Patient Advice and Liaison Services: results of an audit survey in England

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Abstract

Objective To assess the extent national standards for Patient Advice and Liaison Services (PALS) were achieved across England.

Context PALS are an important element of patient and public involvement strategy in England. Seven national standards for PALS were identified. Previous research has not assessed PALS across all trust types in England.

Design Audit survey as part of a mixed method 'realistic evaluation' in which regularities of context, mechanism and outcome are hypothesized and tested.

Setting and participants PALS based in 570 NHS trusts in England between October and December 2005.

Main outcome measures Self reported achievement against PALS national standards.

Results Three hundred and thirty-six valid responses were received, a response rate of 65%. However because some PALS serve more than one trust, this represents an estimated 76% of trusts. Overall, PALS rated themselves highly against all the standards, though somewhat less highly against standard 2 (seamlessness across health and social care) and standard 6 (acting as a catalyst for culture change). There was a wide range of responses with regard to PALS budget, staffing and activity levels, and statistically significant associations between levels of funding and staffing and higher levels of performance.

Conclusions The overall response rate was good so there can be a high degree of confidence in the reliability of the results. The results indicate the challenging context in which PALS are operating. Although the majority of PALS are single trust PALS, there is a high degree of variation in key mechanism factors such as budget and staffing.

Introduction

The last 30 years have seen major challenges and crises in health systems in the developed world. In response governments have initiated a range of reforms which include a broad policy consensus that part of the solution lies in more active and engaged service users.¹ In England the introduction of Patient Advice and Liaison Services (PALS) has been a particularly interesting example of this wider phenomenon. PALS reflect the increasing policy commitment to patient and public involvement (PPI) in the NHS over this period.^{2,3} From the introduction of community health councils (CHCs) in 1974⁴ to the *Patients' Charter*⁵ and *Local Voices*⁶ in the early 1990s, PPI has had an increasingly high profile in national health policy. Although advocacy in specialist areas such as mental health and learning disability services has a longer history, it was in the 1990s that hospital trusts first experimented with more generic patient advocacy services.^{7,8}

During the late 1990s a number of factors converged to heighten the focus on patient involvement and service responsiveness. There was continuing concern over the number of formal complaints, the cost and length of the complaints process and general dissatisfaction by complainants and NHS professionals and organizations.⁹ At the same time there were several highly publicized incidents including paediatric cardiac surgery in Bristol,¹⁰ retention of organs from deceased children at the Alder Hey Hospital¹¹ and the conviction for serial murder of the GP Harold Shipman.¹² Many commentators have argued that these incidents contributed to a wider decline in public confidence in NHS professionals¹³ and led to the development of new systems for clinical and research governance.

One response to these pressures was the development of a new strategy for PPI, which was most clearly articulated in *The NHS Plan*¹⁴ and the *Health and Social Care Act 2001*. Among the key reforms were the abolition of CHCs in England and the establishment of PALS (initially called Patient *Advocacy* and

Liaison Services), PPI forums, local authority health scrutiny, the Independent Complaints Advocacy Service (ICAS) and the Commission for Patient and Public Involvement in Health (CPPIH). The Secretary of State, Alan Milburn, launched PALS at a conference in January 2001 and NHS trusts and primary care trusts (PCTs) were invited to submit bids to establish pathfinder (pilot) PALS for the year 2001–02.

Other aspects of the new PPI strategy were given a statutory basis in the *Health and Social Care Act 2001*, but PALS were established on a non-statutory basis. The first detailed guidance was issued in a September 2001 consultation paper,¹⁵ which, with minor amendments, was confirmed a few months later in the government's response to the consultation.¹⁶ The Department of Health (DH) reported that 'the idea of PALS was widely accepted' but that there had been concern expressed that there was overlap and confusion between the role of PALS and that of ICAS (which was intended to support users with formal complaints). The guidance clarified the different roles intended for PALS and ICAS and changed the name of the former to Patient *Advice* and Liaison Service to avoid confusion between the two.

At the same time as reforming the institutions of PPI, the government embarked upon a wider reform of the NHS under the theme of 'shifting the balance of power'.^{17,18} Central to this reorganization was the abolition of health authorities and the devolution of greater decision making to the local level of NHS trusts and the new PCTs. Thus as in many areas of policy, the DH chose to indicate the general direction of travel by specifying that all NHS trusts and PCTs were required to have established PALS by April 2002, but was not prescriptive around operational details such as the structure, staffing or funding levels for PALS.

During 2002 and 2003 the DH continued to support the development of PALS, including publication of a resource pack,¹⁹ and the establishment of a National PALS Development Group (NPDG). In July 2003 the DH and the NPDG published further guidance refining the national standards and a framework for the

evaluation of PALS.²⁰ The DH funded the NPDG to produce additional resources including training materials, a communications CD and a national PALS website 'PALS Online'. In 2003 the DH funded a region-wide evaluation of PALS in London^{21–23} as well as commissioning a national survey of access to and use of PALS by children, young people and parents.²⁴

Part of the context for the establishment of PALS was the politically controversial abolition of CHCs which the government had to withdraw from the *Health and Social Care Bill* prior to the 2001 general election. CHCs were finally abolished in England by the *National Health Service Reform and Health Care Professions Act 2002* with effect from December 2003. A House of Commons Health Committee²⁵ report critical of PPI policy in general and PALS coverage in particular led the government to make a robust defence of the effectiveness of PALS.²⁶ Following this, the DH announced an independent national evaluation of PALS. The evaluation was commissioned from a team in the Faculty of Health and Social Care, University of the West of England (UWE), Bristol in Autumn 2004.

Since the commissioning of the national evaluation there have been continuing changes in PPI policy and related changes in complaints policy in the NHS. In October 2003 the Secretary of State for Health, Dr John Reid, announced a review of the DH's arm's length bodies. As a result of the review, the decision was announced in July 2004 to abolish the CPPIH. At that time it was intended that PPI forums would continue as the key local mechanism for PPI in the NHS. Following a consultation on future support for PPI in health^{27,28} the DH subsequently commissioned a new NHS National Centre for Involvement, and the *Local Government and Public Involvement in Health Act 2007* abolished the CPPIH and PPI forums and established Local Involvement Networks (LINKs) in their place. In summarizing current arrangements for PPI and what will change, recent guidance emphasizes that 'no changes will be made to PALS'²⁶ and that LINKs will liaise with and use information from PALS.

As a new policy initiative there has been relatively little research on PALS, but there were a number of local evaluations of pathfinder PALS, as well as the DH funded research mentioned above on children and young people and on PALS in London. This research identified a number of factors including resource limitations, unclear boundaries, variable management support and organizational instability which limited the role of PALS to what Buchanan and colleagues called 'repair and maintenance'²¹ as well as the value of PALS in 'strengthening the voice'²² of service users in health-care organizations. These factors were partly explored in this audit but more deeply in our eight case studies.²⁹

Design

The overarching aim of the evaluation was to assess the extent to which PALS are contributing to a change in NHS culture that places patients and other service users at the heart of service planning, delivery and improvement. The overall evaluation used mixed research methods (literature review, audit, case studies and action inquiry) within an overall 'realistic evaluation' framework.³⁰ The audit element of the evaluation reported on here addressed the specific question 'to what extent are the national functions and standards set out for PALS being achieved across England?' The PALS standards audited were those specified by the DH in 2003 (Fig. 1).²⁰

The national audit of PALS in NHS trusts in England was developed from March to July 2005 and sent out to 521 trusts hosting PALS in October 2005. The audit sought self-reported

No.	Standard
1	PALS is identifiable and accessible to the community served by the trust
2	PALS will be seamless across health and social care
3	PALS will be sensitive and provide a confidential service that meets individual needs
4	PALS will have systems that make their findings known as part of routine monitoring in order to facilitate change
5	PALS enables people to access information about trust services and information about health and social care issues
6	PALS plays a key role in bringing about a culture change in the NHS, placing patients at the heart of service planning and delivery
7	PALS will actively seek the views of service users, carers and the public to ensure effective services

Figure 1 PALS National Standards.

assessments by PALS of their achievement against the seven national standards as well as against a number of indicators developed in consultation with the PALS field.

The audit did not itself require ethical approval but was included in the overall PALS evaluation submission which received ethical approval from the Central and South Bristol Multi-centre Research Ethics Committee and from UWE Bristol in September 2005.

The audit instrument was developed in consultation with our steering group following review of a national PALS 'stocktake' pro forma issued by the DH and several local PALS audit and evaluation documents obtained by the project team. It was recognized that the assessment of some PALS standards was difficult to operationalize in a postal questionnaire and that ensuring the validity of the instrument would be challenging. Audit questions were selected and adapted from the collected PALS documents where the project team felt they had face validity in terms of the standards. Unfortunately it was harder to identify valid questions for some standards than others, so there was some variation in the number of questions related to each standard. In order to maximize validity, the questionnaire was piloted for face and content validity with 12 PALS managers, four of whom were also steering group members. Ten pilot forms were returned with additional comments and additional discussions were held with the steering group PALS managers. This feedback was incorporated into the final version of the audit through the adjustment of questions. A front-sheet was developed that stressed the confidentiality of responses and gave a point of contact for queries. A final audit instrument was devised comprising tick box answers and some open questions.

There were 570 NHS trusts at the time but a number of joint trust PALS were already known to the evaluation team, reducing the target population of trusts potentially hosting PALS to 521. A database of these trusts was generated using information provided by strategic health authority PPI leads as the sample frame. The audit questionnaire was sent to the 521 trusts in

October 2005. Each questionnaire was given a number to enable a reminder to be sent to non-responders, but was otherwise treated anonymously.

Audit returns were logged with a data entry number to aid the data entry checking process. The questions were coded as category or number variables in Statistical Package for the Social Sciences (SPSS) Version 11 (SPSS Inc., Chicago, IL, USA). All audit responses were entered by the same person (JP) to ensure consistency of interpretation in data entry. The accuracy of data entry was checked by matching 20 audits picked at random with the data that had been previously entered. Descriptive data analysis was performed to identify incorrect data entry and/or outliers. A small number of data entry corrections were made through the checking process. Descriptive and inferential data analyses of responses were undertaken.

Results

Following the initial mail out and one reminder, 340 questionnaires were returned by January 2006. Four audits were not valid; giving a final sample of 336 responders (65%). This included 255 returns from PALS in single trusts and 81 from PALS covering two or more trusts. Thus responses were received from an estimated 431 out of 570 trusts (76%) in total.

PALS context

A small number of questions were asked to identify key contextual factors including the date PALS was established, the presence of any financial deficit in the trust and the size if present, and history of recent significant structural change.

Table 1 demonstrates the number of PALS established by year. A few were introduced in 2000, the year of *The NHS Plan*, even before the formal introduction of the PALS pathfinders in 2001. The majority were introduced in 2002, the year trusts were required to introduce PALS. Decreasing numbers were introduced in 2003, 2004 and 2005. One respondent reported their

Table 1 Number (%) of PALS established by year

Year established	2000	2001	2002	2003	2004	2005	Total PALS	No PALS	Not known	Total
Number of PALS	4 (1%)	48 (15%)	166 (52%)	78 (25%)	18 (6%)	3 (1%)	317 (100%)	1	18	336

Table 2 Type and number (%) of trusts served

Single acute (%)	Single PCT (%)	Single mental health (%)	Single ambulance (%)	Single special (%)	Joint/consortium (%)	Not known (%)	Total (%)
84 (25)	120 (36)	27 (8)	13 (4)	11 (3)	59 (18)	22 (7)	336 (100)

trust did not have a PALS but we know from other sources that a few other trusts (which are likely to be among our non-responders) also had not established PALS by 2005.

Seventy per cent ($n = 236$) of respondents completed the question on financial deficits. Of those answering this question, the majority 61% ($n = 144/236$) said their trust had a deficit. Almost a third (31%, $n = 72$) said their trusts did not have a deficit and 8% ($n = 20$) said they didn't know about their trusts deficits. Of those PALS that did identify a financial deficit in their trusts, 33% ($n = 46$) said this was more than £5 million. Nearly one quarter of PALS (24%, $n = 81$) reported major structural change in the trust they served in the last 3 years, although the total number of responses to this question was relatively low (66%, $n = 223$).

PALS mechanism

Several questions were asked to help understand the nature of the PALS mechanism.

Number and types of trusts served

Seventy-eight per cent ($n = 262$) reported their PALS served a single trust whilst 18% ($n = 59$) reported their service was a joint or consortia PALS. Two per cent ($n = 7$) reported that the PALS functions were provided, but not as a discrete PALS, with only one reporting no PALS at all. Another question exploring which types of trust PALS served generated a slightly different figure for the total number of single trust PALS, probably due to different respon-

dents completing different questions and/or slightly different interpretations of the two questions. Table 2 details responses to this question by trust type. The table shows responses to this question indicated that 76% ($n = 255$) of PALS serve single trusts compared with the figure of 78% ($n = 262$) on the previous question. The joint/consortia PALS represented a wide range of combinations including joint PALS across one acute and one PCT, PALS covering two or more PCTs, joint acute and ambulance PALS and joint PCT and mental health PALS.

The mean annual budget reported for PALS was £63 871 ($n = 188$, range £1200–£185 000 for individual trust PALS, and £450 000 for the largest consortium PALS which covered eight trusts). Budget data were not normally distributed and the median annual budget was £50 013 ($n = 188$). We have focused most of the analysis on single trust PALS as this is easiest and clearest way to compare PALS between and within different sectors.

Single acute trusts spent a mean of between £15–20 000 more than other types of single trusts on their PALS (Table 3). Larger joint and consortia PALS tended to have the larger budgets, but such budgets are of course pooled across trusts and the mean financial contribution for the largest consortium is within the centre of the range for the mean for single trust PALS. The interpretation of these data must be cautious, however, as the number reporting (56%, $n = 188/336$) is relatively low, and some PALS were clearly estimating their budgets which may or may not reflect accurately their actual budgets.

Table 3 Mean (range) total PALS budget by trust type

Trust type	Single acute (<i>n</i> = 46)	Single PCT (<i>n</i> = 69)	Single mental health (<i>n</i> = 17)	Single ambulance (<i>n</i> = 5)	Single special (<i>n</i> = 7)	All (<i>n</i> = 188)
Budget (£)	69 752	50 131	53 786	53 760	54 070	63 871
mean (range)	(15 000–185 000)	(1200–162 000)	(20 000–170 000)	(13 800–181 498)	(25 000–87 631)	(1200–450 000*)

*Consortium of eight trusts mean budget per trust, £56 250.

Table 4 Mean number of queries by trust type

Trust type	Single acute (<i>n</i> = 79)	Single PCT (<i>n</i> = 124)	Single mental health (<i>n</i> = 25)	Single ambulance (<i>n</i> = 12)	Single special (<i>n</i> = 10)	All reporting (<i>n</i> = 314)
Queries over last 3 months—mean (range)	409 (25–1470)	234 (15–4052)	120 (15–532)	152 (0–1115)	151 (28–330)	281 (0–4052)

PALS queries

Table 4 demonstrates that the mean number of queries over the past 3 months was 281 (Range 0–4052, *n* = 314) or 93 per month. The median number of queries over the past 3 months was 150 (*n* = 314) or 50 per month. There was a wide range of responses within each sector, whilst between sectors the mean was markedly higher in the acute sector and lower in the mental health sector than in other sectors.

Staffing

In a question about the model which best described their PALS, 38% (*n* = 129) were reported as single trust team-based PALS and 40% (*n* = 133) single trust single-handed

PALS. A second question about team composition gave a more nuanced view of what respondents regarded as a single-handed PALS with some clearly meaning a single PALS manager or officer, whether or not they had some administrative support. Table 5 shows that 29% (*n* = 99) had a PALS manager, high band PALS officer(s) and administrative support which we defined as the minimum full complement of staff. As the table shows, this varied markedly between trust types, with acute trusts having the highest proportion of minimum full complement at 44% whilst only 13% of PCTs and 9% of special trusts reported this level of staffing.

Forty-five per cent of professionals running PALS services had a background in management (45%, *n* = 152). Fifteen per cent (*n* = 49)

Table 5 PALS team composition by trust type

Trust type	Single acute % (<i>n</i>)	Single PCT % (<i>n</i>)	Single mental health % (<i>n</i>)	Single ambulance % (<i>n</i>)	Single special % (<i>n</i>)	All reporting % (<i>n</i>)
Team type						
1. Manager, officer(s) high band, admin	44 (37)	13 (16)	33 (9)	15 (2)	9 (1)	29 (99)
2. Manager, officer(s) no admin	25 (21)	17 (20)	15 (4)	15 (2)	18 (2)	18 (62)
3. Officer(s) high band, admin	7 (6)	16 (19)	7 (2)	–	9 (1)	11 (36)
4. Manager or officer(s) high band	13 (11)	32 (38)	22 (6)	39 (5)	36 (4)	24 (79)
5. Officer (low band) and admin	4 (3)	5 (6)	4 (1)	–	–	3 (10)
6. Officer only (low band)	5 (4)	8 (9)	11 (3)	8 (1)	9 (1)	7 (23)
7. Admin only	–	1 (1)	4 (1)	8 (1)	9 (1)	2 (6)
Other	1 (1)	3 (4)	4 (1)	–	–	2 (6)
Missing	1 (1)	6 (7)	–	15 (2)	9 (1)	5 (15)
Total	100 (84)	100 (120)	100 (27)	100 (13)	100 (11)	100 (336)

had a background in the voluntary sector. Eleven per cent ($n = 37$) had a background in administration, usually in the NHS. Nine per cent ($n = 29$) reported that their background was in nursing, health promotion or wider public health.

PALS outcomes

It was not possible in this audit survey to directly assess PALS outcomes but assessment of performance against the national standards was used as a proxy for outcome. A number of indicators were identified for each standard, and each PALS was asked to self assess against all standards on a scale of 1 (no action) to 5 (excellent). Table 6 summarizes PALS performance against the indicators for standard 1 on the accessibility of PALS.

Table 7 shows that in terms of the indicators for standard 2, seamlessness across health and social care, PALS have clearer links within the health sector than with social care.

Standard 3 is concerned with confidentiality and Table 8 shows that on two indicators, less than two-thirds of PALS were assured of access to secure spaces for confidential discussions.

Table 9 shows the distribution of responses to an indicator for standard 4 on systems to make

Table 6 Standard 1. PALS is identifiable and accessible to the community served by the trust/PCT

Indicator	% (n)
PALS contact details available at	
Trust switchboard	98 (329)
Trust website	98 (329)
Local information leaflets	90 (301)
General practices	79 (265)
patient prospectus	79 (264)
BT telephone director	33 (111)
Alternative format leaflets for:	
English not a first language	50 (168)
children and young people	24 (81)
Opening hours	
Staff available to be spoken to > 18 h/week	88 (295)
Response time for queries	
Target time set	80 (267)
Target time within 48 h	79 (265)
PALS input to staff induction	88 (297)

Table 7 Standard 2. PALS will be seamless across health and social care

Indicator	% (n)
Referral protocols with other local PALS	77 (259)
Clear pathways for liaison with	
PPI forums	90 (301)
Trust complaints	98 (328)
ICAS	92 (308)
Social services	62 (209)
Local authority complaints	39 (131)

Table 8 Standard 3. PALS will be sensitive and provide a confidential service that meets individual needs

Indicator	% (n)
Confidential files stored securely	97 (325)
Environment in which conversations cannot be overheard	64 (214)
Priority access to confidential interview room	64 (215)

findings known as part of routine monitoring. Eighty-three per cent ($n = 279$) of PALS respondents also said that their trust annual report included a report on PALS. Some respondents expanded upon their reporting systems in textual comments, for example one reported:

'PALS produces combined quarterly report with complaints, incidents and claims reporting to identify themes and trends across all components' (Q62).

With regard to standard 5 on access to information, Table 10 again shows that PALS are better able to provide information on the NHS, and their own trusts in particular, compared to social care.

Standard 6 is concerned with culture change in the NHS, and Table 11 shows the responses to three indicators around culture change.

A number of PALS used the free text box to give qualitative examples of how they were contributing to culture change within their trusts. For example, one respondent reported:

'PALS influences culture by having involvement in 'Patient Experience Review Groups'. There are four of these in the trust. PALS reps take examples

Table 9 Standard 4. PALS will have systems that make their findings known as part of routine monitoring in order to facilitate change

Frequency of providing PALS reports to groups by percentage (<i>n</i>)				
	Monthly % (<i>n</i>)	Quarterly % (<i>n</i>)	Annually % (<i>n</i>)	Not at all % (<i>n</i>)
Trust Board (<i>n</i> = 319)	8% (25)	63% (202)	24% (77)	5% (15)
Clinical governance committee (<i>n</i> = 320)	23% (72)	63% (200)	7% (21)	8% (27)
Trust staff via newsletter (<i>n</i> = 298)	9% (28)	29% (85)	29% (85)	34% (100)
Patient and public involvement forums (<i>n</i> = 311)	15% (46)	60% (187)	15% (45)	11% (33)
Service user and carer groups (<i>n</i> = 288)	9% (26)	32% (92)	21% (61)	38% (109)

Table 10 Standard 5. PALS enables people to access information about trust services and information about health and social care issues

Indicator	% (<i>n</i>)
Directory of trust services	86 (288)
Information on services provided by other trusts	74 (249)
Information about social services	65 (218)

Table 11 Standard 6. PALS plays a key role in bringing about a culture change in the NHS, placing patients at the heart of service planning and delivery

Principal mechanism by which PALS influences culture (<i>n</i> = 325)	% (<i>n</i>)
Via working with staff to resolve specific problems	40 (131)
Via the Clinical governance committee	12 (39)
Via wider trust PPI Work	7 (24)
Via staff training	6 (20)
Via the trust directors	5 (17)
Via the chief executive	5 (17)
Other	6 (21)
More than one response ticked	17 (56)
Frequency of contact with chief executive/directors (<i>n</i> = 332)	
Once a week	15 (51)
Once a month	32 (107)
In the last 3 months	32 (105)
Never	20 (66)
PALS recommendations to executive team in last year	61 (205)
If made, how many actioned?	
None	11 (22)
Few	24 (50)
Most	22 (58)
Some	28 (45)
All	15 (30)

Table 12 Standard 7. PALS will actively seek the views of service users, carers and the public to ensure effective services

Obtained views of service users via	
Informal feedback	86 (289)
User surveys or focus groups	69 (231)
PPI forums	69 (233)
Trust user groups	50 (169)
Voluntary sector groups	46 (153)

of relevant PALS issues to the group for discussion and action as well as contributing more widely to the work of the groups' (Q449).

By contrast, however, another PALS respondent commented on the difficulty of addressing culture change:

'Influencing culture via PALS remains difficult when the service is struggling to stay on top of coping with the multitude and diversity of issues we deal with. Our priority has to be addressing the issues for the individual' (Q340).

The final standard 7 is concerned with PALS actively seeking the views of service users. Table 12 shows the extent to which PALS reported seeking user views via various mechanisms.

Self-assessment against national PALS standards

Figure 2 provides an overview of PALS self-rating of their own performance in terms of the seven national standards. We asked PALS to rate their action to date on a scale of 1–5 where 1 = no action and 5 = excellent. Most relative

Figure 2 PALS self-rating of scores for action to date [No action (1)–Excellent (5)] for PALS standards (1–7).

progress has been made on standard 3, followed by standard five. PALS own self-ratings also indicate that least relative progress has been made to date on action towards standards 2 and 6. These self-rating findings for PALS for action against national standards are robust as the response rate for these questions was high ($n = 328/336$ – $330/336$).

The distribution of the variables total PALS standards score and PALS team composition were non-parametric and the latter was ordinal. In order to examine inferentially the association between total PALS standards scores and the type of team composition it was therefore necessary to apply non-parametric hypothesis testing with reference to the medians of these variables. The PALS team compositions listed in Table 5 were recoded into three groups. These were: (1) PALS teams 1 and 2; (2) PALS teams 3 and 4 and (3) PALS teams 5, 6 and 7.

The objective of testing was to examine whether groups 1, 2 and 3 do not differ in terms of total scores on the seven PALS standards using medians as the reference point. Chi-square analysis compared the observed median splits to theoretical even splits. This showed that PALS team compositions differed in terms their relationship with total scores on the seven PALS

standards ($X^2 = 10.646$, d.f. = 2, $P = 0.005$). The direction of association between the three PALS team compositions and the overall self-assessed score on PALS standards was established with the Jonckheere Terpestra test (an appropriate test where, as in this case, the data are non-parametric and ordinal). Its negative, but significant value (JT statistic = -3.667 , $P = 0.000$) suggests an association between the group team compositions and the overall score on the seven PALS standards such that as the PALS team compositions became less well staffed, the total score on the seven PALS standards declines.

To test the association between the PALS annual budget and overall standard score for each PALS across the seven standards we conducted an one-way analysis of variance (ANOVA) procedure. This analysis showed that there was no statistically significant difference between the self-assessed standards score of PALS and the size of their annual budgets ($F = 1.258$, $P = 0.215$). The assumption of equal variance was met at 0.01% (Levene Statistic = 1.274; $P = 0.014$). This finding indicates there was a similar pattern of distribution between the two variables and so suggests there may be an association between higher PALS budgets and the self-assessment scores of PALS across the seven PALS standards.

Discussion

The overall response rate to the survey was very good at 65%, although covering an estimated 76% of trusts due to some joint PALS covering more than one trust. The response rate dropped much lower for some of the more difficult questions about trust financial deficits and the extent of recent major structural change. The overall high response rate means, however, that there can be a high degree of confidence in the reliability of the results. The validity of the results is more difficult to demonstrate conclusively. As with all self completed questionnaires, there is a degree of uncertainty over whether what respondents report actually corresponds to reality. Moreover, as discussed earlier, it was

easier to identify questions to test some aspects of standards than others. For example, with regard to standard 3, it was easier to identify a valid question to test confidentiality than to test sensitivity. Thus our results must be interpreted with some caution regarding validity. Nonetheless, we believe our detailed planning including a comprehensive literature review, involvement of both service users and PALS managers through our steering group, review of previous local audits and piloting for face and content validity have maximized the overall validity of these results.

The results indicate the challenging context in which PALS are operating. All trusts were required by the DH to establish PALS by April 2002, but at least 99 PALS, and probably more, were not established until 2003 or later. Seven trusts indicated that they provided PALS functions but had no discrete PALS. One trust reported that it did not provide PALS, but it is likely that some other trusts among the 185 non-responders also did not provide PALS. Although the question about trust deficits must be treated with some caution because of the low response rate, it was notable that 43% of those that answered identified that their trust was in deficit, with 33% of these identifying the deficit as more than £5 million. Such figures are of course consistent with the widely acknowledged financial pressures much of the NHS experienced during the period the audit was undertaken. Equally, one-third of PALS who answered the question reported that there had been major structural change in their trusts in the last three years. Again, this indicates the challenging contexts in which PALS have been developing.

In terms of PALS mechanisms, the survey made clear that the most common model of PALS was a single trust PALS service, either in terms of a trust team or a single handed PALS service. Single handed PALS were more common in PCTs than in the acute sector. At the other end of the spectrum there were a few large consortia. One large consortium includes two acute trusts, three PCTs, one mental health, one ambulance and one special trust, and had a budget of £450 000 per annum.

There was substantial variation in PALS budgets, even if the most extreme figures are excluded as potentially misleading. There were ten PCT PALS reporting budgets of less than £20 000 per annum including salary costs and some textual comments make clear these were not data entry errors. One PCT respondent, for example, indicated that there were no designated PALS staff, with calls taken by generic administrative staff. The mean PCT PALS budget was £19 000 less than that of acute trust PALS. This might seem reasonable in terms of the higher mean number of queries in acute trusts (409 per quarter as opposed to 234 in PCTs) but of course most acute trust PALS are supporting users in one or two main hospital buildings whereas PCT PALS often have to cover a multitude of general practice and community health service settings.

Reflecting the variation in budgets, there was marked variation in staffing levels, with 44% of acute trusts but only 13% of PCTs and 9% of special trusts meeting our minimum criteria for a full complement of staff. The qualitative data made clear how difficult it was for single-handed PALS to meet all the national standards for PALS, particularly standard six around being a catalyst for culture change in the NHS. One vacancy for a single handed PALS post was reported 'covered' for 2 months by a hospital chaplain.

The variation in the number of queries even within sectors was also notable. It is surprising that any acute trust PALS would have as low a figure as just 25 queries over 3 months, whilst the one PCT reporting 4052 queries over the quarter probably reflects a particularly all-encompassing classification of what counts as a PALS query. The differences in mean numbers of queries between the sectors were more expected, with acute trusts having the most, followed by PCTs.

In terms of outcomes, this audit survey was not in a position to measure these directly. However, it was possible to obtain self assessments against the national standards, and to ask some supplementary questions which give a more objective assessment of performance

against the standards. Overall, the PALS reported reasonably high performance against the standards. Performance was almost 100% for some basic indicators, for example the availability of information via trust switchboards and web sites. In some important areas of access for disadvantaged communities, performance was patchy. Thus only 50% had leaflets about their services available for people for whom English was not their first language. It was not surprising that PALS rated themselves least well against standards 2 and 6. Standard 2 concerns seamlessness across health and social care, and PALS workers have struggled to achieve this given that they are located in health sector settings and are often dealing with the immediate information needs and problems encountered by health service users. Standard 6 concerns PALS acting as a catalyst for culture change, and as previous research²¹ has indicated, PALS feel both under-resourced and too busy with immediate problem resolution to fulfil this challenging policy aspiration.

The findings in Table 9 suggest that PALS give greater priority to reporting to trust Boards and Clinical Governance Committees than to service user and carer groups and trust staff. However, it was notable that by far the most common way in which PALS staff felt they influenced the culture of their organization was by 'working with staff to resolve specific problems' (40%) whereas only 5% identified working 'via the chief executive'. This is despite the fact that in the original *NHS Plan* guidance great emphasis was placed on the importance of PALS having 'direct access to the chief executive and the power to negotiate immediate solutions'.¹⁴ The PALS staff response reflects our hypothesis from our wider evaluation that the degree of PALS integration in functions like clinical governance and risk management across the organization, and PALS engagement with front line staff are key determinants of effectiveness. As a chief executive in one of our case studies suggested, it might even be the case that PALS needing to take an issue directly to a chief executive is a sign not of effectiveness, but that

the PALS is not well integrated at more appropriate levels of the organization.

Another dimension to our wider evaluation hypothesis was that effective PALS would be led by senior managers with change management skills and that PALS would need to be adequately resourced to fulfil the role. Two statistical tests on associations between variables supported this hypothesis. First, there was a statistically significant association between a fuller PALS team and the rating across the seven standards. Second, there was a similarly statistically significant association between the size of the PALS budget and higher scores. Association does not of course demonstrate causality, but they are at the very least consistent with the hypothesis of the importance of senior leadership and reasonably resourced PALS teams.

Conclusions

The introduction of PALS into the English health-care system has been a unique manifestation of a wider movement towards patient involvement and advocacy. Previous research in the London region²⁰⁻²² and on children and young people's access to PALS²¹ has demonstrated both the potential value of PALS to service users and the limitations of a relatively poorly resourced service which is not backed by any statutory requirement. This research has provided the first comprehensive national overview of PALS. Our results demonstrate that the contextual limitations identified by the London research are replicated nationwide. We have also shown that there is an association between levels of resources and staffing and performance against standards.

Given the emphasis in current health policy on ensuring universal user choice and service responsiveness,³¹ it is perhaps surprising that the degree of variation in PALS functions and performance is allowed to continue. This is, however, a consequence of a parallel policy stream to devolve as much decision making as possible to local NHS organizations.²¹ Devolution inevitably means that different local decisions will be made about the resourcing, and thus the

performance of PALS. English PPI strategy remains in a state of flux, and recent experience suggests PALS are likely to continue to be affected by the turbulence of ongoing NHS policy and structural change.

With the recent parliamentary decision in the *Local Government and Public Involvement in Health Act 2007* to abolish PPI forums and establish LINKs, PALS are now one of the longer established and more stable aspects of English PPI structures. The emerging research literature on PALS²² as well as our own wider evaluation²⁹ demonstrate that service users value PALS. There are opportunities as well for PALS in the current DH plans for integrated arrangements for handling health and social care complaints, particularly with the policy emphasis on early, swift, local resolution.³² As this consultative document indicates, PALS could potentially be extended to support the informal aspect of handling concerns in social care in the new integrated arrangements. The challenge for policy makers is to ensure that the incentive structures and regulatory frameworks they put in place to manage the increasingly devolved and diverse health and social care system encourage all NHS organizations (and social care organizations if the remit of PALS is extended) to provide PALS that meet national standards.

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