

# Community participation in primary care in Ireland: the need for implementation research

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There are now several decades of history of community participation in health, with significant international evidence to suggest that there is much to be gained by primary health services and disadvantaged communities working in partnership.

In this paper we provide an overview of community participation in primary care, establishing the policy context in which a recent '*Joint Initiative on Community Participation in Primary Health Care*' was developed in Ireland. This Initiative was designed to support the involvement of disadvantaged communities and groups in the development of primary health care services at local level.

An independent formative evaluation of the Joint Initiative took place between September 2009 and April 2010. We present a summary of key findings from this evaluation. We pay particular attention to the issue of sustaining community participation in newly developed Primary Care Teams (PCTs) in the current and changing economic climate, an issue considered crucial if the documented positive impacts of the Joint Initiative are to be maintained and the potential for health gains in the longer term are to be realised.

We then argue that the Joint Initiative referred to in this paper clearly provides a strong prototype for community participation in PCTs in Ireland. We also ask whether it can be replicated across all PCTs in the country and embedded as a core part of thinking and everyday health care. We highlight the need for research to build knowledge about the ways in which innovations such as this can be *embedded* into ongoing, routine healthcare practice. This research agenda will have relevance for policy makers, practitioners and evaluators in Ireland and other healthcare jurisdictions.

**Key words:** community; implementation research; participation; policy; primary health care

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## Community participation in primary care

*'Primary care brings promotion and prevention, cure and care together in a safe, effective and socially productive way between the population and health system'* (WHO, 2008: 41). It aims to

provide first-level contact that is accessible by self-referral and has a strong emphasis on working with communities and individuals to improve their health and social well-being (Department of Health and Children, 2001a). The attributes or functions of primary care have been summarised in the definition of the American Institute of Medicine referring to '*the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained*

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partnership with patients and practicing in the context of family and community' (Donaldson *et al.*, 1996: 1).

In 1978, the Alma Ata Declaration emphasised the significance of community participation in the planning and delivery of primary health care, declaring that 'health for all' was achievable through primary health care by 2000 (WHO, 1975, 1978). However, Draper *et al.* (2010) draw our attention to the fact that many people are still coming to terms with the words and principles that followed this Declaration, and while there have been many attempts to define community participation, 'a standard definition remains both elusive and contentious' (2010: 1103). We note that there are many concepts related to community participation in the literature, such as community involvement (Kahassay and Oakley, 1999), community development, community empowerment (Laverack and Wallerstein, 2001), community capacity and community competence (Goodman *et al.*, 1998). For the purpose of this paper, however, we employ the following working definition of community participation: 'a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change' (WHO, 2002: 10).

There is evidence which indicates that building high levels of trust and group participation is critical to reducing mortality (Kawachi and Kennedy, 1997), while a lack of participation, control or self-esteem, along with poor social support structures, directly contributes to increased morbidity (Berkman, 1995). International literature also shows community participation to have a powerful impact on the outcomes of family and the intergenerational cycles, which have a cumulative effect of disadvantage across the life course on the social patterning of disease (Marmot, 2010). However, there are few rigorous studies that have definitively measured the effects of community participation in terms of health outcomes, well-being and quality of life (Crawford *et al.*, 2002; Frankish *et al.*, 2002; Kearns and Neuwelt, 2009; Preston *et al.*, 2010).

There is, however, stronger evidence of community participation impacting positively on service

improvement (Crawford *et al.*, 2002; Kearns and Neuwelt, 2009; Preston *et al.*, 2010), and a collective understanding that the involvement of communities in primary health care results in more equitable and inclusive services, which are more responsive to the needs of the community (WHO, 1978, 2002, 2008; Crowley, 2005; Draper *et al.*, 2010; Houlihan, 2010). This is in line with contemporary social research ethics, which recognise the importance of active community participation in research processes (Alexander, 2010). Furthermore, it reflects a shift away from 'service-led systems, where people are fitted into the pattern of provision that has developed historically, to user-led or user-centred services' (Beresford, 2010: 438). Indeed, community participation is a central ideal found in almost all the contemporary major national and international declarations on health.

In this paper we provide an overview of community participation in primary care, and the policy context in which a recent national initiative was developed in Ireland that resourced 19 projects to support and enable disadvantaged communities and groups to participate in local Primary Care Teams (PCTs) and Networks within the Health Service Executive (HSE). Each PCT in Ireland is designed to deliver health and personal social services to a local population of ~7000–10000, and is the first point of contact for patients and clients in a local setting, ensuring continuation and co-ordination of services. A small number of PCTs are also connected to a Health and Social Care Network providing services for a population of 30000–50000 (Health Service Executive, 2011a).

We draw on findings from the formative evaluation of the *Joint Initiative on Community Participation in Primary Health Care* (hereafter referred to as the Joint Initiative; Pillinger, 2010), while paying particular attention to the issue of sustaining community participation in these PCTs in the current and changing economic climate; an issue considered crucial if the documented impacts of this initiative are to be maintained and the potential for longer term health gains realised. Finally, we reflect on new areas for research, setting out important implementation research questions pertaining to the integration and embedding of community participation in primary health care as a core part of thinking and everyday healthcare practice, which will have relevance for Ireland and other healthcare jurisdictions.

## Irish health policies for primary care and community participation

The importance of primary care was recognised by the Irish government in its primary care strategy *Primary Care: A New Direction* (Department of Health and Children, 2001a). The strategy acknowledged that Ireland's primary care infrastructure was poorly developed and services were fragmented, with a focus on treatment at the expense of a more balanced emphasis on prevention, health promotion and well-being. This strategy set out for the first time in Irish policy, a plan for primary care as the central focus for the delivery of health and personal social services, with a commitment to the establishment of 500 PCTs around the country by 2011. This has been reiterated in recent years in a number of key policy documents, including the *National Development Plan 2007–2013* (NDP, 2007), the social partnership agreement *Towards 2016* (Department of the Taoiseach, 2006) and the *National Action Plan for Social Inclusion 2007–2016* (Government of Ireland, 2007).

A PCT is considered to be established where there are regular clinical team meetings between the HSE and general practice (GP) staff. In an environment of privately owned general practice, however, it is not always easy to establish such team meetings. A recent update on the HSE's website indicates that there were 383 PCTs (76.6%) holding clinical team meetings at the end of June 2011. However, these figures have been contested by primary care providers and the newly appointed Minister for Health and Children. The Minister has further questioned the operational effectiveness of the Teams, and the lack of sufficiently developed indicators to enable their assessment (Donnellan, 2011; Mudiwa, 2011); hence additional criteria are now being considered.

As outlined earlier, Irish health policy also recognises that communities should be centrally involved in shaping health services, including primary care services. Action 19 of the 2001 primary care strategy states that: '*Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services...at local level, primary care teams will be encouraged to ensure user participation in service planning and delivery.... A greater input*

*from the community and voluntary sector will enhance the advocacy of primary care teams in ensuring that local and national social environmental health issues, which influence health are identified and addressed'* (Department of Health and Children, 2001a: 39).

This recommendation was further reflected by the more recent publication of the *National Strategy for Service User Involvement in the Irish Health Service* (Department of Health and Children and Health Service Executive, 2008). Compiled by the HSE Office of Consumer Affairs,<sup>1</sup> in partnership with the Department of Health and Children (DoHC) and other key stakeholders (ie, union representatives, service users, statutory and voluntary organisations), the strategy was produced in the context of several key DoHC and HSE policy and strategy documents which had previously demonstrated a commitment to service user involvement and the need to engage with communities in addressing their health needs (Department of Health and Children, 2001b, 2001c, 2006).

This strategy for service user involvement presents a strategic framework containing a range of goals ([www.hse.ie/eng/services/ysys/Documentation/](http://www.hse.ie/eng/services/ysys/Documentation/)), but for the purposes of this paper we focus on Goal 5, which refers to the '*participation of socially excluded groups and those whose voices are seldom heard*' in primary care (Department of Health and Children and Health Service Executive, 2008, Goal 5, Action 5.1: 16). It was in this context, and building on the work of the *Building Healthy Communities Programme*<sup>2</sup> (Houlihan, 2010), that in 2008 the Social Inclusion Division of the Department of Community, Equality and Gaeltacht Affairs (DCEGA)<sup>3</sup> and the HSE National Advocacy Unit jointly developed the Joint Initiative.

The Joint Initiative was designed with three key purposes in mind. First and foremost, it was

<sup>1</sup> Renamed the National Advocacy Unit in 2010.

<sup>2</sup> The Building Healthy Communities programme was designed to support disadvantaged communities in Ireland in tackling poverty and health inequalities through strategies and innovative projects and programmes that were embedded in community development principles and practice.

<sup>3</sup> The project was initiated by the former Combat Poverty Agency, which in 2010 integrated with the Office for Social Inclusion to form the Social Inclusion Division, now part of the Department of Social Protection.

designed to help support disadvantaged communities and local health service interests to work together and plan for the participation of excluded communities and groups in local primary healthcare services and in the implementation of the primary care strategy. Community participation in project development, decision making and project delivery is frequently highlighted in the literature as crucial for collaborations that aim to make an impact in local communities (Pickin *et al.*, 2002; WHO, 2002). Second, at a national level, recognising that a 'one size fits all' approach was not practical given the diverse and unique nature of each and every community and PCT (Krishna *et al.*, 1997), it was envisioned that the Joint Initiative would result in a variety of demonstration projects and key learning that could subsequently be adopted by other PCTs across the HSE. Third, this Joint Initiative demonstrated a real attempt by the HSE to implement the 2001 policy *Primary Care: A New Direction* (Department of Health and Children, 2001a) by working in partnership with external stakeholders and across relevant departments, and by providing resources and an infrastructure for its development in a range of settings.

### Joint Initiative on Community Participation in Primary Health Care

In May 2008, the Joint Initiative funded and supported 19 demonstration projects, 17 of which were based in local (urban and rural) disadvantaged areas. The two remaining projects focused on specific target groups: travellers<sup>4</sup> and minority ethnic communities (see Figures 1 and 2). Community partners included Community Development Projects (CDP), Community and Voluntary Forums, Local Development Companies, a Family Resource Centre (FRC) and a Local Regeneration Agency.

In many cases, the projects took a multi-sectoral approach by involving a wider network of statutory and non-statutory organisations and agencies that are tasked with tackling social exclusion and local regeneration. This Joint Initiative added to

the many qualitative case study examples of actions by health systems in Europe to address poverty and social exclusion (WHO, 2010).

Key areas of activity supported under the Joint Initiative included:

- Developing and supporting community representative infrastructure to feed into PCTs/ Networks.
- Developing joint plans between the HSE and community groups to support community participation in PCTs/Networks using participatory methodologies.
- Training and support for PCTs on community participation.

Once-off funding of between €10 000 and €15 000 was made available to each project based on their proposed work package. In addition to funding, and based on best practice (Beresford and Branfield, 2006), the 19 demonstration projects also benefitted from the following support and resources:

- Four national networking events took place, which brought together both community and HSE project partners to share and exchange project developments and link projects to national developments.
- Technical support and regional training was provided,<sup>5</sup> to increase the capacity of community and HSE representatives in areas such as participatory methodologies, establishing representative structures and the provision of support and facilitation to individual projects.
- An online forum was established through HSEland (www.hseland.ie), which enabled all projects to share resources and learning and to network online. Monthly *Community Participation Information Bulletins* were also widely disseminated across the HSE and to community projects, and can be accessed on [www.hse.ie/eng/services/ysys/SUI/Library/participation/](http://www.hse.ie/eng/services/ysys/SUI/Library/participation/)
- A National Working Group was established to oversee the Initiative, with representation from the Social Inclusion Division (DCEGA), the HSE, (including representatives from the National Advocacy Unit, primary care,

<sup>4</sup> Travellers are an indigenous minority, documented as being part of Irish society for centuries. Travellers have a long shared history and value system, which make them a distinct group. They have their own language, customs and traditions. [http://www.pavepoint.ie/pav\\_culture\\_a.html](http://www.pavepoint.ie/pav_culture_a.html)

<sup>5</sup> Provided by Community Action Network (CAN), an independent agency that works with disadvantaged communities using a human-rights-based approach.

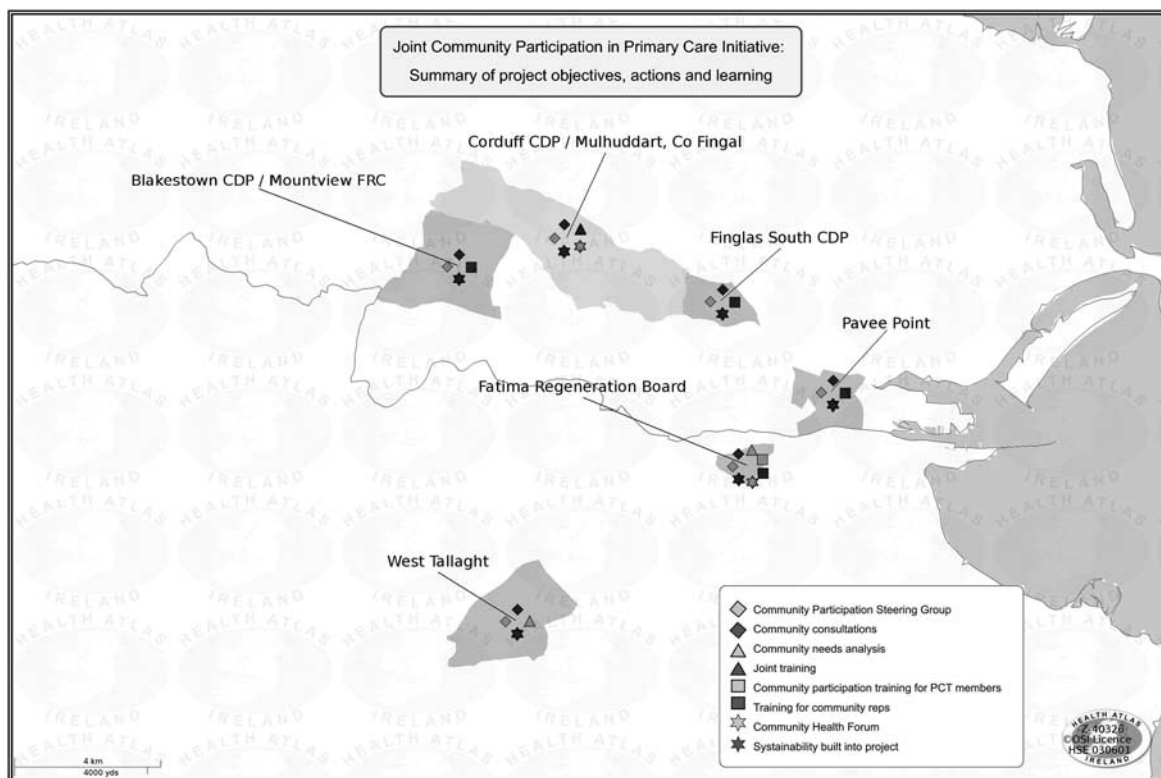


**Figure 1** Joint Initiative on Community Participation in Primary Health Care: Summary of project objectives, actions and learning across the 19 demonstration sites.

population health and social inclusion), the DoHC, the Royal College of Surgeons (RCSI), the Irish College of General Practitioners

(ICGP), the Institute of Public Health (IPH) and representatives from community organisations.

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**Figure 2** Joint Initiative on Community Participation in Primary Health Care: Summary of project objectives, actions and learning across the 6 demonstration sites based in the Dublin region of Ireland.

## Evaluation

In early autumn 2009, the HSE and the former Combat Poverty Agency funded an independent formative evaluation of the Joint Initiative (see Pillinger, 2010). The aim of the formative evaluation was to develop and progress community participation in primary care by focusing on:

- The building of community infrastructure in the Initiative.
- The project work plans, delivery and project outcomes.
- The development of participatory methods and strategies.
- The learning from the 19 projects across the Initiative.
- The potential for the mainstreaming of learning for policy and service delivery.

The evaluation used a variety of qualitative methods and tools, which are outlined in full elsewhere (Pillinger, 2010). The methodology sought to provide for ongoing assessment and reflection, methods for building learning into the process, and the provision of regular feedback to all stakeholders. The evaluation process included the development of a set of principles and benchmarks for good practice, against which the project's objectives, actions, outcomes and processes were monitored (Pillinger, 2010). Given its timeframe and design, the evaluation could not develop any baseline morbidity or mortality data or track changes in health outcomes over time. Therefore, reports on the health impact of the Joint Initiative are limited. This is consistent with Preston *et al.* (2010), who report that health improvements are not gained and demonstrated without an extended timeframe, adequate and sustained resources and strong relationships.

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For the purpose of this paper we draw briefly on the findings from the evaluation report in terms of project activities across the Joint Initiative, the value, learning and outcomes of community participation as perceived by community and HSE stakeholders, and its subsequent impact at HSE level.

### **Project activities across the Joint Initiative**

Through the formative evaluation process Pillinger (2010) documented a wide variety of activities across the 19 projects. The level of activity varied depending on the stage of PCT development within each site. Some of the demonstration projects, for example, were located within well established PCTs while others were working within PCTs that were not fully operating. While these activities have been reported in detail previously (Pillinger, 2010), the most common activities that took place within the projects are summarised in Figure 3.

The activities outlined above are reflective of those in the Health Action Zone Initiative in the United Kingdom (Bauld *et al.*, 2005), particularly in terms of a renewed focus on the broader determinants of health and the development of partnerships with local agencies to ensure that PCT services link into agencies that can impact on health outcomes. The activities, albeit in various combinations, are also evident across projects presented in a recent review of empirical studies in the literature linking community participation and health outcomes (Preston *et al.*, 2010).

### **The value, learning and outcomes of community participation**

The evaluation captured the ‘*perceptions of community, HSE and PCT representatives about the impacts and outcomes of community participation projects, providing some valuable qualitative evidence*’ (Pillinger, 2010: 51). Pillinger reported on the community’s perspectives on working in partnership with the PCTs and vice versa, which revealed something about the ‘on the ground’ policy environment in terms of how the Initiative worked in practice and what the differing perspectives were in relation to each others’ roles (see Figure 4). The data demonstrated an appreciation

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of the value of working in partnership and the sharing of knowledge and experiences.

Pillinger (2010) also reported that there was valuable learning across the projects with regard to the community participation process, including the importance of creating realisable goals and expectations, while building mutual learning and respect. Overall, the evaluation demonstrated that participation is a process that takes time and requires resources, and that different starting points require different methods of community participation. ‘*Participation cannot be assumed but has to be systematically encouraged, and means have to be created to make it effective*’ (Oakley *et al.*, 1999: 117). However, in giving the process sufficient time and resources, initiatives like this can help to break down barriers, promote dialogue between the community and health service providers and subsequently identify and meet local community needs (WHO, 2002, 2008; Houlihan, 2010; Pillinger, 2010).

### **Impact of the Joint Initiative on primary care at HSE level**

The evaluation also demonstrated the impact of the Joint Initiative in relation to primary care, including:

- Community representation on the PCT and Local Implementation Group (LIG). In one project, for example, ‘*The representation on the LIG group has proved very important. Because the LIG group plays a strategic role, it has provided an open door for the community to feed into the process at a strategic level*’ (2010: 140). In another, ‘*Community representatives have played a very active role on the PCTs. This has been based on a huge amount of time and effort to gain respect, trust and support from HSE and PCT members. For example, the Lifford-Castlefinn PCT is chaired by the Community Coordinator from the Lifford-Castlefinn Resource Centre and the community plays a very active role in leading community based developments*’ (2010: 130).
- PCT development was ‘*affected by the critical role of GPs in the process. In some projects there has been active participation of GPs who are supportive of community participation and have seen the benefits of it in practice, for example, in Lifford-Castlefinn. However, in some PCTs GPs*

1. Establishment of a Joint Community Participation Steering Group, which in some cases was made up of a wide network of local agencies. The Steering Groups managed and developed the strategic goals of the projects locally.
2. Community consultations and mapping of community and PCT resources in the project area through public meetings, workshops or focus groups. These consultations often tapped into local knowledge and identified healthcare gaps and needs faced by the most disadvantaged communities.
3. Joint training for community representatives and PCT representatives to develop skills for participatory research and community health needs assessments, or for establishing structures and terms of reference for community representation on PCTs.
4. Training for PCT members to raise awareness of community participation processes and methods and the social determinants of health.
5. Training for community representatives to build the capacity, knowledge and skills of local volunteers, to raise awareness of PCT services and to identify appropriate community participation methods and structures.
6. Community needs analysis.
7. Development of Community Health Forums. The projects presented various different models of how to establish a Forum. In several projects the Forum was established as part of the process of community consultation, while in others nominations were sought from groups in the local community. In most cases criteria were established from the outset in terms of representations from local geographic communities and target groups, with terms of reference setting out the role, scope and purpose of their local Forums.
8. All projects put in place a strategy to sustain community participation in the light of the ending of the funding from the Initiative. This included action plans and facilitated discussions between community and PCT representatives to identify priorities and future actions.

Source: (Pillinger, 2010: X)

**Figure 3** Overview of project activities in the Joint Initiative

*have not been active in PCTs and this has impacted on the frequency of meetings. It is very evident that if the GPs are not active on PCTs the process of community participation has been more limited and less effective' (2010: 60).*

- Understanding of the value of community participation and development of new models
- Joint approaches and working. For example, one project developed a joint action plan with priority

of community participation within the PCT, with a notable shift in the views of many key individuals in the primary care sector about the place of community involvement in the planning of primary health care at a local level.

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For community representatives the value of engaging with PCT members has led to:

- An awareness of the role of health services and their links with community led services.
- Understanding of the scope of PCT activities.
- An appreciation of how the broader social context of health relates to PCTs.
- An opportunity to have a genuine engagement with and potential to influence health service delivery.
- Legitimacy for community participation, which has opened doors for local communities to engage in a sustainable process.

For PCTs the value of engaging in community participation can be summarised as leading to:

- Successful and sometimes creative and inspiring outcomes.
- Mutual learning about and responding to different perspectives and ways of working.
- Possibilities to ‘think outside of the box’ and to recognise and realise the intrinsic value to them of community participation.
- New ways of approaching health and an evidence base for prevention-related work with specific groups in the community.
- An understanding of the broader social context of health.

Adapted from Pillinger, 2010: 56-59.

**Figure 4** The value of engaging from differing perspectives

themes identified on drug awareness for young people, production of a quarterly newsletter, a falls prevention programme, lower back pain clinics, obesity and exercise, joint emergency plan for local communities, engagement with the local GP out-of-hours service and community gardening.

- Improved capacity to identify community health needs and a shared understanding of the wider

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context of health. In one of the projects ‘*an important part of the consultations was to inform groups about primary care services. Sixteen target groups were consulted with through focus groups and interviews, which were facilitated by members of the working group. The consultations captured a broad range of perspectives on the needs of the area, with a specific focus on the determinants*

of health. The consultations highlighted a range of health issues, including the key problem of drug addiction in the area. This has resulted in an addiction counsellor joining the PCT (2010: 134).

- Improved knowledge of PCT and community-led services, with several projects improving the availability of patient information sources within the local community through the development of a Directory of Services and the ongoing delivery of information workshops.
- Economic benefits. One of the projects commissioned a piece of research into *The Economic Impact on Health of the Community and Voluntary Sector in Donegal* (Garratt, 2009), which has been critical to providing evidence of the benefits of community participation to saving resources in health care. According to the report, €26 m/year is being invested by the community and voluntary sector in health-related work in County Donegal, over 60% of which comes from non-public sources.

If the observed positive impacts of the Joint Initiative outlined above are to lead to the health gains that the international literature identifies (Berkman, 1995; Kawachi and Kennedy, 1997; Marmot, 2010), then the issue of sustaining these projects and implementing community participation in primary care across the HSE is imperative. Interestingly, others have stressed that *'participation is not a product or a time-delimited project'* (Morgan 2007: 223), and that participation needs to be *'continuous, sustained and locally grounded'* (Krishna *et al.*, 1997: 5).

### **Reflecting on the sustainability of community participation in PCTs in Ireland**

What is the sustainability of the 19 projects that were established as part of the Joint Initiative specifically? And what is the scope for community participation in PCTs in Ireland in general? In their systematic review of innovation in service organisations, Greenhalgh *et al.* found evidence to be *'very sparse'* with a *'near absence of studies focusing primarily on the sustainability of complex service innovations'* (Greenhalgh *et al.*, 2004: 581). Furthermore, *'the question of sustainability is crucial if the gains ...from organisational innovations are to be maintained, rather than lost to what the NHS*

*Institute has called the "improvement-evaporation" effect'* (Martin *et al.*, 2011: 1).

While funding through the Joint Initiative ceased in May 2010, the evaluation indicated that all projects put in place a strategy to sustain their work plans. This included action plans and facilitated discussions between community and PCT representatives to identify priorities and future actions. However, as highlighted by Morgan, *'Participation can be sustainable only as long as the relevant actors remain committed, and the sociopolitical and economic environments remain conducive, to the process'* (2001: 223).

Although there is no further financial support for the projects involved in the Joint Initiative, dissemination of the learning and benefits that emerged through the Joint Initiative, and utilisation of the networks that developed throughout the process, are ongoing. The HSE National Advocacy Unit, for example, continues to work with the HSE National Primary Care Office to consolidate policy and practical lessons emerging from the Initiative and to link relevant stakeholders (ie, social inclusion, health promotion, community development, performance and development) at a national level to drive the agenda of community participation and primary care forward. This should be a lever to sustainability and should avoid the aforementioned *'improvement-evaporation'* effect (Health Service Executive, 2011a).

A major development is that, working through the HSE's National Advocacy Unit, a key performance indicator (PI) is now written into the National HSE Service Plan to monitor the *'percentage of primary care Local Implementation Groups with at least two community representatives in each Local Health Office'* (Health Service Executive, 2011b: 12).

This PI is collated on a quarterly basis, and within the HSE reporting matrix the PI is further defined and stipulates:

*'The number and percentage of Local Implementation Groups in each LHO, acting on the recommendations of the Community Participation and Primary Care Joint Funding Initiative, who have at least two community representatives in place in each LHO. A Local Implementation Group is a local management structure for primary care teams in each local health office area.'*

*‘Community representatives are individuals, who are “representing”, representative, and/or “consultative” of one or more populations or affinity groups. They can be stakeholders, opinion leaders, organisers and advocates. They serve as a platform and channel for information and voices of community, communicating ideas and concepts between community and health and social services and who hold people and processes accountable’* (Health Service Executive, 2011c: 10).

Notwithstanding the documented challenges involved in working towards representation (Green, 2007) and the different types of representation (Frankish *et al.*, 2002; Green, 2007), nationally this is an important milestone, helping to raise the ‘profile’ of and increase the momentum for the participation of communities in the design, development and delivery of primary health services (Pillinger, 2010). Further discussion to establish how existing and new performance indicators on community participation in primary care can be delivered and built into the performance indicators of health promotion, social work and social inclusion is ongoing. This is particularly important as staff in these areas are well placed to provide strategic and operational support under the key result area on community participation.

Another significant development, at a broader level, is the renewed focus in the *New Programme for Government* (Department of the Taoiseach, 2011) on service users in public service organisations (by giving them a ‘Choice and Voice’), and on patient safety with the establishment of a Patient Safety Authority, incorporating the Health Information and Quality Authority (HIQA). It remains to be seen whether, or how, this high-level policy rhetoric, and indeed the other levers outlined here, will impact on routine practice ‘on the ground’.

Certainly, there are factors that may diminish the capacity of communities and PCTs to continue the activities they have initiated. The current economic crisis in Ireland and cuts to public sector budgets, for example, have seen funding for community development projects cut and consequently two of the 19 projects no longer exist. The *New Programme for Government’s* (Department of the Taoiseach, 2011) proposed restructuring of

the HSE could also impact on the proposed radical reform of primary care, which in turn could impact on the issue of community participation in primary care. In order to effectively engage in the HSE Change Process (Health Service Executive, 2008), which acknowledges that service users and the local community are integral to HSE service, the government, practitioners and the health system must recognise and accept that community participation is a ‘*process requiring a long-term and consistent investment, with health system reform process and restructures managed so that they do not impact negatively on the processes*’ (Preston *et al.*, 2010: 14).

### **Progressing community participation in PCTs in Ireland – implementation research**

Reflecting on the Joint Initiative, we are reminded of Taylor *et al.* (1999) who stated that those who set out to drive programmes of change are confronted with two enormous tasks: ‘*The first is to develop prototypes. The second involves large scale replication. One without the other is insufficient*’ (1999: 322). Clearly, the Joint Initiative referred to in this paper provides a strong prototype for community participation in PCTs but can it be replicated across all PCTs in the country? This is about building knowledge of the ways in which innovations can be *embedded* into ongoing, routine healthcare practice. This is a key issue for further research and practice development, which falls within the field of ‘implementation research’. This is a general term for research that focuses on the question, ‘What is happening?’ in the design, implementation, administration, operation, services, and outcomes of social programmes. It also asks, ‘Is it what is expected or desired?’ and ‘Why is it happening as it is?’ (Werner, 2005).

Eccles *et al.* (2009) have argued that we need to see greater use of theoretical approaches in research focused on implementation, on the basis that this will offer (i) generalisable frameworks that can be applied across different settings and individuals, (ii) opportunity for the incremental accumulation of knowledge and (iii) an explicit framework for analysis. Similarly Nutbeam (2004) outlined the need to invest in research that improves our understanding of how effective interventions should be implemented.

Undoubtedly, given the national and international policy imperatives outlined above, it is apposite to conduct implementation research in Ireland to support the replication of the Joint Initiative prototype across the HSE. An extensive, theoretically informed, empirical analysis of the implementation work that has taken and is taking place to embed the Joint Initiative into routine practice is required. Its findings would inform HSE activities around the specific issue of community participation in PCTs. Moreover, there is scope for such a theoretically informed analysis to generate insights and transferable lessons for the implementation, integration and embedding of service user involvement in other HSE settings and contexts (May *et al.*, 2007; Eccles *et al.*, 2009).

A recently developed social theory, that provides a comprehensive theoretical framework to investigate, assess and support implementation of innovation in routine day-to-day healthcare settings, is Normalisation Process Theory (NPT; May and Finch, 2009; May *et al.*, 2009). It has been applied in several areas of health services research to aid understanding of the implementation of complex interventions including the work processes entailed in implementing treatment regimes into patients' routines, the development and application of decision support tools, and the redesign of primary care mental health services and self-management training packages (May *et al.*, 2011). The authors envisage that as NPT is developed from qualitative empirical studies and is used to generate qualitative data that capture the complexity of innovation, it will help to make the layers of activity and work inherent in the Joint Initiative visible.

The application of a theoretically informed analysis utilising a framework such as NPT is important because, whilst the Joint Initiative is anchored in Ireland, Nutbeam in his editorial on 'Getting evidence into policy and practice to address health inequalities' affirms that this is 'a challenge recognised in countries all over the world' (2004: 137). Hence the issues we have discussed in this paper in relation to engaging with disadvantaged communities, promoting community participation and, most importantly, the sustainability of organisational innovations are relevant to the challenges facing not only Ireland but also other nations, regardless of the structure of the health system itself.

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