King's Fund

Patient and public involvement in Primary Care Groups and Trusts

Hayes & Harlington case study

Final report, July 2001

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Introduction

This report has been written for the members and officers of Hayes and Harlington directorate of Hillingdon Primary Care Trust (PCT) and their partners in the local health economy. It presents the results of a study of the patient and public involvement (PPI) work which the directorate – formerly PCG – undertook between February 2000 and April 2001.

Hayes and Harlington was one of six case studies participating in a King's Fund study of PPI in primary care groups and trusts, funded by the Health in Partnership initiative of the Department of Health. This report is one of six case study reports from each of the six sites. The sites were:

- Central Croydon PCG
- City & Hackney PCG (became City & Hackney PCT in April 2001)
- Dagenham PCG (became part of Barking & Dagenham PCT in April 2001)
- Harrow East & Kingsbury PCG
- Hayes & Harlington Directorate, Hillingdon PCT (formerly Hayes and Harlington PCG)
- North Lewisham PCG

All but one of these case study reports are presented in the same way in order to enable comparison between then. This report is divided into two main sections: a descriptive overview and a more detailed analysis. Although the headings used are not ideal for every case study, and may not always seem intuitive, they provide a guiding framework both for comparison of the individual case reports and for the development of the final output from the study.

A full 'cross-case analysis' will be published early in 2002, designed as an accessible guide for practitioners rather than as a pure research report.

A number of secondary pieces of research were conducted in the participating sites, defined by the interests of the participants within each site. In the Hayes and Harlington case study a particular interest was taken in the differences between the lay member role and the Trust non-executive director role. Special attention is given to these issues at the end of this report.

Description

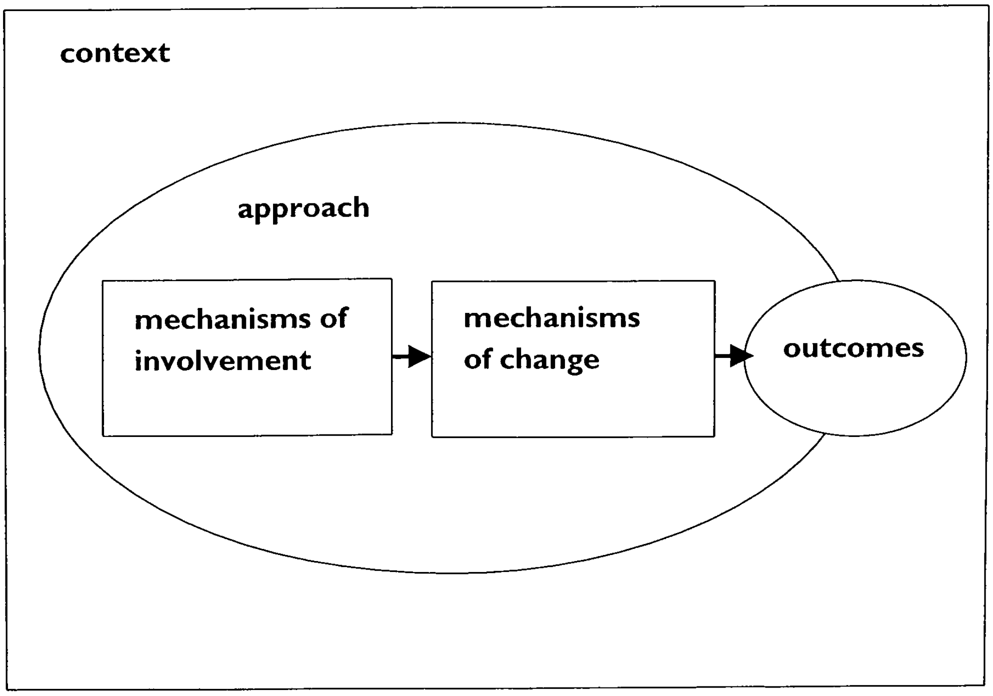
The model

This section describes both the detail of the PPI work that was undertaken and the broader context which shaped this work, including local history, organisational priorities and professional values.

The model, based on that of Pawson and Tilley (*Realistic Evaluation*, Sage, 1997), has five different elements: context, approach, mechanisms of involvement, mechanisms of change and outcomes. Together, these offer a comparative description of each locality. In summary:

- The context is the givens: the things you do not have much choice about.
- The approach is the choices that have been made (recently or otherwise) to shape the form of local PPI.
- The mechanisms of involvement are the specific PPI initiatives undertaken.
- The mechanisms of change are the processes by which PPI has an impact.
- Outcomes are the results (which may include changes in processes).

The main point of the model is this: if something works in one place, it may not work in another. To get PPI right, you have to make it work for your circumstances and your values. Similarly, in order to make sense of PPI initiatives, we have to attend to local history and local priorities as well as to the detail of how they are actually implemented.



Context

- Hayes & Harlington PCG became one of three locality directorates of Hillingdon PCT in April 2000. The PCT is co-terminus with the borough of Hillingdon.
- The locality has a population of 70000, including a large South Asian minority. The area is relatively deprived compared to the rest of Hillingdon.
- The PCG had two lay members. In the transition to PCT, both remained as members of the new locality board (one of three locality executive committees in Hillingdon mirroring the old PCG boards). Both lay members have strong roots in the local community but had limited experience of public involvement work. The lay members are responsible for PPI work in the directorate.
- The new PCT board has, as required by national guidance, a majority of non-executive directors. A non-executive director sits on each of the locality executive boards.
- The local NHS has a history of collaborative working with Hillingdon CHC. A CHC officer proposed PCG public panels in 1998, prior to creation of PCGs, and continues to run them from the independent CHC base. This officer attends the locality board meetings and away days and has played an important role in supporting all the lay members in Hillingdon.
- There is no identified officer time for PPI, although the CEO is personally very supportive. The lay members get a minimum of administrative support from the directorate. There is no subgroup with a specific PPI brief.
- The experience of other board members of PPI is very limited (there are two PPGs in the area); however the views of the lay members and CHC officer are respected.

Approach

- The approach of the directorate (and the PCT as a whole) to PPI is focussed on the role of the institutional lay voices, particularly those of the lay members and CHC.
- The lay members contribute to directorate business at board level, in subgroups and informally. Their credibility is strengthened by their broader role in both leading and undertaking PPI work for the directorate.
- Lay member responsibility for promoting PPI distinguishes their role from that of the NEDs on the PCT board, who explicitly do not to have this responsibility. The NEDs are focussed on issues of corporate governance, but their role embraces a concern for the patient/community perspective.
- The importance attached to lay voices inside the organisation reflects the priority given to the role of PPI in influencing organisational decision-making and accountability.
- These aims are also served by the public panel, run by the CHC. This panel mainly works to an agenda defined by directorate business – board papers and other strategic documents are regularly discussed. However, the panel also provides opportunities for members to raise their own concerns about local health services.
- Although the directorate's focus is on institutional lay voices, they in turn have an active interest in involving a wider local constituency. This has been pursued by the lay members through meetings with community groups in the locality. The CHC has a history of doing focus groups with local people, but this has not happened in the last year (partly because of the resource requirements of the public panel and ongoing uncertainty about the its own future).

- A broader process of communication with local people is also a commitment, but a promised newsletter has repeatedly failed to materialise. A patient-friendly annual report was distributed to all surgeries and clinics in May 2001.
- Practice-level patient involvement work has been encouraged by the clinical governance subgroup, particularly through the inclusion of patient involvement in practice incentive schemes.

Mechanisms of involvement and mechanisms of change

- The lay members are both the principle mechanism of involvement (i.e. as institutional lay voices) and the principle mechanism of change. Their personal contributions to the board, its subgroups and away days and their more informal relationships with the officers of the directorate are a clear means by which lay views can change the policies and culture of the organisation.
- The CHC officer has a similar role, in her case strengthened by a long history of involvement in the local health economy.
- The public panel. The panel members are local patients, recruited initially through the CHC and subsequently through leafleting practices. The panel is funded and run by the CHC, though one of the lay members writes up brief minutes from the panel which are included in the board papers. Usually, the Chair, CEO or an officer from the directorate or another part of the local NHS attends the public panel. The paper to the board has little impact on other members. Organisational/policy change only comes about if the lay members, CHC officer or visiting members or officers take up particular issues raised by panel members. Although this does happen, the panel members do not see this as the necessary process, so do not actively lobby.
- Outreach meetings. The lay members have systematically written to local community groups and offered to go and talk to them about the PCT and local health issues. Although these meetings provide occasional insights for the lay members and directorate, they principally serve an educational purpose for the people attending. Reports to the board from these meetings have little impact. However, the lay members do take up questions raised in these meetings with the appropriate officers in the directorate.
- Asian Day. This half day seminar brought together local people from the South Asian population to discuss pertinent health issues such as diabetes and mental health. More are planned.
- Patient satisfaction survey. This has been conducted by the clinical governance subgroup across all practices in the area and is linked to the subgroup's concern to promote greater patient participation at practice level.
- Patient participation groups. The two local PPGs are well established and have strong memberships. Beyond the involvement of one PPG's members in the public panel, the role of these PPGs has not been explored in this study.
- Professional education. NHS London Region's *Preparing Professionals for Partnership with the Public* – a training programme for all workers in primary care in the practice of working in partnership with patients – was piloted in Hillingdon. Three practices in Hayes and Harlington took part, two of which are hoping to achieve patient-friendly practice accreditation. This programme has not been explored in this study.

Outcomes achieved

- A high profile for lay voices within the organisation.
- Professional acceptance of the value of non-professional views in decision-making.
- Some policy developments which have been significantly shaped by lay views.
- An informed and committed group of local patients who are able to engage with the directorate's agenda.
- Better local knowledge of local health services within community groups.

Analysis

Structure

The structure of the analysis reflects the structure of the main output of the study – a practitioners' guide to PPI in primary care. Although this structure suits some of the case studies better than others, it has been consistently used for all of them in order to enable comparison. It aims to be an accessible framework which covers all the key issues which people involved in PPI work are likely to be concerned about – as well as providing plenty of hooks on which the research themes from the study can be hung.

The gist of the structure of the guide is this:

Why bother?
The case for PPI always has to be made. If people pursue PPI only because it has to be done, not because they see any value in it, little is achieved and lots of people get annoyed. This chapter will encourage a critical attitude to all PPI work.

What counts as public involvement?
PPI means different things to different people. This chapter will map out the scope of what PPI can encompass, stressing the value of a broad and plural vision.

What do you want to achieve?
This chapter will look specifically at the aims which people identify for PPI, and the outcomes which actually emerge in practice. It will stress the importance of being open to unexpected outcomes and to changing your ideas of what success might mean as methods get put into practice.

Working out an approach
This chapter explores the many choices which people make, explicitly or implicitly, in developing PPI work, and the constraints upon these choices.

Making a difference
The question of making an impact (mechanisms of change) gets a chapter to itself, principally because it is so widely neglected.

Getting the details right
The detail of doing PPI is widely discussed in existing 'toolboxes'. This chapter will not repeat these, but draw attention to the detail of what has helped and hindered initiatives in the study.

Dangers and obstacles
This will be a critical discussion of how all the above can go wrong or be obstructed. The emphasis of the chapter will be on seizing the opportunities of PPI and not being put off by the range of common but narrowly conceived criticisms.

Doing it better
The final chapter will explore how people can learn from their experience of PPI, stressing the value of all types of evaluation and learning, however informal.

Why bother?

The PCG began life with a positive interest in PPI, rooted in the long-standing constructive relationship between the local NHS and the CHC and the commitment of key senior officers and the chair. This commitment may not have been universally shared by all members, but it has since prospered, not least because of the unusual presence of two lay members alongside the CHC officer and health authority non-executive director (subsequently replaced by a PCT non-executive director).

Although the directorate has not been hugely innovative, it has made the most of its immediate opportunities for PPI, i.e. the constitutional arrangements (the lay members) and the CHC's enthusiasm and support (the public panel). Hillingdon's decision to keep the two PCG lay members on each of the locality directorates of the PCT is the most striking example of its willingness to maximise the value of institutional arrangements for PPI, even if this means doing things somewhat differently from NHSE expectations.

Respect for lay voices has therefore become established as an organisational value. However, acceptance of this value has not lead to an uncritical acceptance of all PPI methods. The specific initiatives which have been pursued beyond the institutional arrangements – particularly the public panel and outreach work – are not set in stone and have been called into question by the lay members and others. There is concern that the directorate may not be achieving as much as it could be through these methods and that there might be more effective alternatives.

What counts as public involvement?

As the lay members and CHC have played such a central role in leading and doing PPI, their roles tend to define the Directorate's understanding of PPI activity. What the lay members and CHC do, including the initiatives they run, *is* the Directorate's PPI. A strategy for PPI, written by the lay members in 2000, was largely an account of this activity. The two PPGs run largely independently of the PCG, though links are sustained through the public panel and lay member visits.

The creation of the PCT in April 2000 demanded that the difference between the PCT non-executive directors and the locality directorate lay members be defined (see page 15). PPI was a key focus: although lay members and NEDs were all lay people, PPI was to remain the responsibility of the former, leaving the NEDs free to pursue their more detached role as 'critical friends' to the organisation. This means that PPI is now even more strongly associated with the lay member role across Hillingdon.

As the lay members are themselves a key mechanism for PPI but also lead and undertake PPI initiatives, the directorate's understanding of PPI encompasses both institutional roles and specific activities for engaging patients and local people. However, the strong focus on the activity of a few individuals leaves little sense that members and officers of the Directorate might be engaging (or be able to engage) in PPI in broader ways, independently of the lay members and CHC. Corporate commitment to PPI is not reflected in a truly corporate approach.

What do you want to achieve?

The directorate has never formally set out any aims for its PPI work and no-one has very strong views about what the aims should be. The 2000 strategy focussed on current activity rather than aims and objectives. Not unusually, there has never been an obvious moment for the various stakeholders to sit down and decide 'what they are aiming to achieve', as there have always been currents of existing practice to sustain and develop. However, the public panels were initiated prior to the creation of the PCGs as an explicit attempt by the CHC to enhance the local accountability of the new organisation.

The continuing priority given to the role of the lay members and the standing public panel reflects a general consensus that PPI should inform the directorate's decision-making. As the PCG began life with a commitment to both of these mechanisms, this particular consensus is partly a product of the acceptance of these methods (rather than methods following the consensus). However, the adoption of a further method, the outreach meetings to local community groups, was in part an explicit attempt to widen the range of voices that were involved in the process of decision-making.

The approach to PPI which has emerged over the past three years is the product of government policy (constitution of PCG boards), the history of local partnerships (in particular the good relationship between the NHS and the CHC), local grass roots initiatives (the PPGs) and the many contributions and ideas of the individuals involved, who have come and gone at different times. It is therefore unsurprising (and not necessarily problematic) that the articulation of aims for PPI is more a reflection on the possibilities of current practice than a strategic starting point for defining future practice.

The range of PPI activity undertaken by the Directorate has many potential outcomes, all of which are, at different times, articulated by the various stakeholders involved. Beyond influencing the directorate's decision-making and improving its accountability, the following aims have all been voiced:

- educating and informing local people about services and their rights
- supporting local people to gain the understanding and confidence to participate in NHS decision-making
- informing local people about the directorate's decisions and winning them over to the directorate's position
- educating local people about their own health and capacity for self-care

As the focus of the stakeholders is principally on current practice, aims have also been articulated in terms of improving practice, such as:

- involving a wider cross-section of the local population in the Directorate's work
- establishing more PPGs
- improving the representation of local practices on the public panel
- increasing lay involvement on board subgroups

There are many differences in how the different local stakeholders prioritise aims for the PPI work they are engaged in. However, because there is a historical acceptance of the core mechanisms – the lay members and the relationship with the CHC – and the methods which they support, these differences in priorities are usually (though not always) complementary and have not caused major problems. For example:

- The chief executive is principally concerned to have standing processes of involvement whereby lay voices can be heard within the organisation. He does not share, with the same enthusiasm, the interest of the lay members in communicating more generally with the local population. Hence the newsletter has remained a low priority – to the frustration but ultimate acceptance of the lay members.
- The key CHC officer would like to see wider engagement with the diversity of the local population. Nonetheless, she has herself struggled to gain and sustain a diverse membership on the CHC-run public panel, so is well aware of, and acknowledges, the problems.
- The Chair, a GP, is particularly committed to promoting health education and self-care among the local population and would like to see more PPGs running to achieve this. However, his own attempts, supported by the CHC, to establish a PPG ended in failure, so he is sanguine about the effectiveness of investment in this area.

Working out an approach

The particular methods which the directorate has focussed on over the past two years largely reflect the exploitation of choices made prior to the creation of the PCG. The lay member role was a choice made in Whitehall; the decision to have two lay members was made in Hillingdon; and the public panel was an idea proposed by the CHC at the time of the formulation of PCGs.

With this inheritance, the PCG had a clear direction set from the start – and so did not have to make too many further choices. The PCG/directorate has effectively chosen to make the best they can of this inheritance, rather than trying to take a radically new direction.

However, the initiation of the community meetings was a clear attempt to achieve a wider involvement in the local population. This reflected the anxiety of lay members about the limitations of their individual lay voices, as well as concern about the extent to which the public panel could ever be considered representative. However, because the directorate is focussed on methods which work to its own agenda, it has proved difficult for it to gain much from a new method which ostensibly works to a community-defined agenda. In fact, the outreach work is as concerned to win people over to the logic of the directorate's decisions as it is to inform those decisions with public views.

The directorate has not made any strong choices about who it wants to involve. There is a general desire to involve a cross-section of the population, but the Asian Day was the only example of active targeting.

There is doubt among all the stakeholders about whether this existing profile of methods is appropriate. However it is proving difficult for them to articulate alternative choices, partly because of the looming national changes in PPI policy detailed in the NHS Plan, partly because of a lack of knowledge about what these might be – and of confidence in judging their relative merits.

Making a difference

1.Impact on the organisation

If the emphasis of the Directorate's PPI work on institutional lay voices is to succeed, these voices must not only be heard but acted upon – they must be the mechanisms of change within the organisation. Inevitably, their success is partial.

The key issue is where and how these voices should contribute. There are four lay people on the board: two lay members, a CHC officer and a seconded NED. This is a remarkably high representation of lay people, given that PCT executive committees have no constitutional place for any. Nonetheless, debate at board level is dominated by the professionals present, with the lay voices only occasionally being heard. The CHC officer is the most vocal, not least because she has the strongest identity as an outsider and so is most free to bring criticism to bear.

However, although the board is formally the place where decisions are made and considerable debate takes place there, it is not the place where policy is formulated. This happens within subgroups and through the informal relations between officers (who write the documents), members and professionals. The lay members feel that their contribution at this level, particularly on the subgroups, typically has a much greater impact than anything that is said at board level.

Thus, the formal lay member role has an impact inversely related to the formality of the forum of engagement – influential on subgroups and in one-to-one conversations, more of a check at board level and, for the NEDs at PCT board level, largely concerned with performance review rather than actually shaping policy.

However, if officers and members are to be influenced by broader patient or community voices, they cannot rely solely on the lay members to act as conduits. This is simply unrealistic. For example, although an officer is likely to be influenced by direct engagement with the public panel, they are unlikely to be moved very much by the minutes from these meetings, however well written. Nonetheless, there is potential for the lay members to take on a stronger advocacy role in relation to the concerns which are voiced by patients and local people at the public panel or the community meetings.

The engagement of lay voices at each level of organisational decision-making ensures that user and public viewpoints do not get marginalised and prevents the professionals from 'missing the obvious' in their provider-side discussions. However, providing a balance to professional opinion is only half the story – significant impact only occurs when there are opportunities for the user/public perspective to really shift the direction of policy. This is easier to achieve in the development of a model of care (for example) than in annual budgeting decisions. Currently, these opportunities can be missed because there is no systematic process for thinking through how each area of the directorate's work could be enhanced by the user/public perspective.

2. Impact on patients, carers and local people

The patients and local people who participate in PPI initiatives usually gain something from the experience: knowledge of the local health service; understanding of personal health issues; and confidence in dealing with the health service, resolving problems and speaking in public.

These outcomes are certainly achieved through the public panel, where a group of local patients repeatedly return to discuss local health issues despite little evidence that what they say has much impact on local health policy. They value a forum where they can learn about what is going on locally and engage on a level with health professionals. What they learn from these meetings may be useful for them elsewhere – in PPGs and residents' associations, or simply in their own relationships with health professionals.

As the community meetings are individually one-offs, there is less scope for any form of personal empowerment – the outcomes are mainly improvements in knowledge of local services and service providers. Nonetheless, by supporting community organisations and encouraging their interest in health policy, the directorate is contributing to a longer term process of community engagement with health decision-making.

Getting the details right

Board meetings.

Any public attendance at these meetings is rare. The meetings are not actively promoted in the local community and they are run as business meetings with little concern for how the content comes across to anyone else. Papers are made available on the day, but there are no summaries or user-friendly guides to the matters under discussion.

After each item, when all the members have had their say, the chair invites (when he does not forget) the members of the public in attendance to contribute. There is rarely a response and when there is it is normally from one of the directorate officers.

The lay members, CHC officer and NED all contribute to varying degrees, but the meeting is dominated by debate between the GPs and CEO.

Public panel.

The group of patients who are members of the panel include members of one of the PPGs in the area and members of a local residents association. Depending on who is there, they can be quite lively and tend to regularly go off at tangents as people raise issues which are current for them. There is much personal story-telling in the ebb and flow of debate.

The meetings tend not to be tightly chaired. This makes it possible for everyone to have their say about all the things which concern them, but it also means that clear collective decisions about questions for the directorate are rare. Debates can also get bogged down in technical discussions rather than focussing on what participants want from services (most obviously in the discussions about the 'community hospital').

Both of the lay members usually attend. However they do not present themselves as the mouthpiece of the directorate, not least because their limited involvement in the directorate means that they are unable to address the full range of issues and questions which come up. Often it is other members of the group who provide answers to questions which are raised, or questions are left unanswered, impeding progress in the discussion.

Attendance by the Chair or CEO entirely changes the dynamic of the group as they can offer detailed insight into what is going on in the local health economy. Their presence gives much stronger direction to the meetings.

The agenda is usually dominated by PCT business. However, the complexity and length of the papers presented, and the constant triggering of tangential issues, makes it very difficult for the lay members to take away very clear messages to inform the development of these papers. This is exacerbated by the lack of any systematic review of the discussions at earlier meetings. Although there have been calls from members to have more feedback from the PCT, this can only be achieved if the members are clear about what they want feedback on, which in turn requires the articulation of stronger messages for the organisation to address.

Dangers and obstacles

The lay member role has inbuilt difficulties – above all the difficulty of being both an insider and an outsider, part of the organisation and a challenge to the organisation (see page 15). However, both lay members accept their responsibilities as members, engage constructively with the board's business and acknowledge the limitations of the directorate's resources. For them, the danger lies in becoming so familiar with the directorate's values and agenda that their interactions with patients and local people are characterised more by a desire to win people over to the directorate's position than a willingness to accept (and communicate to the board) other positions.

A key obstacle inhibiting the impact of lay voices is the dominance of professional and managerial priorities within the directorate. There is simply too much to do in developing professional practice and delivering government policy to leave much space for consideration of patient and public perspectives. By focussing on the lay member and CHC roles, the directorate is able to keep lay voices alive in dealing with these priorities, but this means that there is little opportunity to reflect on the interests of local people on their own terms.

The impact of lay voices tends to be inversely related to the formality of the context in which they are heard. Yet the lay members still rely on the formal process working 'properly'. In particular, written reports to the board from the public panel and community meetings are assumed to have an impact, when in practice the members are overwhelmed by documents and unlikely to pay much attention to these. Members and officers are much more likely to respond when the lay members actively lobby them about points which have been raised through their PPI activity.

The focus on the lay members and the relatively small membership of the public panel lead to questions being raised, by all stakeholders, about the representativeness of the lay voices who are engaged in the directorate's work. This has been partially addressed through the community meetings, but anxiety remains. Although this is a reasonable concern, it can lead to the existing processes (and the people who participate in them) being undervalued.

Some stakeholders have expressed concern about the problem of public apathy and the difficulties of involving patients in any PPI initiatives. The poverty and low educational attainment in the area is seen as one of the reasons for these difficulties. However, the dominance of the directorate's own agenda in its PPI work exacerbates the problem – public disinterest in professional and managerial issues is not surprising. If more people are to participate, more effort may be needed to identify with the interests of potential participants.

Special focus

Lay members and non-executive directors

Hillingdon's decision to retain its PCG lay members on the new locality executive committees when the PCT was established inevitably meant that some kind of distinction had to be made between the established lay member role and the new NED role on the PCT board.

Although the lay members had some differences of opinion about their own role, they all had a history of engaging as individual lay people (patients, carers, local people) and of seeking the views of others through various forms of PPI work such as the CHC's public panels. The NEDs may have been new, but they had a much stronger policy steer to shape their role, focussed on their governance responsibilities as accountable officers.

The distinction between NEDs and lay members was therefore defined in terms of their relative interests in PPI and governance: the NEDs would focus on the probity of the new organisation's business; the lay members would continue to lead local involvement work. Inevitably, this distinction disguises a much more complex reality – in practice, there is a lot of overlap between the roles and interests of these two formal lay voices.

Insider or outsider?

Are NEDs insiders looking out and lay members outsiders looking in? In practice, institutional lay voices perform both of these functions: they are a bridge between the inside and the outside.

As accountable officers, NEDs are unavoidably insiders. There has always been a tension for NEDs on NHS trusts between their membership and the expectation that they will bring independent, community voices to bear on decision-making. For this reason, most NEDs shy away from describing themselves as community representatives. Nonetheless, the tension remains, evident in the expression 'critical friend': someone who is close to the organisation's interests but who brings a perspective to bear which is rooted elsewhere. For NEDs, this 'elsewhere' is their own experience as local people, patients and carers.

The tension between insider and outsider is just as real for lay members, though is resolved differently. Lay members are also members of boards with responsibility for overseeing and informing the activities of the executive. Their credibility is also based on a perspective which is first and foremost rooted in their own experience as users and citizens. However, they have more scope to be outsiders than the NEDs. Rather than always trying to balance all the interests of the organisation, they can much more explicitly press home a user view on the board's discussions. Their responsibility for and participation in local PPI work strengthens their credibility in pursuing this approach. They can seek to be 'community representatives' without this feeling like this is a contradiction with their roles as members.

There are differences in where individual NEDs and lay members choose to stand on this bridge between inside and outside. One of the lay members in Hayes and Harlington prioritises her own contribution to the work of the executive, the other is more concerned with outreach to a wider community audience. The NED seconded to the Hayes and Harlington locality board has a long history of working with the local Asian community and is more concerned than many of the other NEDs to bring a community voice to the PCT.

The priority given to organisational and user/community interests also varies with the task in hand. An NED sitting on a complaints board will be more focussed on patient advocacy than when she/he considers the PCT's latest performance management report. Similarly, a lay member participating in a discussion about GP recruitment will be more focussed on the organisation's interests (rather than community interests) than in a discussion of the quality of clinical practice. Hence lay members and NEDS like are always balancing community and organisational interests.

Public engagement or public awareness?

The lay member/NED distinction between doing and not doing PPI, also articulated as public engagement vs public awareness, is more of a reflection of the choice in Hillingdon to give lay members responsibility for PPI than of a formal difference between the two roles. After all, the lay member role does not necessarily involve leading PPI work, and much of what the organisation gains from the lay members comes from their personal contributions as non-professional local people rather than their broader community engagement.

The focus on responsibility for PPI work in the distinction between the two roles need not be problematic. However, there are risks. First, this distinction could imply that NEDs ought to focus squarely on their insider role and not worry too much about attending to patient and community interests. Secondly, it could undervalue the contribution that each lay member makes as an individual, not least as a 'check and balance' on professional empire-building (what would locality board meetings be like without them?). Thirdly, it could make it difficult in the future for localities to take a more corporate approach to PPI, simply because of the increasingly established association of lay members with PPI work.

Standing apart or getting involved?

Non-executives are supposed to maintain a 'critical detachment' from the business of the organisation. But in order to do their jobs well, they cannot keep completely removed from the work of the executive. NHS trust non-executives have always been involved, to a greater or lesser extent, in the work of the executive.

The emphasis for the lay member is the other way round. The lay members in Hillingdon have always played a part in executive business, including doing considerable amounts of it in the delivery of PPI work. However, as non-professional voices on professional boards, they have also necessarily stood apart from professional practice.

Once again, the distinction between NEDs and lay members is more a matter of degree in than a categorical difference. Nonetheless, the closer involvement of lay members in the early stages of policy development (on the executive boards and on subgroups) means that they have a much more direct impact on policy than the NEDs (see page 00). The influence of the NEDs is less obvious – performance management is low impact as long as the organisation performs well.