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# Service User Involvement: Development of a Communication Strategy between Service users and Senior Management in a Healthcare Voluntary Organisation.

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“I hereby certify that this material, which I now submit for assessment for the Project Dissertation Module on the Leadership and Management Development is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

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## **Glossary of Terms Used**

HSE	-	Health Service Executive
SU/s	-	Service User/s
ID	-	Intellectual disabilities
MH	-	Mental Health
HIQA	-	Health Information and Quality Authority
SM	-	Senior Management
SUC	-	Service User Charter
SUI	-	Service User Involvement
OD	-	Organisational Development
PCP	-	Person Centered Planning
OECD-	-	Organisation for Economic Cooperation and Development
CAN	-	Camberwell Assessment of Needs
ECT	-	Electro-Convulsive Therapy
D12	-	Dublin 12 Local Drugs Task Force
H&SC-	-	Health and Safety Committee
WHO	-	World Health Organisation

## **Abstract**

The project focused on national and international best practice guidelines on service user involvement, service user involvement has become buzz words in health and social care settings in the past decades. Third sector not for profit services are competing for survival i.e. on how best to get service users involved in the day to day service planning. The project aimed at developing a communication strategy between senior management and service users in a third sector not for profit organization, providing services to adults with intellectual disabilities and mental health difficulties. Changes in legislation and the introduction of a regulatory body (HIQA) Health Information and Quality Authority in Ireland, in the field of health and social care, has resulted in health care organizations across Ireland to look for effective ways to work hand in hand (partnership) with the people receiving services. Traditionally services were designed by the providers, but current trends and regulatory requirements have seen service users in the driving seat. Using the HSE change model monthly residential service users meetings were introduced. Senior management attends these meetings on a quarterly basis. It was discovered that if not carefully managed these meetings will become either paper based activity (tokenistic approach) or used to secure funding. The HSE change model was used to implement change process because it is current, local, user friendly, and relevant model to the subject matter. When done for the right reasons service user involvement can be empowering and can improve the quality of life of the service users.

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## **Chapter 1- Introduction**

### **1.0 Introduction**

The change management project was aimed at introducing a SUI strategy, through the development of a monthly communication strategy between SU and SM in a residential setting of voluntary healthcare organisation. The HSE say if quality and safety is to be at the heart of everything that we do, we must understand it from the perspective of patients ([www.hse.ie](http://www.hse.ie)). From the literature reviewed it was evident that SUI has huge benefits to the service providers and users. (Basset, Campbell, & Anderson, 2006)

There is a growing understanding of the very real contribution that SU can make to developing, or indeed becoming the practitioners of the future. Yet it has to be recognised that whether within services or in educational settings there are also areas where very little progress has been made. Changing the course of institutions whether they deliver mental health services or mental health education can be very hard to do. Progress in the area of SUI requires a complete paradigm shift, thus moving away from traditional service provision methods. (Kuhn, 2012) Think of a Paradigm Shift as a change from one way of thinking to another. It's a revolution, a transformation, a sort of metamorphosis. It just does not happen, but rather it is driven by agents of change. Traditional service delivery methods have such a disempowering effect to the SU.

In the UK, there is a long history of advocacy of SUI through policy documents, and NHS plans i.e. (Newman & Vidler, 2006) say; a consumerist discourse was reasserted in The NHS Plan (Department of Health, 2000) and later policy documents (Department of Health, 2001a, 2002). The UK standards have been very influential to Ireland;

England has been acting as a benchmark for most of the Irish healthcare settings. However things are changing in Ireland, the 2013 edition of Health at a Glance by the OECD shows that Ireland continues to make substantive headway in improving health outcomes (Harvey, 2007).

Traditional services have been characterized by 'vertical' relationships in which staff hold power over SUs, while social capitalists and SU advocates seek 'horizontal' relationships (Riddell et al., 1999) cited in (Bates\* & Davis, 2004). Until staff let go power SUI continues to be tokenism, letting go power leads to horizontal relationships. Crepaz-Keay and others (1997) listed a number of excuses such as 'they're not ready for it' and 'they are not representative/not like our clients' cited in (Basset et al., 2006) suggest that we can overcome these excuses and barriers by just doing it, and the excuses soon fall away as the working relationships develop. These excuses can be removed by empowering SUs with the skills that can support them and by having trust in individuals and affording them opportunities to try new experiences. The project aimed at giving SUs the opportunities to just do it without staff being judgmental. The current situation across national and international organisations, identifies gaps and barriers to effective SUI, i.e. power struggle, culture influence, increase in workload, negative assumptions around people with disabilities and or mental health etc.

## **1.2 Nature of Change**

The introduction of a SUI strategy was planned and implemented using an OD soft system model of change called HSE Model (2008) ([www.hse.ie](http://www.hse.ie)). From the literature

reviewed there are a number of different and complementary views on the nature and assumptions of an OD. The change project draws on (Cummings & Worley, 2009) definition that says OD is a systematic application and transfer of behavioural science knowledge to planned development, improvement, and reinforcement of the strategies, structures and processes that lead to organizational effectiveness. Similar to Cummings and Worley's definition is Beckhard (1969) who defines OD as an effort (1) planned (2) organization-wide, and (3) managed from the top, to (4) increase organization effectiveness and health through (5) planned interventions in the organization's "processes," using behavioral-science knowledge. Whilst Cummings and Worley and Beckhard say this, Anderson (2010) defines OD as a process of increasing organizational effectiveness and facilitating personal and organizational change through the use of interventions driven by social and behavioral science knowledge. There is a common theme from the three definitions which is organisation effectiveness. The project intends to improve communication between SUs and SM.

### **1.3 Rationale for carrying out the change**

It is important as the starting point of the change effort to highlight the idea for what needs to be changed or what new product should be introduced or what particular innovation might bring a significant lead over competitors (Mento, Jones, & Dirndorfer, 2002). The introduction of a regulatory body, HIQA's national standards in residential services for adults and children with disabilities (2013) in Ireland ([www.hiqa.ie](http://www.hiqa.ie)) calls for a complete paradigm shift in the way services are designed and provided. HIQA is responsible for the registration and inspection of residential services provided by the

HSE, private organisations or voluntary bodies. HIQA anticipates that SUs have a range of opportunities to foster relationships, participate in the community, both within the service and in the wider society i.e. Theme 1 of the HIQA standards, says 'people living in residential services should be actively involved in determining the services they receive and should be empowered to exercise their rights. In a bid to meet some of the HIQA standards (quality and safety themes), policy documents, national and international best practice guidelines. The HSE says aside from its iteration in various national policy and strategic documents (e.g. Recommendation 19 of the Primary Care Strategy), the literature in this area clearly states that promoting greater service user involvement will result in advantages at Individual, Community and National Level. ([www.hse.ie/eng/services/yourhealthservice/Documentation/involve/sui\\_framework.pdf](http://www.hse.ie/eng/services/yourhealthservice/Documentation/involve/sui_framework.pdf))

SUI was developed to improve the organisational effectiveness in service provision enhancing the quality of life of the service users through effective communication. Communication is a transaction whereby participants together create meaning through the exchange of symbols. Effective communication, therefore, demands that people work together to ensure that the meaning created is the same for all (Fielding, 2006). There is, however, a danger that the government demands for agencies to demonstrate SUI may mean that activities become a formal procedure to be ticked off, rather than an embedded and powerful organisational practice. (D. Rose, Fleischmann, Tonkiss, Campbell, & Wykes, 2002). SUI projects in neighboring countries like the UK has brought about a lot of positive changes in the way services are delivered (the UK is a benchmark for Ireland healthcare). The change project is in line with the organisation's



mission, i.e. the organisation is dedicated to working in partnership with internal and external stakeholders and empower SUs. Empowerment of SUs comes in different forms, i.e. having information about how services are delivered and where the service is heading to. The project will improve the quality of service provision and shift towards a more user led service thus enhancing the quality of life of the people using the service. The move will form regular platform for getting feedback, feedback is an important indicator for areas of strength and development (appendix 1 - SWOT analysis).

#### **1.4 Brief overview of the service**

The service is a progressive organisation providing services to adults with ID and or MH. Service provision is based on a unique model of care 'low arousal non aversive philosophy,' (Appendix 2 low arousal philosophy) this type of care transcends all the services of the organisation. Alongside low arousal approach is PCP approach. (Mansell & Beadle-Brown, 2004) Defines, PCP is an approach used to organize levels of assistance for people with ID. It is individualized, in that it is intended to reflect the unique circumstances of the person with ID both in assessing and in organizing what should be done. (Appendix 3 – beliefs and core values). The organisation strongly believes that each person is special and unique. Staff are guided by six core competencies (Appendix 4 – core competencies).

The organisation has an open door policy, this means that if at any stage stakeholders i.e. families, service users and or staff are not happy with the service systems they can walk in and out of the management's offices to complain, this system is not deemed insufficient as SM is not always onsite to address grievances. The organisation has

worked in partnership with leading organisations and gained certification in the area of excellence in the delivery of services. The awards confirm the organisation as a first class, leading organisation in the community and voluntary sector. Accreditation was from (CQL) and (ETP). (See appendix 5). The organisation's primary funding source is the HSE, in the past the organisation secured funding from European Regional Development Fund, National Lottery, Dublin City Council and Pobal (Dormant Account Funds).

### **1.5 Aim**

The project aimed at developing a communication strategy between SUs and SM in a voluntary organisation providing services to adults with ID and or MH. With effect from the September 2013, services for adults with disabilities in Ireland are subject to a bi-annual inspection (announced and unannounced) by HIQA who have set standards (table 1.5.1 HIQA standards) that should be met in order for the organisation to be registered ([www.hiqa.ie](http://www.hiqa.ie)). Development of a communication strategy aimed at involving service users in the organisational planning and decision making. This strategy of involvement is in line with the one of the core values of the organisation thus; inclusiveness which says, 'The organisation values involving service users and their representatives, family members and organisation staff, in leadership and decision making at all levels' The strategy intend on improving theme 1, 3, 5 and 8, through having active engagement, consultation, partnership, advocacy, feedback, participation and empowerment.

*Table 1.5.1 HIQA standards for Adult with Disabilities living in a designated setting*

<b>Theme 1</b>	<b>Individualised Supports and Care</b>
<b>Theme 2</b>	
	<b>Effective Services</b>

<b>Theme 3</b>	<b>Safe Services</b>
Theme 4	Health and Development
Theme 5	Leadership, Governance and Management
Theme 6	Use of Resources
Theme 7	Responsive Workforce
Theme 8	Use of Information

*\*\* 1 to 3 themes are quality and safety themes*

The communication forum acts as an information sharing and gathering forum. Information gathered will inform the service for future planning. HIQA expect that each person living in a residential service is given clear and right information to help the person make decisions ([www.hiqa.ie](http://www.hiqa.ie)). Introduction such a strategy calls for effective communication. Larkin (2010) says where communication is regular, open, two-way and more importantly, effective, people tend to be more engaged.

## 1.6 Objectives

(Luffman, Lea, Sanderson, & Kenny, 1996) A prime purpose of objectives is to set targets or benchmarks against which performance can be measured. Thus to be of worth to an organisation, objectives should be: - Measureable, Achievable, Realistic, Explicit, Internally consistent with each other, communicable to others and Time bounded. In implementing a SUI project five objectives were set out, which were measured or evaluated against at the end of the mainstreaming stage of the project and these are:-

Table 1.6.1 Project Objectives

Project Objectives
1. Develop a service user charter which will be included as the terms of reference for conducting monthly residential meetings. This was approved by the line

manager and authorized by the clinical review team (CRM) on the 10th of January 2014.

2. By the 2nd of January 2014, 100% residential staff team and service users will have attended 'how to conduct meetings in house training' programme.
3. By January 2014, have established a monthly communication strategy between service users and senior management.
4. By 18 April 2014, have a service user suggestion box in a central easily accessible place of the residential service.
5. To have a 100% service users' attendance in the anti-bullying and harassment course by 30th April 2014 to develop evidence based practice compliant to HIQA standards, theme 3 'Safe Services from abuse and neglect .

A noted major problem for not-for-profit or voluntary organisations is the apparent lack of a single discipline against which to set objectives as for example profit. Most profitable organisations set their measure against profitable outcomes.

### **1.7 Role of Student**

The student played a central role to the change project, central in the sense of being the communication link between SUs, staff and SM. This included leading and overseeing the change process i.e., initiating, planning, implementing and mainstreaming the change. Planning involved assigning tasks and delegating responsibilities i.e. distributive or shared leadership role to the staff team and service users and ensuring the overall smooth running of the effort. The student's level of authority and power in the organization is at the middle management level. To some extent position power influences the success of the project, but in this case referent and personal power supported the process of leading change. (Roger Gill, 2011) Managers or leaders who

rely on 'personal power' instead of position power are much more likely to achieve people's commitment – a belief in, and desire to do, what needs to be done – and their engagement than those who rely solely on position power. The student's referent power comes from the student leading and delivering successfully the organization's medication training package.

### **1.8 Summary**

Traditionally services were mass managed and were hierarchical in structure; the last few decades have seen legislation, regulations, policy documents, government papers and best practice guidelines paving way to a total paradigm shift, whereby involvement of SU has been mandated in most European countries. The change project's aim was to develop a communication strategy between SU and SM. In Ireland and internationally, it has become understandable that SUs can make very real meaningful contributions to the designing and planning of their services and should not be underestimated as they have the potential to become the practitioners for the future. Progress, however, in making this a reality has been very slow and in some cases a tokenistic gesture. The process was implemented using a soft system planned change guided by the HSE change model. The HSE model was used because it is current, relevant, flexible and user friendly. SMART objectives were drawn out and evaluated in chapter four to identify areas of improving not proving. Comparative study of literature on SUI, it is evident that SUI is still a milestone to a long distance journey, for SUI to be meaningful and integrated, there are a number of significant barriers to be overcome. (Basset et al., 2006). The conclusion discussed findings and the experience of introducing change by bringing all the pieces together and making recommendations for future projects.

Recommendations were based on reflection of experience thus findings i.e. the strengths and weaknesses of the project.

## **Chapter 2 - Literature Review**

### **2.1 Introduction**

The chapter reviewed the literature on the subject of SUI and identifies that it is a subject that has a vast literature base. Search was conducted within both the specific library databases of Eric, PubMed, Journal articles (mainly from the UK mental health survivor movements), a lot of mental health websites were also reviewed, CINAHL and Google Advanced Scholar using date parameters of 2002 to 2014 (appendix 5). Over 4050 articles were found, some of the articles on user or patient involvement had useful information but not be transferrable to the project setting because the information was more relevant to (hospital) medical setting as opposed to residential social setting. Key theme service user involvement in MH and sub themes empowerment, participation, advocacy, engagement and partnership emerged from the literature search.

### **2.2 Service user Involvement in mental health**

(Crawford et al., 2002) carried out a worldwide, systematic study on reports written in English between 1966 and 2000 and concluded that there was evidence supporting the notion that involving patients have contributed to changes in the provision of services across a range of different settings. However evidence based effects on the use of

services, quality of care, satisfaction, or health of patients does not exist. Similar to this finding (Fudge, Wolfe, & McKeivitt, 2008) carried out an ethnographic study using participant observation, interviews and collection of documentary evidence to assess the promise of SUI in health service development ethnographic study found out that SUI may not automatically lead to improved service quality. It is interesting that different methods of study were used, but similar findings were gathered. The SUs who participated in Fudge et al., 2008's study: when asked how their involvement had improved services, few SUs could directly answer the question. Social benefits i.e. an opportunity for interacting was identified and was also noted that staff i.e. providers largely determined how user involvement was put into practice. Very little evidence was found of SUI directly contributing to improved quality of services except in a few limited areas. This can be debated that little steps or areas of benefit to someone that is social excluded can make a huge difference to that individual. The project intended make those little improvements that have huge ripple effect in people's life. Benefits, barriers and examples of user involvement are highlighted in table 2.2.1 below:

Table 2.2.1 Benefits, barriers and examples of user involvement

<b>Benefits of user involvement</b>	<b>Barriers to user involvement in mental health services</b>	<b>Examples of positive practice in user involvement</b>
<ul style="list-style-type: none"> <li>• Experts about own illness</li> <li>• Users may have different but equally important perspectives about their illness and care</li> <li>• User involvement may increase the existing limited understanding of mental distress</li> <li>• User may be able to develop alternative approaches to mental health and illness</li> <li>• User involvement may be</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of information</li> <li>• Financial and time costs</li> <li>• Concerns over representativeness</li> <li>• Resistance to the idea of users as experts.</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement in prioritising and conducting research</li> <li>• Involvement in staff selection</li> <li>• Employment as paid mental health workers</li> <li>• Involvement in education and training.</li> <li>• Social interaction</li> </ul>

therapeutic in itself. • User involvement may encourage greater social inclusion.		
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*Adapted from (Fudge et al., 2008)*

(Nilsen, Myrhaug, Johansen, Oliver, & Oxman, 2006) In an intervention review of methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material, found that there is moderate or little evidence from randomised controlled, trials of the effects of consumer involvement in healthcare decisions at the population level. The trials included in this review demonstrate that randomised controlled trials are feasible for providing evidence about the effects of involving consumers in these decisions. This study does not, however, say what evidence exist, but simply says feasibility studies provide evidence of involving consumers. This does not, however, provide or contribute to knowledge that informs the project. Service user involvement has been a hot topic of late e.g., The Irish Achieving Excellence in Clinical Governance, (McAuliffe & Van Vaerenbergh, 2006), SUI guidance defines involvement as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change. (Tait & Lester, 2005) In their evidence-based research on encouraging SUI in MH services from both policy and practical perspectives agree with the HSE Clinical Guidance on SUI being a hot topic in recent years, (Tait and Lester 2005) say at the start of the new millennium, despite a plethora of policy reforms and pockets of good practice, SUI in MH is still an essentially minority activity, acknowledged as a 'good thing' by many but



relatively practiced. It is, however, questionable why it is relatively practiced yet is seen by many as a 'good thing.'

Globally there has been a lot of emphasises on SUI yet it continues to be relatively practiced. (Tritter & McCallum, 2006) say: recent health service reforms in Western countries emphasise on public and patient involvement. SUI dates back to 1980 when the term 'user involvement' dominated health and social care field in the UK. Literature reviewed, revealed that key themes overlap and in some cases were hotly contentious, i.e. there are different views about whether research carried out within a non-profit organisation by services can be called 'user-led' when service users do not run the organisation. (Wallcraft et al. 2009). The term 'user-led' does, however, not mean that service users run the organisation, but leading the process. There seems to be a lot of confusion around terminology used in the area of SUI in MH.(Telford & Faulkner, 2004) In their research study 'Learning about SUI in MH research' carried out at Sheffield University School of Health and Related Research UK, literature examined found that though SUI in MH research was a relatively new concept for health professionals, there is little empirical research in the area, increasingly SUI in MH research can be found in the peer-reviewed domain, and at all levels of the research process. (Tait & Lester, 2005) Support the view that there is little empirical research in the area of SUI by saying; consumerism is a relatively new ideology within the UK health policy. Users are increasingly seen as customers who can exercise an informed choice about the services they receive and can shop around, which mean that if they are not satisfied, they can take their 'business' elsewhere. Taking the business elsewhere, does not apply

to Irish SUs in healthcare, SUs do not always find it that easy to move their 'business' elsewhere as stated. Services are allocated according to a catchment area and in some circumstances there maybe just one service provider in the catchment area, conditioning the user to stay with that provider. This contradicts the idea discussed above of 'moving business elsewhere.'

(Thornicroft & Tansella, 2005) In their 2005 research study, 'Growing recognition of the importance of SUI in MH service planning and evaluation' in London (UK) and Italy, using patient-rated unmet needs based on CAN, agree with Telford and Faulkner that the material on SU in MH research is still in its infancy. Their study found out including SUs' preferences within the content of the research questions is exemplified by the recent study results that showed that joint crisis plans can significantly reduce the use of compulsory admission during crises and by a review that demonstrated that the use of an explicit SU perspective produced distinctive insights into the long term effects of ECT. Thornicroft and Tansella's study show the importance of collaboration/partnership between providers and SUs. Interestingly the study found evidence of how involving SUs' preferences within the content of the research questions showed that a joint crisis planning can significantly reduce the use of compulsory admission during crises and also demonstrated that the use of explicit SU perspective produced a distinctive insight into the long term effects of ECT. These findings demonstrate the positive benefits of engaging with SUs in planning. They concluded by arguing that SUI is an essential aspect of the range of necessary expertise in MH research, but still a new area of enquiry. In agreement to findings is (Tait & Lester, 2005) who say: SUI encapsulates a

range of different ideas (as does the concept of user itself) from active participation at the micro-level of individual decision making, to more macro-level involvement in service planning and evaluation and increasingly in the training and research arenas. SU participation, partnership, engagement, advocacy and empowerment are areas the project aimed to improve at a micro-level.

(Beresford and Carr 2012) Involvement is perhaps the most opaque of the terms, advanced by some as a route to personal liberation, while seen by others as tokenistic dead end.' Hanley, 1999, 2001 agrees with Beresford's later statement by saying it is merely practice carried out to satisfy the requirements of funding and regulation bodies, or is it because there is a considered and genuine belief in the value of user involvement cited in (Goodare and Lockward, 1999). A service provider in Ireland the D12 shared their thoughts on SUI activities by saying it is a vital way of delivering and developing good services, however, agree that SUI is a complex and contentious idea. (Lowe and Hulatt 2005) Say that there is certainly a very little agreement about it. Why involve SUs in the first place? HSE website suggests providing greater SUI will be of benefit to the individual, the community and also benefit people at national level. ([www.hse.ie/portal/eng/your\\_service\\_your\\_say](http://www.hse.ie/portal/eng/your_service_your_say)). National documents like the HSE National Strategy define involvement as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them in making decisions about factors that affect lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to change (HeBE 2002). Mary Harney the former health minister, (T.D.) in the National Strategy

document for SUI in the Irish Health Services says 'SUs should be able to articulate their views and be listened to in their individual interactions with health care professionals and as key stakeholders where decisions are taken about future health service development. The key for SU is that they get clear feedback and that they feel their contribution has been valued.' Arguably service providers can translate this idea from the National strategy document into their services for wrong reasons i.e. to secure funding by having the strategy down on paper, when the funders or regulatory bodies inspect the service they will see evidence based theory on paper of SUI but when consulting the SUs information may differ, this is viewed as a tokenistic approach. (Beresford, Wallcroft 1997; Church 1997; Faulkner and Layzell 2000; Faulkner and Nicholls 2000; Rose 2001) agree that certain SUI maybe more attractive than others in particular those arising in response to user's requests and those that seek to increase user empowerment. Though there has been awareness of the meaningful contribution that SUs can make to developing, or indeed becoming, the practitioners of the future. It is still yet to be recognised that whether within services or in educational settings there are also areas where very little progress has been made.

HIQA believe like that strategies this can be a key driver for ensuring SUI enabling change in the health services to anticipate problems, avoid complaints, and appropriately develop effective service provision and at the same time placing SUs at the center of planning and efforts to drive up the quality and safety of service provision. ([www.hiqa.ie/system](http://www.hiqa.ie/system)). A study carried out by (R. E. Davis, Jacklin, Sevdalis, & Vincent, 2007) confirms that patients can play an important role in improving patient safety by

becoming actively involved in their health care, there is, however, paucity of empirical data on the extent to which patients take on such a role. (R. E. Davis et al., 2007). Genuine SUI does not happen overnight, but requires a lot of commitment, collaboration and transformation from both parties thus providers and users themselves.

Though SUI is frequently practiced in companies, research findings regarding its benefits for innovation are contradicting. Literature reviewed showed that many scholars deem SUI inadequate for example (Bennet and Cooper 1981, Christensen 1997) cited in the Journal of Service Research November 2013. (Beresford, 2002) In the 'Developing the theoretical basis for SU/survivor-led research and equal involvement in research' says there is a rapid expanding literature and greatly increased proportion of research projects that claim to include SUI. The move to more SUI in research can also be seen to be an international one. But already tensions and conflicting ideas around SUI in research are beginning to emerge. (Tritter & McCallum, 2006) In the study criticizing Arnstein's ladder of citizen participation says, SUI must engage at the micro level but also feed into the organisational planning. The project aimed at; engaging with SUs at a micro level and using the information gathered for organisational planning that is macro-level. Meaningful SUI requires that users' views have a direct impact on shaping healthcare activities and processes, surprising they claim that this cannot ensure service improvement. (Tritter & McCallum, 2006) Concluded their study by saying; understanding SUI as a small part of a larger system helps bridge the division between micro level changes and system-wide reforms. This statement enhances change project knowledge. In the UK SUI is now a legal requirement outlined in Section

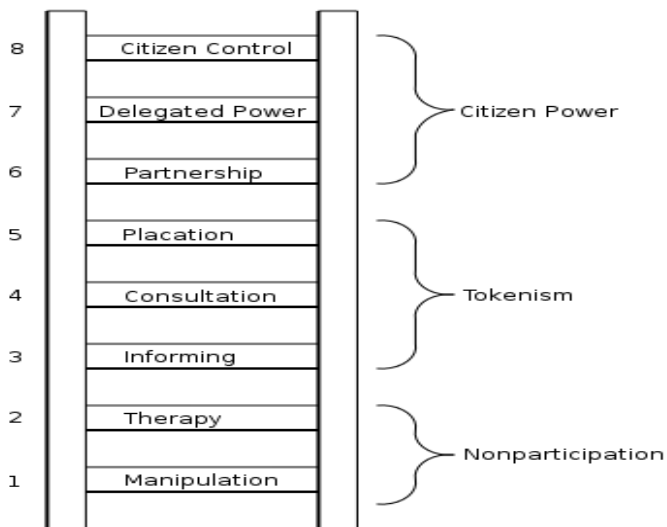
11 of the Health and Social Care Act 2001. There are, however, concerns that SUI activities developed to solely meet the legal requirement may have limited benefit to the SU, this notion is supported by (Hui & Stickley, 2007) says that there is a danger that providers will involve users as a requirement (tokenistic) as opposed to involving users as a way of empowering, consulting engaging, participation or working in partnership. Arguably SUI strategies can be developed in a bid to meet the regulations and or funding providers' requirements and at the same time benefit the SUs such practice is not reviewed as tokenistic approach.

### **2.2.1 Participation**

In SUI the key to genuine participation is ensuring respect for SU's views. UNICEF says; participation cannot be genuine if users have no opportunity to understand the consequences and the impact of their opinions—such non-genuine 'participation' often merely disguises what is actually the manipulation of service users, or tokenism ([www.unicef.org/crc/files/Right-to-Participation](http://www.unicef.org/crc/files/Right-to-Participation)). Arguably SU can participate in organization development projects i.e. in the author's organization SUs are involved in the H&SC of the organization, and their contribution has been rewarding to the organization and their own safety awareness, but it not known if the SUs fully understand the impact of their contributions. Participation has been around for quite some time, dating back to Arnstein's 1969 ladder of participation (Cornwall, 2008). Arnstein's ladder of participation seems to be the key document shaping the framework of SUI. Participation approaches have been used for many years in the health sector, primarily for needs assessment and implementation. (Cornwall, Lucas, & Pasteur,

2000). In the last decade, rapid and participatory appraisal methods have gained increasingly popularity, as a means through which health SUs can be consulted in the design and evaluation of intervention. The Journal of Clinical Nursing, exploring the concept of SUI in MH through a participation continuum (fig 2.2.1 - Citizen Participation Ladder) identifies two approaches to SUI, each with implications for extent to which users can be involved in decisions about the care ([www.onlinelibrary.wiley.com](http://www.onlinelibrary.wiley.com)) the approaches are linked through a 'participation continuum' which is a framework through which the concept of SUI can be explored and against which practice can be assessed. Arnstein (1969) defines citizen participation as citizen power. Arguably others have defined it with misleading rhetoric like 'absolute control' which is something no one including the President of the United States has or can have.

Fig 2.2.1: Arnstein's eight rungs on a ladder of citizen Participation



*Arnstein's Ladder; adapted from Citizen to Service User, where from the top to the bottom of the ladder power shifts from the service user through tokenism to non-participation in relation to the professional.*

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The debate for citizen participation has proved difficult even for scholars but Arnstein's answer to what citizen participation is simply 'citizen power'. This does not however mean absolute power, there are levels of power one can exercise in SUI it is important to note that level of power SUs have when activities they are participating in the H&SC mentioned above, and SUs have equal power to any other members on the committee. In most cases SUs generally maintain non-participatory and tokenism levels. Traditionally society has influenced the current systems in healthcare which are disempowering models like the medical model. Arnstein says citizen power is the redistribution of power that enables the have-nots citizens, presently excluded from the political and economic processes, to be deliberately included in the future. In other words enabling the have-nots to have. (Cornwall et al., 2000) participation is known to be a tool that enhances accountability at national and international levels.

Participation offers the promise of enhancing accountability, improving the effectiveness, scope and impact of health provision. But there are clearly many complex changes involved in putting participatory mechanisms and structure into practice eg;



how many health care professionals are willing to share equal power with SUs, power dynamics continues to be a struggle between users and providers, this is not however unique to just a healthcare setting, hierarchical structures are predominant in most organisations. Brafield and Eckersley (2008) say user participation is a generic term, although narrower than 'SUI' suggesting that users are taking a part in some aspect of the organisation's work and therefore have some influence in decision making. A good place to start in user participation is looking the levels of control SUs have, thus what sort of decisions will they be able to make, or what degree of influence will they have in decision making process. This can be measured by the level of autonomy in decision making the SUs have in, comparison to providers. Critics to Arnstein's Ladder, (Tritter & McCallum, 2006) in their study 'The snakes and ladders of User involvement: Moving beyond Arnstein) critically assessing Arnstein's writing in relation to SUI in health drawing on the evidence from (choice of these countries was based on the common claim of providing universal healthcare) thus United Kingdom, Netherlands, Finland, Sweden and Canada, recognizes major limitations because of its linear and un-dimensional nature. Participation is not necessarily as simple as it is presented in the ladder. Arnstein's ladder and its derivatives generally do not take account of the fact that participation is a complex and interactive process (which citizens manipulate too) that is essentially political in nature and takes place in a broader political context. The change project agrees with Tritter and McCallum (2006) with Arnstein's participation ladder critiques, participation is complicated more than it is presented in the ladder, and does not necessarily follow the sequence it is presented in, someone socially excluded can move from nonparticipation to partnership without necessarily following the linear

order as demonstrated by the participation ladder. (Tritter & McCallum, 2006) also criticize Arnstein's model emphasizes on power, assuming that it has a common basis for users, providers and policymakers and ignore the different relevant forms of knowledge. Tritter and McCallum (2006) propose for a new model to replace the static image of a ladder and argue that for SUI to improve health services it must acknowledge the value of the process and the diversity of knowledge and experience of both health professionals and lay people.

The Journals of Cambridge say; the idea of participation has been central to many policy development in recent years. Both conservative and labour governments have used notions of participation and involvement in attempts to justify and implement their social policies. Yet despite a plethora of initiatives and guidance around 'participation' emerging from all levels of government, and a substantial academic literature, there remains a major and potentially damaging, lack of clarity over many aspects of participation, while the secret of achieving 'real' participation appears to continue to remain elusive ([www.journals.cambridge.org/action](http://www.journals.cambridge.org/action)). Internationally the area of SU participation in decision making particularly in drug services is still one of trial and error and is locally impacted by factors such as timing, finding the right approach for the right group of people, the right facilitation method and even luck. According to the D12 Drug Task Force in Ireland, drug users often face a range of challenges to their participation in decision making, they are more likely to be marginalized, financially disadvantaged, poorly educated and lacking in power. Whist the above factors make the structuring of a working system of involvement more difficult they also underline importance of actively

facilitating involvement of drug users in the services they use. In drug services advocacy is of major importance. Arguably who will advocate for these drug SUs to be involved as SUs can be misled to be involved in areas of less importance (tokenistic approach), there are benefits of using independent advocates discussed under advocacy. (Brafield and Eckersley 2008) say it is quite a complex task to ask the questions 'how would you like us to consult you in order to get your views on our services' this implies that getting SUs to participate and knowing what way to get them involved can be a challenging task for the providers, especially in a service where involvement has never been part of their culture. This complexity can lead to unintentional exclusion if not addressed.

### **2.2.2. Engagement**

(Roger Gill, 2011) defines employee engagement as the extent to which people in an organisation will, willingly, even eagerly, give of their discretionary effort, over and above doing what they have to do. This definition is transferrable to SU engagement. (Cornwall et al., 2000) says engaging users through mechanisms such as user groups and committees has generally been regarded as a means to ensure the appropriateness of service provision, and to enhance project efficiency. In this context SUs have been viewed as recipients of services that are designed for their benefit, rather than perceived as passive recipients. The benefit of engaging with SUs in the areas that concerns them are huge and can impact positively on the quality of life of the individual. (Berger & Tabor Flickinger, 2013) through patient engagement in their own safety say; SUs and their families can help prevent adverse events. It is noted that such

involvement is promoted by several international organisations and educational materials have been developed to facilitate patient engagement in safety practice, (Berger & Tabor Flickinger, 2013) performed a systematic review of Medline, CINAHL, Embase and Cochrane from 2000-2011, with a variety of synonyms for patient engagement and patient safety including physician patient relations, patient participation and patient centered care. Patient engagement can be understood as an implantation in its own right. Although engagement can be challenging to define, this review focused on the effectiveness of interventions intended primarily to elicit patient or family involvement in reducing the incidence of adverse patient safety events. Involvement in this case focused on one element of the patient which safety, like the project is focusing on effective communication.

WHO provide education material for patients and The Joint Commission National Patient Safety Goals include 'speak up' campaign to engage patients in preventing wrong site surgery. Speak up can be linked to self-advocacy which is also key theme. Bergal and colleagues assessed patients 'reliability in regard to marking the site of planned surgery and found only partial compliance (68%). A review by McGuckin and colleagues assessed the importance of patient role (which they term patient empowerment) in HH interventions. Three of the cited studies (themselves authored by McGuckin and colleagues) showed that, while 80 to 90% of patients reported willingness to ask their health care workers to wash their hands, 60 to 70% patients actually did so. This calls for empowerment of patients. Because of the paucity of literature, the authors were unable to conduct a systematic review. Patient participation

in safety practices may be influenced by societal norms and health care environment including whether organizational culture supports patients participation. Senior (2002) organizational cultures differ markedly in terms of their relative strengths (Brown, 1995 p 74). Payne (1990) cited in Senior (2002) suggested that the strength of an organisation's culture can be measured by first the degree to which it is shared by all members and, second by the intensity with which organizational members believe in it.

Many definitions of culture can be found in the literature and (Kroeber and Kluckhohn 1952 p 181) claim to have examined well over 100, it seems reasonable, therefore to give their summary definition:

*'Culture consists in patterned ways of thinking, feeling and reacting, acquired and transmitted mainly by symbols conditioning the distinctive achievements of human groups including their embodiment in artifacts, the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached value'.*

Whilst (Hofstede 1981 p 24) say culture is the collective programming of the human mind that distinguishes the members of the human group from those of another. Culture in this sense is a system of collectively held values. Ireland is a country known to have strong Christianity beliefs and values as a nation, these cultural beliefs and values (societal norms) interferes with the engagement process, i.e. the inadequate prompting of health care professionals to wash their hands example. This calls for a complete paradigm shift. Ignoring or challenging cultural differences in the initial stages of change could be of a future/long-term benefit (Roger Gill, 2011). Introducing a communication

strategy for SUs to engage with SM through residential house meetings involved challenging the status quo in terms of culture in the house. Historically engaging with SUs was a tokenistic approach whereby SUs were asked for their views and instant response has been required. What most of us usually need is time to deliberate and weigh up our thoughts and feelings in relation to a particular issue. (Brafield and Eckersley 2008) Concluded that engagement is much harder to obtain from individuals who do not easily fit into an organized group who choose not to conform to a group at all. Engagement with SUs in this project was not that hard as all the SUs had interest in speaking out. From that, the author deduced that stakeholder's interest in the subject influences the success of the project.

### **2.2.3 Empowerment**

Three definitions of empowerment were compared, (Roger Gill, 2011) uses the Oxford English Dictionary to define empowerment as giving people authority or power – giving people the ability, or making them able to do something or act in a particular way. Rodwell (1996) defines empowerment as ‘a process of enabling people to choose to take control over and make decisions about their lives’ whilst Gibson (1991) describes it as a ‘process of recognizing, promoting and enhancing people’s abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control, of their own lives. Empowerment for this project meant enabling service users, staff redressing power dynamics, enhancing SUs’ quality of life by involving them in making decisions at a micro level. When we talk about empowerment in SUI terms, we look at the level of autonomy, authority and power the SU has, is it the SUs

themselves or providers that determine the level of authority and power/autonomy. (R. E. Davis et al., 2007) Says empowering patients to take an active role in their health care has been nationally and internationally identified as a key factor in the drive to improve health services for the patient. HIQA standards are the same wave length with Davis et al., 2007. This type of empowerment leads to some autonomy. It is, however, not automatic that empowering patients to actively take a role in their health care will improve health services. Improving health services comes with a lot of challenges for the providers and the service users themselves, the steps that follow after empowering patients support the improvement of health services.

Traditionally power was with the provider, in the recent years there seems to be a paradigm shift resulting from the drive through regulations, policy documents, best practice guidelines, which have facilitated the empowerment of SUs to be more involved and/or even taking the lead in some areas of their lives i.e. person centered plans, personal outcome measures and individual care plans to mention a few are best practice guidelines that have supported the shift in the organisation. Segal and his colleagues cited in (Rogers, Chamberlin, Ellison, & Crean, 1997) described empowerment as a process of 'gaining control over one's life and influencing the organisational and societal structure in which one lives. Wouldn't it be great if everyone had control over the own lives, realistically control over one's life is a challenge for everyone, there are certain elements that we have control over and some areas in life where we rely on interdependence. (Rogers et al., 1997) In their study 'A Consumer-Constructed Scale to Measure Empowerment Among Users of MH Services' carried out

in Boston, (America) using a survey designed with the assistance of a consumer research advisory board, under the direction of Chamberlin who was the second author and self-help movement leaders selected scales to measure empowerment and found significant positive correlations between empowerment and quality of life, although no differences in empowerment were found between working and nonworking respondents, a significant relationship was noted between total monthly income and respondents' scores on empowerment scales. (Masterson & Owen, 2006) Any discussion of empowerment would be superficial without an understanding of power.(Masterson & Owen, 2006) Applaud Max Weber's concept of power that says to empower MH SUs, those who possess power, such as professionals and service managers must necessarily surrender some of their own power. The change project aimed at switching the organisational structure of service provision that is a vertical structure to a more horizontal structure i.e. service managers to be on the horizontal axis with the service users, as opposed to vertical hierarchical structure, this is only possible when providers are ready to let go some of their power and maybe go into 50% power partnership with service users.

Furthermore, among the respondents who were engaged in productive activity, a significant positive relationship was found between the number of hours engaged and empowerment. They also found a significant correlation between empowerment with self-esteem. Results from this study identified the relationships empowerment has with other factors, it also suggest that programs wishing to promote empowerment among their members must focus on increasing self-esteem and self-efficacy, decreasing



feelings of powerlessness and increasing feelings of power especially by financial resources. This, however, contradict the above statement saying 'no difference in empowerment were found between working and non-working respondents.' Results of their study provide empirical support for at least part of the advisory board's initial definition of empowerment. There seems to be, however, some bias in the study from self-help leaders who selected empowerment measure criteria/scales used in the study. Like Rosenfield, the results suggest that an empowered person is one who has a sense of self-worth, self-efficacy and power. Arguably this depends with individual circumstances, in some instance yes empowerment result from a sense of self-worth, self-efficacy and power but in some circumstances little things like having information can translate into empowerment for the individual.

Traditionally providers were referred to as leaders in the lives of SUs as they led different facilitation processes i.e. supporting and facilitating SUs with their individual goals. (Roger Gill, 2011a) Says effective leadership entails enabling people to do what needs to be done to pursue a vision, purpose objective or strategy and fulfill their potential. Sir John Harvey-James says 'the leader is an enabler as much as a driver.' Traditionally effective leadership was the opposite of what Gill says about effective leadership, effective was doing things for people not affording them the opportunities to do it themselves likewise the project aimed at affording SUs the opportunity to have a say in what matters to them. Enabling service users to experience a dignified quality of life. Empowerment interacts with both organizational and national culture. Empowerment varies according to culture and leadership style, which in turn are

determined by situations and other contingencies. (Campbell, 2008) Much of the rhetoric around service user involvement links is with greater choice and thus empowerment. One difficulty with this equation is the availability of choices (Main 2006).

Choice is not choice when SUs are not empowered with information and/or supported to access as much information as possible enables SUs to make informed choice having a clearer view of things or surroundings, being knowledgeable in general. (Brafield and Eckersley 2008) Say users who have acquired skills, confidence and knowledge through their participation are no longer considered 'typical' or the 'ordinary' user, but to have become 'professionalised' thus genuine empowerment. In the nineteenth century, the Scottish lawyer and Lord Chancellor, Lord Brougham recognized the relationship between education and empowerment and the implications it has on leadership as 'Education makes people easy to lead, but difficult to drive, easy to govern, but impossible to enslave .' This implies that empowered people can be a challenge to manage; this is among other reasons why providers resist change efforts that drive SUs to be difficult to manage and impossible to enslave. (Roger Gill, 2011) Empowerment often arouses controversy whenever it is mentioned; it is a term like 'total quality management' and 'business process re-engineering, and even 'servant leadership,' often provokes strong negative reactions among many senior executives and indeed among employees at large. It is reported that empowerment implementation has been met by strong resistance in many organisations. Critics highlight on the mental capacity of individuals to be empowered as other people view empowerment as an extra

responsibility. Losing control is another concern the empowering leader has in potentially becoming laissez-faire.

#### **2.2.4 Advocacy**

A voluntary organisation in Ireland, Inclusion Ireland, say advocacy is about saying what you want; advocacy is not about getting what you want ([www.inclusionireland.ie](http://www.inclusionireland.ie)). In other words, Inclusion Ireland is talking about voicing one's opinion as opposed to looking at the response that is the actual outcome from one raising their voice. Whilst another mental health voluntary organisation in the UK Mind, say advocacy is a process of supporting and enabling people to:-

1. Express their views and concerns
2. Access information and services
3. Defend and promote their rights and responsibilities and
4. Explore choices and options ([www.mind.org.uk/advocacyinmentalhealth](http://www.mind.org.uk/advocacyinmentalhealth)).

There is a similarity in definition of advocacy from these two organisations which are Irish and UK based; the two definitions talk about reaching out, voicing and do not talk about the outcome. In the UK mental health advocacy has developed over the last twenty years as one way of challenging the discrimination faced by users or survivors of the MH system. In doing so health and social services staff have a 'duty of care' to the people they work with, which mean that they cannot support users in doing things that they think will be bad for the user i.e. risk assessments take precedence in health and

social services. But an advocate is independent, and will represent the user's wishes without judging them or putting forward their own opinion or systems procedure thus 'risk assessment.' Risk assessments can potentially be barriers to progression for people with disabilities. Mind says people do not need an advocate all the time, but they need to know what advocacy is available and how to make contact if the need arises. It is a known fact supported by Mind Organisation, having a MH problem or experiencing mental distress can be disempowering and often mean that one's opinions and ideas are not often taken seriously, or often are deprived the opportunities and choices available to the mainstream population ([www.mind.org.uk](http://www.mind.org.uk)). Society has for decades perceived and viewed people with MH difficulties as object of pity; this has a disempowering effect on the individual. (Hui & Stickley, 2007) In their study, 'exploring the concept of SUI in MH nursing using a discourse analysis approach' discovered that advocacy by MH nurses was needed in relation to issues of power in MH practice. Mind, Inclusion Ireland, SEAP and A4A organisations in the UK define advocacy by saying advocacy in all its form seeks to ensure that people, particularly those who are most vulnerable in society are able to: - have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives, whilst the later organisation A4A say advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. A4A's definition defers from Inclusion Ireland's definition by saying obtaining needs, Inclusion Ireland says advocacy is all about voicing what one wants not about outcome from the voice. The author's organisation is of the same view as A4A who says advocacy is

about obtaining needs; the project is taking the view of Inclusion Ireland of voicing opinion without worrying about outcome.

WHO (2001) acknowledges that many of the most important functions of advocacy movement are best carried out by organisations that are structurally and financially independent of government. Organisations that are closely tied to the government may not be as outside groups to lobby for changes in current laws and practices, or to denounce human rights violations. In Chile advocacy groups also played an important role in building support for the 2000 National MH Plan. They helped policy makers overcome the resistance of some psychiatrists and other MH professionals to downsize the mental hospitals and to develop community services. In Australia (Lennox et al., 2004) commented on the significant limited number of research into the experiences of people with ID and health care systems. In the UK, several public information campaigns involving professional organisations, advocacy groups and the Department of Health have been able to produce changes in the general population's attitudes in a period of 5 years with a small, but statistical significant reduction of stigma associated to several mental disorders (Crisp 2005). WHO, believe MH advocacy is important for promoting high quality MH care and the human rights of people with MH, they also believe Government Ministries can take action in promoting MH advocacy and act as advocates themselves for better MH care and better treatment of people with mental disorders. (Funk 2006)

### 2.2.5 Partnership

Partnership has become one of the new development buzz words, yet often there is little clarity about what exactly is meant by the term. Jalal 1999, offers a useful lens through which to examine the ways in which the term 'partnership' is used in health, by using two pointers see Table 2.5.1 (Cornwall et al., 2000). Partnership between providers and users if supported by the social model of care. Traditionally services for people with disabilities were based on the medical model, this model focused on the medical aspects of disability and distracted from other aspects like education, employment, social relationships, etc. (Oliver, 1986) Mike Oliver coined the social model in 1983. (Quin & Redmond, 2003) Says a social model of disability, it is argued, requires change in the social world rather than in the people who inhabit it. It further requires radical change on the part of professional service providers to adopting a rights perspective in relation to disability and to planning and creating services in partnership with existing and potential SUs. (Table 2.5.1)

Table 2.5.1 – Difference between two versions of partnership

First Version	Second Version
The primary purpose is to provide a way to match means and competencies between public and private actors.	Here the definition moves beyond simply providing services to embrace the notion of responsible partnership; to one which is based on promoting a sense of co-ownership not only among the providers but also among the SUs Jalal (1999: 8)

The primary purpose is to provide a way to match means and competencies between public and private actors. Here the definition moves beyond simply providing services to embrace the notion of responsible partnership; to one which is based on promoting a

sense of co-ownership not only among the providers but also among the SUs Jalal (1999: 8)

(Cornwall et al., 2000) In comparing the two versions suggests the adoption of a relatively ambitious definition that builds on this sense of 'responsible partnership' where she draws on Cadbury's definition of partnership as 'power' being shared equally with all partners (1993: 11) and Fowler who describes authentic partnerships as understood and mutually enabling; interdependent interaction with shared intentions (1997: 117). The projects aimed at mutually enabling SUs to work alongside providers, working alongside does not however mean 'power being shared equally' with partners as stated above co-ownership. This sounds like the right thing to do, but as providers we are far from this practice of equality, for this practice to be embedded calls for providers to wear different lens when viewing SUs.

(Newman & Vidler, 2006) The image of the consumer stands at the heart of attempts to reform health systems to meet the demands of a 'modern' World in which Citizens are assumed to have greater access to information and improved confidence in challenging clinician authority (Coulter and Magee, 2003, Goode et al., 2004). Realistically how many service users are empowered to challenge clinicians? or are comfortable to work in partnership with clinicians, (Trivedi & Wykes, 2002) in their qualitative review of user involvement in research at the Department of Psychology, Institute of Psychiatry London affirm that many mental health users may not wish to be involved in partnership

research. (Faulkner and Nicholls, 2000), although a recent local conference in south London indicated that SUs can set priorities for research and would like more involvement (Thornicroft et al., 2002). These are two conflicting ideas on service user involvement. Service users tend to choose how and when they want a partnership relationship with providers.

Such a conception has been a central feature in the UK health reforms under both Conservative and Labour administration. The Citizen's Charter of 1991 (cabinet office, 1991) emphasized on the principles of choice, ownership and responsibility, and sought to enhance the quality of public services by providing the public with information and enhancing their rights to redress and recompense. The consumerist model of the public service provision has attracted a number of critiques political and academically. Some say, the focus is on the idea that customer cannot be a 'real' customer since he/she may not pay directly for the service, may be an unwillingly or involuntary user, or may have little choice due to the absence of 'real' competition for most services (Clarke, 1997) Others take a different approach writing in health, Pickstone has suggested that the displacement of a productionist model of health by a more consumerist model was driven by the 1960s emphasis on choice in lifestyle and the 1970s notion of the body as a sexual commodity for individual investment. Yet others focus on the problems consumerism might produce e.g. the increase in what Harrison and Moran term the 'consumer moral hazard' of rising demands and 'increasingly open distributive struggle' between funders, clinicians and patients (2000:499).



Political speeches and policy documents new Labour repeatedly asserts the need for health services to be more strongly consumerist, whereas eighty years ago one size fits all approach of the 1940s' was still in the ascendant. This has been a challenge for services, though progress is being made by initiatives like this project, it has been very slow. The public was supported to be truly grateful for what they were about to receive, SUI was lacking, i.e. the non-availability of complaints procedures. Today there is a paradigm shift whereby people demand services but again at a rate that can be commented as mentioned in the patient safety study patients are not yet fully empowered to challenge clinicians. In organisation SUs have been empowered to use the complaints procedures in line with regulatory bodies, best practice guidelines, national and international policy documents but response from senior management has not been deemed satisfactory by the SUs.

#### 2.2.6 Information Known Before

##### What is already known

- Tokenism approach – SUI strategy are being set up to meet funding requirements, policy documents, best practice guidelines and regulations without being meaningful to the SUs.
- There are benefits of involving service users in decision making process
- Power dynamics (user and provider hierarchy i.e. providers prefer to retain power)
- Partnership between providers and users is not real partnership (tokenistic approach)
- Direct staff cannot independently advocate for service users because of

systems and duty of care.

### 2.2.7 New Information

#### What this project adds

- Despite the term user involvement going viral (thus being a buzz words) there is very little progress in the area i.e. research in the subject area is still infant
- Traditional service delivery methods have disempowering effect on the SU
- The challenges that result from having user involvement activities can be barriers for meaningful involvement (requesting for demands that the organisation cannot meet i.e. front door keys)
- Lack of evidence on how effective user involvement can be
- Staff workload will increase with involvement activity i.e. teaching service users' new skills, having regular meetings, typing minutes, organizing the venue, advocating for service users, etc.
- Education makes people easy to lead, but difficult to drive, easy to govern but impossible to enslave.
- SUI is subject that is debatable
- SUI activities are a vital way of delivering and developing good services
- Empowerment thus education makes people easy to lead, but difficult to drive, easy to govern, but impossible to enslave.

## 2.3 Summary

From the articles/literature reviewed on SUI, it is quite evident that a lot has gone into the subject of involving SUs that has shaped/ influenced how services across a range of different settings are provided. National policy documents like the UK Health and Social

Care Act 2001, best practice guidelines, regulatory bodies have been in the forefront for soliciting for SUI, which has become buzzwords. These changes in the healthcare environment mandate for urgency in introducing a SUI strategy. Reforms in Western countries emphasise on public and patients involvement. However evidence based on the use of services, quality of care, satisfaction, or health of patients does not exist. The benefits regarding SU innovation are contradicting; this has led to tension and conflicting ideas to emerge. There was a general agreement within articles and journals that SUI though relatively new was still in its infancy stage, it is still a new area of enquiry. The term SUI continues to be a subject confusing seen by others as liberating and of benefit to the individual, the community and at national levels whilst others view it as a tokenistic dead end, meaning it is a practice done for other reasons other than benefiting the SUs thus being paper driven and not meaningful to the individual.

Some of the SUI strategies maybe of more benefit than others, especially those that arise in response to user's requests and those that seek to increase user empowerment. There is a paucity of empirical data on the level to which patients can take on such a role. Equality in partnership between SUs and providers continues to be debatable. There, however, seem to be a correlation between SUI and sub themes especially participation, empowerment, engagement and partnership. Arnstein's 1969 participation ladder seems to be a key document shaping the framework of SUI. The UK sets out a benchmark for Ireland healthcare provision, and SUI is now a legal requirement in the UK under section 11 of the Health and Social Care Act 2001, undertaking SUI activity is a proactive strategy, as opposed to reactive for when HIQA

mandate involvement as a legal strategy, at the moment HIQA encourage SUI strategies I foresee this as a mandate in the near future.

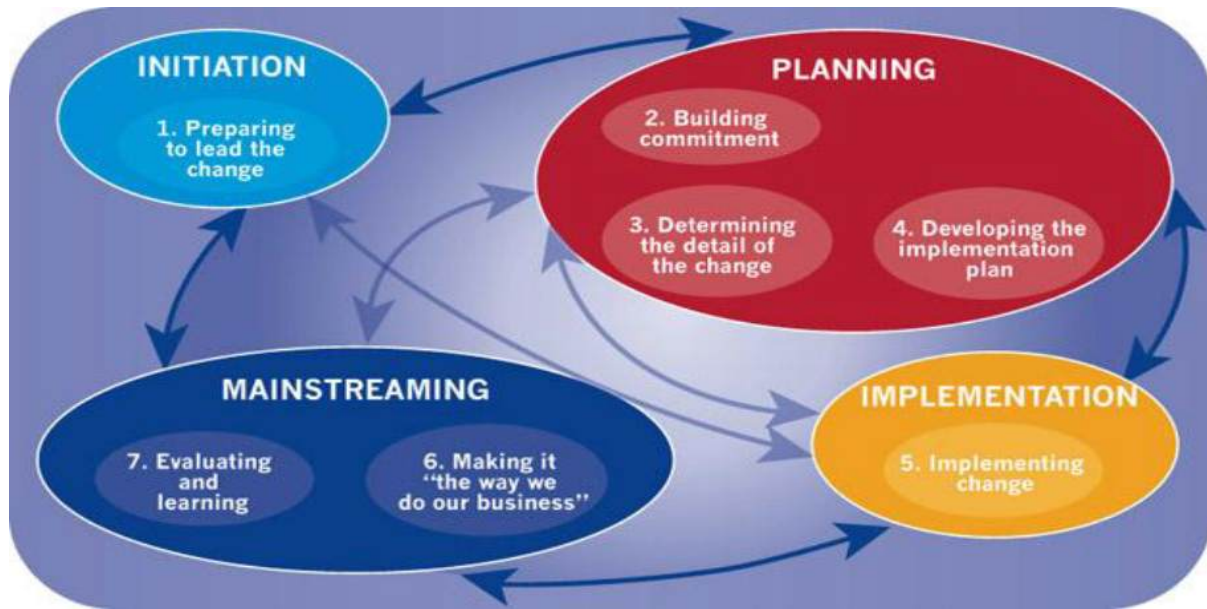
## Chapter 3 - Methodology

### 3.1. Introduction

The introduction chapter provides an overview of the methodology and methods used as part of the OD process. The process was guided by the HSE change model, the model is divide into four stages initiation, planning, implementing and mainstreaming. Each stage is sub-divided into a step or steps, thus starting from step 1 in the initiation to step 7 in the mainstreaming. HSE change model was chosen because the model is current, Irish based making it relevant to an Irish healthcare setting and allows flexible movement from one stage to the other and adjustable, allowing back and forth movement for amending. The HSE Change Model describes the journey of a transformation that guide people to move from the current situation to the desirable future. Unlike other change models like Kotter's eight step model. Appendix 6 Kotter's eight step model and Lewin's Model which are linear in structure, i.e. leaders who successfully transform businesses do eight things right and they do them in the right order (Kotter, 1996). Change is messy as reflected by the HSE model fig 3.1 arrows pointing back and forth. The HSE Change Model has been developed to:

- Improve the experience of patients and service users
- Help staff, team playing a meaningful role in working together to improve services
- Promote a consistent approach for change across the system  
(McAuliffe & Van Vaerenbergh, 2006)

*Fig 3.1 - HSE Change Model*



*HSE Change Model adapted from: Kolb, D. and Frohman, A. (1970), Huse, E. (1980), Neumann, J. (1989), Kotter, J.P. (1995), Ackerman Anderson, L. and Anderson, D. (2001), McAuliffe, E. and Van Vaerenbergh, C. (2006), and Project Management Institute (2004)*

### 3.2 Stage 1: Initiation

The initial stage commenced by carrying out a holistic assessment of the current situation in regards to SUI activities in the organization. The assessment was based on the HSE framework for integrated quality, safety and risk management, comprises of thirteen core elements, each with its own supporting principles or requirements, which healthcare organisations must have in order to achieve excellence in clinical governance ([www.hse.ie](http://www.hse.ie)), describing the system through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the delivered care. For health care staff this mean: specifying the clinical standards to be delivered and showing everyone the measurements made to demonstrate that. The document 'Towards Excellence in Clinical Governance' is one of a series of guiding documents for

HSE funded service providers (HSE (2009a) see below Fig 3.2 Framework for Integrated Quality, Safety and Risk Management)

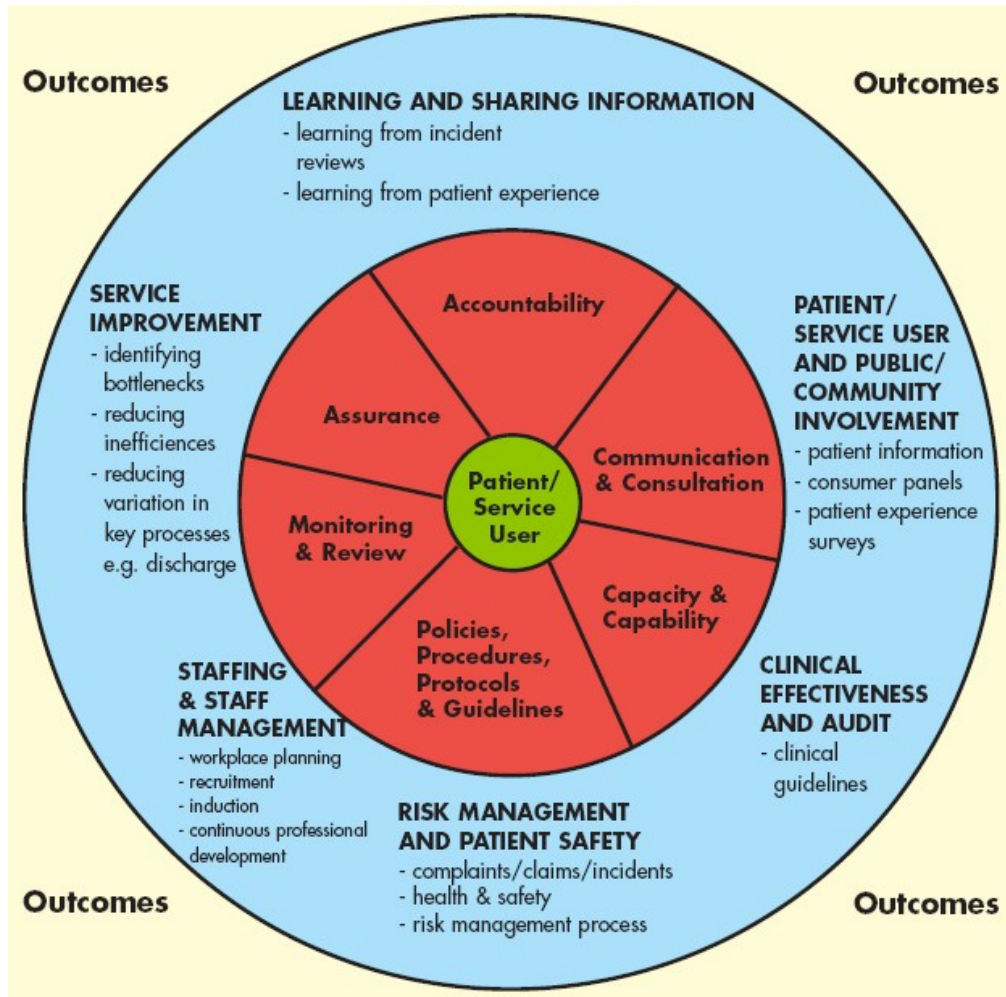


Figure 3.2. Framework for integrated quality, safety and risk management. The term 'Patient/Service User' should also be interpreted as 'client.'

Fig 3.2. Coding

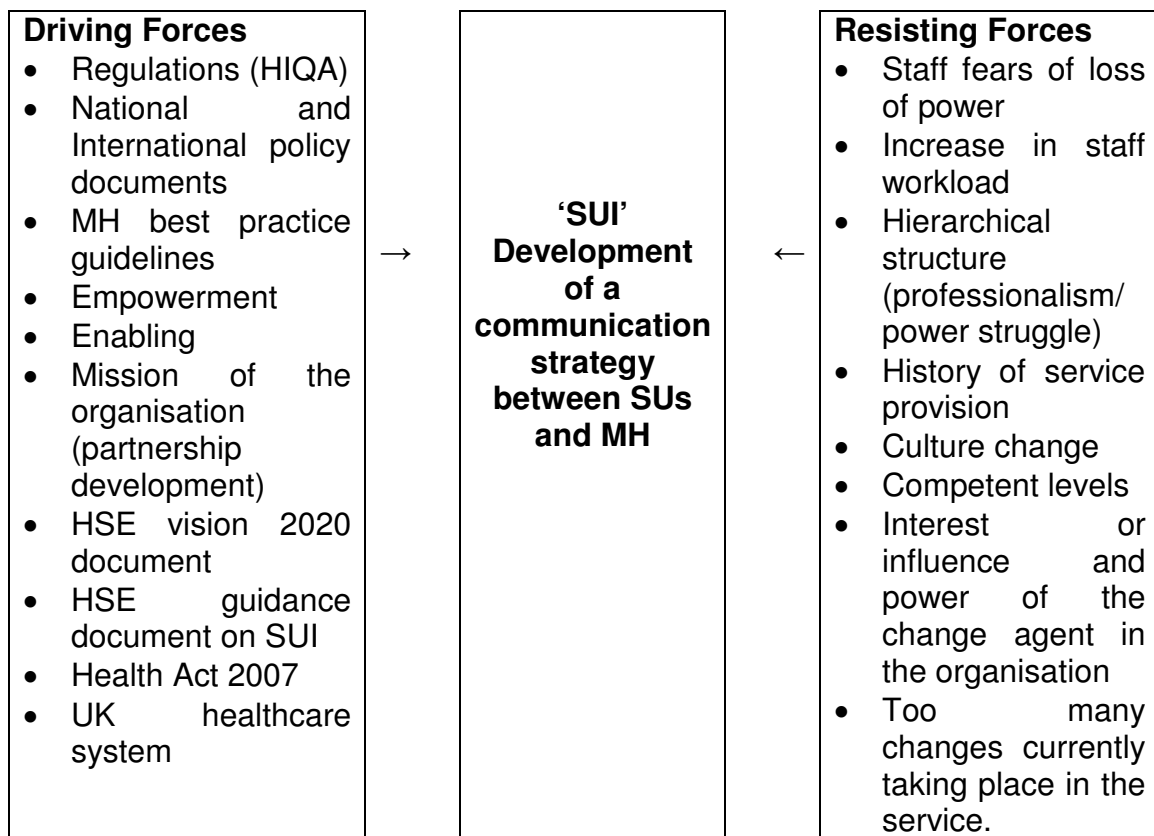


In the guidance document, involvement is defined as a process by which people are enabled to become actively and genuinely being involved with regards issues of

concern to them, making decisions about factors that affect their lives, formulating and implementing policies, planning, developing and delivering services and taking action to achieve change (HSE 2009a) (mm, n.d.) As part of holistic assessment, change management tools like stakeholder (appendix 7), force field fig 3.2.1 and SWOT analysis (appendix 8) were carried out to assess the current organization position, identifying areas of improvement, develop plans for continuous quality improvement and identifying the likelihood of resistance. Appendix 9 defines these management tools.

Fig 3.2.1 Force Field Analysis

### Change Initiative





### **3.2.1 Step 1 Preparing for Change**

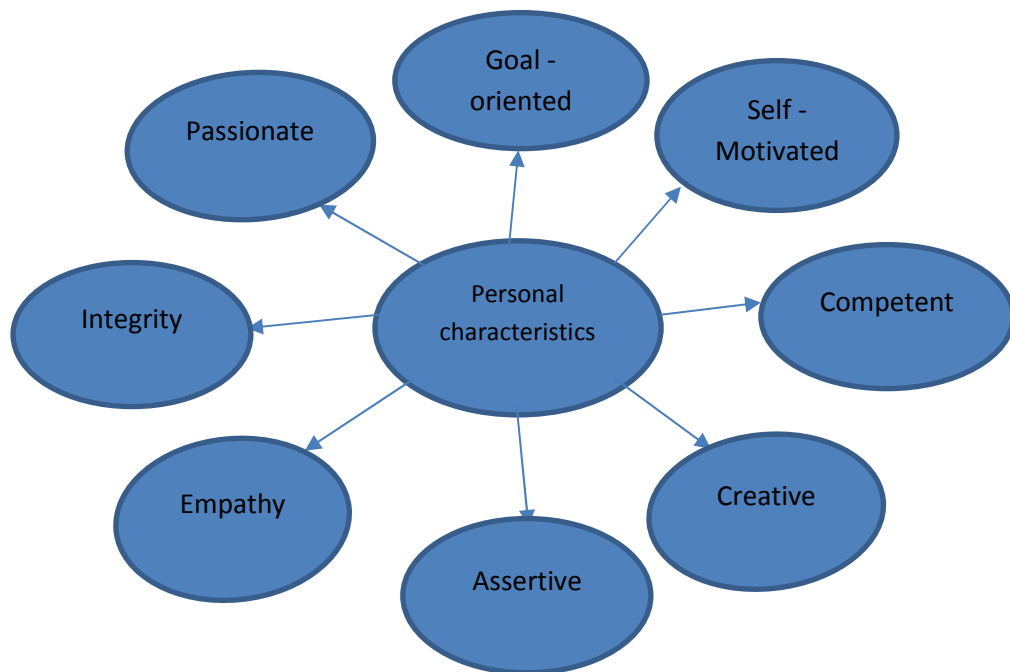
The main purpose for this stage was to identify what was driving the need for change and establish degree of urgency. Force field analysis (Fig 3.2.1) identified the current changes in Ireland i.e. the introduction of a regulatory body HIQA, (best practice guidelines, policy documents, and health and social care legislation), England who are known to set the scene for Irish healthcare settings, all this calls for a complete review of the current situation and how services are being delivered and demands for a paradigm shift from traditional service delivery methods dominated by hierarchical structures. The next stage was to mobilise supports and to build on the foundations for effective transitional process, i.e. defining project leadership roles i.e. shared or distributive leadership among the staff team, SUs chairing of meetings rotationally, minute taking, agenda setting etc.

(Solansky, 2008) The concepts of shared or distributed leadership have made their way into recent research agendas. The traditional perspective of a single leader suggests that the leadership function is a specialized role that cannot be shared without jeopardizing group effectiveness. This view represents the more hierarchical leadership in which the leader directs all activities (Ensley et al., 2003). In contrast, shared leadership represents teams whose members are empowered to share the tasks and responsibilities of leadership (Ensley et al., 2003; Katzenbach, 1997). Those who view leadership as a shared process argue “important decisions about what to do and how to do it are made through the use of an interactive process that involves many different people who influence each other, not by a single person” (Yukl, 1998, p. 3). Bradford (1976) suggested that teams that share the leadership function will be more satisfied with their team, and Katzenbach and Smith (1993) found that teams that engage in

shared leadership are more effective than other teams. Teams with shared leadership have better coordination and cooperation (Yeatts & Hyten, 1998), and Perry, Pearce, and Sims (1999) argued that shared leadership enhances the team's interpretation of needs.

The notion of shared or distributive leadership is not novel, though it has been somewhat ignored in comparison to solo leadership (Ensley et al., 2003; O'Toole, Galbraith, & Lawler, 2002). The resistance to shared leadership "stems from thousands of years of cultural conditioning...in the popular mind, leadership is always singular" (O'Toole et al., 2002, p. 65). Sharing the leadership role amongst the staff team poses the most commonly-asked question 'are leaders born or made? The answer to this question according Larkin 2010, some people are born natural leaders and some people learn along the way, accurately saying that leaders are both born and made. Larkin 2010 says there are certain essential set of skills needed to be effective leaders. Fig 3.2.2 leadership personal attributes, to the successfulness of the project i.e. competent, assertiveness, self-motivation and passion to embed change. The staff team comprise of a mixture of born leaders and nurtured leaders, as identified at the start of the programme that some certain staff need nurturing into leadership position, by mentoring and coaching i.e. those with less experience in leading.

Fig 3.2.2 Successful Leader Personal Attributes



Adopted from Larkin, E. (2010), Quick Win, Leadership, Answers to your top 100 leadership questions, Oak Tree Press, Cork, Ireland

The leadership roles amongst other responsibilities included, creating conducive environment, embracing change as an opportunity for growth and not a threat, communication was key. Effective communication methods and media for contacting identified key stakeholders were drawn according to the level of individuals understanding i.e. face to face communication with SUs, verbal or written conversation with the quality and finance department etc. (Leonard, Graham, & Bonacum, 2004) say effective communication and teamwork is essential for the delivery of high quality, safe patient care. Communication failures are extremely a common cause of inadvertent patient harm. Key to the project was communication and media used for different stakeholders.

Successful change is linked to strong leadership governance. (Roger Gill, 2011) Table 3.2.1 highlights the importance of communication and leadership to successful change. Communication and teamwork are listed third and fourth in the table. Communication at this stage aimed at leadership translating the vision to key stakeholders to build a shared vision.

Table 3.2.1 Key to successful change

% mentioning this as Important	
Leadership	92
Corporate Values	84
Communication	75
Teambuilding	69
Education and Training	64

*The most frequently mentioned key to successful change, according to an American Management Association survey of 259 senior executives in Fortune 500 companies in the United States, is leadership by (Roger Gill, 2011)*

The initiation stage went through the process of reviewing literature on the subject matter 'SUI. The literature reviewed highlighted on the benefits of SUI for example national, international guidance and policy documents strongly advocating for the subject i.e. Vision for Change 2020 (browne, n.d.). There was also some literature not in support of the move i.e., 'SUI' is a current buzzword and appears regularly in policy documents, mission statements and the academic literature, but may be less meaningful in practice. This view is supported by a survey of the mental health service user movement in England, which identified 318 user groups and found that 'local SU groups play a very important role in mutual support, combating stigma, helping people

to recover and stay out of services and participating in local service planning and development (Wallcraft 2003) cited in (Tait & Lester, 2005)

In building on a shared vision with stakeholders, it was important to support key stakeholders to understand why SUI is so important. There are a number of interrelated reasons for believing that MH SUI is more than a politically mandated 'good thing' and is a worthwhile activity with a range of practical and ethical benefits. Fig 3.2.2 summarizes the benefits:-

Table 3.2.2 - The benefits of service user involvement

- SUI are experts on their own illness and need for care
  - SUI may have different but equally important perspectives about their illness and care
  - SUI may increase the existing limited understanding of mental distress
  - Users are able to develop alternative approaches to MH and illness
  - SUI may be therapeutic in itself
  - SUI may encourage greater social inclusion
- (Tait & Lester, 2005a)

### 3.3 **Stage 2: Planning**

The purpose of planning stage was to determine the specific detail of the change and to create support for an effective change process ([www.hse.ie](http://www.hse.ie)). The more planned supports in place, the easier the process became. Planning at this stage of the process was significant, leadership visible actions were witnessed in the planning stage i.e. collaborative meetings were held with stakeholders, several discussions and

psychological contracting with different stakeholders also done at the planning stage. If planning was not collaborated carefully things could have potentially gone wrong. (Roger Gill, 2011) poor leadership can turn the best advantage into a disaster. A good change initiative could fail as a result of poor leadership planning, fig. 3.2.1 attributes which were essential for planning i.e. competent, empathy, and assertiveness etc. demonstrated. The planning phase had an effect on the other phases of the project life cycle (Dvir, Raz, & Shenhar, 2003). The HSE model is drawn systematically making it easy to plan for change initiative to flow. Planning stage is sub-divided into three stages building commitment, determining the detail of the change and developing the implementation plan.(McAuliffe & Van Vaerenbergh, 2006).

### **3.3.1 Step 2 Building Commitment**

The purpose of this stage was to further increase commitment for the process, building a shared sense of the vision for change and engage in activities that will increase readiness and capacity to embrace the requirements of the planned outcome. Activities included drawing of the service user charter, conducting meetings training staff and service etc. A lot of collaboration was required as this was the first stage the project reached out to the key stakeholders. In building commitment with stakeholders several talks and discussions were held, done at a level of understanding of each stakeholder group i.e. the use plain English no professional jargon. Meetings were intended to draw a psychological contract between the SUs and the providers. (Robinson, Kraatz, & Rousseau, 1994) a psychological contract serves to bind together individuals and organisations and regulate their behavior, making possible the achievement of

organizational goals. A service user charter emerged, it was drawn using information gathered from the meetings. The charter informed how meetings were to be conducted i.e. used as the terms of reference. Agreed that the meetings will be held monthly and SU would be guided through the process of chairing meetings. Meeting times were planned, taking into consideration individuals routines and level of activities, time that didn't interfere with routine or culture in the residential service, as interfering with regular routine could potentially lead to resistance.

Some team members had no leadership background, though the social care position involves informal leadership. (Spillane, Halverson, & Diamond, 2004) say literature on leadership, regardless of tradition focusing mostly on those in formal leadership position. The project nurtured leadership from people that wouldn't normally have leadership roles or titles, so as the project was developing staff were professionally developing too. (Bennett, Wise, Woods, & Harvey, 2003) it is evident that the concept of distributed leadership has a variety of meanings, and that some of these meanings (explicitly and or implicitly) resemble earlier notions such as collegiality. This prompts the question of whether there is a conception of distributed leadership which takes understanding of leadership further than a re-naming of previous ideas. Distributed leadership highlights leadership as an emergent property of group of network or interacting individuals. Distributed leadership's primary concern is to mobilize leadership at all levels in the organisation not solely relying on leadership from the top. Two types of leadership emerged talent and Y generation leadership, it is surprising that these emerged from one particular individual who has become the champion of the project

working closely with the project leader, and the individual will take over the project in the event of the author leaving the position or the organisation. This information will be captured in the succession plan.

SM demonstrated their commitment and readiness to engage with service users and improve communication by accepting to provide timely feedback and attend quarterly meetings, demonstrating that change was about to begin marking a new era. The project took into account the activities that needed to be re-designed i.e. staff letting go power (power dynamics), a paradigm shift from traditional service provision to a more inclusive way forward, use of plain English and a strong leadership governance whereby staff would model expected behaviors in day to day interactions. The project looked at the legacy that could be transferred and embedded into the new system i.e. culture. It also looked at the opportunities available for service users to experience and acknowledge that change is underway i.e. culture of engagement into planned activities i.e. meetings, development briefing, psychological support sessions, future planning, celebrating SUI milestone, and publishing in the newsletter of the organisation etc. To get all staff on board the project was grounded on regulation changes in Ireland.

### **3.3.2 Step 3: Determining the Detail for the Change**

Management tools used, identified that SUs had limited involvement in the planning of the service i.e. SUs are represented in some committees like the health and safety committee which is just an element of involvement. From talking informally to SUs across the organisation it was noted that SUs like to have regular structured contact



with SM though the organization has an open door policy, it is not always possible for SUs to meet with SM.

Some SUs and staff view the current complaints procedure ineffective and wanted to try another way of communicating their grievances, suggestions and general feedback. The current complaints procedure was drawn by the quality department which does not include SU or representatives. (Fudge et al., 2008) says service users are experts about their own illness, may also have different but equally important perspectives about their illness and care and maybe able to develop alternative approaches to mental health and illness. With this in mind it will be expected that service users will be involved in the designing of their system.

The project benchmarked the organisation’s SUI activities with other similar organisations in Ireland like St Michaels House and St John of Gods and discovered that the organisation was doing ok but when benchmarked against International organisations like the Turning Point and Mind in the UK and America health and social care organisations it was identified that the organisation needed to do a lot to meet best practice guidelines or regulations. A gap analysis was carried out using the UK community care act of 1990 guidelines.

Table 3.3.2 Gap analysis (current situation and future vision for change)

Concern Issue	Current situation as	Expected Outcome as a
---------------	----------------------	-----------------------

	a %	%
Number of service users involved in committees	25	50
Complaints response	25	100
Information sharing - developments	20	100
Bullying cases in residential settings	50	0
Concept of sharing residents	10	90
Planned activities i.e. meetings between service users and management	0	50%
Number of service users on interview panels	0	10%

Findings from the gap analysis (Table 3.3.2) were presented to management. The current situation in the organization had no structures supporting SM and service users to engage in planned activities like meetings, briefings etc. However some of these activities were available to staff like the monthly CEO briefing. The above table 3.3.2 helped stakeholders to assess the current situation against the future vision for change which is the expected outcome.

### **3.3.3 Step 4 Developing the Implementation Plan**

Step 4 was for developing an implementation plan that will enable to sustain the change process. (Luffman et al., 1996) says successful implementation of any strategy will be dependent on the quality of the leadership. The change leader had personal and referent power which gave leverage to the implementation process. Developing this implementation plan demanded strong leadership skill set, a leader that was ready to transform into the future state. Peter Drucker cited in (Roger Gill, 2011) the best way to predict the future is to create it. Creating the future in this case meant articulating the desirable future to the stakeholders as indicated by the gap analysis desirable outcomes. Outcomes meant strong partnership between SUs and providers.

Partnership is said to be equal in power (Cornwall et al., 2000), realistically this does not happen it is more of a theory than practice. Providers for years have maintained more power than SUs. Providers are in charge of funding, SUs can bring up a suggestion but that does not mean it will be taken on board thus advocacy according to ([www.inclusionireland.ie](http://www.inclusionireland.ie)). Where equality is the order of the day this wouldn't be the case. Implementing this vision meant strong local collaborative relationships between SUs, staff, SM, IT Department, clinical department and quality department. At local level collaboration meant engagement and fostering partnership with other departments of the organisation. According to the organisation's operational plan if a SU bring up something of a sensitive nature the clinical department will provide that individual with psychological support.

Implementation of the project demanded policies to be reviewed or implemented i.e. service users end of life plans, psychological input was deemed important because such conversations i.e. topics relating to end of life planning has a psychological impact on people let alone someone who has ID and or MH difficulties. Key success indicators were based on the quality of information shared, number of meetings held, attendance and response from SM. Inclusion Ireland say advocacy is about saying what you want, and is not about getting what you want ([www.inclusionireland.ie](http://www.inclusionireland.ie)). Speaking out was deemed enough by the project, response from management in this case was a key indicator of success. The findings or desirable outcomes were assessed by the quality department before implementation of the process. Milestones and success are

celebrated and the journey of SUI will be published in the organisation spring newsletter.

Part of the planning focused on implementing and monitoring or reviewing the project plan thus the business case ensuring that it did not deviate from its purpose. A business case is a summary of change, aims and objectives ([www.hse.ie](http://www.hse.ie)). To ensure that the plan was effective and on track, a Gantt chart was drawn out. A Gantt chart, is commonly used in project management tool and one of the most popular and useful ways of showing activities (tasks or events) displayed against time. This allows one to see at a glance:

- What the various activities are
- When each activity begins and ends
- How long each activity is scheduled to last
- Where activities overlap with other activities, and by how much
- The start and end date of the whole project. To summarize, a Gantt chart shows you what has to be done, the activities and when scheduled for. ([www.gannt.com](http://www.gannt.com))

Some challenges were encountered on the way to change i.e. power dynamics in partnership working and collaboration as opposed to working from a hierarchy standpoint this was a challenge from some staff's perspective. Change implementation date communicated to all key stakeholders.

### 3.4 Stage 3: Implementation

Implementation stage focused on two elements the actual implementing of the agreed actions and monitoring or evaluating closely the project plan, ensuring that the purpose is being met. The project leader took into consideration the transitions that people were about to experience, and support plans were in place for when desirable i.e. mentoring to less experienced staff members in running these meetings. The change leader was visionary about the desirable outcome, this vision was used to drive and reinforce the new ways of doing business.

Feedback from service users and staff on how they anticipated the project to be of benefit was sorted consistently. The process involved attentive listening to people's feelings and thoughts about the journey that was about to commence. The puzzles were put in place at this stage, thus agreed actions are put together. (See fig 3.4.1 below).



*Fig - 3.4.1 Implementation plan*

Putting these puzzles together called for strong leadership qualities in engaging with key stakeholders' i.e. coordinating training and meetings, venue and inviting SM to a quarterly meeting. Training was identified important as it supported sustaining SUI for example, staff and service users were empowered through training to effectively use these meetings to speak out. (R. E. Davis et al., 2007) says empowering patients to take an active role in their health care has been nationally and internationally identified as a key factor in the drive to improve health services for the patient.

Change typically takes time to implement ([www.hse.ie](http://www.hse.ie)), with this specify change process it did not take long to implement, but establishing ways of sustaining momentum and energy levels was essential. It was assumed that the service users have finished bringing up their complaints, once resolved they would lose interest in sustaining the project. This concern was raised by one of the staff. It was agreed that this meeting could be used in similar way to the CEO/SM briefing which is in place for staff, it could also be used for learning and development purposes, feedback and also as peer support group. The project went live into operation in January 2014. The second February meeting appeared to be turning the project into a complaints forum thus deviating from aim/main purpose, this was rectified by directing service users to complaints procedure and sticking to the meeting guidelines. Monitoring of emerging trends and patterns was of importance too.

### **3.4.1 Step 5 Implement the change**

The main purpose of this stage was to implement agreed changes and attend to factors that would assist the project with long term sustainability thus motivators. Communication leadership and partnership working were identified fundamental elements of this stage. An agenda for the 1<sup>st</sup> meeting was gathered from SUs and was put out a week before the meeting. The 1<sup>st</sup> meeting was held in January 2014. To some SUs this was their first time of experiencing sitting in a meeting where they will be asked to actively engage in a leadership role thus rotating chairing of their meeting with staff support. A lot of very important information came from the service users at the meeting i.e. two service users requested for a front door key to their residential home, night time routine emerged, another service user expressed concerns over clarity on end of life plans and another SU requested assist in weekly shopping. (Appendix 10 agenda and appendix 11 minutes of the meeting) A challenge arose at the first meeting, one of the SUs had to engage go to the hospital at the staff of the meeting, but this did not interfere with the meeting as the SU shared her views and discussed her points on arriving back from the hospital, there was no contingency plan to cater for such happenings in the planning, it was a learning curve for the team.

#### **3.4.1.1 Sustaining Momentum**

Identifying effective ways of sustaining momentum at this stage was crucial. Establishing ways of embedding and sustaining the newly adopted way of doing things in the service was important too. Strong emphasis was placed on staff to embrace the changes that was planned and implemented. Partnership between SUs, SM and frontline staff became so significant. SU meetings became a standing order on the staff

meetings agenda as a way of sustaining momentum within the staff group. Coaching and mentoring was introduced to support less experienced staff that was facing challenges in leading, conducting and supporting service users to have these meetings. The project leader encouraged staff to pursue with the change as results may not be evidence immediately but in the long run. Key findings or learning from the process will be shared discussed in chapter 4 and 5. The Y Generation and talent leader that emerged during the process will take over the project in the event of the project leader leaving the organisation.

#### 3.4 **Stage 4: Mainstream**

Mainstreaming is for the purpose of focusing attention to the success of the change effort and ensuring that the adapted new working partnership pattern is sustained. This partnership requires that service users adopt and are engaging to the new practice. (Cornwall et al., 2000) says engaging users through mechanisms such as user groups and committees has generally been regarded as a means to ensure the appropriateness of service provision, and to enhance project efficiency. It was hoped that such engagement with a residential SU group would bring about appropriateness of service provision. Human services are constantly changing and will continue to change for the better. Guidance document like the HSE quality and safety framework 2009 have been at the central to improving services. How services were delivered 20 years ago is completely different to how services are delivered nowadays. Despite service changing the SU's needs also change, SU will age or move on to other suitable services of their choice.



### **3.4.1 Step 6 making it the Way we do our Business**

The purpose of this stage was to integrate and practice the new era. This phase is when staff have that feeling of achievement, this was demonstrated by staff having to deal with less challenging behaviors relating to complaints in the house. The SU meetings will be published in the spring newsletter. A milestone celebration was held at the Easter holidays by having a coffee evening, other service locations were invited to this celebration. At the coffee evening positive information about the SUI was shared by SUs and one SU was overheard telling another SU from a different service location how the meetings have changed his life and how the house was so peaceful since the meetings.

### **3.4.2 Step 7 Evaluating and learning**

The main purpose of this step is to put in place, ways to evaluate and learn from the way the change process was designed and implemented. At this the change leader had experience of implementing change successfully, the focus was on evaluating how the stages in the project went and assessing ways of continuously monitor developments and improvements at organisational and service level for future change initiatives. This stage was mainly concerned with lessons learnt from initiation to mainstreaming stage, the evaluation was carried out using Daniel Stufflebeam's CIPP model of evaluation, which is divided into two main parts formative and summative evaluation. (Stufflebeam, 2007).

### 3.5 Summary on Methodology

This chapter provided an overview of how the change was introduced using the HSE change model; initiation, planning, implementing and mainstreaming as part of an OD process. Strategic management tools were used to assess the environment, also a holistic assessment based on the HSE framework for integral quality, safety and risk management. Literature reviewed in chapter 2 was used to inform the stages of the change model. The change was implemented, leadership and communication were key elements of the process. CIPP evaluation method was selected for chapter 4.

## Chapter 4 - Evaluation

### 4.1 Introduction

(Crompton, 1996) defines evaluation as the collection of, analysis and interpretation of information about any aspect of a programme of education or training as part of a recognised process of judging its effectiveness, its efficiency and any other outcomes it may have. One aspect of any sound evaluation is the allowance for the unexpected. Above all an evaluation is a designed and purposeful enquiry which is open to comment. Using the CIPP evaluation model, this section provides a detailed analysis of data gathered from the project objectives. According to (Luffman et al., 1996) a prime purpose of objectives is to set targets or benchmarks against which performance can be measured. Table 4.1 shows the change project objectives.

*Table 4.1 Change Project Objectives/Goals*

- |  |
|--|
| <ol style="list-style-type: none"><li>1. Develop a service user charter which will be included as the terms of reference for conducting the meetings in a residential service location, this was approved by the line manager and authorized by the clinical review team (CRM) on the 10<sup>th</sup> of January 2014.</li><li>2. By the 2<sup>nd</sup> of January 2014, 100% residential staff team and service users will have attended 'how to conduct meetings in house training' programme.</li></ol> |
|--|

3. By January 2014, have established a monthly communication strategy between service users and senior management.
4. By 18 April 2014, have a service user suggestion box in a central easily accessible place of the residential service.
5. To have a 100% service users' attendance in the anti-bullying and harassment course by 30<sup>th</sup> April 2014 to develop evidence based practice compliant to HIQA standards, theme 3 'Safe Services from abuse and neglect'.

## 4.2 Evaluation Method

To identify areas of improvement the project was evaluated using CIPP model, this model was developed by Phi Delta Kappa Committee on Evaluation in 1971. (Tokmak, Baturay, & Fadde, 2013) The CIPP evaluation model is a comprehensive framework for guiding evaluations of programs, projects, personal, products, institutions, and systems. (Stufflebeam, 2007) (Fig 4.2.1 CIPP Model).



Figure 4.2.1: Components of Stufflebeam's (2003) CIPP Model

The CIPP model focus on program evaluations, particularly those aimed at affecting long-term sustainable improvement. Corresponding to the letters in the acronym CIPP, this model's core parts are context, input, process and product. These four parts of an evaluation respectively ask; what needs to be done? How should it be done? Is it being done? Did it succeed? The concept of evaluation underlying the CIPP model is that

evaluations should assess and report an entity's merit, worth and significance and also present lessons learnt. (Stufflebeam, 2007) says the CIPP evaluation should meet the Joint Committee (1994) standards of utility, feasibility, propriety and accuracy. The main theme of the evaluation model is not prove but to improve. Five project objectives were drawn out at the initiation stage of the project (table 4.2.2). These will be evaluated against using the CIPP model guidelines. It is important to note that context, input and process are formative whereas product is summative. The University of Derby says formative assessment is used for improvement whilst summative is used for judgment purposes ([www.derby.ac.uk](http://www.derby.ac.uk)) CIPP seeks to improve and achieve accountability in educational programming through a 'learning by doing' approach. (Zhang et al, 2011)

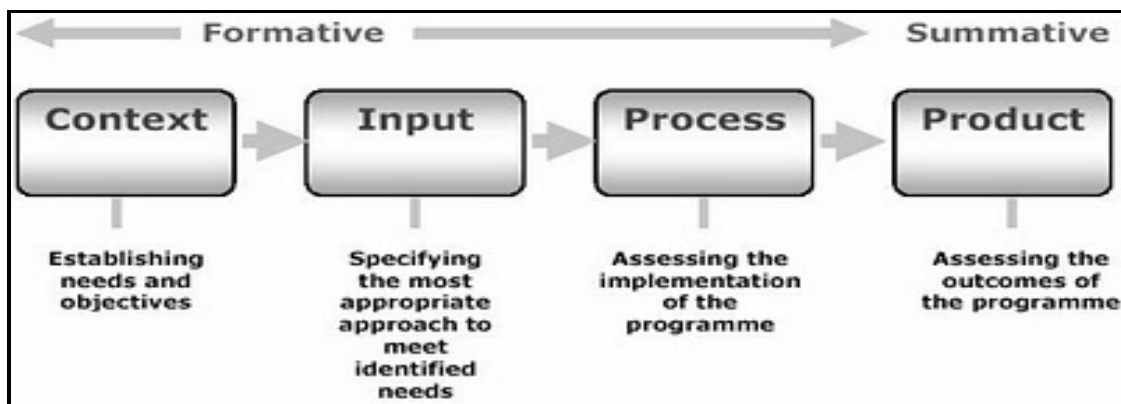


Fig 4.2 CIPP model

### 4.3. Formative

The University of Derby defines a formative as an assessment used for improvement purposes ([www.derby.ac.uk](http://www.derby.ac.uk)). The analysis of the project data is intended to be used as a benchmark or reference point for improving future projects from lessons learnt from the project. Irons (2008) says 'formative assessment' is any task which creates

feedback (or feed forward) for students about their learning. Formative assessment does not carry a grade which is subsequently used in a summative judgment.

#### 4.3.1 Context

The context stage of evaluation enables the evaluator to identify the needs, assets and resources of a community in order to provide programming that will be beneficial. The political climate for the project was conducive. The desirable outcome was articulated and key stakeholders took a strong buy-in to the project. In the initiation stage, the key stakeholder's, the intended beneficiaries of the project who are the SUs expectation/needs, anticipated problems and needed resources where identified through several conversations. (Table 4.3.1 List of resources, needs, assets and problems)

Resources	Assets	Needs	Problems
Time	Not applicable	Transparency	Routine/culture
Stationary		Timely response	Staff relations
Trainers/facilitators		Involved in decision making process	Levels of understanding
Inter-departmental working		Staff advocacy	Confrontation could lead to dishonest
Project sponsor		Training	Lose of interest

Table 4.3.1 List of resources, needs and problems

The goal of the projects was to get SUs involved in the planning and decision making process of the organisation by developing a communication strategy.

Table 4.3.1a Context - Activities to be done

Context – Activities (what needs to be done)
1. Develop a service user charter which will be included as the terms of reference for conducting the meetings in a residential service location, this was approved by the line manager and authorized by the clinical review team

(CRM) on the 10<sup>th</sup> of January 2014.

2. By the 2<sup>nd</sup> of January 2014, 100% residential staff team and service users will have attended 'how to conduct meetings in house training' programme.
3. By January 2014, have established a monthly communication strategy between service users and senior management.
4. By 18 April 2014, have a service user suggestion box in a central easily accessible place of the residential service.
5. To have a 100% service users' attendance in the anti-bullying and harassment course by 30<sup>th</sup> April 2014 to develop evidence based practice compliant to HIQA standards, theme 3 'Safe Services from abuse and neglect'.

#### 4.3.2 Input

Input stage of the evaluation looks at how table 4.3.2 activities to done where carried out. The input stage assess the project's strategy, merit and work plan against research, the responsiveness of the project to the SUs needs and alternative strategies offered in similar projects. The main intent of the stage is to choose an appropriate strategy to implement to resolve the project problem.

#### **Input – How it should be done**

1. A service user charter (terms of reference) - should be the first document to be agreed on by all parties , the HSE guidelines recommend this ([www.hse.ie](http://www.hse.ie))
2. 100% Training - Where something unfamiliar is being introduced, training or teaching thus empowerment should be afforded to people to successfully execute activities. (Roger Gill, 2011) defines empowerment as giving people authority or power – giving people the ability, or making them able to do something or act in a particular way.
3. Established a monthly communication strategy between SUs and SM - meetings should be held at a time that does not interfere with individual's routine/culture or programme, in introducing something legacy should be carried out board thus sustaining culture and routine in the house.
4. Suggestion box - there should be a suggestions box in a central easily accessible place of the residential service, this should have been in place from the project commenced ([www.hse.ie](http://www.hse.ie))
5. A 100% service users' attendance in the anti-bullying and harassment course by 30<sup>th</sup> April 2014 to develop evidence based practice compliant to HIQA standards, theme 3 'Safe Services from abuse and neglect'. – This needed to have happened earlier in the project but it came about as a result of reviewing the project progress.

4.3.2 How it should be done

**4.3.3 Process – Is it being done?**

The process evaluation stage investigates the quality of the project implementation strategy. In this stage project activities are monitored, documented and assessed by the evaluator. Are planned activities in place? Table 4.3.3 shows the project objectives or goals current situation/status.

<b>Process – Is it being done?</b>	<b>√ / X</b>
1. Develop a service user charter which will be included as the terms of reference for conducting the meetings in a residential service location, this was approved by the line manager and authorized by the clinical review team (CRM) on the 10 <sup>th</sup> of January 2014.	√
2. By the 2 <sup>nd</sup> of January 2014, 100% residential staff team and service users will have attended ‘how to conduct meetings in house training’ programme.	√
3. By January 2014, have established a monthly communication strategy between service users and senior management	√
4. By 18 April 2014, have a service user suggestion box in a central easily accessible place of the residential service.	√
5. To have a 100% service users’ attendance in the anti-bullying and harassment course by 30 <sup>th</sup> April 2014 to develop evidence based practice compliant to HIQA standards, theme 3 ‘Safe Services from abuse and neglect’.	X

Table 4.3.3 Project Objectives or Goals Current Status

**4.4 Summative**

The University of Exeter says summative assessment demonstrates the extent of a learner’s success in meeting the assessment criteria use to gauge the intended learning outcomes of a module or programme, and which contributes to the final mark given for the module. Normally used at the end of a unit of teaching to quantify achievements, to

reward achievements, to provide data for selection (to the next stage in education or employment) for all these reasons the validity and reliability of summative assessments are of the greatest importance. Summative assessments can provide information that has formative diagnostic value. (<https://as.exeter.ac.uk>).

#### **4.4.1 Product – Did it succeed?**

This is the final component of the CIPP model. The final stage assesses positive and negative effects the project had on the service users assessing both the intended and unintended outcomes and judged. During this stage, judgment of stakeholders and relevant experts are analyzed, viewing outcomes that impact on the group, subgroups and individuals. Applying a combination of methodology techniques assure all outcomes are noted and will assist in verifying evaluation findings. Table 4.4.1 shows the success rate of the project objectives or goals.



Table 4.4.1 Objectives/Goals analysis (success)

Objective	Service User Charter	S.U. and Staff Meetings Training	Monthly Meetings	Anti-bulling and Harassment Training	Suggestion Box
Positive Impact	Yes	Yes	Yes and No	N/A	N/A
Negative Impact	No	Yes	Yes and No	N/A	N/A
Intended Outcome	Yes	Yes	Yes	N/A	N/A
Unintended Outcome	Yes	Yes	Yes	N/A	N/A

\*\* Yes - Present or achieved  
 No - Absent or not achieved  
 N/A - Activity Not Yet Done or Pending

Table 4.4.2 Recommendations for Improvement

Project Objective/Goal	Met or Unmet on planned date	Success Rate as a percentage	Recommendation
Service User Charter	Met 02.01.14	90%	A standing order for agendas of all monthly meetings
Meetings Training for staff and service users	Met	100%	Introduce training course for service users to chair meetings
Monthly Meetings Attendance	Met	100%	Service users to take ownership of these meetings
Anti-bulling and Harassment Training	Pending	-	Should have been introduced earlier on in the project
Suggestion Box	Pending	-	
Service user voice	Met	90%	Encourage all voices of service users to be heard
Feedback is timely	Unmet	80%	Introduce an effective way of getting timely feedback
Importance of Meeting			

Table 4.4.3 General changes that came about as a result of SUI

Before		After
Complaints lodged in on a daily basis, complaints resolved at macro level	<p><b>Intervention</b></p> <p>↓      ↓</p> <p><b>Service User Involvement</b></p>	Discussing issues with the person and resolving at micro level
Communication with each other		Communication is more respectful
Smoking in the house		One service user still lighting a smoke in the house
House shopping list drawn up by staff		House shopping list drawn in consultation with service users
One service user deciding Sunday roast		Service users plan Sunday roast together at the meeting, each service user get an opportunity to choose Sunday roast
Organisation developments announced via newsletters and emails		Face to face feed forward or organisational developments
No formal way of consulting with service users (feedback)		Formal way of knowing service users' needs
Nothing to look forward from senior management		Looking forward to feedback and interaction with senior management
Running out on ideas for conversational starter		Can be used as a conversational starter to quiet service users
Staff challenged by confrontational some service user confrontational attitudes		

#### **4.5 Summary**

It is quiet evidence that this is a transition that has been welcomed by the key stakeholders (appendix 13 staff team review of the change project) outlines some of the positive outcomes and challenges to date. The SU attendance has been immaculate i.e. 100%. To date four meetings have taken place and there has been a 100% attendance. The quality of information coming through from these meetings has been vital to the organisation i.e. one SU shared concerns around end of life plans and the quality department who are in charge of policies and documentation in the service are working on designing an age related end of life plan in place. SUs have been voicing their opinions. SUs are valuing the meeting days, i.e. on a day the meetings are being held SUs engage into their activities making time for meetings. A milestone celebration was to be held on Easter Monday but circumstances beyond control didn't allow this to happen, it will however be celebrated in the immediate future. To mark this achievement the project will be published in the organisation spring newsletter.

SM are valuing the SUI project by attending quarterly meetings and giving feedback in between the meetings (appendix 12 feedback from the director of resources). The SU charter is being used as a guide for respect and there has been a significant change in the way SUs relate to each other in the residential setting. The project has had a positive impact to the organisation, though there are highlighted areas of development for the future which is reflected in the CIPP model. There was a bit of resistance from 5% staff initially as there were concerns over workload increase when staff are already

over-stretched. Some SUs were concerned that the meetings in the evenings would interfere with the culture that is predominant in the house of gambling. Resistance over culture interference was dealt with by ensuring that SUs engage with their activities of choice before or after the meeting.

## **Chapter 5 - Discussion and Conclusion**

### **5.1 Introduction**

Chapter 5 sums up the findings from the project 'SUI'. It looks at how the project relates to literature that was reviewed in chapter 2, highlighting and critically analysing strength/weaknesses and limitations and the author's experience of the process thus leading and managing planned organisational development process using the HSE planned model described in chapter 3 and chapter 4. Links to literature review will be made where deemed appropriate to methodology and or findings. A reflection of experience of the process, will be incorporated into the discussion to support learning experience, this will be referenced with the reflective diary attached in appendices of the reflection. In conclusion the discussion will round off the process by detailing the impact the project has had on the organisation, staff and the service users who are key stakeholders stating contribution to practice and or theory and making recommendations for future project improvements.

### **5.2 Discussion**

The development of a communication strategy between SUs and SM in a voluntary organisation providing healthcare services to adults with ID and or MH has been a learning curve for key stakeholders. The aim of the development was to involve SUs at

micro level in the planning and decision making which will inform the macro organisation to improve safety and quality of life of the SUs as stated by HIQA ([www.hiqa.ie](http://www.hiqa.ie)). In March 2014 HIQA visited the service location where the project has been implemented, the organisation is yet to get feedback from the inspectorate, onsite they seemed happy with the development of a SUI project.

Ethnographic study by (Fudge et al., 2008) using participant observation, interviews and collection of documentary evidence found out SUI may not automatically lead to improved service quality. The project findings argues with Fudge's finding as the project findings found otherwise i.e. SUs are now involved in influencing 'some' policy development i.e. the end of life plans, (proposal is under review to be included into policy document once approved). SUI is such a broad topic, and there are several ways of getting SU involved in a meaningful way. Integral to involvement process is meeting the needs of the key stakeholders irrespective of how small or big the needs are. (K. Davis, Schoenbaum, & Audet, 2005) nothing about me without me, this can be achieved by involving SUs. Making significant changes towards a health system that is more responsive to patient's preferences, needs and values will require substantially more attention to learning about those preferences from the patient's perspective. Patient's perspective can be gathered by constantly checking in or consulting the patients themselves and facilitating participation opportunities .

It is evidence from the literature reviewed that SUI is a contentious topic, though the subject has been around for a while literature shows that research on the subject is still in its early stages. This is a limitation as studies have drawn conclusions on a subject that has paucity research. SUI comes with a lot of challenges to the provider i.e. level of SU participation and partnership with the provider. SUs may misinterpret the process of involvement. They may also choose to be involved in business that does not concern them i.e. resource redistribution has been a problem area in the organisation. Resources are allocated by funders according to the needs of the individuals i.e. the level of care. Key to genuine participation is ensuring respect for user's views. UNICEF says; participation cannot be genuine if users have no opportunity to understand the consequences and the impact of their opinions, such non-genuine 'participation' often merely disguises what is actually the manipulation of service users, or tokenism ([www.unicef.org/crc/files/Right-to-Participation](http://www.unicef.org/crc/files/Right-to-Participation)). SU through the project have been empowered with knowledge.

The current environment in the Irish healthcare has facilitated competition among providers which may lead to tokenistic participation approaches to meet the regulations or funders requirements. In a case where participation is not real service users are not afforded the opportunity to understand the consequences and the impact of their opinions. They are not empowered with knowledge. This was the author's first time of leading planned change guided by a model. The use of HSE change model made the process manageable for a first timer, because of its flexibility in nature unlike Kotter's eight step and Lewin's model which are linear and do not facilitate back and forth

movement for adjusting a mistake, this flexibility was a strength that supported the author who was new to the process of action learning practice as the author had no previous experience of leading planned OD process using HSE model.

(Beresford and Carr 2012) involvement is perhaps the most opaque of the terms, advanced by some as a route to personal liberation, while seen by others as tokenistic dead end'. When in practice who decides the level of participation and partnership. From Arnstein 1969's ladder of participation (Cornwall, 2008) who decides or benchmark the level of participation, the organisation might view their engagement with service users as citizen power, whilst an external person may view it as either tokenism or non-participation. From experience it is often a time that we consult with service users and view that as involvement but according to the ladder of participation consultation is viewed as tokenism.

### **5.3 Reflection on experience of Change Process**

Reflection is an extremely powerful way to learn from experience. Research has shown that people are generally poor reflectors unless provided with questions about their experience as stimuli (Mento et al., 2002). In framing a stimuli (Garvin, 2000) drew out useful questions that were developed by the US Army in their after Action Review Process:-

Table 5.3. Questions to support exploration of experience (reflection)

Action Review Process Questions
---------------------------------

1. What did we set out to do?
2. What actually happened?
3. Why did it happen?
4. What are we going to do next time?

Using the above framework, the author answered the four questions in relation to the process of the change effort in appendix 14 - reflection practice. (Mento et al., 2002) 'Those who forget the past are condemned to repeat', it is the quote that often comes to mind with respect to change effort.

### **5.3.1 Limitations**

- The literature reviewed excluded people with ID, focused on people MH
- Change agent's limited experience to implementing change
- Timeframe for implementing process and evaluating, change takes time
- Shared/distributive leadership can make the team environment more complex depending on the members of the particular staff team
- Power struggle within the team, members generally prefer to follow someone who is competent and knowledge i.e. leadership attributes listed in Fig 3.2.1
- Traditional hierarchical culture is a barrier to equal partnership between SU and providers.
- Ethics consideration for getting feedback from the service users within limited timeframe, restricted methods of evaluation.



#### 5.4 Impact of Project on the organisation (Strength)

The development of a communication strategy between SUs and SM has impacted positively on the organisation, there however has been a few challenges from the project implementation. (Table 5.3 below and Appendix 10 staff review).

*Table 5.3 Outcomes from Meetings*

<b>Summary of Outcomes from four Meetings held between January and April 2014</b>
<ul style="list-style-type: none"><li>• Service users learning and adopting to living together and sharing a residential setting</li><li>• Bullying has reduced, effectively and appropriate ways of communicating with each other</li><li>• End of life policy to be introduced (under review by the quality department), it was noted that this may be a trigger for challenging behaviours for certain individuals</li><li>• Menu Planning, at monthly meetings service users are reviewing their menu and making necessary adjustment when necessary.</li><li>• Ownership and sense of belonging (service users having a say in their own home)</li><li>• Front door key request from two service users, a challenge to the organisation, risk assessments to be undertaken to rate the risk involved</li><li>• Empowerment (skill set both staff and service users)</li><li>• Service users opportunity to chair and experience meetings</li><li>• Speaking out opportunity and voicing opinions</li><li>• Planned direct interaction with senior management</li><li>• Information sharing, (service users kept up to date with progress and developments in the organisation)</li><li>• SUs expressed their concern over their safety to SM as certain staff were driving the house car whilst on the phone.</li><li>• Suggestions and feedback from service users (improves quality of service provided)</li><li>• Trigger challenging behaviors i.e. requests that cannot be met by the organisation or service users not accepting that the organisation.</li><li>• The service users managed to resolve themselves, a long standing problem in the house i.e. smoking in the house</li><li>• SU addressing issues and concerns among themselves using the SUC guidelines</li></ul>

## **5.5 Conclusion**

The project was carried out in five chapters: - introduction, literature review, methodology, evaluation and discussion and conclusion. Chapter 1, Introduction gave an outline of the project, role of the student and overview of the organisation where change was introduced. Chapter 2, carried out a systematic review on literature relevant to SUI in a healthcare voluntary setting, review findings were critically analysed, compared and contrasted. Chapter 3, looked at selection process of a relevant methodology and methods for implementing change making reference to literature on organisational development process and giving rationale for selection of method. Chapter 4 using CIPP the process was evaluated against the set objectives of the project and lastly in chapter 5 a discussion drew together the findings from the project, the experience of undertaking an OD process. The experience was supported by a quick reflection of the process guided by (Garvin, 2000) question appendix 14 quick reflection and appendix 15 reflective diary. A noted major problem for not-for-profit or voluntary organisations is the apparent lack of a single discipline against which to set objectives e.g. profit. This did not interfere with the process as it was being driven by changes in healthcare environment.

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## Appendices



## Appendix 1 – Low Arousal Philosophy

### Low arousal is:

- A non-confrontational way of managing challenging behavior
- A philosophy of care which is based on valuing people
- An approach that specifically attempts to avoid aversive interventions
- An approach that requires staff to focus on their own responses and behaviour and not just locate the problem in the person with the label
- A collection of strategies that are designed to rapidly reduce complex behaviours

### Philosophies of low arousal

1. **Humane Environment** - It is the responsibility of the Organisation to provide a healthy, therapeutic, and nonjudgmental environment within which change may take place. The uniqueness of each individual is recognized and valued.
2. **Least Restrictive Environment**- The least restrictive environment should be provided to all individuals. In cases where it is necessary in the best interests of service user to provide a restrictive environment then this is evaluated on an ongoing basis by appropriately qualified personnel.
3. **Systems Approach** - We believe in a systemic, consistent approach to supporting people with complex needs. In this view, individual behaviors are given meaning in consideration of the context in which they occur. That context includes the individual personality system, the family of origin, the community, and the greater culture of which a person is a member.
4. **Neutrality**- All intervention should proceed from a stance that respects the inherent value and potential of every person. A position of therapeutic neutrality is consistent with the systemic approach and provides the basis to maintain positive regard for people recognizing that they are more than just their behaviors. Such a stance also recognizes that human processes are reciprocal and needs seeking and disallows bias, side taking, and blaming.
5. **Family Perspective**– Where appropriate all services are coordinated with and cognisant of the family role and importance.
6. **Individual Support Plans** – These are designed with the involvement of both the needs, determination of core issues, and strategies designed to support and guide each service user in leading self-determined lives.
7. **Diversity** - All programs, services, and personnel must honor and respect the diversity of the service user and families served. Emphasis on diversity awareness and education is encouraged as an ongoing process.

## **Appendix 2 – Beliefs and Core Values**

### **We believe that:**

We are part of a larger community and work towards improving the quality of life for all people in our community. Our challenge is not only to engage in person-centred processes but rather to use this direction to build Social Capital & Community Life for ALL people. All Personal Outcomes Measures happen in a social context and when we work to achieve Personal Outcomes Goal in the community we are relying on Social Capital. We have strong appreciation for formal and informal networks in our community Life. We use the same resources available to all community members and we believe in the power reciprocal relationships.

Each person is special and unique

Safety and structure are the foundations for success – Service users need to know that staff within the organisation care enough about them to expect them to succeed. This is demonstrated by staffs' ability to provide safety and structure and by expecting the best from the person they are supporting.

It is difficult to change - People tend to be naturally resistant and fearful of change. Service users must be guided to try new behaviors, succeed, and be allowed to possibly fail before actual change occurs. Much practice and support must occur before internalization of new behaviors is accomplished.

People desire to do well and succeed – Every person hungers for approval and acceptance.

People have needs - Everyone has fears, insecurities, and basic needs including safety, attention, and belonging. Our job is to attend to these needs and assist service users in learning to fulfill these needs in positive and productive ways.

Emotions are not to be judged - Feelings are not right or wrong. Service users may often have limited communication skills and are unable to distinguish between their thoughts and emotions. They often feel very little control over their behavior and perceive feelings as controlling factors in their lives.

All behavior has a purpose - Behavior is often a symptom of unmet needs. Services designed to help address these needs, to help the service user investigate and understand their behavior and its effects, and to explore more healthy alternatives.

People do the best they can with the resources available to them

The family has an important role to play - All members of the family system affect each other. Services provided take into account the values and behaviors established within the family system. Family input and cooperation is an essential factor in service users lives.

Behavior as a symptom - Problem behavior presented by service users can be symptomatic of other and more deep-seated problems. While it is necessary for the problem behavior to stop, long-term change requires contextual issues and concerns to be identified and addressed.

## **Core Values**

We are dedicated to:

The empowerment of service users through advocacy.

The design of services which respond to individual person centred plans.

The delivery of services which maximise social inclusion and community participation for all citizens.

To work in partnership with internal and external stakeholders to develop good practice and to achieve mutually agreed and beneficial outcomes.

## **We Aim**

To provide a comprehensive system of services using a low arousal non-aversive approach, that enable individuals to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life.

To support the service user in their quest for the attainment of individual goals and life experiences through their inclusion and integration into community based resources and facilities

## **The role we play in the community is as follows;**

1. **Active Contributor** - to the development of plans to the local community and the City.
2. **Partner** - we enter partnerships with community organisations at local, regional and national levels to increase the quality of life for all people.

3. **Informers** – we have guided national policy by our involvement with local political parties on national issues and through our membership of the National federation of voluntary bodies.
4. **Leaders** - we recognise the importance of leadership and as such take leadership roles in our working alliances with other organisations.
5. **Educators** – we provide opportunities for all community members to be educated and work in partnership with secondary schools and third level institutes to offer student placement and training.
6. **Facilitators** – we facilitate opportunities for staff, service users, families, and other organisational members to build social capital.
7. **Employers** – we employ many local people in our service

## **Appendix 3 – Core Competencies**

### **1. Human Rights Based Approach**

Believe and demonstrate that all people are equal citizens of society, with the same rights and responsibilities.

Treat and value all people as equals.

Assist the people we support in understanding and upholding their rights.

Promote the abolition of restrictive practice and always use 'least restrictive practice' where rights are restricted.

### **2. Low Arousal Philosophy & Practice**

Supporting people who use our service in a non-confrontational manner.

Avoid sanctions and consequence based punitive strategies.

Question own contribution to incidents of behavioural expression.

Ability to see things from others' perspective.

Demonstrate sincere interest and concern when dealing with people situations.

Accept and be open to the Organisation's position on behaviour support for people who use our service.

### **3. Resilience, Positive Attitude & Openness to Change**

Introduce and support interventions which help to enhance and maintain self-confidence and self-esteem of others.

Has a positive image of and attitude towards the Organisation and the people we support with a willingness to promote that image both internally and externally.

Repeated persistent behaviour to achieve objectives.

Ability to remain calm under pressure.

Support or initiate change which will enable the achievement of the goals of the people we support and the Organisation's goals.

### **4. Effective Communication & Working Relationships**

Build positive and constructive, mutually beneficial relationships with all organisation stakeholders

Use effective communication and appropriate interpersonal skills to ensure effective exchange of ideas and information.

Identify with and work co-operatively with others, through teamwork, to promote a culture where information sharing and support are encouraged.

### **5. Planning, Organising & Prioritising**

Work to optimise outputs with available resources.

Plan and complete work to agreed standards.

Identify and organise time to enable work to be completed.

Ability to handle any unforeseen circumstances using initiative and flexibility.

## **6. Innovation, Creativity & Problem Solving**

Think creatively to introduce alternative approaches or adapt existing ones to meet new situations. Look outside of traditional solutions when appropriate.

Generate workable solutions and make informed decisions.

Ensure that you have sufficient knowledge to make an informed decision, always think before you act.

Identify plans of action and share pathways for completion prior to taking action.

Respond to unforeseen eventualities in an innovative fashion.

## **Appendix 4 – Accreditation to date**

### **The Council on Quality and Leadership Accreditation (CQL)**

Basic Assurances 2007

Personal Outcomes Measures 2008

Responsive Services 2009

Community Life 2009

### **Excellence Through People (ETP)**

What is Excellence Through People?

Excellence through people is the National Human Resources Standard. It was designed in response to requirements from business to maximise their investment in human resources. The Standard is used by many of Ireland's most progressive and successful organisations to become more efficient, productive, flexible, competitive and innovative.

What are the benefits of working under this quality system?

The following is a list of 'benefits' that have been noted by organisations that have been certified with 'Excellence Through People'.

Customer Satisfaction

Employee Engagement

Workforce Optimisation

Bottom Line Improvements

Quality Improvement

Succession Planning

Innovation

Level of achievement in Excellence Through People

The organisation achieved Bronze Level Certification in Excellence Through People.

What are the next steps for moving forward?

The organisation have decided to recertify at Bronze Level for Excellence Through People. This was a strategic decision made by the Management Team and the Board of Directors.

How long does certification last?

The certification is valid for two years.

## **PQASSO**

"PQASSO is a straightforward, user-friendly quality assurance system intended to help you run your organisation more effectively and efficiently. It offers a flexible approach to quality which allows your organisation to work at its own pace. It helps you to take a systematic look at what you do, identify areas where you are doing well and not so well, and decide exactly where improvements are needed. It helps you to plan, budget and allocate the resources for making these improvements over a realistic time period". (extract taken directly from PQASSO website).

In an effort to further enhance the quality of services provided, a review of quality systems available both nationally and internationally was undertaken by the Quality Department in 2009. A decision was made that PQASSO would be implemented in an attempt to tie together all strands of quality service provision and improve business efficiencies. Two members of staff are trained as PQASSO mentors. The PQASSO system offers a flexible approach to quality and was designed specifically for the voluntary and community sector.

The organisation has been engaged in implementing the Practical Quality Assurance Systems for Organisations (PQASSO) since 2009

## **Health Information and Quality Authority (HIQA)**

As well as implementing internationally recognised standards, the organisation is committed to implementing statutory standards.

The Health Information and Quality Authority is the independent authority responsible for driving quality, safety and accountability in residential services for children, older people and people with disabilities in Ireland.

HIQA have produced standards to protect vulnerable people of all ages who are receiving residential care services in an attempt to ensure that people are receiving an appropriate standard and quality of service.



The HIQA standards tell people using these services and the people providing them what their services should be like. They also tell the public what they can expect from these services.

Where HIQA have statutory powers to inspect and register services, our inspectors will inspect against our standards.

The organisation has undergone an inspection by HIQA in March 2014 and below was the feedback (insert feedback from HIQA negative and positive and recommendations after inspection)



## Appendix 5 – Literature Reviewed

Number of studies	Search Area	Date Parameters
50	Eric PubMed, Journal articles (mainly from the UK mental health survivor movements), mental health service providers/websites CINAHL and Google Scholar	2002 to 2014

## Appendix 6 – Linear Models of Change

### **Kotter's Eight Step Model** (K. H. Rose, 2002)

- Thirty years of research by leadership guru Dr. John Kotter have proven that 70% of all major change efforts in organizations fail. Why do they fail? Because organizations often do not take the holistic approach required to see the change through.
- However, by following the 8-Step Process outlined by Dr. Kotter, organizations can avoid failure and become adept at change. By improving their ability to change, organizations can increase their chances of success, both today and in the future. Without this ability to adapt continuously, organizations cannot thrive.
- Dr. Kotter has proven over his years of research that following The 8-Step Process for Leading Change will help organizations succeed in an ever-changing world
- Leaders who successfully transform businesses do eight things right (and they do them in the right order).

### **Kurt Lewin's Model** (Burnes\*, 2004)

- Lewin's model was a simple one, with organisational change involving three stages; unfreezing, changing and refreezing. This quaintly linear and static conception the organization as an ice cube is so wildly inappropriate that it is difficult to see why it has not only survived but prospered.

## Appendix 7 – Stakeholder Analysis

<b>KEEP SATISFIED</b>	<b>MANAGE CLOSELY</b>
<p><b>1. High Power and Low Interest</b>                      Finance/Account HR department                      Board of Directors</p>	<p><b>2. High Power and High Interest</b>                      Senior Management                      HIQA (regulatory body)                      Quality Department                      HSE                      CQL (Council on Quality and Leadership)                      External clinical psychologist                      Clinical psychology department (internal)                      Ethics Committee</p>
<b>MONITOR (minimum effort)</b>	<b>KEEP INFORMED</b>
<p><b>3. Low Power and Low Interest</b>                      General practitioner                      Volunteers                      Drivers                      Psychiatrists                      Internal day services</p>	<p><b>4. Low Power and High Interest</b>                      Service users                      Frontline staff (project leaders)                      Service user families                      Advocates                      Other Similar organisations                      Health and safety committee                      Human Rights committee                      Staff/SU representatives                      Training department</p>

*Adapted from [www.mindtools.com](http://www.mindtools.com)*

Key:-            Vertical axis    -    Power  
                          Horizontal axis -    Interest

## Appendix 8 – Organisation SWOT Analysis in Service Provision

<p><b><u>Strengths</u></b>          Person centered planning          Unique approach of care model          Voluntarily Accredited          Service users and families represented by the Board of Directors          Size of the organisation (small) manageable          Timely use of proactive strategies as opposed to reactive strategies</p>	<p><b><u>Weakness</u></b>          Size of the organisation (small)          Low arousal approach deemed soft approach far from real world by externals          Family business          Complaints procedure very slow and linked to challenging behaviors          Leadership governance          Proactive can be perceived as a barrier to people experiencing failure for learning purposes          Services for people from a certain catchment area</p>
<p><b><u>Opportunities</u></b>          Growth in size (expand services across Ireland)</p>	<p><b><u>Threats</u></b>          Heavily dependent on the HSE, could potentially be swallowed by big organisations.          Approach would potentially send away families that do not believe in low arousal none aversive philosophy.</p>

## Appendix 9 – Definitions

### Management Tools used in the Project

**Stakeholder analysis** is an approach, a tool or set of tools for generating knowledge about actors – individuals and organizations – so as to understand their behaviour, intentions, inter-relations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes. (Varvasovszky & Brugha, 2000)

**Force field analysis** is based on a model for thinking about change as proposed by Kurt Lewin, who saw behaviour in an institutional setting not as a static (motionless) habit or pattern but as a dynamic balance of forces working in opposite directions. (Lewin, 1946)

**SWOT analysis** – There are various frameworks and approaches used in the analysis of a company's strategic position. One of the most straightforward is the SWOT analysis, SWOT being an acronym for “strengths, weaknesses, opportunities and threats”.(Hill & Westbrook, 1997).

### Appendix 10 - Agenda sample

Date: 10/04/2014	Location: .....	Date of last meeting: 31/03/2014	Date Next Meeting: 28.04.14		
Standing orders on agenda:		Service User Charter 'Our Charter'			
People present at meeting:					
People absent from meeting:					
Minutes of last meeting reviewed with following actions arising:		<b>Pending from previous Agenda;</b> <ul style="list-style-type: none"> <li>• Front door keys for John and Anne (subject under review)</li> </ul>			
Agenda Item	Discussion	Actions Arising:	Action assigned to:	Date for Completion	Tick - next meet
<b>Lighting cigarettes in the house</b>	Some people are still lighting smokes in the house.				
<b>Service user X enjoys the house when its peaceful</b>	Can we please ensure that there is peace in the house all the times.				
<b>Staff and Service User Y still talking from the office (shouting to people downstairs)</b>	Respect each other especially when others are in bed sleeping, keeping the noise down.				
<b>Bullying</b>	Calling people names and threatening violence				
Signed off by Manager:		Date when meeting minutes signed off			



## Appendix 11 - Minutes of the Meeting

<b>Date:</b> 01/04/2014		Location: .....	<b>Date of last meeting:</b> 31/03/2014		<b>Date Next Meeting:</b> 29.04.14	
Standing orders on agenda:			Service User Charter 'Our Charter'			
People present at meeting:			Service User X, Y, Z and two staff on duty the 2 <sup>nd</sup> staff is the project leader			
People absent from meeting:			N/A			
Minutes of last meeting reviewed with following actions arising:			<b>Pending from previous Agenda;</b> <ul style="list-style-type: none"> <li>• Front door keys for John and Anne (subject under review – clinical department)</li> </ul>			
Agenda Item	Discussion	Actions Arising:	Action assigned to:	Date for Completion	<i>Tick - next meet</i>	
<b>Being woken early</b>	Service user Z is unhappy about Service User Y calling for staff early in the morning and disturbing Z up from sleep	It was agreed at the meeting that staff and Y will refrain from this practice of shouting in the house i.e. Y talking to staff in the office from the bottom of stairs especially early in the morning when others are still in bed sleeping.	All staff and Y			
<b>Y asking Z for money</b>	Z not happy with Y asking to borrow some money from Z.	Everyone agreed that we will not be asking for a loan of money from each other. We shall all try and manage our finances through individual budget plan.	Everyone			

<b>Smoking</b>	Well done everyone for smoking outside.	In the last month everyone has been smoking outside. Well done everyone.	All smokers		
<b>Service user meetings will be published in the Newsletter</b>	We have send in our achievements so far from the monthly service user meetings in the house	A house meeting photo and a little caption has been sent in for spring newsletter publication.			
<b>Celebration date</b>	Proposed date for a milestone celebration.	It was agreed that we will invite some service users from different service locations within the organisation to our celebration of this achievement of successfully introducing House Meetings thus communication with senior management' this commenced in January 2014.			
<b>Menu planning for Sunday Roast for April</b>	This to be done once a month (planning for Sunday Roast) Every service user will get to pick their favorite roast for Sunday, taking turns (rotationally) to chose	1st Sunday Roast Pork 2 <sup>nd</sup> Sunday Lamb (leg of lamb) 3 <sup>rd</sup> Sunday Chicken 4 <sup>th</sup> Sunday Corned Beef  *Please note fish is to be bought for Good Friday the 18 <sup>th</sup> of April	Service user  Y,  X and  Z		
<b>Any other Business</b>	Z is very happy living in the house (organisation).	Z however requested that X take extra care when handling coffee as Z worries that someone may slip and fall from coffee spillages.	X to address		

<b>Date of next meeting</b>	Staff to check with management for their availability for the quarterly meeting.	Date to be confirmed for April 2014	Staff		
Signed off by Manager:		Date when meeting minutes signed off			

## Appendix 12 – Senior Management Feedback

Quarterly meeting held on the 29<sup>th</sup> of April 2014

Hi ....., (project leader/student name)

Thanks for inviting me to the meeting yesterday. It is always helpful for management to hear directly from service users the issues that are important to them.

I think these meetings are very useful and should be considered for every house

*Regards*

*.....(name).....*

Director of Resources

(This was written on organization letterhead information was copied and pasted for confidential purpose)

## **Appendix 13 - Staff team review of the Change Project 25.04.2014**

### **Positive Outcomes**

- Self and group advocacy, service users are voicing their opinions and articulating their expectations. Project leader explained briefly on advocacy i.e. defined advocacy using Enable Ireland's definition that says:- advocacy is saying what one wants not getting what one wants. (An outcome is bonus in advocacy).
- Service user charter supporting respect for each other (reference point for addressing unacceptable behaviours i.e. referring to user charter when someone is talking behind someone's back.
- Complaints have minimized significantly
- Smoking in the house has stopped as a result of the meeting, point was raised by Paul at the second meeting – staffs have been trying to discourage this practice without success for quite some time.
- More involvement in house shopping i.e. service users saying and picking up from the shop what they want.
- A platform for giving reasons or rationale for what happens in the service sometimes i.e. staff movements.
- A support forum for difficulties and challenges been faced
- Being used to minimize challenging behaviours by some individuals i.e. when someone is annoyed asking staff to write their complaint on the agenda instead of object aggression (venting out mechanism)

### **Challenges**

- No visuals in places to support certain individuals to process or understand information (though minutes are in plain English)
- Can be very negative at sometimes i.e. can at times turn into just a complaints forum as opposed to getting involved in planning, decision making etc.
- Service users are seemingly not being satisfied with response or feedback given by staff as they prefer to receive feedback from management particularly senior management.

## Appendix 14 – Quick Reflection

### Action Review Process Questions

1. What did we set out to do?

I set out to develop a communication strategy between service users and senior management as a way of involving service users in decision making and planning process of the organisation.

2. What actually happened?

I introduced an organisational development process, key to OD is action research. And developed a communication strategy between service users and senior management in healthcare voluntary organisation providing services to adults with ID and or MH, using HSE change model.

3. Why did it happen?

As part of my learning on the 'Masters in Leadership and Management Development Programme' I undertook an OD project to improve communication in the organisation by involving key stakeholders (service users) in planning and decision making process in a bid to meet best practice, national and international guidelines and new regulation standards set out by HIQA inspectorate body.

4. What are we going to do next time?

In introducing change the next time start by researching on the nature project and what strategies are linked with type of change being introduced. I will also involve key stakeholders at an earlier stage of the process to have their strong buy-in of the project. I will also reflect on my preferences, my type on the Myers-Briggs type indicator (1988) is ESFP. Characteristics of these influence reactions and strategies that I chose to use in implementing the project. It is interesting to note that indicators ESTP are not my consistent preferences as some of the characteristics change from project to project, depending on the nature of the project. I will also look at Belbin's team roles and distribute leadership roles according to individual's area of strength as opposed to using shared/distributive leadership style. I seek out clarity on leadership governance in relationship to the project i.e. how will be responsible for approving certain stages of the process.

## **Appendix 15 – Reflective Diary**

Five pieces of the in practice reflective diary are attached in appendices part B of the on practice reflection.

## Project Impact Statement

Evaluating the impact of your project

Fill in the table, identifying up to 3 issues within each category (behavioural, structural, personal, cultural), each with a statement describing the situation now and a description of how you intend the situation to be at the end of the programme.

<b>Describe here how things are now in relation to the issue</b>	<b>Describe here how things should (ideally) be when the issue has been addressed</b>
<p><u>Behavioral</u>: describe current patterns of behavior/ attitudes of the key people involved with the issue</p> <p>Currently service users use complaints forms to communicate grievances to senior management. There is an open door policy for seeing management, but it is practically impossible to see management without an appointment as they are always engaged in meetings internally and externally with outside agencies.</p> <p>Presently service user depend on staff to fill out complaints forms for them, this can be challenging in cases where the service user would like to complain about that particular staff completing the form them.</p> <p>Information sharing (development) within the organization is announced through newsletters which are not in an accessible</p>	<p><u>Behavioral</u>: what sort of behaviors would (ideally) be evident when the issue has been addressed?</p> <p>Self advocacy, service users will do most of the communication for themselves, this enable them to speak their mind without having to worry about staff fears.</p> <p>Service users will be assured of timely response from management.</p>



<p>version for the service users. Speaking to services users, most of them prefer a two way communication system with senior management for instant feedback</p>	
<p><u>Structural:</u> describe the way roles and responsibilities are currently organised</p>	<p><u>Structural:</u> describe how roles/responsibilities would be organised once this issue has been addressed</p>
<p><u>Personal:</u> describe how you participate in and contribute to the current reality</p>	<p><u>Personal:</u> describe how you will participate in and contribute to the new reality</p>
<p><u>Cultural:</u> describe “how things are done around here” now, e.g. accepted ways of doing things,</p>	<p><u>Cultural:</u> what will be “the way things are done around here” when the issue has</p>

implicit understandings

been addressed?