Achieving wider participation in strategic health planning: experience from the consultation phase of Liverpool’s ‘City Health Plan’

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SUMMARY

Background: As a member of the World Health Organization’s Healthy Cities Project, Liverpool (UK) has developed an integrated plan to improve health, the City Health Plan (CHP). Based around the key areas of the former national health strategy for England, ‘The Health of the Nation’, a draft CHP was developed by five task groups. Although multi-sectoral, these groups were not able to achieve the desired level of participation from the community, or from those working in health, local government or voluntary sectors. One of the main goals of the consultation was to redress this situation and achieve wider participation.

Objective: To assess how adequately the consultation process carried out in Liverpool contributed to broad-based participation in the development of the city health plan.

Subjects and methods: (i) Semi-structured interviews with 20 key informants and 17 facilitators who held consultation meetings in a variety of settings, and seven minority group contacts; (ii) Self-administered questionnaires to participants who had attended consultation meetings. So far as was possible, the design encouraged participation in defining the goals and content of the evaluation. Main question areas: Views on the importance of participation in planning; evaluation of the consultation against respondents’ criteria for successful participation in the CHP; views on the purpose of the consultation, and on the methods used to publicise the CHP; inform participants about its purpose and content, and obtain their opinions about the plan. Questionnaires to those attending consultation meetings examined how adequately this process permitted participation in contributing to the final version of the plan.

Findings: This was the most ambitious public policy consultation ever undertaken in Liverpool. There was wide agreement that participation was vital. Expectations varied considerably, but for many commitment and optimism co-existed with cynicism about real involvement and achieving change. The consultation was widely appreciated, but some aspects which might improve effectiveness were identified. Most important was having more opportunity for participants to understand and think through the implications of the CHP, and keeping people in contact with the process of revising the plan.

Conclusions: There is a growing expectation for public policy to be multi-sectoral and participative: this study reports experiences of putting this into practice on a large scale. Despite people expressing mixed feelings, there was a lot of support for the methods used. Clear aims about the level of participation sought, adequate resources, time and facilitation, and good two-way communication can be expected to provide for wider and more effective participation. However, given the investment of time and personnel deployed, this experience raises important questions about the feasibility of achieving wide participation in the development of urban (health) policy on a more routine basis.

Key words: City Health Plan; evaluation; Healthy Cities; participation; strategy development

INTRODUCTION

Community participation and multi-sectoral working are key principles of the World Health Organization’s (WHO) Health for All strategy. The Healthy Cities movement started as a health promotion project within the European Region of WHO in 1986 with the intention of translating
this strategy into local programmes. One of the commitments accepted by member cities for the second phase of the project (1993–1998) was the formulation of a multi-sectoral, participative City Health Plan (CHP).

Liverpool, one of the first cities to join the WHO project, developed the draft of its CHP through multi-sectoral task groups, under the strategic management of a high-level executive multi-agency group, the ‘Joint Public Health Team’. The task groups were asked to accommodate in the CHP the key areas of The Health of the Nation, the then current national strategy for health (Department of Health, 1992). The effectiveness of ‘joint-working’ in these task groups in Liverpool has been evaluated by Costongs and Springett (Costongs and Springett, 1997), but the level and quality of participation achieved has so far not been reported.

It was intended that the participation which could be achieved by the task groups would be bolstered very substantially by the consultation phase, during which the public and members of different agencies would be given the opportunity to contribute their comments on the draft plan. For Liverpool, this consultation was unprecedented in its scope and methods. This report presents an evaluation, from the perspective of those involved, of how well this consultation exercise extended participation. The implications of the findings for carrying out participative public (health) policy development more routinely are also considered.

BACKGROUND

Participation/consultation in policy decisions

The principle of participation is as old as communities themselves, but the deliberate encouragement by statutory sector agencies of community participation as a key element of policy is a relatively recent development (Hardiman, 1986), especially in developed countries. The notion of community is itself not easy to define, and so long as this is the case the meaning of community participation will be unclear (Jewkes, 1995). Participation may be viewed in different ways: thus, Morgan (Morgan, 1993) suggests considering the various definitions of participation proposed in the literature as lying on a continuum, from informal, bottom-up participation to coercive, compulsory participation. Gilbert has also commented on the confusion around defining participation (Gilbert, 1987). He observes that definitions in the literature differ with respect to issues of what is being participated in, and consequently which kinds of participative activities are embraced by any such definition. This suggests that a definition of participation can never be universal, but will depend on the specific setting, agents involved and their objectives.

This study is concerned with participation in planning and decision-making processes. Participation has been described as one form of legitimacy, which is fundamental to justifying planning action, as well as a means of making the planning process a learning system (Smith, 1973). This suggests that participation ought to be desirable; on the other hand, some writers have suggested that not all programmes are equally suitable for popular participation, and that large-scale and technically complex schemes may be better served by a high degree of centralized control [Hughes, 1985; cited in (Gilbert, 1987)]. Achieving effective participation in a process as complex as the CHP is therefore likely to be very challenging. The participation must on one hand be relevant enough to enhance crucial high-level planning decisions, while on the other hand also being genuine and responsive enough for participants to see their contributions being incorporated into policy formulation and implementation. Furthermore, what is seen as successful participation will depend on the expectations of the parties involved. Voluntary participation has been reported to depend heavily on motivation (Gilbert, 1987) and thus on the expectations of success by participants. One issue that the current study sought to identify was participants’ understanding of successful participation, in order to evaluate the consultation process against these expectations.

Consultation has been described as a form of involvement of various individuals or bodies in the planning process, where there is no implicit commitment to act upon the views sought (Lee and Mills, 1982). Pateman [Pateman, 1970; cited in (Syme and Sadler, 1994)] has described consultation as showing a relatively low degree of participant interaction as well as political power. People are introduced to the decision-making process, albeit in a role that is potentially non-influential. Many attempts by health authorities to introduce an element of public consultation into planning processes have experimented with methods, e.g. panels, discussion
groups, citizens’ juries or surveys, which are looked towards for help with, e.g. difficult rationing decisions. In most cases such involvement does not reach beyond mere consultation, whereby decisions are taken by the authority and the use to which the information from participants is put is rarely spelt out clearly. Burton, in his evaluation of a consultation exercise in Bristol and District Health Authority (Burton, 1994), received a high proportion of pessimistic answers to a question put to participants concerning their expectations of what would happen to the views they had expressed during a consultation meeting. Disturbingly, this reaction was most common amongst people who had previously been involved in some form of consultation about health services. Burton’s study seems to be a still rare example of a formal evaluation of a consultation process.

Although the term ‘consultation’ process was used in the City Health Plan development, its purpose was explicitly to increase the extent and quality of participation in what was otherwise a fairly centrally determined undertaking.

The draft City Health Plan

The draft CHP set out a 5-year strategy and action plan with long- and short-term targets, which had been prepared by the inter-agency Task Groups and agreed by the executive-level Joint Public Health Team in the City. The strategy was based on a very broad view of health and its determinants; to sections on each of the key areas of The Health of the Nation (Department of Health, 1992) it added sections on housing, poverty and unemployment, the environment, and young people. The plan was presented in three A4 landscape-format parts of between 24 and 50 pages, one each on ‘strategy’, ‘action’ and ‘context’. In addition, a colourful summary fold-up version was produced.

Overview of the consultation process

Apart from an extensive publicity campaign, the main method employed in the consultation was the use of trained facilitators to hold meetings in community as well as statutory sector groups in order to make consultation more interactive and accessible. Facilitators provided background to the CHP in order to encourage discussion and ideas for the final version of the plan. The sessions varied to fit the needs of particular groups, but a basic framework was provided for a suggested duration of meetings of between 1.5 and 2 h.

Fifty-four such facilitators from a variety of backgrounds were trained, although only 20 of them subsequently held meetings. A total of 58 group meetings were run during the allocated consultation period of 5 months (February–June 1995), involving an estimated 680 people. In addition, feedback on the draft plan was encouraged from other individuals, organizations and (non-facilitated) groups. A total of 18 such group meetings have been recorded by the Healthy Cities Office. All comments were required to be sent to the office, which co-ordinated the modification of the draft and published the final document in April 1996.

It was judged important to carry out this evaluation for a number of reasons: (i) the growing emphasis on public consultation and participation on a larger scale than has previously taken place [see, e.g. (NHSE, 1992)]; (ii) the paucity of reported evaluations of participative processes; and finally (iii) the commitment to the Healthy Cities Project to evaluating methods employed in the process towards achieving Health for All, and to sharing findings with other member cities.

OBJECTIVE

To assess how adequately the consultation process carried out in Liverpool contributed to broad-based participation in the development of the City Health Plan.

METHODS

Information for the evaluation was collected by J.S. using a range of semi-structured interviews and mailed questionnaires for people involved in the process, as follows.

Semi-structured interviews were used for the following.

(1) Key informants:

- staff members from the Healthy Cities office;
- chairpersons of multi-disciplinary task groups developing the CHP;
- Joint Public Health Team members.
(2) Facilitators who actually held consultation meetings, hereafter termed ‘active’ facilitators.
(3) Contact persons from minority communities involved in the consultation.

Questionnaire surveys were used for the following.
(1) Facilitators who were trained but did not go on to hold consultation meetings, hereafter termed ‘non-active’ facilitators.
(2) Participants of facilitated and non-facilitated consultation meetings.

Data collection
Data collection took place almost 1 year after the consultation phase, mainly because commitment and funding to evaluate the process as it evolved could not be secured. Because no record of people participating in the facilitated and non-facilitated groups had been made at the time, the only possible way of contacting these participants was via contact persons (for the groups) who were known to the Healthy Cities office. Most of them agreed to offer questionnaires to the former group participants, in so far as they were still in contact with them. Hence it was inevitable that a substantial proportion of group participants would not be traced. Despite this shortcoming, it was still felt worthwhile providing an opportunity for those participants who could be contacted to comment on the process.

Contact persons were supplied with questionnaires and stamp-addressed envelopes. They were later asked how many questionnaires they had managed to distribute. Only the number of questionnaires actually distributed was used for calculating the response rate. Questionnaires to non-active facilitators were sent by post with a personal covering letter and a stamp-addressed envelope, followed up by telephone reminders. Interviews took place between April and June 1996. They lasted between 20 and 90 min and were audio taped.

Instruments

Interview topic guides
The topics covered by the semi-structured interviews (Table 1) varied only slightly between the respondent groups. Considerable flexibility was used in adapting to the different respondents and situations.

Questionnaires
The questionnaire for group participants was developed using the suggestions of contact persons, and covered how well the consultation process facilitated understanding of, and response to, the draft CHP. The questionnaires to non-active facilitators included questions on the reasons for not holding consultation meetings. Both questionnaires were piloted among a sub-sample of respondents (not included in the final analysis) and were checked for content validity with the members of the Healthy Cities team.

Analysis
Interview transcripts were initially categorized into a limited range of areas, covering the topics included in the schedules. Within those topic areas, themes were then identified. Closed questionnaire responses were tabulated. Answers to open questions were listed and themes identified, in a similar way to that used for analysing the interview transcripts.

<table>
<thead>
<tr>
<th>Table 1: Question areas covered in semi-structured interviews</th>
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<tbody>
<tr>
<td><strong>Introductory question areas:</strong></td>
</tr>
<tr>
<td>Nature and extent of involvement in the process</td>
</tr>
<tr>
<td>What is perceived as the purpose of the consultation phase</td>
</tr>
<tr>
<td>Views on wider participation in policy development</td>
</tr>
<tr>
<td><strong>Main question areas:</strong></td>
</tr>
<tr>
<td>Recruitment, training and motivation to be involved (for facilitators)</td>
</tr>
<tr>
<td>Criteria for successful participation in policy making</td>
</tr>
<tr>
<td>Assessment of the consultation process against those criteria</td>
</tr>
<tr>
<td>Views on the methods and process of the consultation</td>
</tr>
<tr>
<td>How they see the future of the CHP, with particular reference to opportunities for ongoing participation</td>
</tr>
<tr>
<td>Assessment of the effectiveness of the methods and materials used to enable participation</td>
</tr>
</tbody>
</table>
Participative evaluation

Although time and resources did not allow a fully participative research design, efforts were made to incorporate participants’ views. When first written to, contact persons were asked to indicate which questions they thought should be addressed by a participant’s questionnaire. To avoid imposing the researchers’ perceptions about what was successful participation, interviewees were asked to define what they saw as the most important issues. Similarly, participants in facilitated groups were asked, in their questionnaires, to describe what they thought the purpose of the consultation meetings was, and what they expected to result from their involvement.

RESULTS AND DISCUSSION

Table 2 presents the interview and questionnaire respondents and the response rates for each group. Whereas these were satisfactory (70% overall) for the interview respondents, only ~one-third of distributed questionnaires were returned. The interpretation of findings from this part of the data collection process therefore needs to be more cautious.

Expectations of the consultation

Previous experiences of participation can be expected to influence people’s attitudes towards, and expectations of, their involvement in any new participative process. There was strong evidence that this was the case here. Greater enthusiasm was expressed by those involved for the first time, or those having experienced support from the authorities for their participation in groups and fora. On the other hand, the evaluation was an opportunity for others to voice sometimes long-standing frustration and cynicism about their involvement with authorities:

There hasn’t been a kind of belief really that you can actually influence health services (Community Representative)

A point frequently expressed by facilitators and community representatives related to doubts people had about the value and rewards of involvement, or as one facilitator describes it:

I don’t think there is a general belief amongst people that they can participate. Even I sort of think that really nobody pays any attention to me … So I have got this little devil on my shoulder saying, ‘its wasting your time really’, but then on the other shoulder I have got this hopeful one saying, ‘no, you’ve got to start somewhere and you must do this, you must get involved’. So there is this constant battle between cynicism and hope, do you know what I mean?

The assessment of participants’ perceptions in this study was carried out with the expectation of a good deal of cynicism, and that those most disillusioned would be least likely to get involved—either in the original consultation, or subsequently in this evaluation. Among those group participants who could be contacted, and responded, Table 3 shows that there was in fact a high level of optimism about the value of raising issues they thought were important.

However, this optimism was certainly tempered with a more realistic assessment of expectations.

Table 2: Response rates for interviews and questionnaires

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Number approached</th>
<th>Number responded</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interviews:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Cities staff</td>
<td>6</td>
<td>5</td>
<td>83</td>
</tr>
<tr>
<td>Task group chairpersons</td>
<td>6</td>
<td>4</td>
<td>66</td>
</tr>
<tr>
<td>Joint Public Health Team members</td>
<td>15</td>
<td>11</td>
<td>73</td>
</tr>
<tr>
<td>Facilitators (active)</td>
<td>20</td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>Minority community contact persons</td>
<td>13</td>
<td>7a</td>
<td>54</td>
</tr>
<tr>
<td>Totals</td>
<td>60</td>
<td>42</td>
<td>70</td>
</tr>
<tr>
<td><strong>Questionnaires:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitators (non-active)</td>
<td>27</td>
<td>11</td>
<td>41</td>
</tr>
<tr>
<td>Participants of consultation meetingsb</td>
<td>161</td>
<td>50</td>
<td>31</td>
</tr>
</tbody>
</table>

aSome minority community contact persons were not involved in group meetings and were therefore not interviewed.
bFor some questionnaires their delivery could not be determined (161 is the number known to have been distributed).
Thus, 11 respondents (22%) agreed with the statement:

All contributions made during any consultation meeting have to be included in the final plan to make it worthwhile.

Over half (56%) thought that:

Not all contributions made during consultation meetings will be able to be included in the final plan, and someone has to make a decision about which can or cannot be included.

Nearly half (44%) felt that:

The most important thing is to have an opportunity to make contributions, regardless of whether they are included in the final plan or not.

Respondents could agree with more than one answer. In the light of these findings, it was interesting to see that many facilitators and key informants were much more critical of the process as a whole and much more acutely aware of the need to focus on outcomes, than was apparent from the questionnaire responses of the group participants. Hence, whereas it has been noted that people’s motivation to participate depends on their perceptions about the likelihood of a successful outcome (Gilbert, 1987), it was clearly not the case here that people would accept nothing short of full implementation of their requests as success.

**Table 3:** Responses to question: ‘In the meeting, to what extent did you feel it was worthwhile mentioning the issues you thought to be important for health in Liverpool?’

<table>
<thead>
<tr>
<th>Answers</th>
<th>Number (%) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very worthwhile</td>
<td>21 (55)</td>
</tr>
<tr>
<td>Fairly worthwhile</td>
<td>7 (18)</td>
</tr>
<tr>
<td>Not particularly worthwhile</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Not at all worthwhile</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Unsure</td>
<td>8 (21)</td>
</tr>
</tbody>
</table>

*aThirty-eight respondents answered the relevant question.

**Did participants expect their view to influence the plan?**

Table 4 summarizes views on whether those consulted felt their ideas would be acted on. There is much more caution and uncertainty here. Justifications given for negative answers were statements referring to past experiences of not having been listened to, or the lack of commitment given in the draft plan to act upon the contributions. Those answering ‘yes’ had their own reasons for feeling reassured or were convinced of the value and importance of the matters raised. Consequently, positive messages and reassurance about the sincerity of the process and handling of comments might be expected to have a beneficial effect, although experience from a previous participatory exercise may well have the most powerful effect.

When there is a particular issue of interest which sparks the motivation to become involved in policy-making processes, such issue-based participation or lobbying may be difficult to reconcile with the broad approach of strategic health planning for an entire city. A wide consultation may thus result in a large wish list of individual or group priorities, which may be difficult to satisfy and to translate into a coherent strategic framework.

**Table 4:** Responses to question: ‘At the time, did you feel that the contributions made during the meeting would be acted upon by people responsible for making decisions in the city?’

<table>
<thead>
<tr>
<th>Answers</th>
<th>‘Your own contribution, if you made any’ [number (%) of respondents]</th>
<th>‘The contributions made by the group as a whole’ [number (%) of respondents]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7 (18)</td>
<td>8 (21)</td>
</tr>
<tr>
<td>Partly</td>
<td>9 (24)</td>
<td>8 (21)</td>
</tr>
<tr>
<td>No</td>
<td>5 (13)</td>
<td>3 (8)</td>
</tr>
<tr>
<td>Unsure</td>
<td>12 (32)</td>
<td>14 (37)</td>
</tr>
<tr>
<td>No answer</td>
<td>4 (10)</td>
<td>3 (8)</td>
</tr>
</tbody>
</table>

*aThirty-eight respondents answered the relevant question.*
Translating individual ideas into coherent strategy

This consultation did experience problems when it came to formally analysing the comments received and adapting the draft plan accordingly. Some of the facilitators said they would have preferred to use a more standardized approach in holding meetings and feeding back from them, feeling perhaps that they had been given too much autonomy, and/or not enough guidance, and that there was a danger of comments not being reliably translated into the final document. In other words, they were seeking some structure to act as a bridge between individual concerns and the need for a coherent and realistic strategic plan. Indeed, there was regret on behalf of the organizers that the process did not allow for any quantification or prioritization of responses. Concern was also expressed about the absence of geographic and demographic data about participants with which to assess how well those involved represented the city population. Whereas there was some satisfaction with how comments were grouped and handled, a more clearly structured, pre-determined process for doing that would have been preferable. Not least as a result of the consultation process, the final version of the CHP was substantially changed from the draft version, putting considerable emphasis on reporting ‘what people had said’.

Dialogue and collaboration with the statutory sectors

Involved officers from both the local authority and the health authority frequently referred to their own relatively new structural arrangements, which encouraged them to have greater confidence in the possibility of local involvement and two-way communication. A point common to many responses, not only from key informants, but also facilitators, was the emphasis on developing continued processes for involvement or contact with decision-makers, a sentiment which was also expressed by some community representatives.

What we really need is a continual dialogue. (Joint Public Health Team Member)

There was some indication that the long-standing scepticism towards any invitation to engage in dialogue with officers from the authorities was slowly disappearing, as one experienced facilitator expressed:

The local community won’t always accept the professionals, but they need them ... professional people from the City Council come along and they have tried their hardest to work with the people and they are starting to work together, but it has taken an awful long time for the community to accept them.

The expectations of interviewees on what was a desirable level of involvement, however, varied greatly. One community representative described what would seem to be non-participative consultation, where decision-makers have the responsibility to inform and invite comments from the recipients of services. Other respondents expressed their visions about a far more active involvement and more equal relationship, far beyond mere lobbying, recognizing that both policy-makers and community members will have to still undergo considerable development and learning before that can be achieved.

There was wide agreement among key informants on the importance of, and need for, wider involvement in decision-making. Several expressed their conviction that involvement should take place at every stage of the process, from planning to implementation. There was a conviction that:

Statutory agencies come to better decisions, if there is meaningful public involvement. (Joint Public Health Team Member)

Interview respondents understood such ‘better’ decisions as those leading to strategies with broad support and ownership, more appropriate and acceptable services, and more efficient use of resources. Nevertheless, respondents appreciated the constraints of broad participation, e.g. time, effort and resources required, or the danger of creating false hopes and expectations. But these constraints, whilst clearly recognized, were never presented as a justification for not trying to facilitate participation.

Uncertainty about the aim of the process

When asked what in their view had been required for successful participation, many interview respondents identified a clear aim of the process as one of the requirements. In fact, the precise aim of the CHP consultation process seems to have been unclear to many respondents at all
levels. The consensus view among interview respondents on the purpose of the consultation phase was, broadly, to give a wider audience the opportunity to comment on the plan and express their view and concerns. Nevertheless it remained unclear what the consultation process could be expected to achieve, and in particular what influence the comments received should have on the final version of the plan, i.e. what level of participation in deciding the final outcome was being sought.

These apparently subtle distinctions in describing the aims of the process were, in fact, of considerable importance to the people involved. When replying to the question about the purpose of the consultation, active facilitators and key informants showed their uncertainty by starting with phrases, e.g.

for me it was ...

I guess it was ...

I think ...

I thought about it at the time ...

I would hope it was ...

I don’t know really because I was never told what it was really for.

In general terms, the authorities seemed not to have expressed clearly enough their desire to achieve much wider participation in policy-making. Several respondents commented that, in their opinion, the onus for continuing participation in the development of the CHP lay firmly with the decision-makers. Clarity on this issue should perhaps be seen as a prerequisite for participation of this type.

**Assessment of methods used to promote participation**

**Facilitators**

The involvement of trained facilitators in holding consultation meetings was generally evaluated positively, both by facilitators themselves, as well as by key informants. Participants also appreciated the opportunity to ask questions directly during these meetings. The relationship between facilitators and participants varied according to the facilitators’ previous involvement with a particular group: thus, previous knowledge of a group and its concerns was thought to allow for greater openness and a sense of security. To a degree, familiarity with the group and its specific concerns conflicted with the need for knowledge about the content and process of the CHP as a whole, and the capacity to facilitate a meeting in an objective manner. Despite the fact that almost all active facilitators reported previous experience with group work, together with involvement at various times with the Healthy Cities office or the CHP, many still felt their knowledge of the CHP was too limited. Questionnaires to non-active facilitators did not include specific questions regarding their previous experiences or contacts.

**Consultation meetings**

Of the 38 group participants who answered questions about the meetings, 15 were very satisfied with the way the meeting was run, 20 were fairly satisfied, two were unsure and one was not particularly satisfied. Nearly three-quarters said that the meeting gave them enough opportunity to mention what they thought was important for health in the city. Both facilitators and participants identified lack of time as the main shortcoming. In addition, facilitators thought that the lack of information prior to the meeting was a major disadvantage, and a lot of time had to be spent on introducing the CHP. Respondents also reported that dealing with the number and diversity of areas covered in the plan was difficult.

**Consultation as a two-phase and two-way process**

Lack of communication was felt mainly after the consultation period had ended, because between then and the time that the revised CHP was published in April 1996 there was no follow-up communication with participants or many of the facilitators. As one facilitator expressed it:

We need to complete the circle whenever we do any consultation, we need to go back to them and say ‘look, you are effectively contributing: this is now the plan, we have taken on board about x,y,z, and you are actually included in it’.

The limitations reported from this participative exercise appear to have arisen essentially from inadequate communication at different steps in the process. This is despite the very considerable efforts made to publicise the CHP: in general
terms this seems to have been quite successful, but it was in the key steps of extending participation that the nature and level of communication fell below what participants required.

We would therefore like to propose a framework for viewing consultations such as this one (which have the goal of extended participation) as a two-phase process, supported by more extensive two-way communication. The first phase requires concentrating on providing information, clarifying the process—including its aim—to participants, giving reassurance that participation is worthwhile, and allowing time for all the main issues to be considered. The second phase is concerned with providing the opportunity for open discussion and feedback to amend the proposed draft accordingly, through a mechanism that balances individual concerns with the need for strategic planning. This framework is represented in Figure 1.

Resourcing a process with ongoing communication and participation in this manner will not be easy, and it seems unlikely that this approach could be applied routinely. Policy development exercises, e.g. the Liverpool CHP are, however, very important, and we have seen how experience with one participative exercise can have a strong influence on involvement in, and attitudes to, future participation. A limited number of well-resourced policy development exercises may therefore be seen as a good investment.

CONCLUSION

The development of the Liverpool CHP was an ambitious exercise, and one that has in many respects been a landmark in the evolution of inter-sectoral, participative policy and action in the city. The purpose of this evaluation was to report that experience for the benefit of future work in Liverpool, as well as in the many other cities and communities involved in Healthy Cities and Health for All programmes and Agenda-21. The Health Action Zones and Health Improvement Plans arising from new health policy in the UK (Department of Health, 1998) also rely heavily on broad collaboration and participation in policy development. Participation is not a new idea, and certainly not in Liverpool where many smaller-scale participatory activities have been going on for many years. What is new and important with this example is the large scale of the planning process in which participation was being sought. The following observations and recommendations are therefore offered for consideration by others involved in large-scale participative policy development.

It is very important to plan the process carefully, allowing adequate time and resources to carry out all stages, including evaluation (see below). It is important to make clear the exact purpose of the exercise, and to explain the amount of influence that participants can expect to have in initial planning, refining policy, evaluation and ongoing development. Facilitators may be used as a resource, not only to implement a predetermined method of consultation, but also for identifying appropriate means of accessing their respective communities and inviting participation. Nevertheless, for these facilitators, a balance must be struck between knowledge of the policy-making machinery, objective group management skills, and enough familiarity with the groups they work with to gain the trust of participants in the process.

Face-to-face meetings appear to be a welcome and appropriate means for discussing a proposed plan, but a participative consultation of this complexity could be more effective if run as a two-phase process involving more extensive two-way communication. Differences in expectations regarding the type and extent of participation, as well as its outcomes need to be taken account of. They need to be handled carefully to avoid disillusionment and withdrawal of participants from the process. A clear aim, combined with communication during the process should minimize confusion and unrealistic expectations on all sides. A structured process is needed to help translate individual and group concerns into a coherent strategic plan, whilst avoiding the feeling among contributors that their ideas are at best being unreasonably diluted and at worst ignored without explanation.

At the outset of important initiatives, e.g. the CHP consultation (and other stages of its development and implementation), a decision should be taken as to whether evaluation is to be carried out, based on the potential value of this information. If evaluation is decided upon, the methods and aims should be agreed and resources allocated in advance of implementation. A factor which should play a part in deciding the potential value of evaluation is the recognition that truly participative research can play a useful part in the development and implementation of public health policy (Bruce et al., 1995). There is
**Fig. 1:** To achieve greater participation, the consultation may require a two-phase process with greater emphasis on two-way communication. It is important that evaluation is built into large-scale participative policy development initiatives.
no reason why, if planned in advance, participative evaluation could not make a cost-effective contribution to the process.

The authors would like to emphasize that any limitations of the CHP consultation process are reported against a background of what has been an unusually ambitious and well-resourced exercise in broad participation. This experience serves not as a criticism of those efforts, which are widely regarded as having been positive and useful, but as an example of how challenging it will be to obtain quality participation at the scale of city-level policy development.

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