

STRATEGIC APPROACHES TO CONSULTING LOCAL COMMUNITIES

MODELS OF CHANGE and the DEMOCRATIC PARTICIPATIVE APPROACH TO USER AND COMMUNITY INVOLVEMENT

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Introduction

Recent legislation and policy developments require statutory agencies to consult their local communities on a regular and on-going basis. But with NHS Trusts, Local Authorities, Regeneration Projects, Sure Start and a whole host of other agencies all consulting the same local communities, the need to get the process right has perhaps never been greater. With communities complaining of “consultation fatigue”, “lack of feedback” and “tokenistic involvement”, this report argues that it is vital to design and plan any consultation initiatives adequately and properly. As one statutory sector lead on consultation processes remarked to us recently: ‘Doing it half- heartedly is almost worse than not doing it at all, as all that will result is disenchantment amongst the community groups an organisation is trying to work with’.

While there are many different initiatives and processes for consultation being used – questionnaires, focus groups, meetings, talks, interviews, etc. – many that include good practice methods and processes, this report argues that the best benefits to the statutory body, as well as the local community, will be gained from using a **democratic participative approach**. In this approach, local people are trained, resourced and supported to undertake consultations themselves, and are part of a strategic organisational initiative which includes them as equal partners.

This approach to user and community involvement is informed by some of the new thinking around change. The essential notion has been to move away from the ‘tickbox’ approach to consultation which has often consisted of holding an event, inviting in users, carers and community members to comment on statutory services plans, writing up the results, and then possibly making some changes to the plans.

Managers are often working within a system with competing demands, many priorities and usually with stressful timescales. To survive the system, the need to ‘get the box ticked’ simply to lend some formal legitimacy to achieving performance targets is a natural response. Most managers want to do things differently, but do not have the time to think or act in order to bring about anything more than superficial change. On the other hand, most users, carers and community groups complain that there is no feedback after the consultation event, and that nothing much appears to change from their perspective. In addition, they are constantly asked for their views on a range of policies, which is to be applauded but has a spiralling negative impact when the same lack of feedback occurs continually. This leads to cynicism, anger and disempowerment.

Experience has shown that statutory workers ‘going in and out of communities to satisfy work plans’ of their agencies does not work. A longer-term approach and diverse strategies are needed if statutory agencies are serious about reshaping services to meet the needs of different community organisations. *The starting point has to be made by agents committed to change from within and outside the system, who want to kick start a different approach to community and user involvement.* To really establish sufficient leadership to enable user and community participation to happen, this group needs to be drawn from different parts of the Health Service, Local Authorities and community systems, and at different levels of the system. A small cohort of dedicated people can bring influence to bear on developing effective user and community participation.

The challenge is then to **make change stick**. It is noted from the experience of the *BME Health Forum* that recommendations from consultation sessions, via individual events or umbrella groups, are usually not implemented. This seems to have been the result of the competing targets and demands on senior staff. Several mechanisms that are identified in other aspects of this model are important to have in place to address this problem. The need for champions within the system, the role and remit of an external umbrella group to hold the statutory sector to account, and the value of legislative and policy-drivers are all important factors. There is a need to constantly reassess the sources of leverage for change, and to renew sources of power, find new ones, all of which is part of a constant process of change. It is vital that in the system there are champions of change who can make strong links across organisational boundaries, drawing on statutory, community and academic staff to contribute to the process. *At the core, there needs to exist a passion for the values of inclusion, participation and democracy that will influence greater equity and access to services by all.* ■ Kate French and Aisling Byrne

Community-based Participatory Research in Health

Frederick Marais, MRC Research Fellow, Imperial College

There is increased demand for research with a remit to improve the health of marginalised (minority, migrant, 'indigenous peoples' and others) heterogeneous populations. However, in such communities conventional research methodologies have a contentious history which, some argue, are resentful and damaging.¹ Conventional research models do not readily invest in participatory partnerships at community-level. This reinforces the gap between the concepts and paradigms that professionals use to understand and interpret reality, and the perspectives and 'real world' knowledge of different groups in the community.²⁻³ Consequently, this position offers limited opportunities to create knowledge and develop public health interventions that are relevant to community situations and interests.

Participatory research and associated methodological approaches are considered increasingly important in improving the health of disadvantaged communities.⁴⁻⁵ One such approach is Community-based Participatory Research (CBPR). In the context of public health CBPR is "a partnership approach to research that equitably involves, for example, community members, organisational representatives and researchers in all aspects of the research process; with all partners contributing their expertise and sharing responsibility and ownership to enhance understanding of a given phenomenon, and to integrate the knowledge gained with action to improve the health and well-being of community members".⁶ This process includes the investment of community members in the dissemination and use of research findings, and ultimately in the development of sustainable community health. The community-based research strategy democratises the research process⁷ and satisfies the demands by various communities to have a voice in research undertaken in their communities and to participate as equal partners.^{1,8}

CBPR is a tried and tested multi-method approach to public health situation assessment and intervention design.^{3,9-10} Methodologically, it is distinguished from more conventional modes of public health assessment not only by (1) its use of multiple methods in conjunction with multiple information sources, but also by (2) its focus on situations and contexts as well as individuals (particularly the interplay of factors influencing community and individual choice, and health responses), (3) its attention to building relationships between communities and the formal sectors, (4) its establishment of a Community Advisory Board to guide the planning and to participate in all phases of the research process; ensuring that the methodology is culturally sensitive and appropriate (from the planning stage to fieldwork, data analysis, response planning and dissemination and use of findings), and (5) its recruitment, training and employment of 'indigenous' Community Advisers; operating as the link between the research project and the cultural communities participating in the study, and ensuring social, cultural and linguistic compatibility between community participants and project interviewers.

Potential benefits of CBPR include:

1. A research strategy and a reciprocal educational process.
2. Extensive collaboration between the project team and the community at each stage of the research.
3. Partnerships with diverse knowledge and expertise to address complex public health problems.
4. A reciprocal educational process for community members and the research project team.
5. Shared power, control and ownership of the research agenda and dissemination and use of findings.
6. Emphasis on prioritising, developing and implementing appropriate action.
7. Increased research quality and validity.
8. Improved intervention design, appropriateness, acceptability and effectiveness.
9. Increased trust, and bridging of cultural gaps between heterogeneous communities and the formal sectors.

1. Community members are denied active participation in all phases of the process; i.e. from project planning to implementation, evaluation, and dissemination and use of findings.
2. The knowledge and expertise of communities are perceived and rejected by formal sectors as inferior.
3. Participation is not endorsed as a reciprocal educational process between communities and the formal sectors.
4. Participatory planning may result in the acquisition and manipulation of new 'planning knowledge' rather than the incorporation of 'people's knowledge' by projects.⁵
5. Participatory objectives are operationally constrained by institutional contexts that require formal and informal bureaucratic goals.⁵
6. Formal sectors are failing to address the imbalance in bargaining power within and between heterogeneous communities, thus providing further opportunities for the already powerful.
7. Participation is regarded by formal sectors as an (tick-box) 'event' instead of an emerging and sustainable process towards ultimate community development.
8. Inappropriate participatory planning processes might be reinforcing instead of redressing the imbalance in power between formal sectors and heterogeneous communities.

Some recommendations include:

The importance for formal sectors, in partnership with communities, to develop guidelines for critical evaluation of the participatory process and associated objectives and outcomes in order to:

1. Establish the origin of the participatory project and its purpose.
2. Serve as a mechanism to guide individual, collective and competing agendas.
3. Assess who participates and the nature of their involvement.
4. Establish trust and mutual respect between diverse partners.
5. Measure the process of negotiating participatory goals.
6. Evaluate the process and outcome of participation.
7. Establish community benefit and ownership of outcomes.
8. Evaluate (primary and secondary) stakeholder perspectives of the effectiveness of the project.
9. Establish cross-cultural ethical foundations for future projects, research and service developments.

A framework for such guidelines have been proposed by George *et al* (1996)¹¹ and Gibson *et al* (2001).¹⁰

EXAMPLE:

Over an extended period, several sustained methods (including leaflets and posters) were utilised by a health promotion unit in an attempt to improve TB prevention among one of the minority ethnic groups in New York City. The effectiveness and cost efficiency of these attempts were questioned by the commissioners and it was only after conducting a community health assessment that the authorities discovered the gap between provider and community communication strategies. They learned not only that, in line with specific community features, all health promotion materials needed to be endorsed by and channelled via the local church before acceptance by community members, but also that such materials could be translated, produced and distributed free of charge via well-established church and community structures!

References

1. Smith L.T. Decolonising methodologies: research and indigenous peoples (1999) Zed Books, London.
2. Grandstaff S.W. *et al* (1987), in: De Koning K and Martin M. Participatory Research in Health: issues and experiences Zed Books, London.
3. De Koning K and Martin M. Participatory Research in Health: issues and experiences Zed Books, London.
4. Rifkin *et al* Participatory approaches in health: promotion and health planning (2000) Health Development Agency, London
5. Cooke B. and Kothari U. Participation: the new tyranny? (2001) Zed Books, London.
6. Israel B.A. The value of Community-based Participatory Research (2001) Conference on Community-based Participatory Research, Maryland, USA.
7. Meyer J. Qualitative research in healthcare: using qualitative methods in health related action research British Medical Journal (2000), 320: 50-52.
8. Boston *et al* Using participatory action research to understand the meanings Aboriginal Canadians attribute to the rising incidence of diabetes Chronic Diseases in Canada (1997), 18(1): 5-12.
9. Israel *et al* Review of community-based research: assessing partnership approaches to improve public health American Review of Public Health (1998), 19: 173-202.
10. Gibson *et al* Community-based Research, in: Morse J.M *et al* The nature of qualitative evidence (2001), Sage, USA.
11. George *et al* Evolution and implications of PAR for public health Promotion & Education (1996), 3(4): 6-10

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BME Health Forum Task Groups

Aisling Byrne, Former Manager of BME Health Forum

The BME Health Forum is an independent multi-agency policy forum with over 300 members from local Black and Minority Ethnic groups in KCW, and representatives from local statutory agencies. The BME Health Forum focuses on strategic policy issues and exchanges of information and ideas with the aim of engaging BME community groups in policy developments and initiatives related to health care in KCW. The work of the Forum focuses on the health needs of BME communities in KCW, ensuring that their views are heard and acted on, and that communication, partnership and engagement between them and NHS Trusts and other statutory and voluntary groups is excellent.

The Forum aims to create an effective and sustainable mechanism for communication between Kensington & Chelsea and Westminster PCTs, other NHS and statutory bodies, and BME community groups and individuals, in order to empower communities to effectively engage in a debate between them and the local health services.

A key aspect of the work of the BME Health Forum is to set up TASK GROUPS to undertake focused work on particular issues identified by its members. These are time-limited (6-14 months) and accountable to a Steering Group for the particular Task Group. The aim of the Task Groups is to facilitate detailed feedback from BME communities on their health and health-related issues and concerns, and to feed these into the planning, commissioning and delivery of health services.

As part of the Task Groups, the BME Health Forum funded community organisations to run their own consultations. Groups who were interested in participating in the Task Groups needed to commit to organising a consultation event with their members, and coming to meetings (if they could).

The BME Health Forum also organised a series of training sessions with an experienced trainer, on how to run community consultations; and one workshop to develop the consultation questionnaire / discussion points. A note-taker was provided by the BME Health Forum, and the community groups provided the facilitator, interpreter, child-care facilities, refreshments, venue and publicity and outreach for participants. They signed a funding contract with the BME Health Forum which paid £200 per consultation.

The consultation events were done with at least 6-27 participants in each session, and the groups provided a written report whose findings are included in this report.

Regular meetings were held throughout the process and the Forum, in partnership with the KCW Community Health Development Team, provided community groups with extra capacity support, including the provision of a facilitator and a note-taker. Statutory agencies such as Hospital Trusts and G.P surgeries were also invited to run consultations with their users and as a result, St Mary's Hospital Trust ran a series of consultations with in-patients, as well as out-patients.

Although the Task Groups took between 8-14 months to achieve their objective, the **process** proved to be a successful mechanism for providing a co-ordinated approach to getting feedback from various communities and community organisations. The Task Group was a successful structure through which community organisations, statutory agencies – including Hospital Trusts, Primary Care Trusts, Social Services, local and national voluntary organisations were involved, on an equal basis and from the outset. This process involved carrying out the aims and objectives of the Task Group in developing the questionnaires and undertaking the community consultations.

Feedback from groups involved in the consultation events:

- ◆ An important outcome of the Task Groups was the **process** adopted for the community consultations and community involvement in policy development work.
- ◆ A **capacity development** process was adopted; this involved organising a **training session** on how to run community consultations, with resources and materials provided; **support** on preparation and planning for running community consultations; development of a **pro forma questionnaire**; and involvement of the groups and organisations involved in the **process and policy-development aspect** of the Task Group.
- ◆ Members of the Task Group felt that the support, training and resources that were provided helped them to run **well-planned and more strategic consultation events**, and enabled them to see how their feedback would feed into the policy-making and commissioning process for services.
- ◆ Given this, it was suggested that as good practice, **NHS Trusts should offer capacity development and resource support to community groups** when they are involved in consultation events. This should include payment to the group (for venue, refreshments, child-care, etc.), training on running sessions, production of a pro forma on the aims and objectives of the session, involvement in the process of how feedback will be taken up by commissioners and service-providers, and involvement in meetings related to the project throughout its duration.
- ◆ It was suggested that the requirement to involve communities in consultation initiatives – as per the Race Relations Amendment Act – should be **built in to service level agreements**

and contracts with service- providers (statutory and voluntary) to ensure that this process is mainstreamed and that consultation and feedback are received in a sustainable and effective manner.

- ◆ One underlying outcome of the consultations undertaken has been the need to develop a **multi-agency, genuine partnership approach** to service- planning, development and delivery. This should include Health and Social Care service- providers and commissioners – PCTs, Hospital Trusts, Mental Health Trusts, Social Services – and grassroots community organisations as well as umbrella organisations and local training providers.

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NHS Direct Consultations – Simon Barber, Communications Manager, NHS Direct

Several research projects have highlighted a real catch- 22 situation for BME communities. On one hand people experience problems with accessing health care services – problems associated with language and cultural barriers. On the other hand, there is a lack of awareness of the sort of services that can be accessed through the GP, the health visitor and walk -in centres, to mention just a few health care providers.

NHS Direct has the potential to provide BME Communities with a way of breaking out of this situation. With a telephone call, it can break through the language barrier, listen to what the problem is, advise people on what is the best thing to do and where to find the nearest healthcare provider. However, it suffers from the problem that few people from BME communities know that the service exists or how it can help them.

NHS Direct North Central London used community consultations to tell local BME groups about the service, consult on how best to promote NHS Direct and find out what sort of changes it needs to consider if it is to make itself more accessible.

Good Things to come out of the consultations:

- Reached a wider audience than NHS Direct would have otherwise reached, if it had adopted a more direct approach to community groups
- Good opportunity to meet other workers pursuing similar goals and exchange experiences and ideas about working with community groups
- Provided a forum for working in a collaborative way that produces outcomes that benefit both the community group and the organisation. These benefits are over and above what would have been achieved in a more conventional working environment
- Generated good contacts for future user involvement work in shaping local NHS Direct operations
- Produced independent advocates for NHS Direct that are in a position to promote the service and put across main messages about what it offers
- Produced a bridging mechanism between the organisation and the different cultures of its potential users. This allows/enables all parties to express their views about the organisation's service provision and bring about a greater understanding of the organisation's current limitations and what it should consider changing to improve its operations.

Problems that arose:

- The main issue was getting sufficient numbers of community groups involved in the first instance. We recognised that the process of building up contacts with organisations is by its nature slow and can't be rushed. One way of working around this is to piggy-back on to other more established organisations' operations, e.g. MRCF.

Other Thoughts/Recommendations/Lessons Learned:

- The other potential problem will be the growth in organisations conducting user involvement work, and the resulting strain this will put on the community groups
- To minimise the impact of the above, organisations should consult community groups on how best to deal with the problem, and be prepared to fund and run joint operations
- If the consultation process is to be meaningful and mutually beneficial to all parties, it is essential that the organisations listen to the community groups, act on the outcomes of the consultation and demonstrate to the community groups what changes have been instituted as a result of the consultation. It will be very counter-productive if community groups see little or no change resulting from their efforts
- Things that work:
 1. Allow groups flexibility to run their sessions as they see fit, while still achieving the goals of the consultation
 2. Provide a note -taker
 3. Offer certificates to those people who have run the sessions
 4. Provide a set of resources from the organisation, for the person running the session to use if they want to – it provides a useful framework for the session
 5. The training sessions fell into two sections – one on running community consultations and the other on NHS Direct. For those community groups who had already done consultation training, one training session on NHS Direct was provided that covered what the service entailed, and also the opportunity to practice their presentation/consultation.

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Co-ordination of Task Group on Health Needs of Asylum - Seekers - Myriam Cherti, Community Development Worker, Migrant & Refugee Communities Forum

As part of the Task Group on *Health Issues Related to Refugees and Asylum Seekers in K&C and Westminster*, a joint project by the BME Health Forum and MRCF (the Migrant and Refugee Communities Forum), 15 different community groups ran consultation events with their communities. Before running the consultations, community facilitators had to attend two days training on 'How to Run Community Consultations', that were organised for the purpose of this Task Group.

Having attended all these consultations, I can make a number of remarks about the main factors that influenced the running as well as the outcome of each consultation.

1. **Introductions:** the introduction to the purpose of the meeting has a direct influence on the expectations of the participants and the amount of information given by each group.
2. **'Outsiders during consultations:'** the presence of people other than the facilitator of the meeting

- during a consultation also has an effect on the running of the consultation event. For example, the minute-taker or the project co-ordinator can mistakenly raise the expectations of the participants. For instance, the facilitator in one group, when interpreting to the rest of the participants, said that the minute-taker and the project co-ordinator were from the health authorities. Fortunately, the project co-ordinator understood Arabic and stepped in to rectify that. Sometimes, the presence at the consultation of individuals from outside the community can even discourage the participants from discussing issues related to race, for fear of offending them.
3. **Logistics:** the right venue and the right room setting are extremely important in setting up an environment conducive to discussion. For instance, in one consultation the facilitator preferred to set the room in a 'formal way', so that the facilitator, minute-taker, interpreter and project co-ordinator were facing the audience in 'a panel-like' structure. This definitely influenced the level of participation and made the consultation more formal, giving the impression to the participants that the 'panel' was there to hear praises about the health authorities.
 4. **The pro-forma:** for this Task Group, a pro forma was developed to be used as a guideline by facilitators when running the consultations. Some groups found it quite helpful and used it, while others found that it was somehow restrictive, as they thought that they had to cover all the questions.
 5. **Language:** running the consultation sessions in the mother tongue of the community group was very important in making the participants feel comfortable, confident and encouraging them to participate fully in the sessions. A language barrier was experienced even with participants who spoke some English, as they found it quite difficult to express themselves fully because of the specific medical jargon. The presence of an interpreter was, therefore, crucial for the running of the consultation session.
 6. **Group homogeneity.** It was noticed that in a women-only environment participants were able to speak more freely than in a mixed group. In fact, in one consultation the presence of two men in a group of more than 30 women made it very difficult to raise issues related to sexual health, for example.
 7. **Ethnic origin of the group/ Immigration status.** Some groups were more outspoken than others, and this can be associated to some extent with the ethnic origin of the group. According to some ethnic groups, they feel it is inappropriate to criticise the 'authorities' especially those needing their help. I was told that even when they were in their own countries they never dared to complain. Immigration status also plays a major role here. For example, some asylum seekers or refugees felt that they could not complain about anything, as according to them they are only 'guests.' They felt that if they mentioned something it would be taken against them, and they would face deportation.
 8. **Consultations and the ownership of the project.** There was a feeling amongst some groups that this was just another consultation, where their views are noted but nothing will change. However, the way the whole project was structured, from sitting on the steering committee, to funding the community groups to run their own consultations, to organising training for facilitators with a follow-up meeting, to attending fact-finding visits, all contributed to feelings of ownership of the project as a whole and made the community more actively involved.
 9. **Feelings of helplessness by community facilitators.** Raising and discussing different problems experienced by community members did put some pressure on community facilitators. A number of questions were also raised by participants and were directed to the minute-taker, to the project co-ordinator or to facilitators. This, on a practical level, led to a slowing down of the sessions; but most importantly it contributed to a feeling of helplessness of the community facilitators.
 10. **Need for a follow-up meeting.** Reporting back to the community groups and trying to provide more information about which health services and facilities they can access and how is very important for building trust and ensuring continuity of the process that was started.

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CONSULTING WITH PEOPLE FROM BLACK AND ETHNIC MINORITY GROUPS

Mark Beauchamp, Consultation & Research Manager, RBK&C

This report is based on a pilot joint initiative between the Council and the Migrant and Refugee Communities Forum.

Background

The Council, in being committed to fulfil its duties and obligations under the Race Relations Amendment Act, places great importance on working in partnership to develop better consultation with individuals, community organisations and other stakeholders.

The Council is working with the Migrant and Refugee Communities Forum (MRCF) to enable them, in partnership with the Council, to undertake the consultation outlined in this proposal. The MRCF has considerable experience of facilitating and developing effective consultation with BME groups, and in working in partnership with statutory agencies.

Why is this work important?

- ◆ The Council tends to approach consultation with minority groups in an ad hoc and variable way. The Council will sometimes consult in detail with a wide range of minority groups, but at other times does not.
- ◆ There is no process by which departments of the Council can easily and systematically listen to the views of minority groups.
- ◆ People from minority groups are currently less likely to engage in mainstream consultation activities, for example, because of access to information, language, confidence, belief that it will make a difference.

Aims of the consultation

- ◆ To gain an understanding from BME groups of their views of the Council as a service provider and as a potential employer.
- ◆ To understand better how the involvement and engagement of BME groups can be developed and maintained.
- ◆ To get feedback on the Council's Race Equality Scheme, focusing in particular on the stated commitment to consultation, services identified as 'high priority' and the process of service reviews.
- ◆ To understand how existing forums and groups might be able, on an ongoing basis, to work in partnership with the Council.

Process of consultation

The consultation was organised in two stages.

Stage one: Throughout January, February and March 2003 the MRCF set up and facilitated a series of workshops with individual BME groups. These workshops began a process of understanding the issues and concerns of local BME residents. The workshops were facilitated by MRCF staff working together with BME group workers/leaders and took place in local community venues with a Council officer in attendance.

The time participants gave to attend the workshops was recognised with a gift voucher payment of £20 per person. The community/voluntary groups participating were also funded to provide the venue, catering, transport, translation etc. This was paid for from the grant given to the MRCF.

A written report of each workshop was produced, and a summary report at the end of the series of workshops.

Workshops were run with established BME groups as well as more newly arrived groups, to ensure a broad range of experiences, perspectives and views were captured.

A detailed topic guide for the workshops will be developed.

Stage two: In May a feedback workshop was held, bringing together key Council officers, Members, BME groups and their members, other stakeholders and partner agencies. The conference focused on the outcome of the workshops, with the MRCF feeding back their findings to the Council, and discussing the way forward for developing ongoing engagement with the Council.

Outcome:

The outcomes of the consultation for the council and for those BME groups involved were:

For the Council:

- ◆ An understanding of how the Council is experienced and viewed.
- ◆ An understanding of the issues and services that matter most to people from BME groups.
- ◆ Proposals for sustaining the engagement of BME groups in the work of the Council
- ◆ Feedback on the Race Equality Scheme

For BME groups:

- ◆ Confidence that the Council is sincere is wanting to involve them.
- ◆ A better understanding of how the Council works and the services it provides.
- ◆ Meaningful input into establishing a sustained consultation process.

The Consultation Compact

In drafting this proposal, consideration was given to the Consultation Compact which outlines the principles upon which consultation between the voluntary/ community sector and statutory agencies will be undertaken. These include:

- ◆ Recognition that many voluntary groups need extra resources to participate effectively
- ◆ That the time given by individual residents should be recognised and paid for (this is now standard practice for all focus groups).
- ◆ That realistic timescales should be set to enable maximum participation.
- ◆ That consultation should be co-ordinated and planned rather than as random, one-off activities
- ◆ That the findings should be fed back, publicised and acted upon.

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Westminster City Council: 2003/04 City Survey Programme Nick McManus

Westminster City Council undertakes a wide array of consultation and research into the opinions, needs and aspirations of groups as diverse as residents, services-users and non-users, businesses, visitors, as well as stakeholder agencies and organisations. Accurate and high quality information from consultation and research is essential to developing and running effective and efficient public services.

Best Value and the Comprehensive Performance Assessment (CPA) frameworks have placed additional emphasis upon the statutory requirements for Local Authorities to measure resident satisfaction, linked to substantial additional freedoms and flexibilities for councils. Westminster has been designated as an Excellent Council in the first round of the CPA.

The results of the 2002/03 City Survey Programme identify Westminster as an authority leading the way in terms of resident satisfaction for most of its services, and as a place to live. However, such high levels of satisfaction present new pressures on the City Council to sustain and raise

satisfaction levels – not just comparatively but absolutely. City Survey results and reports are currently available on the City Council's Website. The results of the programme in 2002/03 can already be seen to have had an impact upon the Leaders' speech, which drives strategic Council policy, the Local Public Service Agreement (LPSA) programme, benchmarking of the Customer Service initiative (CSi), as well as service development and improvement across the authority.

KEY DEVELOPMENTS

Westminster City Council's corporate consultation programme, entitled the City Survey Programme, together with an authority-wide framework to improve the quality and efficiency of consultation across the authority, is now fully in place for its second year. The consultation framework includes:

- A Corporate Consultation group to co-ordinate and share good practice of consultation across the Council. The group consists of senior departmental representatives who are charged with: working within departments to promote and deliver high quality service consultations; reducing duplication of consultation across the Authority, and therefore the costs of consultation; and feeding strategic departmental issues into, and developing, the City Survey Programme
- Results Dissemination - Effectively communicating and using the results of consultation and feeding back both internally and externally. Using email bulletins to inform and signpost results of key consultations to COB, Cabinet and senior managers. A new, user-friendly forward plan and archive of consultation will also be delivered.
- Consultation Intranet site providing assistance, tools, support, best practice and guidance to improve the quality and effectiveness of consultation. The site also includes a consultation diary outlining completed and proposed work.
- Monitoring and Evaluation - monitoring and assessing the quality, value, benefits and cost of consultation across the Council will take place, and will be reported to Chief Officers Board.

The City Survey Programme provides a reliable and economic method of delivering corporate and strategic consultation on a broad range of issues, together with an opportunity to co-ordinate some departmental consultations. Co-ordinating work in Council departments reduces consultation fatigue, whilst reducing the resource allocation required to deliver high quality consultation results. The City Survey Programme comprises a number of distinct events and activities throughout the year, outlined below:

- ◆ Development of a Corporate Consultation Strategy (September)
- ◆ Corporate Staff Surveys (July)
- ◆ Westminster Connects 2003 – Visitors' street-based survey (July or August)
- ◆ Youth engagement workshops (tbc)
- ◆ City Survey 2003/04 (September to November)
- ◆ City Survey Business Extension 2003/04 (September to November)
- ◆ Statutory BVPI General Survey (November)
- ◆ Additional support, co-ordination and infrastructure for departmental consultation.

The already well established, Area Forums will also be developed during 2003/04, to increase engagement by sections of the community that are currently slightly under-represented, via outreach work. Interactive technology and other new and challenging methods will also be investigated for use in the delivery of Area Forum events, to refresh interaction between speakers and delegates.

CONCLUSION

The City Survey Programme places emphasis upon the quality, reliability and robustness of data collected as an instrument to facilitate and accurately inform strategic policy and service provision.

Consultation and research have become, and will continue to be, more important across the authority and there is increased pressure on departments to deliver more consultation, cost effectively and to the highest quality. In this environment, the role and added value that the City Survey Programme can deliver is essential to co-ordinate departmental work, reduce duplication, and thereby the impact upon the City Council's customers, whilst making both financial and time savings across the whole authority.

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‘LOOKING BEYOND DOCUMENTING LOCAL PEOPLE’S NEEDS & PERSPECTIVES’ Presentation at SEMINAR: *‘Regeneration and Community Development in RBKC – Involving Asylum-seekers and Refugees’*, by Carola Addington, Development Officer, K & C Social Council

Consultations and research - Feedback: Carola’s focus was on the increasing number of Community Consultations and Research studies undertaken in recent years, particularly since the Race Relations Amendment Act 2000. The Act requires local governments to assess the needs of Minority Ethnic communities and although this is to be welcomed, there are a number of concerns amongst the community and voluntary sector. Increasingly, feedback received both verbally and documented in the Golborne United Mid Programme Review¹ suggests that there is:

- Consultation Fatigue (with the same groups being over-consulted)
- Certain groups remain un reached
- Perception that little has changed

Additionally, a national research study² published in January reported that;

‘Repeatedly, individual organisations stated that they were exhausted by being asked to fill in surveys, undertake telephone interviews and support reports and surveys which resulted in no tangible benefit to them’.

Such a response was a concern because it could lead to disillusionment and lack of trust between community development practitioners and those with whom they work. Additionally, it could effectively dis-empower those whom the government seeks to empower.

Questions to ask: Prior to any Consultation or research study proposal, it is useful to ask:

- ◆ Who is asking the research / consultation question and why?
- ◆ Is there sharing and participation in the research / consultation method?
- ◆ Who has ownership of the research results?
- ◆ Who is the information shared with?
- ◆ What opportunities exist for personal / organisational / community development?

Recommendations: The Golborne United mid-term Review made a number of recommendations including the need to: Improve co-ordination of consultation activities; View consultation as an opportunity to establish a dialogue and not just as a way of extracting information; and Use more innovative approaches to listening and reaching out.

Carola gave an illustrated example of an innovative approach to listening and reaching out that has been widely used overseas and increasingly so in the UK. It goes beyond documenting local people’s needs and perspectives and links research with more long term educational processes. It can be described as a Participatory Learning and Action (PLA) model.^{3, 4, 5} The method draws on the use of visual techniques such as mapping, calendars, matrices, etc, as well as using drama and story-telling. These provide a focal point for discussion, a framework for analysis and an opportunity for participants to seek solutions to problems they may experience. The approach is conducted in a relaxed and flexible way with an emphasis on learning with and from the groups. Skills training (such as ESOL) can be linked to the topics under discussion without the need for textbooks, as the participants generate their own material. Over a period of time, participants may explore a range of locally specific information that may relate to health, housing, sources of income, etc. Through such a process, people are equipped with the skills to do their own research and enact their own solutions. Adapting and applying the method to ESOL training is currently being tested in Canada. A similar project is about to be piloted in Camden and Brent, and will be facilitated by the Camden Refugee Network.

References:

¹ New Economics Foundation (2002) *Looking Back: Evidence from Golborne United Mid Programme Review and Looking Forward: Recommendations.*

² BME Sustainability Project (2003) *Finding the Funds*

³ Addington, Carola (2002) ESOL participation: A new approach to literacy needs, *Adults Learning*, September 2002, Vol 14, No.1. NIACE

⁴ De Koning, Korrie; Marin, Marion (eds.) (1996) *Participatory Research in Health: Issues and Experiences*, Zed Books, London

⁵ Flower, Charlotte; Mincher, Paul; Rimkus, Susan (2000) Overview – participatory processes in the North, *PLA Notes* 38, International Institute for Environment and Development, June 2000
Additional info: Moran and Temple (2004) *Best practice guidelines on doing research with refugees and people seeking asylum*. www.icar.org.uk (forthcoming)

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Recommendations from the six case studies for good practice community consultation initiatives:

1. Establish the origin of the participatory project and its purpose.
2. Assess who participates and the nature of their involvement.
3. Establish trust and mutual respect between diverse partners.
4. Recognise the imbalance of
5. Measure the process of negotiating participatory goals.
6. Evaluate the process and outcome of participation.
7. Establish community benefit and ownership of outcomes.
8. Evaluate (primary and secondary) stakeholder perspectives of the effectiveness of the project.
9. Establish cross-cultural ethical foundations for future projects, research and service developments.
10. Language is vital – it is much better to hold the consultation events in people's mother tongue languages, and have an interpreter present for the note-taker.
11. If you have £5,000 or £10,000 to undertake a consultation project, it is better to take time and discuss with others about how best to consult and engage local groups and communities – a one-off event in the Town Hall may not be the best idea!
12. To minimise the impact of consultation fatigue, organisations should consult community groups on how best to deal with the problem, and be prepared to fund and run joint operations with other statutory agencies
13. This process whereby people from community groups are trained as facilitators leads to greater ownership and participation by the communities. The way a whole project was structured from sitting on the steering committee, to funding the community groups to run their own consultations, to organising a training for facilitators with a follow up meeting, to attending fact-finding visits, all contributed to feelings of ownership of the project as a whole and made the community more actively involved.
14. If the consultation process is to be meaningful and mutually beneficial to all parties, it is essential that the organisations listen to the community groups, act on the outcomes of the consultation and demonstrate to the community groups what changes have been instituted as a result of the consultation. It will be very counter-productive if community groups see little or no change resulting from their efforts
15. View consultation as an opportunity to establish a dialogue and partnership work, and not just as a way of extracting information.
16. Use innovative approaches to listening and reaching out - using visual techniques such as mapping, calendars, matrices, etc, as well as using drama, forum theatre, story-telling. These provide a focal point for discussion, a framework for analysis and an opportunity for participants to seek solutions to any problems that may arise. The approach is conducted in a relaxed and flexible way, with an emphasis on learning with and from the groups.

17. Recognise that many voluntary groups need extra resources to participate effectively
18. Be aware of gender dynamics in different communities – for example, you may get much better information if you hold a separate women’s consultation event rather than a mixed one.
19. The time given by individual residents should be recognised and paid for (this is generally standard practice for all focus groups).
20. Realistic timescales should be set to enable maximum participation.
21. Consultations should be co-ordinated and planned, rather than random one-off activities.
22. The findings should be fed back, publicised and acted upon.

PART TWO:

MODELS OF CHANGE and the DEMOCRATIC PARTICIPATIVE APPROACH TO USER AND COMMUNITY INVOLVEMENT

Kate French and Aisling Byrne

This section sets out two contrasting approaches. The first approach, the ‘*consumerist approach to user and community involvement*’ is based on the classical model of change which is still a standard approach adopted by many organisations. The second approach is the democratic participative approach, based on complexity theory.

The *democratic participative approach to user and community involvement* has been developed and implemented in Kensington, Chelsea and Westminster – co-ordinated by the *BME Health Forum* with its partner organisations. It is this model that is described in more detail below.

APPROACHES TO USER CONSULTATION

1. The Consumerist Approach to User and Community Involvement

This approach to consultation is underpinned by the classical model of change.

Ideas on how to bring about change originally stemmed from studies of the army and the church. Lessons were drawn on how to lead, control and inspire disparate people to follow a certain direction in a faithful and loyal way, and how to structure organisations most efficiently into divisions and units, with an overall command at the centre. The language used in organisations today in the western world contains many terms of military origin. Managers talk of marshalling the troops, leading from the top through command and control, drawing up a plan of action with overall objectives and specific targets to hit; and structuring one’s organisation into units and sections. Many bureaucracies in the public and private sector are organised on the assumptions underpinning this approach, and they inform leaders’ ways of bringing about change. This classical approach to change underpins later theories of organisational planning; scientific management and modernist management theory geared at finding the one ‘right way’ to run a rational, stable organisation characterised by clear roles, policies and systems.

This classical approach to change contains assumptions which are set out in Box 1 below:

BOX 1:**Traditional [modernist] approach to change: some features and assumptions**

- Change is a matter of planning through from A – Z in a linear and ordered way: management by objectives, moving step by step through a process of arriving at the outcome is the usual approach used
- Deviations from the change plan represent a failure in the planning process. It is expected that all problems should be anticipated from the outset, and that failure to deliver is likely to be a consequence of incompetent planning or planners, or unreasonable barriers put up by other individuals, parts of the organisation or other external groups/organisations who may be competitors or have different personal or organisational agendas (troublemakers)
- Change in organisations is most effectively conducted as a top-down process: those at the strategic and policy-making levels of organisations are best positioned to develop a vision and to plan change and have the types of power to drive change through
- Strategic planning around change is based on one's own organisation as being at 'the centre' of the field of activity in which one operates, rather than as part of a population of organisations that are in complex relationships and networks within the field
- Leaders will sell change through a range of 'carrot and stick' mechanisms to get staff, and other key parties, to secure support for the change
- People are seen as components to be managed in the production process
- Those who do not agree to support the change process need to be either brought on board, or their influence needs to be neutralised, or they need to be removed from locations of power and influence
- Participation in the change process is seen as positive insofar as it secures support for the direction of travel and enables some modification to the overall plan.

This thinking has many merits, in that we all need to have a vision and idea of where we want to get to, and where we require others to support our ideas and subscribe to the direction of travel. The use of power is necessary to drive change, particularly by those with control of resources, control of information and with decision-making powers.

The problem is that change is a much more messy and complex process than this linear planned approach suggests. Many leaders and champions of change are constantly frustrated by the fact that the best laid plans simply do not go according to design, and those who are required to support the change process are frequently alienated by waves of change initiatives that hit them. Leaders in the army, in private corporations, in the public sector, are faced time and again with unanticipated events that blow plans off course. Change can be initiated or triggered through small incidents, by groups or individuals with less position power than others but who, by acting together, influence change from other parts of the system. Those with different perspectives and agendas and ideas outside the mainstream can change the course of events. It is hard to anticipate the unexpected through planning from the known and familiar. Large multi-national companies will invest in scenario planning, asking the 'what if' questions in order to be ready to meet all future contingencies and minimise risk, but even this is insufficient.

2. The Democratic Participative Model of User and Community Involvement

This model of user and community involvement is underpinned by complexity theory of change. The classical, 'mechanistic' approach to change has been challenged by many disciplines over the last few decades. Ideas on change have been influenced by economists, natural scientists, organisational theorists who have been exploring notions of complexity and chaos, and the relationship of populations of organisations and groups within and across wider systems. A different model of change is being developed, partly as the traditional scientific management approach has not worked; but also to reflect changes in the world, with the development of new technologies, communication and global complexity impacting on day-to-day life at a local level.

Box 2 below sets out the new model of change. See Appendix 2 for a comparison of approaches of the new and old types of thinking.

BOX 2:

Some of the thinking on the new notions of change

- ◆ Change is perceived as a non-linear process that cannot be planned in a mechanistic way; rather it is seen as a complex process requiring negotiation between people to secure agreement for a desired direction of travel
- ◆ Change can be orchestrated, but not controlled, and the ground is always shifting in ways that cannot always be anticipated
- ◆ Diversity and differences of views are to be welcomed and encouraged as sources of innovation and creativity
- ◆ Tensions, contradictions and paradoxes are acknowledged as the norms of organisational and social life; agendas for change can be shaped through the identification and promotion of links between those with common over-arching areas of interests and concerns
- ◆ Change events or interventions are designed in collaboration with stakeholders; a one-size-fits-all model approach and a top-down approach are to be avoided
- ◆ Participation at the outset is encouraged from different parts/levels of organisations and the community (across the whole system or parts of it) - from those participants with differential bases of power in order to open up possibilities of conversations where 'silences' have existed or 'dins' [noise] excluded dialogue in the past
- ◆ To spend whatever time it takes in dialogue with all potentially interested parties, in order to negotiate and agree an agenda and programme of change across the acknowledged areas of interest or parts of the system
- ◆ Participants have equal access to information on all factors that could or do influence the change process, in order to maximise the opportunity for all to fully contribute their skills and creativity towards making a difference
- ◆ To experiment, to learn, and to keep open to new processes and approaches that will engender creativity and inclusivity.

This model tends to highlight the importance of the individual, the connections and alliances forged by people within and across communities and organisations as keys to prompting change. Innovation and change stem from individuals sharing different perspectives and listening and learning from difference. Through dialogue encompassing diverse views, cohorts of people may form an alliance to collaborate in pursuit of a common purpose. Influencing through negotiation, through inspiring, through a vision, through forging links creates the engine for change across the whole system. Networks, partnerships and collaboration are the 'structures' for change. The direction of travel will shift in the light of newly emerging agendas, competing visions, and unanticipated events that cannot be entirely planned for.

THE DEMOCRATIC PARTICIPATIVE MODEL OF USER AND COMMUNITY INVOLVEMENT: IMPLEMENTATION ISSUES AND LEARNING POINTS

This approach to user and community involvement is informed by some of the new thinking around change. The essential notion has been to move away from the 'tickbox' approach to consultation which has often consisted of holding an event, inviting in users, carers and community members to comment on statutory services plans, writing up the results, and then possibly making some changes to the plans.

Managers are working within a system with competing demands, many priorities and usually with stressful timescales. To survive the system, the need to 'get the box ticked' simply to lend some formal legitimacy to achieving performance targets is a natural response. Most managers want to

do things differently, but do not have the time to think or act in order to bring about anything more than superficial change.

Most users, carers and community groups complain that there is no feedback after the consultation event, and that nothing much appears to change from their perspective. In addition, they are constantly asked for their views on a range of policies, which is to be applauded but has a spiralling negative impact when the same lack of feedback occurs continually. This leads to cynicism, anger and disempowerment.

From the experience of the user and community involvement work that has been undertaken to date, there are several factors that need to be in place or taken into account in drawing on and developing a new model of change.

Key factors that need to be taken account of in developing a democratic participative model of community and user involvement.

Statutory workers 'going in and out of communities to satisfy work plans' of their agencies does not work. A longer-term approach and diverse strategies are needed if statutory agencies are serious about reshaping services to meet the needs of different community organisations. Several factors have emerged from experiences in the BME Health Forum's work in this area, that point to the need for a new model.

The starting point has to be made by agents committed to change from within and outside the system, who want to kick start a different approach to community and user involvement. Some key components of a democratic participative model are identified below:

(i) Finding 'champions' of user and community involvement in the statutory system, making the links

- Locating 'champions' in the statutory system, who have an ethical, political, and value-based commitment to working with diverse groups in partnership to develop change plans, and to achieving equity and access to services. The style of developing Generative Partnerships required here is described in Appendix 1.
- Locating 'champions' with sufficient command of power and influence, who can forge links with other leaders in organisations and in the community
- Locating leaders who are competent at bridging the community and mainstream systems; knowing where the potential is in the system to make links and to forge alliances for change; how to promote equality issues on the mainstream agenda; and how to institute a real system of accountability of leaders to the community
- Securing 'champions' who are tough in that they can keep the values of equity and access to services at the forefront of mainstream activities, and who will challenge relentlessly the rigidity and resistance of those who are reluctant to share power through collaborative and partnership developments; who will keep focus on opportunities for change
- Securing 'champions' who recognise the expertise, knowledge and skills within different communities and who are willing to collaborate in partnership, share power and support leadership development from others (Appendix 1)
- Using leverage to secure resources from different parts of the statutory system to develop capacity within user and community groups; to enable communities to have adequate information and understanding of the statutory systems to participate meaningfully in discussions; and to provide training and support to develop leadership skills from diverse communities
- Using symbolic power of position to champion and make visible partnership working with community groups; be there to launch events, etc.

(ii) Developing leadership, supporting leaders and working in collaboration with community leaders; strengthening the links

- ◆ Recognising that the expertise on communities lies with members of those communities, and that leaders from those communities are best placed to design and lead consultation exercises that are appropriate and effective

- Obtaining knowledge of and support from research bodies that will promote evidence based practice in community involvement
- Respecting and building on the relationships and network systems within community groups, where these are established
- Capacity-building through education programmes and training initiatives so that community leaders have the requisite information on the topic, the relevant structures and processes & the resources from the statutory sector to give effective leadership
- Providing training to equip community leaders with different ideas and approaches to community participation, and to enable community leaders to generate and design the most appropriate consultation sessions to reach those often socially excluded from the mainstream
- Supporting community leaders to exercise and use different sources of influence and power
- Encouraging umbrella organisations of community groups to monitor the effectiveness of user involvement and participation strategies, and to challenge statutory bodies on progress in relation to feedback.

(iii) Collaborative leadership across the statutory and community sectors; building connections, strengthening loops between and across the whole system

To really establish sufficient leadership to enable user and community participation to happen, it needs to be drawn from different parts of the Health Services, Local Authorities and community systems, and at different levels of the system. A small cohort of dedicated people can bring influence to bear on developing effective user and community participation. It is important to secure active support from:

- CEO level/ Chair of Board/ Director who has sufficient influence and power to promote and sustain change; to challenge the status quo and be diplomatic at the same time; be visible in supporting initiatives; ensure something happens as a result of consultation, and feedback mechanisms are in place; and engage other leaders in the change agenda
- Leaders from the community, and particularly from umbrella community organisations, are vital to oversee participatory strategies, hold the statutory sector to account, and support small community groups to engage in the process
- Change agents within the statutory system: these may be specialist staff, middle managers, front line service staff who have a specific leadership function to develop partnership and collaborative work with patients, service users and citizens

The first task of those initiating change is to identify whether there is sufficient leadership and leverage across the system, and if not, to analyse where this needs to be in place and work on creating it, in order to develop a community engagement strategy and programme (see Appendix 2 on this approach).

(iv) Recognising the huge diversity of communities, and within them, and that flexible methods are required to engage communities; constructing a vision from multiple realities

In inner cities communities are richly diversified, with different cultures, religions, languages and race. A one-size-fits-all approach to community consultation will not do when beginning to engage members of the community who, for a range of reasons, may be socially isolated and with no experience of having their voices heard in society.

It is not possible for a consumerist approach to consultation through one-off 'tell us what you think of this product or service' approach to get anywhere near surfacing the voices, views, and experiences that would inform how services can be shaped to meet different needs. There are several aspects that have to be taken into account in designing consultation programmes to engage the 'hard to reach':

- Consultation approaches need to be sensitive to the history and background of different communities, with many members newly arrived in the UK, often after experiences of trauma in relation to regimes and those in authority within countries of origin

- Communities have widely different cultures, customs, mores, languages, religious beliefs that will affect how they engage with the mainstream of society; and an approach that will work well with one community may be totally inappropriate for others
- To communicate effectively with members of communities who do not have English as a first language may require a consultation initiative to be led by someone who speaks the mother tongue, or may require the use of skilled interpreters
- Established communities will have some leaders who can advise clearly on the style, content, approach, location and timing for any method of consultation in order to maximise the impact of their voices
- Communities may have had a range of different experiences of health and local authority services, and/or may be quite uninformed of what is available; designing a consultation must take into account the information needs of the community on services available before they can comment on how such services can better meet their needs
- Often community members feel on the margins of society and its mainstream services, and relatively dis-empowered; some cultures of groups may be based on 'not criticising' those in authority; confidence in expressing views may be limited and thus a knowledgeable and culturally sensitive approach from community leaders with expertise is required
- Gender issues are important to understand in relation to consultation sessions; it may be appropriate to design consultation sessions that enable women and men to share their views separately.

(v) The importance of an umbrella community organisation; developing coherence across multiple realities and diverse purposes

Getting power and influence established in the community sector that can be effectively brought to a partnership with statutory agencies is important. Community groups are often isolated and fragmented for a number of reasons. Many are functioning with only volunteers collaborating together to advocate for their needs, with few resources. New communities emerge as refugees and asylum seekers form groups as they arrive in the UK, often resulting in several community groups from the same country. Some groups come from different warring factions in their country of origin. Languages may be common to some groups, but not shared with others, and where the understanding of English may be poor, making links with other groups problematic.

Organisations that can serve as a co-ordinating umbrella across diverse groups can enable different voices to be heard. It is easier for statutory agencies to work with umbrella groups, to draw on their expertise, and through them to maximise their knowledge of the interests and concerns of different communities.

Umbrella organisations can maximise the strengths of the community sector in several ways:

- Through holding the statutory sector to account and formalising this role
- Bridging the gap between the community and the statutory sector
- Orchestrating powerful feedback sessions by bringing together the community and senior officers from across all statutory organisations
- Individual organisations do not have the capacity to pursue some issues, but an umbrella organisation can and does strengthen and support small individual organisations through their work

(vi) Capacity building of leaders in the community: training in facilitation skills in community participation

Community leaders are best placed to undertake consultation work for the statutory sector within their communities. They have specialist expertise; know the community they represent, its cultural beliefs and practices, languages, religion, history and politics. For example, on consulting community leaders on how to design effective participatory processes in their communities in KCW, they were well positioned to both refine the approach and to design innovative approaches to demonstrate in their consultation sessions how NHS Direct could offer services to their communities.

Consultation work has to be resourced by the statutory sector, so that community organisations can hire somewhere for meetings, equipment, refreshment and travel costs. It is important that those undertaking consultation sessions are trained in some of the following areas:

- Planning and designing a consultation session: understanding the importance of pre planning both the shape of the session, the agenda in relation to time available, and the logistics – room set up to promote the most effective participation: the need for an interpreter, the need for separate groups such as gender specific groups, to promote depth and breadth of feedback
- Putting boundaries around topics that will arise during the session, and to keep the focus on the key purpose of the meeting
- Managing the distress that may arise for individuals in the group in talking about their health and social care issues, which can be profound particularly in working with refugees and asylum seekers
- Having ability to convey the purpose, the methods, and the way that the feedback will be used, and how participants will learn about the results of the session
- Having skills in engaging participants in a culturally sensitive way, listening, promoting participation by those unused to being asked for their views, summarising views, dealing with divergent views
- Presenting information clearly and having sufficient background knowledge to empower participants to understand how their views will affect/link into the wider system
- Understanding group dynamics, the types and use of power in groups that can be used to create a collaborative and participative process
- Using materials confidently, such as proformas, videos, case study synopsis
- Learning different methods of running consultation sessions, so that there is a match between methodologies and the community involved.

(vii) Empowering the role of middle and front line change agents within, or working alongside, the statutory system

One of the most stressful roles in organisations can be at middle management or front line management with a brief to orchestrate change across the system. Such individuals have to influence those more senior in the systems, those outside the statutory sector, and those who are delivering front line services. The role requires political and diplomatic skills and knowledge of how to influence a process of change.

Change agents:

- Need to undertake a stakeholder mapping exercise, to take stock of the power, influence and concern in the system that will support the implementation of the consultation strategy and process
- Need to have direct access to CE, Chairs and other senior staff who can champion this work within the statutory sector
- Have an umbrella community group to work to, whose brief is to advise and advocate for change, and who provide a power base independent of the statutory sector
- To have the influence to bring service commissioners into task groups of umbrella groups, so that loops of connection linking feedback and action are in place
- To have the development skills and sufficient authority to link together users, community leaders, statutory staff and leaders into workshops that create listening and dialogue and promote the development of shared purpose across the whole system

(viii) The process and methods to develop an effective consultation event: exploring different viewpoints to discover new ideas to improve services

Training for community leaders provides an opportunity to introduce different participative and democratic methods of consultation. In particular, methods that are especially useful are those that are non-threatening and maximise participation from those whose voices are normally silent, or silenced in society.

The **World Café** (see www.theworldcafe.com) approach is one that is particularly non-threatening. It can encourage communication through stories and drawings, in a pleasant and informal environment. **Open Space** is another technique that can encourage the range of voices heard. Such techniques engage diverse people in collaborative dialogue in ways that easily bring together those with access to power through control of resources and status, and those with access to neither. Such methodologies do help to obtain the views of those who are from cultures from which their experience historically is not to criticise or speak up.

It may well be that groups are not the way to reach some communities for a range of reasons, and that consultation needs to be through one to one meetings in settings where community members can be accessed.

A longer-term education and development programme to build significant leadership capacity in the community sector is required to mainstream those skills within organisations.

(ix) Making change stick: linking action and feedback

It is noted from the experience of the *BME Health Forum* that recommendations from consultation sessions, via individual events or umbrella groups, are not implemented. This seems to have been the result of the competing targets and demands on senior staff.

Several mechanisms that are identified in other aspects of this model are important to have in place to address this problem. The need for champions within the system, the role and remit of an external umbrella group to hold the statutory sector to account and the value of legislative and policy- drivers are all important factors. There is a need to constantly reassess the sources of leverage for change, and to renew sources of power, find new ones, all of which is part of a constant process of change. It is vital that in the system there are champions of change who can make strong links across organisational boundaries, drawing on statutory, community and academic staff to contribute to the process. At the core, there needs to exist a passion for the values of inclusion, participation and democracy that will influence greater equity and access to services by all.

APPENDICIES

Appendix 1

GENERATIVE RELATIONSHIPS IN COLLABORATION AND PARTNERSHIPS

'When individuals with different experiences come together to act for some common purpose, they form a generative relationship that leads to creative ideas that neither party could have dreamed up alone'

Brenda Zimmerman, McGill University

There are 4 aspects of this relationship:

- Separateness; differences in background, skills, diversity and active respect for difference – generating a fuller picture, seeing things from various perspectives
- Talking and listening; real opportunities to talk and listen; permission to challenge the status quo; or implicit assumptions [see also Senge's notion of dialogue]
- Action opportunities; acting together to co-create something new – this implies shared access to resources. It may involve lateral thinking, what other parts of the wider system can do to bring about change
- Reasons to work together; there has to be some mutual benefit derived from the project

Minimum rules

Some minimum rules, plans and structures are necessary to get things done in partnership across systems. Simple specifications in working within a complex adaptive system framework need to:

- Point the direction of change [e.g. an action has to be taken/in place within a certain time frame]
- Set absolute boundaries [e.g. can't go over the budget limit]
- Provide resources for generative relationships
- Give permissions for trials and innovative approaches.

Appendix 2

NEW WAYS OF WORKING and SHIFTS IN THINKING

Approaches to understanding organisations

From 'old' thinking

Organisation as a machine and seen as central within its environment

Linear in structure and hierarchical

Leadership through command and control

Change planned and controlled from top and expectation that this can be regulated

Top down approach

Control is required to manage the process of development and the parts of the system

Vision of the future is that of the powerful - concept of the 'one' right way forward

To 'new' thinking

Organisation as living organism and part of system of organisations within the total environment

Webs of inter-dependence with other organisations with continuous loops linking actions and feedback between and throughout the system

Set frames of reference that is guide to action and how organisation is accountable to the whole system

Considers ways in which system can be influenced from own place in the system

Change is multi-faceted; it is normal for unanticipated consequences to occur; change is creative process through generative relationships in the system

Loops and interconnections between organisations strengthened to influence change within the whole system

Order is inherent within the system and organic ability to adapt and change without control or design by formal system or outsiders

Vision of the future is constructed from multiple realities across the whole system and identification of shared meaning and purpose - lending coherence to multitude of individual actions

<i>From 'old' thinking</i>	<i>To 'new' thinking</i>
Search for solutions	Search for possibilities and inter-connected action
Discussion process: each player seeking to get her/his view accepted by other	Dialogue process: encourage different views and explore assumptions as means of discovering a new view
Problems: expect one agency can fix through rational, linear type thinking	Problems lie in connection between the parts of the system and quality of reciprocity in inter-connections
Consultation occurs with representatives of those who speak for others	Use open system events to get as many parts of a system together and facilitate listening and dialogue through sharing of stories and individual experiences
Legitimacy of power may be uncontested in single organisations	Power is likely to be contested through the partnerships and relationships of organisations within the whole system

Adapted from '*Working Whole Systems: Putting theory into practice in organisations*', Pratt J., Gordon P., Plamping D., *King's Fund* publication 1999 published UK (ISBN 1 85717 233 7)

Appendix 3

Reality check: scoping the leverage for change for one's own organisation, own role capacity, and sources of power and concern in the system

It is important for organisations to take stock and be open with each other to determine what are the:

- must dos
- can dos
- like to dos

in the context of achieving a robust methodology and strategy to user and community involvement.

Questions for statutory sector champions of user involvement within the system:

- Have you got the capacity [time] in your role to go beyond a tick box approach, or are you too stretched with other targets to meet?
- Could you empower someone else to lead the work on your behalf but still use your symbolic power to support the change [occasional presentations at launch events etc.]
- Have you got the time and resources to develop leadership with colleagues in other parts of the whole health and social care system, and with community leaders that are necessary to provide leverage for change?
- Have you got resources to back a user and community involvement approach that may involve capacity building in the voluntary and community sector?
- Do you have enough evidence of the benefits to all partners of greater service user involvement that will support your leadership and advocacy of this area of work?
- Are you prepared to share power, work in collaboration and in depth with community partners, to build equal partnerships across the whole system?

Questions for community organisations leaders/advocates undertaking consultation activities:

- Have you identified, and secured support from, key change agents in the statutory sector to support your work?
- Is there a continuous relationship with key change agents in the statutory system that will support your work in the future?
- Have you had the opportunities to develop your skills in community leadership, and sufficient knowledge to negotiate and work in effective partnership with the statutory sector?
- Have you had the opportunity to develop skills in facilitation of groups and networks, in order to engage community members in consultation exercises?
- Have you got the information from statutory services on the reasons for the consultation and the context in which this is taking place?
- Do you know the legislative conditions that may be driving the need for statutory organisations to consult with you?
- Are you aware of all the types of power and influence that you hold, through legislation impacting on the statutory systems, through your own expertise and specialist knowledge of communities, command of languages, religions and cultures, gender issues through which you can add value to statutory organisations?
- Do you know what will happen to your feedback, and when?
- Have you got the time, resources – people, money, facilities to hold consultation events and do you know what you need in order to do this effectively?

Scoping work: essential process not to be skipped

Identifying the champions who will be interested, committed and bring leverage to the process

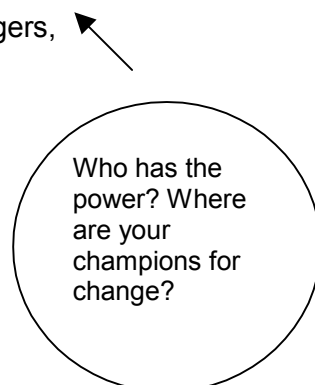
Check list:

- Is there sufficient leverage for change in all parts of the system to support the user involvement strategy?
- How strong is the community sector?
- Are there some statutory senior level champions of change who can support the change process and with time to ensure their presence at key events?

Statutory organisation leaders

e.g. Chair of a Trust, Chief Exec
Directors, Non executives,
partnership development managers,
clinicians, PALs managers,
leaders of BME programmes
equality initiatives, community
development

Community activists; organisations
Individual champions



Other organisations in same population of interest areas; those willing to collaborate

Different organisations; individuals who add value through diverse ideas to the change process; universities, theatres, think-tanks even gurus

Stakeholder 'Power' and 'Concern'

To engage key players in contributing ideas and agreeing to a programme of change re service user involvement and participation, it is important for developers of the initiative to take stock of the levels of power and concern about service user involvement with stakeholders across the network area. Elliot Kemp has produced a useful theoretical model for analysing the issues of 'power' and 'concern', which are central issues for successful collaboration in innovation and change. It will be important for developers to map the stakeholders in the locality in terms of these two factors. In this matrix analysis, power and concern are defined as:

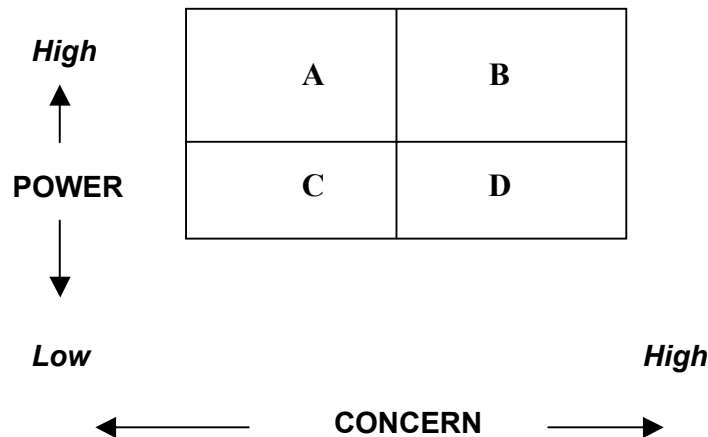
Power is held by a person who is able to increase, to reduce, restrict or limit alternatives available to others. An individual may have limited position power but high influence through acknowledged expertise or personal qualities.

Concern refers here to the level of motivation to support the innovation – from championing it to apathy or active resistance to it.

Appendix 4: Matrix Analysis

Step 1: List all members of the locality who may be involved or affected by the active engagement of service users in service planning and place on the grid below.

Figure 1



Quadrant A

Locality members in this area have considerable power or influence but do not support the innovation of a service user involvement

Quadrant B

In this quadrant are locality members with power and influence who sponsor or support the innovation of service user involvement

Quadrant C

Locality members in this quadrant are low in power or influence and do not support the innovation of service user involvement

Quadrant D

In this quadrant are locality members who support or advocate the innovation but who lack power and influence.

Step 2: Assess the distribution of power in support of user engagement in plan

- ◆ Assess whether those outside quadrant B have adequate information and understanding of the potential benefits of a user involvement
- ◆ Identify the interests/needs or benefits that could shift more people from quadrant A to B in particular, and identify how to increase their stake in user involvement.

Quadrant A

Network members in this area have considerable power or influence but do not support the new model of user involvement

Quadrant B

In this quadrant are network members with power and influence who sponsor or support the model of user involvement

Quadrant C

Network members in this quadrant are low in power or influence and do not support the model of user involvement

Quadrant D

In this quadrant are network members who support or advocate the innovation but who lack power or influence

APPENDIX 5:**POINT 2 CHECKLIST:****ASSESSMENT OF STAKEHOLDER POWER AND CONCERN—ANALYSIS IN RELATION TO THE DEVELOPMENT OF THE NETWORK**

- ◆ What are the concerns underlying individual stakeholders' hostility to the network? Are they to do with the individual or the service/organisation?
- ◆ Can the network meet the underlying concerns?
- ◆ Are there sufficient stakeholders with enough collective influence and position power to begin to develop the network?
- ◆ What other stakeholders need to be engaged in the initial development of the network, who provide services at any point of the patient pathway?
- ◆ Are there multidisciplinary levels of actual or potential engagement in network development?
- ◆ Review membership of the planning group in the light of mapping, and widen if necessary
- ◆ Agree preliminary work to secure commitment to the development of the network: e.g. Individual discussions on potential concerns of current service and benefits of network, information events etc.

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