need | No user, community or voluntary group representation as yet. |
| Cancer | 1 user on the group who was also a member of a Cancer User Group and was to feed information and opinions between the two groups. No representation from wider community. |
| Sexual Health | Area Co-ordination used to ensure the communities' needs were reflected with the HDG. No direct representation from community or users. |
| Diabetes | HDG incorporated voluntary sector organisations such as the British Diabetes Association and the Asian British Diabetes Association through the UK Diabetes Network involvement. Community and user participation argued to come from BDA organised public meetings. CHC person on the HDG to represent the wider community view. |
| CHD | 1 representative from 1 voluntary sector group on the group.<br>No user or community representation. Main community participation strategy employed was the reliance on anecdotes from the Acute Trust about what patient's said and wanted. HDG lead accepted that this was a 'medicalised' way of hearing user views. |

As the table demonstrates, a number of the HImP Development Group leads could report no current strategy for involving wider communities. Reasons given for the lack of attention on public participation to date included:

- "don't know where to start";
- "finding it difficult enough to involve the voluntary sector";
- the greater importance attached to other priorities;
- the time it takes to build partnerships,
- lack of support for the principle.

Furthermore, during my observation of a HImP Development Group meeting one member noted during a discussion around community participation that: "At the moment there is little to invite community representatives to when the group is only reviewing progress" (comment made by HImP Development group member at observed session, 02/11/00). It was suggested that when the group progressed to the next stage of developing plans community participation would become much more important.

A number of additional strategies not highlighted by the HDG lead which were or had been utilised within the HImP Development Groups were noted by HDG members completing the questionnaire. These included community liaison members sitting on the HDG and making use of PCG Public Participation Groups to discuss HImP-related issues. Overall a slightly more positive picture of the extent of participation in HImP activities was painted by the HDG members. Sixty nine per cent of questionnaire respondents stated that their group had tried to involve the wider community in its work.

**Table 6: Efforts to involve the community in HImP Development Groups**

| Has the group tried to involve the community? | Frequency | Percent |
|---|---|---|
| Yes | 22 | 68.8 |
| No - not aware of any | 8 | 25.0 |
| No answer given | 2 | 6.3 |
| Total | 32 | 100.0 |

However, despite the emerging list of different approaches to community participation employed recorded in the comments section of the questionnaire, one respondent qualified this by stating that:

> There is a big question as to our ability and track record in listening to and acting upon views received. We're not very good at seeing through real change.
>
> (Comment from HImP Development Group questionnaire).

This raises an important issue about the need to work with communities as partners, rather than simply to satisfy monitoring arrangements. It is the old adage of ‘quality rather than quantity’. Simply counting the number of different approaches to participation employed tells us nothing about why these strategies were chosen and how those choosing them feel about community participation. This research explores all of these issues in an attempt to paint a more complete picture.

A number of those interviewed from the HImP Steering Group were also able to discuss participation strategies adopted for the HImP as a whole, rather than strategies adopted specifically for use by individual HImP Development Groups. In particular, a number of mechanisms used early in the HImP process to help decide and then ratify the HImP priorities were noted. These included:

- a series of 'Stakeholder Conferences' around each of the priority areas which were open to everyone;
- the use of Coventry's *Citizen's Panel*[1] to ratify the HImP. A health survey was distributed to all 2,143 members of the panel in November 1999 which included questions asking for feedback on the HImP priorities identified as well as seeking suggestions for other key priorities not yet included;
- Findings from the *Coventry Community Research Project*, a health needs assessment project carried out by local people from the six Health Action Areas who were trained as researchers, were also used to help determine HImP priorities.

In both the Citizen's Panel and the Community Research Project the issue of drugs misuse was identified as a priority. As this was not included in the original HImP priorities decided by the statutory agencies it was felt that this should be added as a community defined priority.

A public summary of the HImP was prepared and circulated to every household in Coventry within *Health Link*, a free newspaper distributed by the Health Authority. This newspaper was also made available on tape for the visually impaired and was transcribed into the most commonly used languages in the city. Minutes from the HImP Steering Group meeting on 27/06/00 note that the

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[1] The Citizen's Panel was a jointly owned and funded initiative by the health authority, local authority, Police and Coventry's two universities (Coventry and Warwick) and each of these partner agencies was able to submit questions to be considered by the panel.

Community Health Council were asked to consider whether they may be able to make a representative available to sit on each of the HImP Development Groups to represent the community. As the HImP progressed some of the HImP Development Groups worked closely with small groups of people who were members of the Citizen's Panel to consult on complex issues when a detailed understanding of the issue was required.

Those groups in which involvement of the wider community was already happening tended to be linking into existing groups/networks such as Health Action Groups, Environment Action Groups and other Area Co-ordination networks. The inclusion of representatives from linked initiatives (e.g. SRB Drugs Education project officer attending Drugs Misuse group) was also a strategy utilised to establish and/or formalise links with individuals working closely with community groups.

A number of interviewees noted that where community participation was taking place it was often the same few community members who sat on a variety of boards and participated in a wide range of activities. It was suggested that these individuals were taking on increasing amounts of responsibility and power and concern was expressed about the 'professionalisation' of some members of the public. These suggestions about the existence of a 'core' of community participants prompted me to enquire within the questionnaire about the involvement of traditional and non-traditional decision-makers and agencies within the HImP Development Groups. I was keen to discover whether the HImP had opened up the health policy planning arena to new partners, including members of the public, who had not traditionally been involved with decision-making at this strategic level. Whilst HImP policy and delivery documents stressed the need to have a broad range of partners representing the statutory, voluntary, private and community sectors most of those on the HImP Steering Group had worked together many times before and their descriptions of the membership of the Development Groups they chaired did not sound particularly innovative. Most groups listed representatives from the health and local authorities, the local community and acute trusts, PCGs and a voluntary sector organisation. Innovative partnerships with community groups or private sector organisations did not appear to exist and I wanted to check this with members of the Development Groups.

Indeed, 88% of the questionnaire respondents noted that their HDG did include all the traditional decision-makers or, as one person put it, "the usual suspects". Many of the comments made in response to this question noted the inclusion of important statutory agency staff. For example one person noted that: "The group has influence as well as direct access via its members to all the key players". In contrast, only 44% of respondents stated that their group included a wider range of agencies and/or individuals in addition to those who have traditionally made the decisions relating to the work of their HDG. Comments indicated a slightly increased role for representatives from the voluntary sector but again reiterated the dominant roles of local and health authority employees.

Contrary to the overall feeling that the HImP Development Groups had been successful in obtaining the views of the wider community, none of the questionnaire respondents felt that their group had been either successful or very successful in telling the public about the HImP. In fact, 37.5% felt they were unsuccessful whilst 18.8% stated that their group had been very unsuccessful at communicating with people about the HImP. A couple of the detailed comments noted the difficulty in communicating their work to the public and the need to make their work more accessible. As one respondent acknowledged: "I think that the HImP and discussions about the HImP are all in a language that is alien to most normal people!" The need to remove jargon was recognised by a number of people who noted that communication strategies employed to date had included community conferences and a summary of the HImP produced in newspaper format. One respondent, whilst maintaining that they recognised the importance of sharing HImP information with the public stated that: "This has not been a priority for the group – meeting DoH deadlines and timescales has", pointing to constraints in terms of time, resources and energy.

This poor performance around the sharing of HImP information with the public may reflect the accountability arrangements as perceived by members of the HImP Steering Group. For example, in a discussion about accountability arrangement for the HImP in a Steering Group meeting on 27th June 2000 steering Group members were told that the key mechanism for ensuring accountability which had been devised was to feed into the City's Chief Executive's Group (for health and local authority senior staff) by having a standing item on their agenda to update them on progress with the HImP. This indicates that prime accountability was regarded as being to senior management in the statutory sector, and **not** directly to the public the HImP was intended to serve.

The questionnaire also asked HImP Development Group members how successful they thought their group had been at identifying the needs to be met by their group. The responses were mixed with an equal number of respondents (31.3%) claiming that their group had been successful as stating that they had been unsuccessful.

**Table 7: Success in identifying community health needs**

| **Success in identifying needs** | **Frequency** | **Percent** |
|---|---|---|
| Unsuccessful | 10 | 31.3 |
| Ok | 6 | 18.7 |
| Successful | 10 | 31.3 |
| Very successful | 2 | 6.2 |
| No answer given | 4 | 12.5 |
| Total | 32 | 100.0 |

The comments received suggested that the community health needs had primarily been identified by members of the HDG. Whilst members were recruited for their specialist skills and knowledge in that particular area of work, such an approach was felt to be "inward looking" by one HDG member. It was argued that each profession and/or agency represented on the group had their own assumptions about what people needed and wanted. However, a couple of respondents from the Older People's HDG referred to networks created to canvass views and consultative mechanisms used for this purpose, which suggests that not all of the groups relied on internal skills and knowledge alone.

**Key messages**

- Participation of the general public, as opposed to the voluntary sector and user groups was underdeveloped in Coventry.
- HImP Development Groups in charge of planning and implementation for each area of the HImP consisted of "the usual suspects" and signified little in the way of development of innovative relationships with new partners.
- Interviewees and questionnaire respondents openly admitted that more effort was being placed on increasing voluntary sector involvement in the first place and a number of strategies for doing so provided.
- Whilst participants were able to list the strategies they were currently employing to involve the public concerns were raised by some as to the commitment to act upon the views and recommendations of members of the public.
- Participation was happening to a greater extent where HDGs were able to draw on existing networks.
- Some respondents expressed concern about the professionalisation of some members of the public as a result of their repeated participation.
- Those responsible for the HImP feel accountable to senior management, rather than members of the public.

***What approaches will be used within the future to improve community involvement in Coventry's HImP?***

In the following table the different range of community involvement strategies being considered for future use by members of the HImP Steering Group are presented. The information presented in this table represents direct quotations from each of the HImP Development Group leads. The responses received have been broken down by HImP Development Group in order to demonstrate both the common answers provided as well as the diverse mechanisms for participation which were being proposed within this particular HImP.

**Table 8: Community participation plans for the future**

| HImP Area | Future plans to involve communities |
|---|---|
| Health Inequalities | "It is hoped that Health Action Groups (HAGs) will play a greater role in shaping this work as well as the work of the HImP as a whole in the future. We are looking to devolve decision-making around local health issues to HAGs and support this by devolving up to £1m to Health Action Groups over next few years". |
| Older People | "We are looking at the possibility of devolving around £1m a year to Health Action Groups to work on the whole HImP. For the Older People's HDG more specifically we hope to bring together smaller groups from the Citizen's Panel to look at issues around older people intensively over a couple of days". |
| Learning Difficulties | "We are trying to build effective strategies to involve users and carers by developing a strategy to involve people with learning difficulties and their carers in the HDG and to expand the capacity of people over a couple of years to take on this role. We would like people from the user and carer groups to be able to attend the HDG when they feel it is relevant to them. There are three areas we are particularly keen to improve on and develop:<br>(i) Engaging with the African-Caribbean community<br>(ii) Involving people with severe/multiple disabilities<br>(iii) Working with parents/carers as partners.<br>We do not have a future strategy for how we intend to involve the wider community at present". |

| HImP Area | Future plans to involve communities |
|---|---|
| Environment | "It is a dynamic process which is constantly reviewed to ensure it is as inclusive as possible". |
| Mental Health | "We are trying to set up a network for users with CVSC. We hope to appoint a User Development Worker. We're still thinking about how we could involve the wider community. We hope to get people with an interest in Mental Health involved in the Health Action Groups". |
| Drugs Misuse | "We intend to continue with our existing strategy of involving members of organisations whose remit is to ensure the community view is highlighted and addressed within our work e.g. CHC, SRB Project Workers and staff from the Health Development Unit and Area Co-ordination". |
| Social Exclusion | "We do want to involve communities in the future but not by inviting them to meetings. I'm not sure how it will be done yet". |
| Accidents | "It will perhaps be easier to involve people in the future by looking at specific target groups (e.g. older people) or specific service provision, rather than trying to get the wider community to think about accidents generally. It will also be important to involve those who work in the community (e.g. health visitors), to make use of their knowledge". |
| Children in Need | "We are in the process of developing user, community and voluntary group involvement by service area at grass roots level e.g. appointment of Health Promotion Specialist in Children & Young People's Mental Health problems who is carrying out community development work and organising user forums. However, we recognise that by looking at specific client groups we're not involving people in the overall priority setting. This kind of involvement still has to be developed. The CHC have commented on our chapter [within the overall HImP] and shown an interest so we need to build on that link". |
| Cancer | "The role of the Cancer User Group is to be developed to encompass a city-wide planning role. We are concentrating on getting robust methods of involving users first but hope to involve the wider community in prioritising and planning decisions in the future". |
| Sexual Health | "No plans at present". |
| Diabetes | "We will continue with our existing strategy of frequent contact with key members of the voluntary sector and with community groups through organised events and public meetings. The Citizens Panel will be used for obtaining the views of the general public". |
| CHD | "We are seeking help from the voluntary sector as to how to involve users. We do not have any current plans to involve the wider community. I think that if it is to be done it should be in a systematic way, for example by using the Citizen's Panel". |

The diversity of proposed community participation mechanisms reflects the different client groups affected by the HImP as well as different attitudes held by both the professionals leading on this area of work and the public towards the issue to be addressed. Plans for future involvement also reflect the current levels of participation as well as the extent of participation activities around this issue historically.

A number of respondents identified the need to develop a long term view and build the capacity of all involved from the statutory, voluntary and community sectors to engage in planning around the issues covered in the HImP. This demonstrates an awareness of the time it takes to develop robust community participation and a pragmatic approach to the task. Respondents talked about the necessity of having an iterative approach to participation in such a rapidly changing policy environment as well as the need to work with established voluntary, user and community groups. The need to have a dedicated worker to take this forward was mentioned by two respondents.

Increased use of the Citizen's Panel, both in its entirety and smaller sub-groups to look at specific issues, was also proposed as a mechanism for eliciting and incorporating the views of the wider public in the work of the HImP in the future. Indeed, HImP Steering Group members generally felt very strongly that a mechanism for engaging a broad and representative public was essential, and for them this meant using the Citizen's Panel to full effect. In addition, one HDG lead suggested involving frontline staff who deliver services within the community (e.g. Health Visitors) who, it was argued, are currently an "untapped resource".

Further use of sub-groups to look at specific issues within a particular area of the HImP was also suggested as a way of involving the community on issues which are more concrete and perhaps, therefore, easier to tackle than asking people to participate in developing overall strategies for areas such as accidents or the environment.

One group anticipated employing a Health Promotion Specialist in their area of work with responsibility for community development and liaison with the voluntary sector and user groups. An increased role for the CHC was also hoped for. The CHC had expressed a desire to be more involved but were facing resource limitations at the time. Furthermore, given the proposals for CHCs to be replaced by PALS there was uncertainty about how they may participate more fully.

A number of respondents admitted that at that time they had not developed any plans for how their HImP Development Group may go about involving the community in the future. Many admitted that they were struggling with how they may better involve users and the voluntary sector and had not yet considered how this may be taken further to include the general public. Some HDG leads admitted that they had no idea how they would approach the issue of engaging the wider general public.

### *Main strategy for community participation in Coventry's HImP in the future*

Despite respondents proposing a range of distinct approaches to participation in the future, one strategy was mentioned by a number of HImP Development Group leads. The importance of the Health Action Group as *the* forum within which the community could participate and influence the HImP most effectively was mentioned by three interviewees. Two of these individuals noted that the key strategy for involving the community in the whole HImP in the future being pursued by the Steering Group was the devolvement of HImP development monies to Health Action Groups. Furthermore, this was consistently cited as a purposeful strategy aimed at ensuring local communities had maximum involvement in determining their priorities for health improvement and in determining how resources should be used to meet these needs within Coventry's HImP documentation. Health Action Groups had defined geographical boundaries and as such were regarded as the most appropriate forum for local voluntary, statutory and community groups to participate in health planning and exert influence.

Work surrounding this proposal to devolve HImP monies continued throughout the year that Steering Group meetings were observed, with a number of frameworks developed and revised during this time. These set out the required constitutional arrangements and membership of the HAGs, the monitoring arrangements necessary and arrangements for accountability (for example see Appendix J). Progress with this proposal featured as a regular item for discussion at HImP Steering Group meetings and many discussion papers were circulated on this issue. It was recognised within the HImP Steering Group that to get maximum gain from this resource shift there was a requirement for capacity building with the HAGs, and that a need for training and support existed amongst both community and statutory sector members.

The Health Authority proposed to devolve the money which had previously been allocated as Joint Finance monies to HAGs to address HImP priorities starting with an initial £250,000 in 2001/2 and rising to approximately £1 million in 2003/4. Each HAG was to identify the health improvement priorities they wished their ear-marked monies to be devoted to. The HAGs were to be supported by PCG and Area Co-ordination officers in deciding which of the HImP priorities were the most important to be tackled in their locality. It was noted in the documentation to Steering Group members on this issue that HAGs should be provided with relevant information to help facilitate this process. It was also stated that the money was to be used by Health Action Groups to fund activities that were **not** the core funding responsibility of statutory agencies. Rather, where possible the HAGs should seek to engage voluntary and community groups in the development and delivery of any action plans drawn up.

### *Process for devolving HImP monies to HAGs*

The process for deciding how much of the devolved money each of the six HAGs would receive was not agreed during the period of observing HImP Steering Group meetings. Discussions taking place within Steering Group meetings and documentation circulated for comment to all Steering Group members suggested that a capitation basis would be the most likely formula used. The proposal to devolve this money recommended that the money be deployed in two ways: 50%

of each HAGs allocation should be utilised for addressing local issues whilst the other 50% should be used to address city-wide issues which affect all Coventry citizens. The city-wide initiatives to receive funding would be agreed upon at a meeting of HAG representatives together with representatives from Social Services and the Health Authority. The value of existing programmes of work would be considered at this meeting along with the merits of funding other new city-wide initiatives. Using half of the HImP monies for local initiatives in the six Health Action Areas and half for city-wide initiatives would be consistent with the overall aims of the Coventry HImP: to improve everyone's health and to reduce inequalities in health, flawed as some claim this aim may be[1].

The HImP Steering Group decided that the devolved money for each HAG should be held by the health authority who would advise the HAGs of the amount of money available to each to address local issues. This money would be allocated to the HAGs on the basis of proposals developed for projects, or programmes of work, to address local problems which fit with HImP priorities. It was suggested that HAGs should develop local action plans and submit them to the relevant HImP Development Group working on that issue for endorsement. If the HDG agreed that the proposal set out an appropriate way of tackling local issues the plans would be approved and the health authority advised to release the HImP monies. This need to get proposals endorsed, rather than allow HAGs to spend the money as they see fit was justified in terms of the health authority being accountable for the use of public money.

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[1] Exworthy and Powell (2000) argue that the two aims are incompatible. By improving everyone's health the health gap inevitably also increases.

Throughout the period of observation the framework was continually refined and kept hitting new barriers. Developed by the health authority in agreement with the Steering Group the proposal and framework also needed to be ratified by the three PCGs, Social Services and Area Co-ordination. At the final meeting I was able to observe in February 2001 the framework was about to be submitted to the PCGs for consideration and there was considerable concern that it would be rejected. The Steering Group were worried that GPs, who formed the majority and who were the most powerful members of PCGs may not support the proposition to devolve to community-based groups what would, in the long term, amount to a significant amount of money.

The HImP Steering Group persevered with this proposal, feeling that HAGs had an important role to play in influencing and delivering against agreed health improvement priorities, as well as providing a vital link between communities, voluntary and statutory agencies.

### *The first year of devolving HImP monies*

My findings from interviews with the HImP Steering Group as well as the year spent observing Steering Group meetings and reviewing related documentation highlighted the pivotal role HAGs were to play in facilitating community participation in the future. Consequently, I felt that it was important to interview three HAG members and to observe a couple of HAG meetings. A period of seven months separated my data collection with the HImP Steering Group and with

HAGs. During this period the HImP had changed to the HIMP and the devolution of money to Health Action Groups had become a reality[1].

The three HAG members interviewed informed me that the sum of £72,000 had been devolved across the 6 HAGs for the period 2001/2. This amounts to an allocation of approximately £12,000 for each HAG for the year. It was expected that this would be increased each year, with up to £1 million being devolved to Health Action Groups by 2003/4 in line with original plans.

The HAG members interviewed felt that in principle, devolving money to Health Action Groups was an excellent way of involving communities in the HImP. As one interviewee noted, working within a geographic area provides a focus for community members' participation and the fact that "it has money behind it" served to demonstrate that community participation was taken seriously. However, despite their support for the principle each of the interviewees highlighted a number of problems with the actual practice of devolving HImP money.

*Problems with the process of devolving HImP monies*

Interviewees despondently listed the shortfalls of the current mechanisms for devolving HImP monies to HAGs. Firstly, it was claimed that the timetable for HAGs to draw up proposals for how they wanted to use the devolved money was

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[1] Although the amount of money devolved was significantly lower than that proposed for 2001/2 as will be demonstrated.

unrealistic and prevented any real input from the communities HAGs were established to represent and work with. Linked to this point but noted as a separate difficulty by the interviewees was the bidding process itself. This had proved to be a struggle for some of the HAGs and those interviewed stated that they had required support in completing the funding applications. This had resulted in the professionals on the HAG taking the lead and those less familiar with the proposal writing process, primarily community members, feeling that they had been marginalised by the process.

In addition, concern was expressed about the types of proposals the Steering Group had agreed to fund and those that they had rejected. One of the interviewees suggested that the Steering Group only seemed willing to agree to money being spent on established areas of work whilst another proclaimed that: "They [the HImP Steering Group] want to fund things for which evidence of success exists, but this prevents innovation!" (Interview with Health Action Group member, 18/02/02). The interviewees felt disappointed that the HAGs were not able to use the devolved money to fund initiatives around locally determined health priorities unless these priorities mirrored those of the wider HImP.

It was suggested that the Steering Group were reluctant to give up control. One interviewee stated that:

> Devolving money to the Health Action Groups without also devolving a certain degree of power and responsibility to decide how to utilise this money is a wasted opportunity.
>
> (Interview with Health Action Group member, 18/02/02).

The HImP Steering Group was criticised by HAG members as being professionally dominated and as having a lack of understanding of community development approaches. It was noted that whilst the Steering Group included representatives from the voluntary sector, no community members were represented at Steering Group level. A further criticism was that community participation was not made the responsibility of any member of the HAG. It was felt that this was a key issue and that until this responsibility was allocated there would be no mechanism for ensuring that participation happened on a routine basis.

The HAG members interviewed felt highly pressurised by the HImP Steering Group's assertion that the HAG would be the forum in which community participation occurred. Those interviewed noted that on the whole HAG members had no more training or understanding of how to involve the community than HImP Steering Group members. They agreed that participation in health planning at HAG level was highly appropriate and should be particularly effective. However, the HAG members acknowledged that community participation in the HAGs was *not* happening and that they had found it very difficult to engage community members, particularly given that they were operating to such tight timetables and with such a small budget. Indeed, the observations I made of HAG meetings indicated that the majority of people present at a HAG meeting were from statutory sector agencies (PCG, health authority, and local authority) and had involvement in the HAG as part of their professional remit. Representation by voluntary sector organisations and community members was minimal. At a HAG meeting observed on 18/01/01 members discussed the fact that they wanted to involve 'normal' residents, as opposed to community leaders. The group questioned why residents were not getting involved and what they could do to try and engage them.

Moreover, it was argued that the model of community participation within HAGs which was expected was deficient. One interviewee noted that:

> Rather than operating a community development model and letting the community take a lead, HAGs expect the community to fit in with their way of working.
>
> (Interview with Health Action Group member, 17/01/02).

According to the interviewees the main route available for community members to influence the HAG priorities was through attending meetings. Each HAG meeting should have representation from members of the local community and voluntary sector. However, interviewees noted that the vast majority of those attending HG meetings were statutory sector employees from the local authority's Area Co-ordination team, the health authority and the local PCG. This suggests that my observations had been fairly typical.

Consequently, HAGs were concerned about the legitimacy of decisions taken when community members had not attended meetings and had the opportunity to influence these decisions. The interviewees felt that HAG members were put in the awkward position of needing to make progress on issues but feeling unhappy with the process for doing so.

One of the interviewees noted that public money had been devolved to Health Action Groups before from a city-wide Single Regeneration Budget (SRB) fund[1]. SRB1 money was devolved to HAGs for five years and a total of £250, 000 was devolved over this period of time. The model employed for devolving SRB1 money required each HAG to devise a decision-making process that was open to public scrutiny and capable of audit. Guidelines existed for the Health Action Groups to ensure that the decision-making processes they devised were appropriate and met the monitoring requirements for SRB. HAG members got to decide on the funding priorities for their areas and on the methods they would employ to tackle these issues. The priorities identified by the HAGs did not have to be backed up by epidemiological data. As a result the interviewee claimed that: "There was a much stronger feeling of ownership than there is with the HImP monies" (Interview with Health Action Group member, 18/02/02).

One interviewee questioned why the HImP Steering Group felt the need to draw up new guidelines and frameworks, rather than utilising and adapting where necessary, the framework developed for use with the SRB money within Coventry. It was argued that this demonstrated an inability to share power effectively within the HImP partnership as well as illustrating that those leading the HImP were not fully utilising the skills and expertise of other members of the Steering Group. As one interviewee noted:

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[1] Single Regeneration Budget (SRB) funding began in 1994 and brought together a number of programmes from several Government Departments with the aim of simplifying and streamlining the assistance available for regeneration. SRB provides resources to support regeneration initiatives in England carried out by local regeneration partnerships. Its priority is to enhance the quality of life of local people in areas of need by reducing the gap between deprived and other areas, and between different groups.

> The main problem is the lack of power sharing. A small core of people are trying to do the best they can with their skills. But they are not using partner agencies that often have more skill and experience.
> (Interview with Health Action Group member, 07/02/02).

One interviewee believed that the health authority's insistence on controlling how the money was spent was another example of this refusal to delegate power and control, maintaining that:

> The argument made by the Health Authority about HImP money being public money and they therefore have to be accountable for it so it can't just be spent on whatever the community decide is a priority is rubbish! SRB money was also public money for which the local authority was accountable. But audit guidelines were explained and decision-making responsibilities transferred to the community.
> (Interview with Health Action Group member, 18/02/02).

Moreover, a member of the Steering Group also argued that whilst devolving HImP money to Health Action Groups was to be welcomed, far too much time and energy was being focussed on this one particular strategy which, they argued, would be marginal in terms of the impact on policy making. For this individual:

> The key thing is redesigning the way we use mainstream budgets and ensuring that the public are involved in decisions about how *this* money is used.
> (Interview with member of HImP Steering Group, 31/08/00).

*Role of the HImP Steering Group in relation to community participation*

Discussions within Steering Group meetings about the most appropriate level at which community participation in the HImP should be taken forward suggested that this was at the community level via Health Action Groups. I therefore decided to ask each member of the HImP Steering Group what role they felt the Steering

Group should have in relation to community participation in the future. All of those interviewed were in favour of devolving some of the responsibility for community participation to HImP Development Groups or Health Action Groups and suggested that the role of the Steering Group should be to provide guidance on community participation as well as to monitor participation activity. The following comments, from three different members of the HImP Steering Group, are illustrative of the majority of responses received when asked what role the Steering Group should play with regards to community participation:

> I think the HImP Steering Group should quality assure community involvement. They should be asking "How involving are you of users, the wider community etc?
>
> (Interview with HImP Steering Group member, 07/08/00).

> The Steering Group should specify what it expects in terms of community involvement, provide information on best practice and monitor work in this area.
>
> (Interview with HImP Steering Group member, 26/07/00).

> The Steering Group should advise on community involvement strategies and ensure that community involvement is considered at every level of working.
>
> (Interview with HImP Steering Group member, 18/08/00).

These responses may be regarded as reflecting the 'official position'. At a HImP Steering Group meeting in June 2000 the HImP lead had set out the role of the Steering Group as follows:

> The HImP Steering Group will have the responsibility of ensuring that each HImP Development Group develops 'effective' community involvement.
>
> (From HImP Steering Group meeting, 27/06/00).

It appears that this role was accepted by the other members of the Steering Group.

Other suggestions as to what the role of the HSG may be included:

- To give clear messages about the expectation for all areas of the HImP to be as inclusive as possible;
- To support people's efforts to involve users, carers and communities;
- To play a facilitative role – help to steer individual's through barriers to engaging with the wider community;
- To make the HImP highly visible across the City,
- To provide broad-based criteria about community involvement without being prescriptive.

Steering Group members appeared happy to advocate a knowledge broker and performance management role for themselves and this may be regarded as an appropriate responsibility for a group of senior officers and middle managers. However, I was surprised that the majority felt that the Steering Group should be adequately qualified to provide advice to others on how best to develop effective community involvement, particularly so given the fact that these same individuals when talking personally had stated that they did not know how to go about involving the community.

**Key messages**

- The key strategy proposed to increase participation in the HImP in the future was the devolvement of HImP monies to Health Action Groups.
- The amount of time spent on developing frameworks of accountability and terms of reference has been criticised, particularly in the light of pre-existing frameworks developed by one of the key partners in the HImP – the local authority.
- The potential of devolving money to HAGs was recognised by all, although the process for devolving the money had been found to problematic.
- The model of community participation employed by HAGs was recognised to be deficient.
- The proposed role of the Steering Group as knowledge brokers is incongruous in light of the limited skills and knowledge of community participation strategies held by steering Group members.

### *Why were these strategies adopted and what did their proponents expect them to achieve?*

Those who had attempted to involve the public or who were involved in developing structures to enable community participation in the future were able to offer a number of different rationales for their choice of strategy adopted to engage the public. Furthermore, those who had not involved the public were also able to justify why they had not done so. The rationales offered and the expected outcomes of employing these strategies will now be examined.

A number of interviewees had sought advice from voluntary sector organisations about which community groups and/or individuals might be best placed to act as representatives for the wider community. This strategy of following voluntary sector advice comes from a recognition that the voluntary sector worked closely with the community on a regular basis and as such had much more expertise and knowledge in the area of community participation.

Other HImP Development Groups, rather than seeking advice from local voluntary sector organisations, preferred to work directly with these organisations as their community participation strategy. HDG leads choosing this strategy argued that voluntary sector organisations were the vehicle through which much participation occurred and that voluntary organisations themselves had sufficient connections and skills to represent the views of the communities they worked with. In a similar vein, some HDG leads noted that members of their group worked for community-based organisations and so could act as a conduit for information. Involving community members in addition to these representatives was dismissed as unnecessary.

Working with small groups to examine a particular issue over a period of time was mentioned by two of the HImP Development Group leads as a strategy they had adopted or intended to employ. It was argued that this approach allowed individuals with a strong interest in a particular issue to get involved in detailed discussions. It was suggested that the highly focussed nature of these sub-groups meant that the objectives of working together were clear and the group productive.

Some of the interviewees, particularly those with overall responsibility for the HImP within the health authority, were able to offer rationales for the two major strategies employed to involve the community in the overall HImP, rather than in particular priority areas. Firstly, the Citizen's Panel was used to ratify the HImP priorities as it was considered to represent a "robust method" (Interview with HImP Steering Group member, 04/08/00) for eliciting views from a representative sample of the wider community. Within the next chapter I shall discuss the implications and value of the Citizen's Panel as a form of participation and the perceived need to employ 'scientific' methods and attain a representative sample of the general public I encountered within Coventry. Second, the strategy of devolving resources to and developing the capacity of Health Action Groups to work with the community was perceived as an excellent long-term strategy for embedding community participation into the health planning process and increasing community ownership of the City's health plans. This was perceived as representing a sustainable approach to community participation.

A number of HDG leads had chosen to work with existing community and user groups and build their capacity to participate in the HImP, rather than starting with a blank sheet and trying to identify people interested in the issue. They argued that this was a quicker way of guaranteeing that a confident and effective group of people were participating in the planning process. Whilst it was recognised that this approach required a lot of support and a shift in the relationship between these community and voluntary groups and statutory agencies it was considered important to involve existing groups working on these issues and not to bypass them. As one interviewee stated:

> It is important to build the capacity of the existing user group to take on a prioritisation role. Members don't feel comfortable with this at present because the group was set up originally for users to talk about their experiences. Also, we haven't presented information to them for their debate in the past. Therefore, we need to build their capacity *and* change our style of working with them.
>
> (Interview with HImP Development Group lead, 26/07/00).

Working with frontline workers in community based organisations was a strategy espoused by one of the HDG leads. It was argued that people who work in the community have valuable knowledge about community needs and service provision and that this knowledge was valuable to those working on HImP issues.

One HImP Development Group lead justified the participation strategy employed by their group on the basis that work had been happening around this issue for a number of years using this strategy to good effect.

> We have used this strategy to involve the voluntary sector and public in work around this issue for a few years and are happy with the amount of participation.
>
> (Interview with HImP Development Group lead, 02/10/00).

Some of the HDG leads noted that because their area of work was designated as a national priority central government had specified the agencies which were to be involved in taking the work forward in each locality. Whilst these national guidelines set out the agencies which must be involved as a minimum, given that they included voluntary and user groups where appropriate the HImP Development Groups tended to follow the national guidelines and did not see the necessity of including additional people in their groups.

Where no specific strategy was promoted either for current or future use this was justified by the argument that the HImP Development Group was working to clear government guidelines and targets and that there wasn't the flexibility to respond to community identified priorities and needs.

**Key messages**

- HImP Development Group leads were able to articulate clear rationales behind their choice of community participation strategy, or non-choice in the case of those groups who had not, and did not plan to develop mechanisms for involving the community in their area of work.
- The voluntary sector was heavily relied upon, both to provide advice on community representatives and to act as representatives of the community themselves.
- Recognition of the need to work with pre-existing groups with an interest in that area of work was noted as well as the benefits of involving frontline workers as community representatives.
- A number of HDG leads noted that they were following national guidelines as to which organisations should be involved in health planning around their area of work. These individuals had chosen to not extend these national minimum agency guidelines, justifying this by arguing that their groups represented national requirements.
- Rationales were provided for the two HImP-wide participation strategies employed. One represented an attempt to utilise pseudo-scientific methods and achieve representative participation whilst the other signified an attempt to devolve resources to the community-based organisations in areas experiencing socio-economic deprivation and develop the capacity of local residents to participate in health planning for their area.

### *What factors facilitate efforts to involve the community in the HImP?*

A number of factors were identified which helped to facilitate efforts to involve the community in the HImP. A history of community participation around a HImP priority programme area was noted as especially helpful in assisting those seeking to involve the community in the HImP for two reasons. Firstly, those individuals with an interest in the issue would self-select themselves to participate and secondly, individuals who had participated in other initiatives would be more familiar with the way partnerships operated, thus being less inhibited. Consequently, where HImP Development Groups had been able to build on existing participative mechanisms within the city, such as the local authority's Area Co-ordination team, PCGs Public Participation Groups and other initiatives such as the Better Government for Older People programme, it was highlighted as extremely beneficial: "The places where HImP Development Groups are working in partnership with the community are where strong partnerships *already existed*" (Interview with HImP Steering Group member, 14/08/00).

Having a focused approach to community involvement was also noted as advantageous:

> One of the approaches to community involvement I like is bringing together a group from the Citizens Panel and looking intensively over a couple of days at a specific issue. This approach has the advantage that people can see the factors that influence decisions.
>
> (Interview with HImP Steering Group member, 11/08/00).

For example, where the community had been involved in examining a particular topic it was argued that participation was focussed and led to outcomes such as action plans which had been agreed by all involved. In addition it was noted that breaking the city down into discrete geographical areas, i.e. Health Action Areas, had helped to focus community participation efforts.

Having dedicated resources allocated to the promotion of community participation in the HImP was also noted as a major facilitative factor. These resources could take the form of money, such as the devolvement of money to Health Action Groups, or the employment of dedicated workers, either specific to HImP Development Groups or to work across the whole HImP, such as the Networking Officer employed within the Voluntary Services Council with a remit of generating wider involvement. In addition a number of interviewees and questionnaire respondents stated that the helpful and supportive role played by voluntary sector organisations in the city had aided their efforts to involve the community.

The length of time the HImP Development Group had been operational for was also noted as impacting upon efforts to encourage participation. Some groups had been established longer than others and as a result were more confident that the correct people and organisations were represented. The more recently established groups tended to be based on pre-existing groups working on that issue. Within these groups it was often acknowledged that membership needed to be broadened considerably, particularly to include community representatives.

The existence of the city-wide Citizen's Panel was deemed useful when a representative sample was needed. A number of individuals noted the important role of partnership working in facilitating community participation. It was suggested that a major benefit of working in partnership was the fact that each partner agency had different knowledge and experience around participation strategies which they were able to share.

The important role played by a few key individuals in driving forward the community participation agenda was highlighted by a number of interviewees. Their enthusiasm and determination was regarded as essential in maintaining the momentum and keeping the pressure on everyone involved in the HImP to take this issue seriously. The emphasis on community participation in government policy documents was regarded as adding a considerable amount of weight to the efforts of these key individuals.

**Key messages**

Factors which helped to facilitate community participation in the HImP included:

- A history of participation around the issue to be addressed by the HImP Development Group;
- Having focussed topics upon which community participation was sought;
- Working in discrete geographical areas;
- Having resources dedicated to the promotion of participative activities;
- The good relationship between the voluntary sector and statutory sector locally;
- The amount of time which had been dedicated to participation, which was often related to the length of time the HImP Development Group had been in existence;
- Working in partnership;
- The role played by enthusiastic and dedicated individuals, and
- The emphasis on participation with government policy.

### *What factors impede efforts to involve the community in the HImP*?

Very many contextual, political, organisational and attitudinal factors were identified which impeded efforts to involve the public in the HImP. Many factors spanned a number of these categories. For example, time was consistently cited as barrier to increased participation by members of the HImP Steering Group, HImP Development Group and Health Action Group members. The label 'time' was used to refer to a variety of impediments including the short timeframe within which government expected to see results from HImPs. It was argued that the many short term milestones and targets set impeded the ability of those in charge of HImP priority programme areas to establish the most carefully thought out and representative Development Groups to take the work forward.

Moreover, it was noted that the pressure for these groups to "hit the ground running" (Interview with HImP Steering Group member, 04/08/00) meant that partnerships set up for other purposes but looking at issues related to the HImP priority areas tended to be used as 'acting' HImP Development Groups. Furthermore, it was conceded that in some cases these groups hadn't been told that they were being used for this purpose. One HDG lead who sat on another related group had got the members of that group to comment of the first draft of the HImP chapter and related action plans. It was then claimed that this group was being used as the HDG. Discussions within the HImP Steering Group eschewed this practice and those in charge of the overall HImP warned that HDG leads "must be explicit about the fact that they are using these groups as HImP Development Groups" (Observation of HImP Steering Group meeting, 18/09/00).

Some respondents cited time as a barrier to participation in relation to the amount of time community participation had already taken and was expected to take members of the HImP Steering Group, Development Groups and Health Action Groups who were trying to involve the public in their work. It was recognised that it can take a long time to "get into the community" (Interview with member of HImP Steering Group, 07/08/00) to work on issues where there has traditionally been very little participation. Finding ways of accessing the community, building up a relationship with them, gaining their trust, and establishing effective ways in which they could work together were all believed to take a significant amount of time. Responsibility for HImP related activities was usually just one element of any of the HImP Development Group leads jobs. Therefore it was noted that time to work on these issues was always limited.

Furthermore, it was noted that once the problem of finding community members who wanted to participate in this work had been overcome there were still a number of other time related issues impeding participation. In particular, the necessity to work at a slower pace; explain or get rid of health service and local authority jargon and acronyms; and provide background information and supportive data to back up claims and justify courses of action which those working on these issues for a long time would not necessarily need, were all identified as factors which needed to be considered when working with the community. All of these factors slowed down the pace at which issues could be tackled. As one interviewee noted:

> There's a fair amount of background knowledge about what's happened or is happening that you wouldn't expect them [community members] to know about. It takes quite a lot of tuition to get a group to the point where they understand all of the issues.
>
> (Interview with HImP Steering Group member, 02/10/00).

Community participation was noted by many as difficult to achieve. A number of those interviewed and completing questionnaires from HAGs, HImP Development Groups and the Steering Group stated that they had found involving the community challenging. Respondents cited their lack of knowledge of different approaches to participation as well as a lack of confidence in working with community groups as factors which exacerbated their efforts. One HImP Development lead noted that: "You become much more physically accountable" when working with community groups (Interview with HImP Steering Group member, 11/08/00). A large proportion of individuals within the case study identified the need for training around community participation issues. It was suggested that training was needed both for professionals in how to work with community members and for community members in how to effectively participate in policy making and planning.

It was also recognised that community participation requires a real organisational commitment. Moreover, it was argued that it was necessary to back up this organisational commitment with resources, especially money, which could be used to facilitate participation. This was noted as problematic due to the limited amount of money not already earmarked for other purposes. As one of the questionnaire respondents noted:

> As there is little additional funding associated with the HImP it almost necessitates the reiteration of existing (funded) programmes. New ideas from the community have no mechanism for being funded.

The proposal to devolve HImP monies to Health Action Groups is a recognition of this problem.

Two individuals stated that there was a lack of understanding about the time and resources community participation required. These individuals felt that they were operating in an unsupportive environment in which their efforts to involve the community were not encouraged. These factors proved to pose considerable barriers to participation.

Another factor noted as impeding participation in the HImP was the organisational culture within the HImP partnership. As one member of the HImP Steering Group noted: "The language and the culture of the different agencies will prohibit people from getting involved" (Interview with HImP Steering Group member, 04/09/00). This point was further illustrated by one of the HImP Development group leads who stated that it is often the same group of individuals from a select number of organisations who have been working on a particular issue within the city for a number of years. Consequently, it was argued that this group of individuals can become:

> a bit of a 'club', which can prove to be difficult enough for professionals new to the subject or to the city to break into, let alone for members of the community!"
>
> (Interview with HImP Development Group lead, 31/08/00).

The behaviour and attitudes of those leading the HImP was also noted as hindering community participation efforts. In particular it was argued that the reluctance of those in charge of the overall HImP to devolve decision-making powers to the Health Action Groups was a considerable barrier to participation. The transfer of financial resources without the devolution of the necessary powers to make decisions on how to use this money was regarded as a severe impediment to those trying to develop participation at HAG level. HAGs were to involve community groups in the development of funding proposals and action plans detailing how they would use the financial resources to tackle local issues impacting upon health. However, it was noted by two of those interviewed from Health Action Groups that neither of the HAG proposals which had been developed in conjunction with the community was accepted for funding. Rather, it was stated that:

> The successful bids were those around established areas of work. It appears that they want to fund things for which evidence of success exists, but this prevents innovation!
>
> (Interview with member of Health Action Group, 18/02/02).

The opposing argument was made by some members of the HImP Steering Group who were reviewing the HAG proposals. These individuals felt constrained in being able to agree to proposals for which no evidence of effectiveness existed. They argued that it was their organisations which would be held accountable for bad decisions in how public money was used, not the HAGs, and therefore they tended to 'play safe' when allocating the money.

Sometimes the issue identified as a priority area for the HImP was acknowledged as one in which community participation was difficult. For example, it was argued that the stigma attached to mental health meant that the wider community rarely participated in decision making on this issue. Whilst this was an area in which user participation was relatively well developed it was stated that pubic participation was usually reactive and often negative. The example of 'not in my back yard' campaigns to prevent the building of community-based mental health facilities was given to illustrate this.

Additionally, it was noted that community members themselves can be difficult to work with. A number of individuals within the case study described community members who dominated discussions and others who were obsessed with a single issue rather than with the wider remit of the group. It was argued that having such "unrepresentative" individuals represent the community was problematic. However, none of those making these criticisms seemed to recognise that exactly the same disparaging observations were sometimes made of statutory and voluntary sector 'representatives'. However, it was obvious to me as an observer of the HImP Steering Group meetings that one or two of the Steering Group members were themselves viewed in this way and their views tolerated more than respected.

Another factor which related to the perceptions and attitudes of the professionals leading on HImP development was the difference in the treatment and respect accorded to the views and knowledge of the public compared to that given to the views and knowledge of professionals. Some members of the HImP Steering Group questioned the extent to which 'public' knowledge should be treated as equal to 'specialist' knowledge. In particular, a number of individuals struggled with the extent to which the public's views should be incorporated when professionals felt that they knew better. For example, one HImP Development Group lead stated that:

> There's a real mismatch between community views around health and the Government's agenda which we are charged with delivering. For example, we asked the residents in one of our Health Action Areas what their major health concern was. They said it was Head Lice. Now we knew that in that area of the city the biggest health problem was Coronary Heart Disease. Yet the key thing they wanted addressing was Head Lice! It is very difficult sometimes to get the necessary level of understanding around health in communities.
>
> (Interview with HImP Development Group lead, 07/08/00).

Whilst a couple of other interviewees also expressed concern as to the value of lay knowledge, the number of individuals expressing these views was relatively small. Nonetheless, it must be acknowledged that just a few individuals expressing such opinions can sway decisions and can exert a considerable degree of power over choices about the degree of public involvement accepted as desirable by the whole group.

The factors causing difficulty for those seeking to involve the community noted above were all identified through interviews, the questionnaire and the observation of meetings. These problems and difficulties were never found recorded in any of the documentation produced for public consumption, for instance the HImP document and related summaries, and were rarely documented in internal documentation such as minutes of meetings. These findings therefore demonstrate the importance of using a multi-method approach.

**Key messages**

In summary, those factors identified as impinging upon efforts to involve the community in the HImP included contextual, political, organisational and attitudinal factors. For example:

- Time – government imposed timeframes, the time it takes to involve community members, time to access communities, establish relationships etc,
- The difficulty of realising active community participation,
- The necessity of supportive organisational cultures,
- Stigma attached to certain topics, e.g. mental health, and
- Professional behaviour, including an unwillingness to share power and a lack of parity in how public and professional knowledge are viewed.

### *How important are contextual factors in shaping the form and approach adopted to involve communities in the HImP?*

Each of the HImP Development Groups was different in terms of the nature and strength of the relationships between the group's partners, the monies allocated to support their area of work, the amount of flexibility the group had (i.e. whether they were operating under National Priorities Guidance/to a National Service Framework or whether their area of work was a locally determined priority), and the history of inter-agency working and community involvement around the issue. Therefore a consideration of the various contexts within which the HDGs, as well as the HImP programme as a whole was operating, is crucial. An increased understanding of context should also facilitate an understanding of the barriers to community participation which existed and what was being or could be done to overcome them.

One of the major contextual factors highlighted in the case study was the power of statutory sector organisations within the city of Coventry to dominate the agenda. A strong community movement did not exist and the voluntary sector were under-resourced and hence struggling to challenge the status quo. The involvement of the voluntary sector appeared to be the result of statutory sector organisations seeking their involvement, rather than the outcome of a concerted lobby to participate in strategic level planning. Where participation was working most effectively was around those issues for which either a strong user movement existed or a history of partnership working between all sectors – including communities and voluntary sector organisations – could be found.

Furthermore, within the strategic partnership (HImP Steering Group) charged with developing the HImP the power appeared to rest with health authority employees. This traditional elite of health authority personnel dominating the agenda was far less evident at the operational level (HImP Development Groups). Here the local authority were equal power holders. However, the community and voluntary sectors were still underrepresented. The local authority, particularly through their Area Co-ordination structure did, however, help to promote a culture of participation. Their commitment to working with community groups was matched by a number of years experience, which was lacking within the health authority and PCGs.

The HImPs strategy of seeking to engage the public in the city's six most socio-economically disadvantaged areas, whilst admirable, may have impacted upon their efforts to engage community members given the model of participation employed. As noted by members of the Health Action Groups, the strategy of inviting community members to participate in meetings was not working. Indeed, it was noted that within such settings the articulate and well-educated are more able to participate. Consequently, the institutional context within which people were expected to participate was identified as constraining. Furthermore, members of the Health Action Groups interviewed noted that there was a feeling of being over-researched/consulted in these six areas, without much in the way of tangible outcomes resulting from residents' participation. Therefore, by choosing to pay particular attention to these geographical areas lethargy and/or hostility towards the participation process had to be overcome.

Concern was also expressed about the practice of using ‘community leaders’ to orchestrate participation amongst minority ethnic groups who formed a considerable percentage of the population in some of the Health Action Areas. It was suggested that because these ‘leaders’ were often religious figures or people representing a particular perspective, this sometimes alienated or excluded other community members they claimed to represent.

**Key messages**

- Contextual factors are important in shaping the approaches adopted within the HImP to involve the community.
- The nature of the relationships between partners, particularly in relation to who has power to influence and/or dominate the decision-making process was found to be of particular significance within Coventry where HImP Development Groups, which drew heavily on the knowledge and experience of the local authority were found to approach participation differently to the HImP Steering Group, which was very much dominated by health authority personnel.
- The limited power and resources of the voluntary sector meant that they were participating on the health authority's terms.
- The lack of a strong community movement in Coventry meant that there was little in the way of a challenge to the statutory sector from the grass roots.
- The model of participation employed was inappropriate considering the groups the HImP Steering Group had identified as those most important to involve.
- The use of powerful established figures such as religious leaders and community elders, particularly within areas with a high ethnic minority population was highlighted as alienating for some members of the community and it was argued that this strategy should not be the only one used to seek participation from minority ethnic groups.

### *To what extent can different styles of community involvement across a HImP be identified?*

As demonstrated in the information provided to answer the question on approaches to involving the community a wide variety of different styles of participation were evident within Coventry's HImP. Whilst participation strategies were discussed at HImP Steering Group meetings and a number of overall approaches suggested for the HImP as a whole, in terms of the strategies adopted within HImP Development Groups each group was given complete freedom and discretion to approach community participation as they saw fit (and in reality, as they felt *able* to manage). Consequently, actions taken to enable participation varied considerably across HImP Development Groups reflecting the differing degrees of commitment to public involvement; the level of inclusiveness considered appropriate, the knowledge of group members and their capacity to engage community members.

As discussed earlier in this chapter, the number of different approaches which can be identified does not provide evidence as to the efficacy of these approaches or what they were expected to achieve. Consequently, the findings to this question, whilst interesting in demonstrating the diversity of approaches to participation employed in one particular site, do not provide much in the way of information to enhance our understanding of the complexity of community participation. The diverse range of approaches must be considered as part of the bigger picture.

***Can top-down, Government-initiated programmes such as HImPs cultivate an environment within which public participation may be experienced as empowering?***

Data collected from the case study site does not really provide any clear or authoritative evidence with which it is possible to argue that initiatives such as the Health Improvement Programme, which seek to involve the public in decision-making around health, may cultivate an environment within which participation may be experienced as empowering by members of the public. This may be partly attributed to the fact that the HImP was in the early stages of development and the benefits of developing participation strategies are more often experienced in the long-term. Furthermore, participation mechanisms were relatively under-developed and many of the participation strategies being employed to date had been one-off consultations and participation related to specific issues. The proposal to devolve HImP monies to Health Action Groups perhaps demonstrates a move towards enabling more systematic and continuous participation in the future which I would suggest has more potential of being experienced as empowering. However, according to the HAG members interviewed, at that point in time the processes for accessing and utilising the devolved money were not conducive to empowerment. In order to answer this question more adequately it would be necessary to wait until more participatory activities were underway and then conduct research with members of the public in relation to their experiences of participation.

By synthesising the findings from this case study with the literature around community participation in health in the next chapter I will have more evidence to assess whether initiatives such as HImPs can facilitate empowerment of community members through their participation processes.

## Conclusion

Presenting the findings from the case study as supporting evidence with which to answer my key research questions helps to highlight both the diverse range of opinions expressed as well as draw attention to the frequently recurring issues and ideas. The most commonly recurring themes were:

- Findings from the case study demonstrate considerable support for the idea locally;
- Despite this support for the principle of community participation there is very little activity locally;
- The promotion by central government of community participation as an essential element of the HImP has provided the impetus for many whilst legitimising the efforts of those already engaged n such activities;
- In some cases there was an ambiguity around the extent to which community participation was being used to ratify pre-determined strategies, rather than help set the agenda;
- There was very little knowledge locally about different approaches and existing tools for involving community members;
- Considerable anxiety existed around the issue of accountability for public money;

- The majority of those informing this research were tackling the issue of how to achieve greater involvement of the voluntary sector as a first step and had not yet given the issue of public participation much attention;
- The issue of representativeness caused a great deal of confusion and acted as an impediment to community involvement;
- A number of barriers to wider public participation were identified including the structure and operation of the HImP, time and resources to pursue broad community participation as well as professional behaviour;
- Participation was facilitated through committed individuals; a supportive local voluntary sector, working in partnership and national commitment to public participation,
- Public involvement in the formal channels of the HImP decision-making process, i.e. the HImP Steering Group, HImP Development Groups and Health Action Groups was negligible.

These themes, which have emerged out of the findings from the case study, will form the basis of the presentation of my discussion in the following chapter. The discussion chapter will link these themes to those emerging from the literature presented in Chapter Two.

The findings from the case study presented in this chapter highlight the role of context, relationships, organisational and individual commitment to community participation, history and power as influences which helped to shape community participation in this local HImP. These findings represent a 'snapshot' of the development and operation of community participation within Coventry's HImP at a particular period in time. As HIMPs were formally established in April 2001 it is important to acknowledge that the findings presented here relate primarily to community participation in their predecessor, HImPs. The implications of these findings will be discussed in the next chapter.

# CHAPTER SEVEN

# COMMUNITY PARTICIPATION: TENSIONS BETWEEN POLICY AND PRACTICE

## Introduction

The findings outlined in Chapter Six will now be scrutinised to examine their significance for community participation in HImPs. The findings will be discussed and analysed with reference to the theories and issues identified earlier in the thesis as framing the data to be collected within the empirical stage of the research. In particular, I shall consider the relevance of Alford's (1975) structural interests theory to community participation in the HImP; seek to define the participation model in Coventry using the four models developed by Rifkin *et. al,* (2000); and locate this model on Arnstein's (1969) ladder of citizen participation in order to assess the degree of citizen power available to those participating in Coventry's HImP, and consider the application of Lipsky's (1980) theory of street-level bureaucracy to the guidance about public participation within HImPs. Within this chapter I shall examine, where available, information about community involvement strategies in HImPs nationally. Looking at what is reported to have happened nationally with regard to HImPs will help to determine whether the strategies for involving the public in the HImP and the enabling and inhibiting factors identified in the case study site are typical or unique. The final section of the chapter will consider the implications of the findings beyond the confines of the site specific research and beyond the policy of HImPs to the broader policy context around community participation.

### The HImP as a vehicle for broad participation

As much of the more recently published material on the issue of community participation notes, since the election of the Labour government in 1997 community participation has become a well established tenet of health and social policies. As described in Chapter Four, the involvement of the public in the development of HImPs is a key element of the policy. Whilst participation in health planning is not a new phenomenon, as Strobl and Bruce (2000: 223) note, what is new as a result of the introduction of HImPs is the "large scale of the planning process in which participation [is] being sought." Every health authority in England was to develop a Health Improvement Programme for their locality in partnership with all key stakeholders including PCGs, local authorities, voluntary sector bodies, community groups and local businesses. Duties were placed on statutory sector organisations to underpin this commitment to partnership working. Participation of the public is a key feature of a number of New Labour health and social policies and the publication, during my period of data collection in July 2000 of the NHS Plan underlined government commitment to the issue of community participation in the NHS. Furthermore, the document *Patient and Public Involvement in the NHS*, produced by the Department of Health in 1999 has been further developed and a strategy for patient and public participation has since emerged[1].

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[1] See for example, DoH (2001c) *Involving Patients and the Public in Healthcare: A Discussion Document.*

Whilst patient and public involvement had been promoted by the previous Conservative government through initiatives like *Local Voices*, and through the establishment of a *Patient's Charter*, the emphasis within New Labour policy is on working in partnership with a broad range of stakeholders, of which the community is only one member of the partnership.

Returning once again to Alford's structuralist approach and to the argument put forward earlier that HImPs represent an attempt to bring in the *repressed interests* of community members, a number of positive points can be made about the Health Improvement Programme as a policy. Firstly, by creating new community-based structures, or giving legitimacy to existing community forums, HImPs are providing a mechanism by which members of the public can have an input into decision-making and ensure that their opinions are heard along with those of the more organised structural interests of the *dominant* (i.e. health professionals) and *challenging* (i.e. health service managers and bureaucrats) groups. Secondly, by inviting community participation the HImP is publicly acknowledging the value of lay knowledge to the health care arena.

### *Comparing my findings with the literature*

The findings from this case study of community participation in one locality's HImP demonstrate both the opportunities and constraints faced by local actors seeking to implement community participation in a nationally defined programme with some local flexibilities attached. By synthesising the findings from the case study with the literature I will demonstrate where local actors are repeatedly encountering the same barriers, identify those factors which facilitate efforts to involve the public and make recommendations which build upon both the existing literature and the empirical work undertaken as part of this study.

The case study was carried out between January 2000 and February 2002. The first HImP was in place in April 1999. Consequently, this research followed Coventry's HImP from the last couple of months of year one to the penultimate month of year three. Whilst the research therefore began relatively early in the life of the HImP, following developments within the case study site for two years ensured that my research did not only examine the HImP in its infancy. The duration for which I was able to undertake fieldwork was inevitably limited by the constraints on my time as a postgraduate student and the necessity of completing the fieldwork, analysing and writing up within a prescribed time limit. However, within this timescale it was possible to identify trends in attitude and action around the issue of community participation in Health Improvement Programmes.

### Coventry specific factors affecting community participation

An important and extremely positive factor affecting Coventry's approach to community participation was the City's Area Co-ordination structure. In existence since 1994 this local authority sub-structure consisted of a number of different service departments working together in the City's six most disadvantaged areas in partnership with local stakeholders including the private sector, voluntary organisations, the health authority and local residents. Area Co-ordination teams worked to integrate services and involve local stakeholders in the planning and organisation of services. It was a well established agency and had been identified by the *National Strategy for Neighbourhood Renewal* Policy Action Team 17 as a model of good practice for joint working within local authorities (DETR, 2000b). Consequently, Coventry City Council may be regarded as both committed to and experienced in working within communities, particularly the six areas designated as Health Action Areas.

### *Implications of Coventry's HImP structure for community participation*

It is noticeable that whilst all of the major statutory organisations and three of the larger voluntary sector organisations within the City were represented on the HImP Steering Group no user groups or members of the public were represented at this level. All of the HImP Development Group (HDG) leaders were employees of the statutory sector and, specifically, health authority and local authority employees.

This may be regarded as demonstrating the amount of time and commitment such a responsibility demands. Voluntary sector representatives themselves stressed that they could not take on this role as it did not form a key element of their job as was the case for health and local authority employees. Indeed, it seems clear that under the present arrangements such posts would never be held by voluntary or community sector representatives, whose roles were confined to contributing to, rather than leading such groups.

However, it may also reflect an effort to retain powerful positions in the decision-making process by these two long established organisations. For example, PCGs may have played a bigger role within the HImP Steering Group. Two possible reasons for their minor role were: firstly, they were relatively new organisations at the time of establishing the Steering Group and secondly, it was sometimes determined by Government who should lead HImP Development Groups related to national priority areas.

Whilst membership of the HImP Development Groups was wide-ranging, leads had not been particularly innovative when thinking about who should be included in the group, with many preferring to re-badge existing groups working on related issues as HDGs. Whilst this represents a pragmatic approach it does mean that less thought and attention may have been given to the involvement of the public than if the group were newly established for the purpose.

### Thematic presentation of my research

A number of key themes emerged as a result of this research and the findings will now be discussed in relation to these strong themes found within my empirical research and linked to relevant literature.

**Policy succession and organisational turbulence**

As discussed in the previous chapter, between January 2000 and February 2002 when the fieldwork for this study was being undertaken a number of changes occurred within the home statutory organisations of HImP Steering Group and Development Groups members. The shift from Health Improvement Programme (HImP) to Health Improvement and Modernisation Plan (HIMP), which happened in April 2001 and coincided with the shift from Primary Care Groups (PCGs) to Primary Care Trust (PCT) within Coventry, led to a great deal of organisational turbulence. A number of key personnel withdrew from their leadership roles within the HImP and a new HIMP manager was assigned. As highlighted in Chapter Two, the fact that policies rarely persist unchanged has been noted by a number of authors (Hogwood and Gunn, 1984; de Leon, 1978). Whilst policies are sometimes terminated completely, more often they are succeeded by a similar but modified policy, as the shift from Health Improvement Programme to Health Improvement and Modernisation Plan demonstrates. This policy refinement may reflect an acknowledgement of the inadequacies of the previous policy or, as on this occasion, a change of focus at national government level. This shift in the direction of the HImP away from a broader public health agenda towards the delivery of the NHS Plan, and the personnel changes resulting from both this and the setting up of Coventry PCT, meant that the attention and energies of health authority and PCG representatives were often focussed on the emerging organisational structures and their implications, rather than on developing more effective ways of working with the public.

It is not only health authority staff who are affected by this organisational turbulence in the NHS. As argued in Chapter Four, the emphasis within New Labour health policy is on working in partnership with all relevant local stakeholders to develop and deliver initiatives aimed at improving the health of the population. As Balloch and Taylor (2001) note, it can take a long time to establish effective partnership working. Trust needs to be built between individuals and organisations. If statutory sector personnel change, especially those in charge of the HImP, then this has repercussions on all of those involved in the partnership. Balloch and Taylor highlight the devastating effect of continual and rapid change, particularly on partnerships, stating:

> the actual pace of change, the redrawing of boundaries and the turnover of personnel can prevent relationships of mutual trust from developing as well as disrupt those that previously existed.
>
> (Balloch and Taylor, 2001: 285).

With NHS staff and their partners operating in an environment in which boundaries and roles are continually shifting, it is not surprising to find that involvement of the public is not a key priority.

### *How 'community participation' was (mis)understood in Coventry*

Within this case study I found that 'the public' were conceptualised as a discreet and homogenous interest group and were referred to in the same way as representatives from the private sector, user groups or health professionals. There was no recognition that 'the public' involves all of these groups. Rather the terms 'public' and 'community' were used interchangeably to refer to those people who were not already involved in developing the HImP through other organisations and groups. This notion of the community as a group with no particular interests to represent made community involvement more difficult in Coventry.

An important factor affecting how community participation in the HImP was perceived was the fact that no individual, at any level of the HImP process, from design to delivery, was assigned with the responsibility for community participation. Consequently, no-one was held to account for progress. Despite the responsibility for community participation being devolved to Health Action Groups during the period in which the case study was made, no one person within the HAGs was specifically responsible for community participation. Interviewees from the HAGs felt that making public involvement the responsibility of a particular person would help to ensure that participation was always considered.

### *Defining the HImP Priority Programme Areas*

It was noted that at the time of deciding on Coventry's HImP priority programme areas a number of sources were used to determine the priorities of Coventry citizens. The views of a broad spectrum of people within Coventry were sought via stakeholder conferences open to the general public as well as through the Citizen's Panel. Furthermore, the decision to incorporate drugs misuse, an issue identified as requiring urgent attention by residents of the six most disadvantaged areas of the city within the Coventry Community Research Project needs assessment exercise, ensured that the views of those who were often marginalised from such decision-making were included.

Reviewing these approaches adopted within Coventry to decide on the original priority programme areas against Arnstein's (1969) ladder of citizen participation it is possible to argue that the stakeholder conferences and Citizen's Panel, described in Chapter Six, represent degrees of tokenism. Since interviewees and questionnaire respondents admitted that the views of the public were sought, but with no guarantees that their views would be acted upon, such approaches do not provide an opportunity for increasing citizen power. However, the incorporation of drugs misuse as a priority area, in direct response to the views of residents in the six most deprived areas of the city collected during the Community Research Project may be regarded as representing a degree of citizen power.

Furthermore, the inclusion of this community defined priority within the city's key plan for improving health and tackling inequalities demonstrates that action can result from community participation, an important message to send out at the start of an initiative which will regularly seek participation from members of the public. As Strobl and Bruce (2000) note, if participants find that their views are not accorded significance in the overall decision making, or if it has not been explained that they are one of many stakeholders whose views are being sought on an issue then participation will be deemed as worthless.

## The impact of national priorities

Within HImP policy four areas were predetermined as key areas of focus for each health authority. This meant that the number of locally identified priorities any HImP could choose to address was limited. Within Coventry, the result was that four out of the initial fourteen priority programme areas were defined by central government (Cancer, CHD/Stroke, Accidents and Mental Health). A number of the other HImP priority programme areas, for example, Drugs Misuse, Sexual Health and Children in Need were also national priorities which had strategies and action plans which Coventry chose to incorporate into their HImP. Issues such as Diabetes, Older People and Learning Difficulties were expecting national guidance to be issued shortly through National Service Frameworks or similar initiatives. Furthermore, Health Inequalities and Modernising Health Services were identified as priorities within the NHS Plan. Consequently, at the time of carrying out the case study only The Environment and Social Exclusion HImP Development Groups were not operating to national guidelines, or expecting to do so shortly. However, these two areas were included within the Government's "Floor targets", introduced in 2000 to ensure minimum standards (http://www.neighbourhood.gov.uk/targets.asp.
(Accessed 15/12/03).

Consequently, a considerable focus of Coventry's HImP was on delivering national priorities, which had both positive and negative aspects to it. Participants in the case study welcomed the direction that accompanied these national imperatives, which often included comprehensive guidelines about which agencies should be included in implementation groups. Furthermore, the detailed targets that accompanied national priorities meant that HImP Development Groups were very focussed and clear about what issues were to be addressed and within what timeframe.

However, it was argued by Steering Group members that local flexibility was severely constrained as a result of these directives and the scope and range of areas in which participation could be actively pursued limited. As one interviewee noted, "we have very clear targets set nationally and it's very difficult to reflect anything other than that." (Interview with member of HImP steering Group, 07/08/00). HDGs trying to deliver national priorities locally were following implementation plans which set out who should be involved, which issues should be addressed and by which dates. Government guidelines shaped the organisational structure of these groups, specifying not only which organisations were to be represented on the group but also allocating responsibility for leading the group to a particular organisation. HDG members argued that where the views of the public were sought it was usually in the form of consultation exercises around the pre-defined areas, rather than community planning. It was argued that the opportunity did not exist for community members, or any other partners, to identify the issues that were felt to be of importance locally. One interviewee stated that: "The role of statutory agencies is increasingly proscribed by Government, which makes community involvement more difficult". (Interview with HImP Steering Group member, 31/08/00). Whilst national directives clearly impinged upon the HDGs in Coventry's HImP by constraining their flexibility, this was perhaps exacerbated by the limited knowledge base of some HDG leads as well as a lack of imagination around ways of involving the public in the group's decision-making.

The problem of encompassing nationally and locally identified issues in the HImP is that performance measures exist for the national priorities. Funding is often linked to the achievement of targets relating to these issues and league tables published nationally. The fact that no milestones and targets existed for community participation and that it was not performance managed meant that it was less crucial to those in charge of the HImP than issues such as waiting lists and winter pressures. Indeed, future budgets and ratings were not dependent upon success around involving the public. As Exworthy *et al.* (2002: 88) suggest:

> The ways in which issues [...] are performance managed by the centre indicate the *de facto* priority that the centre places on the issue (thereby denoting its position on the national policy agenda), and can influence whether the issue remains on the local policy agenda.

In short, what this means is that nationally set priorities will always assume greater precedence than local priorities, given the 'stick and carrot' techniques employed by central government.

However, the national imperative to involve the public was also cited as a driver by a number of interviewees. Nearly all respondents referred to the national push to involve patients and the public in health care as a motivating factor behind their efforts around community participation. The importance of political exhortation around public involvement for its raised profile and incorporation in practice has been noted by other commentators (Milewa *et al.*, 1998; Balloch and Taylor, 2001).

**The impact of organisational culture on community participation**

A key issue influencing the approaches adopted to community participation which was identified by a number of those interviewed and completing questionnaires, as well as featuring heavily in Steering Group meetings and their associated documentation, was the impact of organisational culture. The organisational cultures of the health and local authorities were said to inhibit any risk taking. This was particularly relevant to the issue of devolving resources to Health Action Groups (HAGs). HImP Steering Group members argued that the cautious culture was the result of the monitoring mechanisms and quality standards put in place by national government. However, I would go further to argue that, on the basis of the evidence collected within this study, in my view there was also an additional local culture of centralism and caution within Coventry which amplified this national culture. Organisational culture within the health service is also identified as a major factor inhibiting public involvement within the literature (Brown, 2001; Taylor, 1999).

However, this cautious approach to risk taking was not the only issue relating to the organisational culture within Coventry which served to make community participation in health service planning and delivery difficult. Forums open to the public, such as HImP Board meetings, as well as meetings where members of the public were specifically canvassed to attend, such as Health Action Group meetings, were badly organised in terms of community involvement according to a number of interviews, especially interviews from HAGs. It was suggested that the style of the meetings meant that detailed background knowledge and an understanding of the language and terminology used by health service and local authority personnel was required. In particular, the vast array of acronyms utilised acted as a considerable barrier, whilst a number of interviewees and questionnaire respondents pointed to the way in which the structure and organisation of the meetings prevented members of the public from contributing to their full capacity. Similar barriers to participation have been found in other studies of participation. As Taylor (1999: 8) discovered: "It seems that the committee structures, forms and procedures always have to be sorted first – agreement on what the area wants and needs can wait". Organisational culture may also be regarded as influential in shaping the values and attitudes of members of the HImP partnership towards community participation.

### *The need for community participation skills*

Many of the HImP Steering Group members identified the need for training in how to work with communities more effectively. This lack of experience and skill, and the resulting lack of confidence, were highlighted by Steering Group, Development Group and Health Action Group members as hindering the ability of statutory sector employees to develop community participation and work in partnership with community members. In addition, members of the Steering Group suggested that community members would also benefit from training about how to participate effectively in such a forum. The possibility that community members may require training was also noted in the guidelines drawn up for Health Action Groups. Taylor (1999) argues that a lack of training for community members in the past is a major issue which must be addressed if participation is to be effective. I would argue that training community members and professionals together may help to break down some of the barriers between them. Interprofessional training is now recognised as helping to bridge gaps between professionals within the health service (Hearnshaw *et al.*, 2001) and between health and social services (Meads *et al.*, Forthcoming) and the benefits in terms of increased understanding, respect, trust, and equity could be experienced by statutory sector personnel and community members training together.

*The need for a knowledge base around participation mechanisms*

In addition to training in how to work with communities the need to increase the knowledge base of those seeking to develop participation mechanisms is also crucial. Amongst some within the case study site there was very little awareness of alternative ways of involving people. The need to understand which methods are suitable for particular exercises and within which contexts was noted in the literature. Mullen (1995) argues that methods for involving the public are often selected on impulse, with little appreciation of what that approach can and cannot deliver. She argues that:

> At the very least, [...] users of the various techniques should understand the values implicit in them [...] and the relevance/appropriateness of the chosen techniques to the purposes of the exercise.
>
> (Mullen, 1995: 6).

However, as noted in Chapter Six, despite a number of the Steering Group members acknowledging their lack of experience and knowledge around community participation, all felt that the role of the Steering Group should be to provide clear guidance and information around best practice in involving the community. This could signify a belief amongst Steering Group members that other members of the Steering Group had extensive knowledge which would compensate for their own minimal knowledge and expertise around community participation. Alternatively, it may be that despite their lack of practical experience they felt that they could act effectively as 'knowledge brokers'. Either way, it could be argued that this belief in the ability of the Steering Group was naïve. However, it does perhaps represent an established practice whereby those with positions of power often have minimal knowledge and experience in an area. This can be seen throughout society and even in government where Ministers/Secretary's of State for particular topics may have very little personal experience or specific expertise in that topic.

### *The value of lay knowledge*

Local communities and their representatives have considerable knowledge which may be considered extremely useful by those planning health services. Local understanding of health problems, their causes and priorities for action are backed up by detailed knowledge of how to access certain sections of the community, and local resources which could be used to facilitate health improvements. However, as Mayo and Taylor (2001: 50) state:

> this knowledge needs to be validated from above and below – respected and acknowledged by the power holders and recognised as a basis for empowerment by communities.

O'Keefe and Hogg (1999: 246) suggest that professionals have been known to question the validity of public knowledge in informing planning decisions. In Coventry those planning the HImP recognised the importance of lay knowledge and of including local priorities into the HImP. The previously mentioned *Coventry Community Research Project* was a needs assessment exercise commissioned by the health authority. The research is regularly referred to within the city's main statutory organisations as "scientific" and as having "90% confidence levels". The research was conducted by local people (trained as researchers by a market research company) to elicit the views of residents of the city's six Health Action Areas. This gave support to the findings and acceptance by local community members of the priorities identified. The supposed 'scientific' methodology employed by the researchers meant that the findings were seen as valid and reliable by statutory organisations in the city[1]. The support from "above and below" referred to by Mayo and Taylor (2001) for the findings from this needs assessment made it an obvious choice as the vehicle for informing what local priorities, if any, the city should seek to address. Furthermore, the two key problems identified by the public as needing tackling within the Community Research project – drugs misuse and teenage pregnancy – were also highlighted as issues by the Citizen's Panel, highlighting that these were issues of

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[1] However, our findings of the evaluation of this project (Carpenter and Wild, 1999) highlighted a number of problems of using a market research method (*Priority Search)* which was not transparent and used an algorithm that was a commercial secret to indicate community preferences.

concern to residents from across the city, not only from the six Health Action Areas. Sexual Health, which included teenage pregnancy within its remit, had already been decided upon as a priority area for Coventry's HImP.

**Difficulties in involving marginalised communities**

A number of interviewees and questionnaire respondents noted the difficulty in involving the most marginalised groups within the local community. Indeed, this is recognised as a difficulty within much of the community participation literature. As Taylor (1999: 4) states:

> the things that disadvantage people make it harder for them to participate in group activities. This is not apathy. The pressures of bringing up a family on a low income leave little energy for the responsibilities of communitarianism.
> (Taylor, 1999: 4).

According to O'Keefe and Hogg (1999: 246): "Reaching isolated and marginalized people is the major challenge for those attempting to involve [...] the public". It could be argued that participants in the case study site were overly concerned with issues like the representativeness of those they managed to involve, feeling that involvement was not legitimate unless it included the most excluded and marginalised people. Harrison and Mort (1998) suggest that arguments about representation can be used to the advantage of those with the power to develop community participation. They note that:

> The simultaneous construction of user groups' legitimacy by the expression of positive views about them, and its deconstruction by reference to their unrepresentativeness [...] constitutes a device by which whatever stance officials might take in respect of user group preferences or involvement on particular issues could be justified.
>
> (Harrison and Mort, 1998: 66).

A more pragmatic approach to involvement would have placed less emphasis on involving so called "hard-to-reach" groups and seen more efforts to involve the public in general. However, the difficulty of working with the 'general public' was also noted. Working in a focussed way with user groups or special interest groups around specific topics was regarded as preferable and easier to do by the majority of those I discussed this with. This was also found by Milewa *et al.* (1998) who concluded that it is always regarded as easier to work with targeted groups around issues.

*Representation as a factor inhibiting community participation*

The issue of 'representativeness' was one which was frequently identified as causing problems for people in Coventry. Representation issues prevented some individuals from trying innovative approaches and led to an over reliance on mechanisms such as the Citizen's Panel. The Citizen's Panel was frequently referred to as a robust way of involving a representative sample of Coventry citizens. Citizen's Panels are large groups of people (2,143 in Coventry) chosen to represent the views of the public *en masse* (Coote and Lenaghan, 1997). These local residents were used to complete a series of questionnaires on different issues. However, it must be recognised that utilising the Citizen's Panel is not a form of direct participation.

A related strategy adopted in Coventry to ensure representation was the use by HImP Development Groups of sub-groups, drawn from the Citizen's Panel. These sub-groups would meet together over a number of days and examine an issue in detail. Mullen (1999: 233) notes that this use of smaller discussion groups within which issues may be examined in detail provides the opportunity to explore an issue in-depth with a group "constructed to be 'representative' of their target population". Such an approach of working in partnership with groups of community members has the potential, according to Arnstein's ladder, to represent a degree of citizen power. However, as I do not have any evidence to assess whether their views were incorporated or not it is difficult to assess whether this was realised or remained a potential. This approach was advocated as a strategy to be utilised much more in the future by HImP Development Groups.

*Diversity in community participation mechanisms employed*

I found considerable diversity across the HImP Development Groups in terms of both the mechanisms used and the degree to which lay people were involved. The number and type of community participation activities as well as the degree of formality associated with these approaches differed within each of the HImP Development Groups. As noted by Mullen:

> The extent and nature of public involvement in health care varies considerably. Arnstein demonstrated this in her useful 'ladder of participation', which descends from citizen control, through consultation and informing, to manipulation.
>
> (Mullen, 1999: 223).

As well as being a result of the issue's status as a national or locally determined priority, this diversity may also reflect a difference in the values of HDG members, especially of the HDG lead. As Beresford and Croft (1993) argue, the impact of the pessimistic attitudes held by some statutory agency personnel towards the role of communities and users in health service planning should not be underestimated. Brown (2001: 166) states that "differences in values interact with ideologies of participation and penetrate the whole organization".

### *The dilemmas of involving the public*

A number of interviewees and questionnaire respondents highlighted what they regarded as "dilemmas" of involving the public in the HImP. Three people discussed what might happen if those developing the HImP did not like or agree with the suggestions made by members of the public when their involvement had been sought. One of the examples given was the commitment to tackling inequalities of health as part of the HImP. A scenario was described in which the public decided that funding should be allocated across the board to mainstream services, rather than to initiatives in disadvantaged communities, for example projects to increase access to health services, to improve housing or to crime prevention initiatives. It was argued that if such a situation were to arise, those developing the HImP would ignore the views of the public and continue with their strategy to tackle health inequalities. As noted by Harrison *et al.* (2002: 63), "giving people what they want may not be compatible with what the evidence says they should have." Consequently, it was argued that approval for existing courses of action, rather than views on priorities, is what was really being sought. Individuals expressing such sentiments may be regarded as using community participation as a "technology of legitimation" (Harrison and Mort, 1998: 60) used to justify the decisions taken.

My opinions on this approach were sought by a couple of HImP Steering Group members during our interview and I stressed the importance of being honest with communities about how much influence they could exert, and within what framework their opinions were being sought, so that they were fully aware of the agenda and their expectations were not raised falsely. As Strobl and Bruce have argued:

> It is important to make clear the exact purpose of the exercise, and to explain the amount of influence that participants can expect to have on initial planning, refining policy, evaluation and ongoing development.
>
> (Strobl and Bruce, 2001: 223).

That community participation may be sought for legitimation purposes, rather than for genuine planning purposes is not unique to Coventry. Taylor (1999) notes that an examination of many past efforts at community participation shows that members of the public, and often voluntary organisations, are frequently involved to add legitimacy to partnerships or to the decisions they take. Alford (1975) suggests that:

> The presence of equal-health advocates[1] on one or another committee or council is frequently a sign of legitimacy being claimed either by a set of professional monopolists or corporate rationalizers, or sometimes both, in their battle for resources and power.
>
> (Alford, 1975: 219).

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[1] Alford (1975) defines equal-health advocates as including community representatives, trade unionists, academics, community leaders and any other agent representing the interests of the community population.

It could be argued that within Coventry the absence of community members within the HImP Steering Group, the arena where the power is held and key decisions taken, illustrates this point further.

*The important role of the voluntary sector*

Within Coventry at the time of carrying out this research the emphasis was on developing mechanisms to facilitate the wider involvement of the voluntary sector, including users and carers. Involvement of the voluntary sector and of user groups has been noted as easier to achieve than involvement of the wider public (Harrison *et al.*, 2002). Whilst it was widely felt that efforts to involve the voluntary sector had been significant and successful, and a number of pieces of work around how to further involve the voluntary sector had been commissioned from the Voluntary Services Council (CVSC), it must still be recognised that CVSC, the Community Health Council (CHC) and the Racial Equality Council were the only voluntary agencies which were regularly consulted or regularly participated in decision-making related to the HImP. This reliance on certain voluntary sector organisations as proxies for the public was also found by Pickard and Smith who argued that:

> Despite the White Paper's intention of exploring new forms of public involvement this in fact was not occurring yet but relied instead on the 'usual suspects': CHCs and voluntary groups.
>
> (Pickard and Smith, 2001: 176).

As reported in the previous chapter, the CHC were asked if they could make a representative available to sit on each of the HImP Development Groups. Whilst impossible at the time due to staff shortages and the cap on recruiting as a result of the proposed replacement of CHCs by PALS (Patient Advocacy and Liaison Service) in the near future, this situation would not be tenable in the long-term unless PALS were to take on this role. However, as internal NHS bodies, as opposed to independent public and patient advocacy bodies like CHCs, making representatives available to sit on health planning groups was unlikely to be part of their remit.

The appointment of a Networking Officer to establish links with all voluntary organisations working on issues related to the HImPs priority programme areas was a significant step forward and should decrease the reliance on these organisations in the future[1]. However, this must be recognised as a long-term strategy. A strong voluntary sector network will take time to develop. Networking Officers have been established as part of other initiatives, for example Brent's Healthy Living Network, funded by the local Health Action Zone. Here, the Healthy Living Network Manager's post was funded for three years. After two years the beginnings of a strong network could be seen within which voluntary organisations shared information and skills. However, this Network was still very small and had around 10 per cent of the estimated voluntary organisations in the area on board. Furthermore, after two years it was a long way from being sustainable without the Network Manager, which was the ultimate aim of this initiative (Wild, 2002).

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[1] The replacement of CHCs with PALS would also significantly alter the dynamic, since PALS is not an independent voluntary organisation like the CHC was.

Taylor (1999) welcomes the appointment of dedicated workers, such as Coventry's Networking Officer, as she argues that they may be able to act as change agents. She uses the concept of a 'social relay' (Tarrow, 1994) to describe their role of "linking people into networks, finding allies and spotting the windows of opportunity" (Taylor, 1999: 14). However, Taylor suggests that such networks should be extended to include community members, rather than just voluntary groups.

### *Implications of the need to "hit the ground running" for community participation*

Within Coventry's HImP much existing activity was 'rebadged' as HImP activity. Whilst this provided HImP Development Groups with the opportunity to proceed quickly with devising action plans and start making progress towards milestones and targets, it does mean that the first year of the HImP saw little in the way of innovation. This mechanism for speeding up the process of HImP development so that it was possible for HDGs as one questionnaire respondent put it, to "hit the ground running" meant that much HImP activity around an issue was pre-determined before any community participation was sought. This was recognised by a number of individuals within the case study. However, as one questionnaire respondent noted, whilst a tendency existed to rely on existing strategies and programmes of work "there will have been community involvement in developing these". This approach to community involvement relies heavily upon previous participation in initiatives, as opposed to developing effective mechanisms for the community to participate in the HImP.

### *The importance of a history of participation around issues to be addressed by the HImP*

I found that there was more activity around community participation and it was better established where there was a history of public participation around the issue being addressed by the HImP Development Group. Within these areas of work HDGs were often able to build upon pre-established mechanisms, such as the Environment Action Group or Community Reference Group established around drugs misuse. This highlights the amount of time it takes to establish partnerships with communities and the importance of establishing relationships based upon trust, as Balloch and Taylor (2001) have argued.

### *The role of community representatives*

Within Coventry a tension existed between the need to involve community leaders or individuals with previous health planning experience and the need for participation of the wider general public. A number of respondents noted that there appeared to be a small core of community members who participated in a number of forums within the city. This raised concern amongst some interviewees who expressed their unease about the 'professionalisation' of these members of the public. In particular it was questioned whether members of the public who gain considerable knowledge around health and social policy issues can still represent the views of the wider public. However, as Alford (1975: 220) notes:

> Persons who have played that role for some time are likely to become discouraged and leave or will be co-opted into one of the established health organizations.

Mayo and Taylor (2001) argue that being a community representative is not an easy task. It takes a degree of determination and commitment to an issue from lay people for them to give up their time to attend meetings and familiarise themselves with procedures and terminology. Consequently, it is understandable that it is often the same few individuals who continue to attend meetings. It is those community members who have mastered the process for involvement who are likely to be more effective partners. Yet their experience and competence can result in their labelling as the 'usual suspects'. This represents a paradox since the acronyms and language used by professionals act as barriers to wide participation. One of the key ways in which members of the public can overcome this barrier is to learn this language, which can result in their representativeness as a 'lay' person being questioned. As Taylor (1999) states, there is considerable suspicion about community members who regularly participate in initiatives, both from local communities and from the government. She notes that community representatives may be "criticised from above for 'unrepresentativeness', and from below for not delivering the impossible" (Taylor, 1999: 7). Alford (1975) argues that community representatives, or to use his language 'equal-health advocates', are not typical of the wider community, who generally have very little knowledge about health planning. As a result he suggests that:

> The isolation of equal-health advocates from the community increases the chances of their being co-opted into advisory boards, planning agencies, and other devices for advertising the representative character of "community participation" without much chance, let alone guarantee, that the community will be able to evaluate and control the actions of their advocates, much less of the health providers.
>
> (Alford, 1975: 219).

This tension within Coventry could also be seen in the desire to encourage broad participation and wanting to involve community members who already had significant links with other groups and organisations within the community. For example, the guidelines for Health Action Groups, drawn up by the Steering Group, on how to engage local communities in decision making states that: "HAGs should aim to recruit 25 per cent of their membership from local residents, preferably those who have links with wider community groups/organisations" (Coventry Health Authority, 2000b: Appendix 2).

Whilst some statutory sector personnel criticise community representatives for being the 'usual suspects', Mayo and Taylor (2001: 48) suggest that it is often statutory sector agencies who are responsible for creating 'community stars'. Those organisations and individuals who have power have considerable influence over who participates and are often responsible for inviting the same people to participate in many different forums. Furthermore, Mayo and Taylor reason that:

> Conversely, those whose demands and/or demeanour are defined as less acceptable tend to become labelled as 'unrepresentative' and are excluded from further influence.
>
> (Mayo and Taylor, 20001: 48).

This identification of preferred representatives can also be said to be true for voluntary sector involvement. Within Coventry the two strong and well-established organisations – Coventry Voluntary Services Council and the Community Health Council – noted that they had been invited to put forward representatives to sit on every HImP Development Group, in addition to a senior manager from each of these organisations regularly attending the Steering Group. Neither of these organisations had the capacity to respond to these requests. Despite this, apart from Coventry Racial Equality Council having a representative on the Steering Group no other voluntary organisations were regularly mentioned as being closely involved with the work of the HImP.

Community participation is now an integral element of a large number of policies and programmes. As a result Taylor (1999) suggests that community members themselves may feel overwhelmed with the amount of activities within which it is possible to participate. She suggests that:

> For many [...] community involvement [...] has turned into a mixed blessing as more and more partnerships are set up and their limited resources are stretched further and further.
>
> (Taylor, 1999: 7).

### *Community participation in the HImP as a means of tackling inequalities and social exclusion*

As noted in Chapter Two participation is most frequently an act of the well-educated and financially stable members of society, as opposed to more marginalised members of society experiencing significant inequalities in health. Consequently, Coventry HImP's decision to concentrate on local level involvement in the city's six Health Action Areas (the areas in which Coventry citizens experience the worst health) must be regarded as valuable and in the spirit of the aims of national HImP policy - tackling health inequalities and involving all local partners and stakeholders in the planning and delivery of health care (Hunter, 1999). In addition to the geographical focus for involvement employed in Coventry a number of participation initiatives were targeted at specific interest/disadvantaged groups such as those experiencing mental health difficulties, people with physical disabilities, older people and children. These ranged from stakeholder conferences to consultations.

### *The role of community participation 'champions'*

Efforts to involve the public in Coventry's HImP must not be regarded in isolation. Whilst as noted in Chapter Six, Coventry did not have a strong and powerful community movement, it must be acknowledged that a number of activities had been taking place for many years in the City both at the grass roots level, with community groups pushing for involvement or raising the profile of certain issues, and through the voluntary sector, who have campaigned about issues on behalf of users and the public. Furthermore, public involvement 'champions' (Harrison and Mort, 1998) have always existed within the two key statutory agencies with a number of key individuals within Coventry Health Authority and Coventry City Council seeking to involve the public on a variety of issues for a number of years.

Many individuals noted that the emphasis on community involvement in the HImP and other current health and social policies legitimised their efforts and concerns. Some individuals noted that they had been actively working with and engaging members of the public around health issues for 10 years and that there experience was now valued and their knowledge treated with more respect. However, it was argued that despite the high profile of community participation within government policy documents, participation was still dependent upon a few committed individuals for policy to be translated into action. Those with a strong commitment to public involvement still found themselves battling to take the agenda forward in a context where other issues received higher priority locally (which, as noted above, was arguably the result of government targets and monitoring requirements).

### *The devolution of HImP monies to Health Action Groups: redressing the democratic deficit or 'passing the buck'?*

A continual trend during my year long observation of Steering Group meetings was towards the devolvement of responsibility for community involvement in the HImP. What started out as an issue to be addressed by the Steering Group, was then proffered as an area of responsibility for the HImP Development Groups and finally of the Health Action Groups. Despite common agreement by all those interviewed within the HImP Steering Group (15 interviewed out of a total of 17) that public participation was an essential element of the work of the HImP, responsibility for its operationalisation was delegated to the Health Action Groups.

It could be suggested that community participation is most appropriately taken forward by community-based organisations that are better placed to overcome some of the obstacles to participation cited by Steering Group members, such as gaining access and knowing what groups already exist. However, there were a number of problems with how the devolvement of HImP monies to HAGs was followed through. In particular, whilst financial resources were earmarked for devolvement to HAGs, the Steering Group seemed unwilling to also devolve the responsibility and decision-making powers necessary to accompany these resources. Whilst this will be considered in more detail when I move on to examine the issue of power and its impact on community participation, it is worth noting here. It is also worth linking this point to the previous discussion about HImP Steering Group members feeling that they do not having the required skills or knowledge to develop community participation mechanisms. Consequently, it could be that devolving HImP monies to Health Action Groups, whilst conceived of as a means to both increase the capacity of community-based organisations and achieve more sustainable community participation, was also considered to be a way of releasing Steering Group and Development Group members from the burden of trying to develop sustainable participation strategies. As Abelson (2001: 777) notes:

> decision-makers, faced with increasingly difficult resource allocation decisions, welcome the opportunity to share this task (and the associated blame).

Nevertheless, the devolvement of money, even if the amount devolved in the first year (£12,000 to each HAG) was considered insufficient by members of the Health Action Groups I interviewed, represents a tentative first step in the right direction. Following a review of research on local action to tackle social exclusion the DETR's Policy Action Team 17 in their report *Joining It Up Locally* (2000b) concluded that despite the increased knowledge and support for community participation in regeneration partnerships very few attempts had been made to shift the balance of power through transferring resources to community-based groups in the way Coventry HImP was attempting. This point is also made by Basten (2000) who argues that community groups are often insufficiently resourced to take on the role as 'partners' in decision-making and the implementation of programmes. Findings from the literature and the case study demonstrate the need to decentralise both resources and an appropriate degree of decision-making power. This remains a long way removed from the current efforts being employed in Coventry's HImP.

### *Difficulties associated with bidding for devolved HImP monies*

Interviewees from the Health Action Groups stressed their disappointment at what they regarded as the unrealistic timetable for drawing up proposals to bid for HImP money. As noted in the previous chapter, whilst the guidance issued by the HImP Steering Group emphasised the importance of HAGs engaging community members and voluntary organisations within their locality in the development of their proposals, according to HAG members the quick turnaround required meant that proposals had tended to be drawn up by the PCG representative or other statutory sector employee chairing the HAG. Whilst others who were familiar with proposal writing and who could deliver quickly had been encouraged to participate, this primarily describes those members of the group who were representatives of statutory organisations. The damaging effects of such tight deadlines on efforts to involve the public have been recorded in other more established initiatives such as City Challenge and SRB (Atkinson and Cope, 1997), suggesting that the same mistakes are being made repeatedly. Interviewees from the HAGs argued that this represented a lost opportunity to help less experienced members of the HAG, particularly community members, to develop new skills around the preparation of funding proposals.

Jeffrey (1997) highlights another negative element of having a bidding process which may also impact upon HAGs bidding for HImP money. She concludes that the introduction of competition for funding amongst community organisations changes the dynamics of the relationship between the statutory sector and community groups, even where existing and functional relationships existed. Community groups competing for funding from the HImP partnership undermines the partnership arrangements which are supposed to include community members.

This damaging effect of bidding for funds from statutory sector organisations was also noted by many of the Health Action Zones (HAZs). Research commissioned for

Lambeth, Southwark and Lewisham HAZ concluded that the bidding process was institutionally racist and perpetuated the existing hierarchies of power. The research noted that smaller community groups, in particular:

> were often unable to tender to provide services because they lacked the capacity and resources to compete with larger groups. This meant that they were unable to obtain statutory funding for the services they offered. As these smaller organisations are key service providers for black and minority ethnic communities, these communities were missing out.
>
> (Lambeth, Southwark and Lewisham Health Action Zone, 2001: 1).

Consequently, a new approach, '*Developmental Commissioning*', was developed within the locality to overcome these problems. Competitive tendering was removed and a new model of commissioning services introduced which was based upon facilitated partnership working to enable a wide range of organisations from the voluntary, community and statutory sectors to work together to deliver services.

Despite widespread support for the devolvement of HImP monies to Health Action Groups as a means of gaining increased involvement of local communities in the work of the HImP it was noted by a few individuals that the stringent controls being placed on how this money may be utilised and the bidding process HAGs would have to go through to acquire any of this money meant that the money was far from sufficient. It could be suggested that rather than redressing the democratic deficit by devolving decision-making power, the process for the allocation of HImP monies has only served to extend competitive forms of operation to community groups hoping to secure some of this money through involvement with the Health Action Groups.

*Accountability as an inhibiting factor for community participation*

The cautious organisational culture evident in Coventry's HImP identified earlier in the chapter may be seen in the protracted discussions over the arrangements for devolving HImP monies to HAGs. In particular, efforts around the development of a framework for accountability and guidelines for the constitutional arrangements for HAGs persisted throughout the duration of the fieldwork. This 'safety first' culture which eschews risk taking behaviour with public money has been noted elsewhere. For example, Taylor (1999) argues that:

> it seems to be in the nature of public money that each level takes the accountability demands of the level above. Adds a few more to safeguard its own position and then passes them all down to the next level. By the time any initiative gets down to the community, it is weighed down with paperwork. Risk is pushed down to the lowest level.
>
> (Taylor, 1999: 8).

For Taylor, the development of complex frameworks and monitoring procedures serves to exclude the participation of community members rather than facilitate their involvement.

The issue of accountability for public money is a major tension which needs to be resolved if effective community participation is to be developed. Whilst policy documents suggest that statutory organisations should be building informal relationships and trust as the basis for working in partnership with others, including the community, (see for example DETR, 2000b), Coventry Health Authority's need for formal mechanisms of managing the process and monitoring for compliance were understandable given that responsibility ultimately stopped with them. As Taylor states:

> Public accountability is not simply an unnecessary barrier put up by bureaucratic [...] officials. There are very real tensions between accountability for public money and the need to take risks. There are considerable dilemmas involved in securing the commitment at all levels of government to move from control cultures to a genuinely enabling role.
>
> (Taylor, 1999: 12).

Indeed, this issue does not only affect those working on the development of HImPs. Nationally there are a number of programmes, many of which are around area regeneration, where those in charge are seeking solutions to these very same issues.

Whilst the need for the health authority to endorse the proposals for spending money for which they are publicly accountable is understandable, as is the need for guidelines as to what previously identified priorities the money may be spent on by the HAGs, these rules and boundaries place similar restrictions on the Health Action Groups as members of the HImP Steering Group complained were imposed on them by Central government. Consequently, the need to move to a culture, both nationally and locally, which accepts risk is essential.

*Power as a crucial element impacting upon community participation*

It has been argued that all questions around community participation:

> can be located within the larger theme of power and control and [...] how these issues are dealt with has important consequences for both the theory and practice of community participation.
>
> (Rifkin *et al.*, 2000: 2).

Whilst the plan to devolve money to HAGs shows some commitment to devolve real resources to communities, this will be realised within a centralised system of power. As HAGs are health and local authority managed initiatives, using Alford's structural interests theory it could be argued that they do not represent community-led interest groups, rather that they characterise an attempt to co-opt community interests "into bases of legitimation of the activities and role of [...] challenging structural interests" (Alford, 1975: 218).

The framework for devolving money, which requires the preparation of proposals as to how the money would be utilised and the agreement of any proposed plans by the HImP Steering Group, may be regarded as a process which allows those with power to set the agenda and, as noted in Chapter Two, to keep issues off the agenda (Bachrach and Baratz, 1970). The need for technical knowledge on which to base decisions and develop strategies was put forward as a justification for the vetoing of HAG proposals. Barker (1996) argues that whilst technical factors are important they are not the only factor to be considered in decision-making. For Barker (1996: 79), such notions of "technological determinism" may be regarded as manifestations of the distribution of power within society. As Atkinson and Cope (1997) argue, there is no reason why much of the 'technical' knowledge professionals often hide behind cannot be shared more generally with members of the public. Moreover, Atkinson and Cope (1997: 217) argue that organisations maintain power by "divorc[ing] themselves from the 'people', legitimised by their possession of technical and specialist knowledge".

The reluctance to delegate decision-making powers in additional to the financial resources to be devolved to HAGs was noted by a number of individuals within the case study site. If Alford's (1975) structural interests framework is applied, this hesitation to delegate power may represent an attempt by the corporate rationalizers, i.e. statutory sector managers, to maintain the status quo in terms of distribution of power and decision-making responsibilities. Such an approach does not serve the repressed interests of the community population and means that HAGs have insufficient power to effectively perform the function of engaging community members in health planning, which is requested of them.

As documented earlier, the need to keep the overall power and responsibility at HImP Steering Group level was often justified on the basis that accountability for the devolved money rests with the HImP partnership (particularly the health authority as the responsible body), rather than the groups which would receive the money. For many of those representing statutory organisations this was the reality of their situation and they could not see how to challenge it. It would always be their role to use their professional judgement in deciding what public money allocated to them is used for.

The power of the two key statutory organisations (the health authority and local authority) in comparison to the other partners involved in the development of the HImP could be seen clearly. However, of this duo the health authority was unmistakably the key power holder within the Steering Group where Walton's (1968) *pyramidal* concept of power, i.e. a single cohesive leadership group, could be said to apply. The power of the health authority was illustrated by their rejection of the framework for devolving monies to Health Action Groups devised previously by the local authority when devolving Single Regeneration Budget (SRB) money. The adaptation of these previous guidelines was not considered, despite the fact that at least one of the HImP Steering Group members had been involved in drafting these guidelines for the local authority. This demonstrates a lack of confidence in the local authority's procedures as well as reticence to utilise the skills of all members of the Steering Group to their full extent. It could therefore be argued that whilst the health authority was happy to devolve some of the operational power and responsibilities for day to day management of the HImP to the local authority and other HImP partners that they were unwilling to give up any of the strategic power to influence long term plans and policy decisions.

Such an unwillingness to build upon the knowledge and experience of all members of the HImP Steering Group directly undermines the argument put forward by many members that the sharing of knowledge, skills and resources produced the added-value to be gained from working in partnership rather than as discreet agencies. The partners within the HImP process could not be regarded as equals. Balloch and Taylor argue that if partnerships are not based upon equality of the partners then they should not be regarded as real partnerships. Such partnerships are branded as "symbolic" by Balloch and Taylor who note that often "the opinions of more powerful partners are dominating agendas and processes. Where this happens, only limited notions of partnership are entertained..." (Balloch and Taylor, 2001: 284).

The observed reluctance to give up control, and the model of power recognised to be employed with regards to decisions around the HImP, could be argued to reflect the tradition of centralism within Coventry, which has constrained wider participation and innovation. Moreover, the framework of power operating within Coventry's statutory organisations strongly impacts upon the position adopted with regards to community participation. The health authority's commitment to greater public involvement can be seen in their determination to devolve resources to Health Action Groups, yet their inability to let go of decision-making powers and continual fine-tuning of the framework setting out how this money may be devolved served only to curtail real involvement in decision-making. The time taken to agree the framework meant that there was less time left in the life of this policy for community participation to take place.

Mayo and Taylor (2001) suggest that a major element of power is knowledge. By increasing their knowledge on issues they argue that all partners, including communities, may be able to challenge the power imbalance to become more equal. Whilst an increased knowledge base would certainly enhance participants' ability to engage confidently and effectively I would suggest that it is doubtful community members would have the time and resources to gain equal knowledge to professionals who may have worked on these issue for many years. Furthermore, I would argue that increased knowledge alone would not enable community members to become equal partners. As highlighted within this thesis, numerous other factors, for example organisational culture, would persist to prevent all partners from achieving equal status. As Alford (1975) has argued:

> community representatives do not have the information necessary to play an important political role; they do not know the levers of power, the interests at stake, and the actual nature of the operating institutions, and they do not have the political resources necessary to acquire that information...
>
> (Alford, 1975: 219).

Consequently, whilst increasing the knowledge of participants is obviously a strategy to be welcomed, it cannot be presented as the answer to the problem. Whilst a few community members may be able to gain equal knowledge and status through this route it is never going to be applicable to the general public as a whole. It is more important that emphasis is placed on the need for professionals to change the way in which they work with community members. As Taylor argues:

> power [...] remains with those who know the rules, who have the time and training to get to grips with complex accountability requirements. These are the professionals, the best resourced and most established voluntary organisations and the accountable bodies – not the 'real' community that government is so anxious to get to. [...] And yet all the talk about capacity building is about communities; we rarely hear anything about the need for capacity building within [statutory agencies].
>
> (Taylor, 1999: 9).

Coventry Health Authority, as the agency officially responsible for the HImP did, however, take steps to broaden the ownership of the HImP. A number of joint posts were established between the health and local authority for those leading on HImP programme areas in an effort to share ownership and facilitate cross-agency working. However, the creation of joint posts falls short of the overall aim of national HImP policy which describes Health Improvement Programmes as a partnership initiative in which broad ownership of the local plan is realised by *all* partner agencies, including the public and voluntary sector organisations. As Policy Action Team 17 found, in the past:

> Joined-up working has been held back by the fragmentation of effort sustained by a combination of political, professional and administrative pressures which inhibit joined-up cross-sectoral working and provide little reward for innovative cross-cutting work.
>
> (DETR, 2000b: 18).

HImPs are one of many partnership initiatives with flexibilities and opportunities for pooling budgets introduced by the government in an effort to overcome these barriers.

*Development of criteria for judging HAG proposals*

The HImP Steering Group developed a set of criteria for use in deciding whether to allocate HImP monies on the basis of proposals. Two of the criteria devised could be regarded as contradictory. These were (i) the suggestion that proposals must be innovative and (ii) the assertion that proposals must be evidence-based. A third criterion which might also be regarded as contradicting the need to be innovative was that the money should be used to fund pre-existing initiatives or programmes which were regarded as successful. Indeed, this last condition was regarded as representing a 'safe bet' in terms of return for investment.

### *Discretion and street level bureaucracy*

As noted in Chapter Four *the New NHS* and *the NHS Plan* White papers and their accompanying directives stressed the importance of the HImP involving the public as partners in the process of developing and delivering the programme locally, yet these documents were not prescriptive about how HImP partnerships should go about involving the public. According to Milewa *et al.* (2002: 42) this approach by government represents a "policy of encouragement". Fereday (2000) notes the different ways in which this discretion can be used:

> By not prescribing a particular method of public participation the guidance allows the adoption of methods that reflect the needs of the local community. It also allows health authorities to adopt methods that are unsuitable or methods designed simply to legitimate decisions that have already been taken.
> (Fereday, 2000: 61).

However, throughout the period of field work a number of documents were produced by the Department of Health including *Patient and public involvement in the new NHS* (1999) which set out the government's expectation, but also provided examples of good practice and the consultation document for *Involving Patients and the Public in Healthcare* (2001). However, it was not until November 2003 that a *Performance Improvement Framework for Patient and Public Involvement in the NHS* was issued (Strategic Health Authority PPI Leads Network, 2003). This central policy prescription and local discretion is a feature of New Labour according to Lee (2001: 2) who notes that:

> The Blair Government has chosen to implement a series of initiatives which have 'joined-up' and integrated policy at central government level while simultaneously decentralising administrative responsibility to local actors for devising strategies to meet the resulting output and performance criteria for service delivery.

Lee argues that this demonstrates New Labour's 'entrepreneurial government' style. Indeed, he argues that "implementation by entrepreneurial government is based upon the separation of policy decisions (steering) from service delivery (rowing)" (Lee, 2001: 8). The 'rowing' of the HImP is clearly left to the discretion of local officers charged with implementing the programme, Lipsky's (1980) 'Street-level bureaucrats'. As noted in Chapter Two Lipsky's theory demonstrates that policies are redesigned at the point of implementation as a result of the discretionary activities of street-level bureaucrats who are often trying to manage competing pressures such as limited resources. In Coventry the HImP Steering Group demonstrated this discretion in their decision to devolve responsibility for public involvement to local community based groups (HAGs). The decision to make HAGs the key forum within which participation occurs meant that socio-economically disadvantaged communities were the key targets for participation. Whilst combined with other participation mechanisms such as the Citizen's Panel and ad-hoc strategies for involving particular communities of interest, Coventry decided to pursue the involvement of citizens in the areas experiencing the worst health as their main sustainable strategy.

### Models of participation within Coventry's HImP

Within Coventry's HImP a number of different approaches to involving the public were identified. These different strategies reflected the varying degrees of knowledge about participation mechanisms and the differing commitment towards participation by members of the Steering Group, Development Groups and Health Action Groups. Whilst the majority of strategies employed within Coventry's HImP may be regarded as conforming to a consumerist model of participation in which the public were encouraged to participate as 'consumers' of health services, the devolvement of resources to Health Action Groups represents an attempt to employ an approach which is more akin to the citizenship (also known as the democratic) model of participation in which participation is seen as a right and shared decision-making in all decisions which affect people's lives encouraged. However, there is still a need to overcome the previously identified barriers around accountability, organisational culture and ultimately to devolve power as well as resources to HAGs if the principles of social equity and citizen empowerment which underpin the democratic model are to be realised within Coventry. As Brown notes:

> Clearly, public involvement is not something that can be just added on. Existing processes of interaction and communication between people, the values and culture of the organization, are all important.
> (Brown, 2001: 166).

Overall, it is possible to argue that the participation strategies employed within Coventry HImP represent attempts to involve the voluntary sector and user groups (consumers) and the public (citizens). Therefore the strategies adopted within

Coventry's HImP utilised both approaches to public participation. Some commentators would argue that this is not necessarily a bad thing. For example, Pickard and Smith suggest that:

> There are merits in both consumerism and citizenship approaches: while the focus on the consumer has led to responsiveness, particularly patient information, quality monitoring, standards and individual rights, focus on the citizen has led to concerns about accountability and legitimacy and the collective involvement of local communities in making choices that potentially impact on every citizen.
>
> (Pickard and Smith, 2001: 178).

Revisiting the four theoretical constructs of participation identified by Rifkin *et al.* (2000): community development; people's participation; empowerment, and action research, having completed the case study it is difficult to claim that Coventry's approach to involving the public neatly fits into one of the four ideal type models. Whilst efforts within the city did not go as far as *people's participation* or *empowerment* in so far as they did not allow the public complete control over the identification of the issues to be addressed, they **did** embrace the principles of skilling-up local people and fostering the sharing of knowledge around health issues which are said to be typical of these models. These principles are less the concern of *community development* which, according to Rifkin *et al.* does not involve the transfer of any power or resources and regards community participation as a means to an end, rather than as an important process in itself.

However, in all other respects Coventry's participation attempts were more analogous with the community development model, with professionals (and central government) defining what the important issues were and who should participate (either by working in Health Action Areas and therefore discrete geographical communities or through invitations to particular voluntary organisations and user groups representing particular communities of interest). Even here there were inconsistencies however. For example, one of the HImP priority programme areas was included as a result of its identification as an issue which needed to be tackled by local people within the Coventry Community Research Project and the Citizen's Panel. The Community Research Project itself is an example of a needs assessment exercise carried out in such a way not only to illicit the views of local people but also to empower local people to carry out the exercise themselves, in collaboration with the health authority. Although the Community Research Project was not part of the HImP its findings were used to inform HImP development and so it may be regarded as part of the process. Consequently, Coventry's approach may be regarded as higher up the ladder of citizen participation than the rung which the community development model would represent, but lower that that of the people's participation, empowerment or action research models.

It is always difficult to match reality with 'ideal-type' models where constraints such as accountability, meeting government targets and lack of resources do not come into play. Indeed, ideal types can be criticised as models developed within a vacuum, with no consideration for the contextual factors impacting upon those who try to employ them. Light (1997) argues that 'ideal types' are inevitably and intrinsically limited as actual reference points for organisation practice and policy development.

### Empowerment as an outcome of community participation in the HImP

Wallerstein and Bernstein (1988: 380) define empowerment as:

> a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society. With this perspective, empowerment is not characterized as achieving power to dominate others, but rather power to act with others to effect change.

HImPs as an overall policy encourage participation in both strategic and operational decision-making. Whilst public participation at the strategic level of HImP Steering Groups or Boards was found to be rare nationally (Hamer, 2000), citizens were encouraged to influence long-term policy decisions. Within Coventry this can be seen in the inclusion of community identified priorities into the overall HImP. Within the HImP Development Groups participation was sought in the operational decisions about service delivery and implementation. This is important since Hart *et al.* (1997) suggest that power to affect decision-making is often limited to operational level decisions. They argue that participation in operational decision-making does not offer the same possibility of empowerment as participation in strategic level decisions. In this way, HImPs as a policy may be regarded as presenting the *opportunity* for empowerment, even if such potential was far from being realised within my case study site.

A number of factors prevented participation in Coventry's HImP from being experienced as empowering. These include the model of participation being employed; the power imbalance within the HImP partnership; and the organisational barriers, including culture. According to Taylor:

> empowerment means acknowledging the tensions and conflicts [...] rather than trying to find structures that regulate and minimise them. It means looking for lots of links and opportunities to engage, rather that the one all-powerful committee, and building lots of bridges across the sectors, not just the one.
>
> (Taylor, 1999: 14).

Coventry's approach, which involved the utilisation of numerous different strategies to involve the public, including the appointment of a Networking Officer and the proposed employment of community liaison representatives, may therefore be regarded as positive in this sense. However, the determined efforts to develop rigorous accountability structures and terms of reference for Health Action Groups prevented these groups from developing participation structures which may be experienced as empowering and locked them into a bureaucratic mode of operation.

I would argue that empowerment is unlikely where participation is based on a consumerist model, as many of the participatory activities within Coventry were. Indeed, as noted in Chapter Two, consumerism does not recognise the issue of power and hence does not seek to address the differentials in power and in access to opportunities for empowerment. Balloch and Taylor (2001) note that if partnership-based programmes are to deliver empowerment this:

> depends on acceptance of a rights-based approach in which the rights and self-defined needs of individuals and communities provides the rationale for strategic planning and service delivery.
>
> (Balloch and Taylor, 2001: 288).

Such an approach is more readily reflected in the citizenship model of participation.

It is unlikely that top-down, government initiated programmes such as HImPs would ever allow the flexibility needed to provide such opportunities. Therefore, whilst HImPs have provided the opportunity for health and local authorities to work together and in partnership with a wide range of other local stakeholders, including members of the public, to develop health plans which reflect local needs, evidence from the case study suggests that they do not address the fundamental inequalities of power, differences in knowledge levels and cultural barriers, all of which impede empowerment. However, Balloch and Taylor (2001: 287) suggest that involving the public has "the capacity to 'reframe' the way we tackle issues", drawing on local people's knowledge and understanding. Consequently, HImPs and other such national policies which compel community participation, whilst rarely creating the conditions for empowerment, can provide opportunities to develop more responsive and appropriate services.

### Community participation in the HImP: disparities between rhetoric and reality

A key finding from this case study was the existence of an implementation gap between policy and practice with regards to community participation in Health Improvement Programmes. Such chasms between national directives and local action have been found to exist within many different policy initiatives (Hogwood and Gunn, 1984; Milewa *et al.* 1999). One reason for this gulf between policy and practice may be the high levels of discretion those charged with implementing the HImP possessed. Indeed, the impact of those charged with a policy's implementation, Lipsky's (1980) 'street-level bureaucrats', on the final form of the policy can be seen in many areas of the HImP in Coventry. One example of this is the finding that individuals with a strong commitment to public involvement developed more opportunities for involvement within their programme area. In addition the opportunities they created often allowed for higher levels of participation as classified by Arnstein's (1969) ladder of citizen participation (for example, working intensively with a small group over a couple of days as opposed to distributing consultation information with feedback forms to voluntary groups). Another factor contributing to the gap between policy and practice was local context and culture. Participation strategies are not developed in a vacuum are affected by the local context, including the history of public involvement around that area of work; the capacity of individuals to facilitate participation; the capacity of citizens to effectively participate, and the organisational cultures of partner agencies. All of these factors contribute to the development of an implementation gap.

The general commitment to the principle of community participation witnessed in Coventry is fairly typical and was recorded in the national review of HImPs (Hamer, 2000). It may be suggested that the Government, in their assertion of the important role to be played by the community as witnessed by its inclusion in many policy documents, acted as equal-health advocates. It would follow then that this increased role within health planning for members of the public, encouraged by the equal-health advocates, is generally welcomed since, as Alford notes:

> The major consequence of the activity of equal-health advocates is to provide further legitimacy for both the expansion of specific research or service units controlled by professional monopolists and the expansion of the layers of bureaucratic staff controlled by the corporate rationalizers.
>
> (Alford, 1975: 219).

The expansion of the role of Health Action Groups in Coventry, along with the new frameworks and procedures developed in relation to their operation, may be regarded as an extension of the power and control of corporate rationalizers, as suggested by Alford.

As the previous chapter demonstrates, interviewees were able to provide extensive lists of the perceived benefits of involving the public in health planning. However, despite this commitment to community participation and the issue's relatively high profile in HImP Steering Group meetings and HImP documentation, particularly in relation to the process of devolving money to the HAGs, participation activities were relatively few and far between. Moreover, it was suggested that whilst the opinions and views of community members had been regularly collected over the years they were not often acted upon.

This lack of follow through from commitment in principles to delivery in practice has been noted by other authors (Milewa *et al.*, 1998; Brown, 2001). Milewa *et al.* (1998)

state that the discord between rhetoric and reality may reflect the fact that community participation has only recently resurfaced as an important issue for the health service within policy documents. Whilst community development activities have taken place regularly since the 1960s these have tended to be grass-roots-led rather than a mainstream requirement of government policy. Brown (2001) suggests that the dissonance between the limited activity around community participation found in many places as opposed to the profuse rhetoric on the issue may be a left-over from the previous Conservative government's legacy and that we should begin to see a change in activities under New Labour.

> To some extent the superficial engagement with public involvement [...] reflects the approach of the previous government and the limited resources available at the time. Present policy appears to be both more robust (although resources remain a critical issue) and oriented to broader ideas of involvement.
>
> (Brown, 2001: 165).

Community participation in the planning and implementation of Coventry's HImP was happening on an ad-hoc basis and mostly in responsive mode. The issues were nearly always set prior to community participation being sought. This demonstrates a lack of commitment to real involvement in which communities can significantly influence planning and development. Whilst in theory HImPs provide, albeit limited, opportunities to participate in strategic level decisions, Hart *et al.* note that promoting participation when the key strategic level decisions have already been taken means that:

> the process of encouraging community participation and evoking community empowerment at the operational level actually increases the power of the power holders because they are failing to relinquish power in any meaningful way.
>
> (Hart *et al.*, 1997:197).

They refer to this as the "reconsolidation of professional power" (Hart *et al.*, 1997: 198).

Furthermore, a questionnaire respondent suggested that as a result of the many different policies and programmes which now called for public involvement as standard, professionals may begin to feel overwhelmed or cynical about community participation. Professional withdrawal would only serve to widen the gap between rhetoric and reality.

## Conclusion

Participation of the community in the planning and development of local HImPs was a central principle of this national policy. An examination of Coventry's HImP as a detailed case study has demonstrated the strategies developed to involve the public, the rationale behind these strategies and the many different factors which enhanced or inhibited the development of public participation.

### *Implications of the research*

New pieces of research, such as this thesis, which highlight the difficulties of operationalising community participation in contemporary initiatives, demonstrate that despite the political shift and increased rhetoric about the importance of citizen involvement in health, numerous problems persist and lessons are not being learnt from previous policies and programmes exhorting public participation.

Achieving sustainable and 'real' (i.e. participation which would be classified on Arnstein's ladder of citizen participation as enabling a degree of citizen power) community participation is clearly an area which many local agencies struggle with. For example, in October 2002 the government's Modernisation Agency identified community participation as an issue on which PCTs were failing to deliver and for which a dedicated programme of work was required to share learning (Personal communication with Andrew Donald, Development Director for NatPaCT, Modernisation Agency, October 2002). However, if the Government is serious about its commitment to community participation then both structural and cultural changes are required. The structural factors noted by members of Coventry's HImP Steering Group as impeding efforts to devolve power and authority, such as monitoring and accountability arrangements, need to be addressed if the public are to be treated as equal members of partnerships. The form of the structural changes required is not yet clear and different models could be tried. Klein (1984) suggests that if the emphasis on direct participation is removed then moving towards directly elected health authorities (and presumably PCT Boards in today's health service configuration) as a means of democratising the health service and making it more responsive to the needs of the local community may prove to be an effective strategy. However, he notes that local authorities, who are elected, are not necessarily perceived as more responsive than the NHS. Furthermore, the rates of participation in local elections are often very low and there is no guarantee that this would be any higher for the election of health officials. In addition, he notes that responding directly to local views may result in a bias within the health service arguing: "The most vulnerable groups are precisely those least likely to participate in any political market, and least able to assert their own interests" (Klein, 1984: 30).

HImPs represented the first major health policy which put working in partnership with local communities at the heart of mainstream planning activities within the NHS. These programmes demanded that those charged with developing and delivering the HImP consider how they may involve local people within ALL related activities, rather than through traditional NHS consultation mechanisms. The rhetoric surrounding community participation in HImPs within policy documents couched participation as both a means to attain an accountable health service and as a right of all citizens to participate in the decisions which impact upon their lives. Consequently, whilst progress with community involvement was slow, as demonstrated within this case study, the HImP challenged traditional ways of working and paved the way for a number of other initiatives introduced by the Labour Government since. HImPs embodied the new joined-up working approach to health service planning which was designed to replace the fragmentation within the local health system. This approach operates to the model advocated by the World Health Organization in *Health for All* (WHO, 1978).

### *Generalisability of the findings beyond the immediate case study*

In principle these findings of the tensions between policy and practice in relation to community participation in Health Improvement Programmes may be generalized to theories of community participation and provide a wider understanding of the tensions involved in developing community participation in a broad range of health policies and programmes introduced since the election of New Labour to government in 1997. Whilst the initiatives have changed and many of the organisations now charged with the responsibility for involving the public and patients in health care have changed (e.g. PCTs as opposed to health authorities) the structural, economic, social, political and cultural factors enhancing and inhibiting participation as identified within this research will be experienced similarly in many localities.

This research suggests that HImPs have bought about some movement up Arnstein's (1969) ladder of citizen participation, but have not delivered all that they promised as a result of the many factors described in this and the previous chapter. HImPs may be regarded as representing an effort to bring in Alford's (1975) repressed interests of the community population, and some of the structures introduced to facilitate the participation of members of the public had the potential to redress the power imbalances and serve as mechanisms for sustainable participatory activities. However, HImPs, despite their partnership constitution, are led by corporate rationalizers (health service and local authority administrators) whose activities within Coventry, whilst well-intentioned, served to complicate the mechanisms for devolving resources to community-based groups and hence prevent these power imbalances from being redressed. In the next chapter I shall convey my overall conclusions from this research and draw attention to the implications of the findings from this study for the NHS.

# CHAPTER EIGHT

# CONCLUSIONS AND IMPLICATIONS FOR COMMUNTIY PARTICIPATION IN THE 'NEW NHS'

In this chapter I shall draw together the threads of the research to present my conclusions about community participation in Coventry's HImP in particular, and in Health Improvement Programmes more generally. As noted in Chapter One, the focus of this research is on participation, and the identification of the factors that facilitate and inhibit the ability of those charged with developing participation. The HImP was chosen as an ideal policy within which to examine these issues, representing as it did, the first example of wide-scale participation in health planning introduced within New Labour health policy. Therefore, the focus of this chapter is on identifying the key lessons from participation within HImPs in order to make more general points about community participation in the planning and delivery of health services, and to highlight the implications of these for future participatory policies and programmes.

The conclusions will be presented in four parts. Firstly, the conclusions from the case study of community participation in Coventry's HImP will be set out. Secondly, the conclusions about participation in HImPs generally will be presented, drawing on the findings from a national review, a number of research reports and public summaries of individual HImPs. Thirdly, a structural interests theory explanation will be given, drawing on Alford's (1975) work. Finally, as this is a policy focused PhD, the wider implications of the findings from this thesis for community participation developments within the NHS will be discussed.

In order to examine the complexity of the processes involved in engaging the public, I took the decision that a detailed examination of one case study was the most appropriate approach to utilise. This has allowed me to identify the impact of contextual factors as well as to understand the power relations between key actors in the locality. I have provided important background and contextual information to facilitate the reader's understanding of the case study and the interactions within the research site.

Rather than testing fixed and pre-formed hypotheses, the research reported here was designed to be exploratory, in order to identify the tensions between policy and practice seen in the implementation of community participation in the Health Improvement Programme. The data presented mirror and reinforce many of the messages found in the literature on community participation, particularly concerning the difficulties associated with involving members of the public, the professional and organisational cultures which inhibit participation, and the existence of a gap between policy and practice, as discussed in Chapter Two. However, the thesis has also highlighted the great difficulties facing statutory agencies charged with involving the public, which are the direct result of the national culture of audit, accountability and target setting under New Labour (Ellison and Pierson, 2003). This culture was found to severely constrain innovation around community participation.

I hope that through a synthesis of the literature and in-depth primary research in one locality I have contributed towards the knowledge-base and provided an increased understanding of the conditions and factors which enhance and impede community participation in health service planning and delivery. These factors need to be considered by those advocating participative policies and allowed for when designing public participation programmes.

Since the case study was completed the NHS has seen the introduction of Patient and Public Involvement Forums, the Commission for Patient and Public Involvement in Health, Patient Advice and Liaison Services, Independent Complaints Advocacy Services and Overview and Scrutiny Committees, all of which will have a considerable impact upon the future shape of patient and public participation in the health service. Furthermore, in November 2003 a *Performance Improvement Framework for Patient and Public Involvement in the NHS* was produced. All of these initiatives demonstrate that community participation is still a key national and local priority for the health service. This highlights the relevance of my case study findings and the need for the lessons to be considered within future planning.

## Conclusions from the case study of community participation in Coventry's Health Improvement Programme

The findings from the case study demonstrate that in Coventry, as in many other localities, those charged with the development and delivery of the HImP were struggling with many practical issues. Many of those for whom engaging the public was a key element of their position, such as HImP Development Group leads, lacked both knowledge and skills in this area. The range of different approaches employed by the HImP Development Groups to involve the community, described in Chapter Six, resulting from the different values, attitudes and capacities of the individuals and organisations represented on each group, meant that both the quantity and the quality of participation opportunities varied across the HImP programme areas.

As detailed in Chapter Six, a number of participatory mechanisms were used early on in the HImP process when the priority programme areas were being defined. These included 'Stakeholder Conferences' on each of the areas defined by those developing the HImP as priorities, open to anyone within which these priorities were refined and confirmed. These agreed priority programme areas were then put to the Citizen's Panel to be ratified and to provide members with the opportunity to suggest additional priorities. Finally, those developing the HImP incorporated a recommendation from the Coventry Community Research Project, a health needs assessment project carried out by local people from the six Health Action Areas, that a major issue of public concern which needed tackling within all of these areas was drugs misuse.

The key strategy being adopted within Coventry to enable on-going participation was the devolvement of responsibility for community involvement to the community-based Health Action Groups. Following this process for a period of two-years and being privy to all senior officer level discussions on this issue through my observations of HImP Steering Group meetings for a year, gave me a level of understanding into the process of transferring responsibility for community participation which could not have been gained through documentary analysis and interviews alone. In fact, the language used within HImP documentation couched this process as one of devolving power to the grassroots level, allowing those closest to the community to take responsibility for how they effectively engaged members of the local community. This message also came across in the interviews conducted with many of the HImP Steering Group members, particularly those most closely involved with and accountable for the HImP. However, as we have seen, the reluctance to delegate power in addition to resources prevented the community from having any real control over the definition of issues and programmes of work to address local needs.

Seeing first hand the pressure the Steering Group was under to deliver on certain nationally and regionally monitored HImP issues helped me to understand why more emphasis was placed on addressing issues such as access and waiting lists than on developing community participation. The statutory organisations stood to incur financial penalties if certain targets and criteria were not met within set time limits. Indeed the expression "no-one loses their job over health inequalities" (Powell and Exworthy, 2001: 24), used to describe how health inequalities often fell off the agenda before the introduction of national inequalities targets in February 2001, could just as easily be applied to the issue of community involvement. Moreover, as Taylor (1999: 7) notes, the development of inclusive community participation arrangements "requires time, resources, imagination and strategies which encourage a wide range of local organisations", most of which were found to be in short supply in Coventry.

One of the most positive elements of Coventry's approach to community participation in the HImP must be their endeavours to ensure that participation became embedded into the process by devolving responsibility for community participation to Health Action Groups, rather than seeing participation as a series of one-off events. It was hoped that this strategy would generate more robust partnerships between communities, the voluntary sector and statutory agencies. It was anticipated that placing responsibility for community participation with community-based organisations would overcome the difficulties of accessing communities, developing relationships based on trust, and consequently reduce the amount of time spent setting up mechanisms for community participation. Building these relationships with communities through the HAGs may provide an opportunity to address issues of power and control and *could* potentially lead to statutory organisation staff placing equal value on professional and lay knowledge.

It appears that the organisations involved in Coventry's HImP often sought to "re-invent the wheel", developing new frameworks for allocating money to Health Action Groups, despite the existence of previously used frameworks. As noted in Chapters Six and Seven, those leading the development of the HImP did not fully utilise the community participation experience of other individuals and organisations and often felt overwhelmed by the prospect of involving members of the public in their work.

Whilst nearly everyone in the case study site felt that community participation was important in terms of developing transparent, accountable and legitimate services, they lacked knowledge about how to do this effectively or about sources they could draw on for help and information. However, it must be noted that despite this lack of capacity there was a genuine commitment to the notion of public involvement in health planning.

Whilst the many problems and barriers facing individuals within Coventry have been highlighted and the lack of innovation around community participation critiqued, it must be noted that the statutory and voluntary agencies involved in developing Coventry's HImP did act as enablers of participation to a degree. The case study demonstrates the obstacles that remain to be overcome and the inherent tensions of working in partnership with communities. It is clear that Coventry's efforts to develop participation mechanisms, particularly the attempt to devolve resources and create a more sustainable framework for participation, were severely hampered by the dominant NHS culture that prevailed, despite the fact that the HImP was a partnership. Indeed, as noted in Chapter Seven, at the strategic level of the HImP a pyramidal (Walton, 1968) style of power and leadership was evident where Coventry Health Authority were the key power holders.

### Conclusions about participation in HImPs nationally

Having examined reports of community participation activities in other HImPs throughout England, it may be argued that Coventry's approach to participation and range of community participation activities undertaken were not atypical, as will be demonstrated. Whilst certain localities, often those achieving 'Beacon Status'[1] or those which had Health Action Zone status[2] and hence had paid particular attention to issues of public involvement for a longer period of time, were more advanced in terms of their participation strategies and mechanisms (Hamer, 2000), there were also other authorities doing less to develop structures which would enable on-going sustainable participation.

In a Health Development Agency *Update* report on HImPs produced in January 2001 it was noted that: "Around the country, the degree of involvement of other non-statutory sectors, particularly the voluntary sector and local communities, remains patchy" (Hamer, 2001). This report noted that a number of HImPs were in the process of developing community involvement strategies, producing public summaries of their HImPs and providing staff training on community involvement. All of these ideas and practices were evident within Coventry. Some HImPs (for example, Hounslow) reported using a HImP Conference as a means of informing local priorities similar to Coventry's Stakeholder Conference (described in Chapter Six) open to all when developing the first HImP (Hounslow Health Authority, 2001). Wolverhampton, like Coventry, decided to make those individuals and communities hitherto marginalised from such processes their focus for participation:

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[1] The Beacon Council Scheme was established by the Government in 1999 to identify local authorities to act as centres of excellence and to share their learning with others.
[2] See Box 5, Chapter Four for more information on Health Action Zones.

> Many people find it difficult to influence and gain access to services. This will change by developing community networks, creating new approaches to participation, and building on good practice to give local people a real say in decision-making. It will focus on those people who are most often marginalised and excluded because of poverty, age, disability, gender, race and culture.
>
> (Wolverhampton Health Authority, 1999).

Some localities, for example Hampshire and the Isle of Wight, delegated all community involvement responsibilities to the local authorities "in their capacity as community leaders" (Association of Hampshire and Isle of Wight Local Authorities, 1999: 5), whilst other local authorities were arguing that they *should* have this responsibility (Rushmore Borough Council, 1999). Responsibility for community participation in the HImP has also been passed to large local voluntary organisations, such as the Community Health Council, in a few localities (Hamer, 2000). Arora *et al.* (1999) note that giving one organisation responsibility for public involvement may help to avoid fatigue amongst communities and user groups through their 'over-consultation'.

Croydon, which like Coventry had traditionally relied quite heavily upon the voluntary sector, especially the CHC, to represent users' views, had a whole raft of different arrangements for involving patients and the public outlined in its 2001-2004 HImP. Of particular interest was their multi-agency Community Involvement Strategy Group with responsibility for improving community participation (Healthy Croydon, 2001). A critique which was regularly voiced in Coventry was that no-one had responsibility for community participation. The approach described in Croydon, if proven to be an effective strategy, may help to overcome this particular issue within Coventry.

Arora *et al.* (2000) in their study of HImPs in London concluded that the majority of HImPs community involvement strategies relied upon the health authorities:

> usual channels of communication, consulting with their local Community Health Councils and inviting input from the voluntary sector usually via umbrella organisations.
>
> (Arora *et al.*, 2000: 13).

In addition, Carruthers *et al.* (1999) found that in many localities the level of public participation in the HImP had been minimal and that systematic approaches to participation were extremely rare. On the basis of these claims within published HImPs and within national and local research studies, it seems fair to conclude that community participation in Coventry's HImP appears to reflect what else is going on nationally. However, it must be acknowledged that the evidence relating to community participation in HImPs nationally is limited to one major national review; an update of this one-year later; and a handful of research studies based upon a cluster of case studies. However, these sources serve to indicate that whilst Coventry may not be regarded as a leader in this field, with many of the participation strategies employed reflecting typical NHS methods for involving the public, the proposal to devolve money to the community level via Health Action Groups suggests that more attention and thought had been given to mechanisms for embedding public participation in Coventry than in some other localities.

Given many of the above listed constraints facing those charged with developing community participation in Health Improvement Programmes and the lack of tradition of doing so, the finding of limited activity in practice compared to that prescribed in national policy documents and supporting guidance was not surprising.

Were HImPs given more time to develop capacity, both within the communities with which they seek to work, and amongst the statutory sector staff working with these communities, many of the tensions noted above may have been lessened and become more manageable. As noted in Chapter Four, the HImP was the first initiative to require such wide-scale participation. Therefore, it must be considered that HImPs required a cultural change in how those planning health services worked with members of the public. The case study findings presented in Chapter Six demonstrate that within Coventry this sea change was not quick to happen. Indeed, many individuals pointed to the restrictions on their time to develop new ways of working, which were a result of the time-scales imposed for establishing HImPs and meeting targets. However, the development of new ways of working required by HImPs may, over time, facilitate participation in future health service policies and programmes.

Many of the tensions identified between policy and practice relating to community participation in HImPs may be regarded as inherent elements of the contradictions found within New Labour policy. Indeed, the HImP may be regarded as an early example of the contradictions of New Labour noted by commentators such as Ellison and Pierson (2003), Lister (2001) and Driver and Martell (1998), as described in Chapter Four. Ellison and Pierson (2003: 11) note that: "After six years or so of New Labour rule, welfare provision in Britain is epitomized by a number of apparent contradictions", using the example of New Labour's rhetoric of decentralization being accompanied by a high degree of central control to illustrate their point. The important role to be played by members of the public in health service planning was set out in *The New NHS* (DoH, 1997) and one of the major vehicles through which this was to be achieved was the Health Improvement Programme (Grant, 2000). However, as has been demonstrated within this thesis, the HImP did not allow the time for the necessary capacity building essential to make this a reality. Furthermore, the dictate that the HImP must include a set of national priorities from *Our Healthier Nation* (1998), meant that all HImPs included issues that had strict targets attached which, as discussed in Chapters Six and Seven, received disproportionate amounts of attention compared to issues such as community participation.

This research has uncovered many of the rationales behind the decisions and actions taken, or not taken, in relation to community participation by local actors with the responsibility for HImP development. It has also identified some of the reasons for the tensions that exist between policy and practice.

The fact that no performance management indicators related to community participation in HImPs existed at the time of conducting this research had an enormous impact on the amount of time and effort individuals gave to this aspect of the HImP. Those issues on which the two dominant agencies within the HImP – the health authority and local authority – would be judged and would receive financial allocation on the basis of their performance in these areas received considerably more attention. Highlighting these issues and how they influenced the community involvement agenda within HImPs will hopefully lead to action which will ensure that community involvement in the many other government policies introduced since HImPs becomes more than just rhetoric.

The production of a *Performance Improvement Framework for Patient and Public Involvement in the NHS* in November 2003 is a step in the right direction. However, while this framework represents a benchmarking tool that can be used as a self-assessment tool or by overview and scrutiny committees, patient and public involvement forums and/or strategic health authorities, it is not mandatory and its adoption is left to local discretion.

### A structural interests theory analysis of participation in HImPs

Alford's (1975) structural interests theory, described in Chapter Two and applied to the case study findings in Chapter Seven, has provided a useful framework with which to assess power relations within the HImP planning process and their implications for community participation. Specifically, this research sought to examine whether the structures developed to involve the public and represent their interests within the HImPs allowed the *repressed interests* of the community population to be taken into account.

In a parallel to that found by Alford in his 1975 case study of New York, Coventry's corporate rationalizers, i.e. members of the HImP Steering Group, in their attempts to develop and agree a framework for devolving money to the local level, saw their own position as that of the *challenging interest.* Likewise, the interests of the medical profession and health service providers, as represented by the three PCGs, were portrayed by HImP Steering Group members as the *dominant interest,* acting as an obstacle to the devolution of resources and responsibilities.

Alford argues that "corporate rationalization challenges some fundamental interests of the professional monopolies", but contends that: "Corporate rationalization remains an ideology and a vision..." (Alford, 1975: 15). He felt that the power of the medical profession and the esteem within which they were held meant that they would always dominate the planning and regulatory functions within the health service and that the attempts by 'corporate rationalizers' (Senior Officers within health agencies) to introduce planning and integration through administrative regulation, would never be realised. However, in today's UK National Health Service, power is shared between health professionals and administrators. An example of the increasing power of the corporate rationalizers vis-à-vis professional monopolists may be seen in the fact that it was health authorities and their partners who were given the power and responsibility to lead on HImP development, including professional monopolists as they saw fit. This is in contrast to Alford's findings of the US health care system where he argues that:

> The vision of planning and integration presented by new attempts at corporate rationalization through administrative regulation is contradicted by the likely consequences of domination by hospital interests of politically feasible attempts to introduce "planning".
>
> (Alford, 1975: 204).

Furthermore, whilst at the time of conducting this case study PCGs were still dominated by professional monopolists, the Executive Committees of the new PCTs comprise a diverse range of organisations and sectors and are no longer dominated by health professionals.

Moreover, within my case study the framework for devolving HImP resources was eventually approved, suggesting that the power balance between the corporate rationalizers and professional monopolists in Coventry is perhaps less unequal than the terms 'challenging' and 'dominant' suggest, and not necessarily equivalent to the power relations found by Alford in his study of competing interests in the American health care system.

This framework for devolving resources should have allowed community interests to be brought into the HImP planning and delivery process in a more systematic and sustainable manner. However, evidence from the Health Action Groups demonstrated that the strict requirements about what would be funded and the very short deadlines by which applications for a share of this devolved money should be made, meant that community interests were not represented in the way that had been hoped.

Rather, the rigidity of the framework and associated bureaucracy appeared to legitimise the activities of the corporate rationalizers, thus leading to the type of extension of the interests and power of the corporate rationalizers suggested by Alford. Despite appearing to devolve responsibilities and thus provide opportunities for those whose interests were normally repressed within the health system to influence decision-making, power to determine how this money should be allocated remained with the administrators and public health officials charged with developing the HImP.

Furthermore, whilst in theory the shift in policy HImPs represented provided the opportunity to bring previously repressed community interests into the health planning arena, in practice the models of participation adopted by HImPs have not been such that lay communities have had much influence in the planning process.

As this thesis has documented, neither the local case study undertaken, nor the broader literature, including a national review of HImPs, revealed significant activity with regards to community participation. Within the local case study, the most innovative model of participation, and that which appeared to offer the greatest opportunity for participation by those who experienced the worst health, was working with neighbourhood-based Health Action Groups and devolving HImP monies to this level. However, as we have seen, the final model adopted was one which served to reconsolidate the power of the corporate rationalizers. Applying a structural interests theory analysis it could be argued that this represented an attempt by the corporate rationalizers to co-opt community members into activities controlled and organised by them. Participatory activities, as such, would be within a circumscribed agenda set by the corporate rationalizers. However, I do not believe that the co-option of community members was explicitly the intention of the HImP Steering Group. Rather, I think it reflects the way of working within statutory organisations. Alford's observations of how this institutional framework serves to maintain the power of dominant and challenging interests, limiting any power available to the repressed community interests is very perceptive. However, it is unlikely that the senior officers and street-level bureaucrats pursuing this strategy conceptualised it in these terms.

Nevertheless, whether a conscious decision or not, devolving resources to the Health Action Groups did allow the two major statutory bodies – the health and local authorities – via representatives on the HImP Steering Group, to exert power over these local community-based organisations, help set their agenda and assume greater management responsibilities over the groups. Alford (1975) would see this as typical of the activities of corporate rationalizers who pursue the development of more organisations (and thus more layers of bureaucracy), "none of which has sufficient power to do its job" and which, he would argue, only serves to "complicate and elaborate [...] bureaucratic structures" (Alford, 1975: 207-208).

### Community participation in the 'new NHS'

Having set out the conclusions from participation efforts in Coventry's HImP and assessed them in terms of typicality of participation mechanisms employed within HImPs nationally; I will now broaden the discussion in order to outline the general lessons from this research for community participation in the NHS.

Chapter Four illustrated the wide range of health and social policies which now require community participation, thereby demonstrating an ideological commitment to public involvement at the national level. However, as this research has shown, ideology and rhetoric do not always equal practice. Whilst advances are being made towards increased participation in health, progress is slow. This study has demonstrated some of the reasons why participation does not happen quickly and easily and the particular issues around power that must be addressed in order to achieve effective participation. Within partnership initiatives like HImPs, the public is just one stakeholder vying to be heard. Identified as repressed interests by Alford (1975), the public typically have considerably less power than other partners and this research has concluded that the organisational cultures of health planning partnerships such as HImPs perpetuates these unequal power relations, rather than challenges them. Furthermore, it must be recognised that 'the public' is highly differentiated, particularly in terms of the amount of power held by different members of the public as a result of their socio-economic status, 'race', gender et cetera and, as noted in Chapter Two, this has enormous implications upon the ability of citizens to take advantage of participatory opportunities. Within Coventry this diversity was recognised and the development of a specific strategy to ensure that residents from the six most socio-economically deprived areas of the city had a direct route through which it was possible to influence the HImP, in addition to the standard range of NHS consultation activities and small group activities in which the middle classes and the articulate are more likely to participate (Taylor, 1999) may be regarded as a direct attempt to bring in the 'repressed interests' referred to by Alford (1975).

Taylor (1999) has also noted many of the dilemmas and tensions around the practice of community participation I found within Coventry's HImP in her observations of participation in regeneration initiatives. She suggests that there is a long way to go before legitimate and inclusive strategies which "reach well beyond the most articulate and committee-literate" becomes standard practice within community participation (Taylor, 1999: 12):

> Balancing participation with effective representation and entrepreneurial leadership will require dynamic, responsive and accountable community structures, which have the confidence of all parts of the community and can also deliver. There is still a lot to learn about how such structures can be built.
> (Taylor, 1999: 12/13).

The stress placed on participation of the public in a number of national policy documents has led to widespread support for participation. However, it must be recognised that despite the national and local support for public participation in health service planning and delivery evidence from this case study supports that found in the literature which suggests that wider policy and organisational issues continue to serve as obstacles to the realisation of national and local policy objectives.

It is important to acknowledge that whilst community participation can lead to increased cooperation and enhanced partnership working between communities and statutory, voluntary and private organisations, it often also entails a degree of tension and conflict. It is argued that these tensions and conflicts must be accepted as a valuable part of the process and worked through, rather than ignored or abandoned (Taylor, 1999; Atkinson and Cope, 1997).

### Implications of the key findings from the case study

Building on the key messages highlighted in Chapter Six as findings for each of the nine research questions informing the case study, I would identify a number of issues as significant in affecting a locality's approach to public participation, the implications of which will now be considered:

It is important to **build upon pre-existing facilitative structures** and community organisations within the locality, such as Coventry City Council's Area Co-ordination Team. Where a history of community participation around a topic exists, participation is often easier as interested citizens are already identified and mechanisms for their participation established. Even where participative structures already exist, *community participation 'champions'* are often needed to drive through changes and ensure participation is considered at all stages in the process.

The **importance of political exhortation around public involvement** was cited by many within the case study as well as by other commentators for its influence is placing community participation on the agenda locally. Balloch & Taylor (2001: 287) note the "importance of a central government lead in strengthening the hand of those who advocate change and persuading more reluctant colleagues to the partnership table".

**Organisational culture** was found to have a huge impact on participation efforts. Within Coventry the local culture of the key statutory agencies inhibited risk taking which supported a formal meeting-based approach to public involvement and the development of rigorous monitoring and accountability mechanisms related to the devolution of resources to Health Action Groups. Ellison and Pierson (2003) argue that this risk-averse culture results from the governing mechanisms put in place nationally. They suggest that:

> Progress in this regard is likely to have a good deal to do with reducing central control, particularly in the shape of the debilitating targeting regimes, and risking giving partnerships a freer democratic rein.
>
> (Ellison and Pierson, 2003: 13).

Furthermore, the structures within which community members were expected to participate reflected the dominant culture of the health authority; were often formal, and were conducted in a style and language alien to most lay people. This discouraged many individuals who would attend one meeting and then not come back. Paradoxically, those who persevered and familiarised themselves with the process became labelled as 'usual suspects' and concerns about their ability to represent the general public expressed.

Perhaps related to and reflecting organisational culture was the **attitudes** of some professionals towards the value that communities could add to the planning process, which acted to inhibit efforts to involve community members. In particular it has been demonstrated that lay knowledge is not valued as highly as professional knowledge, which is often couched in technological terms in order to preserve its 'elite' status. Within the case study these attitudes were demonstrated through the recognition that it was often legitimation for the decisions made by professionals which was required, rather than participation in priority setting. Furthermore, the perception of 'the community' as individuals with no interests to represent by many within the case study did not help to challenge negative beliefs about the role that community members could play in planning and delivering the HImP.

Another important factor affecting participation was **capacity.** This refers both to the skills and knowledge held by those charged with developing participation mechanisms and to the ability and skills of the public to participate in these structures effectively. A need for training for statutory sector employees in the necessary skills to work with communities is essential to improve both capacity and confidence. This need has also been recognised by the World Health Organization who suggested that community participation skills could become part of the curriculum for health professionals when training (WHO, 1993). In addition, training for community members has been suggested as important. I have made the point that the training of professionals and community members together may help to break down the barriers between them and weaken any stereotypes employed. There is also a need for those charged with developing participation to increase their knowledge base around different participative approaches and their underlying rationales. Despite the rhetorical stress placed on the importance of participation in the HImP within national policy documents and consequently within local HImP documentation, this research found a considerable degree of ignorance as to what participation meant in practice and how to go about enabling and facilitating this participation.

It must be recognised that **community participation can be difficult to do**. It can be hard to get access to communities if there has not been any prior links established and deciding on the most appropriate strategies to employ with different groups of people can be confusing for those new to participation. "One size does not fit all" and a multiplicity of approaches is generally required, which recognise the different needs of those who are being encouraged to participate. Moreover, establishing relationships and building trust are just two other elements of community participation which are far from easy. It is essential that those with the responsibility for developing participation understand that participation is widely experienced as difficult and that this is also recognised by government and other bodies demanding participation, and reflected in reasonable timeframes for community partnerships to be established. Within the case study the difficulties of involving members of the public were felt to be exacerbated by the fact that no one was assigned responsibility for participation. Other HImPs had tackled this by making one agency responsible for all participation whilst others used a multi-agency steering group to take forward participation issues.

Indeed, the fact that **community participation takes time** is worth emphasising. Establishing strategies for involvement, identifying the range of groups and individuals it may be possible to work with and establishing relationships based on trust all require significant amounts of time. These processes are also hindered by continually changing partnerships. There appeared to be more stability of post for local authority staff than that experienced by health service employees. Given the disruption caused to partnerships by the seemingly continual reorganisation of the health service it may be advantageous to **make local authorities the lead organisation** of such partnerships in the future. As disruption of partnerships can lead to a lack of continuity around community participation this arrangement may help in the development of long-term, sustainable participation and provide more opportunities for the capacity-building identified earlier as an important element to be included within participatory activities. Furthermore, such an approach would help to address the 'democratic deficit' within the NHS by placing initiatives which include health under the control of the democratically elected local government (Klein, 1984; Hunter and Harrison, 1997). Whilst this would not replace the need for direct community participation within decision-making and prioritisation, it would be one means by which accountability issues could be addressed.

**Nationally defined priorities and performance management** also impact significantly upon community participation in health service planning and delivery. Findings from my case study echo much of the literature around participation in health, which demonstrates that issues with associated targets and penalties for non-compliance will *always* take preference. Consequently this research points to the importance of developing a national performance management framework around community participation in order to ensure that it achieves equal status as an issue to be addressed. The introduction of **mandatory performance frameworks** for community participation would at least ensure that participation issues were given attention in the same way that other nationally monitored issues are. Furthermore the national adoption of benchmarking tools for evaluating community partnerships may help organisations to identify their strengths and weaknesses in this area.

Efforts to involve the public in Coventry through the devolution of HImP resources to Health Action Groups were significantly hampered by the perceived need for formal **mechanisms of accountability**. A number of authors, including members of Policy Action Team 17 reporting to the Department of the Environment, Transport and the Regions, have suggested that the establishment of trust and use of informal relationships should replace contracts between partners. However, this was not being realised within Coventry and those in charge of budgets felt very insecure about devolving money without a number of formal mechanisms for monitoring and accountability in place. Accountability for the HImP was felt to be upward to the national and regional structures of the Department of Health, rather than to the local communities the HImP was intended to serve. This suggests that a change in the national as well as local culture is required.

The **importance of the voluntary sector** both as representatives of lay interests and as vehicles for the participation of user and interest groups was enormous. Community Health Councils in particular were regular partners in HImP partnerships, attending with a remit of representing the community interest. Yet December 2003 saw the abolition of CHCs. The new structures introduced by government are based within NHS organisations, which considerably changes the dynamics of the relationship with communities.

The **impact of street-level bureaucrats** can be substantial in initiatives such as the HImP where local discretion as to how policies are implemented is found. It has been argued (Lee, 2001; Ham, 1999) that the discretion I witnessed in the implementation of the community participation element of HImP policy is a feature of the New Labour government, who provide policy frameworks rather than instructive guidelines. As noted in Chapter Two, Lipsky's (1980) theory of street-level bureaucracy demonstrates that policies are often remade at the point of delivery.

**Power and control** have also been identified as key factors affecting community participation. Participation is all about power. The transparency with which decisions are taken and the types of decisions in which participation are sought are crucial factors. As Taylor (1999: 12) notes, a fundamental lesson which we can learn from the past is that local communities need to be given "the resources to develop their own ideas and initiatives before programmes are agreed rather than expecting them to come on board afterwards". Within Coventry the centralised system of power and reluctance to delegate power as well as resources prevented the community from having any real control over the definition of issues and programmes of work to address local needs. Power was also unequally distributed across the HImP partnership. Whilst a number of different organisations were represented on the HSG at the strategic level of planning, power to set the overall agenda was predominantly held by the health authority. It is telling that no community members were represented at this strategic level of planning. At the operational level power was more dispersed across all of the organisations represented on the HDGs, but still skewed in favour of the health authority and local authority.

The issue of **representation** served to inhibit the development of wider participation in Coventry where some individuals felt that the only legitimate participatory mechanisms were those which ensured a representative sample of Coventry citizens, such as the Citizen's Panel. This was to the detriment of other forms of participation, which could not guarantee a representative sample.

**Participation needs to be embedded into the culture of mainstream organisations.** The benefit of developing long-term and sustainable community involvement strategies, such as Coventry's attempt to work through Health Action Groups, must be recognised and encouraged. Indeed, the many benefits of community participation, including increased accountability and more appropriate services to name just two, should surely mean that participation within health service planning and delivery remains an imperative.

For meaningful community participation it is necessary to **be open, honest and clear** about the purpose of participation and the amount of influence participants will have on the decisions taken.

It is important to acknowledge the **difficult role of being a community representative.** Community representatives are often criticised from above and below, accused of being unrepresentative, and struggle with unfamiliar procedures and terminology. It takes a considerable amount of determination and commitment to continue to act as a lay representative. Furthermore, Alford (1975: 16) notes that "enormous political and organizational energies must be summoned by repressed structural interests to offset the intrinsic disadvantages of their situation."

It must also be recognised that **the community might not WANT to get involved.** The fundamental belief underpinning HImPs, as well as many other New Labour policies, is that the community will want to be involved in decision making. However, evidence from a number of different studies suggests that there are limited numbers of people willing to participate in such initiatives. Pickard and Smith (2001: 177) argue that: "We may also have to consider the reluctance of the public to be involved where they do not have an obvious personal interest [...] this will continue to present a real challenge to attempt[s] to involve the public." For Hart *et al.* (1997) this reluctance might be best explained by the often-limited amount of power the public have in such initiatives.

Finally, it must be stressed that **community participation is not a panacea for all problems.** Taylor (1999: 3) suggests that "'community' [is presented as] the answer at the less privileged end of the scale". She notes that: "All the evidence suggests that 'community' can be a somewhat 'ironic' prescription for those groups in society who are becoming increasingly excluded from mainstream society". Community participation should not be presented as the only solution to problems such as inequality, which also require intervention at the macro level through, for example, policies aimed at the redistribution of wealth.

There are several policy implications in the identification of the above issues as having a major impact upon local efforts to involve the public in health planning. Firstly, major structural and cultural changes are necessary if real and effective partnerships with communities are to be accomplished. Whilst the new patient and public involvement structures put in place by government over the last 12 months go some way towards embedding participation in the mainstream processes of the health service, a cultural shift will be harder to achieve and will take longer be realised.

The Labour government is undoubtedly committed to public and patient participation in the health service. The wide range of policies which now require participation along with the establishment of a number of new structures to support this participation during the past year, as described in Chapter Four, are evidence of this commitment. However, recognition of the amount of time and resources it takes to effectively involve communities in health planning is either lacking or being deliberately ignored. Whilst initiatives such as *New Deal for Communities* provide funding specifically for community capacity building, especially within the first year, no such funding was available for those seeking to develop participation in the HImP.

My values and commitment to public participation, as described in Chapter One, mean that within my discussion of the implications for community participation in the NHS I have sought to highlight the factors which must be addressed if participation opportunities and experiences are to be enhanced, based upon my findings from conducting this research. Holland and Ramazanoglu state that:

> Coming to conclusions is not just a process of following rules of method to the end point of a research project, but a very active and complex process of social construction that raises questions about what we mean when we claim that [...] knowledge should be believed.
>
> (Holland and Ramazanoglu, 1994: 125).

They go on to argue that: "The differing conclusions to which researchers come are based on the interaction of their various standpoints with their interpretations of their data" (Holland & Ramazanoglu, 1994: 133). Throughout this thesis I have sought to provide as much information as possible about the context within which the research was undertaken, the methods used to collect the data and the grounds on which my interpretations of processes and events were made. de Vaus (2001: 2) notes that "competent description can challenge accepted assumptions about the way things are and can produce action". I hope that by highlighting the many tensions between policy and practice and the continuing 'democratic deficit' (Coote and Lenaghan, 1997) with regard to decision-making in health care planning, that these issues are given renewed attention and future participatory efforts avoid many of the obstacles and constraining factors identified within this research.

# APPENDIX A

## Topic guide for meeting with Director of Health Development, Coventry Health Authority, 26th January 2000

### Health Improvement Programmes and Community Participation

My PhD is looking at Health Improvement Programmes and community participation within them. I am especially interested in how Health Improvement Programmes seek to tackle inequalities through initiatives such as the Coventry Community Research Project.

I am interested in using Coventry as a case study.

- ☐ Each Health Improvement Programme has a 3-year time frame, rolled forward annually, with part of the framework reviewed in depth each year.
    - What is being reviewed in advance of the second Health Improvement Programme in April 2000?
    - Will you be seeking/have you sought views from partner organisations and the local community to contribute to this year's rolling forward process? (i.e. those parts of the programme to be reviewed in advance of April 2000)

- ☐ Health Improvement Programmes must include milestones for year-by-year improvements so that local communities see the Health Improvement Programme process making a difference from the outset.
    - What milestones were set in 1999's Health Improvement Programme?
    - How do you intend to let the local community know the progress that has been made against the original milestones?

- ☐ Who has been involved in the development of the last/the forthcoming Health Improvement Programme:

  - Service users? (the general public, patients, the CHC etc)
  - Service providers? (Trust staff, primary care, public health etc)
  - Other interested parties? (Uni.'s, TEC's, TU's, employers, schools)

- In what ways did Primary Care Groups influence the last/are Primary Care Groups influencing the forthcoming Health Improvement Programme?

- Which partners, if any, have recorded their commitment by signing up to deliver their own contribution to the Health Improvement Programme?

- The Health Improvement Programme will set out objectives and commitments but is then followed through into local operational and delivery plans. The **Improving Health and Tackling Inequalities** action plan is of particular interest to me. Do you have this plan for the next Health Improvement Programme's targets yet? (i.e. the Health Improvement Programme to begin April 2000).

- The Health Authority is accountable to the NHSE West Midlands for reaching the milestones and targets set in the Health Improvement Programme.
  - How is this monitored? Annually? Report? Audit?
  - Who holds Primary Care Groups accountable to deliver?
  - And Local Authorities?

- Government literature on Health Improvement Programmes states that hospital Clinicians should be enabled to contribute their expertise on how best to meet local needs.
  - Have Clinicians in Coventry been invited to contribute?
  - Have they shown any interest in contributing to the development of the Health Improvement Programme?

- ☐ Central Government argues that Health Improvement Programmes replace the fragmentation of the NHS internal market with a coherent planning process.
    - Do you agree? Why?
    - How does it work now?

- ☐ Do local perspectives shape the entire HImP or just certain elements of it? I.e. is there any local consultation as to how to set about trying to achieve the nationally set targets in Coventry?

- ☐ Where can I get hold of information/literature about Health Improvement Programmes? Where do you get yours from?
  I check DoH Health Service Circulars and White papers etc. Are there any practice based/public health based publications/journals that contain information? I am going to start checking the Health Service Journal regularly.

- ☐ Can I get hold of a copy of Coventry's current Health Improvement Programme?

- ☐ Is there any information I can have about the new Health Improvement Programme? I want to make Coventry a case study and understand about the processes that you go through to arrive at your Health Improvement Programme. Therefore, I was wondering if there was any way I could be put on your circulation list for all Coventry Health Authority information/documents about Health Improvement Programmes and partnership working etc?

# APPENDIX B

## Interview schedule for HImP Steering Group Members who are HImP Development Group leads

**Questions about the overall Coventry HImP**

- Could you begin by telling me where you see the objectives in Coventry's HImP as being determined?
  (Follow-up may include: To what extent driven by central govt? And local objectives for Coventry's HImP determined where and by whom? - Chief Exec's, HImP Steering Group, HImP Development Groups?)

**Questions about the HImP Development Group the interviewee leads**

- Could you tell me how long the [.......] HImP Development Group has been in existence?

- And what is the remit of the group?

- Have you begun to set objectives and draw up action plans for how you intend to achieve these objectives yet?

*Representation on the group*

- What agencies are represented on this group?

- And does the group have any representation from the general community, from user groups or from the voluntary sector?

*Involving the community in the HDG*

- Has your group sought to involve community members at all in deciding objectives and devising action plans?
- If yes, how did you go about involving the community?
- Why did you decide to involve them in this way?
- What do you expect such involvement to deliver/provide?
- If no, have you involved community members in any aspect of the [......] HImP Development Group?
- If no, do you have any plans to involve the community in the area of the HImP covered by your group?
- How do you anticipate going about this?
- Why will you adopt this approach?
- What do you think the outcome of adopting this approach will be?
- Do you feel that you are able to make an informed decision as to how to involve communities? Is it something you are familiar with?
- What do you think could help you involve communities?
- What factors make community involvement more difficult for you?
- What barriers do you face when trying to involve community members?

*History of local working arrangements for this issue*

- Do you know if there is any history of community involvement around [topic of HImP Development Group] in Coventry?

- Do you know if this an area where there has traditionally been interagency partnership working in Coventry?

*Government Policy & Community Participation*

- What are your views on the current push to involve communities and user/voluntary groups within current policy documents?

- What advantages do you think can arise as a result of involving communities?

- What are the disadvantages of involving communities in the development of the HImP?

*Coventry HImP and community involvement*

- What, if any, do you think the role of the HImP Steering Group should be with regard to community involvement?

- Do you think it is possible to talk of communities as 'partners' in the HImP development at this point in time?

- Why?

- Do you envisage a time when communities are regarded as equal partners in the HImPs development?

- Why?

- Do you think the multi-agency make-up of the HImP Development Group inhibits or facilitates community involvement in the HImP?

- Do you think the multi-agency make-up of the HImP Steering Group inhibits or facilitates community involvement in the HImP?
  i.e. In what way does the partnership format of HImPs facilitate or constrain efforts to enhance community participation?

- Does the setting of national priorities to be addressed within local HImPs constrain opportunities for enhanced involvement of community members at all? How?

*HImP Monitoring and Community Participation*

- Do you know if anyone monitors community participation in HImPs - anyone like the NHSE? Are there 'targets' set, or guidelines about what constitutes 'effective' community participation?

- Anything else you would like to say about community participation in the HImP?

Thank interviewee for their time etc.

# APPENDIX C

## Interview schedule for HImP Steering Group Members who are NOT HImP Development Group leads

1) Could you begin by telling me where you see the objectives in Coventry's HImP as being determined?
(To what extent driven by central govt? And local objectives for Coventry 's HImP determined where and by whom? - Chief Exec's, HImP Steering Group, HImP Development Groups?)

2) What is your role within the HImP Steering Group?

3) Do you sit on any of the HImP Development Groups as well?
**If no**, ask if anyone from their organisation sits on any of the HImP development groups.

**If yes** ask all of following questions:

- What agencies are represented on this group?

- And does the group have any representation from the general community, from user groups or from the voluntary sector?

- Has the group sought to involve community members, user groups or voluntary organisations in deciding objectives and devising action plans for this area?

- **If yes,**
How did you go about involving the community/users/voluntary sector?

Why did you decide to involve them in this way?

What do you expect such involvement to deliver/provide?

- **If no,**
  Have you involved community members in any aspect of the [......] HImP Development Group?

  Do you have any plans to involve the community in the area of the HImP covered by your group?

  How do you anticipate going about this?

  Why will you adopt this approach?

  What do you think the outcome of adopting this approach will be?

- Do you know if there is any history of community involvement around [topic of HImP Development Group] in Coventry?

- Do you know if this an area where there has traditionally been interagency partnership working in Coventry?

4) Do you feel that you are able to make an informed decision as to how to involve communities? Is it something you are familiar with?

5) What do you think could help you involve communities?

6) What factors make community involvement more difficult for you?

7) What barriers do you face when trying to involve community members?

8) What are your views on the current push to involve communities and user/voluntary groups within current policy documents?

9) What advantages do you think can arise as a result of involving communities?

10) What are the disadvantages of involving communities in the development of the HImP?

11) What, if any, do you think the role of the HImP Steering Group should be with regard to community involvement?

12) Do you think it is possible to talk of communities as 'partners' in the HImP development at this point in time? Why?

**If no,** Do you envisage a time when communities are regarded as equal partners in the HImPs development? Why?

13) Do you think the multi-agency make-up of the HImP Steering Group inhibits or facilitates community involvement in the HImP?
i.e. In what way does the partnership format of HImPs facilitate or constrain efforts to enhance community participation?

14) Do you think the HImP Steering Group is comprised of the "right people" to move the HImP forward in the most effective way?

15) Are there any organisation or groups who you feel are not on the group and should be? (or are there groups represented who you feel should NOT be on the Steering Group?)

16) In your experience, has the HImP altered the planning process and those involved in it in any way? If so, how? If not, why not?

17) Has your involvement with the HImP turned out to be what you expected? Describe...

18) How successful do you think the HImP has been in telling members of the public what the HImP is about?

19) To what extent do you think ownership of the HImP is felt by all members of the Steering Group?

# APPENDIX D

## Example of a covering letter despatched with the questionnaires distributed to HImP Development Group members.

**Community involvement in Health Improvement Programmes**

Older People HImP Development Group Member Questionnaire

**Dear Older People HImP Group member,**
I am writing to ask for your help in completing this short questionnaire. This questionnaire forms part of a PhD study being undertaken at the University of Warwick on community participation in Health Improvement Programmes.

**Purpose of the questionnaire**
As you will be aware, the Government is increasingly seeing community involvement as fundamental to the planning and delivery of public policy. As with many other current initiatives, involvement of the community is one of the underlying principles of HImPs. My research includes a case study of Coventry's HImP and, along with data collected through observation and interviews at HImP Steering Group level, the research aims to elicit ***HImP Development Group member's views*** on the strategies being employed to communicate with and involve Coventry people in the HImP. Your views are therefore being sought via the enclosed questionnaire, to be completed and returned in the pre-paid envelope **by Friday 2nd March 2001.** I appreciate that you are very busy but would be very grateful for your help. I am committed to sharing my findings and will feed back the results of this research to those involved in the HImP in the hope that it may be useful for highlighting the current strengths and weaknesses of Coventry's approach to involving the pubic in the HImP.

**Assurance of confidentiality**
The views expressed in the questionnaire will be strictly confidential and no individual will be identified in the results. Completion of the personal details section will enable analysis of trends in opinion from voluntary, statutory and community organisations, but if you would prefer it is not essential that this information be completed.

I hope you feel that you are able to help me with this study. If you have any queries about this questionnaire or the research of which it is a part please do not hesitate to contact me.
With thanks

Andrea Wild

*Contact details*
Andrea Wild, School of Health & Social Studies, University of Warwick, Coventry,
CV4 7AL Telephone: 024 7667 6765 Email: andrea@public-health.ucl.ac.uk

# APPENDIX E
# Older People HImP Development Group member Questionnaire

### Older People HImP Development Group member Questionnaire

## Community involvement in Health Improvement Programmes

A. Your Participation

These questions will help me develop a profile of those people who have participated in an active way in planning and implementing work in relation to the Older People area of the Health Improvement Programme (HImP).

(A1) Are you participating primarily as a representative of an organisation/agency, or primarily as an interested citizen? *please tick*

☐ Agency representative *(please state which)* ........................................

..................................................................................................

☐ Interested citizen *(comments)* ... ...............................................

..................................................................................................

..................................................................................................

B. Representativeness of the HImP Development Group

This next series of questions asks whether you think that the "right people" to move the HImP forward have been participating and whether the Older People Development Group has had representation from a broad spectrum of interests or groups within Coventry.

1 means “very poor”, 2 = “poor”, 3 = “ok”, 4 = “good”, 5 = “very good”

(B1) On a scale of 1 to 5, how well do you think your group has obtained representation of views from all sections of the community? *please circle*

1 2 3 4 5

Comments:..........................................................................

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(B2) Does the Older People HImP Development Group include those people who traditionally make the decisions in this area of work? *please tick*

Yes ☐

No ☐

Comments: ..................................................................

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(B3) Does the Older People HImP Development Group include people who are not usually involved in decision-making at the planning stage in this area of work?

Yes ☐

Who else is involved now?

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No ☐

Comments: ………………………………………………………………

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C. Reaching the broader community

Questions in this section ask about how well the Older People HImP Development Group has communicated it's work to the wider community and how successful you have been in getting the public to participate in related activities.

1 means "very unsuccessful", 5 means "very successful"

(C1) On a scale of 1 to 5, how successful has your group been in telling the people of Coventry what the Older People area of the HImP is about? *please circle*

1 2 3 4 5

Comments: ..............................................................................

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(C2) On a scale of 1 to 5, how successful has your group been in identifying community needs, strengths and resources? *please circle*

1 2 3 4 5

Comments: ..............................................................................

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(C3) Is there a history of community participation around issues relating to older people in Coventry? *please tick*

☐ Don't know

☐ No

☐ Yes *please describe*

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(C4) Can you describe any ways in which your group has attempted to incorporate the views of Coventry citizens into the work of the Older People HImP Development Group?

☐ No, I am not aware of any community involvement in this work.
***Please go to question C6***

☐ Yes *please describe*

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(C5) Did you find it difficult to incorporate the views of local people?

☐ No

Comments: .....................................................................................

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☐ Yes

How was it difficult? .......................................................................

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(C6) What do you think would help your group to involve community members more effectively?

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D. Personal Details & Experiences

(D1) Please provide your personal details. This will enable analysis of trends in opinion from voluntary, statutory and community organisations, but if you would prefer it is not essential that this information be completed.

Name: ..........................................................................

Position held: ..........................................................................

Organisation: ..........................................................................

Role in the HImP Development Group: ..............................................

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(D2) Please feel free to add any other comments you might have about the involvement of the public in the Health Improvement Programme.

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(D3) Would you be willing to answer a few questions over the telephone about your responses to the above questions if further clarification were required?

No ☐ **Thank you for your help in completing this questionnaire.**

Yes ☐ Please provide your telephone number:

........................................................................

**Thank you for your help in completing this questionnaire.**
**Please return in the pre-paid envelope provided.**

Andrea Wild, School of Health & Social Studies,
University of Warwick, Coventry, CV4 7AL
Telephone: 024 7667 6765

(Adapted from: David Thompson Health Region (1999) *Evaluation Questionnaire for Participants in the Healthy Communities Initiative, Appendix 3,* Action for Health Evaluation Report: Healthy Communities Initiative 1997-1999 ).

# APPENDIX F
## Interview schedule for Health Action Group members

Introduce research. Explain purpose and areas of interest. Thank for agreeing to be interviewed.

- My understanding is that Health Action Groups get to decide what health priorities they wish to spend their devolved money on and submit proposals for ways to address these priorities to the HIMP Steering Group. Is this correct? Has the HAG you are involved in submitted any proposals yet? If so, what were they for? Have they been accepted or rejected? If rejected, on what basis?

- Do you think Health Action Groups have the appropriate skills, training and knowledge to make these kind of spending decisions? Would group training be appropriate/welcomed?

- Are Health Action Groups better equipped than the HImP Development Groups were to actively involve the community in health planning? Why?

- Is devolving monies to Health Action Groups a good way of promoting community involvement in health planning in their locality? Why?

- Do you think there are better or more effective ways of involving the community in health planning?

- Is there anything else you would like to discuss about Health Action Groups and community involvement?

Thank for time, etc.

# APPENDIX G
# HImP Development Group proposed membership

## Model HImP Development Group Membership

**(Guidelines issued to HImP Steering Group, October 2000)**

- Health Authority Strategy and Policy Representative
- Health Authority Public Health
- Health Authority Health promotion Specialist
- Local Authority representative
- PCG representative
- Community Trust representative
- Walsgrave Hospitals Acute Trust representative
- Voluntary sector representative
- Community representative

# APPENDIX H

## Terms of reference for HImP Development Groups

**Terms of Reference for HImP Development Groups**

**(Guidelines issued to HImP Steering Group, October 2000)**

1. With reference to national priorities and targets and Coventry specific data agree priorities for action within specific programme area.

2. Agree city-wide targets.

3. With reference to evidence of effectiveness specify actions and interventions which could be employed.

4. Disseminate details of city-wide priorities and targets, together with guidance on effective interventions to wider stakeholders.

5. Incorporate input from wider stakeholder groups in drawing up a city-wide plan.

6. Ensure reduction in inequalities and the needs of ethnic minorities are integral to all action plans.

7. Convene sub groups to pursue city-wide action plans as required:
    - Define their membership and terms of reference
    - Ensure community participation as appropriate
    - Define timescales for work and reporting arrangements

8. Agree further priority developments and targets in order to ensure co-creation of the HImP.

9. Ensure that the following consequences of action plans are made explicit:
    - Work-force implications
    - Information requirements

10. Identify clinical governance / best value / performance assessment framework requirements and communicate appropriately.

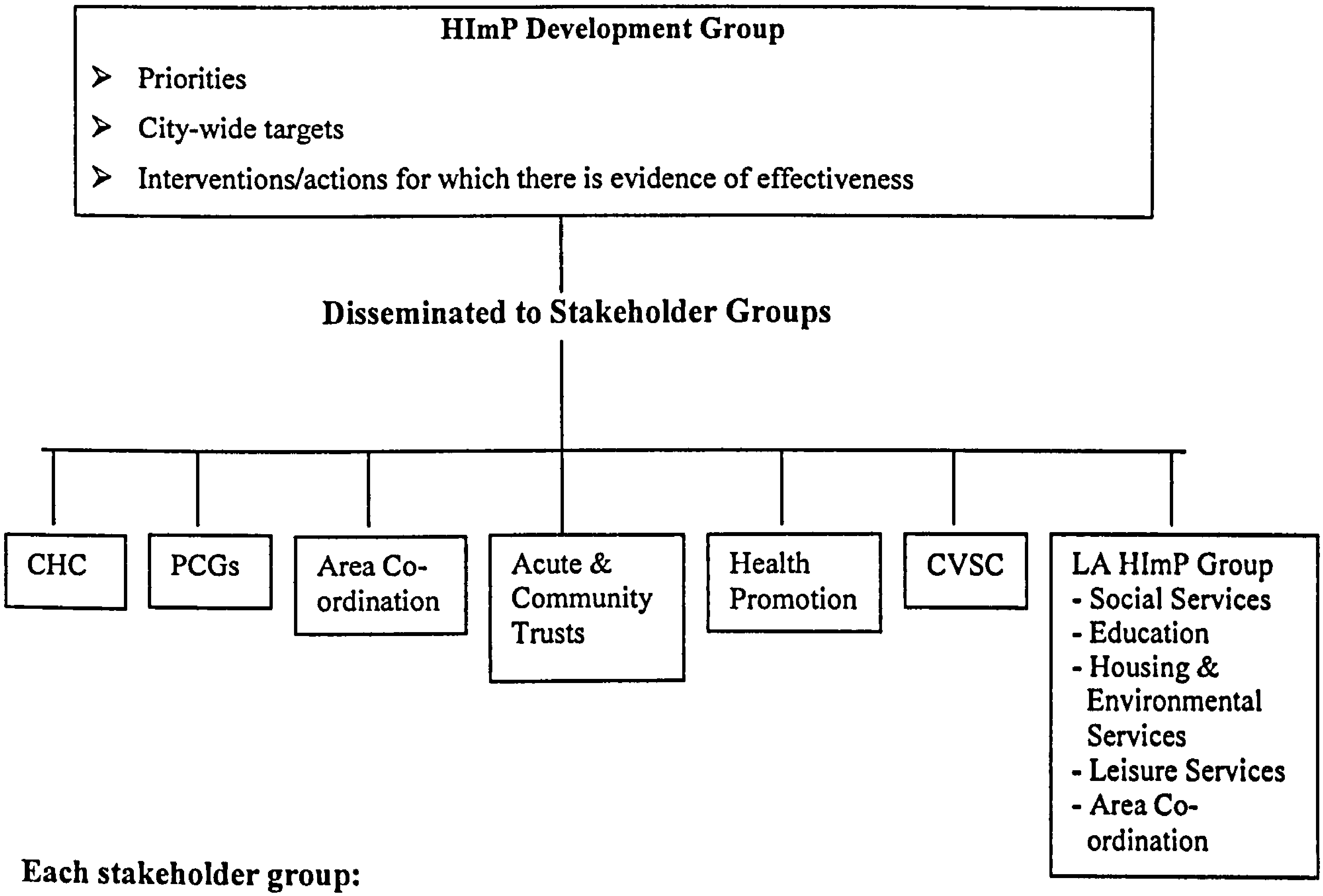
11. Ensure issues concerning patient pathways are addressed.

12. Ensure monitoring and evaluation arrangements are in place in relation to priorities and action plans.

13. Produce draft for HImP document to agreed format.

# APPENDIX I
## Process of Involvement flow-chart

### PROCESS OF INVOLVEMENT



**Each stakeholder group:**

- considers city wide priorities and targets in light of local population or service specific issues
- highlights relevant local priorities, not specified in HDG output
- identifies local priorities & targets in accordance with the city-wide specification
- identifies existing effective action/interventions
- specify additional action plans that could be developed
- respond to the HImP Delivery Group within agreed timescale

**HImP Development Group:**

- confirms priorities and targets
- constructs city-wide action plans
- ensures that, where necessary, sub-groups to deliver action plans are convened.

# APPENDIX J

## Terms of reference for Health Action Groups

### Key Terms of Reference of a HAG

**(Guidelines issued to HImP Steering Group, October 2000)**

- To provide a forum for working in partnership with the local community to identify local health needs and propose ways in which these local needs can be practically addressed.

- To bring together interested professionals, representatives from voluntary organisations and members of the community to discuss and take forward appropriate health development issues.

- To maintain and contribute to an overview of health needs across the area, ensuring that activities are focussed on reducing inequalities within the area.

- To raise awareness within local communities regarding local health issues, initiatives and service developments.

- To support and inform the PCG's health development agenda.

- To contribute to the development and delivery of the Health Improvement Programme (HImP), Area Plan and Primary Care Investment Plan (PCIP) by:

    a) Informing and supporting the delivery of citywide initiatives and strategies to ensure that local needs are best met.

b) Identifying actions and investment priorities to address locally identified needs within the HAG area.

- To prepare and oversee the implementation of approved area plans, recommending remedial action and assisting in the delivery of key actions as appropriate.

- To monitor progress against priorities and targets established, providing a quarterly report to the PCG Board and Area Co-ordination Team.

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