

## Wave 1

# Project Management Pack



Royal College of  
**Psychiatrists**

Charity reg. no. 228636



National Collaborating  
Centre for Mental Health



For better  
mental health



Royal College  
of Physicians

Setting higher medical standards



Faculty of Accident &  
Emergency Medicine

## Contents

Chapter 1: Introduction	
1.1: The issue.....	1
1.2: What is the 'Better Services for People who Self-Harm Programme?'.....	2-4
1.3 The partners and wider collaboration.....	5
1.4 Funding.....	5
Chapter 2: Preparatory work	
2.1 Who needs to be involved.....	6
2.2 Setting up Local Project Team.....	7-10
Chapter 3: Developing a communication strategy	
3.1 Who to communicate with.....	10-11
3.2 How to communicate.....	12
3.3 What to communicate.....	12
3.4 Timetable.....	13
Appendix 1: Involving service users.....	14
Involving nursing staff.....	15
Involving other 'clinical' staff.....	16
Appendix 2: Service user members role	
- Person Specification.....	17
- Proposed Timetable.....	18
Appendix 3: Checklist for involving service users.....	19
Appendix 4: INVOLVE guideline - examples of payments for service users.....	23-24
Appendix 5: How Service User involvement might be impeded.....	25-26

**N.B. The information contained within this pack may be freely photocopied to all those involved in the programme of work**

***Copies of the data collection tools and supporting materials will be sent out in accordance with the timetable.***

***A key measure of the usefulness of the programme of work to your organisations will be your ability to move from the 'learning', to implementing appropriate improvements.***

## **How to use this pack**

This pack is designed to help you set up and run the programme in your local organisations. As well as providing background information about the programme of work, it offers advice about to set up support structures that will allow you to get as much out of your participation as possible. This part of the pack has been drawn largely from the College Research Unit's (CRU) experiences of running national multi-centre quality improvement programmes. The guidance offered is neither definitive nor exhaustive, but should highlight some of the issues you will need to address.

The pack has been set out in chronological order to correspond to the various stages of the programme of work and includes the following.

- Background information about the programme.
- Guidance material to support you to set the programme of work up locally.
- Guidance on recruiting and working with service users

NOTE: All appendices are at the back of the relevant section of the pack.

## **Chapter 1: Introduction**

### **1.1 The issue**

Self-harm is one of the top five causes of acute medical admission in the UK (68,716 admissions in 2001/2002). The quality of care for those who self-harm depends on the quality of joint working between emergency departments and mental health service and this currently varies across the UK.

Although there are, of course, areas of good practice, many people who attend an emergency department as a result of self-harm find the experience unpleasant. This finding greatly influenced the recently published NICE guidelines which concluded that improving staff knowledge and attitudes is the key to better services and reduction in the substantial morbidity and mortality associated with self-harm.

Through auditing local practices, you may be able to confirm commonly held assumptions about 'what is happening'. You may, however, be surprised by some of the things that are revealed.

***To ensure that you are able to get the most out of the programme, it is vital that you plan ahead.***

***Six Regional Collaboratives spread throughout the UK***

Some of the improvements identified through the audit processes will relate to the behaviour of individual practitioners, others to the structure of the services within which they practice. You may be able to act on some of the findings immediately e.g. by introducing a new risk assessment tool. Others will require medium-term solutions e.g. increasing access to liaison psychiatry services during evenings and weekends. Others still may need long-term plans e.g. re-designing your Emergency Department to provide more private space. Clearly, not all changes will be welcomed and many may be resisted.

## **1.2 What is the 'Better Services for People who Self-Harm' Programme?**

Local teams are being established throughout the UK comprising of senior practitioners and managers from emergency departments, their associated mental health services, and local ambulance services. Local teams are also expected to fully involve service users. These local teams are being grouped with neighbouring teams to form 6 regional collaboratives spread throughout the UK.

The first phase of the 18 month programme begins in autumn 2005, and will have the following stages:

<b>Learning Event 1: Regional Introductory Events</b>	Each local team will be invited to attend an introductory event within their region to launch the programme.
<b>Data collection</b>	<p><b>Local Data Collection</b> Data will be collected covering such areas as (for example) service user experiences, staff training, triage, health records and assessments, department facilities, and patient information.</p> <p><b>Peer-review visits</b> Members of teams within the same regional collaborative will conduct visits to explore key themes and support local action planning.</p>
<b>Reports</b>	<p><b>Local reports</b> These will detail compliance against each of the standards.</p> <p><b>Regional and national reports</b> These will allow teams to compare their performance against national averages (note: services will not be named unless to highlight good practice).</p>
<b>Learning Event 2: Regional Feedback and Action Planning</b>	Local collaboratives will come together to discuss their findings relative to the regional and national findings, and to begin action planning using the PDSA cycle ( <i>see page 4</i> ).
<b>Action Period</b>	During Action Periods, local teams will work within their organisations towards measurable and achievable service improvement, however incremental.
<b>Learning Event 3: National Feedback and Evaluation</b>	Members will come together to discuss their findings relative to the regional and national findings, review their overall progress, and celebrate their successes.

NB: This programme of work may be subject to change according to your feedback at the introductory events

### The Plan, Do, Study, Act cycle

Local teams will work through their collaborative, using the 'Plan, Do, Study, Act (PDSA)' model for change. This approach capitalises on team member's ideas, whilst the collaborative itself supports members to try out small changes to see if they bring about service improvements. Specifically, the PDSA approach to quality improvement will allow local teams to:

- a) test ideas for improvement quickly and easily based on existing ideas, research, feedback, theory, review, audit, etc or practical ideas that have been proven to work elsewhere;
- b) use simple measurements to monitor the effect of changes over time;
- c) start with small changes, which can build into larger improvements in the service through successive quick cycles of change.

**Partner organisations:**

- **FAEM**
- **Mind**
- **NCCMH**
- **RCN**
- **RCP**
- **RCPsych**

**National Costs**

**Local Costs**

### **1.3 The partners and the wider collaboration**

The Better Services for People who Self-Harm programme is being led by the Royal College of Psychiatrists' Research Unit, in partnership with the following partners who represent key professionals in the care and support of people who self-harm.

- The Faculty of Accident and Emergency Medicine
- The Royal College of Nursing
- The Royal College of Physicians
- Mind
- The NICE National Collaborating Centre for Mental Health

The work of the central project team at the CRU is being overseen by a steering group made up of representatives from the partnership organisations. Additionally, the programme is also working closely with the National Poisons Information Service as well as various local service user groups, voluntary sector organisations, self-harm support groups, and national self-harm networks.

### **1.4 Funding**

The programme is being funded initially by the Health Foundation, an independent charity that aims to improve health and the quality of healthcare for the people of the UK. This is one of several programmes that form the Health Foundation's 'Engaging with Quality' initiative, which aims to address the gap between 'current' and 'best' practice within various healthcare settings. The Health Foundation is providing tapered funding: the first wave of the programme is largely funded by them; it is intended that the programme will eventually be fully-funded by income from subscriptions.

Although membership for wave 1 is free (a saving of £4,000 per team, per wave), your Trust will incur some additional costs, as stipulated in the 'Declaration of Understanding'. Service user representatives on your LPT should be reimbursed (session fees and reasonable expenses) and staff on your team will need time and funds to be able to attend events. For more details, please see the 'Declaration of Understanding' or contact the Central Project Team.

- **Broad ownership**
- **Involvement from the outset**
- **'Active' versus 'passive' involvement**

**Develop a communication strategy**

## Chapter 2: Preparatory work

### 2.1 Who needs to be involved?

The majority of staff feel committed to improving the quality of the services they provide. If improvements identified through the audit processes are to lead to demonstrable improvements, the process will need to be 'owned' by a lot of different people.

- It is vital that the people who will be expected to **have a role in**, or **be affected by** the work of the programme of work are involved **from the outset** and **throughout** the course of the work.
- Their role may be **active** (i.e. direct involvement in setting up and running the programme of work locally) or **passive** (i.e. being consulted or receiving regular updates).

Careful thought needs to be given to **who** needs to be involved, and **how**. Attached at **Appendix 1** is a checklist of the various groups of people who are likely to need to be involved in, or will be affected by, the programme – either in the short-term or longer-term. Once you have worked through and completed the checklist, you are advised to develop a **communication strategy** that defines the ways that you will keep everyone involved with, or informed about progress (**see chapter 3**).

#### **Task 1: Developing a 'Communication Strategy' (Appendix 1)**

Work through this list, noting down the following:

1. if and how each individual or group needs to be involved;
2. which parts of the audit programme they will be involved in;
3. how you intend to involve them i.e. as a members of the project team; through newsletters
4. how often you will need to be in touch with them;
5. who will be responsible for establishing and maintaining this link.

## The role of the Team

## Choosing a Team Lead

### Think about:

- **Seniority**
- **Respect, credibility and breadth**
- **Time available**

## 2.2 Setting up your local Project Team

### □ The role of the Team

You will need to establish a team of people who will lead and manage the programme of work ***in*** and ***across*** your organisations and services, including service user networks. The role of the team will include the following:

- ensuring the programme of work is integrated within existing quality and audit structures;
- ensuring that appropriate supports/resources are available to your project team <sup>1</sup>;
- highlighting the benefits of supporting the work;
- enthusing and motivating by example;
- monitoring adherence to local, regional, and national time-scales;
- 'trouble-shooting' when problems or delays are experienced;
- linking with the central project team at the CRU;
- fostering networking with other participating teams across your region and nationally;
- devising and overseeing a communications strategy (***see chapter 3***)

Ideally, your LPT should reflect the local community and staff in terms of ethnic diversity, gender balance and so on.

### □ Choosing a team lead

- **Seniority:** this person will need to have the authority to 'make things happen', both in relation to getting the audit data collected, and in driving forward service improvements in the future.
- **Respect, credibility and 'breadth':** the work programme necessitates the involvement of a wide section of people from different organisations. The project leader will need to work effectively with all of these groups and individuals.
- **Time:** each component of the programme will have dates and deadlines for completion. The person you choose will need to be available to co-ordinate input across your local team and to ensure that deadlines are met.

---

<sup>1</sup> An accurate assessment of the resources required in terms of manpower, time and materials is essential to ensure change is managed successfully. The project team may have all the necessary skills and abilities within it to do this. However, they may need support from management, information technology departments, or clinical audit department (Pruce and Aggarwal, 1999).

**WARNING**  
*If you choose someone who does not possess the necessary authority, the programme of work is likely to be unsuccessful*

**Note:** if you choose someone who does not possess the necessary authority, the programme of work is likely to be unsuccessful i.e. they will be unable to motivate others to support the work and/or they will be unable to implement any improvements identified through the audit.

#### □ **Choosing other Team Members**

The composition of the project team is extremely important. A highly committed group can influence others. This will be important when it comes to achieving broad ownership for the programme of work. Key members must include the following:

- Senior personnel from your Emergency Department;
- Service user representatives from either local user groups, self-harm support groups, or voluntary sector groups such as Mind (*please see box below, or get in touch with the central project team for advice.*)
- Senior personnel from your liaison psychiatry service and/or Mental Health Trust;
- Senior personnel from your Ambulance Trust.

#### ***Other people you may wish to consider***

- Respected colleagues
- Support staff e.g. clinical audit or governance staff
- Representatives from specialist self harm services in the local area

#### **Involving service users**

The involvement of service users is a prerequisite to membership of the 'Better Services for People who Self-Harm' Programme. This is the best way you can find out directly the best ways of winning support for the programme of work from this group. Think about inviting at least two people so that they do not feel outnumbered by professionals (for further information, refer to Appendices 2 and 3).

**Avoid 're-inventing the wheel'**

**Involving senior people**

**Get 'hands-on' helpers**

**Involve potentially obstructive colleagues**

**Engage supportive colleagues**

**Aim for stable membership**

### **Other things to think about**

- Avoid 're-inventing the wheel'. It may be that the membership of an existing group could be tailored to meet the needs of this programme of work. Not only will this save time, it will mean that you have a core, cohesive team to work with from the start.
- Involving senior people from within your organisations will demonstrate to those inside and outside that there is commitment to the programme of work.
- Involving individuals who are respected by their colleagues will mean that your team's work will have greater credibility.
- Involving clinical audit, governance, 'quality', or other support staff could give you access to specialised skills and perhaps people who can have a 'hands-on' role collecting audit data.
- Are there people in the organisation who have been **known to obstruct** initiatives of this kind? If so, it might be better to get them actively involved from the start.
- Are there people in the organisation who are **generally very supportive** of initiatives of this kind? If so, it would be good to get them on the team.
- It may not be possible for senior level staff to play an active role in running the programme of work locally. Make sure that clear channels of communication are defined from the outset (**see chapter 3**).
- Stability of membership will increase your team's productivity.

### **Methods of working**

#### **Creating a structure**

At the earliest point, try to establish some core structure for your team. The sooner team members know what is expected of them, the more likely it is that you will work together effectively. You may wish to consider the following.

- How often will you meet?
- Where will you meet e.g. rotate meetings?
- When will you meet? (note: providing a sandwich lunch can enhance attendance figures)
- How long will meetings last?
- Will the meetings be formal/informal?
- How will 'actions' arising from the meeting be recorded and circulated e.g. consider whether secretarial support is needed?

***Understand your audience and be clear about who will carry information and feedback the various 'stakeholder' groups.***

## **Reviewing membership**

It is important to keep checking the appropriateness of the membership of your project team. Often people sign up to new groups and then find that they are over-committed. If this happens, it may be appropriate to invite replacements, otherwise, you may end up with problems, for example:

- resistance from groups of people who feel their views have not been adequately represented in setting up the audit locally;
- a small group of people feeling over-whelmed trying to manage the local data collection;
- loss of momentum.

At worst, it could end up that the audit is yet another paper exercise that does not lead to any discernible improvements.

It is likely that you will identify far more people that can reasonably be accommodated on a working group. This is when you need to consider how you will keep the less 'actively' involved people up-to-date with what is happening. You will need to plan and create a communication strategy.

## **Chapter 3: Developing a communication strategy**

To be successful, this programme of work needs to be supported by a lot of different people. A communication strategy will help you to understand your audience and be clear about who will carry information and feedback about the programme of work to the various 'stakeholder' groups.

### **3.1 Who to communicate with**

#### **□ *Within your project team***

Team members should meet regularly to report progress and to discuss solutions to potential problems that may have been encountered. This will engender co-operation between team members and a sense of individual responsibility working toward a collective goal. Your team will have a wealth of knowledge and skills and it is important to make full use of these. Ensure that all members within the team are enabled to contribute and, most importantly, be listened to by their colleagues on the team.

**Your local project team must have direct access to senior managers in all relevant organisations**

**NOTE TO NHS TRUSTS  
As part of its remit, it is vital that senior management ensures that the trust board is kept regularly informed of the process and outcomes of the audit programme.**

#### □ ***Within your wider organisations and services***

Since improvement does not occur in a vacuum, a change in practice in one area may result in knock-on effects for other processes. Informing related groups within your organisations and services will help ensure that the activities associated with the programme of work - e.g. getting staff to fill in questionnaires – will be supported.

Looked at conversely, if people hear about the work indirectly, they may feel that their contribution or involvement is not important and therefore may feel less committed to the implementation of any service improvements that are identified through the audit processes.

Secondly, quality improvement activities are often perceived as cost-cutting exercises. Keeping people informed can help dispel any fears.

Finally, this type of initiative can be seen as something 'imposed' by management, rather than as a response to a perceived issue. Telling people what is happening from the start can stop this from happening.

#### □ ***Management***

This programme will generate information that relates not only to the departments that are generating the data, but also to other departments e.g. estates, training. The potential areas for improvement that may be identified are equally wide-ranging. Your local project team must have direct access to senior managers across all relevant organisations and services.

You should be able to expect their support:

- around gathering the audit data,
- by requesting regular updates on the findings;
- by agreeing areas for improvement;
- in identifying appropriate action plans;
- in monitoring completion of action plans.

The more visible the involvement of management, the better. As well as the practical supports they can provide, management endorsement will lend credibility to the service improvement activities and they may stand a better chance of being accepted and implemented into clinical or organisational practice.

### 3.2 How to communicate

Again, try to avoid re-inventing any wheels. Find out what systems are already in place and then 'hijack' them. Some examples:

- local newsletters;
- open meetings with senior management;
- bulletin boards;
- existing meetings e.g. management committees; team meetings; CPD sessions;
- intra-net systems.
- Forum meetings of local voluntary sector and user organisations

In addition, you may wish to use one or more of the following approaches:

- plan early meetings with all key stakeholders i.e. service users, unit staff, etc to see how you are going to involve them;
- nominate 'link people' from your project team who will keep specified groups informed of progress e.g. a consultant may undertake to communicate with all other staff from her/his discipline.

### 3.3 What to communicate

#### **The content of the programme**

As work progresses, you may want to let people know about **key events** and dates. Later you will want to communicate back **key findings** from the work and **planned improvements** resulting from the findings.

#### **Hopes and fears**

As indicated earlier, people may have all sorts of concerns about the impact of the programme of work on them. It is advisable to provide a forum where these can be discussed openly.

#### **Benefits of involvement**

Try to stress the potential benefits of supporting the work. Staff are more likely to be supportive if they can see clearly the link between the programme and the impact on the lives of the people who use, or work in, the services they provide.

### 3.4 Timetable\*

	When?	What?
2005	September – October	Set up your local team
	November	Attend a Regional Introductory Workshop
2006	February – April	Collect data
	March – end May	Analysis and reports of local and regional findings provided by the CPT
	May	1 member of each team to attend a 'peer-review and action planning' training session in London
	June	Attend a one day peer-review visit in your region (2 – 5 members of the team) Host a one day peer-review visit by another team in your region
	July – October	ACTION PERIOD
	November/December	Attendance at Regional Learning Event
2007	February	Follow up data collected
	March	National report compiled
	April	Attendance at National Event

\*This will be finalised during the introductory events, after further consultation with local project teams about what they consider to be the most useful and manageable programme of work.

**We hope that this information pack answers some of your questions but please feel free to contact the central project at *any stage of the programme*:**

**Telephone:** 020 7977 6643/42

**Fax:** 020 7481 4831

**E Mail:** [selfharmproject@cru.rcpsych.ac.uk](mailto:selfharmproject@cru.rcpsych.ac.uk)

## Appendix 1

### Involving service users

What information?	<ul style="list-style-type: none"> <li>▪ Aims and objectives of the programme of work</li> <li>▪ Potential benefits to them as individuals and other service users in terms of tangible outcomes</li> <li>▪ Time-scales and what will be involved</li> <li>▪ Assurances of confidentiality and non-blaming</li> <li>▪ A named contact person</li> </ul> <p>NOTE: membership on the Project team should be on an 'equal partnership' basis; It is important to invite a minimum of 2 user representatives</p>	
What format and by whom?	Written	Verbal
	<ul style="list-style-type: none"> <li>▪ Job description</li> <li>▪ clear, concise and jargon-free;</li> <li>▪ initially a news-sheet</li> </ul>	<p>(Local groups)</p> <ul style="list-style-type: none"> <li>▪ provide opportunities for people to talk with one or more of the members of the local Project Team;</li> <li>▪ hold workshops</li> </ul>
	NOTE: be aware of potential language or cognitive barriers	
Who should oversee this?	<ul style="list-style-type: none"> <li>▪ User Groups e.g. MIND; NSF; UKAN; CHC; advocacy services</li> <li>▪ Locality manager or a non-clinical member of the project team</li> <li>▪ Someone with time</li> </ul>	
Incentives?	Individual	Collective
	<ul style="list-style-type: none"> <li>▪ expenses/sessional payments;</li> <li>▪ therapeutic value</li> <li>▪ developing own skills</li> </ul>	Developing better links between local voluntary sector organisations, user groups and statutory services
Potential supports?	<ul style="list-style-type: none"> <li>▪ Local Project team members</li> <li>▪ Knowledge of culture</li> <li>▪ Positive attitude of staff</li> <li>▪ Having a good communications strategy</li> <li>▪ Involving everyone from the start</li> <li>▪ Training and information for service users</li> </ul>	
Potential barriers?	<ul style="list-style-type: none"> <li>▪ Recruitment of user groups; getting user groups 'on board'</li> <li>▪ Lack of empowerment</li> <li>▪ Doubts about the project making a real difference</li> <li>▪ Turnover of staff and service users</li> <li>▪ Poor communication</li> <li>▪ Insufficient resources e.g. to pay service users for their time</li> <li>▪ Different expectations</li> <li>▪ Antagonistic attitudes e.g. attitudes of staff; hidden agendas</li> <li>▪ Historical factors e.g. dynamics between local personalities</li> </ul>	

## Involving nursing staff

What information?	<ul style="list-style-type: none"> <li>▪ Aims and objectives of the programme of work</li> <li>▪ Potential benefits to them as individuals in terms of tangible outcomes</li> <li>▪ Time-scales and what will be involved</li> <li>▪ Assurances of confidentiality and non-blaming</li> <li>▪ A named contact person</li> <li>▪ Visible top-level commitment</li> <li>▪ A view of 'the bigger picture'</li> </ul>	
What format and by whom?	<p>Written</p> <ul style="list-style-type: none"> <li>▪ handouts</li> </ul>	<p>Verbal</p> <ul style="list-style-type: none"> <li>▪ workshop presentations by people with credibility/ward manager/Project Team;</li> <li>▪ teaching sessions</li> </ul>
NOTE: use existing networks and structures		
Who should oversee this?	<ul style="list-style-type: none"> <li>▪ Clinical nurse specialist/clinical practitioner/senior nurse</li> <li>▪ Someone who can be 'trusted' (this will vary)</li> <li>▪ Key people regarding culture change: owned roles and responsibilities; identified change agents</li> </ul> <p>NOTE: Project Team should steer contact issues</p>	
Incentives?	<p>Individual</p> <ul style="list-style-type: none"> <li>▪ personal development;</li> <li>▪ 'being heard';</li> <li>▪ networking;</li> <li>▪ being released from duty to carry out work</li> </ul>	<p>Collective</p> <ul style="list-style-type: none"> <li>▪ improved job satisfaction;</li> <li>▪ improvements to working environment;</li> <li>▪ reduction of 'blame' culture;</li> <li>▪ reduction in 'fear'</li> </ul>
Potential supports?	<ul style="list-style-type: none"> <li>▪ Stress the benefits e.g. for managers – recruitment and retention of staff; creating 'models of understanding'</li> <li>▪ Visible top-level commitment: involve influential people within the trust; all disciplines; Clinical Audit Dept; Quality Team; Occupational Health (counselling); H&amp;S Team; the CRU Team</li> <li>▪ Feedback findings on an on-going basis and if outcome is negative, explain 'why'</li> </ul>	
Potential barriers?	<ul style="list-style-type: none"> <li>▪ Insufficient resources: lack of time; staff shortages; lack of admin support</li> <li>▪ Staff turn-over</li> <li>▪ Defensiveness i.e. associated with fear of criticism; lack of knowledge/ trust</li> <li>▪ Historical factors e.g. past events</li> <li>▪ Unrealistic expectations</li> <li>▪ Lack of organisational strategy</li> <li>▪ Low morale</li> <li>▪ Poor communication: e.g. mixed messages</li> <li>▪ Resistance to change</li> </ul>	

## Involving other 'clinical' staff

What information?	<ul style="list-style-type: none"> <li>▪ Aims and objectives of the programme of work</li> <li>▪ Potential benefits to them as individuals in terms of tangible outcomes</li> <li>▪ Time-scales and what will be involved</li> <li>▪ Assurances of confidentiality and non-blaming</li> <li>▪ A named contact person</li> <li>▪ Stress national, multidisciplinary context</li> <li>▪ Describe the resources available to support the programme</li> <li>▪ Trust Board: time and (potential) money implications</li> </ul>	
What format and by whom?	Written	Verbal
	<ul style="list-style-type: none"> <li>▪ information sheets;</li> <li>▪ existing communication structures e.g. newsletters;</li> <li>▪ set up a dedicated file;</li> <li>▪ e-mail</li> </ul>	<ul style="list-style-type: none"> <li>▪ face-to-face;</li> <li>▪ tailor made meetings</li> </ul>
	NOTE: present an objective, lateral view	
Who should oversee this?	<ul style="list-style-type: none"> <li>▪ Clinical Audit Department</li> <li>▪ A member of the Project Team</li> <li>▪ Project Team should take on specific groups e.g. psychiatrists; social workers</li> </ul>	
Incentives	Individual	Collective
	<ul style="list-style-type: none"> <li>▪ recognition for the CEO and Chairman;</li> <li>▪ CPD points and other professional practice development systems</li> </ul>	
Potential supports	<ul style="list-style-type: none"> <li>▪ Visible top-level commitment</li> <li>▪ Feedback positive results from previous initiatives</li> <li>▪ Being flexible within methods being used</li> <li>▪ Clinical Audit Department</li> <li>▪ College Research Unit</li> <li>▪ Local admin supports</li> <li>▪ Drug companies (free lunches)</li> </ul>	
Potential barriers?	Attitudes e.g. 'just another form' Time-scales Money: need ring-fenced budget	

## **Appendix 2**

### **BETTER SERVICES FOR PEOPLE WHO SELF HARM**

#### **User Member of Local Project Team**

##### **Person Specification**

###### **Essential criteria**

Recent experience of using mental health services

Recent experience of using emergency department services for treatment of self harm\*

Understanding of user empowerment and user involvement

Ability to work in groups

Ability to represent the views of people who self harm

Experience of liaison with user and voluntary sector networks, or, the ability to develop links with these networks

Available to devote 12 to 15 days to the project over the course of the project (18 months), including meetings held during the day

Confidence in communicating with a range of people including service users, carers, mental health professionals, medical staff and service managers

###### **Desirable**

Experience of research or service evaluation

Experience of working in committees or working groups

Understanding of issues facing service users from diverse communities and minority groups

###### **\* Note**

At least one of the service user representatives should have personal experience of self harm and use of emergency department services. However, it is recognised that other service users may have particular expertise to bring, for example membership of emergency department Liaison committee, experience of group advocacy, user consultation etc., and one user representative could be someone with this experience

## **Proposed Timetable and guide to costs**

Many local teams have asked us for advice about how much input we expect from service user representatives on the local project team. This guide adheres to some of the key elements of 'good practice' indicated in the project management pack, i.e.:

- Service users representatives can share some aspects of the role between them, but should not be expected to serve as sole representative in any professional forum/meeting/event
- to minimise the risk of this happening, three service users should ideally be recruited to provide supports to your local project team. If you can only recruit two service users, you should ask them to ensure that they can nominate a deputy to stand in for them if they are unable to attend a meeting (this will not cost you any extra money because you would only pay for the person who attends)
- It is essential that service users are **fully involved** in every stage. They will play a vital role and must be invited to all meetings and events connected to the project and have an equal say in all aspects of decision making.

The guide below indicates 'minimum' and 'maximum' levels of involvement. The list of possible activities is illustrative, not comprehensive and will be up for discussion at the introductory events.

<b>Activity</b>	<b>Comments</b>	<b>Minimum no. of 'person' days*</b>	<b>Maximum no. of 'person' days*</b>
Attend introductory event in the local region (Nov 05)	Essential	2 (people) x 1 (day)	3 (people) x 1 (day)
Data Collection/contact with other networks (Feb – April 06)	Essential	1 x 7	2 x 7
Meet with project team to discuss results of audit (April –May 06)	Essential	2 x ½	3 x ½
Prepare for peer-reviews (May 06)	Essential	2 x ½	3 x ½
Attend a peer-review (with the rest of the project team) within the local region (June/July 06)	Essential	2 x 1	3 x 1
Receive (with the rest of the project team) a peer-review visit (June/July 06)	Essential	2 x 1	3 x 1
Attend a feedback workshop in the local region (Sept 06)	Essential	2 x 1	3 x 1
Contribute to follow-up report (Dec 06 – Jan 07)	Essential	1 x 2	3 x ½
<b>SUB-TOTAL (ESSENTIAL ACTIVITIES)</b>		<b>19</b>	<b>29</b>
Meet with project team to prepare for project (Jan 06)	Optional**	2 x ½	3 x ½
Attend the National Event (March 07)	Optional	2 x 1	3 x 1
Contribute to the Self-Harm newsletter	Optional	2 x ½	3 x ½
Contribute to service user focus group	Optional	2 x 1	3 x 1
Attend additional project team meetings	Optional	2 x 1½	3 x 1½
<b>SUB-TOTAL (OPTIONAL ACTIVITIES)</b>		<b>7.5</b>	<b>10.5</b>

*\*Including preparation time.*

**2 service users = between 19 and 26 days in total**  
**3 service users = between 31 and 41.5 days in total**

## Appendix 3

### Involving Service Users – A checklist

#### Recruiting service user members

- Invite a minimum of two (ideally three) service users to join the local project team. This helps to achieve balance between clinicians, researchers and users in the team and ensures that users have peer support. It allows for the fact that individual users may be absent at times because of fluctuating health.
- Consult with people who use services and their organisations to identify the most appropriate people to join the local project team. Ensure that the people you involve have links with networks of other service users or are able to develop links.
- Make links with more than one local user organisation or service. (Even if service users on the local project team come from just one organisation, it will be important to consult and inform as wide a group of users as possible during the course of the project.)
- Look for people who have experience working in committees or are interested in being trained to do so.
- At least one service user member should have had recent experience of care and treatment in an Emergency Department (see Appendix 2)
- Provide a job description and person specification for the role. (See Appendix 2)
- Consider the implications of including workers and users who are, or have been, in an ongoing clinical relationship with other members of the organisation. Discuss carefully with the workers and users concerned.
- Involve service users from the beginning. It is hard to influence work when decisions have already been made.

#### Working collaboratively

- Make the purpose and remit of the local project team clear.
- Be prepared to relinquish some power and adapt ways of working. But be honest about any areas of decision making which users cannot influence.
- Do not assume there are areas where service users are not competent to take part. Consider service users for all roles in the team, for example Chair, Vice-Chair.
- Be prepared for the work to take longer e.g. because of the need for greater discussion

- Be clear to staff and service users that no-one will be victimised in their use of services for taking part in consultation and representation: this fear can sometimes prevent open criticism by users.
- Let individuals and groups know that you appreciate their input.

## **Access**

- Be aware that users might belong to more than one marginalised or stigmatised group, for example as an older person, as a lesbian or gay man, or as a member of an ethnic minority. Try to ensure that non-user members of the group are drawn from diverse communities.
- Ask service users (and other members of the team) about access needs – don't wait for them to raise the issue. Examples might be:
  - Use of a personal assistant or support worker
  - Access to taxis or other forms of transport
  - Wheelchair accessible venues
  - Hearing induction loop
  - British Sign Language interpreters
  - Community language interpreters
  - Written material in large print, in Braille or on audiotape
  - Reminders before meetings
  - Specific dietary requirements
  - Provision of childcare
- Hold meetings in user-friendly and public transport accessible places: ask people about this.
- Hold some meetings on users' 'home territory', e.g. at the premises of a user or voluntary sector organisation
- Ask about the best time of day for meetings. Early mornings may be difficult for some service users because of the effects of medication.

## **Organising Meetings**

- Ask if service users would like pre-meetings with the Chair - to go through the agenda, ask for background information, and highlight issues they want to raise.
- Invite service user items for the agenda; don't place them near the end.
- Allow enough time between meetings for service users to consult user networks. Plan ahead to allow for use of existing communication networks e.g. monthly newsletters, regular user forum meetings.
- Consult service users on the structure of the meeting – e.g. length of meeting, number of breaks. Check if breaks need to allow time for people to go outside to smoke.

- Consider different formats for meetings to facilitate participation, e.g. small group discussion with feedback.
- Provide plenty of drinks – some psychotropic medication dries your mouth.

### **At the meeting**

- It is the Chair's role to ensure that all members of the group have the chance to participate.
- Ask team members for suggestions for ground rules for meetings.
- Establish a ground rule that any personal information or experience shared is confidential to the group.
- Be clear which elements of the agenda can be discussed outside the meeting and which cannot.
- Use specialist language only where necessary. Consider asking members of the group to prepare 'front sheets' summarising academic papers, if academic papers are being discussed.
- Encourage all members of the team to ask for clarification when terms are not understood.
- Be prepared for strong emotions at times – most service users will bring some painful experiences of services - anger and hurt are normal responses!

### **Study Related Support**

- Where possible, facilitate access to training e.g. in committee skills, introduction to research methods, focus group facilitation
- Provide a mentor e.g. an experienced member of the research team chosen by the service user

### **Practical Support**

- Provide an induction pack (This will be made available to teams at the Introductory event)
- Produce papers, including the agenda, soon after the meeting so that representatives can consult other people.
- Find out what support the service users need to feed back issues from the meeting to other users, and to consult with them.
- Ensure that user representatives have access to computer facilities, phone, email, photocopier, stationery if required.

### **Emotional Support**

- Facilitate time and space for service user representatives to get together after meetings for mutual support and debriefing, either with or without a member of the LPT, whichever the service users prefer.
- Ensure that service users have access to someone outside the local project team to talk through personal issues raised by involvement in the project - discussions about services can trigger difficult memories and feelings.

### **Payment and expenses**

- Service users should be offered a fair rate of payment for their time and expertise. Payment should cover time spent carrying out all aspects of the role: meetings and events, reading papers, research, consulting service users, liaison with other user members of the core team etc.
- Do not assume that service users are on benefits and set rates of payment which are artificially low. However, it is important to inform people that if they are on benefit it is their responsibility to check out the effect of any earnings on their benefit. For detailed guidance on payments to service users see Appendix 4. It may also be useful to contact other teams within your region to discuss local policy on payment for service users.
- Travel expenses should be reimbursed in cash on the day of the meeting where possible.
- If the service user's session fee does not match the rate of professional consultancy fees then the pay should be sufficient to cover any childcare costs plus payment for time.

With acknowledgements to :

Changing Practice: Mental Health Nursing and User Empowerment. Peter Campbell and Vivien Lindow, 1997, Royal College of Nursing and Mind Publications

Involving Marginalised and Vulnerable People in Research : A Consultation Document, Roger Steele, 2004, INVOLVE

Guidance for Good Practice :Service User Involvement in the UK Mental Health Research Network, Alison Faulkner, 2005, SURGE

Involving the public in NHS, public health, and social research: Briefing notes for researchers, Hanley B et al, 2003, INVOLVE

## Appendix 4

### Examples of payments for service users

- **The NHS Health Technology Assessment programme (HTA)** pay £111.18 or £138.71 (if there is preparation) a day for attending panel meetings including any induction/development days if the person is self-employed, not in paid employment or will lose a day's pay by virtue of attending a meeting. Travel, subsistence and carer costs are also paid. They also offer a fixed fee of £200 for peer reviews where the document is more than 200 pages long (2003). For each role HTA have a 'job description' and person specification.
- **The Department of Health** guidance on best practice for national R&D programmes says of payments for peer reviewers who are members of the public, or people who use services (as defined by INVOLVE), and who are being asked to provide a consumer perspective to a review (2003):
  - Lower level*                      £50  
For reviews of short documents such as research briefs and vignettes or lay summaries of reports
  - Middle level*                    £100  
For reviews of larger amounts of information. For example reviewing several grant applications, or medium length reports (50 - 200 pages)
  - Higher level*                    £200  
For reviews of large reports or documents. For example reviewing long reports (over 200 pages)
- **The Joseph Rowntree Foundation** offer a fee of £75 per meeting to service users who are members of their advisory groups if they are unwaged, plus additional payments for preparation time. They will also pay for a support worker as necessary (2002).
- **The National Institute of Clinical Excellence (NICE)** pay £200 a day (2002) for some activities.
- **The National Nursing and Midwifery Council** pay £268 per day to all who attend, both professionals and service users (2002).
- **Devon Social Services** pay £50 for attending a meeting at full day rate and £25 for half day (2002).
- A paper published by **West Midlands MIND**, 'Partnerships in Mental Health' McHarron & Nettle, 1999 recommend that for attendance and participation at work groups/committees /meetings/ recruitment panels etc. a minimum payment of £5.00 per hour or £15 flat rate sessional fee plus travel expenses and any necessary and reasonable subsistence costs.

- **The National Lottery Charities Board** pays user assessors of social and medical research proposals a fee of £125 plus expenses, the same in fact as other assessors (2002).
- **Gedling Primary Care Trust** (PCT) pay £95 per day to lay members participating in meetings (2002).
- **The Department of Health Strategic Review of NHS R&D in Mental Health** agreed to pay £350 a day to the employer organisation (a national charity) to recruit a service user to join the Advisory Group on a consultancy basis. The Mental Health Strategic Review also paid £150 to the members of a specially convened User Panel for their attendance at the meeting, plus expenses (2002).
- **MIND in Dacorum** recommend paying service users £10 per hour, £30 half-day, £65 full day for attendance at a meeting/panel/event for consultation, recruitment and selection, and auditing services (2003).

Taken from: 'A guide to paying members of the public who are actively involved in research' INVOLVE, October 2003.

**The full guidelines can be downloaded from the INVOLVE website [www.invo.org.uk](http://www.invo.org.uk)**

## Appendix 5

### Ten ways for mental health workers to impede user participation in planning and managing mental health services

By Vivien Lindow

#### **Introduction**

*I am introducing this subject in a contrary way. I am going to tell workers how to stop us from getting involved in service planning and management. All these things have happened to me in trying to take part in psychiatric service planning, as someone who has used the services. At the same time, I must acknowledge the very great help that professional people have given to me and other service users in helping us to be involved in trying to improve services.*

#### **1. Do not give resources**

If you want to prevent user involvement, never give service users the money they need to meet and discuss policy matters. Do not offer money for training in committee skills. After all, you do not want them to get the hang of how the power system works.

#### **2. Take charge**

Secondly, take charge. When asked to be treasurer or chairperson by a user group where the members lack confidence, feel flattered, accept the job and wonder why the users will not take responsibility.

#### **3. Sow doubts**

The third way you can prevent user participation is to express doubt about the group's ability to be autonomous. Ask: "What if the chairperson becomes manic"? What happens when any chairperson is unable to fulfil that function? User groups are no different.

#### **4. Not representative**

Suggest to colleagues that the service users who are making representations are not representative because they are articulate. "Real" psychiatric patients are not articulate. If they were, they would have been given drugs to stop them speaking out. How representative are you?

#### **5. Choose someone compliant**

Invite a service user of your choice on to your committee rather than inviting a user group to send representatives. Then you can be sure to hear what you want to hear, not what psychiatric patients have to say.

#### **6. Tokenism: outnumber them**

My next two points are about tokenism. Invite just one service user representative on to a committee comprised of professionals. The user will probably not be confident enough to

present other users' views unsupported. If the person is confident, he or she will be so heavily outnumbered that you will not have to change anything.

### **7. Tokenism: ignore them**

The next form of tokenism is to consult widely, but exclude service users from the decision-making structures of your organisation. Then you can say that you have asked the service users, but will not have to act on what they have told you.

### **8. Embarrass them**

The eighth idea to exclude service users is to embarrass them. For example, if a service user representative starts by making remarks that do not conform to your agenda, ensure that an awkward silence is followed by ignoring the content of what is said.

### **9. Exploit them**

Never pay service users. Expect them to attend regularly as the only unpaid people in the roomful of salaried people. Then they will stop embarrassing you with their presence, and you'll have satisfied your conscience by inviting them.

### **10. Suggest that you are as powerless as service users**

The tenth way to exclude psychiatric patients is to suggest that you are as powerless as they are. Mental health workers have the power to recommend children being taken away, to order compulsory admission to hospital, to remove access to desired services, to release grants of money and give access to housing of various sorts. You have a salary and probably a secure home. You do not carry a diagnosis that invalidates what you say.

<p>The ideas in this paper have been published in "Just Lip-Service" by Viv Lindow in the Nursing Times (UK), 2 December, 1992.</p>
---