Briefing Paper

How managers can help users to bring about change in the NHS

A summary of two literature reviews which examined the best ways of involving users :

- Have a clear idea about the aim of involving service users before inviting them to get involved.
- Be honest with service users about the potential for change, particularly if the options are limited.
- It is not difficult to find out what people want; the difficulty is in achieving change.
- One of the main obstacles to involving users can be the reluctance of health professionals such as doctors and nurses to embrace change suggested by service users.
- Front-line staff need training to help them appreciate why and how service users are involved, and to carry them along with the process.
- If service users are helping to make decisions about complicated and highly technical services, they will need extra time, information and support.
- User involvement does not stop when users' views have been obtained; this process must be followed by continuing work to change services based on users' views.
- Users may need training to enable them to undertake some user involvement activities.
- When involving users, managers need to be sensitive to staff's perceptions of their own status, and their status differential with their clients.
- The onus is on managers to present information for service users in a way that the users can understand.
- In mental health, user groups that are funded need longer contracts so that they do not have to spend all their time trying to get funding for the following year.
- User involvement is not a bolt-on extra. It is a way of changing the philosophy of an organisation and all the roles within it.

sdo
NHS Service Delivery and Organisation R&D Programme

Change *Management*

If managers in the National Health Service (NHS) are to tailor services more closely to the needs of the people who use them, asking people what their needs are is just one part of the process. Equally important is the ability of the NHS to change in order to meet those needs.

This may sound self-evident, but over the past couple of decades, those who have had the task of managing the NHS will have realised that there are many ways of involving NHS users, and that not all of these are either desirable or effective.

The need to know how best to draw on the expertise of NHS users is more pressing now than ever before. The Department of Health now requires NHS Trusts to consult local communities before changing the services they provide, through such mechanisms as Patient and Public Involvement Forums and Patient Advice and Liaison Services. In 2000, the NHS Executive said that its aim was to develop a service in which 'care is shaped around the convenience and concerns of patients'.

> "User involvement does not stop once you find out what the service user wants, it stops once you have made a change to a service, which is based on those views"

Change management

Yet it is notoriously difficult to bring about change within the NHS. As a result, people have become interested in the process(es) by which change comes about – in what is called 'change management'.

In order to find out what role NHS users should have in change management, the NHS Service Delivery and Organisation R&D Programme (SDO) commissioned two literature reviews. The SDO wanted to find out what might be the best ways of involving users, and to learn whether other sectors – such as the private health care industry – had discovered different ways of consulting service users.

The first of these studies, by Mike Crawford, Deborah Rutter and Sarah Thelwall of the Department of Psychological Medicine at Imperial College, London, aimed to "*review literature on user involvement in change management across a range of sectors in order to identify factors that promote successful user involvement*". The second, by Diana Rose, Pete Fleischmann and colleagues at the Service User Research Enterprise, at the Institute of Psychiatry, London, examined "*literature about user and/or carer involvement in managing organisational change within mental health services*", a field of health care in which user involvement is already well developed.

Practical findings

This briefing paper aims to summarise the main findings of both reports, and to report the authors' views about which of their findings will be of greatest practical use to those organising services. Both reports can be viewed in full at:
http://www.sdo.lshtm.ac.uk/changemanagement.htm

In this document, the term 'service user' is used to describe the client group in question, but professionals may wish to ask people how they want to be described.

Crawford's team identified more than 1100 papers, and based their report on 344 of these. They produced a table showing factors that service providers should consider when planning and implementing user involvement in change management (see Table 1 on page 3).

Crawford says: "*One of the most important messages is not to involve service users until you have a clear idea what the aim of their involvement is going to be. Stop, think, and then involve.*"

Honesty is important, he says. "*Often there is a limited choice of options available, and it is best to be open about this, rather than give people the impression that they can totally reform a service which in*

Table 1

Factors that service providers should consider when planning and implementing user involvement in change management.

1. Be clear about the aims and scope of involvement before contacting service users.
2. Make the aims and scope of involvement clear to users and carers who participate.
3. Ensure that your organisation is committed to acting on the views of service users before user involvement begins.
4. Before embarking on new initiatives to involve service users, find out what has taken place previously.
5. If possible, encourage local service users to express their aims and demands, too.
6. Make sure that you allow adequate time and resources to support user involvement.
7. Consider how to give feedback to service users who participate.
8. Ask yourself how important it is for those service users who participate to represent users' views in general. Using a range of methods of user involvement will help you access a range of views.
9. Ensure that adequate information, time, and administrative and financial support is available for service users.
10. Ensure that the staff of your organisation who are involved in the process of user involvement are committed to making it a success.

reality is going to stay pretty much as it is."

It is equally vital, he says, to understand that involving users is not an end in itself. Instead, it should be a means to an end, with the end being to develop better-quality services.

"*User involvement does not stop once you find out what the service user wants, it stops once you have made a change to a service, which is based on those views, and when you have told the user what change you made as a result of their information*," Crawford says.

Feedback is crucial

The review showed that service providers are often very good at involving users at the start of a process, but not always good at feeding back to the people who have been involved about what the outcome of their involvement has been.

Crawford says: "*When this happens, there is a danger that it will lead to apathy or even resentment on the part of the service users who have been involved. It is wrong to involve users in developing services unless we are going to take the time to feed the outcome back to them.*"

As well as looking at user involvement in the NHS, Crawford and his team reviewed user involvement in other public sector services, such as education and local government, and in the private health care industry. They identified some interesting similarities and differences.

It was clear to many people working in the NHS, for example, that one of the main obstacles to involving users was the reluctance of health professionals such as doctors and nurses to embrace change suggested by service users: their training had encouraged them to be sceptical of users' views.

Crawford says: "*We also found that similar discussions had been taking place in many other public sector services, along the lines of: 'We want to involve the people we provide a service for, but we need to retain some decision-making capacity for ourselves because we are charged with providing the best possible service. If our service users are suggesting something which we don't believe is helpful or effective, it does not make sense to make these changes'.*"

Private sector

It was a different story in the private sector. The aims of private health care organisations are rather simpler than those of the NHS: they want to make a profit and/or increase the use of their services. If customers want something new, or something done in a different way, it makes sense for these companies to implement it.

Significantly, Crawford and his colleagues found very little information in the literature on the methods the private health sector uses to involve customers. "*Nearly all of it was instead focused on how you implement what the consumers are telling you*," he says. "*This leads us back to the same conclusion – that if people want to find out what patients and carers want, it is not that difficult, but the problem is in achieving change once you have got the results of your survey, focus group or complaint.*"

Another important difference between the NHS and the private health care industry was in the organisations' attitudes to the role of front-line staff.

The literature review suggested that some NHS staff felt resentment towards patients for having a voice in the development of services when they themselves had none. By contrast, private health care organisations made it clear that front-line staff should be the first people to be consulted about what patients want, because they were the people delivering the services.

Private sector organisations had also discussed in detail the importance of empowering front-line staff, in order to allow them to deliver whatever the patient requested while receiving care. "*That means that they have to have the resources and the flexibility to make adjustments to what they are doing, to meet what the person really wants*," Crawford says.

"It is wrong to involve users in developing services unless we are going to take the time to feed the outcome back to them"

Finding out what users want

Many of the methods used by the NHS to find out what service users wanted were very complicated. They included methods such as citizen's juries and deliberative polling, which involve small numbers of service users but need a lot of time, support and resources to complete. In the private sector, simpler methods tended to be used, such as surveys and focus groups.

If users are to help make decisions about complicated and highly technical services, they may well need more time, information and support to help them come to a conclusion. But, Crawford points out, sometimes the changes being considered are quite simple ones, so simple methods of consulting users would be adequate. He says: "*When patients can't get through to a receptionist in a clinic to rearrange an outpatient appointment, you do not need complex methods of patient involvement to identify or rectify this problem. I think the NHS would benefit from a simpler approach to finding out what the problems are, and simple methods of trying to implement the suggestions.*"

Mental Health *Context*

The review by Diana Rose, Pete Fleischmann, Fran Tonkiss, Til Wykes and Peter Campbell focused on user and carer involvement in change management in a mental health context. The review was a collaborative one, as three of the authors are service users.

Many of their findings resonate with those of the Crawford team. Factors that they identified as facilitating or hindering user and carer involvement in change management are summarised in Table 2 and Table 3 on pages 4 and 5.

In the literature that Rose and her team studied, there was much concern that user involvement was tokenistic. Sometimes, for example, users are 'consulted' about a decision that has already been taken. Then there is the phenomenon, labelled by one academic as 'top and tail involvement', where users are consulted about a proposed change to services, and then asked to evaluate the change once it has happened.

Fleischmann says: "*This means that users are left out of the middle stage of reorganising services. It ignores the fact that the whole thing is a process, and that the process is almost as important as the outcome.*"

Table 2

Factors that facilitate user/carer involvement in change management. These factors are not ranked and many individual factors are interlinked.

Adequate resources are present.
The culture of the organisation makes it easy for users to get involved.
The organisation makes the right information available at the right time.
The existence of autonomous user groups.
Presence of a professional champion.
Staff training by users.
Training of users.
Payment and/or employment of users.
Representatives of users and/or carers are involved in decision-making bodies.
Power differentials are recognised and understood.
The organisation acknowledges and is sensitive to factors linked to mental distress and has practical measures in place to minimise these (for example, advocacy).
Involvement processes are of high quality, are meaningful and measurable.

Table 3

Factors that hinder user/carer involvement in change management. These factors are not ranked and many individual factors are interlinked.

Lack of resources.
The culture of the organisation is resistant to change.
The organisation has a poor information strategy.
There is no autonomous user group.
There is no professional champion.
The organisation and its staff have no understanding of power differentials.
There is no acknowledgement of factors pertaining to mental distress.
The organisation involves users only for 'display purposes'.

Ownership of changes

If managers get the process right, says Rose, users will be involved in the new management structure, and will have ownership of it. Users can become empowered, because the process itself may bring about a change in the power differentials of the various actors involved, Fleischmann adds.

To avoid accusations of tokenism, managers need to ensure that the users who sit on the relevant groups or committees that are overseeing change are accountable to their local user groups. In particular, managers need to avoid choosing a 'pet user'. This may be someone whom they like, whom they think will not be much trouble. But because this person is not accountable to anybody, and is not supported by anybody, he or she is unlikely to have much impact on services.

The representatives chosen by the local user group may not be used to sitting on committees, and may find the agenda, the acronyms and the jargon difficult to cope with. They may not be aware that, often, decisions may be taken outside the committee – over lunch or in the corridor.

"The reorganisation of services is a process, and this process is almost as important as the outcome"

Presentation matters

Rose says: "*If service users are to be part of the process of managing change, it must be completely transparent. One of the messages for managers is that, if service users say they can't understand the papers or what is going on, it is not good enough for managers to say they are not capable of taking on this role. It is up to managers to change the way they present these matters, so that they can be understood, and to build capacity so that users can take a full part.*"

Almost every area has a user group – but the financing and autonomy of these groups varies. The review found that, historically, user groups in both the UK, the US and Europe had not received proper funding. In the UK, those that had received money tended to have been awarded one-year rolling contracts from social services departments, NHS Trusts and primary care trusts.

Rose says: "*One of our first recommendations is that groups need to be given longer contracts so that they don't spend the whole of their year trying to get funding for the next year. This is very draining, and it means the money is not well used.*" Having handed some money over, however, managers need to give the group some space so that it can be seen to be autonomous and independent, rather than part of the institution that funds it.

Training for front-line staff

A key finding of this review was that front-line staff need training to help them appreciate why and how service users are involved. Fleischmann says: "*Sometimes there can be alliances between users and managers in an organisation, and that can have the effect of cutting out the front-line staff. So it is very important to carry them along, and train them in what user involvement is, why it's being done and what it means for them and their status.*"

Rose says that, unfortunately, nurses working in hospitals or residential care often have very low status, and the status of care assistants can be even lower. *"The only people that they can sustain their status differential with are their clients. The fact that these staff are disempowered means that users are even more disempowered. And then, if a manager comes along and starts making changes based on*

"It is very important to carry along front-line staff, and train them in what user involvement is and why it's being done"

what the users say, this can really upset the staff."

Many papers reviewed by the team pointed to a greater need for service users to become involved in training staff, and for more research into how such training can be delivered most effectively. Although some universities have tried to involve users on courses for professionals, this did not always work smoothly. For example, academic course leaders might want a user to give a lecture at 9am, but it would be unrealistic to expect people who are on medication to be able to do that reliably. Some universities will not permit people who have no formal academic qualifications to give lectures.

Unlike the majority of people who use other parts of the NHS, those who use mental health services tend to be much more involved in the organisations or institutions where services are delivered. Rose says: "*This is because, for these people, mental health services make up a very large part of their lives. They may be living in residential care, spending some of their time at a day centre, or at a sheltered workshop, so they are much more inside the organisation than the idea of the 'customer' implies. This means the processes for empowering them are also going to be very different.*"

User involvement is not a bolt-on extra

User involvement must be meaningful and empowering for those who are involved. Fleischmann says: "*User involvement is not a bolt-on extra. It will affect everything an organisation does: it's a way of changing the philosophy of an organisation and all the roles within it.*"

The process may be messy and difficult, and managers may have to pause to remind themselves about the benefits of having users involved, before they dismiss user involvement as presenting too many problems. "*But if it is done right, it will result in a better service,*" Fleischmann says.

Further *Information*

The full reports, this briefing paper and details of current SDO research in the field can be downloaded at www.sdo.lshtm.ac.uk/changemanagement.htm

About the SDO Programme

The SDO R&D Programme is a national research programme managed by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) under contract from the Department of Health's R&D Division.

For further information about the NCCSDO or the SDO Programme visit our website at www.sdo.lshtm.ac.uk or contact:

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Addendum

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