

SUMMARY DOCUMENT

BEST PRACTICE REVIEW

OF

PATIENT PUBLIC INVOLVEMENT

OR...

"I organised a meeting and nobody came!"

Executive Summary

Patient and Public Involvement

“The next big thing in health and social care”

“The Government is determined to give the public a greater direct role in deciding how services are run within the NHS.

“Yet experience on the ground shows there is a gap between the rhetoric of engagement and the practicalities of participation.”(1)

- **In November 2006 the Eastern Health & Social Services Council (EHSSC) commissioned this “Best Practice Review of Patient Public Involvement” – with the sub-title “*I organised a meeting and nobody came*”.**
- **The focus for the research was on finding examples of innovative and creative PPI, to scan Northern Ireland and beyond for a variety of real and meaningful examples of engagement.**
- **While some examples exist, which clearly demonstrate in measurable ways, how PPI has had a dramatic impact for the benefit of patients, healthcare providers and services, the reality is that such clear-cut examples are still thin on the ground.**
- **We were looking for innovative and creative practice – and as such that does not appear to exist widely at this stage, with the exception of some pockets of good practice. Tools for PPI are limited, and in need of a high dose of imagination. A roadmap for radical change is required.**
- **This summary document includes some of the key findings and recommendations from the full research document.**

- **It includes the:**
 - **Executive Summary**
 - **Examples of where innovative, creative and imaginative PPI has had a measurable effect on patients, providers and services**
 - **Recommendations.**
- **The timing of this commissioned research is significant in more ways than one:**
 - New PPI structures are being developed in England – to replace the PPI forums set up in 2003. The new fora will be called LINKs – Local Involvement Networks, and come out of the Westminster Government’s report “A Stronger Local Voice”.
 - PPI is being described as “the next big thing in healthcare” – (a phrase not intended to trivialise in any way its place in a future NHS).
 - Thirdly, this report’s timing is particularly relevant within a Northern Ireland context. The proposed new statutory duty of public involvement and consultation in the draft Health and Social Services (Reform) (Northern Ireland) Order 2007 (draft reform order) will place a new requirement on all HSS bodies. This includes the new trusts, HSS authority, Patient and Client Council and other special agencies.
- **In response, the DHSSPS has issued its draft guidance – “Strengthening Personal and Public Involvement (PPI) in the Health and Social Services.” It lays out the core values and principles of PPI – while identifying that the subject will raise certain challenges.**
- **The potential challenges facing providers was a key theme raised throughout this research. These issues were also reflected in the initial brief from the EHSSC for the research:**
 - How to make PPI meaningful and effective?
 - How to avoid tokenism and ‘tick box’ exercises?
 - How to do PPI effectively?
 - How to reach ‘hard to reach’ groupings?
 - How to engage communities, service users, carers using creative, imaginative and innovative methods?

- How to evaluate its effectiveness?
- **It was a wide ranging brief, that requested the researchers to provide an overview of PPI activity and examples of best practice in Northern Ireland; to provide an overview of PPI structures and activity in the three GB countries – England, Scotland, Wales; and to source examples of good practice internationally.**
- **It soon became clear that the scope and scale of PPI is considerable. There are numerous strong examples of good PPI practice around Northern Ireland – see section 4 of the full research document.**
- **Consultations were carried out with equality managers and community development officers in six trusts, plus with a range of community, voluntary and professional representative organisations.**
- **Awareness of PPI and its future importance was clear. Trusts on the whole already had PPI strategies in place. PPI initiatives and structures of varying levels were underway – however some were more innovative, visionary and creative than others.**
- **Opting for comfortable, tried and tested or traditional methods of involvement was generally the norm across trusts – for example, surveys, questionnaires, setting up patient groups, special interest groups, low key events and so on.**
- **While clearly such 'traditional methods' work to varying degrees of success, they can lack creativity and vision – leading to a scenario of "*If you always do what you've always done, you'll always get what you always got*".**
- **So how do you make PPI meaningful and effective? There are 'pockets of good practice' in Northern Ireland – some examples of which have been written up as case studies in the full research document.**
- **Reaching 'Hard to Reach' groups is a challenge – however there are some strong examples of effective engagement with marginalised communities identified in the overall research.**
- **The reality is that, considering the budget, timescale and resources available for this research project, it is only scraping the surface. Undoubtedly there are numerous other examples of good practice happening in Northern Ireland that are not highlighted in the research.**

One of the recommendations is that further research needs to be carried out on PPI activity.

- **The brief from the EHSSC asked that key themes be identified. During consultation there were aspects of PPI that were raised repeatedly – for example:**
 1. **Terminology** – in GB the accepted term is Patient and Public Involvement (PPI). In Northern Ireland, the Department's guidelines use the term "Personal and Patient Involvement", to reflect the integrated health and social services structures in Northern Ireland. Other suggestions were citizen involvement, service user involvement and so on. The reality is that service providers and users accept the term PPI – and it is more important to focus on actions rather than words.
 2. **Plain English** – it is interesting that this was raised at nearly every consultation – for example "*Health and social care staff talk in jargon and alphabet soup. We want straight talking that everyone can understand. This is an irritation and a barrier to good PPI.*"
 3. **Mainstreamed and given status** – avoiding tokenistic gestures and tick box exercises that people see through was another key theme. "*It needs to be everyone's job and everyone's responsibility – not just an 'add on' to a job description.*"
 4. **Properly resourced** – with training provided for all sides and adequate resources made available so that PPI is allowed to flourish and develop, so that it can realistically be 'meaningful and effective'.
 5. **Hard to reach groups** – reaching the 'quiet voice in the corner', reaching the vulnerable, marginalised and excluded individuals and groupings is just one of the many challenges facing PPI.
 6. **A PPI career structure or path** – if PPI is to be mainstreamed and resourced, it will need a committed and trained group of people who opt to make PPI their professional purpose.
 7. **Culture of fear and uncertainty among health professionals** – some health care professionals are wary and worried about this whole '*PPI thing*' – fearing that it will leave them open to challenge, litigation, adverse reactions and services being '*slagged off*'. PPI will herald a change in health care culture. The NHS needs to respond to a 21st century society – and accountability is key, as is clear, consistent communication. For example, in respect of changes to services "*Once people know and understand why changes need to be made – once the reasons are explained, and the information has been clearly presented, then they are more receptive and less likely to challenge. They feel empowered because they have been treated as*

equals – as partners in the process, and as a result, more often than not, they want to be helpful, not resistant.”

8. **Consultation** – echoing this last point, consultation remains a vital part of PPI – on condition that it is real and meaningful consultation, and not just for the sake of it!

9. **Maturity and equity** – another theme that emerged was avoiding viewing PPI as an opportunity for confrontational *‘them and us’* scenarios or *‘service bashing’*. There was a definite consensus that PPI should ‘rise above’ this perception, for the benefit of both health and social care staff, and people prepared to become involved. Most consulted individuals and groups wanted mature debate and discussion – that would have effect, make a difference and result in positive developments and outcomes.

10. **Finally ... the SAUL principle: Sensitivity, Appreciation, Understanding and Listening to the patient, service user and carer... regarding and respecting that they are experts in their own needs and conditions. These were key words what emerged repeatedly during consultation.**

PPI – TWO LEVELS OF ENGAGEMENT:

- **Individuals and groups have different perspectives of PPI. It's impossible to be all things to all people. PPI means varying things to different people and groupings.**
- **So consistency will obviously be an issue – as will 'defining PPI' for the purposes of both legislation and creating 'meaningful and effective engagement'.**
- **Therefore PPI for a group of learning disabled young people or homeless older people will be completely different from PPI at a policy making, strategic, service design and decision-making level.**
- **Yet – to be genuine, effective and meaningful, it needs to embrace all perspectives – and give equal status to all levels of PPI.**
- **Health and social care hierarchies being what they are, the natural perception is to view the 'higher level' policy, strategic and service-shaping 'level' as being more 'important' than engaging with marginalised, vulnerable and hard to reach groups.**
- **Listening, understanding and sensitivity at the grass roots level of PPI needs to be accorded equal status to what may be perceived as a higher level, policy and service development level.**
- **Finally – a new outlook and approach for the 21st century**
- **Popular culture in PPI ... love it or loathe it, popular culture is powerful in the 21st century. The culture of celebrity, soap operas, blogging, texting, internet engagement are all methods which could shape and mould the long term future of PPI. A soap opera story line can highlight a health issue in the way that no amount of leaflets, consultation or community level engagement ever could. The media has emerged from a passive twentieth century to an inter-active 21st century – and perhaps that is where the future for real and meaningful engagement truly lies?**

(1) *Healthy Democracy* – Anderson, Tritter, Wilson, 2006

SOUND BYTES – THEMES

During consultation the following points – or ‘sound bytes’ were constantly made:

1. Terminology is an issue – needs to be decided – is it Personal and Public Involvement, Patient Public Involvement, PUI etc etc?
2. NI – pockets of good practice
3. Consistency needed, uniformity
4. Staff training needed – how to do PPI, statutory requirement etc
5. Accountability
6. The Gap Is – HOW TO.....
7. Expectations
8. “Everybody’s business but nobody’s responsibility...”
9. Professional anxiety – cultural fear and uncertainty
10. “Them and Us” – need for maturity
11. Challenge – it’s so broad
12. Need to mainstream PPI
13. Need to give PPI real status
14. Resources needed to make it happen – PPI coordinators required in each new trust
15. Not tokenistic – people see through tick box exercises

PPI METHODS – TRADITIONAL V ALTERNATIVES

A wide range of PPI methods were drawn on for this research. Some were traditional, tried and tested methods – others are examples of progressive and innovative approaches.

TRADITIONAL METHODS	NEW ALTERNATIVES
Questionnaires	Inter-active website
Surveys	Blogging
Meetings	T-mail – text campaigns
Committees	Shared interest – e.g. young and older men – sport/football
Special Interest Groups	Inter-active theatre – as per GMC
Fora / Forums	Music therapy- reminiscence activity as catalyst
Open days	Pictograms
Events	TOOLKIT / 'HOW TO...' MANUAL
Councils	Popular culture
User Involvement Strategies	Touch screen questionnaires
Complaints structures	Health Fairs and Festivals
Direct mail / invitation	Patient alliances
Annual Public Meetings	Interpreting services
Advertisements	Language/culture resource packs
Providing expenses/transport	Trained service user facilitators
Interview plans and panels	PCX - Patient Citizen Exchange
Audits	The People Bank
Focus Groups	Support Circles
Service user feedback/comments	CD Roms / Media Packs

EXAMPLES:

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1. EXPERT PATIENTS PROGRAMME

The NHS expert patient programme helps people with long term conditions in England develop their skills and confidence to manage their own conditions. EPP is run by a CIC – Community Interest Company. Described as a pioneering approach, this is the first time a government department has set up a social enterprise organisation. It 'went live' on 1st April 2007.

It is expanding and diversifying the programme to meet the needs of vulnerable groups. The Government plans to increase EPP capacity from 12,000 course places each year to 100,000 in five years time – 2012.

EPP Courses take place over six weeks, and are led by people with long term health conditions. Patients can also train as tutors.

PCTs will be able to commission the EPP CIC to run self-management courses for patients to help them manage their conditions and train volunteers to run courses in their areas.

The new EPP CIC will mean that patients have greater access to courses on how best to manage their illness, avoiding unnecessary hospital trips. Early findings suggest that through better self-management, A&E attendances have been reduced by over 15 per cent for people who have attended an EPP course.

Groups of 8-16 participants – with a mix of different conditions – meet over six weekly sessions and are led through a structured course by trained tutors, who also live with a long term condition.

The aim of the EPP is to give participants the confidence to take responsibility for their own care, while also encouraging them to work in partnership with health care professionals.

Some tangible outcomes of the English EPP programme include:

- GP consultations decreased by 7%
- Outpatient visits decreased by 10%
- A&E attendances decreased by 16%
- Pharmacy visits increased by 18%

National EPP achievements include:

- Nearly 40,000 people with long term condition have attended an EPP course

- The course will be mainstreamed by 2008
- Specialist courses are being piloted for parents and young people
- Bi-lingual tutors are being trained to access non English speaking communities
- Courses are now run in nine languages
- Courses have been delivered in prisons as well as with ethnic minority groups
- A web based course is being trailed for people who are housebound or prefer not to attend groups

2. UNDER THE WEATHER - COPD AND THE WEATHER MAN

People with COPD – or long term breathing problems, took part in an innovative project with the Meteorological Office and their provider trusts. COPD is directly affected by the weather: the colder and damper it is, the more severe the symptoms. Trusts knew that cold damp weather meant an increase in in-patients, and they wanted to plan their services around this. 94% of patients knew that the weather affected them. The Meteorological Office provided weather forecasts to help providers. But the patients affected took control. 'Give us the information you have on the weather and we will use it to manage our own illness, planning our shopping so we can stay in doors, taking our drugs at the right time, turning up the heating'. By allowing the service to be patient led the effect was better for everyone. Providers no longer had to prepare for an influx of seriously ill patients: the patients by their actions, with the support of clinical professionals in the community, kept themselves out of hospital. Hospital admissions were reduced by over 20 per cent.

3. NICE TO BE ASKED... THE POWER OF CONSUTLATION

'Just being asked' was a theme that emerged persistently in this research – especially in respect of change. If changes needed to be made, and if patients and communities felt it 'was being done to them', then the outcome was anger, resentment and questioning. However, if patients, carers and communities felt they had been consulted, or if the reasons why changes had to be made were clearly explained, then they were generally much more receptive.

For example in one Foundation Trust in England significant changes to hospital visiting hours were made, supported by the local community – because they had been asked and understand the reasons why...

The increase in hospital acquired infections such as MRSA is a cause for concern to patients and the wider public. One issue for debate is the impact of visitors in clinical areas. Chesterfield Royal Hospital NHS Foundation Trust chose to consult its entire membership of 10,000 people for their views on establishing shorter visiting hours and restricting the number of visitors per patient.

An impressive 4000 people responded and 94 per cent agreed that visiting hours should be reduced, so the Trust used these results to implement revised visiting hours. This would have been controversial had any hospital imposed this upon patients and their families without a major public debate taking place in which the clinical reasons for a change in direction could be properly understood.

4. ROYAL RECEPTION DAYS

The Royal Victoria Hospital organised a series of "Royal Reception Days" – open days for people from the Sandy Row and Shankill areas. It included community involvement with staff from various departments such as the maternity department, A&E, and with a wide range of health professionals. People – mainly mums and children – got to talk directly to staff.

The follow up survey showed that most people would not have previously considered attending the Royal for treatment – but that after the visits their perceptions had been positively changed

- 86 per cent of people were more positive
- only 4-5 per cent hadn't changed their views
- 60 per cent said they would now apply for jobs at the Royal Group, whereas they would not have considered this before the visits.

“The evaluation of the days suggested that they had a positive impact on the communities in these areas. Organising the events in partnership with other community organisations was central to making the days effective, “explained the Health Inequalities representative.

5. PODIATRY – GOOD PRACTICE OF ENGAGEMENT in SOUTH AND EAST BELFAST:

Podiatry services in South & East Belfast were under major pressure with long waiting lists. Community Development Worker Yvonne Cowan explained that podiatry services are a major issue for older people – and this issue was raised during the S&E Belfast trust's annual public engagement event.

“In the past there were huge waiting lists. The podiatry service was suffocating under the weight of demand. However, that has now been cleared up – with more information provided to older people on good foot care, along with an education programme on how to maintain their own feet.

“One simple solution was providing older people who could not reach their feet with long files for their toe nails. A lot of people were treated at home – some with complex problems, yet with some awareness raising and with health promotion through older people's groups, we were able to significantly reduce the burden on podiatrists.

“Waiting lists are now much shorter. It's a small example about an abuse of a service which can be reversed with education so that older people can be helped to care for their own feet – and feel more in control.”

6. CANADA: MENTAL HEALTH EXAMPLE:

At McMaster University Hospital in Hamilton, Canada, families with children needing mental health services faced waiting lists of six months or more. During that time the children's mental health deteriorated and family stress increased. Some of the more assertive parents asked clinicians what they could do to help themselves and the children.

Working with the families and clinicians, a self-managed home based programme was designed, providing step by step solutions for parents to use. This was backed up by a telephone helpline and coaching service. The results were dramatic. At the end of the six month waiting time for professional help, 87 per cent of families had solved their own problems and no longer met the referral criteria for the service. This was even higher than clinical based interventions where the recovery rate was 63 per cent.

RECOMMENDATIONS – SUMMARY:

21 OUTCOMES FOR THE 21ST CENTURY:

This research indicates that PPI is a massive area – with exciting, interesting and engaging opportunities for the future. It will see the future NHS develop and emerge into a new era for the 21st century, moving beyond the traditional passive patient model to an interactive, informative model which welcomes the 'expert patient' rather than alienates or is apprehensive about a new-look patient or service user who is equipped, informed and educated on their condition, their rights and their ability to take personal control of their own outcomes.

PPI is the future, and from this research and report, twenty one recommendations are made:

1. **PPI needs to be mainstreamed and given real status.** PPI is the future, in a technically sophisticated age, shaped by individuals, capable of being experts in their own right – with an equal share in their own care and needs. The patient or service user also needs to be equally accountable – the onus is on shared responsibility and accountability. Health and social care providers need to see this thinking as a welcome breakthrough, rather than something to be wary or concerned about. For this to happen...
2. **PPI needs a "Champion"** – This point came up repeatedly during consultation. The PCC is generally viewed as the organisation that will have the capacity and position to be able to genuinely 'champion' PPI – if adequately resourced to do so. For this to happen...
3. **PPI needs 'associate champions' or PPI co-ordinators.** New, dedicated PPI co-ordinator/manager positions should be created for each new trust – both hospital and community based. Such a role is imperative to 'pull together' PPI activity, resources, practice within communities and trusts. For this to happen...

4. **PPI Networks should be developed** – perhaps reflecting Trust areas. For example, in Northern Ireland there are five Business Women’s Networks. Four of these local networks have recently joined together – to form a regional network (or networking nucleus) called Business Women’s Networks NI (BWN NI), while retaining their own local identities. A similar model could be shadowed for all professionals, service users, stakeholders with an interest or remit for PPI. For this to happen...
5. **PPI needs a Northern Ireland “Centre of Excellence” or more, realistically, PPI Hub (of activity) or “PPI Cluster”** – a small-scale NHS Centre for Involvement, but specifically for Northern Ireland. Such a resource could sit within auspices and control of the new PPC, thereby ‘making it mainstream’ and ‘giving it real status’. For this to happen...
6. **PPI needs to follow a performance and management approach**, driven and supported by senior management, backed by research and evidence based practice. A ‘PPI career path’ should be introduced into NI’s health and social services. For this to happen...
7. **Training is essential** –There is an immediate need for structured PPI training for existing health and social care professionals. If this is the way forward for a 21st century NHS, then providers need – as a matter of some urgency, to be equipped with the skills, knowledge base and understanding / appreciation of PPI for it to be taken forward in a ‘meaningful and effective way.’
8. **Training – for patients/service users and their representatives** – the receivers of treatment / care will need equal access to training and resources if they are to play a valid, active and meaningful role in future PPI structures.
9. **Training – All health and social care professionals of the future** need to be trained in the theory and practice of PPI pre-qualification. It is only through this route that PPI will genuinely become meaningful and effective for the NHS of the future. It needs to be incorporated into the pre-qualification training of all nurses, doctors, professionals allied to medicine (PAMs) and social care professionals.
10. **INFORMATION – The essence of PPI is INFORMATION.** This is the information age – the gold fish bowl society where we want quick fix information, solutions and outcomes. We are all consumers of information, but we are not all similar in how we interpret and assimilate information. How to scale information is a challenge.
11. **“BIG CONVERSATION” – PPI needs dialogue** (“it’s a two way thing”). There is strong awareness of PPI among those consulted for this research? But how informed is the general public on PPI? A community-led awareness raising campaign will be required. One idea already suggested is for a “BIG CONVERSATION” to take place – a series of high profile, well publicised ‘public meetings’ taking place in tandem with an on-line discussion forum.

12. **ACCESSIBILITY – PHYSICAL, EMOTIONAL AND VIRTUAL** – accessibility is a key issue in PPI – especially for “Hard to Reach” groups. The section on Head to Reach groups in the full report indicates that engaging with hard to reach sections of communities is a slow but worthwhile process. Time is required to build relationships and develop trust – but a process which reaps rewards. With other hard to reach groups, barriers are not just physical but often emotional (ranging from anger to despair), and issues of respect, dignity and understanding are required if genuine engagement is to be a sustained reality.
13. **VIRTUAL PPI** – This will not be suitable for everyone – but for many housebound people, their carers, people with long term conditions PPI on-line is a progressive, meaningful and welcome alternative. Websites such as Patient Opinion have created a body of patients responding to services.
14. **PPI website for Northern Ireland** – perhaps hosted by the PCC, an inter-active web resource for both patients/service users and health professionals is recommended. It could be used to promote and share good practice; to encourage on-line debate/discussion forums, blogging and PPI resources, toolkits etc.
15. **NEW TECHNOLOGY** – Mobile communication/Texts messaging – technology provides additional options for PPI opportunities – for example, use of Text messaging campaigns, response mechanisms, sharing of information, publicising events and other PPI activities. Text messaging is particularly suitable for engaging young people. The Ulster Farmers Union uses text-mail as a cost-effective and time-efficient means of reaching and communicating with its membership – for example publicising events to the Young Farmers Clubs extensive membership. Another suggested method of new technology would be the use of touch screen questionnaires – perhaps using pictograph methods for people with a learning disability, for young children who enjoy screen-based interaction, or for people who do not speak English as their first language.
16. **Production of a PPI Toolkit / Manual** – available both on line and as a folder or file, a PPI manual or toolkit needs to be created. For many groups – especially hard to reach groups, simply getting started is a challenge. A carefully devised “HOW TO DO PPI TOOLKIT – listing various methodologies, looking at other case studies and examples, would be a valuable resource.
17. **POPULAR CULTURE IN PPI** — from soap operas to celebrity magazines. Popular Culture is a powerful force in this society. For example celebrities as diverse as Kerry Katona and Stephen Fry have bi-polar disorder in common, and through their celebrity, are able to highlight and raise awareness of this condition. When soap-characters die from an illness – for example cervical cancer, then it can have a dramatic impact on services (for example, the 25 per cent increase across the UK in requests for cervical smear tests following a Coronation Street story-line).
18. **PPI MAGAZINE FOR NI** – One practitioner consulted during this research suggested that if PPI is genuinely to become ‘real and meaningful’ for Northern Ireland, then it

needs to invest in a 'HEAT'-style magazine for PPI. This would be a glossy magazine – with competitions, opportunities for engagement, articles and interviews – that bring PPI to a wide range of audiences. It would include surveys, questionnaires, etc – with a prize draw competition format. This would be the PPI magazine for the entire DHSSPS and new HPSS structure for Northern Ireland.

19. **PLAIN ENGLISH** – The need for PLAIN ENGLISH in PPI came up time and time again during consultation. Both health and social care professionals and service users/ patients were fed up with health service lingo and jargon – which was referred to as 'alphabet soup'. Service users felt that professionals hid behind jargon and inappropriate language – leading to patients and service users feeling patronised. Another pointed out that the average reading age in Northern Ireland is less than twelve.

20. **CREATIVITY AND INNOVATION** – This is just one of the challenges facing the future of PPI in Northern Ireland. Each of the Trusts consulted – most are now part of the Greater Belfast Trust, talked about their PPI strategies, which were all fairly similar. Methods of engagement by trusts, while clearly effective in many instances, using tried and tested means, seemed a bit bland and unimaginative. The challenge for real and effective PPI is the injection of innovative and creative methods, that generate engagement in an effective and meaningful manner.

21. **PPI – THE CHALLENGE** – To achieve a full vision for PPI in the future, there will be numerous challenges – but that is precisely what will make it interesting; encourage debate and dialogue; and result in improved quality of care and services. The sheer scope of PPI means embracing it fully will present difficulties. It will be essential to view PPI in a two-tiered way – where Level Two refers to PPI at a more strategic level, where service users are involved directly in planning of services, decision-making processes at senior management and policy formation level; and where Level One refers to PPI in the community, in hospitals – where a range of activities reflect the abilities and needs to individuals, communities and special interest groups, where creative, innovative and imaginative projects are jointly devised, designed and implemented by service users and providers.

THE LAST WORD:

This research has revealed that there are several examples of good practice in Northern Ireland, that it is being done well in some areas, yet seems tokenistic in others. However, the aspiration to embrace PPI fully exists across all areas – from service providers, service users, patients, carers, professionals and people with an interest in the subject.

However the scale of PPI is so wide-ranging that pinning it down is particularly difficult. One recommendation or suggestion would be for an extensive and in-depth PPI survey of Northern Ireland. This research – with its timescale and budget – has only scraped the surface. There is a need for further co-ordinated research to be undertaken over the next

year to 18 months; plus a pilot project to take these recommendations forward and make them happen.