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Developing Service User Involvement in the Mental Health Department of a Paediatric Hospital

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Developing Service User Involvement in the Mental Health Department of a Paediatric Hospital

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Abstract

This dissertation traces the development and implementation of a Quality Improvement Plan (QIP) in the area of Service User Involvement within the mental health department of a paediatric hospital. The change management project described focused specifically on the setting up and initial meetings of two Service User panels – one for parents/carers and their representatives and one for young people and their representatives. The dissertation sets out the rationale for this change project drawing on a number of key health policy publications of the last decade and on the literature base generally in this particular policy area. The HSE change model was used as a framework for the design and implementation of the change project. The formative stage of the development of service user involvement described in this dissertation was evaluated using a multi-source feedback questionnaire. The findings from this evaluation are discussed and recommendations are made for the next phase of this work. The project was successful in achieving its aims and the main conclusion from the process to date is the need for further work to mainstream the change within the culture, processes and structures of the mental health department.

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Chapter 1: Introduction

1.1: Introduction

This change management project report sets out to capture the process involved in developing service user involvement in the mental health department of a paediatric hospital. It also seeks to draw out lessons from this process to inform the future development of service user involvement in the hospital and to contribute to thinking and practice in this area of work in the health services generally. For me, the policy of service user involvement is fundamentally concerned with a paradigm shift in power relations between health professionals and service users. It is about the development of real partnership.

At the heart of partnership is the concept of shared ownership – a concept that supports the emergence of services that are rooted in the joint evidence base of the experiences of both service user and professional clinician. As professional clinicians and service managers we cannot afford to ignore the experiences and views of our clients. We must also acknowledge that service users do not have a homogenous experience of a service. On the contrary, a user's experience, and often their health outcome, is impacted by factors such as culture, ethnicity, religion and belief systems, gender and socio-economic status. Therefore our partnerships with service users must both acknowledge and address these differences in how we approach and construct structures and processes for dialogue with service users. Within the change management project described in this dissertation I have attempted to pay attention to these factors and to ensure that real partnership as opposed to tokenistic consultation is the concept guiding the development of service user involvement in my workplace.

1.2: Rationale for the project

The national health strategy 'Quality and fairness: a health system for you' (DOHC, 2001) puts service users at the centre of health and social care delivery. In addition, the policy document informing the development of mental health services "A Vision for Change" (DOHC, 2006) underlines the importance of service user involvement and dedicates a chapter to the discussion of this. Since these initial publications highlighted the importance of service user involvement, a series of publications under

the collective title “Your Service Your Say” has been issued by the Health Services Executive (HSE) to inform practice in this area. Crucially, the National Service User Involvement Strategy was published in 2008. The continuing development of service user involvement has also been a regular target in HSE Service Plans. From all of the above it can be seen that there is an emphatic focus within health services on the need to develop structures and processes to enable the genuine involvement of service users in our service development and planning. This policy emphasis was a major driver of my change management project.

The national policy emphasis on service user involvement came into focus in the last accreditation process within the hospital. A key recommendation from this accreditation was that the hospital should be proactive in the development of service user involvement. This recommendation was one that I noted with interest at the time of deciding on a change management project for my Master’s programme. I was aware that this recommendation would create a fertile environment for a change management project focused on the development of service user involvement. In a Force Field Analysis of the drivers and resistors of change (Lewin, 1951) I noted both the external policy environment and the internal hospital need to improve its work in this area as strong change drivers.

Within the mental health department where I work as a Head of Discipline, it was less immediately obvious what the response to the suggested change management project would be. Colleagues in a nearby community based child and adolescent mental health organisation met with strong resistance from the managers of the service in endeavouring to further the work of service user involvement. However, in looking at the literature on user participation, one finds that mental health is an arena that has been to the forefront in the development of best practice on this issue (Tomes, 2006; James, 2008). I was confident also of both my position power and expert power (French and Raven, 1959) within the department to carry out this project - particularly in relation to persuading key stakeholders of its necessity. This confidence was affirmed when the project proposal met with a strong endorsement from the Department’s Clinical Director.

Finally, and of key importance, I selected this project precisely because it was one which matched my experience, my skills and my value base as a worker. The project indeed could be said to be a perfect vehicle for integrating my training and background in social work, community development and group analysis. All of the above disciplines, in which I am qualified, emphasise the importance of concepts that also underpin service user involvement – concepts such as partnership, participation and empowerment.

1.3: Summary

I chose to undertake a change management project that, for a variety of reasons, could be seen as an opportunity both for the hospital and for my department. The analysis of drivers and resistors evidenced the weight behind the drivers and this in turn was enhanced by the fact that the project offered the opportunity for me to bring my full skills and experience to bear on bringing about positive change and indeed for extracting and mainstreaming the learning from the process of change.

This dissertation will describe the change process using the HSE Change Model (2008) as a framework. It will look at the evidence base in the literature for carrying out such a change process and it will describe the project in its different phases with reference to the HSE change model and to other theories of change management. The dissertation will set out the findings from an evaluation of the project in its start-up phase and, finally, it will discuss the key themes that I and other participants in the project have identified as important for the future of this work.

Chapter 2: Literature Review

2.1 Introduction

The subject matter of my change management project, service user involvement and, specifically, the development of service user panels within a mental health context, is a subject with a broad literature base. As the subject is not specifically a medical area the search was conducted within both the specific library databases of PubMed and Psychinfo and also as a general search using Google and Google Advanced Scholar.

The terms used to build the search were:

- Consumer participation;
- Mental Health/Psychiatry; and
- Informing policy.

2.2 Issues from the Literature Search

The search revealed the conceptual ‘looseness’ of the term Service User Involvement that is widely used to convey the policy requirements of the Department of Health and Children and the HSE. Within the literature the different applications of this term were obvious. In summary I would categorise these as follows:

- Service user involvement and the active partnership between patients and their clinicians in individual treatment programmes;
- Service user involvement as a tool in health promotion; and
- Service user involvement in the planning and development of health services.

The last of these categories is the one most pertinent to my project and is therefore the area to which my literature search was most directed. The search revealed that it is arguably within this area of service user involvement that the least conclusive research has been conducted. Crawford et al (2002) report that “we were unable to identify any reports that investigated the effects of involving patients on the health, quality of life, or satisfaction of those using the services” (p.2). However, the same paper also acknowledges that there is evidence that involvement of service users is a good mechanism for improving service information and making services more accessible which could be considered a key factor in improving the health of patients. Carr (2007) states:

“the impact of ..participation on the change and improvement of social care services is yet to be properly monitored and evaluated. Much progress has been made in establishing the principle of service user participation and on developing ways of doing this but there is now a second stage that will entail examining how organisations, systems and practice need to change in order to respond to participation.” (p.267).

Carr’s finding fits well in my opinion with the current situation in Ireland. The development of service user involvement as a key policy position remains largely at the stage of defining ‘service users’ (Department of Health and Children, 2008) and of developing best practice guidelines (HSE, 2009, 2010). It could be argued therefore that we are at the stage of developing our understanding of the processes of partnership and participation and that we are not yet ready to address the longer-term impact of user involvement on health outcomes.

From the literature review the origins of service user involvement are traced and the key challenges of service user involvement are identified. A model of service user involvement from an Irish context is presented briefly with some key conclusions from the evaluation of this model. The findings from the literature review are summarised and the themes emerging are used to inform the change process that I led within my own organisation.

2.3 History of service user involvement

Whereas service user involvement has only become a policy requirement in the health sector since the early 1990s (Hodge 2005, Carr 2007) the seeds of this policy can be traced back to the ‘Consumer/Survivor’ movement (Tomes, 2006), which Tomes describes in a fascinating paper on the development of this movement in the various phases of it’s relationship with mental health services in the United States. Tomes’ paper identifies that the origins of service user participation are clearly rooted in a conflictual relationship with services. Whereas Tomes was discussing the policy environment within the US it is nonetheless informative for our own services as the paradigm shifts described mirror our own struggles for fundamental change, particularly in relation to power dynamics, within the sector. Tellingly for us in the current bleak economic environment, Tomes makes the point that:

“Efforts to rethink the power dynamics between doctor and patient are occurring in the context of an often brutal economic restructuring of the health

care system. Returning power to end users in a fragmented, politicised health care system remains a daunting prospect.” (p.720)

Tomes’ paper traces the development of service user involvement over a period of forty years starting with the early ‘survivor’ movement which aimed to create an alternative model of psychiatric care drawing on the work of R.D. Laing (1960) and including the beginnings of a partnership approach between the survivor movement and the mental health system in the Carter Commission of 1978. Tomes notes the difference in the nature of engagement i.e. conflict or partnership as reflected in the names of the movements, ‘survivors’ as those firmly in the confrontational camp and ‘consumers’ as those in the partnership camp. The partnership approach to service user involvement has strengthened in the US since the Carter Commission. In a national survey of user involvement in mental health conducted in 1998 Geller et al found that consumer empowerment had developed considerably since the mid to late 1990s although it was still not universal across states. (p.502)

The literature on service user involvement from the UK, although not specific to mental health services, refers to the ‘consumerist’ policies of the early 1990s as the foundation on which service user participation was constructed (Hodge, 2005). This foundation was one that emerged from New Labour’s philosophy of ‘modernisation’ of health services. In their paper, intriguingly titled “The ‘User’: Friend, Foe or Fetish?”, Cowden and Singh (2007) explore the policy agenda underpinning New Labour’s ‘modernisation’ programme and find that it is concerned with the concept of a state which seeks to enable private citizens to look after their own affairs rather than a state which embodies concepts of public responsibility to its citizens. According to Cowden and Singh the political philosophy from which the concept of service user involvement is drawn is one that seeks to target resources rather than one that seeks to identify ways in which services can be improved and developed. Cowden and Singh would argue that, in this context, service users’ opinions of professional practice may lose their unique contribution as critiques arising from direct experience as they become incorporated into a larger process dominated by performance management, audit and evaluation. (p.20)

This is perhaps a very useful point of reference for us in Ireland as we develop our service user involvement at a time of extreme economic austerity. Whilst we must by

necessity accept the need for performance management, audit and evaluation it is also important for us to be clear, as service planners and managers, what the core philosophy and agenda underpinning our policy commitment to service user involvement is. The literature challenges us to ask ourselves the question “are we committed to a paradigm shift in power relations between professionals and users or are we drafting in users to support a reductive agenda and a ‘privatisation’ of services through the development of a consumerist approach to service planning”? For me, the philosophy underpinning the commitment of my organisation to the development of service user involvement is key not only to how this process develops but also to the impact it has on the culture, processes and structures of the organisation as well as on the outcomes of services.

2.4 Challenges in Service User Involvement Practice

Two key challenges identified in the literature on user involvement are:

- Power relations; and
- Embedding and resourcing involvement in organisations.

2.4.1 Power

Carr (2007) reports that difficulties with power relations underpin most of the identified problems in service user-led change processes (p.267). In exploring this phenomenon further Carr identifies that the difficulty in power relations derives from different interpretations of the term ‘service user involvement’. She argues that the policy-makers’ understanding was perhaps rooted in a consumerist approach but that service users in the UK have interpreted their involvement differently – as a means of demanding more active citizenship (p.268). In Ireland, the National Service User Strategy (DOHC, 2008) underlines a commitment to inclusion and, in the core definition of a service user, it includes both direct service users and community and voluntary groups that represent the general service user and specific cohorts ie ethnic minorities, people with disabilities etc. The philosophy of the Irish policy is therefore rooted in an inclusive and empowering approach but, nonetheless, it is in the practical application of this philosophy within individual organisations that the real commitment to inclusion will become apparent. The lesson for those embedding service user involvement change initiatives is that detailed attention must be paid to

the understanding of service user involvement and to the organisational change that will be needed to ensure that such change represents real partnership as opposed to a more individualised and tokenistic consultative approach. Arnstein's Ladder of Citizen Participation (1969) is a very useful frame of reference in planning and implementing the development of user involvement and, to the credit of the authors of the National Strategy, this is a tool which is set out within the strategy and which we can use in informing our practice.

2.4.2 Embedding and resourcing change in organisations

The necessity of bringing about organisational change as a fundamental aspect of facilitating service user involvement remains a key challenge for change leaders (Hodge 2005, Cowden and Singh 2007, James 2007, Stewart et al 2008). Arguably, there is a greater likelihood that those leading service user involvement initiatives will be coming from a particular perspective that incorporates an inclusive, partnership approach to such work. There is always the potential that such an approach will clash with the established culture and *modus operandi* of the organisation. Real and sustainable change means that structures and processes need to change to include users as real partners (DOHC 2006, 2008). Such inclusion must be informed by clear understandings of and commitment to the benefits of user involvement. Crucially this involves a fundamental acknowledgement of the particular expertise of the service user. In her paper Carr (2007) argues that:

“Both service users and frontline workers have ‘critical intelligence’ about social care services, the exercise of which through dialogue, may bring them to points of commonality....and even eventual consensus. But first, user participation strategies must support....the expression of ‘passions’ rather than seek to maintain an artificial consensus or status quo”. (p.273)

This concept of the contribution of users as rooted in the ‘passion’ of direct experience is a crucial challenge to organisations – how do they create a space for honest and open discourse and dialogue and not suppress these very passions through the use of managerial and professional jargon which is, by definition, exclusive of the very different experience of the user?

In addition to changes in structures and processes there is an organisational challenge to resource and support user involvement. At a time of severe budgetary cuts, finding the necessary resources, including both staff time and finances, to support this work

will be a key challenge to change leaders. “A Vision for Change” (DOHC, 2006), the policy framework for the development of mental health services in Ireland, acknowledges the necessity for services to adequately resource service user involvement and recommends the setting up of a National Service Users’ Executive to enable the networking and empowerment of service users. Again, this is a commitment to genuine partnership that has to be replicated by each individual organisation developing its user involvement.

2.5 A Model of Service User Involvement

The literature search identified many models of good service user involvement practice including *inter alia* Wells et al, (2004), James, (2007), Christopher et al, (2008) and Taylor et al (2010). From the Irish context one programme merits attention as a core aim was to identify mechanisms for effective, meaningful and sustainable community participation in health policy and planning (Combat Poverty Agency, 2008).

From 1986 until its closure by the last government, the Combat Poverty Agency was a statutory agency set up to advise the government on the nature and extent of poverty in Ireland and on measures to address poverty. Between 2003 and 2007, Combat Poverty ran a pilot programme called “Building Healthy Communities” (BHC). The achievement of this programme’s aim to explore mechanisms for effective and sustainable community participation in health policy and planning was enhanced by close working relationships with the social inclusion unit of the Department of Health and Children and the Institute of Public Health. The active partnership between Combat Poverty and staff of the Department of Health and Children through the advisory committee to the BHC programme also helped to inform a particular and, arguably, quite radical vision of service user involvement as set out in the 2008 National Strategy.

All the projects that received core funding under the BHC programme shared a commitment to using community development approaches to develop effective partnership with health sector organisations in order ultimately to influence health policy and planning. The 2008 evaluation of the programme found that the support offered to projects through the programme developed the capacity of the funded

projects to participate more confidently and effectively with health sector agencies such as the HSE (CPA, 2008). This is an interesting outcome as it highlights the importance of a support infrastructure for community and user groups in order to facilitate effective and meaningful user involvement. This outcome is captured in the following extract from the evaluation of the BHC programme:

“The programme provided examples of projects which, individually and collectively, became better able to engage with statutory health services and develop positive partnerships with them, leading ultimately to better and more appropriate health services for disadvantaged communities. The collective activity strengthened the community voice and demonstrated the value of collective rather than piecemeal action.” (p.9)

These findings have a real resonance for my own change management project and I will return to the themes raised in my final chapter. For now it is important to note that the fundamental lesson of this particular service user/community participation model is the need for proper support to communities and user groups in order to ensure both effectiveness and sustainability of participation as a core policy and practice within the health sector.

2.6 Summary

The literature review highlights a conceptual looseness in the understanding of service user involvement. It also suggests that, in the key area for my project of service user involvement in health policy and planning, there is not as yet a large body of research. The history of service user involvement traces the development of this policy from its origins in a conflictual relationship with health services to a more partnership oriented approach. The challenges within this relationship are identified in the literature and are related to issues of power, sustainability and of how to embed real involvement and participation within organisations. These themes are reinforced in an example of user involvement in health from the Irish context. Having identified the key debates and themes in user involvement from the literature these will be a reference point for the discussion of my change project in its planning and implementation and in my reflections and recommendations in the final chapter of this dissertation.

Chapter 3: Methods

3.1 Introduction

This chapter will outline the process of the change management project with reference to the change management model used. The model used was the HSE model (2008). The chapter will set out the change process and will explore the reasons why the HSE model was selected. The chapter will then discuss the change project using the phases of the HSE change model – initiation, planning, implementation and mainstreaming. Finally the chapter will be summarised to capture the main issues arising from the change process.

3.2 The Change Process

The change process was initiated in response to the external policy requirement to engage with service users and the internal hospital plan to develop processes and structures to enhance service user involvement (DOHC, 2006 and 2008, HSE, 2009 and 2010, Hospital Service Plan, 2011). The change process involved the development of service user involvement in my department, the mental health department, of the hospital.

The change process began with the facilitation of Quality Improvement workshops to develop an action plan in the area of service user involvement. A key action from this plan, the establishment of two service user panels - one for parents/carers and their representative groups and one for young people and their representative groups, formed the core of the change process.

Although the change process was concerned with the initiation of service user involvement it also sought to enable the beginning of mainstreaming of this change within the department and to inform work on the development of user involvement elsewhere in the hospital. The HSE change model was used as a point of reference for the change process. The reasons for my selection of this model in preference to others are discussed below.

3.3 Why the HSE Change Model?

“To manage change is wishful thinking, implying as it does that one not only knows where to go and how to get there but can persuade everyone else to travel there. To cultivate change is something different, suggesting an attitude of growth, of channeling rather than controlling, of learning not instruction” (Handy 1999, p. 292).

Change, as the above quote from Handy captures, is a multi-layered and complex process, which involves people, processes, structures, culture and behavior and involves these throughout the organisational system. In other words, change involves people and processes from the individual worker, through groups, departments, disciplines to the overall management of the organisation. Thus it is imperative that a change model attempts to capture this complexity and to emphasise the people and cultural elements of change in addition to the structural elements. The HSE model of change claims this very emphasis and acknowledges the necessity of addressing cultural and peoples aspects of change in order to ensure its sustainability.

Although the end result of the change management project I undertook was the establishment of two new structures the project was nonetheless a particularly process-oriented project. In my project proposal I identified strong change drivers but also the possibility of more covert but no less strong resisters. Throughout this project therefore it has been important for me to work in particular with potential cultural and behavioural resisters. This was accomplished by adopting an inclusive approach with an emphasis on establishing strong and effective communication mechanisms. In all of the phases of my project I found the HSE change model a useful frame of reference. The fact that this model derives from an organisational development approach underlines for me it's potential to capture the complexity of change and the fact that this is not a linear process but rather a 'whole-system' approach. In my opinion, this type of approach is particularly relevant to a process-oriented project.

The selection of a change process is to some degree always a subjective exercise and it can be useful to identify one's personal resonances to any particular model. For me, change models that emphasise a step approach to change (Beer et al, 1990, Kotter, 1995) are too simplistic and do not fit well with my understanding of the complexity

of change which derives from my various professional trainings and work experience. The 'step' models fail to capture the dynamic nature of change. In my experience it is rarely the case that one moves in one direction along a linear route of change. On the contrary, change involves a constant revisiting of topics which are underpinned by deeply held feelings and which in turn influence both resistors and drivers of change.

The HSE model is both an organisational development model and a step model in that each phase of the model sets out a number of steps to be achieved. However, the model has resonance for me because of its congruence with my own principles and values particularly in its upfront emphasis on the people and cultural aspects of change. Recognising both my personal strengths and my areas for development (Belbin, 1993), I would also acknowledge that the simplicity of the HSE change phases were useful for me in the planning, monitoring and completion of the change management project.

Having summarised above the reasons for my selection of the HSE change model I will proceed to outline in more detail the process of the change project using the phases from this change model.

3.4 Change Model

3.4.1 Initiation

Step 1: Preparing to lead the change

The task of the initiation phase of a change process is to lay careful foundations for the change. It is at this stage that it is crucial to identify the drivers and resistors of change (Lewin, 1951) and also to identify the potential impact of the change on key stakeholders through a stakeholder analysis.

I outlined the strong drivers of the proposed change in my introduction but it is worth repeating these in order to establish the platform for this change that existed within my work environment. The drivers included the strong emphasis in health policy on developing partnerships with service users in order to enhance services, the internal hospital target of developing service user engagement as set out in the 2011 Service Plan, my own location in terms of both position and expertise power (French and Raven, 1959) within the mental health department and the hospital and my training

and experience in the area of participation, empowerment, organisational development and group work.

At the initiation phase of a change project a stakeholder analysis is a useful tool that enables a change leader to identify the range of stakeholders for a particular project and the degree of their importance and influence over the course of the proposed change. This in turn helps the change leader to plan actions within the change process in order to ensure a receptive reaction to the change amongst the stakeholders. The results of the stakeholder analysis that I undertook at the initiation stage of my project are set out in the table below.

Table 1: Stakeholder Analysis

<p>High Importance/Low Influence Service Users (adult and youth) and their representative groups</p> <p>Department colleagues not directly involved in the project</p>	<p>High Importance/High Influence Mental Health Department Management Department colleagues involved in co-working the project</p> <p>Hospital Senior Management (including CEO)</p>
<p>Low Importance/Low Influence Staff outside of the mental health department</p>	<p>Low Importance/High Influence Hospital Board of Directors Medical Board</p>

The stakeholder analysis was helpful in ensuring that I identified the key stakeholders in terms of both importance and influence and, from this, and as far as it was within my power to do so, I put in place strong and effective communication channels with them from the outset. The particular mechanisms for communication I set up included a project update as a regular item on the agenda of the monthly management meeting in the mental health department and the development of links with hospital management. Initially this link was with the Accreditation Manager but, over the

course of the project, this developed into active participation in the hospital Steering Group on this issue.

In recognition of the high importance/low influence status of staff not directly engaged in the work of the project I tried to ensure a feedback mechanism to staff through email. It is debatable as to how successful this mechanism was as, from experience, management has found that staff who are very busy with clinical work often overlook emails that do not relate directly to their work. However, the process of engaging with staff, although challenging, remains at the same time fundamentally important because of the need to ensure the sustainability of the change into the future and the readiness and availability of staff to take up the role of partnering and championing this change. Handy (1999), speaking about the concept of ownership in organisations, identifies a new paradigm emerging in organisational theory which he conceptualises as the organisation as *community*. According to Handy, the concept of *community* emphasises the need for *belonging* in contrast to the old paradigm of the organisation as *property* which emphasises *ownership*. In an organisational *community* “the fruits of success belong to all the interested groups” (p. 353). The capacity to embed change and fundamental paradigm shifts within an organisation necessitates the ‘buy-in’ not only of managers but also of staff. Without such a commitment the project, over time, would be doomed to fail. The success of my project in the longer-term therefore demanded that I pay attention to the ‘community’ of staff within the department in order to inform them of progress on the project and to ensure their ongoing commitment to it. The question of how to achieve effective communication with the staff of the department was revisited over the course of the project.

In recognition of the high importance of service user representative groups I developed links with a range of groups in order to ensure that they would engage with and nominate participants to the service user panels. This proved to be a heartening and stimulating part of the project as, without exception, the groups responded with enthusiasm to the invitation to participate in this project and, in particular, the service user panels. The need for strong and independent representative groups is identified by Hodge (2005) as a prerequisite for effective service user involvement. I would agree with Hodge and would contend that the existence of independent,

community/user-led projects was a key factor in facilitating the development of my change project in the initiation phase. In Ireland we are fortunate that, despite recent severe cutbacks, an independent community and voluntary sector exists that is both willing and able to engage with us in our planning of services as evidenced by the Combat Poverty Agency (CPA) programme previously cited (CPA, 2008).

In the initiation phase I found the 7S model (Peters and Waterman, 1982) a useful frame of reference in establishing a baseline and in managing the project from a whole organisation approach. This model, with its emphasis on paying attention to both the *soft* and *hard* components of organisational structure, was useful in helping me to frame my initial project impact statement (Appendix 1) and the agenda for the QIP workshops in the planning phase.

Finally, the initiation phase was important in developing my information base and my learning about the most recent developments in service user involvement. This was accomplished through general reading and through participation in a workshop, sponsored by the UK Department of Health and run by the Anna Freud Centre Evidence-based practice unit, on developing the participation of children and young people in mental health settings.

3.4.2 Planning

Clearly, planning is an exercise for all phases of a change management project. However, in the HSE model the very detailed initiation phase leads in to the planning phase. This phase includes the following steps:

- **Step 2: Building commitment**
- **Step 3: Determining the detail of the change; and**
- **Step 4: Developing the implementation plan** (HSE, 2008 p 36)

In my change project the planning phase was the first phase during which the project activities were expanded beyond me to other stakeholders including, crucially, my colleagues in the mental health department. The key mechanism I used to build commitment was the facilitation of two workshops for staff of the department. These workshops explored the detail of the change using the particular lens of service user

involvement to develop a Quality Improvement Plan (QIP) for the department in this area. This QIP became the implementation plan for the change. In facilitating these workshops I used a model based on the 7S model which addressed both the identification of shared values (the *soft* organisational components) and the *hard* organisational components i.e. structure and systems (Appendix 2, Workshop agenda). Ten participants in total participated in the workshops. This represents approximately 48% of the mental health department workforce. Three of the eight managers were among the participants and this helped to strengthen the base of support for the project across the department.

The action plan that emerged from the QIP workshops went beyond the particular focus of my change management project, the setting up of service user panels, to include improvements in other aspects of our engagement with service users. In relation to the development of the service user panels the action plan adopted the definition of service users as set out in the National Service User Involvement Strategy (DOHC, 2008) and agreed that groups representing different cohorts of users as well as direct service users should be invited to participate in the user panels. The workshops established a working group to progress the service user panels. A specific task of the working group was the consideration of how to invite the participation of direct service users on to panels bearing in mind ethical considerations e.g. how involvement with a panel would be balanced with therapeutic work. From these deliberations the working group proposed that one useful guide in inviting direct service users on to panels would be their capacity to engage in a group situation. To this end invitations, in most cases but not exclusively, went to participants in previous or existing group interventions within the department. This is obviously a question which merits more detailed consideration in the context of a thorough evaluation of panel participation in the future.

I evaluated the QIP workshops using a plus/delta model i.e. “what was good/what could have been better”? In this brief evaluation I was struck in particular by the enthusiasm and energy that our discussions generated. Comments such as “it’s very exciting”, “I’m surprised that it’s such an interesting area of work”, “I really want to get involved” were offered. And indeed the enthusiasm expressed was followed through on in the organisation and planning of the service user panels in addition to

work on other areas identified. This outcome of the QIP workshops was particularly noteworthy in the context of a service under pressure due to the impact on resources of both the major change towards the National Paediatric Hospital and the budgetary cuts. This is not a context in which one would traditionally expect to find energy and enthusiasm for yet another piece of work. The lesson seems to be that innovatory projects can generate a different energy. However, perhaps this energy is better explained by Handy in succinct fashion:

“If you want innovative behavior, set selection criteria that capture innovative people”. (Handy, 1999 p 138)

On this point it is worth noting that, although I invited all staff to attend the QIP workshops, those who actually attended self-selected. Perhaps indeed I ‘captured’ those most drawn to and interested in innovation and change?

Following the workshops feedback was given to key stakeholders including hospital and department management and department colleagues who had not participated in the QIP. In addition to feedback from the workshops I also gave department and hospital management my project proposal, Gantt chart and project impact statement. It is important to note here that I experienced my feedback to some stakeholders as cursory – this was not an issue on the agenda of the management group of the department that warranted a lot of time or attention. Similarly, my feedback to hospital management, prior to the initiation of a hospital-wide Steering Group on user involvement, was equally cursory. This is not to say that the response was negative at all. Indeed, the positive attitude towards this change project was re-affirmed. However, the quality of this particular experience resulted in my questioning the real motivation for this change – was the motivation about complying with Department of Health/HSE policy requirements or was it about a real commitment to developing partnership with service users? These are the fundamental questions to do with power relations and paradigm shifts identified in the literature review and raised *inter alia* by Carr (2007), Cowden and Singh (2007) and, from a different perspective, by Crawford et al (2002). I will return to this issue in the final chapter of this dissertation.

3.4.3 Implementation

Step 5: Implementing the change

Following the QIP workshops the implementation phase of my change management project was acted on. Due to the commitment established during the planning phase I was able to share this work with interested colleagues. However, I still remained central to the work and a key actor in terms of inviting participation, in planning for the panel meetings and in communicating our work to all stakeholders including hospital management, department management and, fundamentally, to service users and representative groups.

The key activities of the implementation phase of the project were:

- The issuing of invitations to both direct service users and representative groups to participate on the panels (Appendix 3);
- Meetings/phone calls with participants as required;
- Preparation of a draft agenda for panel meeting in consultation with co-facilitator/s (Appendix 4);
- Facilitation of meetings (3x adult panel, 2x youth panel);
- Planning of next phase of meetings.

The implementation chapter of the HSE change model emphasises the need for change leaders to remain flexible and responsive to factors within the organisational environment which will, inevitably, impact on the change process. It also stresses the importance of ensuring that, within the change process, attention is paid to “sustaining the momentum” of change. (p. 59)

The setting up of the service user panels represented a commitment on the part of the department to establishing partnership with users and their representatives. With a view to establishing the panel as a ‘safe’ environment for participants the plan for the initial meetings was to develop terms of reference that took account of ethical issues such as confidentiality and the need for clear boundaries for our discussions. Consent forms, subsequently re-named ‘group agreements’ (Appendix 5), had been agreed by the hospital ethics committee and helped shape the discussions on the terms of reference.

It was also the intention from the outset to develop the panels as a space where issues, arising from users' personal experience, could be identified, explored and recommendations made as to how to improve these experiences in future service planning. Hodge (2005) discusses the need for genuine service user involvement to really hear the 'passions' of users participating in partnership forums. Hodge acknowledges that this space can be an uncomfortable space for professionals and that, arising from this discomfort, there can be a tendency for professionals to filter or indeed to neutralise the power of the user's contribution through reverting to professional and managerial jargon.

In the language of change management this type of behaviour represents a resistance to change. Specifically, in the classifications of Schermerhorn (1999), such behaviour may represent a cluster of reasons for resistance including fear of the unknown and a loss of control and confidence. This facet of resistance became evident to some extent in the facilitation of our panels when co-facilitators became somewhat disoriented by the loose structure and dialogic style of the meeting. In such a situation it is imperative for the change leader to provide an environment that is supportive of staff engaged in change. In this project the key mechanism for ensuring that co-facilitators became comfortable with the process of the panel meetings was through ensuring first that they were full participants, contributing their own ideas to the design of the change process and second, that at all times they felt facilitated, supported and affirmed in their efforts.

We had thought that the first panel meetings would provide participants with the opportunity to get to know each other, to discuss the role of the panel and to come up with a broad work plan for the year – in Yalom's terms, to develop cohesion as a group (1995). Following this we had envisaged that the panels would not meet again for another two to three months. This, in our view, would have fitted with the planning process at department management level and would have been sufficient to enable the panels to join with the management's planning and to input their own ideas. However, in terms of the need to sustain the momentum of change that the HSE model identifies, the panel participants took a very different view. In order to sustain momentum and, in their view, to make the contribution of the panels relevant, they recommended that meetings would be more frequent - the adult panel proposed

meeting on a monthly basis until the summer and the youth panel suggested fortnightly meetings. This was an unexpected outcome that obviously has implications in relation to supporting the work of the panels. However, in our plus/delta round at the end of the panel meetings it was hard to experience this recommendation as anything but positive and indicative of panel participants' enthusiasm for the overall project. It does however serve to reinforce the point made in the change model that implementation plans will not always go exactly according to plan and that a key task for change leaders is to allow the plan to "evolve naturally, learning from what occurs and influencing appropriately" (p. 57)

3.4.4 Mainstreaming

Step 6: Making it 'the way we do our business'

Step 7: Evaluating and learning

The mainstreaming phase of the change process is where the leader must ensure that the process of embedding the change in the organisation is carried through. The phrase for this process in the HSE model is "making it 'the way we do our business' " (p.61). To ensure that this embedding happens the mechanisms planned for and established at the initiation phase of the project must be utilised. The second and equally important component of the mainstreaming phase is evaluation and learning. For me, it was important to distinguish between planning for a thorough evaluation of the development of service user involvement in the mental health department and the evaluation of the start-up phase that forms the basis of this dissertation. The tool I chose to use for the purposes of this preliminary evaluation was a multi-source feedback questionnaire. I will return to this in the evaluation chapter of the dissertation.

In relation to the all-important issue of "making this the way we do our business", I returned to those mechanisms which had been agreed at the initiation phase of the project. The key mainstreaming exercises included a summarised report of the work on the project to date to the management of both the department and the hospital (Appendix 6), a similar progress update to staff of the department and a further meeting of the QIP working group to review progress on the implementation plan.

The summarised report to the management of the department was written and sent with the evaluation questionnaire prior to the management meeting in March. Unfortunately this meeting was cancelled due to the lack of a quorum. The impact of the cancelled meeting for this dissertation is an absence of information on how management intends to mainstream the project. The summarised report proposed a collective meeting of the management and user panels in early autumn. This meeting was proposed in order to ensure that the project was integrated formally with the work of the department management through the process of service planning. The proposal arose from my experience of the project as, to some extent, peripheral to the work of the department and it reflects a hope that an inclusive and collaborative planning process, involving the full panels with management, will more effectively embed the project within departmental culture, processes and structures. In the absence of the full management meeting this proposal has been discussed and agreed with the Clinical Director of the department.

My relationship with the hospital steering group on service user involvement has developed into ongoing participation in this group. In addition, I am now working in close collaboration with the hospital's 'lead owner' on this issue. This new relationship has greatly enhanced the capacity of the mental health department's project to influence the embedding of user involvement within the overall organisational system. I will return to this theme in my concluding chapter but, for now, it is useful to note that the interplay between two different cultural types – role culture and task culture (Handy, 1999) – seems to me to be crucial to the process of mainstreaming. The working/steering groups in both the department and the hospital are those process-oriented, task culture spaces that allow for innovation and creativity in the work. In turn, the ideas generated in these forums are assimilated, or mainstreamed, into the department and the organisation through the more formal, bureaucratic role culture.

The QIP working group in the department met to review progress on the implementation of the plan. At this meeting it was agreed that a general staff meeting should be organised, with service user involvement as a core agenda item. This meeting is currently being planned by the head of administration in the department

and it is proposed that discussions will be led by the QIP working group and the Clinical Director.

3.5 Summary

This chapter has set out the progress of my change project using the steps and phases of the HSE Change Model as a frame of reference. The project has, to date, progressed well and relatively smoothly. The importance of the channels of communication with relevant stakeholders established during the initiation phase of the project is borne out in the last phase where evaluation and mainstreaming the change are the primary tasks. I have found this change model very useful both in thinking systemically about the change and the people and cultural elements of this and also as an aid to the overall project management. Some questions have been provoked for me in the implementation of the change and in the mainstreaming of this. These questions relate to themes that have been recurring throughout this dissertation and to which I will return in my concluding chapter.

In the next chapter I will address the issue of evaluation of the project to date and identify the outcomes with particular reference to my original project impact statement.

Chapter 4: Evaluation

4.1 Introduction

This chapter will address the evaluation of my change project at the end of this start-up phase. Although the project implementation is at an early stage there have been significant achievements and it is important to note these and to use them in the ongoing promotion of the project. To this end this chapter will address the evaluation tools used in this particular change context and the progress noted and issues identified by contributors to the evaluation. The chapter will also reference my initial project impact statement and assess the extent to which the intended outcomes set out in that statement have been achieved at this point.

4.2 Evaluation Tools

Evaluation is a way of measuring the extent to which a set of actions achieves its original objectives (Lazenbatt, 2002). My change project set out to implement a quality improvement plan in the area of service user involvement. Specifically it set out to establish two service user panels – one for adults/parents and their representatives and one for young people and their representatives. In addition to these structural and systemic changes, my project impact statement identified other objectives related to cultural and behavioural changes to underpin and nurture the structural changes.

I am acutely aware that my change project, whilst having delivered the stated outcomes in relation to the establishment of service user panels, is at a very early stage of development in relation to the more intangible cultural aspects of the change. Because of this however, I considered it a useful exercise to engage in an evaluation, through the medium of a multi-source feedback, to check in with the key stakeholders in relation to their perceptions of the work to date and, in particular, to note any issues of concern they might be raising. As Clarke (1996) notes self-evaluation achieves a number of purposes including the encouragement of participation and empowerment. Given the central focus in my change project on participation and also the need to work at embedding the project within departmental culture, I saw the evaluation as an opportunity to draw in support for the project and to develop awareness about it.

Green and South (2006) also point out the potential of an evaluation to improve health programme implementation, to increase support and to impact on policy decisions.

With the perception of evaluation as an opportunity in the development of my project and bearing in mind the early stage of development I designed two evaluative questionnaires – one for panel members and one for management and staff of the department and hospital (Appendices 7 and 8). These questionnaires were based on a responsive model of evaluation that aims primarily to understand the various perspectives of individuals with respect to the issue. The questionnaires were distributed in late March and early April. The numbers distributed and the response rate is shown in the table below.

Table 2: Evaluations and response rate by category of respondent

Category	Service Users	Department Staff	Department Management	Hospital Management
Evaluations Distributed	9	15	7	3
Response Rate	67%	47%	29%	33%

The response rate of the various categories in itself highlights issues in relation to the embedding of this change within the department. This issue was discussed by the QIP workshop at its April meeting and in particular the low response rate from department management was noted. Arising from this discussion the need for a general staff meeting to highlight the achievements of the project was agreed and is currently being implemented.

4.3 Project Outcomes

4.3.1 Quantitative outcomes

The quantitative outcomes of this project to date are:

- The Quality Improvement Plan (QIP) workshop and draft plan for the mental health department;
- The establishment of two service user panels (adult and youth)

- The holding of 5 meetings to date of these panels (3 x adult panel; 2 x youth panel);
- Plan for further meetings of panels during May and June 2011;
- Liaison between the project in the mental health department and the service user involvement steering group in the hospital;
- Review meeting of QIP Working group in department.

These outcomes represent significant achievements and they are a solid foundation on which to progress the work of service user involvement in both the mental health department and the hospital. One caveat to this is a concern about inconsistent attendance by panel members particularly at the adult panel meetings. This inconsistency can be explained by the existence of very real obstacles to attendance which will need to be discussed and addressed in so far as they can be. The impact of inconsistent attendance and the concern it gives rise to relate to the issue of group cohesion (Yalom, 1995) and the creation of a ‘safe’ space for the deliberations of the panels.

4.3.2 Qualitative outcomes

The various respondents to the questionnaires identified the potential of the service user panels in enhancing service delivery within the department. Some positive comments are noted below:

- “I feel important as a parent and feel that I might be able to offer something of use to the panel”;
- “The influence the panel is likely to have in the guidance and ultimately decision-making process of the facility was a prime motivating factor in my wanting to be part of it;
- “The process will be slow but it will contribute to good ideas if the panel is listened to at the end”;
- “It [the project] strengthens the mental health services’ role in the hospital and for positioning this service in the National Paediatric hospital”;
- “Extremely useful – we need to progress initiatives like this if we are to live up to our mission and ethos”;
- “I feel this project will be very energising and insightful for staff as they strive to provide a good service to children and families”.

Respondents rated the project in terms of its potential impact on a scale of 1 to 5 with one being low impact and 5 high impact. The rating given to the project on this scale was 4.5. This is obviously a very positive rating and it has had a galvanising impact on those involved – particularly on the QIP Working Group in the mental health department.

The concerns identified by respondents reflect the themes from the literature review and from the implementation of the project. Some of these comments are noted below:

- “...for real change to be sustained the culture needs to adapt and ..this will be an ongoing challenge”:
- “interesting concept – but how much power will these groups have to impact management”?;
- “only concern would be that due to the limited available resources the recommendations will not be implemented”.

I am not surprised at how uncannily these concerns match those identified in the literature. They reflect my own thinking about the project and these are the themes that I will address in my concluding chapter.

4.4 Project Impact Statement

Finally, it is important to assess the project in relation to the expected outcomes that I set out in my Project Impact Statement. I am conscious that not all these outcomes have been achieved. However, progress has been made on them and I would summarise this progress as follows:

- **Behavioural Outcomes** – there is a developing awareness in the department of the need to place the service user at the centre of services and of some aspects of best practice to enable this;
- **Structural Outcomes** – the service user panels have been established and the next major task is to ensure that their relationship with management in service planning is clear and they are adequately resources to participate in this;
- **Personal Outcomes** – this outcome has been achieved in that I have taken a lead role in facilitating user participation in the department and will continue this role into the future;

- **Cultural Outcomes** – it is clear from staff and management feedback that there is a growing awareness about user involvement and a commitment to embedding this within the department. However, the level of this awareness and how it will translate into the *hard* components of organisational structure remains a task for the next phase in the development of user involvement.

Summary

In my initial project proposal I proposed a focus group with groups representing service users as part of the evaluation of my project. However, I now realise that, due to the very early stage of development of my project, this would be an unproductive exercise at this point. Instead I chose to conduct a responsive evaluation exercise, using a simple feedback questionnaire. The results of this feedback are largely affirming of the project and some useful and constructive comments on improving the work into the future have emerged. These comments will be used to inform the work of the panels and, in particular, the work of embedding the change within the department in the next phase of the project.

The evaluation themes resonate with the issues that were identified in the literature review and which emerged as concerns during the implementation of the project. In the next and final chapter of this dissertation I will discuss these issues in more detail, drawing on the relevant theory in order to make recommendations for the future of this work.

Chapter 5: Discussion and Conclusions

5.1 Introduction

In this final chapter of my dissertation I will identify the strengths and limitations of my change project and the implications arising from this process for the management of my department and of the hospital. The implications for management relate directly to issues that were identified in the literature review and that subsequently became evident during the actual change process and the evaluation. These are issues such as power relations, sustainability and embedding the change in the organisation. In this chapter I will explore these topics and make recommendations for future improvements in this area of work within the mental health department and the hospital. In recognition of the fact that the issues discussed are core concepts and processes in service user involvement, it would also be my hope that the recommendations will be applicable to other organisational situations. In concluding this dissertation I will summarise my reflections on the project from the perspective of my personal learning from the process as a change leader and manager.

5.2.1 Strengths of the project

The core aim of my change project was to develop service user involvement in a mental health context. In particular, the project set out to establish two service user panels – one for parents/carers and their representative groups and one for young people and their representative groups. The project was managed in accordance with the relevant strategies of the Department of Health and Children (DOHC), the HSE and “A Vision for Change” (2006), the policy framework for the development of mental health services in Ireland. In leading this change process, best practice guidelines as set down by the DOHC in the National Strategy for Service User Involvement (2008) and the series of publications “Your Service Your Say” (HSE 2009/2010) were followed as far as it was practical to do so. The change project was also informed by the principles underpinning social work and community development. In particular, due attention was paid to issues of empowerment, participation and ownership. I led the change process from a place of commitment to the fundamental principle of community development as set down in the handbook of the National Community Development Programme (1999):

“Community development is about promoting positive change in society in favour of those who usually benefit least. However, it is not just about making concrete changes in the quality of people’s lives. It is also about how this is done ie both the task and the process are important.” (p.3)

The fact that I worked throughout the project out of the principles of community development was a strength as it meant that there was a consistent theoretical framework underpinning the project. Equally, both the general policy environment and the specific policy environment of the hospital gave a strong impetus to this particular change project. The HSE Service Plan 2011 (p.11) and the Mental Health Commission’s “*Quality Framework for Mental Health Services in Ireland*” (2007, p.29) both highlight the ongoing target of developing and improving service user involvement. The policy context created fertile ground for this change process and contributed to what, to date, can be seen as positive outcomes. However, despite the readiness for change created by the policy environment, other factors exist which could potentially counteract this and limit the successful mainstreaming of this change within the organisation.

5.2.2 Limitations of the project

One of the key limitations of the project is the absence to date of a broad-based consensus among both staff and management of the department on the progression and development of this work. At one level this can be attributed to the impact of budgetary cuts and, in particular, to the reduction in staff numbers resulting in high levels of stress for the remaining staff. At another level however the fact that the project is perceived to be so peripheral relates to the very challenging task of shifting attitudes and, fundamentally, power relations. The most critical limitation of the project is this factor – the perception of the project as an added extra without particular significance within the spectrum of the primary task of the department. It is quite likely indeed that my personal commitment to this project and the fact that it was the subject matter of my Master’s programme increased the likelihood of it being marginalised by management and seen as ‘my’ project rather than an embedded *modus operandi* of the department.

5.3 Implications of the change for management

From my experience of leading this change project to date I would identify four key implications of the project for the management of the department and of the hospital. Each of these is explored below.

5.3.1 Clarity of Definition and Purpose

The National Strategy on Service User Involvement (2008) sets out a clear definition of the term ‘service user’. The definition is broad and encompasses direct service users and groups representing these. It also emphasises the need for services to recognise the different experiences of service users across a range of grounds including *inter alia* age, ethnicity, religion, sexual orientation and disability. The strategy then addresses the issue of defining ‘involvement’ and offers Arnstein’s Ladder of Citizen Participation (1969) as a vehicle for identifying the difference between consultation, ‘token’ participation and partnership.

This change project has accepted the strategy’s definition of the ‘service user’ and the project has been progressed out of an understanding of working towards a genuine partnership model. However, in order for the project to be fully assimilated by the department these understandings will need to be revisited and fully accepted by the department management.

5.3.2 Developing Partnership

In 1999 the Institute of Public Health (IPH) organised a workshop on the theme of strengthening partnership in health services. The IPH Strategic Plan for 2000-2003 identifies the need for “multi-sectoral collaboration... in health strategies”. (p.3) Prior to the publication of this strategic plan the IPH also recognised the difficulties intrinsic to the development of such collaboration and, in order to further explore the nature of these difficulties and to devise strategies to address them, the workshop was held in 1999 with 31 participants from different disciplines, sectors and parts of Ireland.

The framework model for strengthening partnership devised by the IPH from the workshop discussions is an extremely useful tool for management in taking on board the implications of this change process. In particular the “Levels of Partnership”

model is a tool for ensuring that there is a clear plan when developing new partnerships. This model (Appendix 9) is akin to Arnstein's Ladder of Citizen Participation. It sets out the progression to full collaboration through networking, co-operation, co-ordination and coalition. Collaboration, as the end point in partnership, involves, among other characteristics, shared vision, shared decision-making, formalised links and high levels of trust (2001, pp. 7-8).

From this model it is possible to see the progression over time of partnership from a relatively loose and informal networking arrangement to a more formal structure. This progression has begun over the course of my change project. The service user panels are in the process of developing from a space for dialogue and common understanding to a more defined space with links to the formal structures of the department i.e. the management group. It is important that the management of the department takes on board this progression in order to facilitate the transition from networking to a more formal co-operation and alliance. This is what is envisaged in the original plan from the QIP of the coming together of the management and the user panels in the context of service planning. However, the major challenges inherent in a progression towards genuine partnership must first be addressed in more formal planning incorporating the 7S (1982) approach that addresses both *soft* and *hard* organisational components.

5.3.3 Embedding the Change

Embedding change in an organisation means ensuring that the change becomes 'the way we do business'. I have spoken about my experience of this change project as being perhaps perceived by management as peripheral to the core business of the department. This experience perhaps captures some of the unconscious resistors to change (Hirschorn, 1990) that are most difficult to address and which relate to organisational culture.

Handy (1999) refers to four types of organisational culture – power culture, role culture, task culture and person culture. I would identify the prevailing organisational culture within both the mental health department and the hospital generally as a role culture. According to Handy the 'role' organisation derives its strength from its various functions and specialisms which are co-ordinated at the top by the senior

management of the organisation. Crucially, Handy names position or hierarchical power as the main type of power recognised in this culture. This definition of role culture highlights how challenging the integration of a genuine partnership with service users, those with little or no position power, will be for the department and hospital management.

Within the department and hospital however a different culture co-exists with the role culture. This culture is, in Handy's terms, a task culture. Task culture is more flexible than role culture and is important in developing and management of particular projects. In order to integrate change, which is frequently driven by a task culture, into the mainstream of organisational life, the role culture and task culture must be facilitated to come together and the former must, inevitably, make appropriate adaptations in order to take on the changes initiated through the more project-oriented culture.

My experience of the service user involvement project as peripheral to the work of the department highlighted the need for me to adopt a more proactive strategy in ensuring the integration and assimilation of this work by the management. In proposing a facilitated, collective meeting of department management and service user panels I am hoping to ensure that the change is properly embedded in the organisational culture, processes and structures. Such a gathering will of necessity not be a once-off but will hopefully be built in to the work of both the management and the service user panels on an annual basis.

Also key to the embedding of this change within the culture, processes and structures of the department is the issue of communication. In their paper "Beyond interdisciplinary boundaries: views of consumers, carers and non-governmental organisations on teamwork" Macdonald et al (2002) conclude that listening and responding to the expressed views of service users is key to effective partnership. This conclusion resonates with the views of Carr (2007), previously quoted, about services valuing the particular expertise of the user, an expertise that is rooted in the passion of their experiences. The type of communication management needs to aim for is *dialogic* (Waddell, 2007) i.e. it is two way and based on a value which respects the different contributions of professionals and users. The issue of communication style

will be important in the identification of suitable facilitators for the planned meeting of management and user panels.

5.3.4 Resourcing the change

Partnership, by definition, implies the active involvement of department management and staff. If this involvement is to be real, it must be an accepted role within the organisation with a ring-fenced allocation of time. “A Vision for change”(DOHC, 2006), the framework for the development of mental health services, talks about the need for service user involvement to be resourced financially and specifically recommends that users are reimbursed for out-of-pocket expenses at the same rates as health care workers. This document also recognises the need for user groups to be funded to enable their participation. Given the broad definition of service users in the National Strategy (2008) and the identified need for the inclusion of disadvantaged groups, a funding strategy for appropriate voluntary groups is an important implication of this area of work for health sector management. It is also important that organisations taking up this work are advocates for such funding arrangements. The resourcing of user groups is fundamentally related to the concept of a shift in power relations between users and professionals. Power, according to Hannah Arendt (1965) is about people coming together to take social action and this coming together must be properly resourced.

5.4 Recommendations for future improvements

Related to the points made above I would recommend that the management of the mental health department undertakes a facilitated planning process with the service user panels in order to define and locate service user involvement work within the culture, processes and structures of the department. This planning process should be carried out at the earliest possible date. Perhaps anticipating some of the outcomes of such a planning process I would also recommend that, on an annual basis, management dedicates a minimum of two meetings a year to planning and that these planning meetings should include service user panels (or their representatives). Finally, I would recommend that management formally allocates staff time to supporting the work of user involvement and that it should seek to resource this work from the hospital budget. Such an allocation of staff time should also include a formalisation of the current link to user involvement work in the hospital.

In terms of the development of service user involvement more generally in the health sector I would recommend that the participation of users is facilitated through the core funding of a range of groups across the equality grounds identified in the definition of service users in the National Strategy. If users do not receive funding towards their own networking and collective support it is likely that the core issue in the debate on user involvement which is about a paradigm shift in the power relations between professionals and users will be fudged. This issue has been identified throughout the history of user involvement (Tomes, 2006; Hodge, 2005, CPA, 2008) and is fundamental to the development of partnership.

5.5 Reflections on the project

The recommendations above focus on the role of management in the department, the hospital and the health sector generally, in sustaining the momentum of change towards genuine partnership with service users. In identifying the strengths and limitations of this change project however it is also important for me to reflect on my learning about myself in the role of change leader and as a leader generally in the overall organisation (Eriksen, 2008).

My profile in the Myers-Briggs type indicators (1988) is ENFP. The descriptor for this profile identifies an energetic, enthusiastic, inclusive leadership style with good communication ability. Interestingly, this 'type' is identified as innovative and preferring to lead in the start-up phase of projects. The area where the ENFP is potentially weaker is in attention to detail and in the application of project and time management skills. Another potential weakness of this type is the possibility of over-extending themselves. According to the descriptor ENFPs, particularly when under stress, are susceptible to being overwhelmed by detail. In such circumstances ENFPs have a tendency to "focus on an unimportant or distorted detail, letting it become the central fact of their universe." (p.21)

It is interesting to revisit the Myers-Briggs in reflecting on my leadership of this change project. I can identify with both the positive qualities described in my 'type' and the areas for development. I feel that I led the change from a place of confidence and enthusiasm. I feel that this enthusiasm energised others and that they also had confidence in my ability to progress the project. However, I can also acknowledge

that the project has been an additional stress for me at an already challenging time and that, under this stress, I was open to becoming absorbed with the “unimportant or distorted detail”. However, when I could potentially have drifted off course and lost my perspective, I was helped by my Action Learning Set on the course to see what was happening and to ensure I kept my focus. The events that triggered this slight deviation relate to organisational politics. I have learnt from this experience to be more strategic politically according to my strengths which, in my case, means using my networking/alliance-building skills (Buchanan and Badham, 1999).

5.6 Conclusion

When I initiated this change project it was with a view to developing service user involvement in a child and adolescent mental health setting. Although this has indeed been the main focus of the work it must be said that the location of the project in the mental health department of a paediatric hospital meant that the focus of the work was rarely just about issues related to mental health services. The direct service users on the panels in particular have experience of both the hospital and the mental health department and their comments and suggestions relate to both. However, the literature on service user involvement reports many examples of good practice that are situated within mental health services. It is my belief that service user involvement fits well within the context of mental health where there is an intrinsic understanding of concepts such as empowerment and therapeutic partnership. Perhaps indeed mental health can be a specialism within the health services that leads development in this exciting area of work? And within mental health, social work, with its value base in empowerment, participation and partnership, has the potential to be a lead discipline. This is work to engage in with passion and social work as a discipline is a natural advocate for service users and therefore for the progression of this work.

This change project has presented me with an opportunity to use the experience I have gleaned from my work in different settings in the interests of progressing partnership and participation practice within my workplace. Even at this early stage in the development of service user involvement in my work setting I am aware that the participation of service users contributes a different energy to the work of health sector organisations. In addition, I have been impressed by the impact of this work on the morale of staff who are currently working under extremely challenging conditions

as a result of budgetary cuts within the sector. This project has demonstrated the efficacy of innovation and partnership in dealing with the challenges of current times. At the conclusion of this project dissertation I can assert that service user involvement, although a relatively new area of work within the health services, is nonetheless exciting and energising for both health services staff and users. It is an area of work that requires attention, in the first instance, to the understanding of the concept and of the desired outcomes of the work. It is an area of work that poses many questions including, most fundamentally, the question of whether we are genuinely committed to real partnership and a paradigm shift in power relations from the professional to the user.

Service user involvement is a relatively new 'buzz term' in health sector jargon. However, through my work on this project I have come to more fully understand the fact that the kind of change that is envisaged on this issue will not happen because it is a policy or a written requirement. This, like all change, will only come about because someone takes it up as a cause with commitment and passion. Change happens because someone initiates it, gathers a group together and ensures that a common vision and plan is articulated and implemented. This implementation is then evaluated and re-planned in the management parlance of a continuous quality improvement cycle (CQI). Change brings with it the space for creativity and innovation. It generates excitement and energy. Change is a process that is necessary for the survival of life but it is still unsettling and disquieting on occasion and so it requires strong, compassionate, supportive and strategic leadership, akin to that defined by Alimo-Metcalfe (2006) as "nearby leadership". I believe that, in my leadership of this change project, I have demonstrated such leadership and that I have also engaged enthusiastically with the concept of reflective practice so as to ensure my ongoing personal and professional learning and the development of best practice as a leader and a manager.

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Appendix 1

Project Impact Statement

Describe how things are in relation to the issue	Describe how things should be when the issue has been addressed
<p>Behavioural: there is no agreed and systematic approach to the issue of service user involvement. It has not been seen as a key issue and has not featured in service planning discussions. There is no conscious resistance to the issue but it probably exists at a less conscious level.</p>	<p>Behavioural: There will be an agreed and systematic approach to service user involvement and a commitment to resourcing this as required. There will be an increased awareness generally about the need to place the service user at the centre of services and of best practice models in terms of enabling such involvement.</p>
<p>Structural: The management group of the department has responsibility for co-ordinating service planning and devolves a role in this to discipline groups. No responsibility has as yet been devolved to service users.</p>	<p>Structural: The Service User panels will be included in the groupings which influence and inform service planning and evaluation in the department. These panels will be resourced in order to enable participation by users and their representatives.</p>
<p>Personal: I participate in the current structure as a member of the management group of the department and as the leader/manager of my discipline group.</p>	<p>Personal: I will continue in my role as a member of the department management and as the leader/manager of my discipline group. I will take on a lead role, relevant to my discipline and training, in facilitating the participation of service users in department service planning through the service user panels.</p>
<p>Cultural: It is culturally accepted that the current structures ie discipline groups to management is the method for conducting service planning. The importance of service user involvement is not in staffs' awareness.</p>	<p>Cultural: Staff will be aware of the importance of service user involvement to service planning and evaluation. This will be seen as the key way in which we ensure that service users are at the centre of our planning.</p>

Appendix 2

Staff Workshops, 10th/17th December, 2010

Proposed Agenda

2.00: Introducing the project and the workshop

2.15: Why develop service user involvement – improving clinical outcomes

2.30: How do we currently involve our service users?

2.45: Ladder of participation – where are we currently and where do we want to get to?

3.15: Methods of Service user involvement – what do we want to implement?

3.30: How will we measure our success? Monitoring/evaluation

3.45: Next steps – who, what, when

4.00: End

Appendix 3 Letter of Invitation to Panel Members

15th February 2011

Dear

xxxx clinic provides supporting services to children and adolescents that have attended or continue to attend the xxxxxx Hospital. We are keen to hear ideas on how to make our service better and are currently trying to develop a forum for adolescents to discuss their experiences of the clinic and generate some ideas on things we could do.

We would like to invite you to be a member of this group and have proposed that we get together on **14th March** from **5 – 7pm** for the first time to decide on:

- How often we might get together and for how long
- How we will agree on ideas
- How the group will pass on these ideas to the management of the clinic
- What support the group will need to do this

We fully appreciate that you will be committing your time and we should be able to cover any travel expenses that you may occur. We think that you will find the group interesting and it should be very helpful for us to make our service better.

If you would be interested in helping us with this project please contact xxxx at xxxxxx and she will arrange to meet up with you or to have a phone call with you to tell you more.

We look forward to hearing from you.

Best wishes

Ms. xx xxxx

xxx Clinic

Appendix 4

Draft Agenda for Initial Panel Meeting

11.30: Welcome and preliminary introductions

11.40: The Mental Health Department and Service User Panels – background, structure of Department, how the panel might fit in with this - Discussion

12.00: Discussion in pairs to look at:

- why I'm here?
- what my hopes and expectations are?
- what my concerns might be?
- what questions do I have?

12.15: Feedback and Discussion

12.35: Next steps:

- next meeting?
- roles and structures of the panel?
- any other issues?

Appendix 5

Service User Panel, xxxxxx Clinic

Group Agreement for Service User Panel Members

The purpose of the service user panel for xxxxxx Clinic has been explained to me.

I understand that panel members will be discussing issues of interest and concern to service users in xxxxx Clinic.

I understand that a record of the service user panel meetings will be kept and that issues raised will be reported to the senior management group of xxxxx Clinic and in particular to the Clinical Director, Dr. xxxxxxxx, Consultant Child and Adolescent Psychiatrist.

I understand that the issues discussed are not confidential but I also agree not to discuss what other panel members have said outside the meetings of the panel in order to respect the privacy of all concerned.

I understand that panel members must never discuss with anybody any private or privileged matters that may inadvertently arise during the panel's discussions.

I understand that all records relating to the service user panel are subject Freedom of Information and data protection legislation.

I consent to take part in the service user panel and to abide by the above conditions.

Signed: _____

Date: _____

Appendix 6

Summarised Report to Staff and Management of Department/Hospital (April 2011)

Development of Service User Panels 2010-2011

Mental Health Department

Background

The Mental Health Department has initiated a Quality Improvement Plan in the area of service user involvement. In particular, two service user panels have been established – one for parents/carers and their representatives and one for young people and their representatives. To date there have been three meetings of the adult panel and two meetings of the youth panel. Response from participants has been enthusiastic and panels will be meeting regularly over the next few months with a view to linking with department management around service planning.

Summary of work to date

- October 2010: Preparation for change project including proposal to Scientific Committee and attendance at workshop on youth participation in mental health services organised by UK Dept. of Health.
- December 2010: Facilitation of a Quality Improvement Plan in the area of service user involvement in the department (attended by 10 staff members over 2 meetings).
- Service User Involvement as an agenda item for monthly management meetings in the department.
- January 2011: Invitation to representative groups and to direct service users to participate on panels.
- February-April 2011: Facilitation of three adult panel meetings and two youth panel meetings.

Plan for next phase of work

- Continue to facilitate and participate at panel meetings
- Complete Terms of Reference for panels
- Agree realistic work plan with panels
- Report to management and plan for joint meeting in early autumn.

Appendix 7

Questionnaire (Staff/Management)

1. From what you have read of this change management project how useful do you feel this is to the work of the hospital/department (as appropriate)?

2. Have you any ideas that you feel would help progress this development?

3. Have you any concerns about this development and, if so, any thoughts on how these concerns might be addressed?

4. "This development will have a positive impact on the services of SFC/the hospital" (Please circle according to your view)

1	2	3	4	5
<i>Strongly</i>	<i>Disagree</i>	<i>Don't</i>	<i>Agree</i>	<i>Strongly</i>
<i>Disagree</i>		<i>Know</i>		<i>Agree</i>

Appendix 8

Service User Panel 2011 - Evaluation of Start-up Phase

Introduction

The Adult/Parent Service User Panel is a new initiative of xxxxx Clinic. We are trying to create a space for parents/carers and their representatives to come together in order to identify both the strengths and weaknesses of our service and to work in partnership with us to ensure that we provide the best possible service to our clients – the children and their families.

As someone who has participated in the start-up phase of the Service User Panel we would very much welcome your feedback at this stage on how you have experienced this group. As well as feedback we would welcome hearing your suggestions as to how we might improve this new forum.

Thanks for your co-operation on this.

xxx and xxx

1. In your own words could you give your thoughts on what participating in the panel has meant for you so far?

2. What aspects of the panel have been most helpful?

3. What aspects of the panel have been least helpful?

4. “This development will have a positive impact on the services of xxx clinic/the hospital” (Please circle according to your view)

1	2	3	4	5
<i>Strongly</i>	<i>Disagree</i>	<i>Don't</i>	<i>Agree</i>	<i>Strongly</i>
<i>Disagree</i>		<i>Know</i>		<i>Agree</i>

5. Please list any suggestions which you feel could be made to improve the working of the panel.

Thank you for your input.

Appendix 9

Levels of Partnership – choices and decisions (*Institute for Public Health, 2001*)

Levels	Purpose	Structure	Process
Networking	<ul style="list-style-type: none"> * dialogue and common understanding *Clearing house for information *Base of support 	<ul style="list-style-type: none"> *loose/flexible link *roles loosely defined *an area of common interest 	<ul style="list-style-type: none"> *low key leadership *minimal decision-making *little conflict *informal communication
Co-operation or Alliance	<ul style="list-style-type: none"> *Match needs and provide co-ordination *Limit duplication of service *Ensure tasks are done 	<ul style="list-style-type: none"> *Central body of people as information hub *Semi-formal links *Roles somewhat defined *Links are advisory *Group leverages/raises money 	<ul style="list-style-type: none"> * Facilitative leaders *Complex decision-making *Some conflict *Formal communications within the central group
Co-ordination	<ul style="list-style-type: none"> *share resources to address common issues *merge resource base to create something new 	<ul style="list-style-type: none"> *Central body of people consisting of decision-makers *roles defined *Links formalized *group develops new resources and joint budget 	<ul style="list-style-type: none"> *autonomous leadership but focus on issues *group decision-making in main group and subgroups *communication is frequent and clear
Coalition	<ul style="list-style-type: none"> *shared ideas and willingness to pull resources from existing systems *develop commitment for a minimum of three years 	<ul style="list-style-type: none"> *all members involved in decision-making *roles and timescales defined *links formal with written agreement *group develops new resources and joint budget 	<ul style="list-style-type: none"> *shared leadership *decision-making formal with all members *communication is common and prioritised
Collaboration	<ul style="list-style-type: none"> *accomplish shared vision and impact benchmarks *build inter-dependent system to address issues and opportunities 	<ul style="list-style-type: none"> *consensus used in shared decision-making *roles, timescales and evaluation formalized *links are formal and written into work assignments 	<ul style="list-style-type: none"> *leadership high, trust level high, productivity high *ideas and decisions equally shared *highly developed communication

