"Standing On the Shoulders of Giants"

Understanding Mental Health Promotion and Social Inclusion through Work Based Experiences and Patient and Public Partnership

Stephen P Young

Ph.D. Thesis 2009

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Abbreviations

A for E	Action for Employment
ALAC	Active Learning for Active Citizenship
CHC	Community Health Council
CLC	Creative Living Centre
CMHT	Community Mental Health Team
CVS	Council for Voluntary Services
DTC	Democratic Therapeutic Community
DGH	District General Hospital
DOH	Department of Health
GNC	General Nursing Council
HAZ	Health Action Zone
HEA	Health Education Authority
HMSO	Her Majesty's Stationary Office
HPMHS	Health Promoting Mental Health Services
ICAS	Independent Complaints Advocacy Service
IPAC	Individual Profile in Active Citizenship
LHARA	Local History and Regeneration Awareness
MBA	Masters in Business Administration
MSc	Master of Science
NatPact	National Primary and Care Trust Development Programme
NDC	New Deal for Communities
NHS	National Health Service
NHSU	National Health Service University
NIMHE	National Institute for Mental Health England

NSF	National Service Framework
NVQ	National Vocational Qualification
PHCRC	Primary Health Care Resource Centre
PSA	Public Service Agreements
RGN	Registered General Nurse
RMN	Registered Mental Nurse
SALI	Seedley and Langworthy Initiative
SARP	Social Action Research Project
SRB	Single Regeneration Budget
SSE	School for Social Entrepreneurs
SSSE	Salford School for Social Entrepreneurs
TEACh	Teaching European Active Citizenship
UEFA	United European Football Association
WHO	World Health Organisation
YTS	Youth Training Scheme

Preface

"Standing on the Shoulders of Giants" is a quote from Sir Isaac Newton, the famous physicist, mathematician and scientist, who said in a letter to his colleague Robert Hooke, dated 5th February 1676, "If I have seen farther it is by standing on the shoulder of giants." (Hawking, 2002).

This statement implies that if he had been able to conclude more about the universe than those before him, it is because he was conscious of the fact that he was working in the light of others and their achievements.

This thesis is an account of how action learning processes were embraced by local people in Salford who wanted to make a difference to their lives and the lives of their communities through working on issues that were important to them. It points the way for patient and public involvement for influencing future social and mental health policies and programmes.

In the context of this thesis the "GIANTS" are the local people who have learned how to cope with the many challenges that life has thrown at them and yet continually strive to make a difference to their lives and that of their community.

*"If **I** have seen farther it is by standing on the shoulder of giants."*

Abstract

This inquiry focused on my practice which required me to increasingly engage patients and the public in developing health and social care provision. Both retrospectively and in real time, I sought to, review and understand my own learning processes and their application into a number of successive community based projects.

Through these successive projects I have observed how local knowledge can provide value to personal and collective knowing through learning to work with patients and the public at three levels, at an individual level to improve personal care, with current service users to examine and improve existing services, and with the public developing new services that are creative and innovative.

This qualitative inquiry had an epistemology where the findings are specific to the particular context at particular points in time. This was important as there was no way of knowing how the participants of the projects and myself as practitioner and researcher would develop. Not one discreet event was researched, but a process of phases with different types of activities that were recorded and examined. The inquiry was underpinned by an Action Learning methodology that enabled, rather than constrained, the emergence of appropriate and varied practice methods and techniques and facilitated their integration.

The theory generated from this inquiry resulted in the development of a framework for patient and public involvement. This framework provides a

context for engagement at different levels of involvement through adopting critical factors for empowerment which are guided by the process and ethos of Action Learning.

Consequently Action Learning is positioned as the process for facilitating transformational change in practice and practitioner development. It reinforces how appropriate the character of Action Learning can be at increasing learning at both an individual and societal level and specifically for the changing contexts of involvement, inclusion and citizenship.

Section 1

This section provides the reader with an introduction to the foundation for understanding the nature of the thesis.

The section contains Chapter 1 which focus's on an introduction to the thesis and Chapter 2 which provides the relevant aspects of the author's personal and professional background.

Chapter 1
Introduction

This Chapter provides an introduction to the research context of the work, and an overview of its focus.

It also provides a summary of each chapter.

One of the purposes of this thesis was to critically examine how I learned from my work and life experiences, and how I consciously used that learning to influence change in the NHS.

When I commenced the doctoral programme in 1999 at the Revans Centre I was employed by the Mental Health Services of Salford NHS Trust. In April 2002 the Trust merged with Bolton, and Trafford Mental Health Services to become the Bolton, Salford and Trafford Mental Health Partnership, and in April 2003 became a new organisation known as the Bolton, Salford and Trafford Mental Health NHS Trust. From here on I will refer to that organisation as the Trust.

These experiences have had a profound impact on me and in particular the way in which I have learnt how to appropriately engage patients and the public as an integral part of my work and particularly in my role as Service Director (Developments) in a large Mental Health NHS Trust.

These experiences have required me to examine and change the way I engage people who use mental health services. This has served to demonstrate what

can be achieved when supporting people to learn how to manage their lived experiences as they are influenced by life's many challenges. Some of those challenges contribute to the development of emotional distress, mental health problems and sometimes a mental illness.

Underpinning this personal change was an emergent relationship with action learning and research that allowed me to explore my experiences and expand my understanding of, and find solutions to, my work based problems. This thesis also examines the value of this process (action learning) for progressing work based problems and opportunities.

I commenced and completed this programme at the Revans Centre for Action Learning and Research which then became the Revans Institute. However for simplicity it will be referred to throughout the thesis as the Revans Centre. However it should be noted that due to the closure of the Revans Centre the final resubmission of this thesis was under the School of Nursing and Midwifery which is in the Faculty of Health and Social Care.

It is my intention that this thesis will inspire and motivate others working in mental health and social care provision to discover for themselves the value of working with people who use our services and consider how they can engage both the patients and the public in a way that ensures services take full account of what people who use services say they need and want. However responding to these aspirations requires an approach where a dialogue with each other is important to establish mutually agreed priorities. The engagement with patients and the public from my experience needs to be at three levels:

1. Involving individuals in identifying their health needs and making an informed choice regarding the appropriate treatment. And in doing so improve personal care at an individual level;
2. Working with current service users to examine and improve the way existing services are provided and organised;
3. Exploring with the public, innovative and creative ways of redesigning new health and social care provision.

Why is this Important?

Having worked in the NHS since the age of fifteen, it took some twenty five years for me to learn how to develop services **with** and not **for** people with mental health problems and understand the value in doing so.

In discussing these experiences I have summarised how past and recent experiences have influenced my practice, whilst examining the reality of working in this way. In sharing my experiences I hope to influence others with the expectation that they can consciously learn how to influence the development of health care provision based on partnerships with people who use these services, without them having to wait twenty five years.

These experiences acknowledge that organisations and their culture can themselves be restrictive in progressing modern health and social care provision that puts the "person" (patient) at the centre of their health care. This is despite the many policy imperatives that stress the importance of the service user being at the heart of health and social care provision.

Improvement in health and social care provision has not developed and is not developing in keeping with the expectation of the people for whom those services are being provided. Clearly policy makers continue to search for the solution that is going to solve all the problems of the NHS. I am clear that there isn't one. There needs to be a conscious change in the behaviour of clinicians and managers when considering the implications of any policy change. It is not enough to continue to issue policy directive after policy directive. Arguably there is a need to develop a culture of learning that allows us to consider and ask insightful questions which helps us to understand the challenges associated with service improvement through patient and the public involvement.

This thesis describes the health and social care policy context as it relates to this research question and the agencies it is required to work in partnership with, namely health, local authority and government agencies.

The government has set itself the aim of a patient led NHS. However, policies to give more control are less developed in mental health, and our health services have a long way to go before we can say that they are really putting the patients first, (Health Care Commission, 2005).

The question for me then is why is the NHS still not putting "people" (patients) first despite the many policy imperatives to do so?

This thesis also explains the circumstances that prompted me to seek answers to this question, and how I have learnt from doing so and applied this learning to

my practice. The application of learning to my practice also had an impact on my role and work as Director of Service Development in the Trust.

It provided an opportunity for me to work at the Revans Centre for Action Learning and Research at the University of Salford. This arose after a challenging debate and dialogue with the Trust's Chief Executive that resulted in securing explicit support from the Trust Board, to develop a Centre for Community Learning to progress and understand the potential of this work further. This is explored in depth later on in this thesis.

One of the projects within the Centre for Community Learning was the Salford Social Entrepreneur Programme. As well as being a member of the Advisory Group for the development of this programme, I have been the Set Advisor supporting two Action Learning Sets. The first set commenced in November 1999 and concluded October 2000. The second ran from January 2002 to December 2002. Both Sets met monthly for approximately four hours for each set meeting over twelve months.

It was from those set meetings that I was able to collect further information as a participant observer where I recorded, questioned and reflected on the activities of the members of both sets.

This thesis also describes the challenges and the success I have had in convincing the Trust of the importance of this work and its contribution in developing mental health and social care provision. This is despite the explicit

support from the Trust for the Salford Social Entrepreneur Programme and the other projects that made up my portfolio of work.

This work contributes to the promotion of mental health and social inclusion, and as such is not the sole responsibility of one organisation as mental health and social inclusion is influenced by many factors. This thesis also explores the problems of ownership and commitment to the mental health promotion and social inclusion agenda, despite the acknowledgement of the many factors that influence mental health that lie outside health and social care and the current health and social care policy imperatives.

Structure of the Thesis

This thesis has been constructed in an iterative manner based on the reflexive exposition of my experiences as a mental health practitioner and facilitator and this is reflected in the headings of each chapter. However towards the end of the thesis Chapter 11, Making Sense of the Research, provides a summary of this work which is written in a different format that reviews this work in the light of a more conventional research project.

This has been written through answering in sequence a set of questions I asked myself, which relates to a format appropriate to a more formal approach to research and development. The questions in this list are interrelated to and complement the Central Picture Model, (Botham and Vick, 1998) which is described in Chapter 11.

The reader may find it useful to refer to Chapter 11 as a preview to reading the rest of the Thesis and referring to it later as a review of my work. Writing the thesis in this way reflects the complexity of the process of learning in action, and could only be written with personal conviction having looked back at the range and complexity of my work based challenges.

Summary of Chapters

Chapter 2 Personal and Professional Background

This Chapter provides an insight into my family background and the impact of the family values on me as I came face to face with the stark realities of a mental institution where I commenced my career in mental health nursing.

It describes an account of my baptism into the National Health Service at the age of fifteen, providing an insight into why I entered the nursing profession, the experiences of working in a "Psychiatric Institution" and a personal struggle with the conflict of my values and those of the Institution.

It provides an overview of the range of posts I have held since qualifying as a nurse and an understanding of the action I took when I realised that my employment in the Trust was potentially at risk.

In doing so this Chapter provides an account of my personal experiences. It provides the foundation and context for my progression in mental health and for understanding how the focus of my work has moved from one of "mental illness" to "mental health", "mental health promotion" and "social inclusion."

This progression was influenced by undertaking an MSc by action learning and research from 1995 to 1998. This provided the opportunity for me to research the development of the Creative Living Centre, a new community based mental health project. This was the first of many new experiences for me and was the catalyst for further learning, awareness and understanding. This motivated me to develop other innovative services that involved working with local people and communities.

Chapter 3 A New Understanding in Practice

The Chapter describes the experience of developing my first community based project (Creative Living Centre) which provided the foundation for learning and understanding the emerging challenges to my practice as Service Director (Developments).

It also provides an account of each of the subsequent projects that followed and built incrementally on the additional experience and learning arising from each new project.

This Chapter also explains the rationale for undertaking an MSc by action learning and research and how it augmented my learning.

It describes my experience, learning and understanding of the importance in working with patients and the public. It also gives an insight into how my practice has changed as a result of working with individual service users through to whole communities and then with members of the public.

The Chapter explains the challenges of trying to develop an empowering approach that supports people with mental health problems in identifying their own needs and making an informed choice about how they might best meet those needs. It draws a comparison with the relationship between the behaviour required to empower people and the behaviour required to use an Action Learning approach to resolving work based problems.

It also documents the achievements and challenges in trying to influence these new ways of working whilst undertaking my role as Service Director (Developments). Those many challenges acted as a powerful driver for me to be able to articulate the value of this work in mainstream mental health provision. Undertaking the doctoral programme was the process for understanding this further.

This Chapter also presents the development of my research theme.

Chapter 4 Learning in the Context of Mental Health and Social Care Policy

This Chapter describes my experience of working in mental health and specifically my understanding of the application of policy imperatives that drive mental health reforms and developments within health and social care.

It includes how my practice experience influenced my thinking and learning as I explored the development of mental health promoting communities through a range of mental health promotion and social inclusion activity.

It highlights a number of organisational and cultural blocks that I have encountered through my work.

Chapter 5 My New Role Develops

I was appointed to the role of Service Director (Developments) in October 1999 six months before I commenced the doctoral programme. It was whilst in this role that I commenced my research although this thesis also draws on some of my previous work and personal experiences which was an inseparable part of the research evidence.

In this Chapter I describe the ideas and opportunities that emerged in this new role and specifically the development of a Centre for Community Learning and my appointment as Honorary Director of Community Development at the Revans Centre at the University of Salford.

It explores the challenges involved in influencing the Chief Executive of the Trust to support this initiative. It also demonstrates the impact on my work as the Trust responds to national and local changing priorities with a focus on people with "serious and enduring mental illness", despite the acknowledgement and support for my work on the development of mental health promoting communities.

Chapter 6 Research Design-Approaches to Understanding My Practice

This Chapter provides an overview of my research and describes the process I used to capture the data.

It also explains the methodology and methods used that underpins my research.

The Chapter also considers the context of my work based practice and its implication in answering my initial research theme and associated questions.

Chapter 7 The Social Entrepreneurs Programme

In this Chapter I explain the background to the Social Entrepreneur Action Learning Sets and describe the development of the Salford School for Social Entrepreneurs.

It provides a personal profile of all the set participants, why they wanted to be on the programme, what they wanted to achieve and their success in doing so. It gives an insight into my developing role as a set advisor and the challenges of their roles.

Chapter 8 Action learning as a way of learning to learn by doing

This Chapter explains my relationship with action learning and how this supported me in developing innovative services in my role as Service Director (Developments).

It describes the process of learning that has occurred throughout this doctoral programme and the support received from being a participant of a Research Action Learning Set.

It also describes my personal experiences of learning that explains why I have used an action learning approach in my work and as the preferred methodology for this research.

Chapter 9 Findings and Conclusions

This Chapter describes the findings that arise from my research and considers those findings and discusses the conclusions arising from them. It describes a process for patient and public involvement and offers six critical ingredients for successful partnership.

Additional to this it explains the impact of using an action learning approach to support local people on the programme. It also explains the inclusion of an additional component to an already established model of health promotion that currently includes health protection, health prevention and health education. This additional component is "Autonomous learning".

Chapter 10 The Relevance and Application of My Experience

This Chapter provides the reader with a rationale for the importance of this research in the context of health and social care provision, highlighting how the research may be transferable to the wider public sector.

It also proposes that the findings can further the development of active citizenship across the public, private and voluntary sectors.

Chapter 11 Making Sense of My Research

This Chapter is a consolidation of my research. It gives the reader an explanation of the origin of my research and the processes that influenced the direction I took both in my work and in answering what came to be my research questions.

Chapter 12 Life after the Social Entrepreneur Programme

This Chapter provides the reader with an overview of my work following the completion of the Salford Social Entrepreneur programme. It highlights the work undertaken since the main stages of this research and describes how I see this work developing both now and into the future. It also informs the reader of my own aspirations both post doctoral and personally and a rationale as to why.

Chapter 13

This Chapter provides a meta position of the action and learning arising from my inquiry into the role of action learning in facilitating transformative change within the field of patient and public involvement. This thesis then is located in the field of patient and public involvement, which commenced with my practice as health practitioner, manager and facilitator in mental health and broadened out to working with local people in various communities.

The Chapter addresses the issues arising from the joint examiners report following the first submission of this thesis and the subsequent viva. It commences with an introduction and purpose of the inquiry and is followed by the methodology and specifically the use of published material. The next

section provides a statement on the character of action learning, the limitations of the research and the findings which includes the original contribution to knowledge and practice. It concludes with the opportunities for further research, development and direction and a final section that critically reviews how the final chapter was written.

Chapter 2
Personal and Professional Background

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It describes an account of my baptism into the National Health Service at the age of fifteen, providing an insight into why I entered the nursing profession, the experiences of working in a "Psychiatric Institution" and a personal struggle with the conflict of my values and those of the Institution.

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In doing so this Chapter provides an account of my personal experiences. It provides the foundation and context for my progression in mental health and for understanding how the focus of my work has moved from one of "mental illness" to "mental health", "mental health promotion" and "social inclusion."

This progression was helped by undertaking an MSc by action learning and research from 1995 to 1998. This provided the opportunity for me to research the development of the Creative Living Centre, an innovative community based mental health project. This was the first of many new experiences for me and was the catalyst for further learning, awareness and understanding of working

with patients and the public. This motivated me in developing other innovative services that involved working with local people and communities.

I was born in November 1955, my father was an Industrial Chemist and my mother had a full time occupation as a housewife. I come from a large family and have four brothers and a sister. My two older brothers are nurses, who are also married to nurses. My sister, who is the youngest, is also a nurse. As for my other brothers one works as an instrument mechanic in the chemical industry and the other as a teacher at a school for visually impaired children.

In 1976 I married Karon; also a nurse and we have two children. Adam is working as a community psychiatric nurse and Laura works as a Buyers Assistant in the retail business.

Being part of a large family has given me a sense of identity, security and belonging. It is where I have learnt my values and norms about right and wrong, providing me with a sense of purpose and direction.

Unbeknown to me, those values were to be challenged when I started work as a messenger at Prestwich Hospital in 1971. Here I came face to face with an institution that was devaluing of people and more concerned with the day to day running of an institution, rather than responding to the individual need of its patients. This resulted in the institution controlling the lives of the people who lived there (albeit unconsciously). In his book "Institutional Neurosis" Barton (1976) writes about how the asylum (institution) produced a disease "Institutional neurosis" which is characterised by

> "apathy, lack of initiative, loss of interest more marked in things and events not immediately personal or present, submissiveness, and sometimes no expression of feelings of resentment at harsh or unfair orders. There is also lack of interest in the future and an apparent inability to make practical plans for it, a deterioration in personal habits, toilet and standards generally, a loss of individuality, and a resigned acceptance that things will go on as they are unchangingly, inevitably and indefinitely"
> (Barton, 1976, Pg 2)

Although there have been many changes over the years in mental health care it is often provided in institutional settings. There remains a constant challenge to provide more responsive services in more appropriate settings for people who experience emotional distress or mental health problems i.e. Home, community and locality based provision.

Professional Background

A nurse by profession, I have worked in the National Health Service (NHS) for thirty five years. Most of my work has been in the field of mental health as both a manager and a clinician providing services for people of Salford and surrounding districts. Of those years: two were spent in Bury, where I trained as a Registered General Nurse (RGN), and five in Rochdale where I commenced my first management post, the remainder was spent working in Salford.

Why and how I entered the world of mental health nursing and more amazingly why I stayed for so long are questions I have asked myself on many occasions. I only started to think about the answer during an Action Learning Set meeting as a part of this doctoral programme in 2001. I mentioned that it was only for the previous four years that I had truly started to enjoy my work. I was asked "*why*"? I felt compelled to answer! It was with some ease that I talked freely

and openly of my experiences, it felt as though this was something I had needed to do for some time. The set provided a safe place for doing so and motivated me to describe this early part of my employment history. The act of writing down some of these experiences, has given me new insights into how they have influenced the work I do today and is described later in the thesis.

Why Mental Health

In April 1971 I embarked on a career in the National Health Service. I wasn't clear why I wanted to work in the NHS, but it may have had something to do with having spent some considerable time in the St. John Ambulance Brigade from the age of five. This was influenced by my father who ran the Prestwich Division and my two brothers who were also members, my two younger brothers and a sister were to follow. I always felt that I was destined for a career in a caring profession, but I was not sure which.

In retrospect my career in the NHS seems to have been influenced by:

- Living across the road from Prestwich Hospital;
- Following in the footsteps of my two older brothers who also became nurses at the same hospital;
- Taking advice from a good friend of the family who was a tutor at the hospital;
- It seemed to be a "secure job with prospects".

I left secondary education in 1971 without any qualifications knowing that I could work at Prestwich Hospital as a messenger at the age of fifteen and then

at sixteen I could commence as a Cadet Nurse on a programme that would involve attending Bury Technical College. Here I would have an opportunity to undertake three "O" Levels that would provide me with the appropriate educational qualifications to be accepted for nurse training and if successful would lead to me being a Registered Mental Nurse (RMN). I also knew that if I "failed" those exams then I could sit the General Nursing Council (GNC) entrance exam.

My Experience of the Institution

My early experience at the hospital was predominantly negative and there were many times when I felt like leaving. I was still not clear why I stayed. However I learned so much from that negative experience that I could not have achieved the changes I was to later realise in my work without it.

The experiences of working in an "institution" have had a profound effect on me, both personally and professionally and are described below.

My first day as a messenger was spent on a male ward, Ward 7, which introduced me to the institutional world of the "asylum", Prestwich Hospital, where I started to learn how institutions can do more harm than good. The ward housed approximately forty men with a diagnosis of "epilepsy" and who where referred to as "the epileptics". It was as if the people on the wards were some how not "real" human beings and appeared to have no rights.

There were no mixed sex wards in the hospital at that time; in fact the main road into the hospital literally split the hospital in two. The male wards were on the left and the female wards on the right and the two rarely met.

All wards, at that time, were always locked, which made my imagination run riot as the first thing I saw as I entered Ward 7 was a resident being hit by a member of staff which made me wonder who the doors were being locked to protect? (I later learnt that hitting a patient on the back of the neck with an open hand was commonly known as "a neck warmer") The second was a snooker table; it was immaculate! It soon became obvious that the staff had priority of use of the table over the patients. In fact I cannot ever recall seeing any residents use the table. One of my first jobs was to take the score for the Charge Nurse and Deputy Charge Nurse who were arch-rivals on the snooker table.

Meal times, which should have been a pleasant occasion, would often start with the nurse in charge taking their own meal off the dinner trolley. They served themselves first and whoever amongst the staff was a close friend (not everyone was privileged). There was no choice of food, if you didn't like what was on the menu you went hungry.

One of the tasks before the tables could be set for mealtime was for two staff to count the cutlery. Likewise it had to be counted when everyone had finished their meals. This meant that no one could leave the table until the nurse in charge was satisfied that the entire cutlery was accounted for.

The institution dictated at what time patients went to bed and where they slept. This was in an open dormitory ward with no opportunity for privacy and where everyone saw you dress and undress. You were told at what time to go to bed, to get up, what clothes to put on and were given those clothes from a communal stock which included underwear. How degrading to be expected to wear underclothes that had been worn by many other people. There was an expectation that you had a wash and shave before breakfast, which again was in facilities that offered no privacy. You would be woken at seven am for breakfast at eight. Can you imagine forty men waking in a morning needing to have a wash and shave in an hour and using shared razors and soap? I couldn't believe that an institution that should be "caring" for people was doing exactly the opposite. Not only did I find myself powerless to do anything about this, I also felt that through virtue of me taking no action, I was condoning and reinforcing institutional practice and potentially in danger of adopting the same behaviours.

I Am Not Alone

Although I didn't have the necessary "O" Levels to be accepted as a trainee nurse, I successfully passed the General Nursing Council (GNC) entrance exam and commenced nurse training in 1974. I remember working on Farnworth Ward (previously know as Infirmary 3) in approximately 1974. Unbelievably, they changed the wards from numbers to names and the wards were becoming mixed sex. This was an attempt to be less institutional, but in fact was just a cosmetic exercise.

On Farnworth Ward, because the people were elderly and not mobile, the Charge Nurse of the Ward would fill in a request for "comforts" for the patients who were not able to visit the hospital shop. They would basically write a list of items they thought the patients would like from the shop; cigarettes; chocolate; perfume; bubble bath; etc (The money came from the patient's own hospital based bank account). When they were delivered to the ward and before the items were put into their individual lockers a particular Charge Nurse would divide "the spoils" between the staff who was on duty and who could be trusted to keep quiet.

I was horrified when leaving work one evening to be given a brown paper bag by the Charge Nurse, with items for me, mainly cigarettes (I used to smoke at that time). Why did he believe this would be something I would approve of? I realised whilst writing this thesis that this was my first overt challenge to the system. The charge nurse was bewildered when I told him that I didn't want them and didn't think it was right to take what didn't belong to me. He really thought it was "a perk", a "right" to do so. I am not sure what happened after that but he was more than cool towards me and suddenly there was no overtime available. It could have been my paranoia but some of his friends also appeared to ignore me.

During the summer holidays the hospital used to employ part-time staff from the local teacher training college. There was a student on this particular ward who I became good friends with. I remember going out one Friday night and we ended up talking about work. As the night went on I discovered that he was also troubled about his experience of working at the hospital. It was incredibly

liberating being able to hear his concerns and for the first time feeling alright to share my personal thoughts and experiences with another person and hearing their response, a response that confirmed my own experience. It felt wonderful to know that it wasn't just me. That realisation contributed in re energising my resolve to continue my training and strive to improve things. I am not sure what that meant at the time or how I might go about this, but I knew that if I was to continue my training and a career in mental health nursing then I couldn't condone these sorts of practices.

So why did I continue?

One of the major reasons I think I continued with my training was due to the preparation for each clinical placement which was preceded by six weeks in the classroom at the School of Nursing. The intention was that the theory that was provided in the classroom setting would support my practice in the following clinical placement. Its actual value to me was in providing a baseline for assessing the reality of its application in practice, through asking questions and reflecting on my practice.

It was some eighteen months into my training when I realised that I was constantly being challenged by the experiences of working in an institution and its expectation of me. These negative experiences created a tension between the expectation of being in a caring profession and providing that care within the constraints of an institution. I sensed a mismatch of my personal values, the ethics instilled in me in my nurse training and the expectation of the institution.

At this point I was half way through my training, and I had gone past the point of no return and felt sure that I could continue for another eighteen months. The lack of alternative employment options was also a great leveller that spurred me on. And so on the 28th March 1977 I qualified as a "Registered Mental Nurse" and took up my first qualified nursing post within an acute admission ward. It was quite clear to me that my learning and career in the NHS had really only just begun.

A Profile of My Roles in the NHS

Having qualified, I was determined that whatever job I was to undertake it should provide me with an opportunity to make a difference to the lives of the people I was serving. When I look back, most of the jobs I have had almost always gave me an opportunity to influence change and develop new approaches and services and are described in detail in the following pages.

This desire for change was driven by the negative experiences in my early days and reinforced with positive experience as a nurse as I progressed into numerous posts in the NHS that allowed me to influence change. A full employment profile can be found in **Appendix 1.** The conscious action for change began with my first post as Acting Charge Nurse and through the following jobs.

Nursing Officer Rochdale Health Authority – 15/6/1981 to 5/1/86

This was my first managers' post and my first job outside of Prestwich Hospital. Here I experienced the difference in the provision of mental health care in the

context of a District General Hospital (DGH) from that of one based in a dedicated mental health hospital. These differences centred on competing resources as the mental health unit at the DGH was considered a Cinderella service when competing for resources with medical, surgical, paediatric services etc. There wasn't the same commitment to mental health service provision as experienced whilst working in a dedicated mental health organisation.

In this post I was responsible for all the Nursing staff on both day and night duty and the development of a completely new service, both residential and day care provision for the elderly. This provided the opportunity to recruit new staff to assist in shaping the philosophy and operation policy of these new services. This post gave me the opportunity to use my experiences to improve health care provision across a number of clinical areas, both inpatient and day care services. After two years I became responsible for all the services for elderly people and for the adult acute services, expanding my area of influence further.

Salford Area Health Authority

Assistant Director of Night Nursing Services – 6/1/1986 to 3/4/1988

This post was one of only four Assistant Director of Nursing posts in the Mental Health Services provided by the Salford Area Health Authority. I was responsible for all the night nursing services in the Trust. These services were spread geographically across Salford on approximately twenty four sites and covered all the night services that were managed by the other three Assistant Directors during the day time. They were as follows;

- Assistant Director of Nursing for Acute Services

- Assistant Director of Nursing for Rehabilitation Services
- Assistant Director of Nursing for Regional Specialty Services.

The main focus of this post was to integrate the day and night services through the internal rotation of staff from day duty to night duty and vice versa along with the development and appointment of Ward Managers. The Ward Manager would be responsible for managing the total resources available over twenty four hours to ensure a consistent approach to care and taking responsibility for personal and professional development of the staff team.

This was a major challenge as a significant number of staff had become clinically and professionally isolated over the years and were often reluctant to move due to the financial enhancements paid for unsociable hours which were negotiated by a strong trade union. They became reliant on this income which could not be matched by comparable posts on day duty.

Salford Area Health Authority

Manpower and Service Development Officer – 4/4/1988 to 31/12/1989

My next challenge was as Manpower and Service Development Officer and a member of the "Relocation Now" project team (Sang, 1988). This was the name of the project that was an essential part of a strategy to vacate a specific piece of land (on the Prestwich Hospital Site). This site was sold to a property developer and the revenue used to provide modern purpose built services for Salford people in Salford.

I was responsible for providing advice to the project Director and Project Teams on service requirements, service delivery and professional standards for individual schemes. I was also responsible for the staffing requirements for each element of the programme, formulating manpower plans and forecasting staff changes and redeployment programmes. I also assisted in the determination of training programmes and liaising with colleagues in other districts and the Regional Health Authority on manpower planning issues.

Salford Area Health Authority

Service Manager – 1/1/1990 to 27/4/1994

With the advent of General Management in the Health Service my next post was Service Manager Rehabilitation Services and I became responsible not just for nursing staff but also for all the allied health professionals, administrative and clerical staff. My main responsibility was to ensure that the contraction and closure of the historic long stay services was managed efficiently and effectively, paying attention to the maintenance and improvement of quality during this period.

This post has probably been my most challenging. It required me to close the whole of the historical long stay services through the development of appropriate services for each individual long stay resident, some 1000 in total, most of whom were resettled into a community setting. This required me to ensure that staff affected by the contraction and ultimate closure of the services were redeployed into appropriate posts. The relocation of patients into new services and the redeployment of staff required a detailed ward closure programme that would release revenue to fund the new services. This

managerial post came to an end on the 27th April 1994 as a result of the successful reprovision of services and closure of the long stay services. This achievement resulted in resettling people from an old run-down mental institution into more appropriate accommodation and clinical support across the geographical area of the North West. This was the closure of those services in the institution that I entered at the age of 15 in 1971. Although this was an amazing achievement, I still believed that there was so much more work needed to address the responsiveness of services in meeting the individual needs of people who experience emotional distress and mental health problems.

During this time I was given additional responsibility for the management of the Salford District based Rehabilitation Services and the development and implementation of an employment and training strategy for people with mental health problems. This was from 1/4/1992 to 27/4/1994.

Mental Health Services of Salford NHS Trust

Director of Service Developments (Capital Projects) - 28/4/1994 to 31/3/1995

In April 1994, Prestwich Hospital ceased to be managed by Salford Health Authority and became a Mental Health NHS Trust (Mental Health Services of Salford NHS Mental Health Trust). My next post was as Director of Service Developments (Capital Projects). I was responsible for coordinating service planning and assisting in the planning and design of all capital programmes.

This involved me working with different clinical services across the Trust, facilitating the clinical teams through a process of identifying a preferred solution to the service consequences of a building problem by using a prescribed process outlined in the “Capital Investment Manual”. The “Capital Investment Manual” described an explicit process and procedure for securing revenue for capital developments and was introduced by the NHS Executive. (DOH, 1994)

One of those projects was to move elderly acute admission services from the Prestwich site into Salford, so services could be more easily accessed. Clinical teams often had a solution in their own minds to that building problem. My role was to ensure that the teams explored a range of options from doing nothing right through to a new build managed by the Trust, with different options in between i.e. tender the service out to other providers, use vacant accommodation elsewhere, develop partnerships with the independent and private sector etc.

What Next

Although successful in that work as a member of the Capital Project Team (securing £7.8m for five capital projects) I found myself for the first time in my career involved in work that I had not initiated, wasn’t one hundred percent committed to and wondered how I might take control of my future direction given my background, experiences and emerging aspirations. Having never been unemployed and still believing I had a great deal to offer, I concluded that I needed to broaden my then 23 years experience in the NHS.

I had to prepare myself for my next post, which might or might not be within the current organisation. In anticipation I realised that I needed to expand my experience to include community based work and improve my educational qualifications. Having a degree was an essential educational criterion for comparable senior management posts. I had completed my first step for moving forward, that was setting myself two goals:

- Developing experience of community based working (which would have traditionally been within Community Mental Health Teams).
- Obtaining a degree. Which at the time the trend was to "do" an MBA, Master in Business Administration, this filled me with dread.

The dread of "doing an MBA" was fuelled by the recollection of my own education both at secondary school and during my first and only year of "doing" a "Nursing Diploma" at the University of Salford. My memory of that time was one of having information thrown at me, and an expectation that I was to remember the information and regurgitate it when I was to be tested on it. It seemed to have no relevance to my work or practice.

I achieved those two goals as a result of a personal journey, a journey that wasn't planned, and that commenced with an emergent partnership with North West Mind (a mental health charity) and a growing relationship with action learning and research at the Revans Centre for Action Learning and Research at the University of Salford. These relationships are expanded further in the following chapter. Both these experiences provided me with the foundation for my research (MSc) (April 1995 to 1998) and a new role (Director of Service

Development) in the Trust that led me to the developing further community based projects and a range of exciting opportunities for learning.

Mental Health Services of Salford NHS Trust

Director of Service Development – 1/4/1995 to 5/9/1999

Accountable to the Chief Executive I was responsible for the strategic management of specific developing services, ensuring effective operational management of them and that they met agreed service objectives and consistently achieved standards of best practice. This new role grew over the next few years and was influenced and shaped incrementally as I worked on new projects.

This post as Director of Service Development required me to facilitate a number of agreed community based projects (focused on health rather than illness) that commenced with the Creative Living Centre, a mental health Healthy Living Centre and progressed to developing the Angel Healthy Living Centre on behalf of Salford and Trafford Health Authority and in partnership with the communities of Trinity, Islington and Greengate and Salford City Council. This project provided an opportunity to build on the work of the Creative Living Centre and integrate a range of mental health promoting activities in a none stigmatising environment.

Building on this work the Chief Executive of the Trust and the Director of Salford Social Services agreed that I undertake a piece of work to develop a strategy for mental health promoting communities working in partnership with the Community and Social Services Directorate of the Salford City Council (1997).

This approach by the Trust was a clear recognition of the value of my work and my approach to it, and was reinforced at a Trust Board meeting. The Trust Board meeting reported that:

> "The development of a city wide strategy for the promotion of positive mental health in individuals and communities will require an understanding of the needs of communities as they are developed and reflected in the Community and Social Services Directorate, the City Council's service delivery areas and their community action plans.
>
> An evolving approach will require the development of strong links across Salford, which will be initiated by an induction programme that will provide a strategic overview of the Community and Social Services Directorate; its Community Affairs Division and the communities of Salford.
>
> This activity would be consistent with and complement further work (should the Health Authority so decide) in developing the opportunities for a community focused initiative, which grows out of the earlier thinking about a Primary Health Care Resource Centre in Trinity. This would be a further opportunity to test out models of partnership in the development of healthy alliances reflecting the Health Authority and Community strategies."
> (Mental Health Services of Salford NHS Trust and City of Salford Community and Social Services Directorate, 1997, pg4)

The Trust board formally approved this work in 1997 and the Trust Board paper outlining the full proposals can be found in **Appendix 2**.

This work progressed for two years, and during that time I developed an understanding of the value and importance of community health development and the value of involving and supporting local people both individually and collectively in influencing and promoting positive mental health promotion within their own communities.

Bolton, Salford and Trafford Mental Health NHS Trust

Service Director (Developments) – 6/9/1999 to 4/1/2004

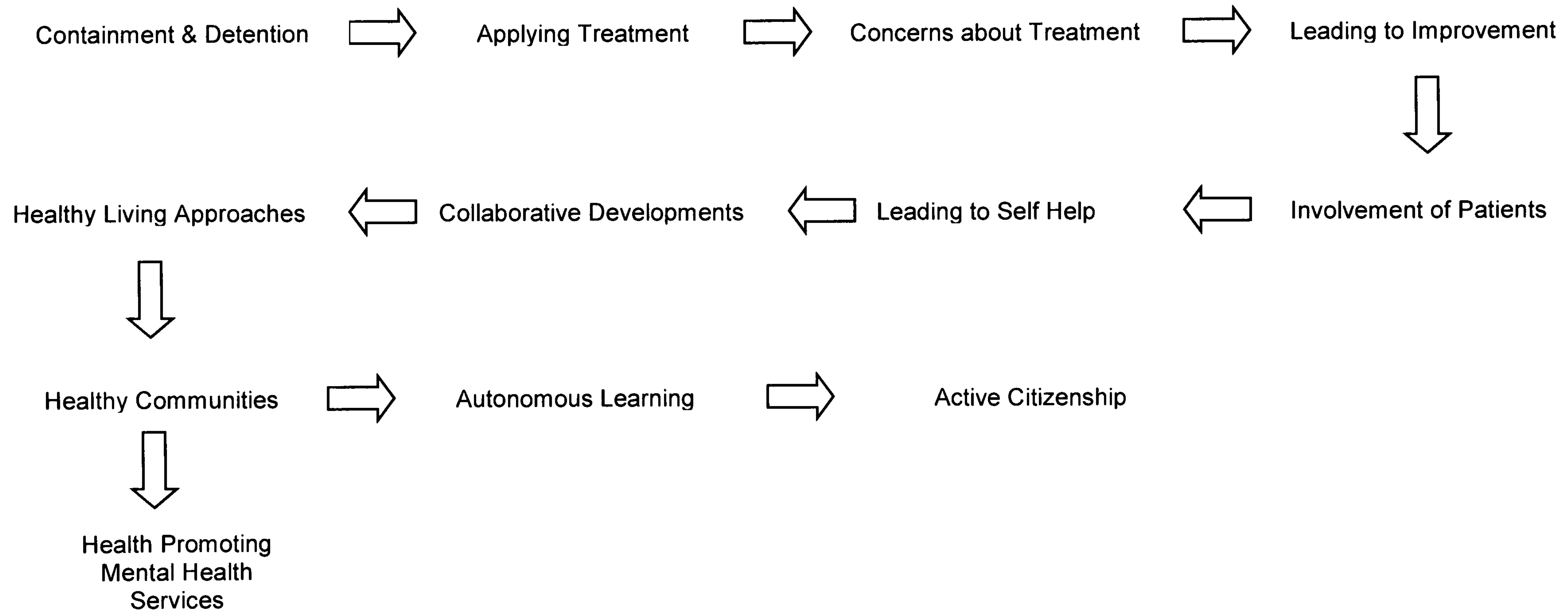
In April 1999 during a discussion reviewing my performance, I discussed with the Chief Executive of the Trust the importance of formalising the work that had developed from my understanding about mental health promoting communities and consequently agreed a new job description that was explicit about the new aspects of my role. See **Appendix 3** for further information. I was now Service Director (Developments) and also had a place at the Trust Board giving me an opportunity to influence the wider mental health agenda of the Trust. As the Service Director (Developments) my role now was to:

> "Initiate, develop and strengthen partnership working with local authorities, local service providers, neighbouring health authorities and local people. Building on the capacity of those people and their organisations in order to respond to identified mental health promoting activities, and other opportunities as identified by the Trust."
> (Mental Health Services of Salford Mental Health NHS Trust, 1999, pg1.)

The following flow chart **Figure 1** shows the evolution of my personal journey highlighting how my thinking has developed. It starts with my early experiences of the institution which appeared to me to contain and detain people. With the application of treatments came my concerns about the limitation of treatments leading me to think about opportunities for service improvements that involve patients. This service improvement was essentially promoting self help approaches and then the value of working collaboratively with patients and other providers. Through collaborative working I then developed a number of healthy living approaches which prompted me to understand the components of mental health promoting communities. Expanding this further I have developed my experience in supporting healthy community initiatives. This included the development of health promoting activities that impact on people's mental

health. The main focus to emerge from this work was to support people to learn how to manage an aspect of their lives they want to change. This used an action learning approach and influenced my thinking about using this approach for both patients and the public. The following Chapter provides the reader with more detail related to this personal journey.

Figure 1.



Section 2

This section provides the reader with an account of three critical work based experiences that provided me with new experiences that were a catalyst for change, both for me personally, my work based practice, and the Trust.

Although the context of my critical work based experiences are described in the next three chapters it is important for the reader to understand that these learning experience occurred almost simultaneously. For the purpose of this thesis it is necessary to describe them separately as the emergence of the experience was complex and not linear.

The section contains Chapters 3 which explains my new understanding for engaging patients and the public.

Chapter 4 describes the mental health and social care policy context of this work and Chapter 5 describes how my role changed as a consequence of these experiences.

Chapter 3
A New Understanding In Practice

This Chapter describes the experience of developing an innovative community based project (Creative Living Centre) which provided the foundation for learning and understanding the emerging challenges to my practice as Service Director (Developments).

It also provides an account of each of the subsequent projects that followed and built incrementally on the additional experience and learning arising from each new project.

This Chapter also explains the rationale for undertaking an MSc by action learning and research and how it augmented my learning.

It describes my experience, learning and understanding in the importance of working with patients and the public. It also provides an insight into how my practice has changed as a result of working with individual service users through to whole communities and then with members of the public.

The Chapter explains the challenges of trying to develop an empowering approach that supports people with mental health problems in identifying their own needs and making an informed choice about how they might best meet those needs. It draws a comparison with the relationship between the behaviour required to empower people with mental health problems and the behaviour required to use an action learning approach to finding solutions to resolving work based problems.

It also documents the achievements and challenges in trying to influence these new ways of working whilst undertaking my role as Service Director (Developments). Those many challenges acted as a powerful driver for me to be able to articulate the value of this work in mainstream mental health provision. Undertaking the doctoral programme was the process for understanding this further.

This Chapter then also presents the development of my research theme.

In the previous chapter I explained my experiences of working in mental health, both my early experiences and subsequent roles that I have undertaken. Although I am able to demonstrate the many changes I have been able to affect, these changes have occurred with little or no involvement from the people who would be using those services. I now know that although I then worked with integrity this was influenced by my professional background and a culture that the "NHS knows best."

This Chapter is important as the experience of developing the Creative Living Centre had a profound affect on me personally and my work, and provided the foundation for further personal change in me and my practice.

What follows is an overview of the projects and the milestones that were influential in my journey. These key milestones were:

- The Creative Living Centre – October 1994 to September 2004.
- MSc by Action Learning and Research – April 1995 to March 1998.

- Webb House Democratic Therapeutic Community – September 1996 to September 2000.
- Angel Healthy Living Project – September 1997 to September 2000.
- Mental Health Promoting Communities – 1997 to 2000.
- Manchester, Salford and Trafford Health Action Zone – January 1999 to March 2000.
- Social Action Research Project (S.A.R.P.) – January 1999 to March 2002.
- Real lives, Real People – Millennium Awards Scheme March 2000 to June 2003.

These experiences informed my belief that local people given the appropriate support could make a difference to their lives promoting individually their inclusion and positive mental health and collectively that of their community. This support was achieved through using an action learning approach. The journey begins with the Creative Living Centre the detail of which is captured in "Managing without Shoes" a MSc thesis (Young, 1998a) which provides a detail account of the experiences in that journey.

The Creative Living Centre – October 1994 to September 2004

In January 1995 I was involved in a process to explore in partnership with Mind (a national mental health charity) the germ of an idea to develop what is now known as the Creative Living Centre.

The idea for a Centre developed from a Mind survey of mental health service users. The survey indicated that the majority of mental health service users wanted more choices of response to their distress (Mind, 1994).
North West Mind facilitated an envisioning process with a group, which included mental health service users and creative therapists. This process created a vision that led to the development of a different model for meeting the needs of some mental health service users.

The vision was to create an environment where people are approached as individuals with mind, body and spirit. It acknowledges that everyone has the ability to realise more of their hidden potential and define their own needs as part of a process towards taking responsibility for themselves.

A partnership with the Trust and Mind North West developed a core project group to realise this vision. I was the representative from the Trust. The pilot project group started with the aim of developing the culture and the philosophy of the centre and realising the vision.

The Creative Living Centre is now a thriving community based project for people with experience of emotional distress and mental health problems and became a registered Charity and Company Limited by guarantee in September 1997.

It provides a person-centred holistic approach to people experiencing emotional distress/mental health problems. Central to the work of the Centre is the recognition that the physical, mental, emotional and spiritual aspects of a

person all contribute to a person's well-being. People attending can choose from a wide variety of activities to improve and support their well-being. These services are as follows;

Individual Therapies

These include, acupuncture, counselling, flower remedies, homeopathy, massage, reflexology.

Therapeutic Groups

These include music and creative movement.

Creative Art Classes

These include watercolours, art for well-being, ceramics, design and decorating, samba drumming, creative gardening and garden maintenance.

Self-Help Skills

This includes yoga, qi qong, self-healing, and relaxation.

Social Support

This includes open space facility to socialise and develop friendships and support networks, evening self–help support group, Saturday evening art focused club, and shared meals to promote healthy eating.

Miscellaneous

This includes quiet space, an organic allotment and garden, community café, information and advice.

In this way people become actively involved in improving their well-being. The range of activities available enables them to find their own starting point, selecting the most appropriate support that meets their needs.

As part of the project's development it was important to think about what it means to provide support in a way that ensures that people who access the services are not passive recipients of care and that our actions are not disempowering. This is important as medical responses often encourage passivity and resignation to the "illness" diagnosed, and the associated prescribed drugs often have a debilitating effect. People with mental health problems are more often concerned with managing the impact of their mental health on their daily living.

Whilst developing the Creative Living Centre I found I was spending some eighty percent of my time on the project. During a meeting at the Creative Living Centre I remember thinking that "I didn't feel at work". This felt good and I thought how wonderful it would be to always not feel at work. I started to question why? Although I was not able to immediately answer the question I felt that the answer lay with the people I was working with and the relationship we had with each other. I recorded in my journal (Young, 1996, January 25th & 26th):

- How comfortable we felt in each others presence;
- How we trusted each other;
- How we became open and honest with each other;
- How despite coming from different backgrounds and starting points we were able to value each other's contribution to the projects development;

- How we listened to each other;
- How we challenged and questioned with a need to understand without being critical or interrogating each other;
- How we are caring and sharing;
- How we are not competitive.

This helped me to discover that:

- We have developed creative ways of doing things;
- We have developed a "can do" culture;
- We are not frightened of pushing the boundaries of our thinking and doing;
- We are learning to be creative and innovative.

I have also learned from various roles whilst a Trustee, working as Treasurer and more recently Chairman. These experiences also introduced me to the world of the voluntary sector that appeared to be better at working and engaging with local people and communities and this seemed to be reflected in the services they provided. My initial impression was that they also appeared to benefit from not having the same bureaucratic constraints of public sector organisations. However it soon became clear that they were increasingly expected to develop systems for governance arrangements.

As we started to explore and understand how to implement a model that empowered people using the services at CLC, it became clear that the relationship required to deliver this model was the same relationship, underpinning the partnership developing the CLC and that experienced as a member of an action learning set. These experiences provided the foundation

for further enquiry that was to further enable my understanding and knowledge of action learning and research.

As part of this learning process I discovered that in my role as Service Director (Developments) I didn't engage the people for whom I was planning and developing the services for. In fact the way I worked was disempowering.

Central to the project's development was the understanding that the purpose of this new service was to:

1. Support people experiencing emotional distress/mental health problems in a way that allows them to identify their own needs, and that
2. In doing so they are supported to make an informed choice as to how those needs would be best met.

This was easy to say, but it required us to be clear about what that meant in practice. At every stage of the project's development it required us to be clear about our own behaviour so that we did not behave in a way that was disempowering. The process for achieving this clarity was one of reflecting on the decisions made at the core group meetings (this group was responsible for progressing the vision of the project) along with questions to ensure that the outcomes of our decisions were consistent with the philosophy of the project.

One of the significant learning points arising from the project's development was how people using the centre were able to clearly articulate their needs. Those needs were often not articulated in health terms, they were expressed as they related to an aspect of their "lived experience" that became disrupted as a

consequence of their distress, e.g. not sleeping, not eating, no concentration, housing, environment, employment and financial problems etc.

From this experience I learned how to engage patients and the public in a way that ensures services take full account of what people who use those services say they need and want. This experience came from me being consciously aware about the way I developed a relationship with people who used the services available at the Centre and reflecting on my experiences at Core Group meetings. This helped me to develop new skills, and offered new insights that helped me progress and develop these skills. These experiences challenged me in many ways from learning to listen and hear what local people said and hearing them say it in a way that was sometimes blunt and uncomfortable.

Action Learning and Research – April 1995 to March 1998

In April 1995 I enrolled at the Revans Centre for Action Learning and Research to undertake a diploma with the intention of converting to an MSc. The need to undertake this programme was in response to realising that my post as Service Manager was coming to an end. I had to widen my experience of mental health (which was mainly hospital based) to include community experience and if I was to apply for another post then I would require a degree which was considered to be essential educational criteria for comparable posts. I didn't realise at the time, but the Creative Living Centre development was to provide me with the community experience I required, though clearly not in a traditional sense.

The action learning programme at the Revans Centre provided me with the opportunity to evaluate the project's development and to make sense of these new experiences.

Not only was I able to learn from the reflection of taking personal responsibility as a set member on the action learning programme, I was also learning from the process of the partnership developed with Mind.

I was also able to observe, witness, and compare how members attending the Creative Living Centre, (CLC) through being supported to take responsibility were able to make a significant impact on their lives, e.g. increase in confidence and personal control in their lives, and a reduction in the dependence on other treatments

Action learning at this stage was a new experience. I was some twelve months into the programme and I remember thinking, *"When is this action learning"* going to happen and "when will I know?" In my MSc thesis I commented

> "I still waited for us to "Action Learn". I wondered when we were going to be supervised, when and how would the Revans Centre help us to get started? It was at this point that I realised that I was waiting for others to help me, both members of the set and the Centre. I realised that I could either wait for something to happen or I could usefully contribute to making something happen."
> (Young, 1998b Pg107)

It was this stark realisation that was the next milestone that motivated me to take action and ask the question "what does taking responsibility mean". What do I need to do differently if I am to take responsibility and support others to do so? Where do I start? Asking the question I was able to reflect on my

experience of developing the Creative Living Centre and the emergent similarities of developing an empowering approach for people using the centre.

Webb House Democratic Therapeutic Community – September 1996 to September 2000

In August 1996 I was asked to project manage this exciting residential and Outreach service where people who are there to receive treatment would live and manage their community together.

The service was a Democratic Therapeutic Community (DTC), which was designed to help people with emotional, and relationship problems through working together in a structured environment.

It was part of a National Specialist Democratic Therapeutic (DTC) Community Service. It, and a similar service in South Birmingham, was funded by the National Specialist Commissioning Advisory Group of the Department of Health, based on the successful Henderson Hospital in Sutton, London. (Young, 1996).

It was a specialist treatment approach, which included high levels of client participation and responsibility, group psychotherapy, a 24 hour "living and learning experience", a structured daily programme with clear boundaries and multi-disciplinary team work to facilitate the therapeutic process. No psychotropic medication was used. Residents would work with each other and with staff to run the service. The proper functioning of the unit depended upon their active participation. Responsibilities of residents include chairing community meetings, organising support for one another and ordering and

preparing food. The democratic style meant that the community itself has an important decision making function. The democratic nature of the community was illustrated daily in the community meetings where decisions about the service were made by voting in the meeting. For many people, this was the first time their views and thoughts have been taken seriously and the first time they have been given the opportunity to discuss the feelings behind their actions.

There was also an Outreach Service, which prepared prospective residents prior to their stay at Webb House and supported them after they left. The Outreach Service worked in conjunction with local services with a "shared care" model and provided supervision, consultation and training.

The service was for men and women (17 to 45 years) who have serious emotional, relationship and behavioural difficulties. Often such individuals would have attracted the diagnosis of personality disorder or been labelled pejoratively "heart-sink", "difficult to place", and "untreatable".

They may present with alcohol and illicit drug misuse, eating disorders, mood disorders, and other psychological symptoms. The difficulties may be expressed interpersonally or behaviourally through deliberate self harm, overdosing and a range of impulsive and criminal acts. Many will have experienced severe emotional, physical or sexual abuse in their early lives. Many will have had repeated contact with a range of services without substantial or lasting benefit.

Residents cannot be at Webb House as a condition of their probation or parole, or when a court case is pending, so entry to Webb House might be delayed until the outcome of a court case was known. Residents must be drug and medication free to begin treatment. The Outreach Team can work with prospective residents to help them come off illicit and prescribed drugs. The service aimed to be accessible to people from all ethnic and social backgrounds.

As the project manager for this service development this experience broadened my awareness of how service users can also support each other in a way that provides insight into their behaviours and the opportunities this provided for learning to learn how to change/manage their behaviours.

Angel Healthy Living Project – September 1997 to September 2000

As a direct result of developing the Creative Living Centre I was asked by Salford and Trafford Health Authority to project manage the development of a Primary Health Care Resource Centre (PHCRC). Learning from the experience of developing the Creative Living Centre, I spent the first six weeks meeting individually with the major stakeholders which revealed that there was not a need for this project. However having spoken to local people from the communities of Trinity, Islington and Greengate, I was able to establish that there was a need for a range of services that responded to their needs as they articulated them. Although these services were not traditional health services, they were services that would have an impact on their health and well-being. An idea that emerged from this work was that of developing a healthy living initiative that was developed with the people for whom it was intended for.

This shift from a Primary Health Care Resource Centre (PHCRC) to a healthy living initiative required approval from the Salford and Trafford Health Authority, and this was given following the meeting held on the 23rd July 1998. This approval represented a significant shift from developing a PHCRC which was shaped by health care professionals, to one of developing a Healthy Living Centre that was shaped by what local people said they needed. This centre was now known as the Angel Healthy Living Initiative and provided me with experiences in engaging communities and the idea that was to be the next milestone in my journey.

Project managing the Angel Healthy Living Initiative gave me the opportunity to combine my learning from the development of the Creative Living Centre and my relationship with action learning. Using an action learning approach helped me to encourage the communities of Trinity, Islington and Greengate to take responsibility for shaping; developing and managing this community centred healthy living initiative. This occurred through asking specific questions at community based meetings from each of the communities. These questions were;

1. What services have been taken away from the area?
2. What is it that you need?

Following three consultation meetings a long list of needs and wants was created and from this a number of working groups identified and led by both local people and representatives from health and the local authority. They were given the following tasks to undertake, through group work as follows:

Project Planning and Development Group

Consider options for integrating existing community groups into an overall strategy, balancing the options against the philosophy of the project, the building and financial constraints.

Community Consultation Group

Develop strategies for extending the consultation process, for ownership and management of the building, and for communication. Identify core community resources. Develop options for coordination of the centres activities, for engaging schools and the link to the local regeneration of Chapel Street.

Employment and Training

Explore options for skill sharing, training, education, employment issues, and a transitional employment project.

Information Services

Develop ideas for a one stop shop, diary of events and general information services.

Health, Well-being and Complementary Therapy Provision

Explore options for support groups, well person clinics, district nursing, health visiting clinics, baby/family –planning clinics, exercise provision, dietary advice, first aid provision, complementary therapies, befriending activities, playgroups.

Carers Centre

Develop a project brief based on the profile of service requirements.

Community Café and Food Cooperative

Develop a project brief to include, options for a food cooperative, considering options for offering a nutritional advice service and funding opportunities.

As the various activities progressed "mental health promoting activities" developed as an integral part of a general health and well-being project. It became evident that this work had a potential contribution to reducing the stigma associated with "mental health." The Angel opened on the 3rd December 1999 and was celebrated with a community event.

Mental Health Promoting Communities – 1997 to 2000

This work arose from the recognition of the innovative work that was being undertaken with the development of the Creative Living Centre and the Angel. In discussion with the Trust's Chief Executive and the Director of Social Services at Salford City Council, I was asked to work in partnership with representatives from the Community and Social Services Directorate to develop a strategy for mental health promoting communities. Approval to undertake this work was obtained by the Trust Board in July 1997. The discussion paper for the Trust Board can be found in **Appendix 2**.

This approval provided the opportunity to build on the learning from the Creative Living Centre and the Angel and to support the work with the Community and Social Services of the Salford City Council looking at opportunities for developing mental health promoting communities and social inclusion. Whilst working with the Community and Social Services Directorate of Salford City Council I gained new experiences which added to and complemented my work

by expanding my understanding of how to influence mental health promoting communities. Some of the experiences are as follows:

- Member of the Chapel Street Regeneration Project Group;
- Chaired the SRB 5Health Group;
- Member of the Salford Cathedral Day Centre management committee (homeless project);
- Member of Salford City Council's Capacity Releasing Strategy Steering Group;
- The development and implementation of a City wide strategy for the provision of employment and training initiatives;
- The development and integration of the Creative Living Centre within mainstream services;
- Integration of the Angel Healthy Living Initiative with the Chapel Street Regeneration Project and the priorities of Salford East Primary Care Group;
- Involved in the development and implementation of the Social Action Research Project (SARP) looking at the implication of Social Capital in four communities across Salford;
- Supporting the development and contributing to the Salford School for Social Entrepreneurs through providing the action learning programme;
- Recruitment and employment of a mental health community development worker through the Cheetham and Broughton Regeneration Scheme, looking at social inclusion of young people;
- Active involvement with Mind Mental Health Charity involved in their social inclusion working group, and the development of national quality standards for employment and training;

- Director for the Centre for Community Learning at the Revans Centre for Action Learning and Research at the University of Salford.

All these developments and activities are a consequence of growing a network and relationships with a wide range of partners that are able to understand the principals of engaging with local people, and actually striving to work in this way. Each of those developments provided me with new opportunities for learning.

Manchester, Salford and Trafford Health Action Zone – January 1999 to March 2000

Health Action Zones (HAZ) were set up by the Department of Health to deliver better outcomes across a wide range of high profile issues. The vision for a Health Action Zone for Manchester, Salford and Trafford was to improve the health of its residents by focusing on whole communities, addressing the needs of those groups who are socially excluded and reducing inequalities in health care. The purpose of the Health Action Zone was to:

- work in partnership with local people so they have a real opportunity to influence the policies and services which affect their health;
- break down the barriers between statutory agencies to create genuinely integrated services;
- develop a strong health focus in all areas of public policy;
- develop more public and private sector partnerships;
- focus on the needs of vulnerable groups, particularly to address the health problems associated with social exclusion;

- deliver measurable and sustainable improvements in the health of whole communities;
- emphasize prevention and earlier intervention.

(Health Action Zone, 1998a, Pg2)

In January 1999 I was appointed as an Associate Director of the Health Action Zone. This provided me with the opportunity to use my experience in developing community based healthy living initiatives across a larger geographical area and to also learn from the other partners. In my role as Associate Director of the HAZ I became involved in supporting the programmes of the zone with a specific involvement in the development of the Community Programme and leading on healthy living initiatives.

Social Action Research Project (S.A.R.P.) – January 1999 to March 2002

This was a three year action research programme funded by the Health Development Agency (previously the Health Education Authority) (HEA, 1999). This was in partnership with the Salford and Trafford Health Authority, Salford City Council and the University of Salford and people living in Salford (Popay, 1999). It started in January 1999 and was completed in March 2002. We were one of two demonstration sites - the other being in Nottingham.

The study in the two sites explored the relationship between "Social Capital" and health and well being; exploring whether "social capital" can be increased and if so how. The project aimed to tackle inequalities in health by strengthening communities through initiatives that aimed to support the development of social capital.

This project was researched independently and the process evaluation was undertaken by Keele University along with an independent outcome evaluation (Popay and Picken, 1999).

I was member of the original panel that put the bid together and a member of the Steering Group.

The SARP project worked to empower local people and their communities to take responsibility for their communities. At the same time it was challenging the statutory sector to support them in their work.

The SARP project appointed four local people as Social Action Coordinators to work in their communities and become involved in activities to improve the quality of life. As part of that work I supported one of the Social Action Coordinators through a system of "buddying", his work was in the communities of the Angel Healthy Living initiative, integrating the ideas arising from working with local people into the agenda of the healthy living initiative.

A key requirement of the project in its final year was to promote organisational and community learning in the key agencies in particular:

- Salford and Trafford Health Authority;
- Salford Primary Care Trust;
- Mental Health Services of Salford NHS Trust;
- Salford City Council;
- Local Communities;
- Voluntary Sector.

Funding was committed by the Salford Social Action Research Project to support three action learning sets (18 people) to explore how to:

- Ensure that the knowledge, values, beliefs and interests of local people are integrated into their work;
- Link public policy and the work of the organisations more effectively to the skills and energies of local people.

Real lives, Real People – Millennium Awards Scheme March 2000 to June 2003

As a result of the initial partnership with Mind (Creative Living Centre), I became actively involved with a number of Minds activities and became a Trustee of Mind in December 2001. Having been a member of a previous award panel, I was approached to be the Chairmen of Mind's Real Lives, Real People grant giving panel, which was supported by the Trust. The panel awarded grants to over 300 people with mental health needs to enable them to access personal training and development opportunities that would benefit them and their local community. Funded by the Millennium Commission a total of £1.1m was distributed over the three years of the scheme. These small investments have significantly changed the lives of people who have benefited from the grants. Two examples of the award winner's projects are provided below:

Award Winner 1 – Project Better Self-Esteem

This award winner had undertaken six months of voluntary work in black and ethnic minority communities on mental health related issues, and took the opportunity to set up her own self-help project involving various ethnic community groups in London. Focusing on Afro-Caribbean men who

experience depression but are reluctant to seek assistance, the award winner was aware that she needed to begin by tackling the stigma attached to mental distress. The sessions she provided sought to define, address and offer practical advice on how to deal with the problems faced by the individuals.

Training

The award winner trained for a mental health diploma, covering topics such as working with depression and emotions, suicidal tendencies, distress, anger, active listening and client and self-support.

Award Winner 2 – Project Organic vegetables and Salads

The award winner's community benefit aspect of this project involved the award winner using his new skills to grow his own crops. He obtained an allotment, which he maintained on a daily basis, growing his own crops for the purpose of giving them to vulnerable or less affluent members of the community. In particular, he grew organic potatoes, carrots, beetroots and onions. He also set up a gardening group at the local hospital using their greenhouse and a patch of land.

Training

The award winner learned more about growing organic fruit and vegetables through a short course at Walford College. He also had independent tuition in different forms of horticulture enabling him to learn about different types of crops and raising his awareness of their similarities and differences.

A flow chart outlining my experience of the relationship of mental illness to mental health and the growth of my community experiences is shown in **Figure 2** at the end of the Chapter.

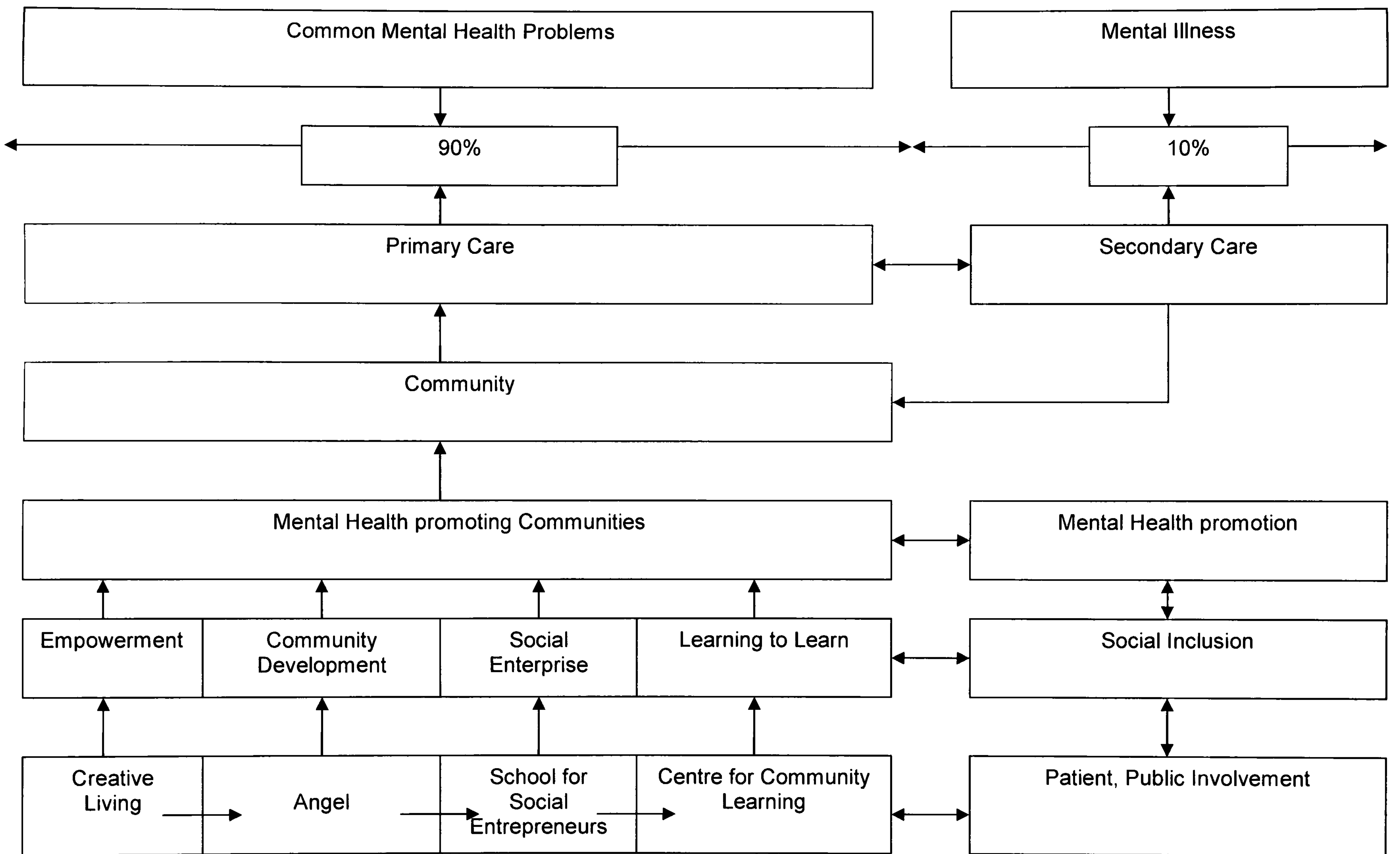
The right hand section is concerned with mental illness where only 10% of people with mental health problems will need to use these services and is referred to as Secondary Care. The link to primary care provision and community represents support for patients when discharged from Secondary Services.

The left hand section represents my move into community based developments where 90% of people with mental health problems will receive care or treatment.

My community involvement commences at the bottom left hand side of the chart with the Creative Living Centre through to the Angel, School for Social Entrepreneurs and the Centre for Community Learning. These developments served to influence my thinking regarding mental health promoting communities and community development. Those developments in turn led me to considering them in the context of patient and public involvement, social inclusion and mental health promotion.

The following Chapter provides more detail on how my experiences have influenced this journey.

Figure 2



Chapter 4
Learning in the Context of Health and Social Care Policy

This Chapter describes my experience of working in mental health and specifically my personal review and understanding of the application of policy imperatives that drive mental health reforms and developments within health and social care provision.

It includes how my practice experience influenced my thinking and learning as I explored the development of mental health promoting communities through a range of mental health promotion and social inclusion activities.

It highlights a number of organisational and cultural blocks that I have encountered through my work.

Introduction

In the NHS, local and national priorities have been driven by the need to improve mental health (mental illness) services with a focus on ensuring that those people with a serious and enduring mental illness who are thought to need medical treatment receive it, (Pidd and Newbigging, 2002).

Generally not all secondary health care providers see prevention as their primary responsibility, especially for interventions that are normally implemented by sectors other than health, (Saraceno, 2004a).

Less consideration has been given to issues affecting well-being, such as isolation, loneliness, low self esteem and fear which are often debilitating and have direct effects on people's mental and physical health. Mental health is directly affected by the conditions in which individuals and communities live and interact, as well as by predisposition, (Heer, Woodhead 2002).

Mental health policy focus, debate and the service responses have been predominantly in the context of and concern for people with a mental illness. Of those people with a mental illness only 10% will require access to mainstream mental health services (mental Illness services). The remaining 90% of all people with mental health problems (including 30 to 50 percent of all those with a serious mental illness) will receive their care and support in their local community from a General Practitioner and Primary Care Services, (Kendrick *et al*, 2000).

There is little active work being undertaken to focus on and promote positive mental health or social inclusion for those people who will probably not need to access mainstream mental health services (i.e. those 90% of people with mental health problems who will receive their care from Primary Care services), despite the fact that one in four people will develop a common mental health problem and will be treated by their General Practitioner.

In common with the World Health Organisation "mental health" is referred to as a state that is determined not only by an absence of mental illness, but also, by a sense of well-being. In order to establish critical thought about

promoting mental health and well-being, it is useful to establish a shared understanding of what it is to be mentally healthy and to experience well-being. To date, much of this debate has focused on mental illness rather than mental health, being concerned with conditions such as anxiety, depression and schizophrenia.

The policy context that follows is specific to this piece of research and includes Local Authority and Government policy as well as health policy in recognition of the partnership work required with other agencies if there is to truly be a holistic approach to positive mental health and social inclusion.

The Government has identified four priority areas for action to improve the health of the population: heart disease and stroke; accidents; cancer; and mental health, (DOH, 1999).

Policy Context

The National Service Framework for Mental Health, 1999

The National Health Service Framework (NSF) sets national standards and defines service models for promoting mental health and treating mental illness. This framework when published provided the policy context for legitimising and validating my work in the Trust, (DOH, 1999a). The NSF sets out seven standards:

- **Standard 1** Mental Health Promotion;
- **Standards 2 & 3** Primary care and access to services;
- **Standards 4 & 5** Services for people with severe mental illness;

- **Standard 6** Services for people who are carers for people with mental health problems;
- **Standard 7** Action necessary to achieve targets to reduce suicide.

Standard One of the National Service Framework (NSF) for Mental Health sets out to address mental health promotion and combat the discrimination and social exclusion associated with mental health problems. It specifies that health and social services should:

> - "Promote mental health for all, working with individuals and communities
> - Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion."
>
> (DOH, 1999b, Pg14)

Social Exclusion

The National Service Framework for Mental Health (NSF) also acknowledges that, social exclusion can both cause and come from mental health problems. Initiatives designed to promote social inclusion will all strengthen the promotion of mental health and individual well-being, and reduce discrimination against people with mental health problems. Furthermore it states that:

> "Mental health promotion is most effective when interventions build on social networks, intervene at crucial points in people's lives, and use a combination of methods to:[sic]
> - Individuals- to enhance their psychological well-being
> - Communities- in tackling local factors which undermine mental health."
>
> (DOH, 1999c, Pg15).

Standard One of the framework aims to:

> "Ensure health and social services promote mental health and reduce the discrimination and social inclusion associated with mental health problems"
> (DOH, 1999d, Pg14).

The Social Exclusion Unit at the Cabinet Office sees social exclusion as:

> "A shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environment, bad health and family breakdown"
> (Social Exclusion Unit, 1999, pg3).

From this it is clear that the responsibility for social inclusion cannot be the sole responsibility of Health and Social Services. Tessa Jowell, Minister for Public Health (1998) stated that:

> "Social exclusion is about more than poverty. People who are socially excluded lack the means - material or otherwise - to participate effectively in social, cultural and political life. We need to focus on the interplay of homelessness, crime, drugs, unemployment, local concentrations of social problems and the awful pessimism of feeling that you don't matter, that you have no control over your life and that you are a victim of decisions that other people make on your behalf"
> (Jowell, 1998, pg1)

The ultimate aim of social inclusion therefore is enabling participation in the mainstream of society for all those who desire it.

Health Act 1999, Partnership Arrangements

Section 31 of the Health Act (1999) provided the power for health and local authority partners to work together more effectively and came into force on the 1st April 2000 (DOH, 1999).

Within mental health this provided the opportunity for mental health and social care provision to come together with their staff, resources and management structures. This provided the opportunity for partners from health and local authority service providers to come together to design and deliver services around the needs of users rather than concerning themselves with the boundaries of their organisations.

The NHS Plan – A Plan for Investment, a Plan for Reform, 2000

The NHS plan set out a statutory duty for the NHS to involve and consult the public when planning or changing services (DOH, 2000a).

This became enshrined in the Health and Social Care Act 2001, Department of Health (DOH, 2001a).

Neighbourhood Renewal: National Strategy Action Plan, 2000

The action plan aimed to renew the country's most deprived neighbourhoods and achieve common goals aimed at lowering unemployment and crime, and improving health, education, housing, and environment. The strategy emphasised the need for organisations to come together at a local level engaging with local communities (Social Exclusion Unit, 2000).

"Making It Happen" National Strategy for Mental Health Promotion

"Making it Happen", the national strategy for mental health promotion (DOH 2000a), points out that the implementation of a wide range of policy

programmes through housing, education, employment and regeneration initiatives, may all contribute to promoting positive mental health.

The responsibility for addressing mental health inequalities is with Primary Care Trusts (DOH, Health and Social Care Act 200b). The Primary Care Trusts are responsible for assessing the mental health needs for their local population, and for commissioning services to meet those needs. It is however acknowledged that NHS organisations need to work in partnership with other agencies at a government, community and individual level if they are to have any impact in reducing health inequalities.

Although the policy guidance mentioned above has been useful in providing direction, I have some concern that those policies that give direction to working in partnership either with other agencies or the public didn't necessarily require new policy, with the exception for pooling budgets when integrating mental health and social care provision. This integration of health and social care provision could have been achieved without any legislation, if the will to do so was there.

It is the opportunity to improve people's mental health and well being and increase inclusion through working with local people and communities that is the focus of this research. This has been driven by learning from a number of work based experiences that have shaped my learning and understanding and are described below.

Learning from Practice and Experience

Mental Health (Mental Illness)

The NHS fosters a dependency culture and has been predominantly paternalistic, where patients are passive recipients of care with interventions being carried out on service users by a range of health professionals, with the latter seen very much as the experts. Repper and Perkins state that;

> "As practitioners, we often believe that, because of our professional training, we are better able to understand a person's situation than he/she can. We are the experts and we know best. But unless we acknowledge the expertise that personal experience brings, it is unlikely that we will spend time trying to understand a person's situation from their own perspective."
> (Repper J, Perkins R, 2003a, p21).

This dependency culture is reinforced by the relationship imposed by health professionals who often function within a medical model, i.e. they interpret the way people express their problems (as symptoms) through assessing those symptoms into the context of a diagnostic category in order to diagnose their illness and then prescribe treatment, rather than consider the impact of their mental health problems on their day to day living. Repper and Perkins state that;

> "In our professional quest to remove people's symptoms and problems it is easy to forget that they have lives to lead. Mental health problems are not a full-time occupation, but they can easily take over the whole of your life. It is essential that mental health workers move beyond the narrow goals of symptom relief and problem reduction."
> (Repper J, Perkins R, 2003b, p13)

A cultural shift therefore is required so that the service user is an active participant in their care, and a care that is holistic in nature. This holistic approach is required as mental health is a process and not a static state. People do not wake up one morning and think they need to go to the Doctor

as they think that they have a mental health problem. They often go to their Doctor and articulate the outcome of the impact of their mental health on their day to day life experiences. It may be that their sleep is poor, or they feel that there is no reason for getting up in the morning; they may not be bothered to eat and may be off their food, be impatient and snapping with family members etc. The medical response is often to prescribe medication with no exploration of the total needs of that person.

> "There are two main problems with the medical model. It disregards the meaning of a mental health problem and it also labels persons experiences as abnormal."
> (Thomas, *et al* 1996, pp401-404)

The medical profession has often appeared reluctant to embrace

> "changes, which challenge traditional beliefs of doctors that their skills should be measured by examining the impact of their treatment on symptoms of ill health rather than on whether or not the patient feels they have benefited from the care they receive."
> (Pfifferling 1980, pp197-122).

There is a strong argument for a shift in this culture where people become dependent on the NHS as an illness service, (which prevents people from taking responsibility for their own lives), to one where people are active partners in their health care.

Creating a Patient – Led NHS states there should be an:

> "ambition.....to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health –a fundamental change in our relationships with patients and the public. In other words, to move from a service that does things "to" and "for" its patients, to one which is patient led, where the service works "with" patients to support them with their health needs."
> (DOH, 2005a, Pg3).

Mental Health Promotion

Most of my early mental health promotion work in the Trust was within "mental illness communities". It is important to restate that 90% of people who experience mental health problems will not need to access mainstream mental health services. They may however require varied opportunities for support as the challenges of daily life impact on their well being. There is a need therefore to think creatively about how we can influence the development of a range of mental health promoting activities that impact on individuals and communities.

> "Mental well-being is not just the absence of mental disorder it is a state in which a person is able to fulfil an active functioning role in society, interacting with others and overcoming difficulties without suffering major distress, or abnormal or disturbed behaviour."
> (Donaldson & Donaldson, 1998 pg.320)

Mental health promotion has more often than not been a mental illness agenda offered as a preventative measure for someone who has experienced a mental health problem or illness, with the intention of that intervention preventing a relapse or re occurrence. I believe that the development of positive mental health promotion should be an integral part of promoting health and well being. We should not wait to experience a mental health problem or a mental illness to trigger mental health promotion interventions. We should consider mental health promotion just as we consider general health promotion e.g. smoking cessation, healthy exercise. This requires us to consider activities that are not "mental health" activities, but activities of which the consequences are mental health promoting.

This will require us to consciously consider and refine the language associated with mental illness and mental health if we are to be "mental health promoting" in our work with local people and their communities. The concept of well being rather than mental health could provide us with a basis for promoting positive mental health. In doing so it would also require us to be willing to think and act beyond our traditional boundaries. There is a need to focus on how people can learn to manage the activities of daily living rather than to limit our concern with why people have developed dysfunctional coping systems.

Regeneration

Strengthening neighbourhoods is central to many government initiatives, including regeneration. Neighbourhood regeneration presents a significant challenge to all public agencies. The success of neighbourhood policies must be judged by the experiences of the most deprived residents, including those who experience mental health problems. Poverty, fear and unemployment are associated with poor mental health, so improvements for the whole community can pay dividends for people with mental health problems.

My early observation when working with the Community and Social Services Directorate of the Salford City Council was that regeneration initiatives were excellent at improving the physical environment. But not in working with the same damaged people that were destined to return to those areas or indeed in avoiding damage to others.

> "It has been noticeable that the investment in regeneration schemes has predominantly improved the environmental infrastructure of local communities with too much emphasis to physical and economic regeneration at the expense of social regeneration."
> (Hoggett. *et al*, 1997, pg ii).

More thought and action needs to be given in supporting the social needs of local people to assist them and their communities to realise their individual and collective capacity.

Working in Partnership

The benefit of working in partnership is not a new concept for the NHS, but the continual reminder over the last 25 years or so, of the need to work in partnership suggests that we have not yet discovered what true partnership working means. Why is this, and how would we know if a partnership was successful? Partnerships are a means to an end and not end in themselves, so I return to the question what is it we are trying to achieve?

Working for the Manchester and Trafford Health Action Zone (HAZ) as an Associate Director prompted questions regarding partnership working. Here two Health Authorities (Manchester Health Authority and Salford and Trafford Health Authority) and three local authorities (Manchester, Salford and Trafford Social Services) came together to work in partnership to:

> "Improve the health of its residents by focusing on whole communities, addressing the needs of those groups who are socially excluded and reducing inequalities in health".
> (Health Action Zone, 1998b, Pg2).

I wondered how the partners of the "Health Action Zone Status" would be more motivated to work in partnership. In other words why didn't they come

together to explore opportunities for partnership working anyway given the geographical relationship and cross boundary issues etc? It seemed to me that the same people, who had now publicly pledged to working in partnership together, were the same people who had apparently not been motivated to work in partnership previously.

The reason for partnership working is most often articulated in the need for multi-agency working in a way that crosses traditional organisational boundaries so that the experience of the services delivered is seamless for the service user, and to ensure efficient use of resources. But again this is a means to an end. What are we trying to achieve?

If no one organisation has all the skills to offer to all the people all the time, then an expectation of partnerships may be to utilise the combined skills from the public, private and voluntary sector to provide a more holistic response to meeting the needs of people using our services. To achieve this would require a cultural change within statutory, private and voluntary organisations requiring clarification of each other's role and responsibilities in the provision of health care services. This will require changes in attitudes and relationship of local people and staff from both health and social care provision. If this was achievable and those organisations were able to work in partnership this would allow patients to move through those services in a seamless way as their needs fluctuate.

Involving Service Users

The experience of developing the Creative Living Centre and the Angel Healthy Living Initiative demonstrated that most people know and can tell us what they want. It may require time and a will to understand, but it is possible. The main barrier to people telling us what they want is our failure to hear and act on what they are saying. It is difficult for a person without experience of living in an area of deprivation to fully understand what life looks like from the point of view of those living it. Only they can claim to be the experts. It is important then to create the conditions that allow us to understand people's experiences as

> "Individuals construct the social world in which they live and through this interpret and make sense of it; such constructions are seen as self-sustaining and self renewing."
> (Williams *et al,* pg477).

Over the last seven years my work has been rooted in developing partnerships with service users and a wide range of public and voluntary organisations. I have learnt the value of working in partnership and the importance of developing new working relationships. This learning arose from the many partnerships I have been involved in e.g. with Mind for the Creative Living Centre, the Princess Royal Trust at the Angel. Through my work in the Trust I have encouraged and influenced a focus of positive mental health promotion and that of exploring, understanding and influencing the development of mental health promoting communities through partnership working.

Current policy reform in health and social care promotes partnership working as a way of improving services and maximising resources. Unfortunately it often ignores the most crucial partnership, that of the relationship between the health care professional and the patient. To be successful in responding to the needs of people who use our services it is this partnership that is critical. Too often the balance of power in the relationship between the giver and the receiver of care is in favour of the provider of care and their funders.

In pursuit of this cultural change there needs to be an understanding that to respond to the needs of people who use our service then we need to:

- engage and support people who have experience of emotional distress and mental health problems in a way that allows them to identify their own health needs; and
- support them in making informed choices about how those needs might be met.

If this is what we are aiming to achieve then the next step is rooted in the question "how do we need to be in relationship differently in a way that moves us from a medical model of command and control to one of true participation that integrates the role between giver and receiver?"

This requires a conscious change in our thinking and behaviour when involving and consulting with patients and the public. Section 11 of the Health and Social Care Act states:

> "Involving and consulting"……….means discussing with patients and the public their ideas, your plans, their experiences, why services need to change, what they want from services, how to make best use of

resources and so on. It is more about changing attitudes within the NHS and the way the NHS works than laying down rules for procedures." (DOH, 2001c).

Citizenship

People who have mental health problems have a full right to citizenship and to be part of the community in which they live. Ensuring full citizenship is a challenge both for the community and the services that support them.

If this is to become a reality then the challenge is to develop communities so they can accommodate people with a disability. This challenge is to promote and ensure equality of access for vulnerable people and to encourage them to participate in the decision making processes that have an impact on them and the communities in which they live. This is not just about people having the opportunity to participate, but also about possessing the skills, knowledge and confidence they need to take part.

As well as contributing to improving the quality of life of their community, getting involved in local affairs can provide individuals with opportunities to acquire training, skills, and give them pathways into education and employment.

CHOICE, Responsiveness and Equity in NHS and Social Care.

In 2003 the Department of Health distributed a resource pack to support a national consultation on CHOICE, responsiveness and equity in NHS and social care. One of the key messages in the resource pack stated that:

> "Real choice includes decisions about 'where' and 'when' care is received as well as 'what' services and 'how' someone wishes to be treated or manage their condition"
> (DOH, 2003a, Pg 3).

The choice agenda will challenge the notion of a National Service Framework and central guidance on models of best practice with performance measures and star ratings for every Trust across the country to deliver against this policy guidance. Assertive outreach teams for example work with individuals who are difficult to engage because they choose not to use services.

There is equally a tension in mental health between choice and risk and the management of risk which is a key responsibility of care providers. From a professional requirement and organisationally from a governance requirement, the management of risk will limit the scope for choice for some service users. i.e. some people will require detention against their will.

In accessing services it is acknowledged that different people need different levels of support during different phases of their life. Therefore there should be a range of choices of services available in respect of the support service users might need at each point of their recovery journey. It is also crucial that in offering choice there is appropriate information available so that choice is truly informed.

A Community Development Approach

A community development approach is about change in society, in communities, in groups and in individuals. It is about the way in which change

is achieved, working with people's experiences; their own stories of pain and joys as they express them. This takes time and trust, which is needed to build the confidence that will improve one's feeling of self worth and of the possibility of achieving change.

A community development approach is about learning by doing, so that people can develop skills, knowledge and experience to achieve their shared objectives. It encourages participation and democracy in community life.

It aims to work in partnership with groups, enabling development according to their needs and wishes and at their own pace, provided this does not oppress other groups or communities and is not perceived to do so, or damage the environment. These groups may be either based in particular localities or around "communities of interest".

It's about working to enable people and communities to get back control of and to own responsibility for their own lives and the life of their community. It requires us to work with them to tackle the causes of social injustice shown through poverty, ill health, poor housing, non-participation, etc.

It's concerned with transfer of power to those who have little or none in local communities. Those who have the power will need to enter into genuine power sharing with those who do not. Community development is about the creation and support of general ways and means, as well as specific practical initiatives, which enable real participation and the possibility of ongoing

challenge and change. It is also important to work directly with institutions which hold power to achieve these changes.

It's also important to apply this principle by ensuring that partnerships with groups are meaningful, and they can fully participate and share power within our organisations. This requires us to confront the attitudes and practices of individuals, groups and institutions, which discriminate against each other.

This is a way of working and relating which is often informal and organic, i.e. when new opportunities are sparked but change doesn't necessarily come about in the way we think it will. The approach itself changes and grows in the process and involves us all in vulnerability and risk. It requires us to think about an exit strategy to achieve sustainable and ongoing change controlled by communities in which we have engaged this approach.

Discussion

Although mental health promotion is an explicit task of the National Service Framework for Mental Health it is important to acknowledge that there are many factors that influence the mental health of local people and their communities. The quality of social relationships as well as the quality of the environment also influences how people feel.

Working in the communities of greatest need, it is important to look at how best we can assist local people to realise their individual and collective

capacity to manage those component parts of their lives they wish to change. According to Whitehead;

> "People who live in disadvantaged circumstances have more illness, greater distress, more disability and shorter lives than those who are more affluent."
> (Whitehead, 1996, Pgxvii).

In this context it is important to assist people in strengthening their emotional and spiritual resilience in a way that enables them to live a fulfilling life enjoying the positive aspects and coping with the negative.

Part of the challenge of mental health promotion is encouraging local people and their communities to be aware of those aspects of their lives that impact on their mental health. Mental health promotion therefore needs to relate to the implementation of a range of policy initiatives, e.g. social inclusion, neighbourhood renewal, community strategies, employment etc.

Attention to the underlying causes of health is rarely recognised, in favour of consideration to disease and life style, such as smoking unhealthy eating, yet these are influenced by poverty, poor education, low prestige, which are themselves caused by inequity, social injustice, alienation, lack of empowerment etc. (Seffrin, 1997).

In considering the health of the population a focus is needed on the wider social determinants of health. For individuals this includes social inclusion, participation in decision making, social support etc., and in considering the risk conditions of communities rather than the risk factors of individuals. A focus on “health capacity assessment” rather than “health needs assessment”

might present a more accurate and positive picture acknowledging community resources and self determination rather than perpetuating community deficits and the need of external help and dependants.

> "If everyone concentrates on what you cannot do, then it is easy to lose confidence in yourself as a worthwhile person and lose sight of life's possibilities. Mental health services are replete with people who have 'given up' on themselves and their futures – a tragic waste of human lives and potential."
> (Repper J, Perkins R, 2003c, p13).

The use of a social model of disability deliberately redresses the emphasis away from the functional limitations of an individual to looking at problems faced within the totality of a person's "living experience" and to focus on a society which needs to act to remove the barriers which it places on people. According to Baquer;

> "....we find ourselves in the school of thought which challenges that biology is destiny and human conditions are inevitable. We believe that the opposite is true...If we accept that the medical definition of disability then it also follows that people with disabilities should be grouped according to their conditions... When disability is defined as a social and political category then human beings are identified by their experience. Disability, in such conditions, is not solely seen as a personal condition.... We have argued that it is the non-disabled who, either because of their ignorance or prejudice, actually disable people with their impairments or handicaps."
> (Baquer, 2002, pg 195)

The experiences of developing the Creative Living Centre and the additional projects that have emerged have been undertaken in the context of the many policy imperatives discussed above. Arising from these combined experiences was a change in my role which is described in the following chapter.

Chapter 5
My New Role Develops

I was appointed to the role of Service Director (Developments) in October 1999 six months before I commenced the doctoral programme. It was whilst in this role that I commenced this research although this thesis also draws on some of my previous work and personal experiences which was an inseparable part of the research evidence.

In this Chapter I describe the ideas and opportunities that emerged in this new role and specifically the development of a Centre for Community Learning and my appointment as Honorary Director of Community Development at the Revans Centre at the University of Salford.

It explores the challenges involved in influencing the Chief Executive of the Trust to support this initiative. It also demonstrates the impact on my work as the Trust responds to national and local changing priorities with a focus on people with "serious and enduring mental illness", despite the acknowledgement and support for my work on the development of mental health promoting communities.

As a consequence of my interest in action learning I became increasingly stimulated by my involvement at the Revans Centre initially as a result of undertaking a MSc programme from 1995 to 1998. Additional to this I had started to consider the value of using action learning as a process for community development. This was influenced through my work and

developing an understanding of mental health promoting communities. This was to sow the germ of an idea for a Centre for Community Learning that required further discussion in the Trust.

At that time I had started to be involved in a number of projects that could be the focus of such a Centre. These projects came about as a result of other partnership work in Salford through the links I had established. I was approached by a member of the Salford and Trafford Health Authority to develop three action learning sets as part of a Social Action Research Project, (Popay and Picken, 1999) and from the Chief Officer of the Community Health Council to develop an action learning set as part of the first Salford School for Social Entrepreneurs programme (Lee, 1999).

For me to develop these action learning sets it required me to obtain support from the Trust. This provided an opportunity for further learning and would build on and complement my earlier work. I decided that I would raise this with my manager at the annual review of my performance.

Within the Trust each manager was involved in an annual process of setting individual objectives with their line manager. This occurred at the start of each financial year. In March 2000 in preparation for the annual review of my previous year's objectives (April 1999 – March 2000), and the setting of the next year's objectives (April 2000 – March 2001), I decided to explore if there would be support for secondment to the Revans Centre from the Trust. In preparation for this review with the Acting Chief Executive, I was able to

outline in principle a case for supporting me in exploring options for offering programmes of action learning for local people to aid individual and community development. The proposal built on my experience of action learning and community development and witnessing how people if given the appropriate support are able to improve their lives. I believed that action learning was a process worth exploring for providing this support as it would support people to question their experiences, explore ways of taking action in the context of their lives not just in the context of their mental health and one that would give them power and control. This opportunity had to be explored further. In April 2000 I completed a written proposal to the Chief Executive to aid further discussion. This proposal can be found in **Appendix 4.**

My idea and emerging proposals couldn't have come at a more opportune time, as I had developed a strategy to exit from two major pieces of work, the Angel Healthy Living Initiative and the Webb House Personality Disorder Service.

The timescale for exiting the Webb House service was September 2000, as the Personality Disorder Service had developed a core management team who I expected to implement and shape the project plans that we developed together. The responsibility for the Angel Healthy Living Initiative, transferred to the Salford East Primary Care Group in November 2000. This gave me the capacity therefore to take on a new project.

On the 2nd March 2000 I received a written response to my proposal from the Chief Executive. Little did I know at that time where this first step was to lead. I received the following comments:

> "I think that this is highly appropriate in terms of social policy and personal development. I can also see how you individually, with appropriate support and partner agencies would have a lot to contribute to it. Because I do not see much that is explicit or direct about mental health in it, my initial view about funding/resources (i.e. your own time) would be: Happy to support you in an exploratory or developmental/definitional phase of work but, any substantial or longer term involvement would (on the present definition of the aim/outline) need to be funded by another agency – different from the MHSS"
> (Lee, 2000a, pg1).

This response was to become an important milestone in developing my practice as initially it was not felt to be a piece of work that contributed to the strategic objectives of the Trust, despite my belief to the contrary and my frustration of not being able to articulate why. The difficulty in articulation was due to the limitation of language. I am used to working in mainstream "mental health services" and talking about "mental health". However in that context of the Trust this is really was about "mental illness". In describing the many external factors that can impact on people's mental health, I needed to ensure that there is an understanding in the Trust that I am talking about "health and not "illness". This barrier to understanding will require me to constantly explain to others what I mean until a new sense of words can be found. Until then I have found that specific stories are the most appropriate of explaining what I want to say.

I decided to meet with him to discuss his initial comments. This discussion resulted in him supporting me to undertake further work to develop the proposal further.

I continued to shape the proposal and explore options for securing funding that would allow me to be seconded to the University to put the proposal into action. It soon became clear that I would not be able to generate sufficient income (the main source of which would come from funded action learning programmes) to cover my salary.

I became aware that I was in danger of thinking more about how I could secure funding to work at the Revans Centre rather than concentrating on how to articulate my belief in the value of action learning in promoting social inclusion and positive mental health. I intuitively knew its value but this wasn't enough to convince others.

I decided to re-look at my first proposal in the context of the National Service Framework for Mental Health. The National Health Service Framework (NSF) sets national standards and defines service models for promoting mental health and treating mental illness.

I was able to describe the proposal in a way that gave a more explicit link to "mental; health" and Standard 1 of the National Service Framework for Mental Health which required the development of mental health promotion for all. This description stressed the opportunity for learning from this new approach

in a way that could influence practice. The National Service Framework for Mental Health outlines new ways of working and new models of service delivery for people with mental health problems. Standard 1 is concerned with mental health promotion and tackling the discrimination and social exclusion associated with mental health problems. Additional to this I presented a detailed description of the proposed programmes of action learning that had emerged e.g. the Local Neighbourhood Link Officers, the first Salford Social Entrepreneurs programme and their associated aims. On the 1st August 2000 I received a written response as follows:

> "I think the paper is primarily written in terms of community development, rather than mental health. Community development will have many effects/benefits. It might be worth identifying a bit more clearly whatever/how/why community development would have particular effects on mental health. If it is worth supporting, where might the £ come from?" (Lee, 2000b, pg1).

The response was not what I had expected and I wasn't sure what to do next. I was obviously not communicating the benefits to the Trust of the proposal and its importance for the mental health agenda, which in my view was innovative and groundbreaking. For the first time mental health policy provided an opportunity to promote positive mental health, tackle the causes of mental ill health and address the stigma and discrimination surrounding mental ill health. I had developed a proposal that had the potential to assist the Trust in the delivery of performance targets for Standard 1 and as a consequence extend the Trusts portfolio of mental health provision.

I decided to review the second proposal and submitted yet another revised paper to the Chief Executive that was strengthened through its links to health

promotion and social inclusion policy and was titled "Mental Health Promotion – A Proposal for Action". On the 29th August I received the following response,

> "I am not sure yet if we should support this initiative...If possibility of a secondment to the Revans Centre (who pays)...Is potentially supportable (£+time) by MHSS, but might depend on competing priorities."
> (Lee, 2000c, pg2)

My initial response was mildly positive, but at least my proposal had moved from being supportable but needing to be "funded by another agency" to being "potentially supportable (£+time)". Having received these comments, I took this as a green light to continue to develop my proposal with colleagues at the Revans Centre to pursue the opportunities for two emerging action learning sets.

- One with three local people from Seedley and Langworthy (Wards in Salford) and three people who work in that community but are employed by the local Authority.
- The second was with employees of the City Council who had responsibility as "Link Officers" to provide a link to the communities of specific geographical areas of Salford and the relevant local authority councillors.

As I was certain that these sets would happen I decided to make an appointment to meet with Robert Lee, the Chief Executive to make him aware of this progress so that he would be clear of what I was committing myself to.

In preparation for that meeting (17th January 2001) I had decided that my approach (to the Chief Executive) would be to get him to acknowledge that I now had sufficient external interest and commitment supporting two action learning sets and that this was the potential start of a Centre for Community Learning. I decided to be direct in my approach and seek approval for me to take the lead for the development of this Centre and that this project would be a legitimate component of my role as Service Director (Developments), and it should not be seen as a secondment that would expect an income from the University to cover my costs. There was no hesitation from Robert in his support for what I proposed and I left the meeting with a renewed confidence and made an appointment to speak to Professor David Botham to consider the next steps. From that point on it seemed natural to just get on and progress the work further.

In February 2001 I met with David who was pleased about the proposal and the support given and asked me to provide him with a business plan and to arrange a three way meeting to discuss the next steps. This meeting took place on 28th March 2001 the result of which was total support for the project and the following action plan was agreed:

- Develop a Strategic Partnership Board to support the project's development;
- Identify a core group to provide practical advice and support to the centre's development;
- Produce a business plan to cover an initial three year period which was to include values, outcomes and costs;

- Take the proposal to the Revans Centre Core Group;
- Discuss further with the Pro Vice Chancellor of the University;
- Produce a discussion paper to inform the Trust Board.

It was further agreed that after Professor David Botham had spoken to the Pro Vice Chancellor we should meet again on the 15th May 2001. I would also meet with David to update him on my progress on the 8th May.

I completed a discussion paper on the proposal for the Trust Chief Executive that outlined what had been proposed. This was discussed and approved by the Trust Board on the 14th May 2001. It was recommended that:

> "The Trust's Service Director (Developments) will take the lead in this major initiative to develop a Centre for Community Learning and start to develop and implement a project plan. The first phase of which will be to:
> - identify a strategic partnership board initially across Salford;
> - identify a core group to provide practical advice and support to the centre's development;
> - Produce a business plan to cover an initial three year period."
>
> (Lee, 2001, pg3.

The detailed Trust Board paper can be seen in **Appendix.5**. This was a significant achievement that provided the opportunity to demonstrate the value of this approach to mental health provision. This innovative initiative also had the potential for influencing cultural change within the Trust. I had managed to influence the Chief Executive's thinking from initially supporting the idea in principal but not the funding or time to one of total acceptance and support and understanding of the value of the project in terms of:

- Mental health promotion and social inclusion;
- Commitment of my time and resources;

- A priority for the Trust.

If any further confirmation was required then it came in the form of a memo I received from the Chief Executive of the Trust on the 9th April 2001. It read as follows:

> "Further to our recent discussions, I enclose a copy of the first draft of my personal objectives for 2001/2002. If you have not already prepared your draft objectives for the year, would you please take these into account in drafting them? If you have already prepared yours would you please take these into account when we meet to discuss them?"
> (Lee, 2001a, pg1)

I read the memo with interest and was somewhat pleased to see

> **"Objective 3 Mental Health Promotion and Community Development**
> Lead, with other agencies as appropriate, initiatives in Salford and a wider area to promote mental health, develop positive attitudes towards people who experience mental ill health, and support the social and economic development of communities in ways that will improve people's mental health.
>
> - Support the Greater Manchester Campaign for mental health;
> - Establish, with the Salford University Revans Centre for Action Learning and Research, a Centre for Community Learning."
>
> (Lee, 2001b, pg2).

This was a significant achievement as the Trust had always only seen the agenda for providing health care to those people with a "serious and enduring mental illness". For the first time mental health rather than mental illness was acknowledged as important. However the challenge was how to move forward these ideas that required further development in practice.

Further discussion with the Chief Executive revealed that the reason for this change of view was the connection with The National Service Framework for Mental Health.

There were a number of discussions between myself the Chief Executive of the Trust and David Botham through out the next six months that explored the work of the Centre for Community learning and the relationship with the Revans Centre. On the 18th December 2001 I was interviewed by Robert, David and a representative from the Personnel Department of the University and subsequently appointed as Director for Community Learning at the Revans Centre for Action Learning and Research.

Centre for Community Learning

Following approval from the Trust Board (May 2001), I started my job as Director of Community Development at the Revans Centre, working two and half days a week.

Despite this commitment however I was still asked to undertake different tasks in the Trust that took me away from the core of my responsibilities as follows:

- Undertake an investigation of a senior manager for alleged poor performance (September 1999 – February 2000);
- Undertake an investigation of a senior manager for alleged harassment (August 200 – January 2001);
- Supporting the Chief Executive in the coordination of a financial recovery plan for the Trust (May 2001 to December 2001);
- Managing Salford District Services. (January 2002 – May 2002).

There were also external influences that required me to support the delivery of the many targets and changing priorities of the Trust. These external influences prevented me from pushing at the boundaries to develop creative and innovative solutions to service developments.

In April 2002 the Trust appointed a new Chief Executive who made a number of changes to the Trusts management arrangements. For me this initially meant reporting to another manager in the Trust and being asked to project manage the Integration of Mental Health and Social Care in Trafford. This work reduced the opportunities for me to continue developing the Centre for Community Learning. However it served to motivate me to be able to demonstrate the importance and value of my work for influencing community based mental health provision.

Challenges to my Practice

As a result of developing the community based projects referred to in Chapter 3 and understanding the value of patient and public involvement, I gradually moved away from contributing to the traditional core business of the Trust.

The core business of the Trust is that of providing "mental illness" services where as my work on mental health promoting communities has led me to the provision of services that "promotes mental health and well-being". Consequently over time I progressively felt that I was becoming disconnected from the organisation. At Trust Board meetings and other Director meetings the discussions bore little relevance to the world I was now working in.

As I sat at these meetings I was conscious of the chasm that existed between the Trusts dominant world of mental illness and my working world of mental health. It hindered me at times from contributing to discussions and debates as I struggled to find the correct language that could connect our two worlds. This area of concern raised questions about the future of my role in the organisation. I increasingly wondered what I was doing there. I found myself asking the following questions:

- Was the Trust happy with me continuing to work on promoting mental health and well-being?
- Was this where the Trust wants me to put my energies?
- Was this where I wanted to put my energies?

My work had created a tension between my growing understanding of the value of developing services (often not traditional health services) that promotes mental health and the conflicting expectations on me by the Trust.

This tension was not just an issue of communication, but a fundamental difference in understanding mental health and mental illness. Unfortunately mental health providers and commissioners are constrained by their role in responding to the needs of people with a “Serious and Enduring Mental Illness”.

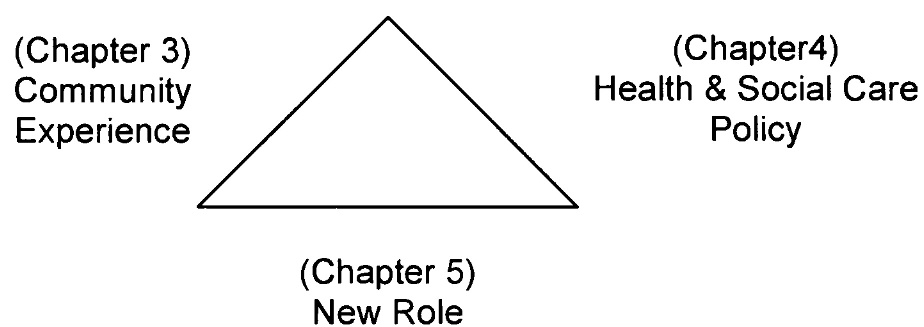
So in April 1999 I enrolled for a doctoral programme. The Programme would allow me to continue my journey of personal development and focus on a piece of research that would allow me to articulate and demonstrate the value

of my work in the field of mental health. This was important to me as I felt confident that the promotion of mental health and well-being was a credible piece of work which needed to be understood further. The PhD could also provide a framework for moving forward my ideas into application.

Summary of the Rationale for My Research

The triangulation (as indicated in **Figure 3** below) of my experiences, challenges and tensions described in Chapters 3, 4 and 5 motivated me to want to understand my work further and so I decided to undertake this doctoral programme.

Figure 3



The projects described in Chapter 3 provided the foundation for my learning, changing my perception and understanding the value of patient and public involvement in the development of service provision. This was complemented by the reflection of those experiences against policy imperatives as outlined in Chapter 4 which helped me in undertaking my new role in the Trust as described in Chapter 5. These learning experiences have influenced my practice and moved me forward towards my specific area of research and through it.

Using principles underpinning a community development approach alongside a process of action learning provided a powerful medium for improving mental health and well being and contributed to the development and understanding of mental health promoting communities.

The idea of achieving social well being through social regeneration links the community to the individual level by emphasising the overlap between the social development of communities and the personal development of the individuals belonging to them. From those key milestones of:

- developing the Creative Living Centre and learning the value of supporting individuals in managing their own mental health needs;
- understanding my relationship with Action Learning and learning what it means to take responsibility, and the similarity in behaviour required to empower others;
- developing the Angel Healthy Living Initiative and working in partnership with communities and witnessing them grow individually taking responsibility and influencing the development and day to day running of the Angel;
- and developing a strategy for mental health promoting communities,

prompted me to think further about what local people might achieve if they were supported to use an action learning approach to manage their personal aspirations. My belief was that there are many people in our communities who would like their lives to be different both for them individually and the communities in which they live.

Working with the Chief Officer of the Community Health Council who was exploring the development of a community based Social Entrepreneur Programme I decided to put my beliefs to the test and developed and supported the following two action learning sets for local people.

Set 1. Five people November 1999 to October 2000

Set 2. Six people January 2002 to December 2002

This is discussed in more detail in Chapter 7.

My Research Question

My research at this stage took the form of two explicit questions. Can Action Learning:

- assist in improving people's mental health and well being?
- assist in bringing about social inclusion?

I believed that action learning and research offered a powerful process for people to be engaged in developing a deeper understanding of personal and community development. This was an integrated process and provided the vehicle for taking action and for learning.

Section 3.

This section outlines the methodological approaches used to progress this research and highlights why the different approaches were used.

This is outlined in Chapters 6, which explains the methodological approaches to my research and is followed by Chapter 7 which provides a background to the Salford Social Entrepreneur Programme and the progress made by the participants.

It also explains the development of my research Action Learning set in the context of this research.

Chapter 8 describes action learning as a way of learning to learn and how this helps me with my research. This is followed by Chapter 9 which explains the initial findings and conclusions arising from this research and why they are of value to the outside world.

Chapter 6
Research Design – Approaches to Understanding My Practice

This Chapter provides an overview of my research and describes the process I used to capture the data.

It also explains the methodologies underpinning my research.

The Chapter also considers the context of my work based practice and its implication in answering my initial research theme and associated questions.

Introduction

Having experienced how patients and the public came alive as a consequence of their involvement with the Creative Living Centre and the Angel Healthy Living Centre I intuitively sensed that there were some positive influences on their mental health and social inclusion. Working with participants on the Salford Social Entrepreneur programme I felt it important to explore this further. As a consequence the focus of my work based inquiry became concerned with two questions:

1. What ways can action learning assist in improving people's mental health and well being and
2. What ways can action learning assist in improving social inclusion?

I explored these questions as a focus for my research whilst Set Advisor for two community based Salford Social Entrepreneur programmes. These questions emerged incrementally whilst learning from the development of those new community based services.

The Research

The doctoral programme commenced in April 1999 and the background to how and why I undertook the programme can be found in the Chapter 5. The focus of my research centred on my work and built incrementally on the experience of working in partnership with patients and the public on a number of projects that required me to actively encourage their participation.

The range of practice based experiences reported in this thesis demonstrates that there are many factors that influence people's mental health and well-being. Using an action learning process alongside a community development approach has shown how new and innovative services can be developed if people using those services are actively involved in their planning, development, delivery and monitoring.

In keeping with the National Health Service governance requirements it was necessary for me to obtain approval for this research from the Trust. Having completed the Trusts declaration form for research and development projects, I received the following response;

> "I am pleased to inform you that the above project has received management approval from the Trust. Trust management approval of such research is subject to unconditional approval from the relevant Research Ethics Committee. We note that as this project does not involve any Trust patients it is not conducted under the auspices of a Research Ethics Committee."
> (Colgan S Dr, Medical Director, 2003, pg1).

At the initial meetings held with both SSE action learning sets, I explained the nature of my research work to the participants, making them aware of my research questions and why I was undertaking this work. I asked them if they

were happy to be involved in the research, and for their projects to be included in the written work arising from it. Verbal approval was given at both these meetings by all participants and reinforced by their active cooperation as the research progressed.

Ensuring Anonymity

In writing this thesis I have had to be conscious of ensuring that the work is anonymised. It should not be possible to directly or indirectly identify the individuals that were the subject of the research.

This thesis has been written to reflect my personal experiences of work and that of the other participants of my research. It tells their individuals stories as they have articulated them and as such adds a rich perspective to the research.

The thesis also describes the many projects I have been involved in that have developed in partnership with many other organisations. A description of these is vital to provide the reader with an overview of the diverse range of partnerships involved with this research.

However I have given serious consideration to the anonymity of the many people and organisations referred to in this thesis. In doing so I developed a matrix that recorded the various Chapters in the thesis and listed the names and organisations that were mentioned. Please see **Figure 4** for further information.

I then looked at each of the individuals and organisations mentioned in each chapter and felt that they came under at least one of the following categories:

- Information that was in the public domain;
- Information that was a matter of fact;
- Agreement to include from organisations and individuals;
- Information where I am critical, but where individuals or organisations cannot be recognised;
- Information requiring further discussion.

The above categories where also included in the matrix. In considering the above categories to decide if further attention to anonymity was required, I applied the following questions;

1. Can individuals or organisations be identified?

   And if so,

2. Is the information I present harmful to the individuals and the organisation?

After considering this question I decided that there was one area that required further discussion. I met with Dr Chris Rivlin the Director of the Revans Research Centre to discuss this further. It was decided that I would write to Dr Rivlin outlining the issue that required further consideration by the Universities legal department. This was related to Chapter 2 of my thesis. In this Chapter I describe my early experiences in mental health that started at Prestwich Hospital (1971) and specifically my observations of a patient being hit. I also describe the conditions that I experienced which where probably typical of institutions of the day. These were as follows:

- 40 patients nursed on one ward;
- Patients referred to as the "epileptics";
- No choice in what time you went to bed;
- No choice of when to have meals;
- No choice of what to eat;
- No choice what clothes to wear and clothes coming from a communal stock, including underwear;
- Poor washing and shaving facilities.

Additional to this I also observed:

- Staff taking meals off the meal trolley for themselves;
- Staff stealing from patients belongings.

As part of my professional background it was important to describe the various roles undertaken as I progressed through my nurse training and the many changes I have influenced in a bid to improve service provision. The unacceptable conditions are important to describe as they give the reader an indication of my experience and the motivation to develop the improvements described in this thesis. I also provide a profile in **Appendix 2** of my posts in the NHS.

Having worked mainly within this organisation for 36 years albeit that its name had changed many times over this period it would still be possible to identify the hospital if I was to refer to a large mental health trust in the North West.
In response to my letter Dr Rivlin discussed this with the University's Legal Executive who confirmed that it was their view that by naming the hospital in the

Thesis there was not a significant risk of legal action being brought against the University or myself.

Figure 4

Ensuring Anonymity

Chapters	In the Public Domain	A Matter of Fact	Agreement from Individuals	Where I am critical, but cannot be identified	Further action/Discussion required
Chapter 1	SSE programme	The Trust.	Trusts CEO		
Chapter 2		My different roles and responsibilities in the Trust.		Poor practice, neck warmer, stealing, meals, privacy, Ward name changes,	Relatives
Chapter 3	Creative Living Centre. Webb Hse, The Angel its history and the communities of initial focus, HAZ, Salford City Council, Salford Cathedral Centre,	Real Lives Real People, SARP, North West Mind, Chapel Street regeneration project group, Chaired the health group of SRB 5. Chapel Street regeneration project group. Chaired the health group of SRB 5. Salford PCT			
Chapter 4					
Chapter 5	Integration of mental health & social care Trafford & Salford, Chief Officer of the CHC,	Salford East PCG, link officers Salford City Council, Trust Board, Centre for Community Learning, Salford District Services, Financial recovery plan,	Robert Lee CEO, Chris Dabbs	Investigation Snr managers	

Figure 4

Ensuring Anonymity

Chapters	In the Public Domain	A Matter of Fact	Agreement from Individuals	Where I am critical, but cannot be identified	Further action required
Chapter 6		Dr.S Colgan Medical Director, NIMHE,	All SSE participants,		
Chapter 7	Jack Straw Home Office Minister, Tiny Tots Play Group, Millennium Commission, SRB5 Regeneration funding, SSE participants projects, New Deal for Communities, David Kennedy deceased, Salford Lowry Exhibitions,	Social Entrepreneurs Programme, Lord Michael Young of Dartington, Donna Vick Set Adviser, Professor John Morris, Communities were work is undertaken by TinyTots, Mossfield Primary School, Salford Council for Voluntary Services, Action for Employment,	Research set participants		SSE participants communities are identified, Mcr Methodist Housing Association
Chapter 8	Prestwich Hospital, Griffiths Report	Rochdale Health Authority			
Chapter 9		Salford Community Profiles, NHSU, Mersey care NHS Trust, North West Chief Execs, Liverpool Capital of Culture, IPAC, ALAC,			
Chapter 10					

Figure 4

Ensuring Anonymity

Chapters	In the Public Domain	A Matter of Fact	Agreement from Individuals	Where I am critical, but cannot be identified	Further action required
Chapter 11	The Angel, CLC, SSE	Salford & Trafford HA, Salford University, City & Guilds	Proud City		
Chapter 12		The Trust, NHSU, Mersey Care, Chief Execs North West, NIMHE, Liverpool Capital of Culture, Home Office Civil Renewal unit	DOH		

Methodology

The approach to my research was to use action learning both as a participant undertaking a doctoral programme with my Research Action Learning Set at the University of Salford and as a Set Advisor with the Salford Social Entrepreneur Action Learning Sets. The process of action learning provided a framework for this research which allowed for the integration of specific practice methods and techniques that assisted my research. These integrated processes provided a structure for learning without being constrained by a single method. A list of the inputs to the methodology can be found at the end of this Chapter, **Figure 6.**

When I commenced this programme I didn't have a specific focus for my work based challenges that would be the heart of my research. However I was being encouraged by the Chief Executive of the Trust to explore new approaches to mental health provision. This exposed me to many challenges and opportunities for working with multiple partners.

The methods therefore were also constrained by the demands and expectation of me in my role as Service Director (Developments) in the Trust and the differing expectation of various partners. These constraints related to the expectation to achieve specific work based objectives and the time available to do so, given that the development of partnership working is often emergent. Further information about the specific experience in the development of partnerships can be found in Chapter 4.

Why Action Learning

The Salford School for Social Entrepreneurs (SSE) programme was based on the national Social Entrepreneur Programme and had action learning as the preferred process of learning for the programme participants. The SSE programme, how it developed, my role and the participant's projects and progress are described in more detail in Chapter 7. My research uses action learning at the heart of my methodology which was compatible with the approach I was already using for my practice.

This allowed me to expand my experience of action learning in my role as a researcher and as a set advisor for participants on the SSE programme. Additional to this I have developed a broad range of experience in using action learning and research having completed an MSc by action learning and research in 1998. I also developed an interest in encouraging and supporting others in considering the value of this approach.

My understanding of action learning commences with and builds on my experiences of action learning and community development work. This was influenced by my personal experiences as a set member learning to take responsibility in resolving my work based problems and feeling empowered. I have also had the opportunity to learn the value of empowering others and supporting them to take responsibility for themselves and their lives. This approach is fundamental to my work as it acknowledges that people have within themselves the ability to resolve their own problems.

One of the key lessons I learnt early on was that I was able to contribute and influence mental health provision more through supporting individuals and groups of individuals in community settings, rather than influencing the Trust. As mentioned earlier I felt a lone voice, and consciously continued to apply action learning to explore and support the development of mental health promoting communities.

My experience of action learning has also been influenced by my relationship with the Revans Centre for Action Learning and Research at the University of Salford and my role as a Visiting Fellow from December 2001 up until the closure of the Centre in 2005. Through this relationship I have:

- been a member of the Core Group developing the Revans Centre and the Health and Social Care Group;
- published a number of articles a list of which can be found in Appendix 6;
- attended the annual development days and led on specific topics i.e. developing a vision for the Centre;
- facilitated and led workshops and presentations on various action learning topics. The range of workshops and presentations can be seen in Appendix 7;
- supported the development of the Revans web site;
- as part of a team from the Revans Centre, I have been an assessor for the appointment of action learning set advisors, for the National Primary and Care Trust Development Programme (NatPact), the Modernisation Agency for supporting innovation in Primary Care Trusts;

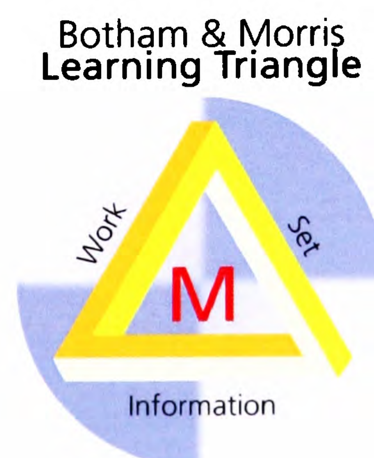
- developed a Centre for Community Learning at the Revans Centre and was appointed the Director for the Centre in partnership with the Trust and the University;
- I have also developed experience as an action learning Set Advisor, advising two sets as part of a Social Action Research Programme, two action learning sets as set advisors, one for Mersey Care NHS Mental Health Trust and one with participants in health and social care organisations from the North West, and a Set advisor for the National Institute for Mental Health England (NIMHE) to explore how to develop health promoting mental health services.

These combined experiences gave me the understanding and confidence to use action learning and research as the central approach for my research.

Action Learning and Research – A Framework

The Botham, Morris Triangle (Botham, Morris 1998,) provided the framework that assisted me in understanding action learning within the context of an academic setting. This Penrose Triangle, which is a three dimensional equilateral triangle represents the equal importance to three distinguishable elements of learning. See **Figure 5**.

Figure 5.



1. Learning from Work

Here the critical focus is on learning from work and provides the opportunity to focus on work based problems, opportunities or difficulties replacing the generalised syllabus of traditional teaching programmes or specific narrowly defined research questions of traditional research. It was acknowledged and sustained through observing and recording work based action and experiences.

2. Learning from the Set

This represents learning from the set and working in the company of others in an action learning set. The action learning set participants replace the tutors and placed a demand on the set to explore and ensure how to learn to learn with and from each other. This experience in the set was monitored by observation and recording of events that occur. Additional to this the focus was augmented as the set participants challenged and questioned the learning experiences arising from work and the set. These challenges and questions served to motivate the participants to review what was previously believed.

3. Learning from Information

The learning from the information relates to any medium that is considered to be of value and that the recipient believes will inform their research, e.g. newspaper articles, reports both academic and government literature and information received from training programmes. This information it is felt can contribute to thinking that is different from the experience gained from work and the Set.

At the centre of the triangle is "M" which represents "Monitoring". Monitoring begins from the point of exploring the work based problem and asking questions associated with the inquiry, processing and considering the information and help that might be needed to answer the questions. This questioning was a continuous process that develops a rigour to the research as challenging questions are asked. Monitoring learning is continuous as are the progressive actions needed to pursue research requiring questioning, observing and recording what is being learnt in work, the set and from information. It also allows for monitoring the effectiveness of my own research and learning processes.

This exploratory inquiry was conducted within the interpretative practice of qualitative research. Working in this way enabled me to develop a better understanding of the experience of the SSE set participants as they used action learning to realise their personal aspirations.

This investigative methodology was developed in response to my research questions which are based on a set of beliefs (a paradigm). Guba and Lincoln defined a paradigm as:

> "A set of basic beliefs (or metaphysics) that deals with ultimates or first principles. It represents a worldview that defines for its holder, the nature of the "world", the individuals place in it, and the range of possible relationships so that the world and its parts, as, for example cosmologies and theologies do. The beliefs are basic in the sense that they must be accepted simply on faith (however argued); there is no way to establish the ultimate truthfulness."
> (Guba and Lincoln 1994, pg104.)

These beliefs are that people given the appropriate support often have the capacity to resolve their own problem. Action learning is a process for problem

solving, developing opportunities and realising potential. It was proposed that supporting people to realise their aspirations would result in improved mental health and well-being and social inclusion.

There are three levels for patient and public involvement arising from this inquiry,

1. Involving the patient in identifying their needs and making an informed choice regarding the appropriate treatment and in doing so improve care at an individual level.
2. Working with current service users to examine and improve the way existing services are provided and organised.
3. Exploring with the public innovative and creative ways of redesigning new health and social care provision.

It is my belief that If health and social care providers are to truly engage with patients and the public they need to consciously consider the implications of doing so and how different their relationship might need to be. To support the engagement of patients and the public, organisations need to develop an organisational culture that is empowering.

Schwandt refers to the interpretive paradigm as a set of beliefs reflecting multiple elements. This underpins some qualitative methodologies which by contrast with quantitative, concerns one of truth; theory and replicability, could be described as a broader church (Schwandt, 2000).

According to Kant qualitative research appears to be an umbrella term embracing a range of methods each underpinned by unique beliefs and history. Within each method there are also similarities. They relate to meaning, understanding, the human viewpoint or the human environment, study in the natural environment and the individuals perspective. This relationship between qualitative research and meaning has its origins in the philosophy of Kant (Hamilton, 1994a).

As such, there is no single definition of qualitative research; as it embraces concepts such as interpretation, understanding and inquiry in a so called natural setting as opposed to a setting which is controlled (Denzin and Lincoln, 2000).

Kant believed that knowledge could be based on human understanding, as opposed to empirical enquiry. The investigator or observer was considered integral to the interpretation and understanding of the experience. He distinguished between theory knowledge; which can be checked, tested and accepted, and practical knowledge which refers to decision making and moral judgement (Hamilton 1994). It could be argued that Kantian thinking as applied to the Salford Social Entrepreneur programme was useful because it encouraged the participants own experiences of their personal development based on knowledge coupled with understanding (Hamilton 1994b).

However, Revans believed in the scientific method (system beta) which clearly contrasts with Kantian thinking. According to Pedler and Coghlan, Systems Alpha, Beta and Gamma are at the core of Revans' theory of action learning (Pedler and Coghlan, 2006).

System Alpha focuses on the identification and analysis of a real organisational problem.

System Beta involves the rigorous and scientific explanation of the resolution of the problem through cycles of action and reflection.

System Gamma emphasises the learning of the individual and the change in their views and understandings.

Heron (1981) argues that orthodox scientific methods are inadequate for a "science of peoples" as it systematically and intentionally excludes the subject from the choice of subject matter of the research, all consideration of appropriate inquiry method and all the creative thinking that goes into making sense.

As I was working with a colleague to develop the Salford Social Entrepreneur Programme I decided that this should become the next phase of my work based inquiry. In doing so I designed, developed and supported two action learning programmes for the participants on the Salford Social Entrepreneur Programme.

These programmes provided a powerful process for participants to engage in developing a deeper understanding of how to progress and implement their projects, providing a framework for learning and taking action.

Using an action learning approach allowed me to ensure that the participants in my research were able to be observed and questioned as they personally chose the direction of their actions. The valuing of their authentic individual experience is the essence upon which this inquiry is based and which I was able to witness first hand as their set advisor. This provided the opportunity for me to observe record and question Set Participants during the set meetings. Through this approach I was able to relate meaning to their experience.

As a participant of a Research Set I was able to share and discuss the outcomes of those set meetings testing and exploring my many interpretations of what I witnessed. It was in the set where I was asked the most challenging questions which prompted reflection and further analysis.

Throughout both SSE Programmes I also received information from the programme Coordinator in the form of quarterly reports, from which I was able to analyse and compare the progress of Set Participants with my own observations. This information was at two levels, the first through the eyes of the Coordinator and secondly from the participants themselves. This provided an opportunity to validate my interpretation of their progress.

I also encouraged participants in both sets to write about their experiences and share this with others in the Revans Centre In-house publication, Link-Up. As a result all participants of the first set decided to write about their experiences and these where published in Link-Up, (January to March 2001).

The second action learning set members at the end of the programme, wrote a brief paper on their individual experiences, which although not published in Linkup are also considered as part of my research.

At the completion of the SSE Action Learning Sets I interviewed each participant to validate the interpretation and analysis of my findings. I asked each individual where the most comfortable place would be for the interview so that the conditions in which this would take place would put them at their most relaxed, and as a consequence encourage open and honest communication. Most of the interviews were undertaken in the participant's home. In other cases they were undertaken in their place of employment.

I used a semi-structured format which provided flexibility for the discussions to emerge from the questions asked. Because the discussion was the personal experience of the participants, this approach allowed the discussions to unfold in a way that a more structured agenda with closed questions might have stifled. I asked the following questions which were expanded on in free flowing discussion:

1. Did you achieve what you set out to achieve?
2. What has happened since we last met?
3. Are you now more involved in your community?
4. Has the SSE project increased your inclusion/mental health?
5. What do you think you would be doing if you hadn't attended the SSE Programme?
6. How do you think you have changed?
7. Can you tell me three learning points?

8. Explored statistical information & employment profiles.

The Salford School for Social Entrepreneurs programme provided the opportunity to undertake my research and the two action learning sets was where I gathered information that assisted me in exploring my research question.

The sets met for approximately five hours every month for twelve months. The first set commenced in November 1999 until October 2000 with five people one of who withdrew from the programme for personal and work reasons. The second set commenced in January 2002 until December 2002 and there were six people who all completed the programme.

At the set meetings I collected information through observing what was happening in the set and recorded this in notes, some written during the set and some written following the set meeting so as to capture the sets activity. After each meeting I then typed up the written notes. The use of spontaneous questions helped me to clarify and understand what I was observing as well as giving set members opportunities to reflect and consider the questions further eg, What are you trying to do? What is the difference between the current situation and the way you would like it to be? Can you explain? What assumptions are you making etc?

Participants provided additional information from the many newspaper cuttings and articles on their activities whilst on the programme. e.g. The Big Issue In The North, No317, 19-25 June, 2000, pg18-19, an article promoting the work of

the first Social Entrepreneur Programme, Manchester Evening News, an article "Social Superstars" how "Caring Volunteers win backing to transform their community" January 17th 2000; Salford Advertiser, January 17th 2002. An article on how "Community Spirit makes a difference". Information from quarterly reports both to and from the coordinator of the programme are also used.

Keeping a personal journal, allowed me to record and learn from my thoughts, feelings and questions as I reflected on their impact on me, my practice and my behaviour. This helped me in developing my self awareness as the research progressed.

As part of the doctoral programme and my own development and learning I attended regular Research Action Learning Set meetings for four hours every fortnight which provided a safe haven for sharing my uncertainty, challenges and vulnerability. I was not only researching my work but also my transition from set member to set advisor as well as grappling with the notion of undertaking a PhD. I also kept a record of these set meetings, recording what was taking place in the set.

Because of the amount of information being collected it was important that It was organised and so I developed a file for each of the action learning sets, both the SSE programmes and my Research Set. In the file I ordered the information on the SSE programme with a section for each of the participants and stored the information in date order. There were other sections for the set meetings, quarterly reports and a miscellaneous section.

Further information from my wider world of work has also been considered as I learnt from the many partnerships and networks that have developed from my work. This work exposed me to many different cultures in the public, private and voluntary sectors. An indication of some of those partnerships are discussed in Chapter 3.

Making Sense of the Information

At times I have been overwhelmed by the sheer volume of information that has been collected and had to consider how to collate and make sense of it. I read through the information on each of the SSE participants and started to order it in a way that told their individual stories which are described in detail in the following Chapter. It was important that they told their stories in a way that didn't restrict what they wanted to say.

I decided on a framework for recording their stories and started with the following headings, personal profile, the project, background to the project; achievements and learning. It was important to start with a personal profile of each of the participants as people are at the heart of this work and allows the reader to understand the person in the context of their project, its background and their achievements and their learning.

Over time as their stories were pieced together they provided a powerful way of communicating why participants undertook the SSE programme, what they had actually achieved, what they had learnt and how that was impacting on their development and their community.

Why Stories

This thesis then is a collection of interacting and interlocking stories that commences with my early experience of working in a "mental health asylum," and how this had an impact on me, followed by the story of how I progressed through various roles within the NHS. This built on my clinical experience as a nurse where during one to one meetings with patients I would invite patients to share with me how things had gone since our last meeting. From this experience patients were able to talk freely, not only about their mental health but all that had occurred since we last met. This provided a more holistic view of their lives, rather than a narrow focus of their mental health symptomatology. This allowed me to consider their ill health in the context of their lived experience.

Writing in this way was a process of continuous evolution, moving from observation, interview, and discussion and provided the opportunity for rich insights to emerge with meaning to that developed as the work progressed. These stories provide a framework for understanding me, my work, the SSE participants and the context in which I undertook this research. Reason (1986, pg25) argues that

> "stories and storytelling as a method of inquiry may be multidimensional. They are often
> - co-operative rather than unilateral
> - qualitative rather than quantitative
> - holistic rather than reductionist
>
> and take place in the real world rather than in an artificial laboratory." He further argues that "storytelling as an aspect of inquiry can work to explain or to express; to analyse or to understand."

Reason and Hawkins (1998) advocated storytelling as a way of undertaking inquiry into one's experiences or practice.

> "Meaning is part and parcel of all experience, although it may be interwoven with that experience that is hidden: it needs to be discovered, created, or made manifest, and communicated. We work with the meaning of experience when we tell stories, write and act in plays, write poems, meditate, create pictures, enter psychotherapy etc. When we partake of life we create meaning; the purpose of life is meaning. Here we follow James Hillman (1975) who argues that 'my soul is not the result of objective facts that require explanation; rather it reflects subjective experiences that require understanding' (p15). Indeed, Hillman has developed his own rich archetypal epistemology 'of the heart', based on loving and personifying as a way of knowing, which is one of the influences of our thinking."
> (p. 80)

Some of the stories were told in set meetings, some where published in Link Up, Volume 1 No10, pg4, Volume 1, No12, pg2. This is an in house publication produced by the Revans Centre for Action Learning and Research and was created for individuals who want to bring together research and practical experience. In the telling of those stories the language used in many instances was not amended so as to ensure that there was no misinterpretation in what people wanted to say and not distort it so as to retain the meaning. Professor David Megginson states that "Stories have a salience and meaning within the communities of practice that recognise their authority" (Megginson, 2001).

These stories are described in detail in the following Chapter. They provide a way to develop in-depth knowledge of the lived experiences of the SSE participants over the period of the inquiry.

In order to analyse the data I reviewed the information collected to assess what the preliminary findings might be. From this I:

- Read notes from set meetings;

- Reviewed the case studies ensuring they had incorporated the stories I had heard;
- Interrogated the notes from the semi structured interviews;
- Developed a list of emerging themes.

Writing this thesis has been frustrating and challenging due to a number of tensions that have emerged throughout my work as Service Director (Developments). These tensions stem from the fact that my work has developed from a position of developing service for people with mental health problems, with little or no involvement from them to a position of working in partnership with patients and the public and other potential partners in the public, private and voluntary sector organisations.

In the case of the Creative Living Centre we were working to realise a vision created by people with mental health problems. Although there was a clear vision this was quite a radical approach to service provision and we didn't know how we were going to realise the vision. Alongside this, so unconventional was this provision there were the challenges of this approach being understood by the Trust and any future funders' of the service.

I was also personally challenged as the approach was at odds with my previous experience and required me to fully understand the rationale behind the vision. If I was struggling to understand this how would I get the Trust and the wider mental health world to understand the model?

I decided to write an article about the Creative Living Centre which provided me with the opportunity to explain the approach and its position in the wider service provisions of mental health. This was my first refereed article and was published in the Royal College of Nursing Journal of Mental Health Practice, (Young, 1998).

Likewise the Angel Healthy Living Initiative was intended to be a Community Primary Health Care Resource Centre providing a range of services and treatments to be transferred from a local hospital. Talking to local health care professionals and commissioners it was clear that there was not the need for such a centre. Talking to local people revealed the need for a range of activities and services that would have an impact on the health of the local communities and are described in Chapter 3. Again there was a difference in the understanding of what local people said they needed and what the health Authority thought there should be.

The participants on the Salford Social Entrepreneur programme all became community activists as a result of the tension between their aspirations and dissatisfaction with the public sector response. The action learning programme at the heart of the SSE programme provided an opportunity to explore the individual and collective tension as they took action to realise their projects. Seeing the benefits of the SSE programme also challenged me to communicate to the Trust the value of this work in the context of Mental Health Promoting Communities.

These examples challenged me to be clear about how I describe the value of this work so that it would be understood by the Trust and other partners. This became a critical issue for me as the future of the projects were dependant on how well I could communicate the importance in the value of these services and the involvement of patients and the public. This was important as the funding of new services by the commissioners was expected to be evidence based.

The development of new services that are rooted in fundamentally different approaches cannot be based on existing evidence as essentially these services have never previously existed.

These experiences therefore have been complex and I have also had the challenge of communicating their complexity in the thesis. The experiences however have not been linear yet I have to write this thesis in a way that allows me to communicate what it is I want to say within a recognisable research framework that is understandable by the reader.

I have needed to take control of this tension as I feel I have something important I want to communicate about my experiences. I have therefore had to take control and position myself in a way that provides a balance to the conflict of these tensions. This has required me to put myself in the position of who might read this thesis, acknowledging the different starting points and mind sets between researcher and practitioner.

The development of my work has demonstrated the value of working with patients and the public and the need to ensure all partners are acknowledged

as equals but with different inputs. Equally it is also important that the practitioner as a researcher is also treated as equal with external observers as researchers.

Figure 6.

Methodology
List of Inputs

1. My action learning experience
2. My clinical and managerial experience
3. SSE action learning set – Observing, recording and questioning
4. Set notes
5. Research set – Observing recording and questioning
6. Research set notes
7. SSE Programme Coordinators reports
8. SSE participants reports
9. My reports
10. Articles for Link Up
11. Newspaper and magazine articles
12. Interviews with participants
13. Stories told by set members in set meetings
14. Journal
15. Published documents and literature
16. Policy documents

Chapter 7
The Salford Social Entrepreneurs Programme

In this Chapter I explain the background to the Social Entrepreneurs Action Learning Sets and describe the development of the Salford School for Social Entrepreneurs.

It provides a personal profile of all the set participants, why they wanted to be on the programme, what they wanted to achieve and their success in doing so.

It gives an insight into my developing role as a set advisor and the challenges of their roles.

Introduction

The first 'Salford Social Entrepreneurs' Programme started in November 1999 and was the first of its type anywhere in the United Kingdom. It was run by the School for Social Entrepreneurs (SSE) in partnership with Salford Community Health Council. The funding came from the Manchester Salford and Trafford Health Action Zone for a pilot programme to support a group of community activists from socially deprived neighbourhoods. The purpose of the Programme was to

> "Increase the confidence, capacity and skills of local people by;
> - tackling the problems of their own communities
> - giving them access to local and national support networks
> - bringing about practical community improvements in Salford"
>
> (Dabbs, 2000a, Pg4).

In doing so it provided the opportunity to address problems in communities in Salford by bringing together local people to work on those problems. A copy of the full programme can be found in Appendix 8.

The first programme developed from five grassroots activists working on projects in their own areas in which they determined the form, nature and theme. The Programme has built on the model of the SSE's national programme, which includes action learning. The Local Coordinator of the Salford Entrepreneur Programme having completed the national programme translated the model to one appropriate to a local level. The approach adopted by the SSE is

> "Learning by doing through experience, inquiry and discussion. It is based on a belief that entrepreneurs learn best by taking action and by learning from other practitioners. Core principles are therefore: action learning; 'just-in time' learning; and person-centred learning"
> (Dabbs, 2000b, Pg5)

As well as this their individual projects the participants also benefit through study days with 'expert witnesses' who were acknowledged leaders and role models from a variety of backgrounds.

Background

I have known (Chris Dabbs) the Local Co-ordinator of the Salford Entrepreneur Programmes, for approximately ten years, through his role as Chief Officer of the Salford Community Health Council. In that time we have "been there for each other" offering mutual support and sharing ideas in times of difficulty. Whilst Chris was on the National Social Entrepreneur Programme in 1998, he often shared his experience of the SSE Programme its benefits and what he

was learning. The national SSE programme was based in London and we questioned why many exciting programmes were always in the South and not developed in the North. Chris decided to pursue this further and explore the potential opportunities for developing such a programme in Salford.

To this end Chris made contact with Michael Young (Lord Young of Dartington) who founded the School for Social Entrepreneurs and the Open University. Chris encouraged Michael to come to Salford to explore the possibilities of a project to address social exclusion with a view to establishing a partnership with the National School for Social Entrepreneurs by having local people involved in a local programme. Following the visit of Michael Young to Salford in 1998 he encouraged Chris to develop proposals for establishing the Salford programme. The draft for this new programme was initially completed by Chris and circulated to a number of people (of which I was one) for comments and was completed on the 13 November 1998 and as a result, the Manchester, Salford and Trafford Health Action Zone funded the pilot programme in Salford with the aim of addressing social exclusion through developing the capacity of local people. The Salford Community Health Council worked with the School for Social Entrepreneurs on the development phase of the project; as a result in July 1999 people were invited to consider applying for a place on the programme. Consequently five people were selected as part of the first Salford Social Entrepreneur Programme.

As part of the planning of the project I was approached by Chris and asked if I was interested in developing and providing the action learning programme.

Without hesitation I agreed and got immediate support from the Trust. (See Appendix 9 for copy of the letter of support from the Trust).

I saw this as an opportunity to build on my community development experience and specifically explore how local people could benefit through using an action learning approach to understanding, explaining and taking action as they wrestled with their projects that were the focus of the SSE programme. This provided me with the opportunity to research the impact of local people embracing action learning, on their lives and specifically their mental health and social inclusion.

First Salford Entrepreneur Programme

This first programme commenced in November 1999 for twelve months with the participants being given a bursary to support their living costs. Having agreed to be Set Advisor and obtaining support from the Trust, I met all the participants for an introduction during their first week of the programme and to fix a date for the first action learning set meeting.

The Set Commences

So In November 1999 I started as set advisor to five women from Salford who had an incredible amount of energy individually, and when they came together I feel sure that they could have powered the National Grid. I had enough anxiety about my role as a Set Advisor without having to concern myself with how I would "cope" with the collective energy of these "live wires" or as Chris Dabbs the local SSE coordinator calls them "Spark Plugs ".

In anticipation of the programme commencing I gave some thought to the first meeting, which was shaped by the following questions:

- how should I introduce the concept of action learning?
- could I do it, and why was I asking the question, why was there some doubt?
- where should we meet?
- how effective would I be as a Set Advisor and how would I know?
- how do I ask them to agree to be part of my research?

I remember thinking about my experience of being in action learning sets, both with Professor John Morris and Dr Donna Vick. I recall that although they were the Set Advisors they also felt like members of the set. How did this happen? I thought I would be reasonably OK if I behave in the same way. This naive and arrogant view gave me the confidence to take my first step in experiencing life as a Set Advisor. It didn't take long for me to ask myself questions regarding my new role as I experienced periods of discomfort with the role. It was clear to me that there was more to it than just "behaving" like another set member.

The first SSE set meeting was held at the Revans Centre for Action Learning and Research at the University of Salford which met with the approval of the participants (they had never been in a University before and seemed quite excited about the prospect. It appeared to be an immediate recognition of their value). I began to give some thought to the first day and how best to introduce the concept of action learning.

Although action learning is such a simple concept I found it difficult to explain. I remember thinking how I have never explained my understanding of action

learning in the same way more than once. I decided that I would ask Dr. Donna Vick to present an introduction to action learning as it was more important for this to be communicated right first time rather than risk me leaving the set members with more questions and confusion than when we started. It also provided the opportunity for me to observe and record what was happening. Why did I doubt myself? I also invited Professor John Morris. They had never met a real professor before.

In preparation for that first set meeting I wondered how I might hold together the many strands that make up the process of action learning that would provide me with a point of reference, for ensuring that what took place in the set was action learning.

From the very first set meeting I was welcomed with open arms by all the set members. As our relationship developed I was accepted into their lives unconditionally, sharing their hopes, fears and aspirations. At set meetings there was a natural sharing and reflecting (and sometimes tears) of their personal pain as set members recalled their personal struggles. Equally there were many joyous occasions, successes and achievements. I am truly grateful to them for allowing me to be a small part of their lives and their willingness to contribute to my research, as it provided the opportunity to immerse myself in the research rather than just standing on the sidelines and observing from a distance.

It should be noted that the language used by the participants is reflected in the thesis as they presented it i.e. in their own words as it was pertinent to the

positions they found themselves in and allows the reader the opportunity to get along side them.

There were a total of eleven people (in two action learning sets) that were the focus of my research each with unique life experiences and aspirations. The SSE programme exposed them to many challenges in pursuit of their individual goals.

In trying to make sense of the information arising from my research I decided to use a case study approach that would provide me with a profile of each of the participants. In doing so I wanted to highlight the background to their project, their achievements and learning, bringing their experiences to life. In doing so I am conscious of the fact that the written word has its limitations. Throughout the process of compiling the case studies I made a record of the themes that emerged that were common to all participants.

The People – The First Set

Jay Brennan Little Hulton

Jay described herself as being 43 years young. She was a single mum with three teenagers and had lived in Little Hulton for nineteen years. Although Jay has been unemployed for the last ten years, she has kept herself busy through voluntary work. She initially became involved in community work with a local Heart Start initiative. Heart Start aimed to train local people in basic life support skills and have trained local people to become instructors who in turn train other local people.

The Project Healthy Living Centre

Jay's project was to develop a community-led healthy living initiative in Little Hulton, which would provide services to five estates with a population of 10,000 to 12,000 people. Her aspiration was that of developing a Healthy Living Centre to promote healthier lifestyles. The centre would provide

- A community café;
- A Drop In Centre;
- Young peoples Advice and Information Service;
- An Equipment Loan Scheme;
- Activities for children and young people;
- A Community Transport Scheme;
- Community Garden
- Complementary Therapies.

The Background

Jay's involvement in community work started in 1994, after years of "being put down and being mentally and verbally abused." She woke up one morning and felt that she deserved to be treated better than this. After years of questioning and challenging people, she'd been put down so much that she had:

- No confidence in herself;
- Low self esteem;
- Believed it was wrong to challenge and question people in authority e.g. teachers, tutors, authorities.

She decided to take a step back and look at her life, and ask herself two questions:

1. Why did I not challenge anymore? Her response was, because I had been put down so many times.
2. How could I go about turning the situation around and be a much stronger person?

She responded by looking for taster sessions in assertiveness and confidence building. She decided to take action and joined a local group, which became Action on Health. That group identified new health issues in their community. Jay wanted do something to progress these health issues further. This motivation slowly increased her confidence and within a year she started to notice a change in herself. She was feeling more confident, relaxed, and easygoing. She'd let go of a lot of anger that was pent up inside her. She also learnt that she wasn't a failure, and was "worth something". She felt that joining the group was the best thing she could have done,

> "Learning with other people and sharing information is the best thing you can do. I know that without joining this group I might not have been the same person as I am today."
> (Brennan, 2000a, pg5)

When she saw the advert for the Salford Social Entrepreneur programme, she wasn't sure if it was for her. However her group encouraged her to apply for a place on the programme. Although she still had feelings of "will I be good enough? Will I meet their expectations?" she would now have to face more challenges, which was frightening.

She was also concerned that she wouldn't be able to spend as much time with friends from the Action on Health Group who had given her so much support and encouragement. Despite her fears and anxieties Jay states that;

> "I've never had a job for years. When I applied to be honest, the same fears re-appeared and I started faltering. Should I? Shouldn't I? Did I really want to - and after all what was an entrepreneur? I had never heard of it, and I remember being scared of even looking it up in the dictionary."
> (Brennan, 2000b, pg2)

She felt that if she was successful then not only would she benefit, but so would the group members as she would be able to pass her skills to the group, not only could she move on but so could the group.

Achievements

Since leaving the SSE Jay states that

> "My confidence has grown. I am able to communicate with people at all levels. I have successfully put a bid to the Health Action Zone for development money and received £39,000 to develop my project. I went onto get the job as Project Development Officer in the local Primary Care Group. I was elated; I could not believe it, now I could take my Healthy Living Centre Project forward and make a difference to my community. I am now in full time employment."
> (Brennan, 2001a, pg2)

Once in her new post, Jay's next step was to submit a first stage bid to the New Opportunities Fund for £1.7m to fund the development of the centre. She worked closely with people in Little Hulton, consulting with them so that the proposals were based on what local people say they want and need. The bid went in on 10 December 2000. The partners to the bid were Salford Community Health Care Trust, Mental Health Services of Salford NHS Trust (represented by myself), Salford East Primary Care Group and Salford City Council.

Having set up a steering group they developed a funding proposal to the "New Opportunities Fund" for a community led healthy living initiative in Little Hulton. Although the proposal for funding was not successful Jay continues to be employed by Salford Primary Care Trust and is now employed (December 2000) as Community Health Development Worker. This was the first time she had had a job for fourteen years.

However although there was no funding for building a healthy living centre, this did not deter Jay. She has successfully developed the following services:

- Community cafés in two different estates open in the afternoon, with aspirations for them to offer catering services to local community groups;
- A Drop In Centre was developed at St.Pauls, and a young peoples Advice and Information Service in a young persons centre called K.I.S.S. (Keep It Safe In Salford) providing condoms and sexual advice and health promotion;

- An Equipment Loan Scheme was established providing safety equipment for children. This was being extended to include lawnmowers, power tools etc;
- Supporting activities for children and young people in three sports clubs.
- Organised health promotion events at a local school which has become an annual event. At the event participants were able to explore opportunities for counselling for bullying, sexual help and advice;
- Undertaking a Diploma at Manchester University in "Youth and Community Work" and developed her counselling skills for the "Freedom Programme" for supporting women who have been subject to domestic violence

She has also been involved with the development of

- Homework Clubs on all three estates.
- Senior Moments Group providing activities for isolated older people.
- Established a FLU jab promotion scheme, negotiated the use of the dental bus to travel round her community stopping at "local pubs and the bookies". As a consequence there was a 9% increase in uptake of the flu jab that year in Salford.
- Health improvement activities with a team of others for people with drug and alcohol problems.

Although there have been many changes in terms of the development of the project the main changes that have helped Jay to develop the project are her own personal development rather than the development of specific skills, she identified these as follows:

- Feeling in greater control of events, better able to make her own decisions;
- Greater self confidence, including dealing with people in positions of authority;
- Better communication and interpersonal skills, especially in managing different personalities and clashes;
- Taking time out in stressful situations;
- Healthier life style, lost weight, and cut down on smoking.

Charlotte Richards **Stowell and Ordsall**

Personal Profile

Charlotte lived in Stowell near Ordsall is aged 37, and a single mother of two confident children aged 15 and 18. She established and chaired the Stowell Community Group which was made up of other local residents, and succeeded in starting a weekly club for local children.

The Project

Charlotte's project was to develop clubs and facilities for all the children and young people in Stowell.

Background

On the estate where Charlotte lives there was no green space, no sport or play areas. There are 250 children, and young people who she feels were "ignored and left to find their own entertainment". Charlotte believed that people should do something to give children and young people a place to go to, to let off steam. The nearest play grounds were a mile away, one is accessed via a dark subway, the other across two busy main roads.

Charlotte was prompted to take action when her son came home from school one day after having been beaten up at school he "got a battering." She recalled her son saying "but I didn't fall down; if I did I would have been murdered." This motivated Charlotte and instead of waiting for others to do something Charlotte decided to act and stated that "I'll be the one to give my

community what they need". She initially set up a Monday Club for young people on her estate. However she knew of a piece of vacant land locally that could be developed into a play area, so she approached Salford City Council. She was initially told it would cost too much to develop. She knew she needed to gain more support to progress with her project, but what? She became aware of the Social Entrepreneur programme and decided to apply, and was accepted.

Achievements

Charlotte acquired the land she wanted for her project from the City Council and successfully negotiated a partnership with Manchester Methodist Housing Association who offered to maintain the land. Their motivation for doing this was because they own most of the housing on the estate and they believe that some of the damage to the properties was a result of local young people having nothing to do. The development of the land would give young people something to do, and it was anticipated that damage to the housing stock would reduce.

Charlotte developed a Steering Group to progress the project further. She secured the services of the Fire Brigade and Territorial Army to clear the land which was overgrown, to develop a football field and provide a safe place for young people to play.

Unfortunately Charlotte's motivation for the project was affected as a consequence of being burgled. Money was taken from her house that belonged

to the project. There had been an inference that this was an "inside job", which devastated Charlotte. Unfortunately it since transpired that Charlotte was in the house when she was burgled and knew the person. Despite this she continued to develop the project and secured and developed the land for local children and young people to play, and this was now a local fixture. Since the completion of the programme, despite frequent attempts, it has not been possible to speak to Charlotte. I believe she has a new partner who has his own business and she is now working with him.

Janette Ball **Valley Estate Swinton**

Personal Profile

Janette lived on the Valley Estate in Swinton. Aged 46 she had two children aged 26 and 22 and a beloved grandson. She was involved in setting up a resource centre, a women's group, a community lettings initiative and the Valley Partnership. She was also the Chair of the Swinton Community Committee.

The Project **Operation Valley**

Jeanette's project was to develop a "backing" area on the Valley Estate with local residents for play and leisure activities and to improve the environment.

Background

Jeanette had, for many years, recognised the potential of the land on the estate, but it was during the 1999 Summer Play scheme that young people made demands upon the Local Authority to cut the grass in order that they could have an outside play area. As a result, the Lightbourne Green Development Project was born, purely as a consequence of local people saying what they wanted. The children and young people identified the need for safe play areas, sports areas and a community garden and it is their designs which were the focus of Jeanette's project, the aim of which was to realise the dreams of local children.

The land adjoining the estate was used as a dumping ground and a haven for drug users. The area houses an under used pre-fabricated Social Services run Community Centre with a leaking roof. The approach to the centre was poorly lit, there was no safe parking.

Achievements

On the 7th August 2000 on the Valley Estate 100 people came into the community every day for 10 days to help develop her project.

Every single garden on the Estate had something done to it at the house holder's request. They painted the Community Centre. Built 3 storage cupboards in the Centre, altered the kitchen, provided a path and steps to link the Community Centre and the Resource Centre, built a community barbeque, hard core was laid and six acres of land cleared. (Young, 22nd August 2000, Notes from Set Meeting

They didn't manage to finish it completely but local people said "sod it, we will do it ourselves."

Home Secretary Jack Straw on a visit to the site heaped praise on the project where a massive community makeover led to a dramatic drop in crime. He toured the previously rundown Valley Estate in Swinton, where an army of young Christians, Police, Council workers and residents carried out a Ground force style operation over 10 days in summer 2000. The blitz against the clock involved sprucing up hundreds of gardens and neglected areas, as well as creating a community garden and an outdoor amphitheatre. Despite some of the tasks falling behind schedule, Operation Valley has since seen crime fall by 45% in an area once known as Salford's worst crime spot. Speaking to residents and project workers at the refurbished Valley Community Centre, Mr Straw said

> "Operation Valley has lifted people's spirits and given them a sense of confidence in themselves and their ability to raise the quality of life for their children and raise their own quality of life away from the pool of demoralisation which can fall on an area like this."
> (Straw, Manchester Evening News article, July 2000)

He added "this is just the first phase of Swinton's regeneration. A 45% reduction of crime is extremely impressive and I look forward to hearing about how the project progresses."

In a local newsletter Operation Valley Update local people confirmed what had been achieved and stated that:

- 300 tons of rubbish removed from the Valley;
- All residents were asked what they would like to be done to their garden. As a result all the gardening requests were completed and they were left with the tools for them to maintain their garden;
- Linear Park cleared and path laid. More people have walked down the path in the last two weeks than in the last few years;
- New flowers planted;
- Dog walking area in place, dog bins and signs are on the way;
- Resource Centre now has a new larger meeting room which was decorated and fitted with new carpets and shelving;
- Community Centre was painted inside and out. New play equipment was donated;
- Base foundations for the community garden were completed;
- The amphitheatre mound has been grassed over;
- Painted goal posts and new football kits so that Valley United can get training and playing;
- All graffiti was removed off the walls.

On completion of the programme Jeanette remained unemployed. This did not deter her from continuing the work that she started. In fact it provided space for her to reflect on the wide range of activities she was involved in and concluded that she could not continue to sustain the level of input into those activities. As a consequence she resigned as secretary of the Residents Association and now feels as though she has the weight of the whole world taken off her shoulders. In fact she feels that this has helped the wider community as it has given other people on the estate a chance to stand on their own two feet empowering them to take responsibility through taking over from where Janette left off.

Janette felt that on a personal level this has created time to think about herself and what she wants. She has learnt the benefit of sharing the workload and tasks with others and that it is ok to say no! It has given her more time to spend with her grand children. She values herself more now, was undertaking some consultancy work and had aspirations to undertake an academic qualification at degree level. Following an interview with Jeanette (8th February 2001) she informed me that:

- they have since secured £92,000 from the Home Office to develop the neighbourhood liaison service;
- has been offered a part time job with the audit commission working across the North West with the housing inspectorate.

The "backing area" (which is the term local people use to describe the waste ground at the back of their estate) which was a three year project was progressing after securing £10,000 from "Green in Greater Manchester" which

is finishing the development of the community garden. As an offshoot of that development a local football team and club has been established and play in a local league with sponsorship for the football team's strip from Umbro.

Janette had also been busy expanding "Helping Hands" a community business in Swinton providing a minor repair services for the elderly, disabled and households with children under five years old. On the 26th of January 2001 she secured £25,000 to expand the service into Irlam and Cadishead. The services provided are decorating, curtain hanging, changing light bulbs etc. Such was the success of the scheme they are hoping to provide the service across the City. Securing new funding in February 2001 has allowed the scheme to purchase two new vans. The project now employs five people, which has doubled the number of people they employ.

Gwen Rolfe Lower Broughton

Personal Profile

Gwen aged 32 lived in Lower Broughton Salford, and was a mother to five daughters. She was the Chair and a founder of the Tiny Tots Play Group.

The Project Tinytots

Gwen's project was to set up a community child care business that would provide not only child care, but also a range of services such as training, after school clubs, youth groups, homework clubs and parent craft sessions.

Background

Gwen left school at 15 to have a baby, she left without any qualifications and her confidence severely dented. She was told that her "life was over" and she'd made a great mistake and was told "You've made your bed now lie in it". Gwen said that "she was bright and determined not to be left out of society". She felt neither an adult nor a child so she joined a local youth club as the junior DJ. This led her into community work. She took her baby with her and soon became an expert "body popper" and became confident and outgoing. Gwen then decided to start a parent and toddler group, so they could both socialise. She felt that they were "a little team" and soon they were running the group and organising new activities. Some of Gwen's motivation was rooted in the many stories she has heard from local people over the years. She recalls

> "One broke my heart; it was a young mum aged nineteen with two children. She tried to get them into a nursery. She was refused because she was told she was coping. So she went to her GP and asked for Prozac

(antidepressant) just so she could say she wasn't coping and get a place in the nursery."
(Rolfe, 1999)

Achievements

Gwen had secured partners to develop Tinytots Vision Ltd and was now employed as Project Coordinator implementing and developing her dream. This was her first and only time she had been in employment. The following represents the services that Gwen has developed building on the initial Tinytots Playgroup that she ran with other mums and volunteers. She now employs 27 people all from (Salford) the local area. Her achievements are as follows:

Tinytots Nursery

This was the business that Gwen worked on as her project in the SSE. This dream was realised in March 2005 when the nursery opened. This was a new build provision having raised £565K for the capital development and £250K revenue. The nursery provides 55 places and employs 15 people.

Tinytots Playgroups

These are held at the Angel Healthy Living Centre, Nazarene House, and Lower Broughton.

Tinytots Mobile Crèche

They provided play activities through a play worker, working in the following areas and organisations:

- Mocha Parade Community Precinct;
- Higher Broughton;

- Salford City Council;
- Jewish Community.

Tinytots Play Spot

They provided any play activities required on the streets often encouraging children to explore the use of older games e.g. Hopscotch, whip and top, yo yo etc. This she said was as an opportunity to divert energy that could have otherwise led to anti social behaviour.

Tinytots Family Activity Days

These were provided during the summer holidays and involved the parents as well as the children. The activities varied and involved some health promotion activity e.g. healthy eating, promoting good dental hygiene.

Tinytots Training Sessions

Here they provided a range of training activities e.g. relaxation techniques, photography, flower arranging, car maintenance for parents with facilities for childcare.

Tinytots Outreach Work

Provide advice and information services supporting parents and children.

Tinytots Health Promotion

Employed a Nursery Nurse who worked with parents promoting positive health.

Tinytots Fit City Club

Dance exercise weekly held at the Angel Healthy Living Centre.

Tinytots Consultancy

Here Gwen provided a consultancy service to housing association tenants working in the local streets.

Mary Ryan – Little Hulton

Mary established and ran the Clegg Lane Community Nursery in Little Hulton. Her project was to secure the long term sustainability of the nursery developing, broadening and diversifying its childcare and training services so that they are available to local people.

Unfortunately in February 2000, Mary withdrew from the programme for personal and work reasons, although she felt that she would have benefited by staying on the programme. Despite this Mary had been able to secure the long-term future of her nursery in Little Hulton and also managed its relocation to "Tinkerbells" were she remains as manager.

Reflection on the First Salford Social Entrepreneurs Action Learning Set Learning as a Set Advisor – October 2000

On completion of the first action learning programme for the Salford Social Entrepreneurs programme I was amazed that the first 12 months passed so fast. I thought it would be useful to think about the programme including a reflection of my role as Set Advisor.

The first issue I considered related to the set participant's projects and the frequency of the meetings. As well as the set meetings there were personal reviews, study days, meetings with the SSE Coordinator and meetings with the course tutor. These different forums became opportunities for talking through problems and progress related to their project and their personal development. This coupled with the set meetings only being monthly often meant some important issues were not able to be brought to the set meetings. This was identified at a set meeting on the 21st January 2000 I recorded in my set notes:

> "There was so much happening that the set participants felt that they would benefit from fortnightly set meetings. Additional to this there would be a gap of two months if one participant was unable to attend a set meeting."
> (Young, 2000)

The value the participants placed on the action learning set meetings was reported in the report (by the programme coordinator Chris Dabbs) of the first quarter of the programme covering the period November 1999 to January 2000, which stated;

> "Everyone particularly values the action learning set meetings. These are described as a "priceless" opportunity to discuss relevant issues to personal and project development, including the highs and the lows.....It is a place were you can "let off steam"... and enables people to answer their own problems."
> (Dabbs, 2000, Pg2)

I had also recorded in my journal in February 2000 how;

> "The set has come together and gelled with ease, probably because of the amount of work they have undertaken together outside of the set. Although confident the set participants have started to share their doubts and fears. They are questioning and challenging almost automatically and, although it is early days, there is clear action being taken outside of the set."
> (Young, 2000)

The next problem was that the SSE programme contained too many formal study days and that this had disabled and overwhelmed some of the programme participants. This however, had been acknowledged by the SSE Programme organisers and in fact the last three months had seen a significant reduction in the number of organised study days. I believe quite strongly that the money that would have gone into putting on the study days should go into the individual learning accounts that the programme participants have so that they can access different activities as and when they required it.

Within the Set I had been able to listen to each set participant's many stories and have observed plenty of questioning. Those stories were so powerful that it was decided by the set to write the stories down with a view to them being published in Link Up. This was a publication in the Revans Centre, by and for individuals who desire to bring together research and practical experience. The article was published in July 2000. Seeing the article in Link Up revealed a powerful amount of information that they had struggled to record but had a lot to contribute to their personal projects and individual learning. They could not believe that other people would be interested in what they had to say.

There were only two occasions where written material was actually brought to the Set Meetings. This issue about recording learning and action has lead me

to question whether you can run an Action Learning Set that is not a formal programme, as the formal programmes require a demonstration of how progress is recorded. This raised a question as to what mechanisms was used to record what they were learning and experiencing. This prompted me to observe and monitor how the participants in the next Action Learning Set recorded their progress. I discovered that this second set took individual notes and wrote monthly reports on their progress that went into the overall project reports that were written by the Chris Dabbs the Project Coordinator.

In preparation for the second action learning set for the Salford Social Entrepreneur programme I decided to build on the experience as Set advisor for the first SSE programme. I decided that following the introductory session on the 8th January 2002 I commenced the set meeting and

1) explored if there were any questions following the introductory session,
2) invited them to think about ground rules,
3) explained my role as Set advisor,
4) introduced my research and seek approval from them to be the focus of that research, and
5) Confirmed dates for future meetings.

(Young 2002)

The set meetings took place at the Angel in "Young's" Room – it felt strange having a room named after you.

Second Salford Entrepreneur Programme-January 2002 to December 2002

The second Salford Social Entrepreneur programme began in January 2002 and was supported by Salford Community Health Council, The Millennium Commission and SRB5 Salford Regeneration Budget. There were six local people from Salford who I first met on the 30th February 2002 where there was an introduction to each other and I initiated a dialogue that introduced the group to action learning. The time invested in this "getting to know you session" was well spent and provided a solid foundation for a relationship that was to develop throughout and beyond the SSE programme.

The value of this session for one of the participants was recorded in his reflection of the first set where he states that at;

> "Our first action learning set....the group just opened up with comments that they wouldn't have any other time and I think from that moment the group just bonded together. That's when I realised that my confidence was growing by not only being able to talk to strangers about my project, but also being able to work in a team"
> (Dabbs, 2002, Pg46)

The People – The Second Set

Kevin Coakley **Charlestown**

Personal Profile

Kevin was 49 and lived in Charlestown, Salford. He has lived in this community all of his life and was passionate about wanting to make a difference to his community. As well as having run his own small business, he had a long history in community action including education, environment and health.

The Project **Clockwork Orange**

Kevin's project was to improve local people's access to fresh fruit and vegetables at affordable prices through the development of a fresh food co-operative.

Background

It was almost impossible to buy fresh fruit in Charlestown. It is a food desert. Public transport is poor and 46% of the population have no transport.

In March 1999 Kevin became involved in New Deal for Communities (NDC) which was an important part of the Government's plans to help some of the most deprived neighbourhoods in the country. The money could be spent on tackling unemployment, improving health, tackling crime and raising educational achievement. Other local concerns such as housing could also be included however not all the money could be used to improve one specific area.

He had heard about the SSE programme and felt that he could make a practical impact on the health of people in his area. His project grew from the

assessment of the health of people of where he lived (the NDC area). This resulted in him discovering that there was a high rate of Cancer in lower Kersal and Charlestown.

Achievements

The idea to develop the food co-op coincided with the governments "Five a Day" Initiative which was a drive for encouraging healthy eating through the promotion of eating five pieces of fruit and vegetables a day. Funding was made available from the New Opportunities Fund for the 88 most deprived communities to put forward applications for funding for local projects. Salford Primary Care Trust (PCT) who were aware of Kevin's work approached him to explore if he wanted to work in partnership to put a bid together to develop a community enterprise to supply quality fruit and vegetables at affordable prices in an accessible manner.

The bid was successful securing £55,000 for two years and as result Kevin developed a community enterprise "Clockwork Orange". They sold fruit and vegetables both in bulk to organisations and to individuals. Some examples where this service was provided are as follows:

Sheltered Housing Schemes

Peter Loo Court and Lancaster Lodge for elderly people.

Play Schemes

Scallywags, Match Sticks, Tinytots and Cheeky Cherubs Nursery.

Community Centres

Langworthy Cornerstone Community Café, Humphrey Booth Centre, for elderly people and Brierley Lodge.

Schools

Charlestown Primary School.

Community Events

At Salford Quays and the Healthy Salford Fair.

Mike Felse **Salford 5**

Personal Profile

Mike was aged 50 and made a life changing decision to move to Salford from South Yorkshire in 2000 and left his job as a manager of a training organisation.

The Project **Active Citizenship**

Mike's project was to develop and implement a sustainable approach to developing citizenship.

The Background

Mike left school at 15. He came from a mining family and consequently worked as a miner and had all the experience of the miner's strike. He was made redundant from that job and became a training manager providing information and technology training to assist people into employment. He got to know a lot of people on the courses that were provided. He made a conscious decision to finish work at 50 to do those things that he wanted to do. Having spent time working as an NVQ assessor he wanted to explore options for developing standards for citizenship for adults.

Achievements

Mike has developed better networks having moved to Salford and feels more rooted in his new community, increasing his social inclusion. This has helped him develop a new career which he now states has given him a purpose in his life.

He has successfully developed and piloted an active citizenship programme in partnership with City and Guilds which developed from his work on the SSE programme. The programme is "The Individual Profile in Active Citizenship NO 35925." In doing so he successfully guarded the development of his active citizenship programme so as to ensure it remained rooted and owned by grass roots people and not manufactured and boxed as a traditional training programme.

He has set up Proud City which is a Salford based Social Enterprise, created in 2002 and is committed to contributing towards the meaningful revival of public participation through intergenerational Active Citizenship assets.

He also set up Team Salford with colleagues from the Salford Social Entrepreneur programme which was a new social enterprise that aspires to turning citizenship in Salford into a reality.

Julie Hull Swinton

Personal Profile

Julie was aged 36 and married with two children aged eleven and ten and lived in Swinton. She was a registered childminder and playgroup leader for ten years. She was also studying for an NVQ3 in childcare and education and had undertaken several other childcare related courses. Julie previously worked as an Insurance Broker until she became pregnant. She worked as a voluntary playgroup worker, registered childminder and developed after school clubs.

The Project Kool Kidz

Julie's project was to open a purpose built childcare centre which would provide good quality affordable childcare for mums in her area who are not as lucky as she was. The project would be a community enterprise providing opportunities for voluntary and paid workers.

Background

Julie had previously set up a playgroup and an out-of-school club in her area which was unable to expand due to lack of space. Julie's wants to realise this expansion of facilities and it is this "DREAM" she wanted to make come true through her involvement as a participant of the SSE programme.

Achievements

Julie had negotiated the use of a building which unfortunately fell through for two reasons. The first was that the owner wanted to continue to live there above the ground floor, and secondly some one else bought the building. She then had discussion with the headmaster of Mossfield Primary School. They had a

spare piece of land at the back of the school which could have taken a porta cabin as an interim measure. Unfortunately this was not able to be progressed as the vehicle access route to the land was problematic in that in the case of a fire a fire engine would not be able to get to the building.

Julie then had a number of personal problems which prevented her from continuing to progress her project. When the SSE programme finished in January 2003 Julie worked as a private child minder until December 2003. She then worked for a short period providing school meals.

She then took a position working for Salford's Council for Voluntary Services (CVS) based at Eccles. She was responsible for administering small grants and believed her experience from the SSE equipped her with the skills for this job. She commenced in February 2004 until January 2005, when she was appointed as an information support worker, with CVS. Her role was supporting community groups providing them with information and access to information technology, printers, photocopying etc. Julie now states "I have found my niche" Interview with Julie (February 10th 2005) She has also been actively involved with other set members in setting up "Team Salford" a social enterprise and undertakes voluntary work as:

- Secretary for a local football team;
- Secretary for Swinton Youth Partnership;
- Treasurer Manchester United Supporter Club (Swinton Branch).

Dave Kennedy **Irlam**

Personal Profile

Dave lived in Irlam with his wife Heather. As well as setting up a local Heart start scheme, he had been actively involved in a range of activities to promote cycling in his area. Dave suddenly died in May 2004 and is sadly missed.

The Project **Pedal Power**

His project was "Pedal Power" which was about recycling old bikes for re-sale and looking at the development of a bicycle taxi service for the elderly and disabled.

Background

Dave had no educational qualification and had spent most of his life working in the building trade where he developed a back problem and had to leave. He felt that he hadn't made anything of his life and decided to "get off his backside and do something". He took an interest in cycling (mainly as a result of losing his driving licence).

Achievements

Dave trained all the SSE participants in "Heart Start" who are now qualified in basic life support skills.

Dave successfully negotiated a lease on a shop from the Council and secured funding to make improvements to the shop and provide a computer for the office.

This provided the base for Pedal Power where he repaired and sold bicycles and spare parts. He launched a bicycle taxi service on the 1st May 2002 and received his first booking for a wedding on June 14th 2002. He employed two local people working four days a week and provided opportunities for volunteering and offered two placements for local people in partnership with Action for Employment (A for E) an employment agency for six months.

John Pennington Little Hulton

Personal Profile

John was 36 years old, married with four children, two boys' two girls one grandson and lived in Little Hulton. A qualified sports leader, he worked with hundreds of local young people to involve them in sports. He left school at the age of 16 for an YTS scheme earning a grand total of £25 per week. He started work at the age of 18 as an apprentice thermal installation engineer. He left after an accident, leaving him with a back problem and had not worked for 12 years before starting on the SSE programme.

Project Peel Community Sports Development Centre

John's project was to develop a sustainable facility for sporting and other activities for young people. John's aspiration was to open a Community Centre in Little Hulton where youth can participate in various sporting activities. And encourage families to live a healthier lifestyle and work together in a positive manner through sport.

Background

John previously lived in Kersal and his involvement with sport started approximately seven years previously when he saw his friend's 4 year old son kicking a ball in the front garden. An elderly couple next door complained and told him to move. He went into the road playing football and was killed by a bus. In Little Hulton children were also playing on the Green and parents told them to move. There are three estates within Little Hulton - Kenyon, Amblecote and Peel. He joined the football club on the Kenyon estate. Some time later he realised there was no team on the Peel estate so he started a football club

there. He didn't know much about how to go about this but he got himself booked on a UEFA coaching course and passed with flying colours and is now a qualified teacher.

He decided to attend a local resident meeting but discovered the focus was on political party issues, not about the issues of importance to local people. He generated a vote of no confidence and the committee actually resigned because of the numbers of people who had no confidence. As a result he was encouraged to be on the committee and was now the Chairman.

From that experience he got to know local counsellors and developed various relationships that have helped him to secure a grant of £3,000, which allowed him to buy football strips. He then negotiated the use of the local schools football pitch. Then they needed money to join a league and pay for a referee, which he achieved. He worked with approximately 80-90 children and they have five football teams. He encouraged other parents to go on coaching courses and five local youngsters have been on referee courses. As a result they can earn money from refereeing football matches. Teaching rules of the game as a referee also taught young people about discipline. He then thought about those people who don't like football and felt he wanted to do more and so he enrolled on a Sports Community Leader's Award course and this led to his project to get other kids to have a taste of other sports.

Achievements

John's project has grown from working with 80 children out of a shipping container to having a fully refurbished building, with over 350 people taking part

in various activities. He also had 12 volunteers developing various skills and getting qualifications through being involved, a stepping stone to a job. John's vision was to complete the building in Little Hulton (which was achieved) and now planned to develop similar sporting activities in other areas of Salford.

John feels more involved in his community and is employed as the Manager of the Centre working full time. He explained that he had to behave different now. This was due to the fact that he knows a lot of local people personally, some are employed and others are volunteers and he had to separate previous friendships from working relationships. He also achieved the following:

- Set up a web site www.peelunitedfc.colsol.org.uk;
- Ten young people have gained certificates in "Safe Sporting Activities" through the Youth Sports Trust;
- Six young people have also undertaken training to be referees.

Bernadette Wright **Seedley & Langworthy**

Personal Profile

Bernie was 47 years old and a single mum with a seventeen year old son and was passionate and proud of her family. She had lived in Seedley for the last twenty two years. She described her self as "a Salford girl born and bred".

Project **Local History and Regeneration Awareness Club (LHARA)**

Bernadette's project was to provide support to her local community through the Local History and Regeneration Awareness Club, by introducing living local history into the lives of people in Seedley and Langworthy. This was intended to gently guide residents and build up their trust for regeneration, and to inform and include them in social activities and services in the area.

Background

The environment in which Bernie lived had a major impact on her personally, leaving her feeling totally isolated. She found that there was no one to turn to regarding the regeneration in Seedley and Langworthy. To cope with this Bernie would visit the docks, the Lowry or Castlefield. It helped her to "lose" herself and escape from the problems of her community and her life through reminiscing. She wanted other people to have the chance of escaping for those valuable pieces of time. This is why she developed the LHARA Club. She discovered that she knew little about what was happening in her community despite the fact it has won "SRB" funding to "regenerate" her area. She felt that communication was poor. She says;

> "Something was going terribly wrong in my community, high crime rate, vandalism, anti-social behaviour, bad housing conditions, house prices dropping, anyone allowed to move in, and decent people moving out. All in

all I was living in a half boarded up slum area. An area many years ago where it was quite hard to purchase property, always known for being a nice well-kept area, even known to be posh if you lived in Seedley and Langworthy."
(Wright., 2002a)

As a result in the decline of the community the area was awarded funding under the Single Regeneration (SRB5). Bernie stated that

"We were then officially named as a DEPRIVED community. Things didn't get any better, in fact they got WORSE. What was REGENERATION? Residents began to feel more isolated, angry, stressed and uninformed of what was going on in their community."
(Wright, 2002b)

This made Bernie so angry at the lack of communication and made her wonder how she might contribute to changing what was happening to her and her community that she described as

"Terrible, stressed, angry environment. I wanted people in my community to feel empowered not invisible."
(Wright, 2002c)

Achievements

Bernie set up the Local History and Regeneration Awareness Club (LHARA). The club was managed and run by local residents. The purpose was to share information, creating opportunities for isolated members of the community using "local living history" as a tool to bring various people together. But the most important thing they do is have fun. The overall plan for the LHARA Club was to make a difference to the lives of ordinary people. It aimed to use local history and digital imagery as a tool to inform, enthuse and empower.

Some achievements to date:

- Knowing Me, Knowing You, a photographic exhibition at the Lowry Art Centre, January 2002, being able to show 150 images of Seedley and Langworthy. This ran for approximately 6 weeks;
- The Lowry hosted a special preview evening for Knowing Me, Knowing You, inviting 100 residents to the evening. Further organised visits were made to the exhibition for older members of the local community. The Lowry hosted a buffet evening for the LHARA Club and invited a further 100 residents who wanted to find out more about local developments i.e. Salford Quays and the Imperial War Museum.

Bernie had also been involved with various Steering and Focus Groups to do with the cultural side of the community, attending an arts in the community course at University of Salford.

She was involved in the following SRB5 task groups:

- Crime and Safety;
- Living Environment;
- Seedley and Langworthy Partnership.

Social Enterprises

Bernie was also involved in the following social enterprises

- Salford Film Festival as a member of the management board;
- Salford Community Radio as a member of the management group;
- Seedley and Langworthy Venture (SALV) as a Director.

Other Activities

- Seedley and Langworthy Initiative(SALI) – Small Grants Group – resigned 2004;
- Community Committee, Devolved Funding Sub group – Resigned December 2004;
- Serendipity – Secretary;
- Became a lay assessor assessing GP practices using PCT led "Quality Assurance Framework."

She obtained a base at the local Church, St. Luke's and discovered an army of new volunteers and provided support in various funding applications:

- Salford small grants;
- St. Luke's art and drama group, £500 for equipment;
- Funding to host a celebration for St. Georges day;
- Funding to host a celebration for the Queens Jubilee.

Chapter 8
Action Learning as a Way of Learning to Learn by Doing

This Chapter explains my relationship with action learning and how this supported me in developing innovative services in my role as Service Director (Developments).

It describes the process of learning that has occurred throughout this doctoral programme and the support received from being a participant of the Research Action Learning Set.

It also describes my personal experiences of learning that explains why I have used an action learning approach in my work and as the preferred methodology for this research.

Background

My relationship with action learning commenced whilst at a turning point in my career and having spent some twenty four years working in hospital based mental health services as clinician and manager. The focus of my work at that time was the closure of the historic long stay mental health services that were based on the Prestwich Hospital site. Being successful in achieving this resulted in me doing myself out of a job. Not knowing what to do next I looked at comparable posts in the NHS and discovered that they required a degree as essential educational criteria, I also realised that I had little or no experience of community based mental health services.

I decided to explore opportunities for undertaking a degree and met with Dr. David Botham at the Revans Centre for Action Learning and Research at the University of Salford in 1995. Having explained my situation to David he shared with me the emerging opportunity to undertake a research programme using an action learning approach.

Although not fully understanding what action learning was, what I had heard was that the programme would provide the opportunity for exploring the resolution of work based problems with support from other colleagues working in an action learning set. Researching the problems would provide the opportunity for me to explore my work further and help me to understand the value of this work in the context of mental health.

With this in mind I enrolled on a diploma programme at the Revans Centre, commencing in April 1995, converting after eighteen months to an MSc and completing this in 1998. As a result of the programme I was able to resolve two personal work related issues as discussed earlier in this thesis, namely developing community based experience and obtaining a degree.

Why Action Learning?

My affinity with action learning needs to be understood against my experience of education which was negative and resulted in me leaving school at the age of fifteen. Action learning offered me a unique way of learning that was appropriate for me and relevant to my work. I feel I have been able to reclaim the education I never had. To understand why requires a review of my early experiences of learning.

My Education

Learning from the Memory of My Experience

The first recollection of my education was at primary school were there was an expectation from both my parents and my teachers that I would "PASS" my eleven plus examination. I was obviously a failure if I didn't. Sure enough I eventually "FAILED". I say eventually as the first result was "borderline" and I was able to sit it a second time. I concluded that whilst at primary school the goal appeared to me to be to pass the eleven plus, which would then determine if I would go to a Grammar School or a Secondary Modern School.

Having secured a place at a Secondary Modern School I soon realised I was still expected to pass examinations and obtain as many CSEs or GCSEs with the expressed intention that the more you obtained, the greater the opportunity for securing employment. I had to pass more exams. I really had no motivation for remembering what appeared to me to be meaningless information that appeared to bear little or no relation to me or my aspirations at that time. I also still bore the scars of previous "failures". So I left school at fifteen to pursue a career in Mental Health Nursing. In his book Learning Beyond the Classroom Bentley states that:

> "there are two crucial tests of an effective educational experience: how well students can apply what they learn in situations beyond the bounds of their formal educational experience, and how well prepared they are to continue learning and solving problems throughout the rest of their lives."
> (Bentley, 1998a, Pg1).

This early experience not only didn't help when I left full time education, it didn't motivate me to learn either.

Having considered and reflected upon what learning meant for me, I concluded that my early experience of learning was confined to the "school" environment, whose sole purpose was to train me in the first instance to pass my eleven plus through providing me with the knowledge to do so through being taught. Secondly it provided the opportunity to collect further qualifications in the form of CSEs and GCSEs to assist my chances of employment.

Even if I was able to pass the exams, there remained the question of how relevant this information would be to me in trying to resolve problems in the future. Tom Bentley in his book "Learning beyond the Classroom "states:

> "Even those with sophisticated formal knowledge of a subject can be bad at using it in unfamiliar surroundings or to solve novel, complex problems. This inability to transfer knowledge from one domain to another points to a lack of real understanding"
> (Bentley, 1998b, Pg9).

My frustration with mainstream education can be summarised in the following statement;

> "All I learnt at school was that every problem in the world had already been solved: It was just that I didn't know the answer, the teacher did. That totally incapacitated me for life in the modern world, because every time I had a problem, I ran for help to an expert."
> (Handy, 1995, Pg92).

Action learning helped me to understand that knowledge was available in many forms and I increasingly became motivated to learn as I started to ask questions regarding my work and how this could be improved. Early indications of that learning can be found in Chapter 2.

Action learning as a process has also helped me to resolve complex problems, ask questions and seek knowledge that was appropriate and relevant to the

problems, offering new insights and understanding. This learning according to Reg Revans;

> "implies the acquisition of the power to perform the action as well as to specify it", further more; "the point is more subtle than it seems, because so much managerial action is fulfilled in the issues of orders, namely in words"
> (Revans,1998a, Pg11).

It was the opportunity to influence service developments that motivated me as I grew into various senior posts (with the power to perform the action) in the Trust. From this my learning from the previous project was used in considering the next new project. The detail of these developments can be found in Chapter 3.

My Education – My Work Experience

Having started work as a messenger at the age of fifteen my next brush with formal education occurred at the age of sixteen when I transferred from being a messenger to a Cadet Nurse. I had the privilege of attending Bury Technical College to study for three "O" levels which were required for acceptance into nurse training. Although I failed miserably, I was able to sit an entrance exam set by the General Nursing Council and passed with flying colours. This was an IQ test and a mix of multiple choice questions and puzzles that required logical thinking.

> "The IQ test measures several factors of intelligence, namely logical reasoning, math skills and general knowledge. It also measures your ability to classify things according to various attributes, and to see analogies and relations among concepts or things."
> (queendom.com, 2005).

This was a boost to me, I had passed my first exam, and this was soon complemented by passing my driving test. Although I passed two examinations

in one year which helped my self confidence, my thoughts soon turned to how I would pass my nursing exams.

In 1977 and 1979 I qualified as a Registered Mental Nurse and a General Nurse respectively. The success in passing those examinations I put down to the way the training programme was organised with weeks of theory in school, that was relevant to the next clinical placement where that theory could be put to the test. It also appeared to be a pre cursor to my action learning experiences that stimulated my thoughts in thinking about the application of that theory into practice.

Following nursing qualifications further education was essentially mapped out for you. There was an expectation that you would become an assessor for new Student Nurses, undertake a first line management course, then later a middle managers course, and eventually a senior managers course. Interspersed was a range of training programmes that were often developed in response to some new policy, or a topic that became the flavour of the month, e.g. "Managing the Violent Patient".

All these taught courses although appearing relevant, had little practical application in the work place, and reminded me of the same experience and feelings from my earlier educational experience, which also questioned the practical value and relevance to my work.

Throughout my working life my motivation has been influenced by my dissatisfaction with many negative experiences whilst working in mental health.

(See early experience in Chapter 2). The dissatisfaction with these negative experiences came from a tension between my expectation of being in a caring profession and providing that care within the constraints of an institution. I sensed a mismatch between my personal values, the ethics expected through being a nurse and the expectation of the institution. This was a preview of the tension that will be described later in the thesis both personally and for others.

Learning from the Present Experience - Why learning became important to me

The Creative Living Centre referred to in Chapter 3 was consciously grown at a pace at which we were able to discover how to best develop this new service without limiting the vision created by service users. It was important to be mindful that there was a danger of inadvertently influencing the project with the experience gained working in the NHS and limiting the projects development, e.g. understanding mental health in the context of a person's mental health experience and not led by a diagnosis of a mental illness.

Not knowing how to develop the project without limiting or distracting from the philosophy underpinning the vision created by service users was initially difficult, but once we had acknowledged the importance of not knowing it became liberating. Not being worried about not knowing how the vision might be brought to a reality encouraged a culture of questions, honesty and trust. This experience of questioning in order to understand, honesty, trust and not knowing was also a feature of working in the action learning sets.

This approach although at odds with my working experiences prompted me to think about my NHS experience and how it might have influenced a more traditional response; I felt it important to understand why. I believe this was due to how we are conditioned by the expectations of the organisational culture in which we work. Consequently we often tend to see things not as they are, but as we are conditioned to see them. I recall my first management post at Rochdale Health Authority and having to respond to the recommendations of the Griffiths Report. That report had a direct influence on the expectation of managers and the management culture of the health service through the introduction of general management. I remember quite clearly the report systematically attacking the managerial style of the NHS. They observed in a single sentence that:

> "If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge"
> (Department Of Health And Social Services, 1983, Pg12)

It established the notion that professionals should be subject to the same kinds of accountability and control as is found in contemporary business. It noted that the most obvious failing was the lack of a clear line management hierarchy and the report initiated the culture of General Management. The Regional Health Authorities, District Health Authorities and NHS hospitals were ordered to appoint General Managers by the end of 1985. These new managers were to be responsible for the overall direction and strategic management of the NHS.

General Managers were appointed on short term rolling contracts, placed on performance related pay and subject to annual performance reviews based on the achievement of agreed objectives. The achievement of those objectives

appeared to me to become the focus of management activity, often resulting in a single determination to "perform" so as to ensure the renewal of their contract.

This change appeared to be a criticism of managers of which I was one. In anticipation of the expected change in managerial style I recall quite clearly not receiving any training and development to respond to those new expectations. The same managers that were being criticised by the report were the very managers that were expected to implement the recommendations but yet there was no investment in order to develop their leadership/management skills.

Learning from these experiences raises questions about how we can respond to the many changes in the NHS. We cannot continue with a purely task oriented approach and manage through a system of command and control. This can limit our initiative, control and diminish our creativity, and ultimately destroy our loyalty and that of our colleagues. The concern to deliver these tasks (and demonstrate achievement) often becomes the focus at the expense of a time frame that acknowledges due process with key people that potentially could improve the quality and appropriate response to service provision.

Revans, (1982a), believed that organisations and individuals cannot flourish unless their rate of learning is equal to, or greater than, the rate of change that they are experiencing. According to Revans this rate of change is outstripping our ability to learn.

What we need is for all who practice management at whatever level and who have some responsibility for others, or influence over events, to develop their

own leadership capacity. That is, the capacity to create a climate of confidence, trust and enthusiasm from which we and others can give our best. I believe that the behaviours associated with an action learning approach provide opportunities for creating this climate.

Action Learning – Developing my Understanding as a Researcher

My relationship with action learning commenced in 1995 having enrolled for a Postgraduate Diploma transferring to an MSc following an interim assessment. On completion I continued to use an action learning approach in my work. In April 1999 I enrolled on an MPhil programme and transferred to a PhD programme again having undertaken an interim assessment. During both these programmes I have had the opportunity to continue my relationship with the Revans Centre for Action Learning and Research at the University of Salford as a Visiting Fellow.

The Doctoral Programme Commences

On the first day of the PhD programme I arrived at the Revans Centre confident and excited at the prospect of meeting new and old friends. In preparation for the day we had to produce on a side of A4 an "expression of interest" that gave an indication of the area of work that was to be researched through the process of action learning. The day went well until it was my turn to share with the group my research topic. As I was speaking I realised how unfocused I was, I left feeling deflated and flat but challenged as more questions came into my consciousness.

The day left me with questions about the academic challenge that lay before me and wondering what flexibility there might be for creativity and innovation.

What I thought I heard that day was other people's interpretation of the difference between a Master's programme and a PhD, which prompted me to question the role of action learning and research. Is it the methodology by which we would undertake the research? My thoughts brought me to the conclusion that

> "I am undertaking a Ph.D. by using an action learning methodology for research. I hope this is correct! Who might I check this with? Perhaps this is a question for the action learning set? Why am I feeling vulnerable? Is this vulnerability not part of experiencing the process of action learning and working in a set?"
> (Young, 1999).

What I have learnt about undertaking this doctoral programme is that I am responsible for managing my own learning, what is required and for carrying it out. What I am aware of however is a tension with undertaking a traditional PhD and one based on using an action learning approach. Some of this tension appeared to result from being forced into an academic framework that suits an examining institution, rather than developing a structure of examination that is sympathetic to an action learning approach. I have been aware throughout the programme that there is a tension with how I present my thesis, as the experiences of my work based problems and their resolution has not been a linear process. It has at times been messy and chaotic and has proved difficult for me to write the thesis in a way that communicates the reality of the way my work unfolded and shaped my learning.

This increased my vulnerability but required me to remind myself that the process of action learning involves “learning to learn” by doing, so you can work on those problems or realise opportunities that are unique to you and your work. It may be that you are not quite sure what the problem is or how to progress an opportunity. The problem may not have a known solution and it may be unique to you and the environment in which the problem exists and could be subject to many variables. It is therefore not unreasonable in these circumstances to acknowledge that you don’t know. So I continue my journey of not knowing in hope that I find some of the solutions to my work based problems.

Taking deliberate and conscious action to deal with these questions was the place to start and encourages you to access and harness different kinds of knowledge and uses it in new and innovative ways. It is not merely a question of what you know, but how you can creatively acquire and apply knowledge. Throughout the process it is important you continue to question, take action and reflect.

The Research Set

Action learning as a process provided regular space and time to raise real issues with set colleagues who over time could be trusted to be honest, open and supportive. This was a valuable investment of time that provided the opportunity to share my doubts, fears, aspirations and develop lasting learning relationships. This clearly wasn’t another course that “I was sent on”.

Reg Revans whilst working in Belgium on an inter University programme at the Foundation Industrie-Universite`, in trying to describe the part set participants

played in an action learning programme, he asked them to write their impressions of the functions of the set they belonged too. On completion all set participants voted on which was considered to be at the top of the list, this was "What is an honest man, and what need I do to become one"? (Revans, 1980a, Pg297).

It is through being honest that allows deep relationships to be formed where set members feel they are able to explore their issues with each other e.g. evaluation of personal strengths and development needs.

Writing this thesis raises a question about how one grows, develops, or injects honesty into the individual, the researcher and the decisions maker. Although not able to answer this categorically I believe that the process referred to earlier where a relationship grows out of partnership goes some way to answering the question. The process of developing a learning relationship with colleagues in an action learning set focuses on helping each other with their learning and action requiring the relationship to be open and honest. If not, the set will fail.

This resonates with the openness, honesty and trust that provided a strong foundation for the relationship with my set colleagues many of whom I am still in contact with. The growth of our relationship created a bond within the set and we became as Revans stated "comrades in adversity". This was a different relationship than that experienced with work colleagues where there was often limited honesty or trust often working in a climate of competition.

The conditions that support this honesty and trust was based on a commitment to themselves and their set colleagues to take action and explain their learning to each other in the context of their practice. Developing this learning relationship with each other was challenging and risky but can provide the opportunity to be truly honest and open debate and influence further reflection.

Working in an open and honest way influenced our interpersonal skills and our understanding of each other's problems as we learnt to ask insightful questions in a way that didn't feel as if we were being interrogated. In doing so it has allowed us, (as Reg Revans observed whilst working in the Cavendish Laboratory) to explore our own "ignorance". It was quite liberating being allowed to say that you don't know.

This opportunity to admit that you don't know is at odds with usual education, professional and organisational perspectives. For educationalists working in a learning environment, they have often been trained to teach/instruct. Their pupils/students would indeed be puzzled if they openly declared their ignorance.

The patient receiving care from the health care professional would equally be suspicious about how they might be treated if they were informed that the health care professional didn't know what was wrong with them, or what the best treatment might be.

Organisations often strive to be perceived as the best and do not like to admit that they are unable to resolve the many organisational challenges that they are presented with.

However many of the problems they are challenged by require them to look through different lenses, as many of the problems are often not new. They need to invest in taking time and space to bring stakeholders together exploring through multiple voices how each perceive these problems and take bold steps to influence new action for change and development. This will require new and challenging relationships.

Throughout the action learning programme an unwritten code of principles emerged that has allowed our relationship to flourish. These principles are that:

- We accepted each other for who we are;
- We were constructively critical but not judgemental;
- Everyone in the set had a contribution to make;
- Everybody's contribution was valued;
- In seeking to understand each other's views, we learnt to question in a way that didn't increase an individual's vulnerability, but yet was challenging;
- We learnt to listen to each other and more importantly hear what was said;
- We took responsibility for our learning and actions.

It was this learning relationship with set colleagues that I compared with the relationship required to engage both patients and the public, as I developed the Creative Living Centre.

The first doctoral action learning set meeting, took place in June 1999. The action learning set was supported by Dr Donna Vick Research Fellow.

This reflective practice was a key activity of action learning. It has now become a conscious activity that has developed as my relationship with action learning progressed and was supported and nurtured by my action learning set colleagues, helping me to understand what I was learning. This understanding prompted me to consider what action I needed to take. Reg Revans is clear that a problem or opportunity is treated by action learning as;

> "The resolution of problems (including opportunities) or difficulties about which different reasonable, experienced and honest men would wish to pursue different courses of action, because no singular solution can exist" (Revans, 1998b, Pg11 (iii).

This for me provided the foundation for action learning providing opportunities for finding resolutions to real work based problems for which there is no known solution. Working in the Research Action Learning Set created the opportunity for understanding and exploring the problem through questions with set colleagues. This required set participants to be open and honest and develop trust with one another. Planning and committing to taking meaningful action creates material for reflection and drives the process of sharing, understanding and creating learning. There are dangers therefore, that if the action disappears the set becomes little more than a talking shop. Conversely, if the focus is dominated by action the set could becomes a project group with limited longer term learning.

The Action Learning Set provided a regular opportunity to meet with like minded people who would challenge and question each other about their work experience and what has been learnt from those experiences. Working as:

> "Comrades in adversity learning with and from each other as they work together on their own problems and on the problem of helping each other to make the best guesses about what their problem is and what to do about it"

(Revans, Action Learning in a Few Hundred Words, Found in the Revans Archive, University of Salford, no date recorded, Pg iv)

In anticipation I was thinking about my previous set experiences and started to wonder how this new Research Set would develop. Would it be any different because there were five people as opposed to three as experienced in an earlier set I was involved with?

Being in a new set with different people from different backgrounds was a new experience. It was important to let those new relationships grow and be shaped by the interaction of each set colleagues. I initially found this difficult, as I had previous experience of the process of growing with and into a set. I wanted to tell other set members about that process and describe those experiences so as to influence "how the set should function". I had to hold myself back. I have learnt that the process of set development is unique to the individual people that make up the set; no two sets are the same. I still had a contribution to make but not through imposing the outcome of the process of my previous set experiences. I had to experience the process again, with my new set colleagues. A profile of my set colleagues can be found in Appendix 11.

What is a PhD?

One of the first issues I wanted to explore was "the difference between a Masters degree and a PhD". It was interesting that Steve Grainger (set colleague) felt I was after a concrete answer there and then. I discovered that my reaction to this was initially defensive. I thought that this might have been the case four or five years ago but didn't feel this was the case now. This to me was an inaccurate assumption, unless I had not changed as much as I thought I

had. The discussion however helped me clarify that I wanted to understand the difference between a Masters and a PhD programme so as to develop my thinking, as I didn't want to discover this too late in the process. It also prompted me to think of my PhD as a more in depth examination of a specific work based problem. I decided to go with the flow and trust in the process. An easy thing to say but not to do.

In pursuit of this understanding I decided to visit the bookshop at the University of Salford to see if there were any books that might give me greater insight. Well there it was staring at me from the shelf, "HOW TO GET a Ph.D.," A Handbook for Students and their Supervisors (Philips and Pugh 1998). It seemed like the answer to my prayers, the book would fill some of the time waiting for the programme to commence. Having read the book from cover to cover it offered some new insights, but raised more questions. Why does new knowledge always raise more questions? It seems like the more you know, the more you realise what you don't know. The challenge of this PhD seemed to require a balance between using what we know and producing new knowledge.

The book indicated that the outcome of a Ph.D. project was said to be "an original contribution to knowledge". Am I capable of this? Why are there doubts? What a daunting thought. Could I live up to that expectation? Has anyone really been able to explain what a Ph.D. is in a comprehensive way? What would the focus of my project be? I thought I was clear! Although these are all reasonable questions and comments I had a sense that I wanted to run before I could walk, and again experienced that feeling of vulnerability.

As part of my journey to understand the difference between a M.Sc. and a Ph.D., I recall a set meeting where Linda (a member of the Research Set) gave a presentation of her progress in preparation for her interim assessment. This was an assessment undertaken after eighteen months to assess a candidate's progress and understand the next steps for progressing their research.

Linda explained her research and the progress made. Her work had taken her to a point where she wanted to set up action learning sets to progress her work, but to do what? This was essentially to explore further her research that needed to involve others. Steve Grainger asked "is the answer to the question that Linda is searching for, the link that moves you from MPhil to Ph.D.?" Set meeting notes 21st January 2000. We collectively felt as though it could be.

Presenting My Problem to the Set

At an early action learning set meeting I realised how quickly we worked well together, but we seemed to do a lot more talking than questioning. I was anxious to provide an overview of my work so that set members could appreciate my work based problem in the context of the whole of my work. So at an early set meeting, I gave a brief presentation about my challenges at work but didn't receive the help and support or questions to help me. This was more to do with the timing of my presentation and not the willingness of the set members to support me. I felt I had unrealistic expectations of the set, as we had only met on two occasions. I felt frustrated and anxious about wanting to make a start (I am motivated to take action) and I didn't acknowledge the process required for the development of the set. This stands, as a reminder to me not to run before I can walk. This seems to be a characteristic of mine.

Donna (Set advisor), however, asked whether I should think about not building on the work I had previously undertaken, but explore if there was something different. Perhaps if I started to take some action it would help the process.

I immediately started to commit my thoughts to paper. Some time later I e-mailed Donna to arrange to meet to discuss what I had written. I was conscious that my enthusiasm might get the better of me, and I wasn't sure if she would think I was circumventing the set. I felt that I wasn't, but I could have waited for the next set meeting. This was fuelled by my enthusiasm which I feel can be over bearing.

We met on the 29 June 1999 to discuss this further. I was pleased that she had taken time to read and comment on my paper. Her feedback was practical, rewarding and gave me ideas for taking action. I felt frustrated however that although the responses were extremely useful and practical they didn't at this point move me on, or so I thought. I felt as though I hadn't communicated what was happening to me at the end of the last set meeting. But with hindsight I feel I was trying to rush the process of set development through getting down to discussing what was important to me without each of the set members knowing each other. On reflection I believe that I was asking Donna to advise me what I should do next instead of answering the question myself. Her feedback was useful and after further consideration I concluded that:

- I need to let things happen organically, not force things;
- I need to forget that I am doing a Ph.D. and let my work progress and develop into a PhD;

- action learning and research, although simple in its origins, is complex in its application.

Considering the action learning process further I started to visualise it as a jigsaw, and:

- although you have an image of the overall picture you don't know how many pieces there are, or you have a sense of the overall theme of the picture but not what the picture is;
- the pieces are not even in a box but need to be discovered;
- the most likely places where those pieces can be found are: at work, in the set, through knowledge/information, through questioning, through reflection;
- success in completing your picture is to search for each piece at a time and discover how those pieces best fit together;
- this process of discovery is enlightening, powerful and life changing.

At a supervision session with Donna, we talked about the sheer breadth of work I am involved in. She asked me why I took on so much. Reflecting on the breadth of work reminded me of the fact that I always seem to be chasing my tail giving a little everywhere, a stressful way of working. They did however seem to be a natural progression of one piece of work to another.

This raised a question about the sustainability of the breadth of work and the way that impacted and integrated my work in a significant way across the Trust. Coupled with the way that my role has emerged, I felt that if I am not consciously developing my role then I could be "out of a job". Surrounding myself with the breadth of work/demands has acted as a comfort/security

against me being made redundant. However, the experience of the last 5 years has equipped me with a range of knowledge, skills and experience that has given me the confidence to spread my wings.

Transfer from M.Phil. to PhD.

Learning From a Process of Assessment-Interim Assessment October 2000

Having initially registered for an MPhil there was a requirement to undertake an interim assessment where the decision for transfer to a Ph.D. would be made. We were required to prepare a progress report of approximately 8000 words and this was presented to a panel comprising of an external examiner, an internal examiner and a senior academic of the Revans Centre on the 27th September 2000. The presentation lasted approximately fifteen minutes and provided the opportunity to describe my progress and what I had learned.

The process of completing a progress report demonstrated the value of each set member as we supported each other in being as clear as we could be in articulating the progress made to date and explaining the relationship of that progress to our research. Committing those thoughts to paper to provide a written progress report, allowed me to consolidate my thinking.

An important lesson emerged from the questions that were asked by the assessment panel. This was the importance of recognising and being aware of the implications and the impact of organisations, and how they can condition you and your learning.

I was reminded of the need to be aware of the influence that organisations such as the School for Social Entrepreneurs and the National Health Service can have on learning. It was viewed by a panel member that these professional influences can be "ordering and controlling" and as a consequence can constrain and work against taking action and learning. Additional to this the title (Creating Social Inclusion through Positive Mental Health Promotion) on the cover of my progress report was felt to be "ordered and controlling" and using the constraining language of the NHS and health professionals.

These comments have made me realise how I can allow the external environment to influence me. I did not initially see the relevance of the comments of the title of my report or indeed the implication of the title of an organisation such as the School for Social Entrepreneurs (SSE). Both the title of my report and the name of the organisation are neat sound bites that are not my own words, and in fact did not reflect either what I wanted to say or indeed the work being undertaken with the participants on the SSE programme. I needed to learn to balance my tendency to accept what I see at face value with a questioning approach that allows me to critically assess and examine what I see before me.

Supporting Local People with Action Learning

It was my personal experience in the power of the process of action learning that informed my belief that this could be of value to local people to support them in exploring aspects of their life they wanted to change. The crucial issue was that they are "motivated" to do something (take action).

This thinking led me to explore the idea of developing a Centre for Community Learning at the Revans Centre. I came across many local people who wanted to improve their lives and the communities in which they live. This motivation to improve their lives required appropriate support. It was my belief that action learning offers a framework for that support. How this approach was offered however was critical as local people will want to "do" something, and may not necessarily have an interest in the process/methodology associated with action learning, or what they have learnt arising from their action. It is important then to acknowledge that the role of a set advisor in supporting a community based action learning set should not lose sight of what is being learnt and how that learning might inform other community work. The introduction of a community based action learning programme requires a different process from that of introducing an action learning programme in an organisation as the motivation and expectation is often different.

Set Advisor or Facilitator

I continue to be challenged regarding my understanding of action learning and continue to realise how important it was to sustain my learning through being in a set. One of those challenges was understanding the difference between a Set Advisor and a Set Facilitator.

Through my work at the National Health Service University (NHSU) my role was to support the development and practice of action learning across the North West's three Strategic Health Authorities. This challenged the way I articulated my understanding of what action learning is and isn't. This was heightened as

most of the people I worked with are from Teaching and Training departments who had spent many years in the field of education.

This was prompted following a request from a colleague at the NHSU to contribute to a network event on the 6th October 2004. The event was with a range of partners who delivered a "Managing Health and Social Care Programme". My contribution was to explain how I was working to support the development of action learning across the North West.

I was asked what the difference was between a "facilitator" in the context of action learning" and that of a general facilitation approach. I had to acknowledge that I wasn't clear, and couldn't think fast enough (its not comfortable telling a group of people your not sure). When I left I suddenly recalled the context in which she had asked the question. She "facilitated an action learning set as part of a module in "a leadership programme" the purpose of which was to work on a project. This then reminded me that the project work was for 3-6 months. The time frame itself can severely constrain a natural process of learning with the project being delivered in an expected timescale. As a consequence the process could constrain any learning or action will be limited to that timeframe. This limitation prevents people from learning at the rate that is in keeping with their ability to understand the "work based" issue. It is also possible that a "project" is not a problem or real issue.

Further dialogue with a colleague helped me to understand that traditional "facilitation" is one that is applied to a group of people. This assumes that each person in a group (or set) learn at the same rate at which the "facilitator"

progresses the intent of the group. Within an action learning set the "facilitator" supports the individual to learn at the rate of their ability to understand through questions reflection and action. Professor David Botham states that facilitation is "a way of introducing a person to their own learning process" (Botham, 2000).

These experiences of action learning both as a set participant and as a Set Advisor gave me increased confidence to continue my practice of action learning. The Salford Social Entrepreneur programmes provided the next opportunity to continue to learn and explore the value of an action learning approach in increasing social inclusion and positive mental health and well-being through;

> "Learning to learn by-doing with and from others who are also learning to learn-by doing"
> (Revans, 1980b, Pg228).

The findings and conclusions that arise from the Salford Social Entrepreneur programme are described in the next Chapter.

Chapter 9
Findings and Conclusions

This Chapter describes the initial findings that arose from my research and considers those findings and discusses the conclusions arising from them.

It describes a process for patient and public involvement and offers six critical ingredients for successful partnerships.

Additional to this it explains the impact of using an action learning approach to support local people on two community based Social Entrepreneurs programme.

It also supports the inclusion of an additional component to an already established model of health promotion that currently includes health protection, health prevention and health education. This additional component is "autonomous learning".

This practice based thesis advances knowledge in two areas:

1. further understanding of engaging with patients and the public, and specifically that there has to be a conscious change in behaviour both at an individual and organisational level if there is to be active patient and public involvement based on equal partnership, mutual respect and understanding;
2. further understanding of learning in the promotion of mental health and well-being. Here I have been able to demonstrate how local people have been able to improve their mental health and social inclusion as a result

of using an action learning approach to resolving issues that are seen as a priority to them. This has not been through accessing "health service provision" but as a consequence of being supported to take responsibility for understanding how to realise an individual aspiration and bring it to life.

Further Understanding of Engaging with Patients and the Public – A Case for Change

This Thesis is concerned with the need for public sector organisations to consciously review, consider, develop and change their relationship with the people and the communities for whom they provide health and social care provision. This is imperative if they are to work effectively in partnership with patients and the public in a way that ensures services are responsive to their needs.

The process that resulted in this view commenced during my early experiences of working in a large mental health institution. Here I witnessed how the institution controlled the lives of those who lived there, and where the "system" seemed to do more harm than good. This experience created a tension in relation to my values of being in a caring profession and the negative impact of the institution on the lives of the patients. See Chapter 2 for further information.

This provided me with the foundation from which to compare and contrast future work experiences prompting me to ask many questions and where I developed a determination to improve services and make a difference to the lives of people with mental health problems, although I wasn't clear what that meant or even

how I would do this. The opportunity to do this occurred as I progressed and undertook the many roles in health and social care provision. Working both as a clinician and a manager I have been able to influence the development of a range of new mental health and social care services. Those new services that were valued the most by service users were those that actively involved them and the public. See Chapter 3 for more information.

Learning the importance, the value and how to engage patients and the public, and witnessing them realising their personal aspirations had a profound impact on me, my practice and role as Service Director (Developments).

From these experiences I concluded that patients and the public need to be involved at three levels.

Level 1. Involving individuals in identifying their needs and making an informed choice regarding the appropriate treatment, in order to improve personal care at an individual level.

Level 2. Working with current service users to improve the way existing services are provided and organised.

Level 3. Exploring with the public innovative and creative ways of redesigning health and social care provision.

These three levels developed from my experiences with the following projects.

Creative Living Centre

1. The experience from the development of the Creative Living Centre helped me to understand how to involve people with mental health

problems as indicated in level 1. This is described in more detail in Chapter 3.

The Angel Healthy Living Centre

2. The development of the Angel Healthy Living Centre helped me to understand how to involve and consult with local communities to improve how current services are provided and organised as indicated in level 2. Chapter 3 provides further information on the detailed development of the Angel.

The Salford School for Social Entrepreneurs

3. The Salford School for Social Entrepreneurs programme provided the opportunity to support local people from Salford to develop innovative and creative ways of improving their lives and that of their communities as indicated in level 3.

From these experiences I learned how to engage patients and the public in a way that ensures current services and new service developments take full account of what people who use those services say they need and want. This helped me develop new skills, and new insights that helped me progress and develop these skills. It challenged me in many ways but specifically learning to listen and hear what local people said and sometimes hearing them say it in a way that was blunt and uncomfortable.

From Responsive to Participatory Working – Some Challenges

In the development of these community projects there seemed to be a pattern emerge where some people felt it important to express their anger. This often commenced at the first meeting where local people used this as the opportunity to off load their anger about anything and everything, whether appropriate to the focus of the meeting or not.

As I was project managing these projects I had to listen and not dismiss what was being said and more importantly not to take this anger personally. This is an important learning point for any manager involved in consulting with the public, as at their first meeting they could be forgiven for not wanting to continue with the consultation.

The anger from local people could be viewed as inappropriate. However their anger needs to be understood in the wider context of their lives and their community.

For example, the Creative Living Centre was developed out of frustration and anger with the way mainstream mental health services often labelled and stigmatised the people who used them.

Similarly the participants of the SSE programme were motivated to act as a result of dissatisfaction and frustration with an unresolved problem. This dissatisfaction and frustration appeared to be a precursor to the projects that members of the SSE programme initiated and made a reality. See Chapter 7 for further detail.

Our Perception of Each Other

Associated with this anger are the preconceived ideas we often have of each other. Working in the Creative Living Centre I discovered sometime later that some members of the projects development team initially referred to me as "the suit". I also had my own ideas and opinions about Mind which could have got in the way of the partnership.

As our relationships developed I was referred to as the representative from the Trust, then as Director of Service Development leading eventually to being referred to as Steve. I felt I had made progress when this happened.

This experience was repeated at the first meeting for the development of the Angel Healthy Living Initiative. I was viewed as a representative of the Health Authority. Although for this project I was, they took the opportunity to vent their anger (as if this was my fault) at the closure of Salford Royal Hospital, which they said led to them "having the heart ripped" out of their community.

Although this had the effect of sabotaging the original content of the meeting it was useful to hear local people speak passionately about their communities. I couldn't help sense that this anger was rooted in them feeling powerless about what had happened to them and their community.

If patients and the public are to be encouraged to play an active role in shaping the diverse activities that influence their lives and the lives of their community we need to redress the balance of power through an empowering approach. It

has been the use of an action learning approach that has helped me to understand how I can work in an empowering way with patients and the public.

Partnerships

From this experience I learnt that the development of partnerships with patients and the public is a process. As part of that process the expression of anger from some people was an initial hurdle that needed to be worked through in order to move on and progress the partnership. These partnerships can only grow overtime and develop into a relationship where shared objectives and a mutual understanding of each others aspirations and constraints would unfold but not necessarily with agreement of all issues at every stage.

The development of the Creative Living Centre, The Angel Healthy Living Centre and the individual projects of the SSE participants demonstrate that involving patients and the public in their development has resulted in radically different models of provision. Conversely services will not change and will continue to fail to meet need if they are not involved. These services would not have developed in the way they did if patients and the public had not been actively listened to and involved in their planning, development and provision.

This process of moving from a potential partnership to a more open, honest and trusting relationship based on mutual understanding was also evident in the experiences of the participants on the SSE programme.

One of the early themes that emerged from my inquiry that was common to all participants was their dissatisfaction with lack of facilities, services and

inappropriate response from the local authority. This dissatisfaction led to frustration and often anger as they tried to obtain appropriate responses from the officers at the "council". The detail describing the background to each of the participant's projects can be found in Chapter 7. This describes their individual frustration and what they have achieved whilst on the programme.

This frustration appeared to motivate them to ensure there was an appropriate response to the issues they highlighted, leading to an incremental involvement in their communities.

From initially trying to resolve their problems through venting their anger and on occasions being aggressive with officers at the council, many of the participants had identified that this was not appropriate behaviour and had learnt to think about what they had wanted to say. Jay Brennen in recording her experiences on the programme stated that;

> "I listen more and challenge better; I don't attack people verbally anymore. I realise people have different views to me and I have learnt to accept them. I have also learnt that everyone is entitled to his or her opinions. I think one of the biggest lessons I have learnt in this programme is how to work with people with different personalities. I've learnt to deal positively with people where before I would verbally attack someone if they had spoken down to me."
> Brennan J (2000c pg5)

The SSE participants have all also developed a critical understanding in the working of the City Council and an appreciation that officers at the council are constrained by the organisations in which they work and that they need to find new ways to engage with local people and their communities.

I could only conclude that staff from the local authority had not given much thought to how they might work towards finding new and innovative ways of responding to the needs of the communities they serve. I also wondered why we needed the SSE programme to support local people. Why was the local authority not able to facilitate this work through the Capacity Releasing Strategy of their Community Plan (Salford Partnership 2001 – 2006)?

If the public sector is to work in this way it requires them to think consciously about how they initiate partnerships with patients and the public and developing a working relationship with them. It will require a shift from providing services that do things to and for people to one that works with patients and the public as equal partners.

This shift will require a profound change in behaviour moving from a culture often of command and control to one of equal partners were the role between giver and receiver becomes blurred and a relationship based on mutual trust, honesty and respect becomes established.

This empowering approach needs to be imbedded within the corporate culture of public, private and voluntary organisations. Unless the leaders of these organisations demonstrate their commitment to an empowering organisation, they will probably not persuade their staff to embrace this approach to public and patient involvement.

Networks

This way of working in partnership is an emergent process and has the potential to develop deep and long lasting relationships. From the many partnerships I have developed, a network of like minded people has emerged which support and energise each other. We all met monthly to discuss specific themes that were common to us all. These themes were concerned with how to be creative and think laterally in developing services. This network of mutual support was essential as development work can be lonely.

It requires you to work in an enabling way working with and through others. Consequently you are often perceived differently (by colleagues) because you are not directly responsible for managing a service or significant resources. This way of working is stated by Parston, to be entrepreneurial and requires;

> "behaviour which consistently exploits opportunities to deliver results beyond one's own capabilities.....demanding vision and a sustained commitment – sometimes in the face of much more mundane things that have to be done. It requires the mustering of new and other people's resources to produce better outcomes. Through this they build up capabilities much bigger than their own and produce results much larger in scale than we should expect. "
> (Parston G 1998 Pg 7)

Working in this way is challenging and describing the value of this work in a job description is difficult. The development of my work has often been rooted in responding to gut feeling, seeing the potential in other opportunities not all of which are possible to predict or understand the importance of until you are touched by the experience.

The public, private and voluntary sector need to understand the leadership qualities required to work in this way and what can be achieved in doing so.

The development of the Angel was one such experience of a partnership that emerged from the network (referred to on the previous page) and specifically the provision of a complementary therapy service. This was initiated by a conversation with a physiotherapist who was interested in a holistic approach to health care. This led to me being involved on a planning team at the University of Salford to develop the curriculum for the first master's programme in Complementary Medicine. The students from this programme provided complementary therapy services at the Angel Healthy Living Centre, to local people as part of their training.

Similarly we were able to offer accommodation to develop a Carer's Centre which provided a resource in kind that allowed the centre to use this as matched funding which funded the development of a service for young carers.

Learning

It is important that a project issue or discussion should only progress at the rate in which both partners have developed an understanding of each others views. This may require both partners to learn and progress their understanding either at the rate of developing a project or through progressing based on trusting each other. This can create a tension with project plans and timetables if outcomes and outputs and specific deadlines are not flexible enough to meet the different levels of progress and understanding.

My personal understanding of these new working relationships have been shaped by my experience of action learning and service development as I endeavoured to hold the patient and the public at the heart of any new

developments. Exploring, questioning and understanding the different cultures were important not the least as I had to think of different exit strategies at the start of each project. Those exit strategies were often about developing the capacity of others so that they would not become dependent on me, and ensuring that the projects were sustainable by the many partnerships that I was able to broker. This role as a "partnership broker" enabled me to be free to consider the next opportunity for improving service provision. How this work has grown and which project resulted in germinating the next project can be seen in **Figure 11** at the end of this Chapter. Some of the detail behind the milestones of influence can be found in **Chapter 3**.

Mutual learning is required as the shift from working in a system that is centrally directed is complex. This learning needs to involve all potential partners including patients, carers, public, staff and other partner organisations.

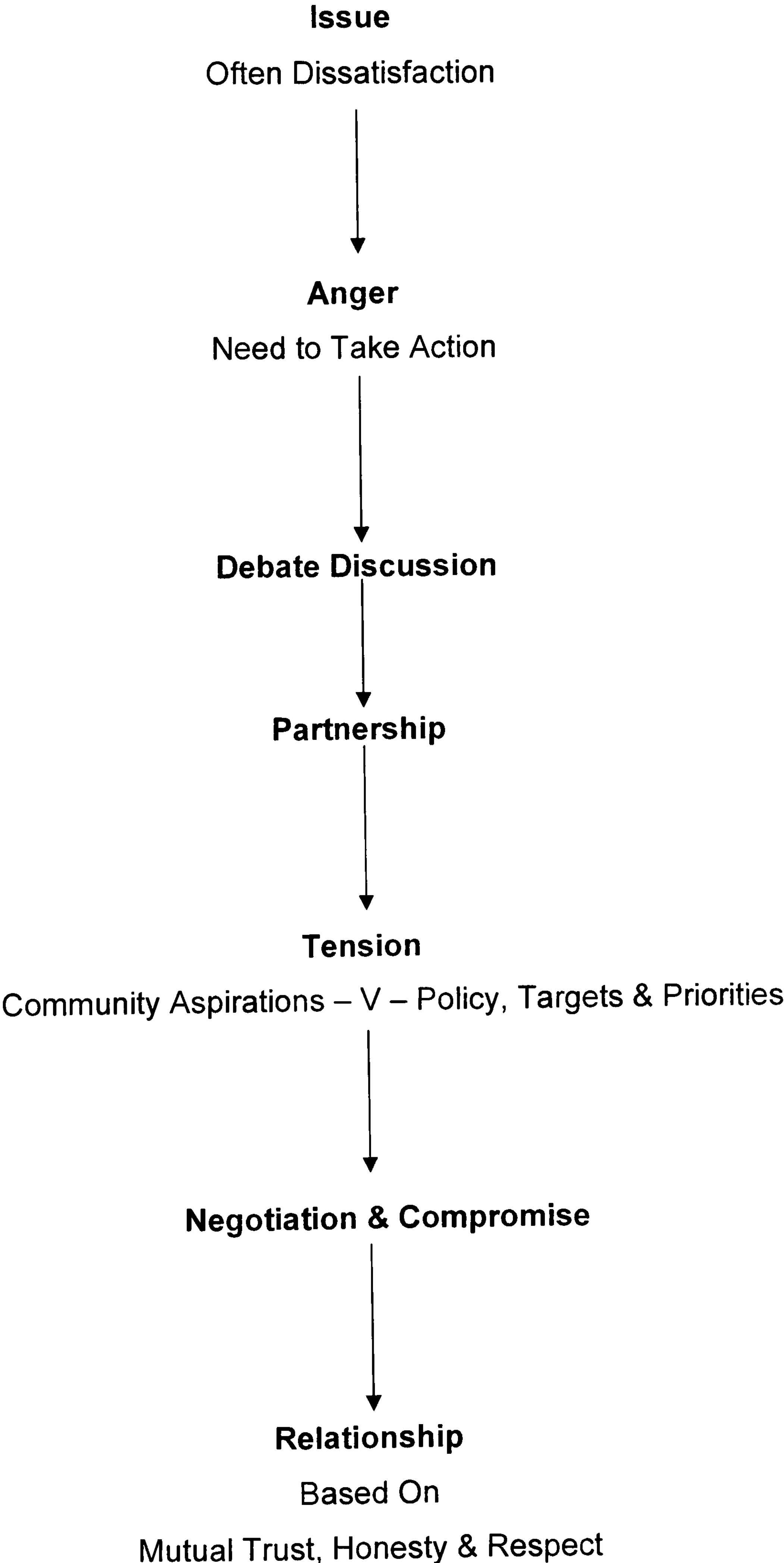
These organisations need to be able to adjust to meet these challenges and this as Reg Revans states "is only achieved by learning". Furthermore learning is not just for the sake of knowledge, but to influence a shift in behaviour. Revans states that the "organisation that continues to behave tomorrow as it did yesterday has not learned", (Revan, 1998c).

Moving from partnership to a more open, honest and trusting relationship based on mutual respect is a necessary process for patient and public involvement and often has a predictable pathway. A pathway based on my experience can be seen in **Figure 7** on the following page.

Figure 7.

Developing a Relationship

A Pathway to Patient and Public Involvement



Six Critical Ingredients for Patient and Public Involvement

These six critical ingredients for patient and public involvement have been distilled from my own learning as set advisor to the participants on the two Salford Social Entrepreneur programmes that have been described in greater detail in Chapter 7 of this thesis. It has been influenced by, and draws on the collective experience of working for many years both as a clinician and a manager in health and social care provision.

The six ingredients are not intended to be prescriptive but offer insight into the challenges of public and patient involvement from my experience and provide guidance into what individual practitioners can expect as they embark on their personal journey of patient and public involvement. Further critical ingredients for how organisations need to develop an empowering culture that enables patient and public involvement is covered later in the thesis.

1. Involvement

A strategy needs to be considered about who and how patients and the public can be involved, providing the opportunity for them to determine how they wish to be involved. It is important to ensure that we do not restrict involvement for people either because of time or child care constraints. Consideration for a budget to pay travel and childcare costs will be required.

It's important for meetings to negotiate items for the agenda with all the partners. As health care professionals we often think that our issues are a priority, there needs to be a balance.

Consideration needs to be given to different ways of communicating to those who are not able to attend or who are not able to be actively involved because of other commitments.

We need to learn to listen and hear what others have to say and not what we would like to hear acknowledging that everyone has a contribution to make and their contribution needs to be valued.

Meetings can be boring and many people have different spans of concentration. Think about how social events might be used to obtain and receive information. Consider art based activities as a way of encouraging people to express themselves. For those who are uncomfortable with meetings other methods of involvement need to be considered.

2. Towards a Meeting of Minds – A Process

Patient and public involvement requires a process that provides the opportunity for developing a working relationship with communities and the local people for who the public sector provides services for. This process needs to grow so as to develop relationships were you are able to work in partnership and develop services together. It is important therefore to invest in those relationships as all parties can help to achieve common goals and objectives, remembering that success is not in the hands of one party.

This is a journey for all parties and although challenging provides the opportunity for each other to be open to new ideas and learn from each

other. We need to be aware of any preconceived ideas we may have about each other as they could influence your thinking and stifle progress.

It is important that all partners are considered equal in that everyone has an important contribution to make. Working in this way will allow traditional boundaries to be challenged which can be uncomfortable in the first instance as often this process can challenge traditional ways of thinking and working. Working in partnership may require the sharing of responsibility with equal but different involvement, valuing each person for the variety of skills they can offer.

This will involve working in a way that the traditionally accepted balance of power and responsibility alters in favour of each taking more responsibility in such a way as to promote growth personally, socially and spiritually.

3. Understanding their Ideas and Experiences

Based on my experience people have within themselves the ideas and the ability to solve their own problems rather than the resolution of those problems being the exclusive responsibility of public sector providers.

It is important at an early stage to ensure your differences are out in the open so as to clear the way for establishing mutually beneficial ways of progressing.

Learning from the many experiences of people who use our services provides vital information on what they want from services and how those

services might be delivered differently. This will challenge us to think about what is possible rather than how traditionally we might respond.

The Creative Living Centre is an example of how ideas from service users created a vision for an innovative service for people who have mental health problems. The realisation of this vision was entrusted to a partnership with the Trust and Mind North West. I was the representative from the Trust and the Director of North West Mind was Mind's representative. The progress in delivering the project was monitored against the vision and its philosophy by a core project group of people made up of services users and members of the public who created the vision. For more information please see Chapter 3.

4. Learning Together

As Service Director (Developments) I have learnt to develop services with people with mental health problems and not for them. It is important that the views of patients and the public are understood and where agreed, integrated into service plans.

As public sector providers this will require an open mind to think creatively and "out of the box" and yet at the same time ensuring participants are aware of the realistic constraints of the many local, regional and national policy imperatives and expectations.

The Creative Living Centre was a good example of thinking creatively and out of the box. It used a process of creative visualisation to encourage

service users to imagine what their ideal services might be like and how those services be provided. This provided a firm foundation and a strong belief and confidence regarding the need for the service. Traditionally we would initially have explored where the funding would come from and probably not progressed the centre as there was no available revenue. Progressing the project incrementally resulted in some funding to appoint a dedicated project worker with a responsibility for obtaining funding. This resulted in securing further funding of £350,000 over three years.

5. Taking Action Together

It's important that there is appropriate debate and negotiation when confirming a course of action so that informed decisions can be made. When discussing a course of action it is important to be creative and consider how that action will make a difference and add value. If you agree a course of action follow it through in the agreed time. Remember to include patients and members of the public as leads for taking action as appropriate.

6. What Not to Do

When putting information together avoid big consultation documents. Too much information and jargon can turn people off.

When organising events don't meet in NHS buildings or have too many senior people there have a dialogue, don't lecture. Don't have events in the same venue.

Experiencing and understanding patient and public involvement is crucial if we are to deliver on the many policy imperatives (as discussed in Chapter 4) that have the patient and public at the heart of services.

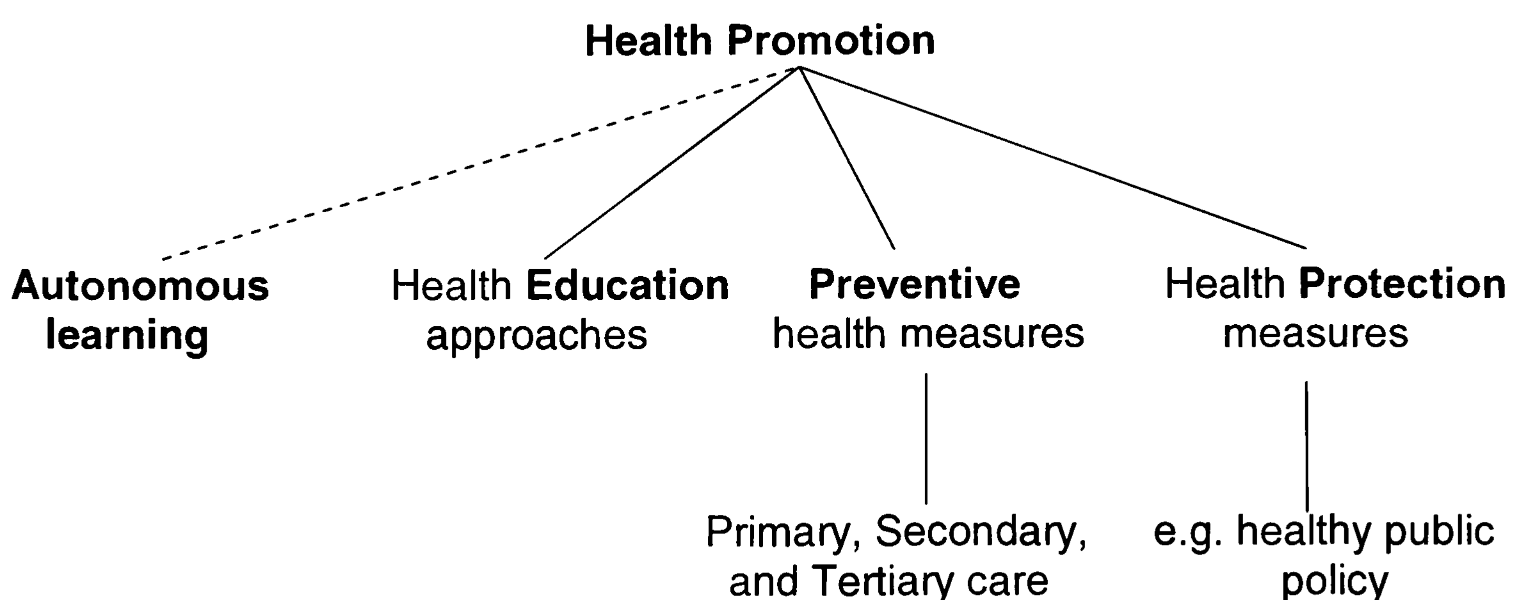
Working in this way not only requires an empowering approach, but also to ensure that our own behaviour was not disempowering.

The Further Understanding of Learning in the Promotion of Mental Health and Well-Being

In response to my initial research themes I propose an additional component, to an already accepted model of health promotion that currently includes; health protection, health prevention and health education (Tilford etal,1997). This additional component I've called "autonomous learning". This component combines the processes of action learning and a community development approach to support individuals and communities to explore problems or issues that they themselves identify.

The term autonomous learning has been used for convenience though it does not fully reflect the learning relationship with partners in the action learning set. Its significance lies in the fact that the health education, preventative and protection measures are done to others where as an autonomous learning approach is initiated and enacted by the individual. In the context of learning this is self directed rather than being directed by others. This model can be seen in **Figure 8**.

Figure 8.



The additional component "autonomous learning" emerged from my research as I collated the information arising from the participant's individual stories, the detail of which can be seen in Chapter 7. The outcomes for each participant have been brought together in individual charts the detail of which can be found in **Figures 11a to 11j** at the end of this Chapter. From this information it was clear that most of the participants have developed new skills and a capability in utilising those skills to further their personal development and critical understanding in order to bring their project to reality.

Action Learning as a Process for Change

The SSE participants used action learning as a framework to manage the many challenges of their projects. They had each developed individual aspirations for their community but were often faced with a tension with "officers" from the public sector. This tension showed itself as a mismatch between what local people (on the SSE) saw as an opportunity or priority and that of other local people and the public sector. As participants in the action learning sets they were able to explore this tension through learning to learn with and from each other and take new action.

Action learning therefore accepts that people do not only learn from being taught, but from tackling real problems and issues for which they carry real responsibility and in which they have to take real actions, and is not confined to academics or to the pursuit of knowledge for its own sake. Developing understanding in this way required the participants to develop learning relationships, with interactions which are meaningful as they encourage the exchange of knowledge and insight and wider understanding.

In contrast, much of the education world has some imposed constraints being constrained by the curriculum, time, limited resources and reliance on a text-based assessment. Education then can become bound up with the specific situations and routines of school. Education providers can also have their own interests and bias and can often see the relevance differently from the student. This "conventional" education seems to have limits in supporting and integrating knowledge in a curriculum within a wider learning context.

The background to the SSE participant's projects and what they actually achieved is provided in detail in Chapter 7 of this thesis. It is important however to understand the context and the contribution in which these projects were undertaken.

Salford – The Local Authority Context

In Salford there were still severe pockets of deprivation. It was placed the fourth most deprived local authority area in the North West and twenty eighth nationally according to the 2000 index of deprivation. Fifteen out of the twenty wards in the City are within the worst 20% nationally. The loss of almost a third of the City's traditional employment base over the past thirty years has had a marked effect on Salford, with areas blighted by physical dereliction and social deprivation. More specifically **Figure 9** below indicates the areas where the SSE participants lived and an indication of how this relates to the overall level of deprivation in Salford. Further information can be found in **Appendix 12** Salford City's Community Strategy and SSE Participants Community Profile.

Figure 9.

Ward Name	City Rank	Rank Index 2000	Participant
Broughton	1	126	Gwen
Little Hulton	2	138	Jay, Janette
Blackfriars	3	156	
Ordsall	4	166	Charlotte
Pendleton	5	201	
Langworthy	6	260	Mike, Bernadette
Winton	7	471	
Weaste & Seedley	8	570	
Barton	9	729	
Walkden North	10	880	John
Pendlebury	11	1030	
Kersal/Charlsetown	12	1542	Kevin
Eccles	13	1551	
Swinton North	14	1608	Julie
Cadishead	15	1652	
Irlam	16	1914	Dave
Claremont	17	2099	
Swinton South	18	3009	
Walkden South	19	3043	
Worsley&Boothstown	20	6108	

Mental Health and Well-Being

Health promotion is defined by the World Health Organisation as:

> "the process of enabling people to increase control over and improve their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change and cope with the environment. Health is, therefore, seen as a resource for everyday life, not as the objective of living. Health is a positive concept emphasising social and personal resources as well as physical capacities. Therefore health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well being."
> (World Health Organisation, 1986, pg1)

Many mental health promotion interventions are worth implementing on their own merit, even if the evidence for their effectiveness for preventing mental disorder is sometimes weak. The search for further scientific evidence on effectiveness and cost-effectiveness however should not be allowed to become an excuse for non-implementation of urgently needed social and health policies.

Indeed innovative methods need to be found to assess the evidence while these programmes are designed and implemented. These methods should include qualitative approaches derived from social, anthropological and other humanistic sciences as well as stakeholder analysis to capture the complexity and diversity of the outcomes (Saraceno, B. 2004b).

Recent research (DOH, 2000b pg25) indicates that in a survey of adults, a range of social and environmental factors are associated with increased likelihood of reporting poor health. Some of these factors were as follows:

- lack of control over decisions affecting life;
- lack of influence over neighbourhood decisions;
- low neighbourhood social capital;
- having no support; and
- having no involvement in community activity.

These factors have a significant impact on stress levels. Anxiety, insecurity, low self esteem, social isolation, and lack of control over life and work can trigger biological stress-responses. If this response is triggered too often and for long periods, there may be multiple health implications, including depression, infection, diabetes, high blood pressure and accumulation of cholesterol in blood vessel walls, with the increased risk in heart attacks and strokes (DOH, 2000c).

The projects that arose from the SSE Programme have had an influence on the mental health and well-being of both the SSE participants and the communities in which they have worked. The individual participants themselves benefited

directly and the communities indirectly as a result of the community based provision that is now available.

Individual Benefits

There were many benefits to the individuals which presented themselves in many differing ways, but for the majority of the participants they reported an increase in self confidence and self esteem adopting new, more effective approaches to problem solving. The following participants on the programme stated that;

> "I have developed a wonderful support network of people. None of this would have happened if I had not took control of my own life but most of all people took the time to listen to me and believe in me and I have been given a new lease of life; it has changed my life completely. I feel really good about myself."
> (Brennan, 2001b, Pg2)

> "I am more self-confident and have used that confidence to pursue what I originally wanted to do rather than be influenced by other people's agendas. I like myself now for the person that I am. I previously saw that the things I used to struggle with were my faults. I now like the things I cannot do, they are a challenge."
> (Rolfe, 2005 pg1)

> "I feel that I have greater self-esteem and value myself more believing my opinions are valid. I am more confident working in my community, and more comfortable speaking at meetings and communicating and putting my point across to others."
> (Coakley, 2005 pg1)

> "I don't feel a failure anymore and have developed an inner strength. Feel more confident and I have stopped putting myself down."
> (Hull, 2005 pg2)

Community Benefit

The communities of Salford have benefited from the impact of the different enterprises. Some of the communities included had the opportunities to

undertake voluntary work. Kevin Coakley's food and vegetable co-operative provided placements for six volunteers. Three of them secured employment in a local school as a direct result of the experience gained as volunteers.

Within John Pennington's project local people now have access to a community sports development centre. It not only provides a range of sporting activity, but also includes an education programme, and while young people are using the services their parents are safe in the knowledge that their children are safe. It was also reported to me that young people are also kept off street corners. Ten young people have gained certificates In "Safe Sporting Activities" through the Youth Sports Trust. Six young people have undertaken training to be referees, (Pennington, 2005).

Social Inclusion

One hundred percent of all participants of the first SSE programme were unemployed prior to the programme; although all were involved in community based voluntary work. On completion seventy five percent were in employment and one participant continued with voluntary work.

In the second SSE programme only one person was in employment at the start with eighty three percent unemployed but working in a voluntary capacity in their community. On completion all participants were in employment. For further information please see **Figure 10**.

Being in employment not only provides a purpose in life and a reason for getting up in the morning, it also allows you to be economically active.

The Salford School for Social Entrepreneurs was the very first community based programme and became the role model for influencing the development of the following community based SSE programmes;

- Belfast and Ireland;
- East Midlands;
- Fife and Scotland;
- Restormel and Cornwall;
- Aston (West Midlands);
- Newcastle;
- Shrewsbury;
- and Cardiff.

These new schools are also contributing to community development and to an inclusive society (School for Social Entrepreneurs, 2002).

Figure 10

Salford Social Entrepreneurs Programme Participants Employment Profile

Set 1.	Pre Programme	Post Programme	Comments
Jay Brennen	Unemployed (10 Yrs) Community Voluntary worker	Employed	Community Development Worker Salford PCT
Charlotte Richards	Unemployed, Community Voluntary worker	Employed	Care Assistant Nursing Home
Jeanette Ball	Unemployed, Community Voluntary worker	Unemployed	Undertaking voluntary work
Gwen Rolfe	Unemployed, Community Voluntary worker	Employed	Tiny Tots, Project Coordinator

100% Unemployed before programme. 75% Employed following the programme.

Set 2.	Pre Programme	Post Programme	Comments
Kevin Coakley	Self Employed Decorator, Community Voluntary worker	Employed	Self Employed Decorator
Michael Felse	Unemployed, Community Voluntary Worker	Employed	Chief Executive, Proud City, Social Enterprise
Julie Hull	Unemployed Volunteer Playgroup Worker	Employed	Community Support Worker, Feels she has found her niche.
Dave Kennedy	Unemployed, Community Voluntary Worker		Employed Manager Pedal Power
Bernadette Wright	Unemployed, Community Voluntary Work	Employed	Director Proud City, Social Enterprise
John Pennington	Unemployed (12 Yrs), Community Voluntary Worker	Employed	Employed Manager Peel Sports, Salford City Council

83% Unemployed before programme. 83% in employment following the programme.

In considering the information arising from my research I drew on the work of Benzeval, *et al* (1996a) on tackling health inequalities.

Health Inequalities

Inequalities in health are caused by an unequal distribution of the determinants of ill health which contribute to the cause of health inequalities as follows:

- Economic determinants;
- Social determinants;
- Psychological determinants;
- Environmental determinants;
- Personal behaviour;
- Access to treatment and care.

Margaret Whitehead suggests that policy initiatives that can influence health inequalities exist at four different levels (Benzeval *et al.* 1996b).

1. **Strengthening Individuals**

Policies at this level attempt to change individual's behaviour or their ability to cope with the demands and stressors through education or personal empowerment. Interventions which are sensitive to the circumstances of disadvantaged individuals and combine education with support can have a positive impact.

2. Strengthening Communities

These initiatives aim to increase the social cohesion within the community and involve them in changing the local environment and services in ways that promote better health.

3. Improving Access to Essential Facilities and Services

Efforts to strengthen individuals and communities alone are likely to have a limited effect on health inequalities. Broader policy initiatives aimed at improving living and working conditions will be vital for major sustained reductions in health inequalities.

4. Encouraging Macroeconomic and Cultural Change

Tackling health inequalities in a coordinated and sustained way will require a strategic approach that takes into account the complex interactions between the determinants, the multiple levels at which the effects are seen and the relationships between possible solutions. There are individual, community, organisational and societal factors that influence and maintain the inequalities locally.

The following Chapter explains the relevance and application of these findings and conclusions both personally and for others.

Outcomes

Jay Brennan Healthy Living Project **Figure 11a**

Action & Achievements	**Personal Development**	**Critical Understanding**	**Skills & Capability**	**Progression**	**Employability**
Heart Start training. Community house. Community café. Drop in centres. Advice & information service. Equipment loan scheme. Community transport scheme. Community garden. Complementary therapies. Health promotion events. Homework clubs.	Self confidence. Self esteem. Self awareness. Feels in control. Lost weight. Reduced her smoking. Not intimidated by council officers.	Value of each others contribution. Community involvement. Council structures. Participative appraisal. Working in partnership.	Working as a member of an action learning set. Listening. Communication. Questioning. Reflection. Support Network. Consultation. Interpersonal. Fund raising. Counselling.	PCT Development Worker. Developing others. NVQ Community Work. Diploma in Youth & Community work, Manchester University.	Community Development Health Worker for the PCT.

Outcomes

Charlotte Richard's Play facilities Project **Figure 11b**

Action & Achievements	**Personal Development**	**Critical Understanding**	**Skills & Capability**	**Progression**	**Employability**
Stowell Community Group. Monday club for young people. Developed a project steering group. Acquired land from the city council. Cleared land for football pitch. Contract for land maintenance.	Increased confidence. Self awareness. Self esteem. Found my own voice. Not intimidated by council officers.	Community involvement. Partnership working. Council structures.	Working as a member of an action learning set. Questioning. Communication.		Nursing Home Care Assistant.

Outcomes

Janette Ball Operation Valley **Figure 11c**

Action & Achievements	Personal Development	Critical Understanding	Skills & Capability	Progression	Employability
Secretary of Residents Association. Community handyman service. Renovated community centre. Resident's gardens made over. Community barbecue built. Cleared & laid hardcore to six acres of land, disposing of 300 tons of rubbish. Plants provided. Dog walking area. New football pitch	Self awareness. More reflective. Increased self esteem. Increase in confidence. Not intimidated by council officers.	Community involvement. Local government. Partnership working.	Working as a member of an action learning set. To be less controlling. Fund raising.	Consultancy work with the Audit Commission, part-time, North West Housing Inspectorate.	Unemployed. Undertaking voluntary work.

Outcomes

Gwen Rolfe Tinytots Vision Ltd. **Figure 11d**

Action & Achievements	Personal Development	Critical Understanding	Skills & Capability	Progression	Employability
Secured partners for developing Tinytots. **"Tinytots"** Playgroups. Mobile Crèche. Play Spots. Family activity days. Training Services. Outreach Work. Health Promotion. Fit City Club. Nursery new build project. Employment of local people. Placements for voluntary workers.	The value of being honest in her relationships with others. Self confidence. Self esteem. Self awareness.	Partnership working. Business planning. Local Authority working.	Working as a member of an action learning set.	Networking. Not to be influenced by other people's agenda's. Received an award from MEN, for "Adult Learner Achiever". Book keeping course. Past driving test.	Project Coordinator of Tinytots Ltd.

Outcomes

Kevin Coakley Clockwork Orange Food Coop **Figure 11e**

Action & Achievements	**Personal Development**	**Critical Understanding**	**Skills & Capability**	**Progression**	**Employability**
Provision of voluntary placements. Employed local people. Developed a community enterprise providing fresh fruit and vegetables. Provide to housing schemes, play schemes, community centres, schools and community events.	Self esteem. More confident. More self awareness. Not intimidated by council officers.	Constraints of working with public sector organisations. Interviewing process. Community working.	Working as a member of an action learning set. Public speaking. Communication. Funding skills.	Chairmen of CHAP.	Self employed decorator.

Outcomes

Mike Felse Active Citizenship Programme **Figure 11f**

Action & Achievements	**Personal Development**	**Critical Understanding**	**Skills & Capability**	**Progression**	**Employability**
Set up the following social enterprises, Proud City, Team Salford, Developed an Active Citizenship programme in partnership with City & Guilds.	Now has a clear purpose to his life. Self awareness. Feels more rooted in his community.	In the value of voluntary working. Partnership working. Local authority.	Working as a member of an action learning set. Problem solving. Business planning. Fundraising.	Increase in networking opportunities. New career opportunity.	Chief Executive, Proud City

Outcomes

Julie Hull Kool Kidz Child Care Centre **Figure 11g**.

Action & Achievements	Personal Development	Critical Understanding	Skills & Capability	Progression	Employability
Secretary for local football team. Secretary Swinton Youth Partnership. Treasurer Manchester United Supporter Club (Swinton Branch). Her original project didn't materialise.	Increased self esteem, confidence and self awareness.	Community development.	Working as a member of an action learning set. Fund raising and grant giving. Communication. Reflective skills.	NVQ In Child Care and Education.	Private child minder. Worked for Salford Council for Voluntary Services (CVS) responsible for administering small grants. Moved on to become an Information Support Worker with CVS.

Outcomes

Dave Kennedy Pedal Power **Figure 11h**

Action & Achievements	Personal Development	Critical Understanding	Skills & Capability	Progression	Employability
Set up a local Heart Start programme locally. Opened a local bicycle re cycling shop. Employs local people. Provides voluntary work placements Bicycle taxi service.	Feels more valued. Increase in confidence. Increased self awareness. Not intimidated by council officers.	Community working. Of local politics.	Working as a member of an action learning set. Negotiation skills. Fundraising. Partnership working.	Trained all set members in Heart Start.	Unfortunately David died in May 2004

Outcomes

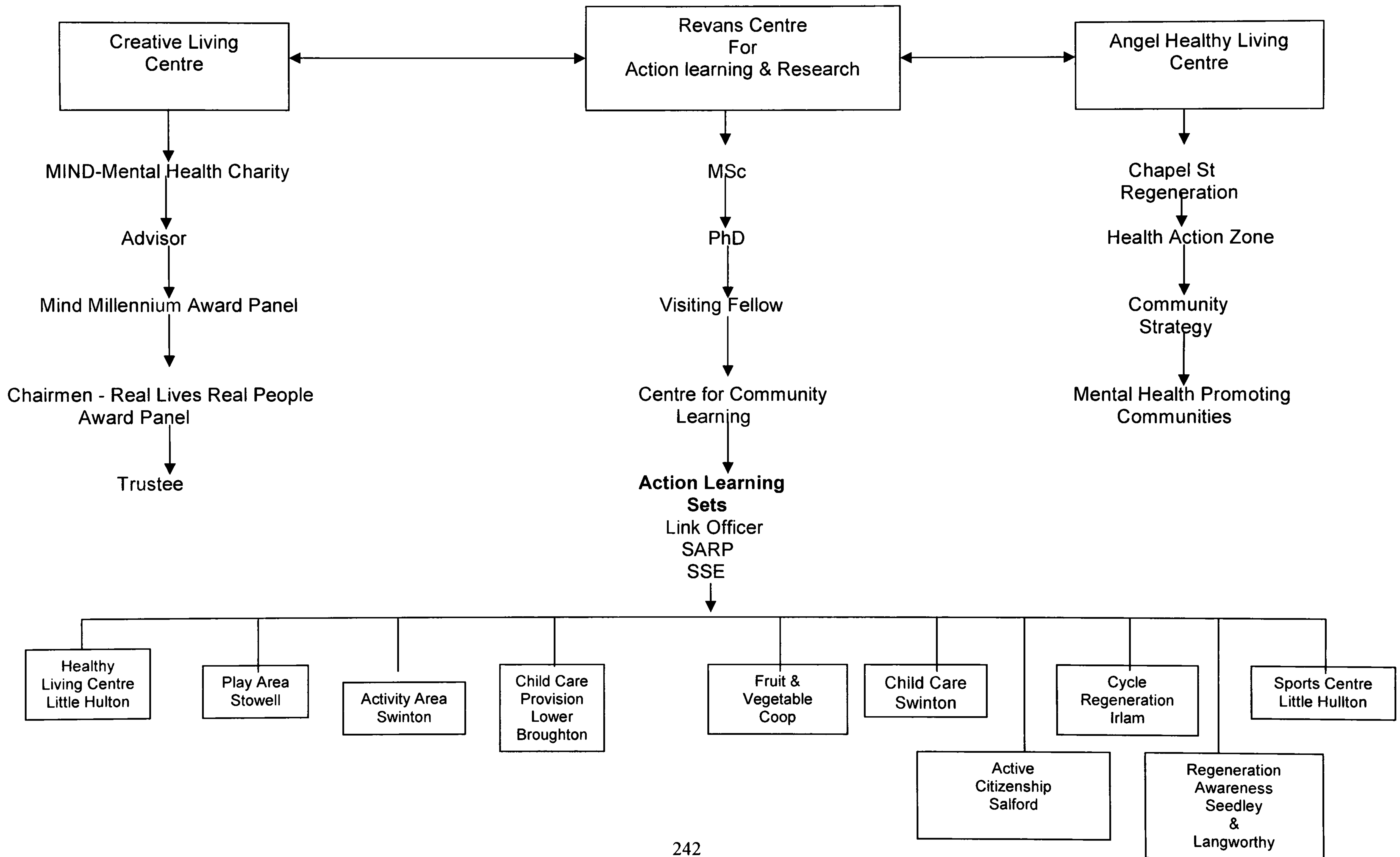
John Pennington Peel Sports Centre **Figure 11i**

Action & Achievements	Personal Development	Critical Understanding	Skills & Capability	Progression	Employability
Initiated a football team on his estate. Encourage other parents to undertake coaching skills course. Young people on refereeing courses. Developed a wide range of sport facilities. Peel Community Sports Centre. Employs local people. Provides voluntary work placements.	More involved with his community. Self awareness. Increase in self confidence. Increased self esteem.	Of the working of the City Council.	Working as a member of an action learning set. Fund raising. Negotiation skills. Networking. Business planning. Presentation skills.	UEFA Coaching Course. Became Chairmen of local Community Committee. Obtained a Community Leaders Award course.	Manager of Peel Sports Centre.

Outcomes

Bernadette Wright Local History & Regeneration Awareness Club **Figure 11j**

Action & Achievements	**Personal Development**	**Critical Understanding**	**Skills & Capability**	**Progression**	**Employability**
Exhibition of her work for local people at the Lowry. Knowing Me, Knowing You photographic exhibition at the Lowry, on regeneration. Set up the Local History & Regeneration Awareness Club(LHARA)	Learned to think before acting. Increased confidence. Self awareness. Self esteem.	Of regeneration and its impact on communities. Of local authority working. Community working.	Reflective practice. Working as a member of an action learning set. Questioning. Communication. Leadership.	Active Citizenship Programme. Salford film festival- member of the management board. Salford community radio, member of the management group. Member of the following task groups; Crime & Safety, Living Environment & the Seedley & Langworthy Partnership	Director of Proud City a social enterprise.


Learning to Learn – Milestones of Influence
Figure 12
Creative Living Centre
Revans Centre For Action learning & Research
Angel Healthy Living Centre
MIND-Mental Health Charity
Advisor
Mind Millennium Award Panel
Chairmen - Real Lives Real People Award Panel
Trustee
MSc
PhD
Visiting Fellow
Centre for Community Learning
Action Learning Sets
Link Officer
SARP
SSE
Chapel St Regeneration
Health Action Zone
Community Strategy
Mental Health Promoting Communities
Healthy Living Centre Little Hulton
Play Area Stowell
Activity Area Swinton
Child Care Provision Lower Broughton
Fruit & Vegetable Coop
Child Care Swinton
Active Citizenship Salford
Cycle Regeneration Irlam
Regeneration Awareness Seedley & Langworthy
Sports Centre Little Hullton

Section 4.

This section provides an account of the relevance and application of my experiences of working in partnership with patients and the public for the improvement and development of service provision.

It also provides an overview of the processes for researching my practice and references key aspects of my work experiences for further description and understanding.

It gives an update of how my role has developed in the Trust and how I have continued to pursue my work and the new directions it has taken me.

It concludes with a final Chapter that provides a meta-position of the action and the learning arising from this inquiry, building on the initial findings in Chapter 9. It presents the key themes of the thesis and its original contribution to knowledge and practice.

Chapter 10
The Relevance and Application of my Experience

This Chapter provides the reader with a rationale for the importance of this research in the context of health and social care provision, highlighting how the research findings are transferable to the wider public sector.

It also proposes that the findings can further the development of active citizenship across the public, private and voluntary sectors.

Conclusions - The Wider Context

The lessons arising from this work has wider implications for what health and social care services are provided, why and where and how.

Organisations in the public, private and voluntary sector need to respond to the many demands and new standards of service delivery, which in my opinion requires the involvement of patients and the public in learning together how to best respond to those challenges.

Developing better public services have been a key aim of the government since its election in 1997. The government now believes that

> "The NHS has the capacity and capability to move on from being an organisation which simply delivers services to people to one which is to being one which is totally patient-led – responding to their needs and wishes."
> (DOH, 2005b).

This research has demonstrated that involving patients and the public in the development of services can result in radically different models of provision.

The radical models referred to are the Creative Living Centre where I learned to involve service users and the Angel Health Living Centre where I learned how to involve the communities of Trinity, Islington and Greengate (in Salford). The accumulation of my personal learning from my experience gave me the confidence to work with individual members of the public who applied for and were successful in securing a place on the Salford Social Entrepreneur programme. These three services would not have developed if service users and the public had not been actively listened to and involved in its development.

My experience of engaging the patients and the public and the associated learning in the three project areas referred to above is transferable, and of value to others whose work requires them to involve patients and the public.

Despite the many policy imperatives (referred to in Chapter 4) that require partnership working with patients and the public there is a long way to go before there are natural working relationship with the communities in which the public, private and voluntary sector serve.

However it seems as though the NHS is not good as it thinks it is in involving patients and the public. Recent research, NHS Users – The Silent Majority, undertaken by the Developing Patient Partnership (a UK health education charity working with Primary Care Organisations and the public to make the most of health care services) states that

> "76% of people in Britain have never been asked about what they want from local NHS services. This is despite the fact that the public and health professionals almost unanimously (90% and 93% respectively) agree that local people ought to have a say in how health services are run.

The research shows that many people (50%) feel that they have no power to influence what happens with their local NHS services, with 26% of people saying that they think it is a waste of time to involve ordinary people in the first place."
(Developing Patient Partnerships, 2006 pg1)

See **Appendix 13** for a break down of statistics by each Region.

However the following statutory, health service and people requirements will require the public, private and voluntary sector to consider how they can improve their relationship with local people and their communities.

1. Statutory Requirements

Health and Social Care Act, Sect 11

Under the Section 11 of the Health and Social care Act 2001 Health Authorities and Primary Care Trusts (under law) have a duty to consult scrutiny committees, patients and the wider public over substantial changes to services and it is crucial that they are held to account (Department of Health, 2001c). Unfortunately the consequences of government actions have often ignored their own policies.

For example Independent Sector Treatment Centres (ISTCs) have been set up by the government to take the pressure off NHS Hospitals; the consequence of this is forcing services out of the NHS and into the private sector, and threatens many hospitals in the country. They are also paid more for the same work done in the NHS (Pearce, 2006).

Clearly although there is widespread support for treatments to be community based the Government does not appear to have considered the financial consequence of redirecting revenue from NHS Provider Trusts to the private sector and the effect of this on the trusts financial viability.

Independent Complaints and Advocacy Services

Section 12 of the Health and Social Care Act 2001 placed a duty on the Secretary of State for Health to make arrangements to provide Independent Advocacy Services to assist individuals making complaints against the NHS. The new Independent Complaints Advocacy Service (ICAS) contracts were launched on 1 April 2006 (DOH (2001).

The Independent Complaints Advocacy Service was established to support patients and the public wishing to make a complaint about their NHS care or treatment. This statutory service was launched on 1 September 2003 and provided a national health complaints advocacy service delivered to agreed quality standards.

ICAS aims to ensure complainants have access to the support they need to articulate their concerns and progress through the complaints system, and providing the opportunity for their complaint to be resolved quickly and effectively.

ICAS is a patient centered service, delivering support ranging from provision of self help information, through to the assignment of a dedicated, specialist advocate able to assist individuals with more complex needs.

Clearly the very fact that there has been the need for an independent advocacy service demonstrates that the NHS is not able to resolve locally the many complaints about people's health care experience. I suspect that there would be a reduced number of complaints if there was a different relationship between the giver and receiver of care/treatment.

Foundation Trusts

NHS Foundation Trusts or "foundation hospitals" were created under the Health and Social Care Community Health and Standards Act 2003 (DOH 2003).

NHS Foundation Trusts have been set free from central government control. They possess three key characteristics that distinguish them from NHS Trusts:

- Freedom to decide locally how to meet their obligations;
- Accountable to local people, who can become members and Governors;
- Authorised and monitored by Monitor - Independent Regulator of NHS Foundation Trusts.

The proposed benefits are aimed at improving the relevant care for their patients because they have been "set free" from the following central government control as follows;

- NHS Foundation Trusts will have the freedom to decide locally the capital investment needed to improve their services and increase their capacity;
- They will be able to borrow to support this investment, as long as they can afford it, without needing to seek external approval;

- NHS Foundation Trusts will establish stronger connections between local hospitals and their local communities. Those living in communities served by a hospital of an NHS Foundation Trust will be invited to become a member. Members will be able to stand and vote in elections for Governors of the NHS Foundation Trust. This form of public ownership and accountability will ensure that hospital services more accurately reflect the needs and expectations of local people;
- The public will still experience healthcare according to core NHS principles – free care, based on need and not ability to pay.

The principles behind NHS Foundation Trusts build on the sense of ownership that many local people, including staff, feel for their hospital.

Anyone who lives in the area, works for the trust, or, in some cases, who has recently been a patient there, can become a member of an NHS Foundation Trust. This gives staff and local people a real stake in the future of their hospital and enables them to elect representatives to serve on the Board of Governors. The Board of Governors will work with the Board of Directors – responsible for day-to-day running of the Trust to ensure that the NHS Foundation Trust delivers NHS care and acts in a way that is consistent with the terms of its authorisation. In this way, the Board of Governors will play a role in helping to set the overall direction of the organisation.

This accountability to local people and the stronger connections required between local hospitals and their local communities will require the Foundation

Trust to think carefully about how it moves from where it is now to where it needs to be. Local people will also have the opportunity to be members of the Foundation Trust and indeed will be invited to become members of the Trust and will be able to stand and vote in elections as Governors of the Foundation Trust. There is a need to develop a clear understanding of how the Foundation Trust can develop a closer working relationship with local people. I believe the conclusions from the research can help support this.

2. Health Services Requirements

Patient and Public Led Services

The many policy imperatives and specifically Creating a Patient-Led NHS, Delivering the NHS Improvement Plan (DOH, 2005c) acknowledges that the NHS needs a change of culture as well as systems if it is to truly become patient-led.

This will require providers of services to behave and work differently as outcomes will become measured by their impact on patients and the benefit to people's health.

This will mean thinking about the whole person, becoming relationship centred and concerned as much with health promotion and prevention rather than patient centred and dealing with illness.

Supporting staff in delivering a patient-led service will require some of them to have as much authority as possible to make decisions and respond to the needs of patients in their care. Along with this authority will be the need for staff

to accept the responsibility for their practice and actions and this should minimise the need to refer things to their line manager for permission.

Commissioning

Delivering better public services is a key aim of the government and the concept of choice in public services is an important element of the transformation that is expected to drive a service that is more responsive to the needs of the people they are provided for. A further theme of the reforms is a move away from the traditional commitment of service delivery by the public sector to one that embraces plurality of provision to include the involvement of the independent sector (DOH, 2005).

The commissioning of services therefore is important as it needs to ensure that people are able to receive the appropriate care at the right time and in the right place regardless of organisational interest or the interests of those who work in the NHS.

The commissioning of services therefore requires a detailed service specification that is developed collaboratively, encouraging integrated care, and placing patient's needs and health improvement at the heart.

Services can then be subject to a process of tendering that invites organisations or collaboratives to respond to a tendering exercise ensuring that the organisation who best demonstrates their ability to meet the requirements of the service specification are appointed. The priority therefore focuses on the ability

to deliver a needs led service, and not whether the public, private or voluntary sector is the most appropriate provider.

It feels appropriate therefore that the commissioners of services need to ensure that service providers demonstrate that models of care should be based on an open and transparent strategy of patient and public involvement.

The private sector are often held up as the model for which the public sector providers should aspire and is reinforced in part by the policy of Choice in the NHS and the imperative to achieve plurality of service provision. Service provision therefore is not now viewed as being the preserve of the NHS, but also the private or voluntary sector. Current debate continues regarding who might be the most appropriate provider with the private sector often trusted more than the voluntary sector, but the voluntary sector are often considered better at looking at what users of services really need. Either way both have strengths and weaknesses (DOH, 2003b).

The commissioning of health and social care provision appears to offer the key to ensuring the appropriate provision of responsive services. Strengthening a model and process of commissioning, that clarifies the service provision expected against a set of values, principles and expectation would provide the opportunity for ensuring who had the appropriate skills and organisational infrastructure for the provision of services and not wether they were from the public, private or voluntary sector.

3. People Requirements

Health Impact through empowerment – the expert Patient

One of the fundamental challenges occurring in the NHS is the recognition that patients are no longer being viewed as passive recipients of care, with an increasing emphasis on the relationship between the NHS and the people it serves. These relationships being one where health care professionals and patients become genuine partners working to find the best solutions to a patient's problem.

The vision for a patient centred NHS needs to be in the context that the "prominent disease pattern" in this country is one of chronic rather than acute disease.

> "When acute disease was the primary cause of illness, patients were generally inexperienced and passive recipients of medical care. Now that chronic disease has become the principal medical problem, the patient must become a co-partner in the process."
> (Holman and Lorig, 2000, pg526)

The concept of expert patients is one where people with a chronic disease can enjoy a good quality of life, with the confidence, skills, input and knowledge to play a central role in the management of their life.

The overall aim of self-management or 'expert patient' programmes is to develop confidence and motivation to enable patients to understand their circumstances and needs, to establish effective relationships with professionals and to take control of the management of their condition. The training courses address issues such as confidence-building, relaxation, cognitive symptom

management, exercise, fatigue, nutrition, problem-solving, action planning, communication, and relating to/working with health care professionals.

Expert Patient Programmes are run by volunteers who themselves have a chronic condition and who are keen to build up their own expertise and then pass this on to help others.

In the provision of health and social care, service providers need to explore how to promote an expectation that the expertise of patients is a central component in the provision and delivery of their care, and specifically ensure that self management programmes are integrated into National Service Frameworks.

Citizenship

The relationship between local government and the public is changing and effective local governance now requires informed, engaged citizens who vote in elections, participate in decision making and contribute to designing, delivering and monitoring services.

Developing effective citizenship is not just something councils do to the public, it requires that decision-making bodies operate in ways which value the input of citizens and foster mutual learning. This will probably require cultural change and can also require organisational structures which support the public in learning about local democracy, and which make decision-making processes easier to understand and access. This means public bodies need to go beyond providing opportunities for participation, to embark on a process of learning, both for the public and for the organisations that need their input.

The Three Levels of Patient and Public Involvement as described in the previous chapter appear to be a useful model for considering levels of involvement in citizenship as outlined by Woodward (2004), and are shown in **Figure 13.**

Figure 13.

Three Levels of Patient and Public Involvement in Health and Social Care	Three Levels of Involvement in Active Citizenship
• Involving the patient in identifying their needs and making an informed choice regarding the appropriate treatment.	• Giving citizens more power to deal with their own individual and community concerns
• Working with current service users to examine and improve the way existing services are provided and organised.	• Giving citizens the power to protect their interests in relation to those organisations not under the control of the state.
• Exploring with the public innovative and creative ways of redesigning health and social care provision.	• Giving citizens the power to influence the activities of government that affects their lives.

The findings of my research as indicated in the previous chapter offers six critical ingredients for involving patients and the public in the development of health and social care provision at three levels as indicated in **Figure 12** above. These critical ingredients are based on my personal work based practice and although they offer a framework for involvement, consideration needs to be given to the organisational context in which public and patient involvement is required. This organisational context requires the development of an organisational culture that is empowering and I also offer six critical ingredients for developing an empowering organisational culture. These are as follows;

Six Critical Ingredients for Developing an Empowering Organisational Culture

1. ensuring that the organisation respects the views of others, and is committed to partnership with local people, service users and community groups;
2. consider the executive team's behaviour and how the way they work might disempower others;
3. provide support for staff to learn about the meaning and practical implications of working in an empowering way;
4. consider the needs of people in a holistic way and from their perspective and not just as patients or members of the public;
5. motivate staff to respond to the concerns of the people they work with;
6. and regular two way performance appraisal should clarify overall objectives, but let the staff deliver their objectives in their own way with minimal intervention. This will involve giving greater flexibility and autonomy in running their own services.

This will require staff to take a wider interest in the communities in which they work, providing them with the support to develop their skills in areas that can benefit community groups.

Chapter 11
Making Sense of My Research

This Chapter is a consolidation of my research. It gives the reader an explanation of the origin of my research and the processes that influenced the direction I took both in my work and in answering what came to be my research questions.

Introduction

The work based experiences and the learning that underpins my research has been complex and challenged me in communicating its complexity in this thesis. The experiences have not been linear yet I have had to write this thesis in a way that allowed me to communicate what it was I wanted to say within a recognisable research framework that is understandable by the reader.

I have needed to take control of this tension as I feel I have something important I want to communicate about my experiences. I have therefore had to take control and position myself in a way that provides a balance to the conflict of those tensions. This has required me to put myself in the position of who might read this thesis, acknowledging the different starting points and mind sets between researcher and practitioner.

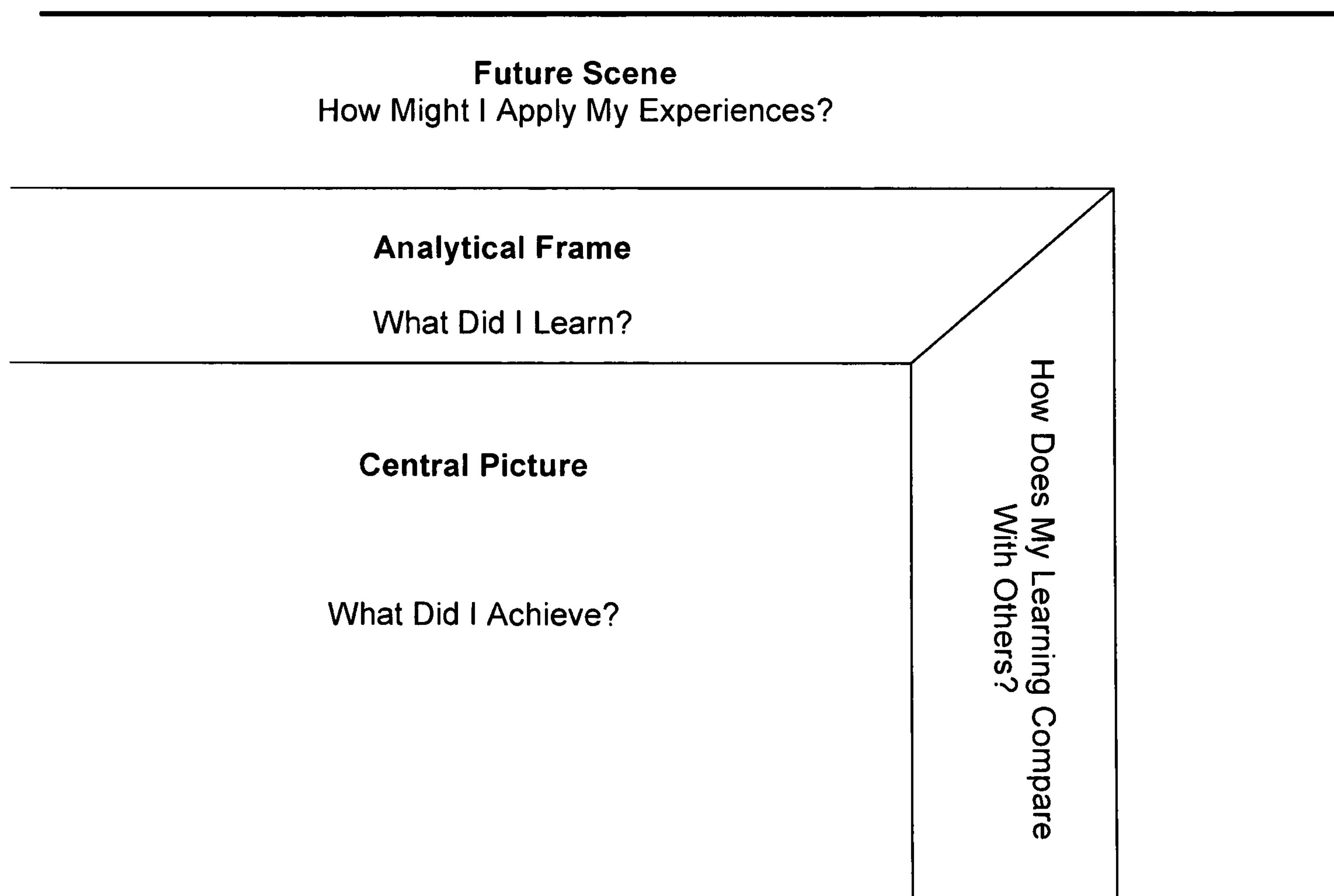
The Central Picture Model

I have therefore used the Central Picture Model as developed by Botham and Vick as a procedure to help me communicate the process of writing this thesis (Botham and Vick,1998, pgs. 5-16). See **Figure 14**.

This model offers frameworks around four questions which help the practitioner, who is also the researcher in analysing the complex experiences gained from learning from work, set and information as indicated in the explanation of the Botham Morris triangle in Chapter 6. These questions are posed within a specific area of the frame which provides a primary focus.

To assist me in answering these four primary questions I asked myself a number of secondary questions which are listed in **Figure 15**. This provided a logical sequence of questions allowing me to review the progress of my research. These secondary questions where taken from an unpublished paper, (Allison, 2006) which I have amended to indicate how the questions relate to the Central Picture Model.

Figure 14. Central Picture Model



Central Picture

This is underpinned by the question "What have I achieved?" This question creates the central picture and provides the form for analysis, which leads to a clear account of those experiences observed and recorded at a particular time. This therefore provides the relevance and meaning to those experiences and real events. What is recorded here then can only be a partial relevant account of the total picture.

In order to be clear about what my central picture might look like, I asked myself the following questions, which are answered in detail further on in this Chapter;

- What was the situation?
- What did I know about it?
- Why was I concerned?
- What did I do about it?
- How did I do this?
- What did I achieve?

The central picture is surrounded by an additional frame which is based on two questions and forms the basis for the frame around the central picture.

Analytical Frame

This frame is concerned with, "What have I learned?" and "How does my learning compare with others?" The mitre joint is intentional as each side of the frame should support each other giving weight to the explanation. This part of the model attempts to bring a personal account of learning into a wider discussion by contrasting it with what has already been described and recorded

by others. Responding to this part of the model I asked myself the following questions;

- What did I learn, specific to the issue and wider?
- How did I evaluate the experience?
- How does my contribution compare with others, selected by relevant areas of interest and by different approaches to the issue?
- What does this add to my learning/abilities?

Again these questions are answered in detail further on in this Chapter.

The final frame explains the relevance and the application of the Central Picture and its supporting analytical frame to other contexts which challenges what has been learned and achieved.

The Future Scene

This frame is concerned with the future and the question "How can I apply my experience?" It provides the opportunity to explain how the learning arising from the research can influence further development into the practitioner's work which is considered under developed.

In order to respond to this part of the model I asked the following questions;

- What have I added to general understanding/abilities in this field?
- What can I add further?
- What can others add further?

These questions are answered in more detail in this chapter.

Figure 15

Outline of "project life"

Central Picture

- What was the situation?
- What did I know about it?
- Why was I concerned?
- What did I do about it?
- How did I do this – study, collaboration, action?
- What did I achieve?

Analytical Frame

- What did I learn – specific to the issue and wider?
- How did I evaluate the experience?
- How does my contribution compare with others?
    - Selected by relevant areas of interest
    - Selected by different approaches to the issue
- What does this add to my learning/abilities?

Future Scene

- What have I added to general understanding/abilities in this field?
- What can I add further?
- What can others add further?

What was the situation?

The motivation to undertake this research came from a range of work based problems and experiences that resulted in new understandings in how to involve patients and the public in undertaking my role as Director of Service Development.

Through the development of a community based mental health healthy living initiative, I explored new ways to develop services based on working in partnership with patients and the public and the voluntary sector. In this work I discovered many things about myself and my work but specifically in my role as Director of Service Development. Here I discovered that I undertook that role without much reference to the people who would be using those services. I would arrogantly use my professional experience and expertise in order to influence and design new services.

Working in partnership with patients and the public demonstrated to me the contribution they can make to service development. As a consequence of this experience I have changed in many ways. I have discovered how I had been conditioned by the expectations of the organisations I have worked in. This resulted in me seeing healthcare in the context of hospital based provision and limiting my understanding in other models of health care provision. As a result my role in the Trust was developed to reflect these new experiences and the detail is described in Chapter 5 of this thesis.

Being involved in the development of a holistic approach to healthcare as experienced in the development of the Creative Living Centre resulted in me

working in a different way that ensures the person using the service is at the heart of all that is done. There was no going back to working in a way that doesn't involve patients and the public. The experiences of developing the Creative Living Centre and how this influenced a new understanding in my practice is described in further detail in Chapter 3.

There were many challenges whilst learning to develop the Creative Living Centre not the least how do I communicate these experiences as my work reconnected me back in the Trust? The challenge of communicating this new and innovative approach to mental health provision was not just about how to find the words to articulate what it is I wanted to say. I also knew that the concept of health within an "Illness Service" would not only be received negatively but also would not be understood due to a prevailing medical model. These personal challenges also needed to be understood against the backcloth of trying to reinterpret was happening to me as I wrestled with trying to understand new concepts and ideas that challenged my professional background and experiences. These challenges are explained in Chapter 5 and provide an understanding of how I was able to influence the Trust about the value of my work.

During this time I was also asked to project manage what was intended to be a Primary Care Resource Centre by Salford and Trafford Health Authority. I decided to use the experiences of involving patients and the public in the development of this project. As a consequence of talking to local people in the communities of Trinity, Islington and Greengate (in Salford) and other potential stakeholders, it soon became clear that there was no need for such a centre.

However what I learnt from local people was that they were more than able to articulate their needs and as a consequence secured agreement from the Salford and Trafford Health Authority to consult further with local people building on their initial feedback. The consequence of this was the development of the Angel Health Living Centre in Salford. Here I learnt the value of consulting with the public in the context of their communities.

The approach used for the involvement of patients and the public was largely based on action learning processes. Seeing first hand the consequences of using this approach initially at the Creative Living Centre for people with mental health problems, and then with local communities (at the Angel) led me to think about the value of offering an action learning approach to support individual members of the public to work on their individual aspirations. Its value was based fundamentally on improving and sharing through mutual support rather than being told what to do.

One of the experiences that influenced this was witnessing how people at the Creative Living Centre and the Angel Healthy Living Centre came to life as they used the various services at each Centre. There appeared to be a significant improvement in their well-being and community involvement.

Having learnt how to involve people who have mental health problems and the local communities of Trinity, Islington and Greengate I became increasing stimulated and attracted to this way of working, which was by now dominating most of my time. As a consequence of those experiences I was asked to work

in partnership with Salford City Council to explore what developing mental health communities might mean.

These collective experiences challenged me even further as I wrestled with my new found ways of working which seemed to move me further away from the Trust's priorities of working with people with serious and enduring mental health problems, towards a more holistic approach to responding to peoples needs. This holistic approach is explained further in Chapter 3.

I decided that I needed to understand these work based challenges and experiences further as, although I could intuitively see the value of this approach in the promotion of mental health and social inclusion, it wasn't enough if I wanted to continue working in this way. I would need to be able to articulate the value of my work in the context of mainstream mental health provision. After discussion with the Trust Chief Executive I was supported to do so and consequently enrolled in a doctoral programme at the Revans Centre. See Chapter 5 for further information.

What did I know about the situation?

Based on my personal experience I had observed how people using the Creative Living Centre and the Angel grew and developed in many ways as they explored their individual needs and made decisions for themselves about how those needs might be best met.

I was also aware of many health and social care polices that encouraged the development of services based on health need as identified by patients and

other partners and not on the exclusive views of health care professionals. However I wasn't aware that there had been any practical experience of specific work in this area. An exploration of my experience of working in mental health and my understanding of the practical implication of policy imperatives that drive mental health reforms are described further in Chapter 4.

I was specifically aware of the government imperative for the improvement in health of the public, through the production of a number of policies the fundamental aim of which was to redesign services from the perspective of those who receive them:

> "Patients are the most important people in the health service.....Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment and more influence in the way the NHS works."
> (NHS Plan, DOH, 2000b, pg88)

Similar intentions have been reiterated in may other policy directives, e.g.

> "Patients, service users and carers will be involved in their own care and in planning services."
> (DOH, 1998, pg7)

> "Patients provide a uniquely valuable perspective on services, and it is impossible to get the best from the change process without actively involving them. People with mental health problems can expect that services will involve service users in planning and delivery of care."
> (DOH, 1999e, pg9)

Why was I concerned?

These experiences gave me significant insights into working with patients and the public. As a result I was able to analyse, learn from and integrate new ways of working into my practice.

The consequences of doing so resulted in the development of significantly different services and an awareness that my behaviour had changed in order to establish a working relationship with the patients and the public.

It became increasingly important to me to be able to explain the value of working in this way as I was starting to understand the implications of doing so for the provision of health and social care. This research was my opportunity to influence others. This way of working is described in Chapter 3. I was also concerned as I felt that these personal changes needed to be understood by others with responsibility for working with patients and the public. In doing so I hope to contribute in supporting others in thinking about their own practice and how they involve patients and the public.

What did I do about it?

My initial action took place during the early experience of developing the Creative Living Centre (CLC) were I decided to write an article about the role of the Creative Living Centre in the context of mental health. The process of writing this helped me to consider how the CLC might fit in to mainstream mental health provision. I also decided to undertake an MSc by action learning and research which provided me with the opportunity to research the development of the Creative Living Centre.

I later decided to undertake this doctoral programme by action learning which gave me the opportunity to offer an action learning approach to support individual members of the public to work on their individual aspirations. This provided the opportunity to explore my research themes.

How did I do this – study, collaboration, action?

Having experienced how patients and the public came alive as a consequence of their involvement with the Creative Living Centre and the Angel Healthy Living Centre I intuitively sensed that there were some positive influences on their mental health and wider issues of social inclusion.

Having used action learning processes as a way of finding solutions to my work based problems since 1995 it seemed to be the most appropriate method for exploring how action learning processes might influence mental health and social inclusion. The opportunity to explore this further came as I developed the action learning programme for a new community based programme the Salford Social Entrepreneur Programme. The background to this programme is described in detail in Chapter 7 of the thesis.

As a consequence the focus of my work based inquiry became concerned with two questions:

1. What ways can action learning assist in improving people's mental health and well being? and
2. What ways can action learning assist in improving social inclusion?

How I undertook this study is described in detail in Chapter 6 of this thesis.

What did I achieve?

There were many achievements over the course of this research and these essentially related to achievements at work, supporting the participants of the

Salford School for Social Entrepreneurs to realise their aspirations and the associated research.

The most important achievements for me were the development of a range of new innovative community based services that developed through a range of collaborative partnerships with patients and the public and other public sector partners.

I was also successful in reviewing my role as Director of Service Development and negotiating a change in focus that reflected the development of services through partnership with patients, the public and other organisations. See Chapter 5 for further information.

In doing so I secured support from the Trust Board to work in partnership with the Revans Centre for Action Learning and Research at the University of Salford to develop a Centre for Community Learning. Both these two achievements were an indication that the Trust was starting to see the importance of my work.

I was also successful in securing support from the Chief Executive of the Trust for working in partnership with the Chief Officer of the Community Health Council for me to develop and provide the action learning component of the Salford School for Social Entrepreneurs. The achievements from the SSE programme are described in more detail in Chapter 7 which has a longer term impact both for the individuals and their communities.

I also became a Trustee of Mind (a national Mental Health Charity) which gave me the opportunity to use my experiences to influence mental health policy.

What did I learn – specific to the issue and wider?

I was exposed to many learning opportunities throughout this research not the least how action learning processes have a significant contribution to make in supporting individuals and groups of individuals in realising their individual or collective aspiration. Doing so in this way generates full involvement of all partners.

I have learnt to change the way I work in order to ensure that I can communicate and work with patients and the public as equal partners and in a way that encourages their active engagement. From this I believe that other people who are required to engage with patients and the public will also have to change, both themselves and their organisational culture.

From this experience I have learnt that it is not enough to issue policy directives that state there must be patient and public involvement. There has to be a conscious consideration about what this means for the individual, their organisational culture and how it might be undertaken.

As a consequence of my research I have been able to distil my learning experiences and offer six critical ingredients as an aid to working in partnership with patients and the public and six critical ingredients as an aid for developing an empowering organisational culture.

Learning from the personal experiences of people from the various projects I have been involved with, I have learnt that the public sector still has some way to go in changing their culture to one that values as equal but different partners the people they serve.

An insight into my learning experiences is given in detail in Chapter 8 of this thesis where I explain how I have embraced action learning processes as a preferred way of learning and contrasting this with my formal educational experiences.

How did I evaluate the experience?

The evaluation of my experience was an integrated process that commenced with reflecting on my earlier experiences of working in mental health and my progression through various roles throughout of my career. Further detail of those roles is described in Chapter 2.

As a consequence of these experiences I have become a more confident practitioner able to express what I feel and draw on my experiences to influence service development. Further information can be found in Chapter 3.

At the heart of these service developments are my experiences of working in partnership with patients and the public. Here I have made a significant shift from developing services for patients to developing services with people. This is explained further in Chapter 4.

Throughout those experiences I have learnt to take control of my personal development. This has been underpinned by me moving from an environment that taught/told me what to do to one where I have learned to learn through taking deliberate action in my work. This is described further in Chapter 8.

My experiences were also evaluated by others both in the Trust and externally by other organisations.

Internally within the Trust this resulted in an acknowledgement of my achievements and a change in role that reflected the specific skills I had developed. This is discussed further in Chapter 5.

The quarterly progress reports written by the SSE Co-ordinator with contribution from all the participants also confirmed the value of the action learning approach and specifically my role and contribution.

Local and national newspaper articles with comments from many others also praised the work being undertaken.

This result of this pioneering project has been replicated throughout the country. This is described further in Chapters 7 and 9.

How does my contribution compare with others?

Mental Health

There have been many policy directives that emphasise the importance of user involvement in the planning and delivery of mental health services over the last

ten years. My sense is that the repeated issuing of such policy directives is an indication that it is not often taken seriously by health and social care providers. The NHS and Community Care Act, 1990 stated that the empowerment and involvement of the user was to be a priority, (DOH, 1990).

Rose (2001) in a report on research that explored the perception of mental health service users of community and hospital care reported that users still do not feel involved in making decisions about their care at any level. She further states in the report that it is clear that the government's intention of putting the patient at the centre has not filtered down to all those who provided mental health services be they organisations or individual mental health professionals.

In 2004 the Department of Health issued guidance and information on Patient and Public Involvement in Health: The Evidence for Policy Information. In the document it recognises that:

> "In the evidence driven culture of the NHS, patient and public involvement has often had to struggle for attention....there has been a nagging sense that patient and public involvement is a nice idea with real justification".
> (DOH, 2004, pg1)

This reflects my own personal experiences having worked in one of the largest mental health Trusts over the last thirty six years where there were minimal efforts to engage service users. My understanding of the importance of doing so was triggered by my early experiences of working in mental health and with the later experiences of developing the Creative Living Centre. An understanding of these early experiences and how they challenged and influenced me is described in Chapter 2.

The benefits of involving the public as well as patients became increasingly important as I understood the incidence of mental health problems and specifically that 90% of all people with a mental health problem will never need to access mainstream mental health problems. See Chapter 4 for more information.

This fact led me to think about the work I was asked to undertake to explore what it might mean to develop mental health promoting communities. In the context of mental health promotion I felt that it was important to offer a range of community based activities (for the 90%) the consequences of which could be mental health promoting and help people to manage their lives without their lives deteriorating to a point where they need to seek help from their General Practitioner. The Salford School for Social Entrepreneurs was one of those activities on offer.

The Department of Health and the Neighbourhood Renewal Unit in their guidance on Health and Neighbourhood Renewal prioritise areas for improving the health of populations. Alongside these they highlight those factors that influence health outcomes and the public policy interventions that impact on these wider determinants of health. See **Figure 16** for those factors impacting on mental health (DOH and the Neighbourhood Renewal Unit, 2002, pg34)
. They are as follows:

Figure 16.

Priority Area	Known positive/negative influencing factors	Examples of policy interventions than can have a positive and/or negative impact in these areas
Mental Health	Self esteem Social networks Fear of crime Noise	Education Employment schemes Crime prevention Sustainable communities Transport & housing policies

The examples of these influencing factors and interventions indicated above correlate and support the findings arising from my research with the participants of the Salford School for Social Entrepreneurs and can be found in Chapter 9 Figures 11a to 11j.

Social Inclusion

People experiencing mental health problems are the most excluded in our society. Equally social exclusion is a key risk factor for a range of mental health problems. It is crucial therefore that mental health services engage with the broader public health agenda and look beyond service delivery goals. It is important to integrate mainstream mental health promotion within mental health and other services.

Although medical care can be effective its achievements will be limited unless the broader social needs of people with mental health problems are addressed.

The absence of work or meaningful day time activity, inadequate housing and support from family, friends etc can lead to a cycle of despair. Effective mental health promotion and social inclusion at a local level needs to engage with a whole range of broader community development initiatives in order to strengthen social networks and structures to support local communities.

Action Learning

My approach to mental health promotion and social inclusion has grown as I have learnt how to work in partnership with patients and the public. This approach has embraced action learning processes, and was developed incrementally as I learnt from the Creative Living Centre, the Angel Healthy Living Centre and tested through my research with participants of the Salford School for Social Entrepreneurs (SSSE).

This approach encouraged all participants of the SSSE programme to explore how they progress their individual aspirations through using an action learning approach. Underpinning this approach is an acceptance that people have within themselves the ability to solve their own problems, rather than problem solving being the exclusive domain of others. My experience of using action learning is summarised in Chapter 6.

The Creative Living Centre and the subsequent projects that followed had the service user at the heart of what was provided. Indeed the purpose of the CLC was to support people experiencing emotional distress and mental health problems in a way that allowed them to identify their own needs and to make an informed choice about how those needs might be met.

This approach has similarities with the recovery model where people with mental health problems self direct the rebuilding of a meaningful and valued life based on their aspirations. Recovery is about taking back control over one's life. Mental health problems are often presented and perceived as uncontrollable, or their control is seen as the province of experts. According to Deegan (1998);

> "Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of disability......they experience themselves as recovering a new sense of self and of a purpose within and beyond the limits of the disability"
> (Deegan, 1998, pg15)

Recovery is not an end product or outcome but a continual journey. Deegan (1993) states that;

> "Recovery is a process, not an end point or destination. Recovery is an attitude, a way of approaching the day and the challenges I face......I know I have certain limitations and things I can't do. But rather than letting these limitations be occasions for despair and giving up, I have learned that in knowing what I can't do, I also open up the possibilities of all I can do."
> (Deegan, 1993, pg9)

What Does This Add To My Learning/Abilities?

There have been many aspects to my personal development and learning throughout this doctoral programme. In relation to this research I have been able to conclude that unless the public sector change their behaviour in a way that results in an equal relationship with patients and the public, then public and patient involvement will continue to be legislated for and will have minimal impact. See Chapter 9 for further information.

I have also started to consider that the term Patient and Public which is derived from the public sector, doesn't encourage us to think about the person. This

has prompted me to think about the term citizen as a generic way of describing the target audience. It shouldn't matter if you are a patient or a member of the public we should look beyond these labels and see the person. Citizens and citizenship seems to take me closer to what I want to say. The value of citizenship is explained further in Chapter 10.

I have also grown in confidence as a result of the combined experiences and achievements. My achievements and experience have been reflected in many ways, not the least being asked to undertake other related work in this area. The various projects I have been involved in since the Salford Social Entrepreneur programme are described in Chapter 12.

What Have I Added To General Understanding/Abilities In This Field?

This practice based thesis advances knowledge in two areas:

1. further understanding of engaging with patients and the public, and specifically that there has to be a conscious change in behaviour both at an individual and organisational level if there is to be active patient and public involvement based on equal partnership, mutual respect and understanding;

2. further understanding of learning in the promotion of mental health and well-being. Here I have been able to demonstrate how local people have been able to improve their mental health and social inclusion as a result of using an action learning approach to resolving issues that are seen as a priority to them. This has not been through accessing "health service provision" but as a consequence of being supported to take responsibility for

understanding how to realise an individual aspiration and bring it to life. How I have arrived at this is described in Chapter 9.

Through using an action learning approach I have been able to learn about learning and the general application of research. This has strengthened my understanding of how knowledge from learning can be integrated into practice and in doing so it widens the range of people and influences on the process of research and its application.

What Can I Add Further?

Citizenship

Following the second Salford Entrepreneur Action Learning Set I have been involved in supporting the pilot of "The Individual Profile in Active Citizenship Programme" (IPAC) with Proud City a social enterprise. As part of the piloting process I have successfully completed the programme.

The Active Citizenship programme is about taking part to build quality of life and a better understanding between individual, communities and the relevant organisation(s). The aim is to centre on the individual.

It includes taking opportunities to become actively involved in defining and tackling the problems of communities, consider solutions and improve the quality of life.

The journey includes reflection, personal choice, action learning, discovery, communications and confidence building. Themes are used to identify areas of interest and to help connect with other citizens who can help the individual to learn. Completion can result in the issue of the City and Guilds certificate award "The Individual Profile in Active Citizenship".

The journey is suited to people interested in taking part in their community's development or linking with a range of topics. Staff from the public and voluntary sector are able to identify with related opportunities in the themes.

The journey is suitable for employees interested in corporate responsibilities, community development or care work, or can complement a range of personal development programmes. Supervisors, Team Leaders and Managers are able to reflect and learn about local communities and can use themes as team building or for individual learning opportunities.

Pursuing this further is crucial as the relationship between local government and the public continues to change and effective local governance now requires informed, engaged citizens who vote in elections, participate in decision making and contribute to designing, delivering and monitoring services.

Developing effective citizenship is not just something the public sector do to the public, it requires that decision-making bodies operate in ways which value the input of citizens and foster mutual learning. This will probably require cultural change and can also require organisational structures which support the public in learning about local democracy, and which make decision-making processes

easier to understand and access. This means public bodies need to go beyond providing opportunities for participation, to embark on a process of learning, both for the public and for the organisations that need their input. Further information is provided in Chapter 10.

What Can Others Add Further?

What others can add further is described in detail in Chapter 10. In this Chapter there is an explanation of what others can add under the following headings.

1. Statutory Requirements

- Health and Social Care Act, Sect 11
- Independent Complaints and Advocacy Services
- Foundation Trusts

2. Health Services Requirements

- Patient Led Services
- Commissioning

3. People Requirements

- Expert Patient
- Citizenship

Six critical ingredients are also offered in this Chapter for organisations to consider for developing an empowering organisational culture.

Chapter 12
Life after the Social Entrepreneur Programme

This Chapter provides the reader with an overview of my work following the completion of the Salford Social Entrepreneur programme. It highlights the work undertaken since the main stages of this research and describes how I see this work developing both now and into the future.

It also informs the reader of my own aspirations both post doctoral and personally and a rationale as to why.

Following the completion of the Salford Social Entrepreneur programme I was asked to project manage the integration of mental health and social care provision in Trafford. This involved the integration of mental health services provided by the trust and the health and social care provision of Trafford Social Services. This work required me to undertake a process of consultation with patients, public, carers, and staff from the Trust and Social Services. This consultation was completed in November 2002 and I produced a document on the management arrangements in February 2003 with an implementation of the new management arrangements which were to be implemented incrementally from April 2003.

During this time I was also asked to co-ordinate the development of the legal partnership agreement for the integration of mental health and social care provision between Salford City Council and the Bolton, Salford and Trafford Mental Health NHS Trust.

Although this experience added to my experience in patient and public involvement it also had an impact on my ability to develop the Centre for Community Learning at the Revans Centre where I was appointed Director in December 2001 and took up this post in 2002.

In April 2002 the Trust appointed a new Chief Executive who in April 2003 produced a paper for consultation on the new management arrangements for the Trust. In those new management arrangements my post as Service Director (Developments) was disestablished by the Trust.

As part of the formal process for discussing my future I was successful in negotiating a secondment for two years from January 2004 until December 2005. The secondment was to the National Health Service University (NHSU), Mersey Care Mental Health and Learning Disabilities NHS Trust and the North West Mental Health Chief Executives. The profile of this work is as follows;

NHSU

I was employed as Learning Coordinator – Action Learning working two and a half days a week and covering the North West. The role was developed in partnership with the Revans Centre for Action Learning and Research at the University of Salford. The aim of my work was to

> "To promote the awareness and use of an action orientated approach to learning in partnership with the Revans Centre for Action Learning and Research across the North West."
> (Jones. 2003 pg1).

The objectives of which was to:

- Develop the capacity for staff working in health and social care training organisations to develop their potential to facilitate action learning sets;
- Develop an action learning network across the North West to support the development and practice of action learning;
- Facilitate the development of action learning sets with staff from health and social care organisations and local people;
- Facilitate and encourage the development of action learning sets for people who want to use an action learning approach for learning and improving practice in the workplace.

Through this work I was able to support a wide range of individuals and organisations in exploring and developing opportunities for using action learning as an approach for solving work based problems.

In sustaining this work I produced a DVD which provides an introduction to action learning. The DVD was the outcome of a workshop I ran in February 2005. From the evaluation of this event participants particularly valued the background to action learning, and wanted to know more regarding the evaluation of action learning and its application in the work place. The DVD was designed to meet those identified needs. As a consequence two hundred and fifty copies were produced and distributed to all training and development managers in health and social care training and development departments across the North West. It was distributed to all the participants of the action learning network. The DVD includes:

1. A Revans Approach to action Learning;

2. The juxtaposition of Action Learning in an academic setting;
3. Action Learning – Application in the Work Place;
4. A DIY Action Learning Handbook.

Closure of NHSU

Unfortunately as a consequence of an arms length review of NHS bodies in 2004, the NHSU was closed for business on the 30th June 2005. As part of the closure process I successfully completed and submitted a proposal and portfolio of work undertaken whilst working for the NHSU to the NHSU Programme Migration Team. The proposal suggested the work continue to the end of December as originally planned and transfer to a host organisation, Mersey Care Mental Health and Learning Disabilities NHS Trust. This was approved and I transferred to the Trust on the 1st July 2005. My work programme was as follows:

- Developing and completing an Action Learning Network, web site;
- Set Advising a Health Promoting Mental Health Services action learning set;
- Set advising an action learning set for Sefton Social Services;
- Contributing to the development of a Revans Society in partnership with like minded people;
- Facilitating an Action learning Workshop for the University of Bolton;
- Completing an article for Action learning Research and Practice Journal;
- and Completing the final project report.

Mersey Care Mental Health and Learning Disabilities NHS Trust

Here I worked one and a half days a week as a Learning and Development Associate. I was involved in developing an action learning programme for developing set advisors, set advising other action learning sets, mentoring and connecting the Trust's internal action learning network to a North West Network and the development and launch of an active citizenship programme.

North West Mental Health Chief Executives Partnership

As Development Manager I worked one day a week responsible for supporting the North West Mental Health Chief Executives in delivering the mental health agenda across the North West, particularly on those issues that were of common interest and/or cross the boundaries of individual organisations. During this time workshops were undertaken two monthly. The initial workshop explored "The Future of Mental Health Services" and from this a number of themes were identified as being the focus for exploration at further workshops. These themes were as follows:

- How to Mainstream Mental Health Services;
- Developing New Models of Health care;
- Workforce Development;
- and Commissioning Mental Health Services.

I was also responsible for ensuring the delivery of a co-ordinated set of projects targeted at modernising mental health services in the North West on behalf of the Partnership.

Whilst at Mersey Care I was also encouraged to build on my experiences of mental health promotion and public and patient involvement as opportunities arose. This resulted in me developing and supporting the following projects.

Health Promoting Mental Health Services

Health improvement within mental health services has become a priority since the introduction of the National Service Framework for Mental Health (NSF). Whilst Standard One of the NSF (as referred to in Chapter 4) is concerned with mental health promotion across the whole population it has helped to highlight the need to improve the physical and mental wellbeing of people with mental health problems, and integrating Standard one throughout all of the other standards of the NSF, (DOH, 1999f).

The Public Health White Paper and recent planning framework highlights the responsibility of the NHS to prioritise a public health approach – to take a long term focus in delivering sustained action to improve the health of whole communities, (DOH, 2000a).

Mental health services, as significant employers and providers of care, can make a contribution to improving population health through considering its organisational systems and functions whilst still providing care and treatment to people experiencing mental health problems.

Whilst many services will be implementing some health improvement practice, the Health Promoting Mental Health Services Framework promotes a co-ordinated approach across the whole of the organisation. The framework can

enable 'big picture' thinking and exploration of the wider determinants of health and long term impact of the organisation and outcomes for patients whilst co-ordinating achievable goals that will contribute to health gain for staff, patients and the wider community.

In November 2004 the National Institute for Mental England (NIMHE) North West invited expressions of interest for the development of a pilot site for "Health Promoting Mental Health Services" (HPMHS). This recently launched HPMHS project received interest from most of the Mental Health Trusts in the region, (Stansfield, 2004).

This ten month programme aimed to support participants to consider and take action on what "A Health Promoting Mental Health service" means to them and their organisation. It was expected that participants would:

- Have a service development role in their organisation;
- Be supported by their manager;
- Be committed to regular attendance with set colleagues;
- Be committed to taking action and explaining their own learning within the context of your work;
- Share their learning through workshops or published articles;
- Keep a learning journal.

My support as Set Advisor to the set concluded in December 2005 on completion of my secondment.

Liverpool Capital of Culture

The Creative Communities' Team within the Liverpool Culture Company looked to commission a series of creative health workshops. These workshops were planned to take place within different health and community settings to further develop participation of the health sector in understanding and developing creative health opportunities in Liverpool and its neighbourhoods. My involvement was as a member of the Steering Group.

You're Health, Your Care, Your Say

In 2005 I was invited to attend a "Listening Event" organised by the Department of Health which was held on the 19th July Café Royal, London.

The listening event included approximately 150 people who have experience of listening and consulting with local people including those people who are often overlooked or excluded. This event drew on their experience and provided the Department of Health with the information for the design of a programme of consultation.

The outcome of the event was to produce a framework for a consultation exercise and involved the public and staff, including people like the homeless, people with learning difficulties and teenagers who are often not heard in consultation exercises. A number of deliberative, or 'listening', events took place as part of the consultation process. Between 50 and 100 people had the chance to give their views on what they wanted from services in their everyday lives.

Around 1000 people took part in a national event on 29 October 2005. Other events were also run by NHS, local government and voluntary organisations locally.

Anyone who couldn't attend one of the listening events but wanted to contribute was able to do so in an online survey that became known as Your health, Your care, Your say.

The consultation gave more than 100,000 people the chance to put forward their ideas. Their opinions shaped the resulting White Paper Our Health, Our Care, Our Say on improving community health and care services. The proposals in the White Paper - A New Direction for Community Services, aims to:

- change the way services are provided in communities and make them as flexible as possible;
- provide a more personal service that is tailored to the specific health or social care needs of individuals;
- give patients and service users more control over the treatment they receive;
- work with health and social care professionals and services to get the most appropriate treatment or care for their needs.

(DOH, 2006)

To achieve these aims family doctors, Primary Care Trusts and Local Authorities who have direct contact with patients and service users will have more say in how best to plan and buy services for local communities. Public,

private, voluntary and charitable organisations will need to work in partnership to put the interests of the public first, ensure health and social care staff receive the right training and make good health and social care services an essential part of local communities.

Making it Possible – A National strategy for Mental Health and Well-being in England

On the 19th October 2005 I attended the launch of the first national framework for improving mental health and well-being in England which was launched by NIMHE. The strategy supports standard one of the National Service Framework for Mental Health and the commitments made in the White Paper Choosing Health. The strategy states that;

> "we will ensure that Standard One of the NSF for mental health which deals with mental health promotion is fully implemented......we will have delivered if we improve the mental health and well-being of the general population"
> (NIMHE, 2004, pg3).

It is now recognised that Public Service Agreement (PSA) targets, in health, education, neighbourhood renewal, crime, community cohesion, sustainable development, employment, culture and sport will improve peoples mental health (Cabinet Office, 2006, pg).

Developing a Learning Framework for Active Citizenship

Through the Active Learning for Active Citizenship Learning Framework Group the Civil Renewal Unit (2006) developed a strategy for achieving widespread citizenship learning opportunities for adults. The core curriculum was to be based around the following values:

- Social Justice;
- Participation;
- Equality and diversity;
- Co-operation

It was anticipated that the curriculum would be delivered through regional hubs, which provide a deliberative and educational space where people can reflect on their willingness and ability to be active citizens. The programme acknowledges the particular value of community based learning and will utilise a broad spectrum of educational styles and settings.

I was invited to be a member of the Active Learning for Active Citizenship Learning Framework Group representing "Proud City" a social enterprise based in Salford.

New Opportunities-New Horizons

In November and December 2005 I had a number of meetings at the Trust to consider my future employment following the conclusion of my secondment on the 31st December 2005.

On the 8th December I met with representatives of the Trust and was formally informed that there were no suitable alternative positions available in the Trust. As a consequence I was dismissed on the grounds of redundancy. Although this was the best option for me, the stark reality of it actually happening was another matter. However it has provided me with the opportunity to take stock of my life and decide what it is want to do!

In Chapter 3 I have made reference to the tension between my experiences in developing mental health promoting communities and the priorities of the Trust. Such was the tension, I realised that I was a lone voice in a large organisation.

It was important to me to use what I was learning in a way that influences improved service provision. From my experiences of working with patients and the public I decided that my experiences and use of action learning would be best served supporting them to realise their personal aspirations. The motivation for doing so was driven by what I have achieved through learning to learn. I thought "if I can do it" then I was sure others could. I wanted the other people to have the same opportunity.

I have therefore, where possible, integrated what I have learnt into many aspects of my work. Reflecting and reviewing the experiences of the Creative Living Centre with fellow Trustees of the Centre for example, I was able to describe the Centre in a way that shifted the focus from a "mental health" project, to one where the centre supported its members to learn how to manage their life as it was disrupted by their experience of emotional distress/mental health problem.

I have continued to work in this way developing a specific interest in moving my work with patients and the public further forward developing and building on supporting people to become active citizens.

Work Undertaken to Date

On the 1st of January 2006 I became self employed undertaking learning and development work, and had the following portfolio of work.

Active Citizenship

I have become an Associate of Proud City (a community enterprise). As part of the "Celebrating Difference" theme of the Active Citizenship Programme and facilitated a day on mental health.

I also worked with the Civil Renewal Unit, of the Home Office as a representative of Proud City supporting the development of an Active Learning Framework for Active Citizenship, (ALAC).

Additional to this I have attended the TEACh Programme – Teaching European Active Citizenship. The programme focused on different dimensions of Active Citizenship, exploring what it means to belong In Europe. The programme took place in November 2006 and was held in Larnaca Cyprus. I am now working with Proud City to integrate the European dimension into the current active citizenship programme.

National Institute for Mental Health England

I also worked with the National Institute for Mental Health England (NIMHE) and a large mental health trust in Lancashire to support the development of their "Effective Team Working programme". My role was as an action learning set advisor for the community mental health Team Leaders.

Modernising Pathology Services

In October 2006 I commenced work as an area facilitator in the North West supporting the development of Pathology Services through an action learning approach. The Modernising Pathology Services through Action Learning: PHASE 2 aims to:

- continue the momentum of the Pathology Learning Sets Programme of 2005/6 to support people in tackling the Pathology modernisation challenges such as the re-configuration of services, 24 hour working and connections with primary care;
- expand the work of the earlier programme by initiating and supporting a greater number of local pathology action learning sets to reach more parts of the service;
- offer training and learning opportunities in action learning ideas and methods in order to develop local facilitators wherever they are needed;
- further embed action learning, as a valuable tool and a simple and effective way of working, in NHS pathology services;
- and disseminate the emerging learning both to the benefit of pathology services nationally and to enable other services to learn about the use of action learning as a means of implementation of service improvement.

Trustee Mind

In December 2006 I was elected as a Trustee for Mind a mental health charity as part of this work I have been elected to the role of Chairman for the Opportunities for Volunteering Scheme. This funding scheme exists to increase the opportunities for mainly unemployed people to undertake voluntary work in the health and/or personal services.

I am also a member of the Developments Committee which is concerned with service developments across Mind.

Together We Can

Together We Can is the government's plan to enable people to engage with public bodies and influence the decisions that affect their communities. It is led by the Home Office and twelve government departments are contributing with policies that empower people to get involved (Civil Renewal Unit, 2005).

This is a promising policy that for me can influence processes across the twelve government departments that should cascade to local government and local public service providers. I continue to believe that policies only provide a framework for action that needs to commence with the individual realising their individual and collective role in understanding what the policy means for them their organisation and how they may need to change.

Change will not happen because it is stated in a policy. I believe that the critical ingredients for patient and public involvement and the six critical ingredients for developing an empowering organisational culture as described in this thesis offer a framework for starting this process. In adopting these frameworks I hope that it will not belong before we are able to state that "Together We Are" instead of "Together We Can".

Chapter 13
Making Sense of the Action and Learning – A Meta Position

This Chapter provides a meta position of the action and learning arising from my inquiry into the role of action learning in facilitating transformative change within the field of patient and public involvement. This thesis then is located in the field of patient and public involvement, which commenced with my practice as health practitioner, manager and facilitator in mental health and broadened out to working with local people in various communities.

The Chapter addresses the issues arising from the joint examiners report following the first submission of this thesis and the subsequent viva. It commences with an introduction and purpose of the inquiry and is followed by the methodology and specifically the use of published material. The next section provides a statement on the character of action learning, the limitations of the research and the findings which includes the original contribution to knowledge and practice. It concludes with the opportunities for further research, development and direction and a final section that critically reviews how the final chapter was written.

1. Introduction

The involvement of patients and the public in health decision making is a central theme of national and local policy in health and social care provision. The NHS Plan set out a commitment to Patient and Public Involvement to achieve an improved patient experience and a more patient centred approach to health service provision both nationally and locally, (DOH 2000).

The national system for patient and public involvement include:

- Patient and Public Involvement Forums;
- Patient Advice and Liaison Services(PALS);
- Independent Complaints Advocacy Services (ICAS);
- And Local authority overview and scrutiny of health decision-making.

(DOH, NHS Plan, 2000b)

These structures are supported by the Commission for Patient and Public Involvement and provide the ***structures*** for involvement.

Since this study began the Commission for Patient and Public Involvement and Patient and Public Involvement Forums have been abolished and replaced with new ***structures***, Local Involvement Networks (LINks). These are now based in localities rather than institutions and cover both health and social care (DOH 2006). Further guidance has also been produced which strengthens the duty to involve (Real Involvement, DOH 2008) which requires Primary Care Trusts to engage patients and the public in developing plans for local health services which took effect from November 2008. A new duty to report on consultation has also been introduced and came into force in October 2009. This duty to report on consultation now requires the NHS to feedback to people and communities not only the results of consultations, complaints by patients and results of surveys, it now requires the NHS to inform people what action they have taken in response to that feedback and how people's views have shaped the decisions they make when commissioning services.

Although those ***structures*** provide a framework and the opportunity for more rewarding personal and community relationships, they do not prepare potential partners for understanding and managing the ***difference*** in interests, priorities, expectations, values and attitudes in the specific contexts that people with a responsibility for patient and public involvement could be exposed to.

In the context of patient and public involvement managing this ***difference*** can be extremely stressful and there is the potential according to Raelin (2001a) to become defensive, antagonistic, or surely. According to Jenson (1997) behaviour in this way is pain avoidance. In pain avoidance according to Argyris et al (1985) we tend to avoid personal error, remain in control, maximise winning and avoid losing, act as rationally as possible, cling to our theories of the world and our view of self, and suppress negative feelings. Reacting in this way can be non productive and requires us to consider other ways of responding.

In the course of this inquiry I have developed a framework (Young's' Framework for Patient and Public Involvement, 2009. pg330) for understanding and managing these differences which presents an alternative to the defensive mechanisms referred to above when engaging with patients and the public. This conceptual framework outlines processes for action and is appropriate for understanding many of the challenges that impact on and are of concern to the public especially where there are multiple stakeholders who have different purposes and priorities and where there are different levels of power to make things happen, (Boydell and Blantern, 2007).

For example the impact of poor housing, environment, crime, fear of crime, unemployment and the link to people's health and well being are well documented, (Benzeval. et al 1995b). The more we increase our understanding of these determinants of health, the more certain will the conclusion be that a person's health cannot be divorced from the social and economic environment in which they live and work. The more likely then we will be able to manage those interactions.

Clearly these challenges cannot be met by central government alone and could be assisted by harnessing the knowledge, energy and innovation of the public, communities and front-line professionals and local government through active patient, public and stakeholder involvement. The importance of this PhD then lies in the opportunity to provide a means of meeting those challenges through harnessing this alternative epistemology through Young's' Framework for Patient and Public Involvement and the contribution to knowledge arising from this inquiry. This framework is explained later in the chapter.

The focus of my work based inquiry which produced this framework was concerned with the following two questions (and is discussed in Chapter 6).

1. What ways can action learning assist in improving people's mental health and well being? and
2. What ways can action learning assist in improving social inclusion?

2. Purpose of the Inquiry

The purpose of this inquiry was to understand my practice as the researcher and the researched as I became incrementally exposed to a number of new

insights into how to engage patients and the public in my role as Director of Service Development.

The knowledge arising from my practice based inquiry was bound in the context in which it was undertaken. The thesis then is a narrative of inquiry into my practice and of how a number of experimental changes had been introduced, carried out and evaluated.

In pursuing this inquiry I didn't set out to add to the sum of new knowledge within a limited clearly defined framework, but to look for new insights that would support me in improving my practice. However, I as the researcher and the researched along with the SSE participants gained from the wider use of this approach as it evolved over the period of the inquiry.

I considered it important that if people are to make the most of their lives there needs to be a move away from a narrow health perspective of treating symptoms to one which focuses on rights, opportunities and citizenship. The important issue was ensuring that the voice of the participants was at the heart of this research. The aim was to support people to overcome their difficulties and achieve their ambitions through the use of their individual resources and the collective resources of their communities, and not from the often tight constraints of traditional subject definition. The outcomes of the support provided to the SSE participants are explained further in chapter 9.

3. Methodology

This inquiry used action learning which allowed for the integration of specific practice methods and techniques that helped me to integrate and assist my research and development as detailed in Chapter 6. These integrated processes provided a framework for learning without being constrained by a single method and was aligned with the initial research themes and the context of the inquiry.

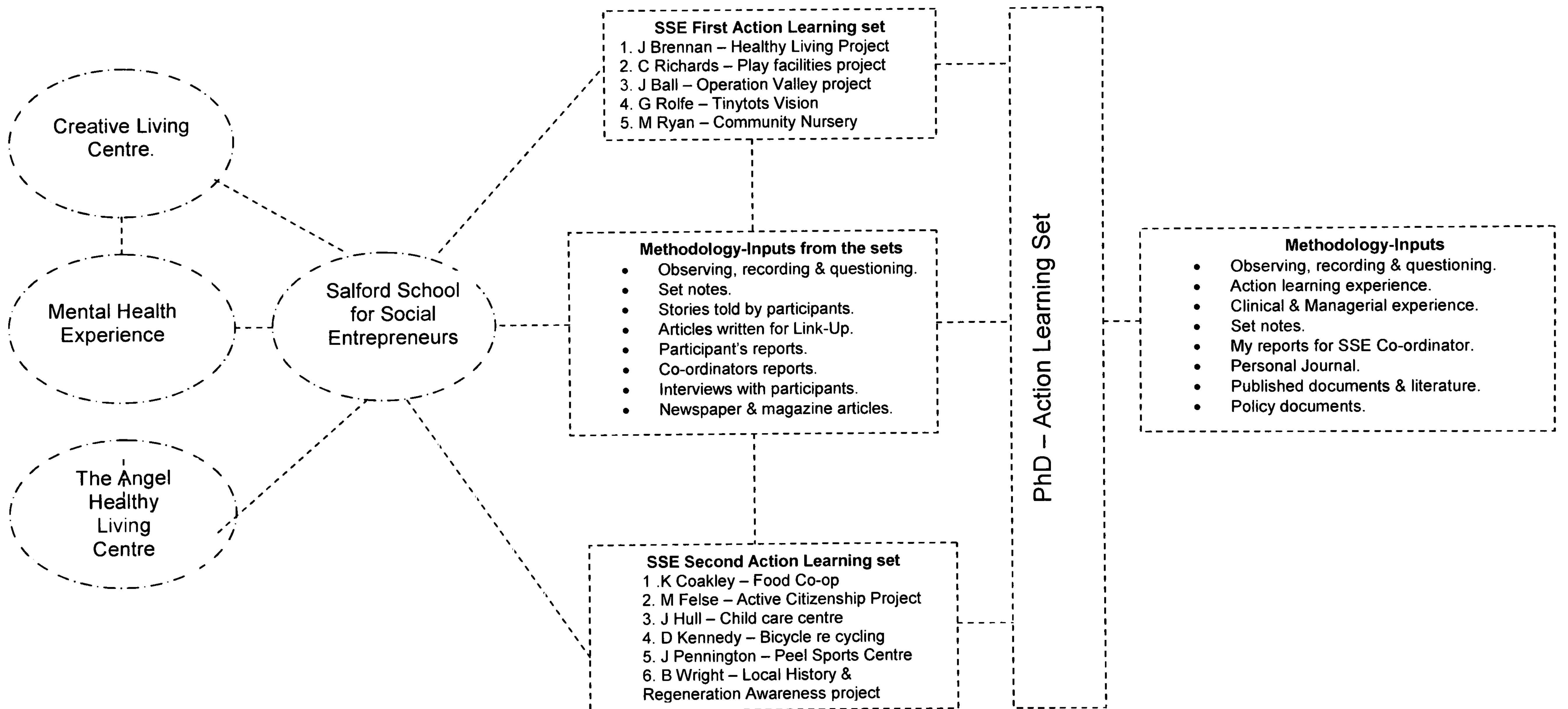
This was essentially a qualitative inquiry with an epistemology where the findings are specific to a particular context at a particular point in time. According to McDermott *et al* (2004) this means that it cannot be assumed that concepts, experiences and practices have the same meanings which stay constant across time and place, as different contexts support a range of meanings. According to Sandelowski *et al* (1997) it is the rich detail that arises from such contextualisation which gives unique insight into understanding "social phenomena."

The process of the inquiry can be seen in diagrammatic form on the following page (304) in **Figure 17**. It may not be consistent with an academic approach which has become a conventional approach (as discussed in the section under The Use of Literature in this chapter), and with the awareness I now have I may have considered other approaches. However I still believe this was the best approach for this context as I had the opportunity to work with people in their communities, with their ideas and aspirations, which was an important component of my practice and links to the recognised need of policy makers referred to earlier. Mingers (2001, pg.245) states that;

"Different research methods focus on different aspects of reality and therefore a richer understanding of a research topic will be gained by combining several methods together in a single piece of research."

Figure 17

The Process of Inquiry through Action learning Processes



One reason for using an action learning approach was that it was aligned with the aims of the Salford School for Social Entrepreneurs Programme. The learning style of the Salford School reflected the National School for Social Entrepreneurs core principles of:

> "**action learning:** that is learning by doing, working on a real life project, **just in time learning:** that is learners learn skills at the time they need them, **participant centred learning:** that is, an emphasis on the learners personal development with a range of learning methodologies."

Dabbs (1999, pg.37)

The participants on the programme came from a varied range of backgrounds, worked on different problems providing a broad range of views adding to the value of the information and bound with a common aim of wanting to take control. Additional to this there was no way of knowing how the SSE participant's projects would develop and therefore not one discreet event to be researched, but a process of phases with different types of activities. Particular methods were more useful for some functions than others so a combination of methods was used which are discussed in chapter 6. For example, to validate the interpretation and analysis of my findings I undertook a semi structured interview with all the SSE participants which is described further in Chapter 6. This allowed for a focused, conversation a two-way communication used both to give and receive information. Unlike the questionnaire framework, where detailed questions are formulated ahead of time, semi-structured interviews start with more general questions or topics and allow all participants to be asked the same questions within a flexible framework (Dearnley 2005). All participants were asked questions from the same loose set, but there was no defined ordering of the questions. Participants were encouraged to talk about their experiences through open-ended questions, and the ordering of further questions was determined by their responses.

In my judgement another academic approach would not have been as engaging and the participants may have distanced themselves as I could have been seen as an outside observer. And the relationship may have appeared that of a disinterested researcher rather than a person who supported the participants. This relationship according to Bryman (2008) can be described as a participant observer and has its roots in ethnography where the observer also uses non observational methods and sources such as interviewing. This required me to evaluate their development in terms of their own needs and in turn that required me to evaluate my own role in terms of their interests and mine. According to Denzin and Lincoln, (1994) this reflexive continuous process allows the researcher to understand the complexity and richness of people's experience.

This was an exploratory process chosen as the most appropriate as I wanted to evaluate the achievements of the SSE participants against my research questions requiring me to be able to explore, understand, explain and describe those achievements and the resultant change rather than measure and predict them. The focus was on their action in their world as they defined it and through learning by doing rather than from the predicted outcomes or direction of others i.e. researchers.

The importance of this approach is that it seeks to address the often chaotic but dynamic process of developments that can lead to findings that focus on what could be and is concerned with influencing policy and practice, through revealing how to get there, (Richie *et al* 2009). This approach then has used an interpretative approach which according to Lois & Bartunek (1992) is epistemologically an inquiry from the inside which acknowledges multiple

realities. This is in contrast to an inquiry from the outside which is more akin to a logical positivist approach that seeks one absolute truth.

As the researcher, working in this way helped me to share the same experiences as the participants exposing me to the various range of emotions that the participants experienced. According to Aktinson and Hammersley, (1994) this approach represents a unique humanistic, interpretive approach as opposed to supposedly "scientific" and positivist" positions. In the context of a "scientific" approach, the deliberately un-involved researcher (and possibly the participants) may become more detached and would not be changed if not involved in the same way.

The value of action learning derived from an exploration of the participants and their individual situation providing the opportunity for them to spend specific time on a problem or opportunity that was unique to their situation. The nature of the SSE Action Learning Set was where participants explored and debated issues as part of their inquiry into realising their aspirations. The focus was on asking questions not initially to find the answers but to understand and get to the core of the issue being explored. The flexibility of action learning processes can deepen the understanding as situations change, and can meet the diverse problems and aspirations of the participants rather than using a fixed approach for all occasions which could have been limiting.

Co-operative inquiry was another form of research that could have been used which also emphasises participation. According to Reason (1998) co-operative inquiry is essentially about people working together as co-researchers in

exploring and changing their worlds. Although there is some overlap of co-operative inquiry with action learning, the participants on the SSE programme individually researched their own projects rather than collectively co-researching a shared theme.

However, working with others does not automatically remove the problems of power: who designs the research, interprets the data and assesses the findings' validity? As Brechin (1993, p.73) writes:

> "Research tends to be owned and controlled by researchers, or by those who, in turn, own and control the researchers. Those who remain powerless to influence the processes of information gathering, the identification of truth, and the dissemination of findings are usually the subjects of the research, those very people whose interests the research may purport to serve."

Schratz and Walker (1995) note that researchers tend to see themselves as the experts who are reluctant to allow public participation and in doing so argue that objectivity is sustained by the powerful interests within the scientific and research communities.

In this research the participants decided the focus of their work individually (which I was to research) and the medium of action learning as the framework for the realisation of their aspirations, together with their individual approaches to specific issues i.e. data collection. Other research approaches may be a necessary condition for service improvement outcomes in order to influence the ability of a service to reach its full potential. It may however not be sufficient unless it is complemented by what the beneficiaries believe the potential might be, and their ability to realise that potential.

In the context of the individual participant's inquiry, my sense is that their starting point is unique to them and the specific context of their world as they are living it in real time. And because of the ever changing nature of their worlds, the knowledge of others at a particular point in time, may or may not be relevant or beneficial. Indeed I would suggest that there would be some value in considering that the starting point should be looking at what the participants (as in the SSE programme) know and can do, rather than simply considering the specific knowledge of others. Researching in this way I was able to take action and learn to improve my practice through new relationships that added to my professional knowledge. This provided the opportunity to acquire "understanding in use" rather than 'reconstructed understanding", (Coghlan and Pedler, 2006,).

In the context of patient and public involvement, it is through new relationships that I believe we can start to articulate our differences and develop our understanding of each others views to influence the policies, plans and services within the public sector.

The Use of Literature

My initial understanding of a PhD was that it includes a definition of the boundaries of the field in which the literature can be located. The traditional starting point is a review of the literature on the chosen area of study in order to identify a gap in the literature. The research then is directed at that gap. If the candidate then is able to fill any aspect of that gap then they can reasonably claim to have an original contribution to knowledge. Traditional research uses records of what is known to identify what is not known which helps identify the

gap to be researched. In contrast, Bourner and Simpson (2005 pg.141) state that

> "Whereas the PhD starts from what is already known about a topic (i.e. through a literature review), practitioner centred research starts from what is not known about a topic."

The fundamental difference is that in my research there is an imperative to take action now rather than wait for the potential illumination of a possible but undefined action at some future time. It was important then not to predetermine the central issues that might emerge, and of equal importance not to predetermine which literature might be relevant.

I have therefore engaged with a range of literature and other information from a variety of sources which has challenged my fundamental professional views. One such fundamental change in views is learning that I need to develop services with people and not for them. This has meant learning how to engage with patients and the public so as to authentically involve them in influencing individual care, current service provision and the development of new services.

I initially searched for information via the world-wide web to obtain an overview of the extent to which other mental health organisations had actively engaged patients and the public and the types of methods used. The intention was to compare those methods with my own experiences. I had some initial ideas for references when I commenced this inquiry and some which were recommended. Further ideas came from reference material from books and other articles that I followed up further. In searching for existing literature I also

accessed online databases of published literature that was accessed via the internet, e.g. Applied social science, Medline, PsycINFO, Eric.

As I identified literature it led me to discovering other examples of articles. This type of approach is known as 'snowball sampling', where the search strategy is responsive to the literature obtained (Greenhalgh and Peacock 2005). As I identified emerging issues I was able to turn to the relevant literature, whilst at other times literature from a variety of sources (see Figure 17) helped me see my practice in a new light. One such aspect of my practice was where I was able to understand from the patient and public involvement literature of others that what I was advocating is unique which give me the confidence to develop my ideas further.

I therefore considered literature that made a difference to my thinking, challenged my assumptions and supported me in exploring new ideas and finding new ways of looking at different aspects of my practice. It seemed important to me that the relevant literature was that which developed my thinking and helped moving my inquiry forward. Green (1999, pg.101) argues that;

> "The justification for my choice of literature can only come after the literature has been read and has made its contribution to the development of my thinking."

Other fields of literature could have been used i.e. medical, nursing or organisational which would have required me to adopt a traditional approach of identifying a gap in the literature and perpetuate the position I initially found myself in. A more typical systematic review could have been used, which

according to Abalos *et al* (2001) is where a comprehensive search for relevant studies on a specific topic is undertaken, with those identified being appraised and synthesised according to a pre-determined explicit method. However In the context of a qualitative systematic review, the main purpose according to Booth (2006) is "interpretive" not "aggregative", with the point of termination when you no longer identify new insights and not when you have identified all the studies.

I therefore considered various pieces of literature which developed my thinking at different stages of the inquiry, with the literature that felt most relevant changing as my thinking developed and as new issues emerged from the information and my personal reflections. The action learning process of inquiry which was essentially exploratory resulted in the main issues emerging slowly over time rather than focused on predetermined issues. According to Reason (2009) emergence in action research means that questions, relationships, the purpose and what is important can change over the period of the research and as such can not be "programmatic" or defined in terms of "hard and fast methods".

In the context of this inquiry and through my work I have used a range of opportunities to debate, question and explore my understanding of patient and public involvement with many people facing the same fundamental issues of change in various fields of patient and public involvement locally, regionally, nationally and internationally. Presenting my thinking at various meetings, workshops and conferences provided the opportunity to debate and receive feedback from people with varied experiences and expertise. I also received feedback through the processes of engagement with many of the stakeholders

involved with the service developments I project managed. In essence, I have been learning with and from others. An indication of the breadth of these learning opportunities can be seen in diagrammatic form in **Figure 18** on the following page.

Consequently I have been able to consider new forms of knowledge arising from listening to patients the public and other practitioners and acknowledge the importance of that knowledge as "expert knowledge" which I have accepted as being of equal value to the "expert knowledge" arising from the published literature of others. This knowledge according to Bourner (2000) is "received knowledge" that is received from others through "words" usually written or spoken. The written knowledge from this inquiry was generally from a variety of published literature and the spoken word from listening to patients and the public and other practitioners arising from the relationships formed through practice. I was also able to "receive knowledge" through observation of the participants at the action learning set meetings and other events. Reason (2006) argues that knowing in this way starts from a relationship between self and others through participation and intuition. This way of knowing asserts;

> "the importance of sensitivity and attunement in the moment of relationship, and of knowing, not just as an academic pursuit but as everyday practices of acting in relationship and creating meaning in our lives."
> (Reason & Bradbury, 2001, pg9)

Appendix 18

Learning with and from Others – Considered Data

Citizenship

- Active learning for Active Citizenship – member of group to develop a learning framework-Civil Renewal Unit.
- Piloted individual profile for Active Citizenship Programme-Proud City
- Attended Teaching European Active Citizenship programme-Cyprus

See Chapter 12.

Conferences & Workshops

- Involving communities in regeneration-W/P
- Health Entrepreneurship in the NHS-W/P
- Towards collaboration between service users & providers-W/P
- Unlocking community learning-W/P
- Learning cultures-W/P
- Innovative approaches to work based learning in health & social care-W/P
- Sustaining Learning communities-W/P
- Making improvement happen-sustaining action learning-W/P
- A process for influencing work based practice-W/P
- Various Seminars-Revans Centre

W/P denotes workshop presentations I have undertaken.
See Appendix 7

Service Developments

The services developed were through a process of dialogue and in partnership with multiple stakeholders;

- Creative Living Centre
- Angel Health Living Initiative
- Webb House-Democratic Therapeutic Community
- Salford School for Social Entrepreneurs

See Chapter 3.

Miscellaneous

- Member of the Salford Cathedral Day Centre management committee (homeless project)
- Associate Director of the Manchester, Salford and Trafford Health Action Zone – Community programme.
- Manchester Common Purpose Programme Graduate
- Working for Inclusion programme-NIMHE
- Mental Health promotion steering group-Salford & Trafford Health Authority

See Chapter 3.

Publications

- References
- Bibliography

See Appendix 13 & 14

Action Learning Sets

- MSc Set
- SSE Sets x2
- Research Set
- Developing health promoting mental health services – Action learning set advisor-NIMHE
- SARP Action learning Sets
- Sets for Set Advisors x 2

Mind Mental - Health Charity

- Involvement in social inclusion working group.
- Chair of Real Lives Real People-grant giving body for personal development.
- Trustee
- Chair of grant giving body Opportunity for Volunteering scheme

Social Inclusion & Regeneration

- Member of the Chapel Street Regeneration Project Group.
- Chaired the Health Group of SRB 5.
- Member of Salford City Council's Capacity Releasing Strategy Steering Group.
- The development and implementation of a City wide strategy for the provision of employment and training initiatives.
- Involved in the development and implementation of the Social Action Research Project (SARP) looking at the implication of Social Capital in four communities across Salford.
- Recruitment and employment of a mental health community development worker through the Cheetham and Broughton Regeneration Scheme, looking at social inclusion of young people.

See Chapter 3.

The value of knowledge from others is demonstrated in a study by Steur and Marks (2008) that measured people's well-being. The research found that measures of self reported wellbeing, (that is answers to questions about how people felt about their quality of life), correlated well with other indicators of "human happiness and well-being". Steur and Marks (2008 Pg.11) further state that this applies to peoples:

> "physical health, mental well-being, patterns of economic activity, educational attainment, person and family relationships or involvement in pro-social activities-many of the areas targeted through local public services".

Additional to this the inquiry into the Bristol Royal Infirmary (1984-1995) highlighted the problems associated with a sustained period of organisational culture which resulted in the persistence of a rationale for the high level of mortality rates for children under the age of one. This culture precluded learning, reduced openness to information, and minimised cross-communication. This was despite the fact that as events unfolded there were at least 100 formal concerns being raised about the quality of care being delivered, (Weick and Sutcliffe 2003). It is difficult to know what would have happened if the culture in the organisation was open to a more engaged relationship with other stakeholders, but one cannot help believe that things may have been different.

4. The Character of Action Learning

Action learning owes much to the work of Reg Revans which holds that there can be no knowing without the effort to practice and implement what is claimed as knowledge (Revans, 1998e). It accepts that people do not only learn from being taught, but from tackling real issues and taking real actions for which they

carry real responsibility, (McGill & Brockbank, 2004). It is a process of learning to learn by doing through taking the time to question and reflect on what occurred as a result and then gaining new insights so as to consider how to act next.

The value in hearing these questions and having to give answers and explanations helps in unravelling meaning. It enables participants to explore and understand the wholeness and the roots of their problem and not just to treat a symptom of it, concentrating on resolving the symptom could merely bury the problem. In Senge's terms working in this wider way is engaging in dialogue with each other rather than having a discussion. Senge (1990) believed that discussion was primarily about presentation and response. His emphasis was on the view of one participant or one side, prevailing over the others which could result in conflict. In dialogue, however, the emphasis is not on which perspective comes out on top, but the 'flow of meaning' between participants. Battram (1998, pg.63) believed there are three rules for dialogue;

> "1. Respect the person who holds the context.
> 2. Suspend your tendency to judge.
> 3. Treat everyone's views as equally valid."

This is supportive of some of the core principles of action learning

1. The problem holder in the action learning set.
2. Learning to listen.
3. Valuing each others contribution.

Dialogue brings people to a new way of perceiving an issue that may be of concern to all and may be more to do with the nature of the relationship between people. As people talk to each other they not only hear what is said but also get to know the person. This relationship becomes valued, respected and people can start to trust each other if the quality of the dialogue is

appropriate. Dixon, (1998) suggests that dialogue is not a difference in technique but a difference in relationship. The relationship expressed through dialogue is one where each other is valued, trusted and equal and whose ideas are respected if not always agreed with. People are in a person-to-person relationship with the other which can provide the foundation for authentic involvement.

Working in this way practitioners are able to gain contextual understanding of the issues which allows them to see the wider effects of how an intervention can affect the overall experience. Consequently practitioners can transform their practice. However, this transformation involves altering their taken for granted assumptions about their world and their relationship to it. This is not a one off change, but a process of evolving new meaning as we interact in our world in a way that changes the world and are changed by it, (Freire, 1970).

The practitioner then is able to gain new information or knowledge through understanding other people frames of reference (their own inner worlds of memory, experience, and response). This allows people to seek meaning in context; that is, in relation to the person's current environment. Practitioners then can discover meaningful relationships between abstract ideas and practical applications in the context of the real world where concepts can be internalized through the process of discovering, reinforcing, and relating.

Through action learning participants create and try out new ways of doing things (e.g. behaviours, processes, systems) relevant to a problem or opportunity and related to the reality of their situation. This situation which they own may or

may not be readily definable but they have a passion for taking action. They may initially only see the problem or opportunity, but can develop their ideas about this and ways forward from a variety of resources. The range of resources available are infinite which raises questions about how one defines the boundaries of scope and feasibility, especially as those boundaries can change throughout the process. It is important to draw on resources as it feels appropriate and at a given point in time as you can't define how appropriate they are until you explore them further.

Participants observe and reflect on what happens, learn from it and make modifications. This learning triggers them to make further relevant inquiry and collect relevant data or views etc. This reflection in and on action is a process that attempts to discover how what you did contributed to the outcome. Although this may initially be an individual response its value is in sharing reflections in the presence of others. Taylor (1997) suggests that without the medium of relationships, reflection can be ineffective and empty, lacking the genuine discourse necessary for thoughtful in-depth behavioural change. Raelin (2001b, pg 16) suggests that critical reflection in the presence of others can;

> "increase learning at all levels of experience, even at a societal level. In this sense reflection can assist in achieving a sense of common good – a condition in which all parties in the human condition are treated as empowered entities or as human beings with dignity."

This is a continuous and at its best an intentional process of learning from actions taken and means working and learning simultaneously. Action learning therefore is a process by which knowledge and understanding can grow because of the intrinsic motivation and unique opportunity of the individual

(Weinstein, 1993). Each person although taking responsibility for their learning and actions does so in a mutually supportive environment of an action learning set. Action learning then embraces the notion that people learn best when they have a burning desire to face and solve real problems in the company of others doing the same (Revans, 1998d).

This provides the opportunities for participants to take part in their real life contexts for learning as identified by themselves and helps develop the ability to define problems, ask hard questions, work independently and hold a coherent dialogue which can establish a model for life long learning.

5. Limitations of the Research

This inquiry was qualitative in nature and therefore exploratory and conducted in a specific setting that was my practice; as a result, the findings may not be considered generalisable. This is because qualitative research is often questioned by some researchers as it is considered that you cannot make generalisations from the results of qualitative research when the sample is not statistically representative of the whole population in question (Falk and Guenther 2006). However Hammersley (1990) argues that qualitative research represents a distinct paradigm and as such should not be judged by conventional measures of generalisability, or validity and reliability. However if there was a long term accumulation of evidence from similar inquiries this may become generalisable, and its applicability modified.

My research was concerned with understanding how the context of my work can be explored with outcomes which do not necessarily have neat conclusions

that can be applied across a variety of contexts because my work was based on the uniqueness of the people on the SSE programmes and their various aspirations and situations.

Although this approach could be used by others, it is not the specific techniques but the testing of the approach in different situations by more people that is required. However this inquiry generated a framework for patient and public involvement that could be applied to practice in other contexts and could provide guidance in situations where learning in this area is evolving.

One other difficulty in presenting this work is that the researcher was also the practitioner and there was the potential for the two roles to become confused. Clearly then the author of this thesis could be perceived as being a limiting factor in the research process, when considered in the context of a traditional research paradigm where the researcher might consciously avoid personal involvement that might bias the study. However for what I needed to learn this was a strength as I was able to collaborate with the SSE participants to determine meaning, generate findings and reach conclusions. According to Toma (2000) getting closer to your "subjects" makes better qualitative data as a consequence of more intense interactions, which he states "strengthens end products" in qualitative research.

Another limitation of the research although it was also a strength, was that it only engaged people who were motivated and willing to learn. It is not possible to know how the individual participants of the SSE programme would have

developed without the programme and what alternative methods they would have used to achieve their aspirations.

6. Findings

The key ideas arising from researching my practice are based on an understanding that individuals are experts in their own condition and expectations and have the capacity to resolve their own problems. This is endorsed by Coulter (1999, pg.19-20) who states that;

> "Although the doctor should be well informed about diagnosis, treatment options and preventative strategies, only the patient knows about their experience of ill health, social circumstances, habits and behaviour, attitudes to risks and preferences."

There are two fundamental ideas that arise from my research. The first is the need for individual practitioners at all levels to consciously consider their practice of **how** to involve patients and the public in the commissioning, planning and provision of health and social care. To be successful practitioners will need to ensure multiple points of view are heard, which can lead to new ways of thinking and ultimately of acting.

The second key idea to emerge is the need to ensure that the organisational context for the successful development of the first idea is implemented and is enabling and supportive of those practitioners, i.e. it needs to be empowering of its staff.

The Key Ideas and their Origins in Resourceful Collaborative Practice

The origin of the first idea (***for practitioners to consciously consider their practice of how to involve their patients and their public***) emerged from

reflecting on my past experiences of working in mental health and the development of new models of working such as the Creative Living Centre and the Angel (as discussed in Chapter 3 of this Thesis). These new models have significance in practice as they were developed through involving patients and the public in developing the idea, new service models, and the planning, development and contribution to the day today running of those new services. This resulted in outcomes significantly different from those likely in a more traditional approach. Consequently I learnt the value of and how to, engage with various stakeholders, understand their needs and ensure that services developed were appropriate to meet those needs. This emergent reflection and understanding revealed how I had earlier developed services ***for*** people and not ***with*** them as described in Chapter 3 of this Thesis.

The origin of the second idea (***ensuring that organisations are empowering***) emerged from reflecting on my experience of feeling isolated in a Trust that wasn't empowering and was at odds with working in an empowering way. At Trust Board meetings the discussions bore little relevance to the world I was working in. This isolation was gradual and I became aware of my feelings of being disconnected from the organisation and considered why and what would need to happen for the organisation to be empowering. This is discussed further in Chapter 5.

Outcomes Arising from Practice

Individual Outcomes

The individual outcomes arising from my practice realised the aspirations of the participants on the SSE programme. These outcomes were an increase in self-

confidence, self-belief and self esteem. Although the participants were highly motivated the confidence gained from the programme took their motivation to new levels and allowed them to put their ideas into practice. They also developed a broader vision providing the opportunity to see the bigger picture as opposed to concentrating solely on their project. They also adopted creative and more effective approaches to solving problems or realising opportunities. This led to greater capacity, knowledge and skills to address issues and increased their capacity for learning. The specific outcomes for each of the SSE participants can be found in **Figures 11a to 11J** in Chapter 9.

Community Outcomes

For local people and their communities the SSE participants became local role models who were trusted and who infected others with confidence and a "can do" culture. This was seen to be inspiring and motivating and consequently led others to become involved in community centred work. Local people also benefited from taking up new opportunities on offer and gained increased control to improve their well-being.

The development of a number of new community enterprises created accessible opportunities for volunteering and employment for local people and the community, though the level of impact varied depending on the nature of the service offered. Further details on the community benefits can be found in Chapter 9.

Organisational Outcomes

The organisational outcomes of my practice although limited, influenced the Trust in adopting mental health promotion as a component of their strategic direction. This was reflected in the Chief Executive's objectives which resulted in the provision of new services i.e. Creative Living Centre, The Angel, Centre for Community Learning, and Salford School for Social Entrepreneurs. In the process of continual change it is difficult to understand the long term impact of these developments. However this was a step forward in demonstrating new ways of working.

Contribution to Practice

Effective patient and public involvement is fundamental to an NHS based on choice, responsiveness and equity. Delivering and designing health services around the needs of people are key to the modernisation of the NHS and integral to improving patients' experiences of health services, (DOH, 2007). Involvement illuminates the patient experience and helps to shape health and social care services that are truly responsive to individual and community needs.

Much of the policy thrust for Partnership working in Health and Social Care has been at the level of inter-organisational working and inter-professional partnerships. In my experience this has been at the expense of partnerships between the NHS its patients, their carers and the public.

It needs to be recognised that involvement is a process and not an event (Cook, 2002), and that genuine involvement requires the transfer of power, (Arnstein,

1969). However longstanding professional and managerial interests in the NHS may resist such a transfer, and could result in token public involvement with no real impact on decision making. In fact health service managers have expressed scepticism about the "red tape" and complexity of new public involvement arrangements (Smith 2003).

This research supports the view that professionals need to look beyond the way they currently engage with patients and the public, they should consider and act on **how** they might go about identifying who the stakeholders are and **how** to involve them in their practice. This will enable patients to engage in the full range of decision-making activities and to develop a positive sense of involvement in these activities.

In considering how my research related to others in the field, it has been difficult to make a balanced assessment of the impact of patient and public involvement so far, despite it being in existence for at least the last eighteen years (DH 2004). As yet there has been;

> "a striking lack of published evaluative research, especially on a national level, and some evaluative projects are still at an early stage."
> (Forster and Gabe, 2008 pg.333)

Empirical evidence of the current extent and nature of initiatives for public involvement in primary care is limited. A general conclusion is that such development has been patchy; activities the work of an enthusiastic minority of general practices rather than integrated within the mainstream (Audit Commission 1996), (Mays et al. 1998) & (McIver 1999).

However Street et al (2008) used a survey from a personal weblog maintained by people living with diabetes. This presented a valuable and readily available source of community views and a deeper examination of people's experiences which through the blog discussions, described in stark detail the hour by hour burden of managing diabetes.

There is considerable evidence that people will disclose more information in an on-line environment compared with off-line qualitative research as the depth and detail is often absent in the snapshots taken through interviews and focus groups, (Joinson, 2005). This is however an approach worthy of consideration for further research although weblogs appear limited by the lack of formal mechanisms of evaluation and validation.

In exploring the relationship of the nursing profession to public involvement as enacted in a patient and public council, Brookes (2008) concluded that a shift is required by nurses towards acceptance of members of the public functioning as critical and powerful agents in health care decision making. The development of an equitable dialogue between service users and nurses represents a challenge for nursing staff. Instead of being intrinsically directed by the concepts of partnership, the established relationships appear to mirror the professional defensiveness and protectionism found among other health and social care professionals, (Barnes, 1999).

The use of an action learning approach and the transition to a more engaging approach through dialogue and the learning arising from these experiences has

implications for service provision, commissioning and policy development and the potential to influence;

- **Individual patients** so they can influence their care and treatment through becoming co-producers of care.
- **Members of the public** so they can be inspired to become active citizens.
- **Practitioners** so they can start to take action on improving their practice in patient and public involvement and in doing so become more responsive to need.
- **Organisational development**, to develop empowering organisations.
- **Foundation Trusts** to assist them in their role in ensuring that public, patient and stakeholder involvement is at the heart of their governance, so that services are responsive to the needs of the communities they serve.
- **Commissioners** so they can appropriately engage with local people to identify their health needs and ensure that services are procured to meet those needs.
- **Policy makers** to encourage them to consider ***how*** health and social care providers and commissioners actually engage patients and the public.

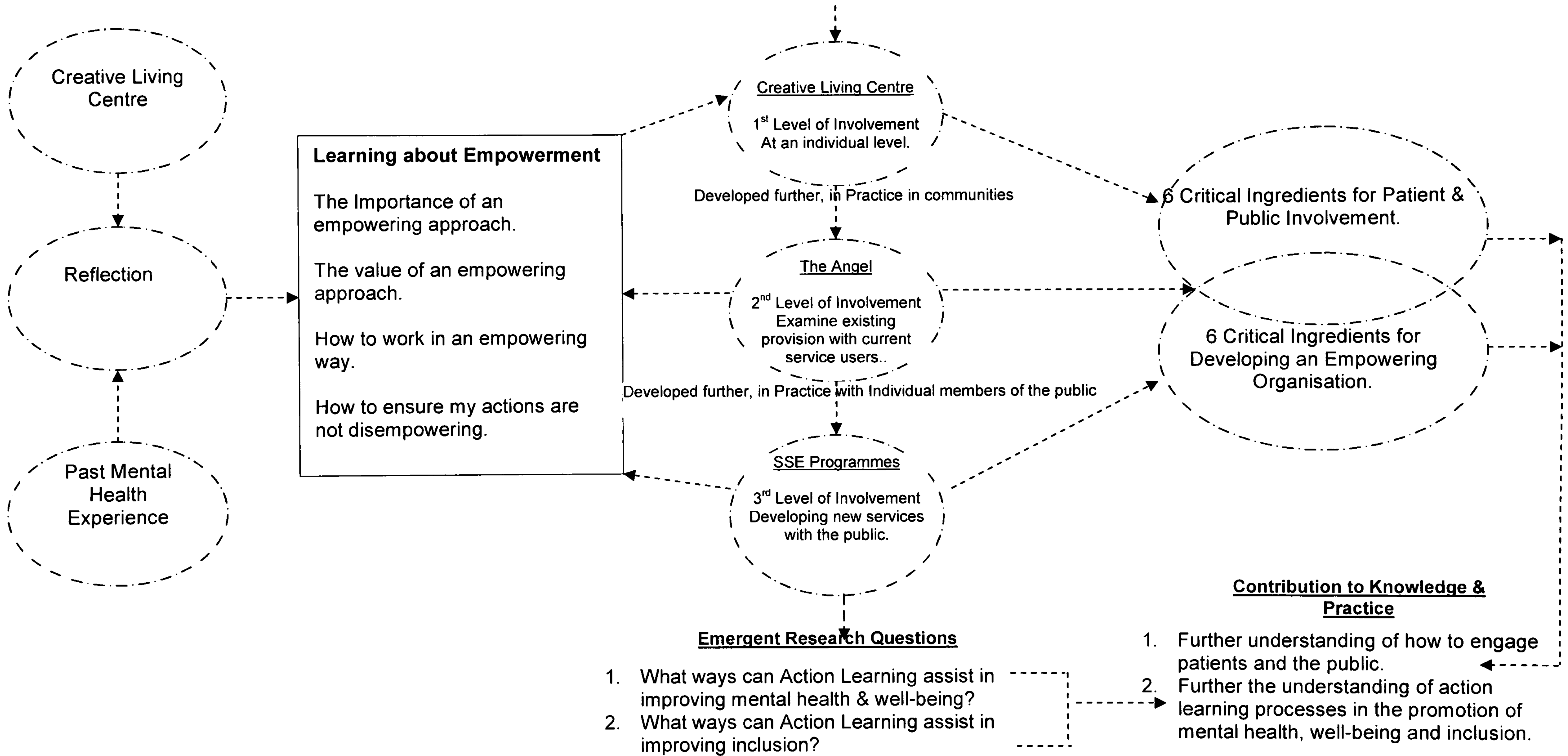
In actively influencing the above it is anticipated that service provision should better meet the needs of the people for who those services are provided.

Contribution to Knowledge

The outcome of a PhD is the capacity to make an original contribution to knowledge. As a consequence of this inquiry I believe that I have made an original contribution to knowledge of practice in the context of patient and public involvement. Additional to this I have developed professionally and personally in my professional practice.

The contribution to knowledge emerged over the period of this inquiry and initially arose from the realisation and understanding of ***how*** I had developed new relationships in my practice when engaging with patients and the public. This knowledge emerged through reflecting on my work based experiences and is shown in diagrammatic form in **Figure 19** on the following page.

It commenced with my reflection on the experiences of developing the Creative Living Centre against my previous experience of mental health. See Chapters 2 and 3 respectively for further information. This was the starting point for understanding how to engage patients and the public. At this point I noted the similarity of action learning processes and the processes used working in an empowering way at the Creative Living Centre which is discussed further in Chapter 3. It was during this project through working with individuals on a one to one basis where I identified the **First Level of Involvement** the aim of which is ***to improve care at a personal level***. Chapter 9 explains the origins of this level of involvement.


The Process of Discovery and Learning
Figure 19
Three Levels of Patient & Public Involvement
Creative Living Centre
Reflection
Past Mental Health Experience
Learning about Empowerment
The Importance of an empowering approach.
The value of an empowering approach.
How to work in an empowering way.
How to ensure my actions are not disempowering.
Creative Living Centre
1st Level of Involvement
At an individual level.
Developed further, in Practice in communities
The Angel
2nd Level of Involvement
Examine existing provision with current service users..
Developed further, in Practice with Individual members of the public
SSE Programmes
3rd Level of Involvement
Developing new services with the public.
6 Critical Ingredients for Patient & Public Involvement.
6 Critical Ingredients for Developing an Empowering Organisation.
Emergent Research Questions
1. What ways can Action Learning assist in improving mental health & well-being?
2. What ways can Action Learning assist in improving inclusion?
Contribution to Knowledge & Practice
1. Further understanding of how to engage patients and the public.
2. Further the understanding of action learning processes in the promotion of mental health, well-being and inclusion.

I chose to further this understanding in a different context as I project managed the development of The Angel Healthy Living Initiative. The change in context was with members of the public in three different communities in Salford who were not known users of mental health services. My belief was that using an action learning approach would facilitate more active engagement of local people in the projects development and in doing so the services developed would be relevant and responsive as a result of being based on what local people said they needed. I also wanted to understand the impact of this approach on my practice.

The value of using an action learning approach was demonstrated by the level of active engagement in the planning, development and running of the Angel, and added to my learning about empowerment. It was during this project where I identified the **Second Level of Involvement,** examining existing service provision with current users of services the aim of which is ***to improve the way current services are provided.*** Chapter 9 explains the origins of this level of involvement.

From the combined experience of the Creative Living Centre and the Angel I had seen people grow in many ways through becoming increasingly involved in various activities where I was able to witness an apparent improvement in their mental health and social inclusion.

Consequently it was my belief that if this approach was available to local people in Salford it could make a significant difference to their lives and that of their immediate communities with the expectation that it would improve their mental

health, well-being and social inclusion. I decided to test this belief with participants on the Salford Social Entrepreneurs Programme. The emergent research questions were;

1. What ways can Action Learning assist in improving mental health & well-being?
2. What ways can Action Learning assist in improving inclusion?

From the collective experience of the Creative Living Centre, The Angel and the Salford School for Social Entrepreneurs I reflected on the development processes and my learning and analysed the information I collected. This resulted in me discovering that I had learnt to work ***with*** patients and the public and not ***for*** them. Working in this way required me to be in a different relationship with patients and the public. It was during the SSE programme where I identified the **Third Level of Involvement,** to develop new services with the public, the aim of which is ***to develop creative and innovative new services***. Chapter 9 explains the origins of this level of involvement.

I also learned that I had encountered a number of consistent experiences in the process of developing these projects which are shown in diagrammatic form in **Figure 7** (Chapter 9) "Developing a Relationship, A Pathway to Patient and Public Involvement". The development of the pathway (referred to above) and further reflection helped me explore and understand what was different about the way in which I worked and how I had managed my experiences and informed the formulation of the **6 Critical Ingredients for Patient and Public Involvement**. These critical ingredients are recommendations that help to construct a context for involvement and initiate a process for dialogue that can

assist the development of new and longer term relationships. Chapter 9 explains the origins of the 6 Critical Ingredients for Patient and Public Involvement.

The organisational context in which these 6 critical ingredients would be used is crucial and was developed from my own negative experience of isolation in a Trust that wasn't empowering and was at odds with working in this way. I felt it important that an organisation that supported active involvement with patients and the public needed to be an empowering organisation and consequently identified **6 Critical Ingredients for Developing an Empowering Organisation**. It is actively working in the context of these Critical Ingredients that ***furthered my understanding of how to engage patients and the public***. See Chapter 10 for the origins of 6 Critical Ingredients for Developing an Empowering Organisation.

The individual outcomes arising from working with the SSE participants (which are described in Figures 11a to 11j and explained further In Chapter 9) ***furthered my understanding of action learning processes in the promotion of mental health, well-being and inclusion***.

The Original Contribution to Knowledge and Practice

This thesis presents a unique contribution to the knowledge and practice of patient and public involvement. It is unique not only as a result of the theory generated from the outcomes but also because of the theory generated from the context in which it was undertaken and the participants on the SSE programme. The context was the here and now of my work where I had to take

action in real time which allowed me to create a new theory. According to Raelin (1999) when theory is introduced in this way it is done parathetically rather than hypothetically which is in anticipation of the action, where there is an attempt to predetermine the central issues before the start of the inquiry.

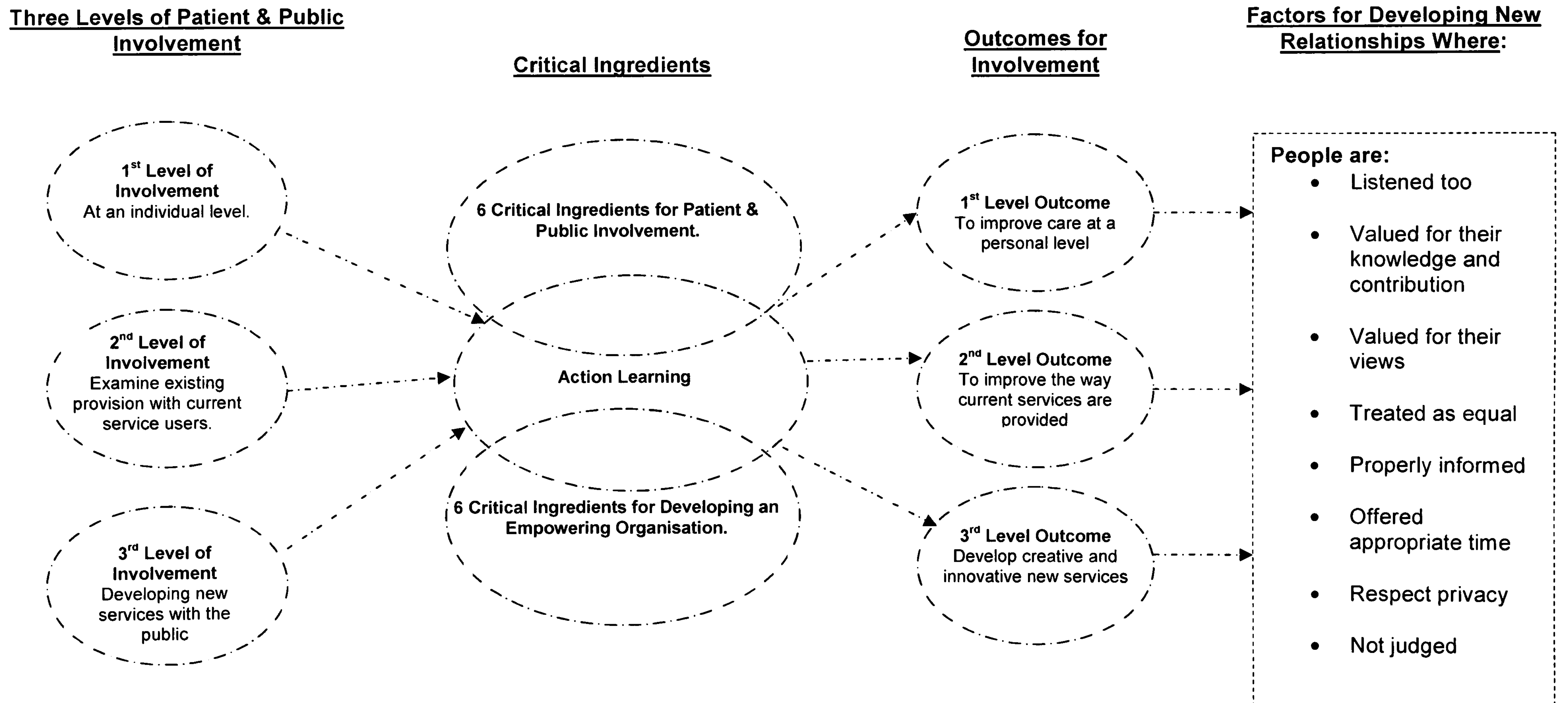
The contribution to practice is embedded in the innovative models of the Creative Living Centre, The Angel and the individual projects arising from the participants of the Salford School for Social Entrepreneurs. These models are real live services that have the potential to influence others and are explained further in Chapter 3.

In doing so I have developed a new framework for patient and public involvement as outlined below, (Young's Framework for Patient and Public Involvement) a theory generated from this inquiry into my practice of patient and public involvement and service transformation. This will be of direct value to others working in the public sector that are required to engage a range of different stakeholders, within the three levels of involvement as indicated in the framework. The framework can be found on the following page, **Figure 20**.

The framework commences with the three levels of patient and public involvement. Along side are the critical ingredients for patient and public involvement and the critical ingredients for an empowering organisation which support the framework through providing a context that helps in realising the anticipated outcomes of the three levels of involvement. The framework is bound by the processes of action learning which are generated by the learning and reflection arising from action taken.

Figure 20

Young's Framework for Patient and Public Involvement



The framework is further enhanced by adopting key factors that were generated from my experience that augment the process of patient and public involvement through developing new relationships.

The importance of these new relationships are that they open up new opportunities to understand the views of stakeholders in a way that assist in understanding and managing the potential differences articulated earlier in the chapter. In doing so it can contribute to removing the barriers of professional defensiveness and protectionism that can be found in health and social care professionals.

The essence of the difference that this relational practice has made is explicitly related to the achievement in the outcomes in the three levels of involvement all of which aim to improve the likelihood that services are more responsive to the needs of people who use those services.

In level 1 patients are more likely to become more actively involved in identifying their own needs and making informed choices about how those needs are met through becoming co-producers of care and treatment as evidenced in the experience of the Creative Living Centre.

In level 2 involving patients at this level is more likely to result in an authentic feedback on how current services could be improved and developed, which is evidenced by the experiences of the Angel Healthy Living Centre.

In level 3 members of the public potentially have a blank canvas for exploring their individual and collective ideas for new service provision which can result in radically different services that might have developed differently had they been solely influenced by the ideas of health and social care professionals. This is evidenced by the outcomes of the participants of the SSE programme.

Autonomous Learning

Additional to the framework for patient and public involvement I have furthered the understanding of action learning processes In the promotion of mental health, well-being and social inclusion. Throughout this inquiry I wanted to understand the impact of action learning on the mental health and well-being of the SSE participants as I held a belief that this could be health promoting. Health promotion according to the Ottawa Charter (WHO 1986), is supposed to initiate and drive processes of social change aiming at the improvement of living and working conditions conducive to health. The key strategic concept guiding the Ottawa Charter is empowerment.

Empowerment is often referred to as power that is handed down from one group or individual to another, (Hothi 2008). However this inquiry demonstrates that empowerment doesn't always require this redistribution. It requires that individual's organisations and communities maximise their own capabilities by working together and involving themselves in civil society through a social action process that promotes the participation of people. In doing so people can improve their individual and collective skills and the scope for enhancing their lives in a given community. Empowerment according to Rappaport (1981, pg 6) embodies;

"a broad process that encompasses prevention as well as other goals of community connectedness, self-development, improved quality of life and social justice."

The term Autonomous Learning is used to indicate that the participants through the empowering processes of action learning have been able to develop new beliefs in their ability to influence their personal and social spheres, and that the initiation came directly from the individual participants rather than being directed by others.

Cunningham (2000) however prefers the term self managed learning which he states is not about self-centred individualism, but about learning groups of about five or six people. The differing perspectives of the group offer a rich source for planning action and checking on the appropriateness of plans. He stresses that the most important feature of such groups is the notion that each person is different and is encouraged to work on what ever is felt appropriate by them.

Based on the achieved outcomes of the SSE participants I have identified an additional component (autonomous learning), to an already accepted model of health promotion that currently includes; health protection, health prevention and health education. See Chapter 9. Its significance lays in the fact that health education, prevention and protection measures are done to others whereas an autonomous learning approach is initiated and enacted by the individual.

The combination of autonomy and learning in the real world with access to a broad range of social experiences has a positive influence on the process of

socialisation. In an autonomous learning situation the balance between being a social person and the growth of personal knowledge are not put under the enormous and artificial pressure for conformity. The importance of learning in this way has the potential to facilitate lifelong learning which is affirmed by Bandura (1997 pg.227) who states that:

> "Development of capabilities for self directedness enables individuals not only to continue their intellectual growth beyond their formal education but to advance the nature and quality of their life pursuits. Changing realities are placing a premium on the capability for self directed learning throughout the life span."

As a consequence I believe I have demonstrated the impact of an empowering approach on well being and positive mental health and inclusion of the SSE participants and established the value of autonomous learning in the promotion of health. The impact of this approach is evidenced through the outcomes achieved by the individual participants and assists in furthering the understanding and link between empowerment and well being.

Autonomous learning however requires the intrinsic motivation of the individual, those who are not sufficiently motivated may require the support of a facilitator, but care needs to be taken to avoid being controlling. Further work is required to consider how to engage those people who are not intrinsically motivated.

Contribution to Method

I have also added to my knowledge and practice throughout my work and this inquiry where I have developed action learning as a unifying framework for working with patients the public and other practitioners which has allowed me to bring together the knowledge to my practice arising from diverse fields. This

required me to adopt action learning as an integrated approach to my practice which has helped me understand others through listening and hearing what people say and asking questions in order to clarify any outstanding issues.

Additional to this I have demonstrated the importance of knowledge arising from patient and public involvement as being expert knowledge that is of equal importance to expert knowledge arising from published literature.

7. Opportunities for Further Research Development and Direction.

The opportunity for further research, development and direction is intended to influence policy and practice in patient and public involvement in the context of public service provision. This is essentially in three areas:

- Further research;
- The potential for published papers;
- Personal development and practice.

Further Research

One option for further research and personal development arise from the development from this inquiry of "Young's Framework for Patient and Public Involvement". It would be valuable to test the framework in another setting.

Encouraging further doctoral research by different disciplines could usefully compare the influences on practice development of different types of input, e.g. legislation, clinical science, economical analysis etc.

There has been recent discussions regarding the development of a Manchester based School for Social Entrepreneurs. This could provide the opportunity to undertake a comparative study of the outcomes of a new group of Social Entrepreneurs with that of the outcomes associated with the participants from the Salford School for Social Entrepreneurs.

A longitudinal study could also be undertaken using a panel study to understand the cumulative affects of the participant outcomes arising from the Salford School for Social Entrepreneurs programme.

Potential for Published Papers

The potential for published papers provides the opportunity for further development and the opportunity to demonstrate the power of what I am advocating and the opportunity to engage with those who may come from a different tradition. Other people can benefit from this contribution to knowledge and practice in two ways, those working in developing methodology in research and development and those who want to apply this in different sectors. The scope for publications and the use of it by others could be as follows.

The Action Learning Community

This provides the opportunity to share my understanding in the potential of and the compatibility for integrating an action learning approach with other research approaches. A useful publication to further this aim would be the International Journal for Action Learning, Research and Practice, published by Routledge who are part of the Taylor and Francis Group. As a consequence of this research I have co-authored a refereed paper with colleagues from the

University of Salford on the nature of action in action learning, entitled *Doers of the Word? An enquiry into the nature of action in action learning* published in this Journal in 2007.

The Mental Health Community

There is an opportunity to demonstrate how a more engaged approach to involving patients and the public can lead to improved mental health and well-being. This could be through a published paper in the Journal of Psychiatric and Mental Health Nursing which is an international forum for the advancement of psychiatric and mental health nursing practice.

The General Health Community

The opportunity to influence the general health community in the value of involving patients and public in taking responsibility for their health has the potential to reach a broad range of health care professionals. This could be through a paper published in the Health and Social Care in the Community Journal which is essentially for nursing, social work, physiotherapy, occupational therapy, general practice, health psychology, health economy, primary health care and the promotion of health. It is an international peer-reviewed journal supporting interdisciplinary collaboration on policy and practice within health and social care in the community.

Influence policy

Publishing a paper on the impact of using a relational approach to patient and public involvement through the use of "Young's Patient and Public Involvement Framework" has the potential to influence policy across a broad range of

disciplines. I would consider the Journal of Health Politics, Policy and Law which focuses on the initiation, formulation, and implementation of health policy and analyses the relations between government and health.

Personal Development and Practice

I have used the knowledge arising from this inquiry within my practice to continue to work in partnership with others. More specifically I have been collaborating with Proud City a Social Enterprise in Salford where we have integrated an action learning approach into the development and piloting of an active citizen programme. Proud City is now the National Centre for this award, the "Individual Profile in Active Citizenship" (IPAC). This is a personal journey for self development and achievement for participants, which aims to improve health, well-being and lifestyles. City and Guilds are the awarding body who have introduced the award into their 7,500 learning Centres.

This collaboration with Proud City has developed further and I have been involved in the development of a Health Trainers Programme. The role of the Health Trainer is to work and support individuals and groups of individuals who want to develop a healthier lifestyle through changing their behaviour. This is a level 3 Certificate for Health Trainers that is mapped to the competences produced by skills for health. More specifically I have developed Unit 302 (one of the four mandatory units) of the programme which is about "Establishing and developing relationships with communities while working as a Health Trainer". The programme integrates action learning and recognises the candidate's previous experiences which are accredited with the certificate awarded by City and Guilds.

Additional to this I have worked for a large inner city Primary Care Trust where I have used action learning to review their Expert Patient and Health Trainers Programmes. Both required me to work with the beneficiaries of the programmes to hear about their views, experiences, ideas and aspirations for how the services could be improved.

As a Trustee for Mind (a leading mental health charity) I have been able to use the knowledge from this research to influence the organisations strategic direction. This has now transformed from supporting "users of mental health services" to supporting all people with "direct experience of mental distress" wether or not they have used mainstream mental health services or received their support from various community services.

Through my involvement on Minds Networks Committee I have been able to influence the development of Mind's "involvement" strategy.

8. Critical Review of How the Final Chapter was written

My approach to writing this Thesis was to think and reflect as I wrote, producing a succession of drafts. The act of writing allowed me to record my thoughts giving me a great deal of satisfaction when new insights were revealed helping me to think about my practice in different ways. I started writing early in the inquiry and my approach was to record what I wanted to say, followed by periods of reading and reflection, rereading and asking myself does this really say what I want it to say? As a result I believe that I have improved my ability to express myself in writing in a more focused way which has given me the confidence to consider writing articles for publication.

I adopted the same approach for writing this final chapter, although I had an additional constraint of having to complete it in 12 months. However a number of personal challenges resulted in an extension to the deadline for resubmission. The challenge was to ensure that my rate of learning and understanding and responding to the expectations of the examiners would allow me to complete the final chapter of this thesis within the expected time scale.

Additional to this I had to consider differing views about research both personally and from others that emerged following the closure of the Revans Institute for Action Learning and Research. One of the outcomes of this reflection was that I realised that I initially limited my inquiry as I allowed myself to be directly influenced by my experience of the Revans Institute which I felt didn't encourage exploration of other research methods which appeared to me to be portrayed as inappropriate and not compatible with action learning. Consequently I have learnt the value of other research methods and the published literature of others which has enriched my understanding of research methods and my practice helping me to broaden my knowledge and support me in completing this final chapter.

A major challenge following my viva in May 2007 was responding to the examiners requirements to write this final chapter and specifically demonstrate my use of published literature of others. My initial response was that I did use literature, but reflection through further reading, dialogue with others and writing this chapter, I realised that I initially used more informal knowledge, and that I needed to consider the use of published literature from others to help me

critique and analyse what I was advocating. Writing this final chapter then became a means of discovering new knowledge.

As I read and considered more published literature I found that it elevated my understanding of various topics and gave me the confidence to return to other published work that I would have previously disregarded. In doing so I found that I actually enjoyed the experience which seemed to be associated with me accessing the literature when it was required and at an appropriate time in the process of this inquiry. I probably would not have appreciated it if I had done so earlier. Drawing on and critiquing published literature was one way of learning, which complemented the received knowledge arising from my experience in practice, of listening to others.

Engaging with others in practice provided the opportunity to explain my work to others and solicit their views. My expectation was that there would be unanimous support for what I was advocating and an understanding in the value of action learning in patient and public involvement. In reality my approach was recognised as valuable but I realised that there are many ways of involving patients and the public of which my approach was one. This encouraged me to consider what was unique about what I was advocating and think about how to best explain this. In parallel I also learnt the potential of and the compatibility for integrating action learning with other research approaches.

A major frustration in the process of responding to the requirement of the examiners was not having the opportunity to explore, reflect and question a range of issues with others in an action learning set. This was not only in the

context of completing the final chapter but also in the context of promoting the value of action learning in patient and public involvement. As a consequence I have been actively involved in developing a number of opportunities to assist me with this work.

Northern Action Learning Network

I have been involved in the development and growth of a Northern Action Learning Network. The aim is to grow an innovative network of practitioners whom together can create a rich learning environment for all those interested in action learning, research and practice. In creating a network with practitioners and academics from different fields, we aim to design a range of stimulating, thought provoking and energizing opportunities for action learners who may want to:

- hear how action learning has been used across a wide range of disciplines;
- test out ideas and get some help;
- develop some creative collaborations across organisational boundaries
- meet other action learners informally;
- form action learning sets with people from different organisations/ settings;
- publish and find new writing partnerships;
- support individuals who want to use action learning (mentoring etc.).

As a consequence I am involved in a new action learning set "Beyond Boundaries" which supports each other with our different actions including events and partnerships beyond set meetings for which I can benefit from the

diversity of set participants. We now have a web site for which I am responsible for show casing innovation in practice from across the network.

North West Primary Care Patient and Public Involvement Forum

I have recently become a member of the North West Primary Care Patient and Public Involvement Forum at the University of Manchester. This is a group of people with an interest in health care research which meets every six weeks for development sessions and to discuss research topics and projects, current and potential, in primary care. The forum brings different insights to the research process, where I hope to share my experiences of patient and public involvement with the forum with a view to influencing practice.

Along with the opportunities for further research, development and direction as discussed earlier the action learning network and the North West Primary care patient and Public Involvement Forum provides me with the foundation for developing my practice further and influence the practice of others in patient and public involvement.

Appendix 1

Employment Profile

FROM/TO	EMPLOYER	POSITION HELD
01/04/1971 31/10/1971	Prestwich Hospital	Messenger
01/11/1971 31/12/1973	Prestwich Hospital	Cadet Nurse
01/01/1974 31/01/1977	Prestwich School of Nursing	Student Nurse
01/02/1977 31/08/1977	Salford Health Authority Prestwich Hospital	Staff Nurse Acute Services
01/09/1977 31/03/1979	Bury General School of Nursing	Student Nurse
01/04/1979 14/06/1981	Salford Health Authority Prestwich Hospital	Charge Nurse Adult & Elderly Services
15/06/1981 05/01/1986	Rochdale Area Health Authority Springfield Park/Birch Hill Hospital	Nursing Officer
06/01/1986 03/04/1988	Salford Area Health Authority Prestwich Hospital	Asst, Director of Nursing
04/04/1988 31/12/1989	Salford Area Health Authority Prestwich Hospital	Manpower & Service Planning Officer
01/01/1990 27/04/1994	Salford Area Health Authority	Service Manager Long Stay Rehabilitation Services
28/04/1994 31/03/1995	Mental Health Services of Salford, NHS Trust	Director of Service Development (Capital Projects)
01/04/1995 05/09/1999	Mental Health Services of Salford, NHS Trust	Director of Service Development
06/09/1999 04/01/2004	MHSS NHS Trust Bolton, Salford, and Trafford Mental Health NHS Trust	Service Director (Developments)

On Secondment from Bolton Salford & Trafford Mental Health NHS Trust

05/01/2004 31/12/2005	NHSU 2.5 Days	Learning Coordinator Action Learning
	Mersey Care Mental Health Trust 1.5 Days	Learning & Development Associate
	North West Mental Health Chief Executives 1 Day	Development Manager

Appendix 2

Mental Health Services of Salford NHS Trust
and
City of Salford Community and Social Services Directorate

Mental Health and Community Strategy

INTRODUCTION:

The Trust has expressed a commitment to a strand of work, which relates to the provision of understanding about mental illness, the influencing of attitudes to those who experience it and the promotion of more positive mental health in individuals and communities. Following discussions with the Community and Social Services Directorate of Salford City Council and the Salford and Trafford Health Authority the opportunity has now been opened up to enable the latter part of the commitment to be progressed. It is important to recognise the relevance of this to both the Health Authority Strategies and the emerging government approach.

It has been agreed that Steve Young should be able to pursue a development strategy by working with the Community and Social Services Directorate. His tasks will be to pursue a mental health agenda defined in terms of this Trust's objectives, but to do so within and in collaboration with the Community Affairs Division of the Community and Social Services Directorate and with the explicit endorsement of the Health Authority.

It will be necessary for some adjustment of Steve Young's workload and personal objectives in order for him to develop the role in this way. In general, however, it is a case of this being a more effective vehicle for achieving previous intentions and building on existing involvements. This paper describes the background to this important and innovative development and outlines the initial areas of focus.

It is intended that Steve Young will report regularly to the Board as well as ensuring close contact with the relevant services and other structures within the Trust.

BACKGROUND:

The Mental Health Services of Salford Trust was commissioned by the Salford and Trafford Health Authority to undertake work to develop in Trinity a Primary Health Care Resource Centre.

The outcome of that work, which was presented to the Health Authority in May, indicated that the model of service development contained in the original plan was not appropriate for the needs of the community.

The Salford and Trafford Health Authority in their Purchasing Plan for 1997/98 supported the need to work with people in local communities, particularly the most

disadvantaged in order to improve their ability to take action to improve health. It recognised the importance of community health development and the role of local people in influencing and promoting health within their own communities.

The recent Public Health Research and Resource Centre Study undertaken on the Blackfriars and Ordsall areas also identified a number of factors impacting on people's health needs.

Trinity Primary Care Resource Centre is situated within the six highest areas of deprivation in Salford and its development should be seen in the context of a jointly developed strategy with the Local Authority, Health Authority and the communities of Salford.

This will require an approach that would provide more of a community focus than was originally planned and as a consequence gives an opportunity to involve local communities which:

- Draws its agenda from people's immediate experiences and needs in the area where they live
- Involves a commitment to revealing and mobilising the worth, capacities and untapped skills of all individuals
- Emphasis's collective activity as the most dynamic and creative medium through which personal growth and social development take place
- Strives to assist and enable people to take increased control over their lives and to participate in the making of decisions which affect them

This approach is consistent with the Community and Social Services Directorate and offers opportunities for working in partnership to develop healthy alliances that ensures the mental health needs of local communities are incorporated into community development plans and are in the context of the new public health strategy, Salford and Trafford Health Authority purchasing plan and the Community Care Plan.

The role of the MHSS Trust Service Director (Development) would provide an opportunity for the development of that strategy and is consistent with a range of work currently involved in.

AREAS OF INITIAL FOCUS:

Developing a strategy for mental health promoting communities.
This means:

- Understanding the profile of each Service Delivery Area
- Understanding each element of the current community strategy
- Understanding the health needs of each Service Delivery Area
- Testing the understanding of those needs with the MHSS Trust and Health Authority.

- Identify and prioritise those needs
- Explore what options there may be to capacity build what currently exists to meet those needs
- Explore options for developing new responses to peoples needs, ensuring that people from minority groups are appropriately represented
- Consult and confirm a strategy for development
- Initiate the development of a range of projects to deliver new responses to need

Explore options and initiate opportunities for developing a network of existing support services

This means:

- Identifying what creative support agencies services exist
- Explore what options/opportunities there may be for partnership working
- Facilitate the development of collaborative and partnership working

Employment and Training

- Explore options for ensuring employment and training needs of people with a mental health disability are reflective in the authorities economic development strategy
- Initiate the development of employment and training projects

Explore options for the development of a network of Healthy Living Responses

- Identify and network with similar projects exploring options and opportunities for partnership working i.e. Creative Living Centre, Kath Locks Centre, Zion Centre
- Facilitate the development of collaborative working

Single Regeneration Budget Health Task Group

- Support the development of mental health related inputs into SRB
- Explore options for partnerships and project developments for inclusion into futures bids
- Initiate the development of specific SRB projects

Young People

- Explore options for development of young people related projects, building on previous work
- Initiate the development of specific responses to need

Users and Carers

Initiating the collaboration for developing responsive service provision for people with experience of emotional distress, their carers and families

THE APPROACH:

The development of a city wide strategy for the promotion of positive mental health in individuals and communities, will require an understanding of the needs of communities as they are developed and reflected in the Community and Social Services Directorate, the City Council's, service delivery areas and their community action plans.

An evolving approach will require the development of strong links across Salford, which will be initiated by an induction programme that will provide a strategic overview of the Community and Social Services Directorate; its Community Affairs Division and the communities of Salford. Additional to this, Steve Young's base will be situated in the Little Hulton area and will provide an opportunity to experience and understand the needs of a high need community undergoing significant development, and the contrasting localities of Worsley and Walkden.

This activity would be consistent with and complement further work (should the Health Authority so decide) in developing the opportunities for a community focused initiative, which grows out of the earlier thinking about a Primary Health Care Resource Centre in Trinity. This would be a further opportunity to test out models of partnership in the development of healthy alliances reflecting the Health Authority and Community strategies.

1997

Appendix 3

Mental Health Services of Salford NHS Trust

Job Description

Job Title: Service Director (Developments)

Grade:

Accountable: Chief Executive

Job Purpose:

To initiate, develop and strengthen partnership working with local authorities, local service providers, neighbouring health authorities and local people. Building on the capacity of those people and their organisations in order to respond to identified mental health promoting activities, and other opportunities as identified by the Trust.

Key Relationships:

Internal: - Trust board, Chief executive and the Trusts directors. To be an integral member of the Trusts executive team.

External:- Salford and Trafford Health Authority, City of Salford Community and Social Services Directorate, Local Trusts, local communities, University of Salford, National and North West Mind, Voluntary organisations, Community Health Council, Manchester, Salford and Trafford Health Action Zone.

Principal Responsibilities

Service Development

1. Lead the development and project management of specific projects as agreed with the Chief Executive.

2. Work with the Community and Social Services Directorate of the Salford City Council to integrate the philosophy of mental health promoting communities into their strategic planning.

3. Provide project management and support as appropriate across the Trust.

4. Work in partnership with a range of agencies exploring options for service development.
5. To explore and develop new ways of working with existing resources to improve services for local people.

6. To advise/assist in the process service planning and developing business cases to secure capital investment.

Mental Health Promotion

1. Build strategic partnerships with the local authority and others to influence social and environmental factors, which affect positive mental health.

2. Develop partnership working within the NHS, Local Authority and other agencies in a way that encourages lifestyles that promote positive mental health.

3. Focus on communities with particular need.

4. Provide advice on the development of healthy living initiatives across the Manchester, Salford and Trafford Health Action Zone.

5. Co-ordinate and support planned activities for World Mental Health Day.

6. To work in partnership with Mind and other voluntary organisations to ensure social inclusion for those with mental health problems.

Trust Specific

1. To encourage partnership working amongst Trust staff and external agencies.

2. To contribute to the Trust service and resource plan.

3. To be a panel member for service reviews.

4. To contribute to the Trusts Training and development programmes as required.

5. To provide supervision and mentorship as required.

6. Provide advice and support as a member of the senior managers on call rota.

7. Integrate the Trusts values into the Health Action Zone.

8. Represent the Trust on the Social Action Research Project

9. Chair/be a member of grievance panels or meetings of a potential disciplinary nature.

Although an employee of the Mental Health Services of Salford NHS Trust and directly responsible to the Chief Executive of the Trust, the Service Director (Developments) through the nature of development work will take its lead from the existing and emerging partnerships. These are presently as follows:

- Salford and Trafford Health Authority.

- Manchester, Salford and Trafford Health Action Zone.
- City of Salford, Community and Social Services Directorate
- Mind

April 1999

Appendix 4

First Proposal to Robert

Mental Health Services of Salford NHS Trust

The Mental Health Services of Salford have a commitment to the development and the delivery of a wide range of quality mental health services. Although the Trust work is mainly focused on the provision of services for people with serious and enduring mental illness, it also recognises the value of providing services that contribute to the development of positive mental health and well being, both of individuals and their communities.

Although there has been some debate about whether this is the Trusts core business, the Trust has demonstrated its commitment to the promotion of positive mental health and well being in a number of ways. Some examples are as follows:

- The development and implementation of a City wide strategy for the provision of employment and training initiatives.
- The development of the Creative Living Centre
- Supporting work with the Community and Social Services Directorate of the City of Salford, looking at opportunities for mental health promoting communities and Social Inclusion
- Development of the Angel Healthy Living Centre in partnership with local people from the communities of Trinity, Islington and Greengate and sponsored by Salford and Trafford Health Authority, City of Salford Social Services Department and the Mental Health Services of Salford NHS Trust.
- Integration of the Healthy Living Initiative with the Chapel Street Regeneration project.
- Secondment to the Manchester Salford and Trafford Health Action Zone, with an active involvement in the community programme and also as an adviser for the development of healthy living initiatives.
- Involved in the development and implementation of the Social Action Research Project (SARP) looking at the implication of Social Capital in four communities across Salford.
- Supporting the development and contributing to the Salford School for Social Entrepreneurs through providing Set facilitation for the students working in an Action Learning Set.
- Recruitment and employment of a mental health community development worker through the Cheetham and Broughton regeneration scheme, looking at social inclusion.
- Active involvement with Mind Mental Health Charity involved in social inclusion working group, developing national quality standards for employment and training and panel member for distributing grants under the Mind Millennium Awards.

- Chaired the health group for the Seedley and Langworthy initiative.

Most of this work has been project work that has been time limited and requires me to work in a way that each project is able to stand alone and continue to develop on completion of my role.

As part of my IPR review and considering my objectives for the year 2000/2001, I am conscious that I am planning my exit strategy for two major projects that have been a dominant feature of my work for the last three years. Namely the Angel Healthy Living initiative and the Webb House Therapeutic Community Services. My current thoughts about my objectives for 2000-2001 include the following

Manchester, Salford and Trafford Health Action Zone.
There is a need to reassess my role with the HAZ following their re focus as they work as change agents in specific communities.

Social Action Research Project
Consider picking up on a recently agreed role of being the lead for the Whole Systems Working approach across the project.

Mind
Continuing to be an advisor for Mind and undertake my new role as Chairman of the Mind Millennium Awards "Real Lives, Real People".

Salford School for Social Entrepreneurs
Continue to be set facilitator for students working in an action learning set, and explore contributing to the development of additional projects.

Creative Living Centre
Continue to integrate the services and philosophy of the project into the Trust and the communities of Bury, Salford and North Manchester.

Webb House Democratic Therapeutic Community Services
Continue to project manage the development of the project up until the successful opening. (July-August 2000)

Revans Centre
Continue to explore opportunities for introducing action learning and research across the areas of influence.

Ph.D.
Continue with my personal development using action learning and research.

Mentoring
Continue with my role as mentor for
- Clinical Leadership Programme
- North West Region

The work I have undertaken for the last three years has been rooted in developing new partnerships with a range of organisations in a way that brings the skills of those organisations together achieving added value, for the benefit of local people and their communities. The focus has been in those areas of Salford where there has been the greatest of need. This has often been in areas that are also part of an SRB schemes.

It has been noticeable that the investment from those schemes has predominantly improved the environmental infrastructure of local communities giving too much emphasis to physical and economic regeneration at the expense of social regeneration. I have a sense that minimal work has been undertaken to look at the social needs of local people.

There is a need to look at how best we can assist local people and their communities to build their individual and collective capacity.

The idea of achieving social well being through social regeneration links the community to the individual level by emphasising the overlap between the social development of communities and the personal development of the individuals belonging to them.

The present government has made the improvement of education a key part of its long term strategy to overcome social exclusion. Initiatives are being developed on several fronts, all within a vision of creating "a Learning Society".
This proposal contributes to the creation of that vision through the use of action learning. This would use action learning as a process for social regeneration working with individuals and communities across the Manchester, Salford and Trafford Health Action Zone and would contribute to the development of a "Learning Society". In such an ideal collaboration as a Learning Society, there is:

"A social drive to provide equality of opportunity for learning to all citizens, at least partly in order that they may contribute to that society being a good place to live".
Mike Pedler 1998

The first step would be to explore the level of interest for such a project through a workshop at the Revans Centre for Action Learning and Research at the University of Salford. This would involve key people from across the Manchester, Salford and Trafford Health Action Zone to assess the level of interest and support.

Stephen Young **March 2000**

Mental Health Services of Salford NHS Trust

The Mental Health Services of Salford have a commitment to the development and the delivery of a wide range of quality mental health services. Although the Trust's work is mainly focused on the provision of services for people with serious and enduring mental illness, it also recognises the value of providing services that contribute to the development of positive mental health and well being, both for individuals and their communities.

The Director of the Revans Centre for Action Learning and Research Professor David Botham has been in discussion with the Trust to explore support for the development of a centre for community learning to be led by Stephen Young Director of Service Development. The Centre for Community Learning would provide community based programmes of action learning that would support the development of mental health promoting communities.

Background
The Trust has demonstrated its commitment to the development of positive mental health and well being initiatives through supporting the work of the Director of Service Development in exploring ways of developing mental health promoting communities. The progress made with this difficult agenda can be seen in **Appendix 1 (to this paper).**

This work is underpinned by the "growth" of new partnerships with a range of organisations that brings their differing skills together achieving added value, for the benefit of local people and their communities

Building on those partnerships, an opportunity has been created for a piece of work that offers programmes of action learning for local people and people who work in Salford who have a role for community development in Salford. This work was supported by Salford East Primary Care Group and the City Council who have committed funding for the first action learning set in Seedley and Langworthy, with a second action learning set with link officers from the City Council.

As part of this work, the work of SARP and the Salford Entrepreneur programme and links to the Revans Centre for Action Learning and Research at the University of Salford there has developed a wide interest in developing a Centre for Community Learning using an action learning approach.

The centre would offer programmes of action learning for people who want to make a difference to their lives through working on personal issues. The aim of the programme is to give local people or people with a role in facilitating community development an opportunity to increase social inclusion through:

- working on a community based project or problem
- working on a lifestyle or life changing activity

- managing a significant life event.

The Programme
Action learning and research offers a powerful process for people to be engaged in developing a deeper understanding of personal and community development. This provides the vehicle for *taking action* and for *learning.*

Participants will work in action learning sets of six members each. Set members can work on issues of individual interests, which must be relevant to their personal development and the development of the local community. These can be clustered on a thematic basis to address key agenda issues for example

- social inclusion
- social regeneration
- social capital
- developing mental health, promoting communities
- tackling health inequalities
- improving access to essential facilities
- encouraging cultural change.

Alternatively participants can work in mixed sets with people from a range of communities and organisations. Set advisers will support each set and participants can draw on the wider practical and academic expertise within the Revans Centre for action learning and research at the University of Salford. Participants will have the option for their action learning programme to lead to an academic qualification if they so wish.

It is anticipated that working in an action learning set will help:

- promote independence
- develop new and build on existing social networks
- tackle factors that undermine health and well being
- develop their local community
- promote citizenship
- lifelong learning
- positive mental health promotion
- reduce discrimination
- share and promote learning.

It gives an opportunity to address key strategic issues arising from

- National Service Framework for Mental Health
- National Strategy for neighbourhood renewal
- Health Action Zone tackling health inequalities
- Tackling social exclusion.
- NHS Plan.

The programme can offer a complementary series of seminars or workshops as identified by the programme participants. Applicants will have the opportunity to work with the local people from Salford and potentially across Greater Manchester. The programme is open to

- local people
- community development workers
- leaders of local community groups
- voluntary sector
- carers.

The idea of using a community development approach to promote mental health links the community to the individual level, by emphasising the overlap between the social development of communities and the personal development of the individuals belonging to them.

The government has made the improvement of education a key part of its long-term strategy to overcome social exclusion. Initiatives are being developed on several fronts, all within a vision of creating a "learning society". This proposal contributes to the creation of that vision through the use of action learning and research.

Future Plans and Actions

The Trust's Director of Service Development will take the lead in this major initiative to develop a Centre for Community Learning and start to develop and implement a project plan. The first phase of which will be to:

- identify a strategic partnership board initially across Salford
- identify a core group to provide practical advice and support to the centres development
- Produce a business plan to cover an initial three year period.

Progress to Date

Appendix 1 (to this paper)

I have been involved in a range of activities that are mental health promoting and encourage social inclusion. These activities have provided the foundation for my learning, changing my perception and understanding of mental health promotion in the context of a community development approach. This learning has moved me forward towards my specific area of research. These activities are as follows:

- The development and implementation of a City wide strategy for the provision of employment and training initiatives
- The development and integration of the Creative Living Centre within mainstream services (a community based mental health, healthy living initiative)
- Supporting work with the Community and Social Services Directorate of the City of Salford, looking at opportunities for mental health promoting communities and Social Inclusion
- Development of the Angel Healthy Living Centre in partnership with local people from the communities of Trinity, Islington and Greengate and sponsored by Salford and Trafford Health Authority, City of Salford Social Services Department and the Mental Health Services of Salford NHS Trust. (a community based healthy living initiative)
- Integration of the Angel Healthy Living Initiative with the Chapel Street Regeneration Project and Salford East Primary Care group.
- Secondment to the Manchester, Salford and Trafford Health Action Zone, with an active involvement in the community programme and also as an advisor for the development of healthy living initiatives.
- Involved in the development and implementation of the Social Action Research Project (SARP) looking at the implication of Social Capital in four communities across Salford.
- Supporting the development and contributing to the Salford School for social Entrepreneurs through providing set advice for the local people working in an Action Learning Set.
- Recruitment and employment of a mental health community development worker through the Cheetham and Broughton regeneration scheme, looking at social inclusion.
- Active involvement with Mind Mental Health Charity involved in social inclusion working group, development national quality standards for employment and training
- Chairman of the Mind Millennium Awards Panel Real Lives, Real People that awards grants to people with mental health needs so they can access personal training and development opportunities

May 14th 2001

Appendix 6

Publications

Young, S 1997: **Lighting Small Fires in the Darkness**- An article of experiences in the first year of an M.Sc. In action learning and research LINK UP With Action Learning-A publication created by and for individuals who desire to bring together research and practical experiences, Vol (1), P.5

Young, S 1998: **The Creative Living Centre**, Mental Health Innovations in Primary Care, The Sainsbury Centre for Mental Health, a summary of some of the innovative mental health in primary care projects from around the country, Alan Cohen, Kelly Thompson, Martin Davies and Geraldine Strathdee.Editors.

Experiences of Action Learning - An article following an interview by the Revans Centre on experiences of an MSc programme in Action Learning and Research. Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 1, no.5, July - December 1998.

Successful Partnership, Progress In Practice, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 1, no.7, July - September 1999.

From Uncertainty Towards Enlightenment, Experiences of Action Learning, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 1, no.9, April - June 2000.

Learning to Make a Difference, Experiences of Action Learning, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 1, no.10, July - September 2000.

What Has Been Achieved, Special Feature, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume, no.1, 12, 2001.

Towards Collaboration, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume, no.1, 13, 2001.

What Has Been Achieved, Progress In Practice, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 2, no.1, January-March 2002.

Towards Collaboration, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Volume 2, no.1, January-March 2002.

Young, S 2002: **Towards Collaboration**, Published in Action Learning and Research Link Up. A publication by and for individuals who desire to bring together research and practical experience, Vol (2), No. (1), P49

Evaluative Report, **"The Selection of Action Learning Set Facilitators for Primary Care Trusts"**, A Collaborative report, Dr Davina Clarke: Senior Research Fellow, the Revans Centre, Elaine Clarke: Researcher at the Revans Centre, Dr Donna Vick: Senior Research Fellow, the Revans Centre, Stephen Young: Researcher at the Revans Centre, Professor David Botham, Director of the Revans Centre, 25th March 2003

Case Study Involvement, **"Managing Without Shoes",** Putting an empowering approach into practice is extremely challenging and requires conscious questioning and reflection, PPI Monitor, May 2004, a Bearhunt publication

Appendix 7

Conference and Workshop Presentations

- "Towards Collaboration Between Service Users and Providers", A workshop with the Revans Centre for Action Learning and Research, and the Institute for Social Action Research at Swinburne University, Victoria, Australia in Partnership with the Mental Health Services of Salford NHS Trust, July 2001.

- Developing a Vision for the Revans Centre, A Creative Visualisation Workshop at the Centre's Development Day, September 2001.

- Involving Communities in Regeneration, Social Action Research Conference, Action Learning As a Process for Change, February 27 2002.

- Health Entrepreneurship in the NHS, London, Workshop on "Entrepreneurship in Mental Health, London, April 2002.

- Workshop for the Primary Care Team Executive and Local people. Facilitated a workshop on 17th June 2002 with Salford PCT Executive Team and local people from Seedley and Langworthy. This workshop was part of my work at the Centre for Community Learning . The purpose of the workshop was to:

1. Re confirm the vision for the Langworthy Corner stone
2. Inform stakeholders of the progress made by the Langworthy Cornerstone
3. To agree plans for governing Langworthy Cornerstone.

- "Unlocking Community Learning", A workshop for the Education Centres Association in partnership with the North West Regional Development Agency and the North West Regeneration Network, "Action Learning and the Centre for Community Learning", March 2003.
- Response to the national consultation "Choice responsiveness and equity in the NHS and Social care – Fair for all personal to you", A Workshop with representatives form all North West Mental Health Trust, October 2003

- NHSU, Learning Coordinators Development Day, 15th July 2004 The development of an action learning approach to consider three key problems previously identified,

- NHSU and Blood Transfusion Service, Learning Cultures Seminar, 9th June 2004, Workshop, Action Learning – A Revans Approach, Scarmen Centre Warwick University

- NHSU Institute, Innovative Approaches to Work Based Learning in Health and Social Care, Workshop, A Case Study on Engaging with and contributing to communities of Interest, Northcote House, Sunningdale Park, Sunningdale 1st & 2nd September 2004

- NHSU Managing Health and Social care, 6th Annual Conference, "Sustaining Learning Communities, Developing a Vision of a Learning Community – A Creative Visualisation, Ramada Jarvis Hotel, Sutton Coldfield, Birmingham, 28th & 29th September 2004

- NHSU Managing Health and Social Care-Management and Leadership Network, Action Learning – A Process for Influencing Work Based Practice, Bolton Institute 6th October 2004

- National Primary and Care Trust – NatPact, Making Improvement Happen – Sustaining Action Learning. Case Studies - Sharing Experiences of Service Development Through Using An Action Learning Approach. 7th October 2004

- NHSU, Developing an Action Learning Network, Workshop, February 8th 2005

- An Introduction to Action Learning, Sefton Social Services Development Day, 6th June 2005

- Workshop, An Introduction to Action learning, University of Bolton, Annual Learning and Teaching Conference, 6th July 2005.

- Supporting the development of Action learning Set Advisers, Introductory Workshop, Mersey Care Mental Health NHS Trust, 14th July

Appendix 8

The Salford Social Entrepreneurs' Programme.

2.1 Purpose.

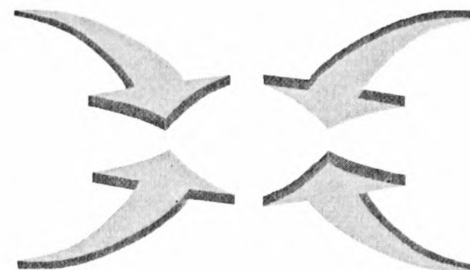
To increase the confidence, capacity and skills of local people

- ❑ to tackle the problems of their own communities
- ❑ to give them access to local and national support networks
- ❑ to bring about practical improvements in Salford.

2.2 Aims and objectives.

Local aims:

- provide the Team with skills and training to become social entrepreneurs capable of setting up and sustaining local projects
- expand the horizons of the Team members
- obtain a new perspective on social exclusion
- deliver the capacity for projects to encourage social inclusion
- mobilise human and financial resources.



Local objectives:

- develop the social economy
- empower local people
- build capacity for future self-help
- provide skills and training for sustainable regeneration
- increase volunteering and involvement
- increase sense of ownership in population
- a blueprint for tackling social exclusion elsewhere.

➢ Vision of an organisation to support social entrepreneurs in Salford . . . Greater Manchester . . . North-West England.

National aims:

- a national network of social entrepreneurs
- other perspectives and new ideas to tackle social exclusion.

National objectives:

- provide experience and data to feed into Government Strategy
- provide a blueprint for tackling social exclusion that can be replicated.

➢ Linked to the Social Exclusion Unit.
➢ Informing Government policy and strategy on social exclusion.

2.3 The Approach.

"Learning by doing" through experience, inquiry and discussion. For entrepreneurs:

- People learn best by taking action.
- Practitioners and organisations with a track record provide the most valuable material.
- Expert knowledge is of most value when directly relevant to current need to know.
- People can learn much from one another.
- Self-awareness enables people to use talents, make choices, and solve problems better.
- Individuals have different learning needs and learn in different ways.
- Values are as significant as action.

2.4 Core Learning Principles.

♦ Action learning.
♦ 'Just-in-time' learning.
♦ Person-centred learning.

2.5 The Learning Themes.

❑ social change and social policy.
❑ entrepreneurial behaviour.
❑ the basic tools of entrepreneurship.
❑ team work and community participation.

2.6 The Course Elements.

(a) Learning by doing – innovative projects.

- Project development plan.

- Support from Local Coordinator and Tutor.

(b) Learning from practitioners - study days.

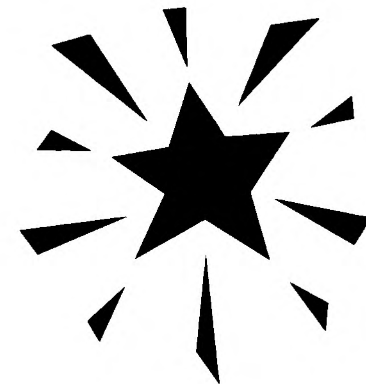
- 'Expert witnesses': leaders and role models.
- Skills training.
- Visits to other organisations.
- Individual and group work.

(c) Learning from each other - peer education.

- Action learning set.
- National network.
- Partnerships.

(d) Learning across the country – study weeks and national conferences.

- Study weeks in London.
- Cross-city visits.
- National conferences.



(e) Support and mentoring.

- Supporters' Network.
- Mentors.

(f) Personal development and learning.

- Personal development plans.
- Personal learning accounts.
- Open learning.
- Personal learning diaries.

Appendix 9

MENTAL HEALTH SERVICES
of SALFORD
NHS TRUST

Tel. No. 0161 772 3621
Fax No. 0161 772 3639

Your Ref:
Our Ref: RL/ac/13a

5 July 1999

Chris Dabbs
Salford Community Health Council
22 Church Street
Eccles
Manchester
M30 0DF

Dear Chris

School for Social Entrepreneurs Project for Salford People

I refer to your fax message of the 2 July asking for support for the proposal to establish a project in Salford for people who are social entrepreneurs. I am very pleased, on behalf of the Mental Health Services of Salford Trust, to offer our support to this initiative.

The initiative is consistent with the broadest of the Trust's objectives, to contribute to the development of the health and well-being of people in Salford, and to build successful partnerships with local people and local organisations to achieve these aims. Several of the staff of this Trust are contributing actively, on secondment or on a part time basis, to the work of the Manchester, Salford and Trafford Health Action Zone. I see the social entrepreneur training in Salford as a potentially very exciting development of this initiative.

A number of people within the Trust, most especially but not only Steve Young, the Director of Service Development, would, I am sure, be only too pleased to contribute personally to the initiative.

I am copying this letter and your message to Steve Young and to Gary McNamee, so that they can consider whether any local people with whom they may be in contact might be encouraged to contact you about becoming social entrepreneurs.

Yours sincerely

Robert

R H Lee
Acting Chief Executive

c.c. **Gary McNamee**
Steve Young

Appendix 10

Action Learning Research Set Colleagues

Linda Dack
Linda is a nurse/midwife and health visitor. When she joined the set she was a manager, managing professionals allied to medicine and leading on research and development in a NHS Community Trust. She initially stated that she had a blind faith in action learning and wanted to research how to involve health practitioners in the clinical effectiveness agenda. She struggled with the tensions she experienced as she moved from clinician to manager. She has had to handle that tension in a challenging work environment and although she has experienced some personal difficulties I believe she has become a stronger person. In fact it has given her the courage to move to a new job in a neighbouring Trust.

Steven Grainger
Steve when he joined the set worked for Manchester Children's' Hospital and when we first met he was eager to inform us that he has no "O" or "A" levels and no certificates in education. He has had a traditional apprenticeship and his background was in public transport for 20 plus years until he was made redundant. This appears to have had a profound effect on Steve, but I am not clear about the depth of this. He next became responsible for health and safety within the Trust which merged with Manchester Royal Hospitals Trust and his interest is taking action to understand the effects of violence and aggression on staff. Not the immediate physical impact but the "psychological impact". As I heard more about Steve's research I started to see a deeply caring side to Steve.

Steve later gained promotion and whilst writing this Thesis was employed by Warrington Primary Care Trust (PCT).

A Liverpudlian by background, he was quick to inform us that if we feed him a line he will crack the joke. He wasn't wrong. Steve is an active set member and is eager to learn and I find his honesty challenging but refreshing.

Caroline Altounyan
When she commenced in the set Caroline worked for the University of Salford in the Department of Professional Studies, working 3 days a week. She informed us of her need to balance her work with the demands of a family. She described her need to undertake a Ph.D. in order to legitimise her academic status. This appeared to be an indication of Caroline's insecurity, and the importance that the University system places on staff having formal academic qualifications. She indicated that having her work published would legitimise this status. As the set progressed we learnt that Caroline had become disillusioned with her work in the department of Professional Studies and pursued a transfer to the Revans Centre. Caroline was the first of the set members to show her vulnerability with the set. In doing so she made the first contribution to the development of the set. Thank you Caroline. She appears to be more fulfilled in her work since her move and I sense

that she feels more valued working in the Revans Centre. Because she has been growing into her new role she has been developing her thinking about the focus of her research. It took an incredible amount of time for Caroline to develop a focus for her research but she eventually settled on exploring what "communities of Interest" are within the context of action learning.

John McDonald
John has worked for 20 years in the construction industry. He started his working life as an apprentice joiner; he supports, and is a great believer in the apprenticeship movement. He also holds high values for family life. He has been learning about action learning through actively being involved in a construction industry action learning set, which was part of Donna Vick's (our set advisers) research. John's interest and focus for his Ph.D. is exploring how you can integrate the various work sites into the local communities, making them safe, secure and sound throughout the contracting phase through actively engaging local people in taking some responsibility for ensuring the site remains safe when contractors are not on site. The motivation to do so was influenced by recurrent damage/thefts from the building site.

John joined the set and demonstrated an incredible amount of enthusiasm and I waited with anticipation what John's contribution to the set would be. Unfortunately John's enthusiasm for "Action" wasn't matched with his enthusiasm for talking. John's involvement gradually diminished from being late to meetings, to not even informing us that he was unable to attend (despite having agreed this as a ground rule early on). After numerous contacts from most of the set members and John's lack of response, we could only conclude that John has decided not to continue. I can only think that John's busy work schedule has prevented him from continuing. I wish him well.

Salford City's Community Strategy

Participants Community Profiles

Introduction
In 1992 the City Council developed a Community Strategy to ensure that local people participate in local decision making and shape local service delivery.

The City has been broken down into 9 service delivery areas with area based Community Committees. These Committees develop local Community Action Plans (CAPs) for their area. Devolved budgets of £1 per head of population allow Community Committees to progress some of the priorities from their CAP and bring in match funding from other sources. Community Committees will play an increasingly important role in developing scrutiny of service delivery.

Each Community Committee has developed an action plan that is directly fed into the community planning process. Local people want to see investment in the priorities they have recognized within their own neighbourhoods, particularly in terms of crime, environment, young people and jobs. These issues are consistent with research recently undertaken through the City's Quality of Life Survey.

The community profiles presented here give a flavour of the problems in the communities in which the participants of the Salford Social Entrepreneur programme are undertaking their projects.

Little Hulton - Jay Brennan, Mary Ryan, John Pennington

The Area

Little Hulton has experienced an economic decline and an increase in social and housing problems. Significant attempts are being made to try and arrest this decline through SRB 3, Capital Challenge and private partnerships.

Key Issues Facing the Community

Despite significant investment, Little Hulton continues to suffer significant levels of deprivation. The Index of Deprivation 2000 indicated that both Little Hulton and Walkden North have significant health problems. The area has the highest amount of recorded incidents for all key crimes, with particular problems in terms of burglary and juvenile nuisance. Unemployment and lack of skills are particular problems. Other key issues facing the community relate to the proposed closure of Little Hulton Community School, the proposal for open cast mining in the area, and the need to develop an exit strategy for the SRB programme once it ends in 2002.

Key Priorities for Action

The key priorities are:
- To consider options for there development of Little Hulton Community School;
- To improve transport provision;

- To sustain environmental and housing improvements undertaken through the SRB 3 and Capital Challenge programmes;
- To improve skills and access to employment and training opportunities;
- To develop a strategy to tackle business crime through the use of CCTV;
- To engage young people through diversionary activity and promote positive citizenship.

Ordsall and Langworthy
The Area
The Ordsall and Langworthy Community Committee Area forms the southern most part of Salford's inner-City bounded by the Manchester Ship Canal on 2 sides. It comprises the old docks that are now better known as Salford Quays. They are the location of the Lowry and other housing and leisure developments. The eastern half of the Community Committee Area was an area of terraced housing which underwent clearance in the 1960s. The area has good links to the motorway system and the Metrolink is now linked to the Quays and Langworthy, on the way to Eccles. Langworthy is an area that was identified by Jack Straw as being an area in urgent need for regeneration, and is an SRB5 area. It is an area suffering from social exclusion and physical decline with many people suffering from negative equity because of a slump in house prices, which has led to high levels of people wanting to leave the area.

Key Issues Facing the Community and Priorities for Future Action
In the recent Index of Deprivation Ordsall and Langworthy's ranking within the City did not change, although both wards' position nationally has deteriorated significantly and both remain in the top 10% most deprived wards in England. The Index highlighted significant levels of child poverty. Ordsall ranked 12th nationally for child poverty, with over 82.9% of children living on means tested benefit, and 16th for educational deprivation. Langworthy also shows significant levels of deprivation ranked 153rd nationally for child poverty, with 69.9% of children living on means tested benefit and 164th for health deprivation, out of 8,413 nationally. The Community Committee Area has at least four distinctive neighbourhoods, and although there is commonality across all four, only three of the neighbourhoods are described as they relate to the SSE participants.

Salford Quays – Michael Felse
Salford Quays has been an extremely successful regeneration project, breathing new life into the old Salford Docks area. Home of the Lowry, the Quays area houses substantial office developments, recreation facilities and accommodation. The major issue facing the Quays is to ensure the sustainability and continuing success of developments to date.

Ordsall and Stowell – Charlotte Richards
This area comprises the remainder of the Ordsall ward, apart from the Quays. It comprises mainly social housing and has seen a major physical redevelopment of that housing stock and its environment over the past 10 years. The crucial question now is about sustainability of that development. Steps are currently underway in Ordsall to identify future priorities in partnership with the local

community and all key stakeholders. Priorities as identified by local people in a recent survey listed their top five as:

- more Police presence;
- safe places for young people to go which they can afford;
- curb anti-social behaviour and nuisance neighbours;
- slow down speeding traffic;
- somewhere for children to go after school.

Seedley and Langworthy – Bernadette Wright

The key priorities for the SRB5 area have been identified following extensive consultation with the local community and as outlined in SRB5 proposals for the area. They are:

- Securing the long term redevelopment of the area through the Physical Development Master Plan;
- Resolving the issue of negative equity through Home Swaps;
- Ensuring local people have access to high quality employment and training opportunities;
- Releasing capacity within the community;
- Tackling crime and anti-social behaviour and improving community confidence;
- Supporting retail and shopping provision;
- Supporting the development of the new Cornerstone Centre.

Swinton – Jeanette Ball

The Area

The Swinton SDA comprises three wards: Swinton North, Swinton South and Pendlebury. Much of the area is a stable and attractive suburban residential area, though there are pockets of deprivation. It is a stable and relatively prosperous area of Salford although a number of small pockets of deprivation have begun to appear over recent years. The City Council has recognised the need for project-based and environmental works in the Clifton Green area, the Valley Estate, Ackworth Road and Beech Farm Estate.

Key Issues Facing The Community

The area has generally lower rate of unemployment than the national average. Educational attainment is on the whole above average for the City and on a par with national levels. The crime statistics highlight particular problems with Swinton town centre suffering high levels of vehicle crime. The Poets Estate has a high level of juvenile nuisance and house burglary and the Valley Estate has high overall levels of crime.

Community Priorities for Action

Three overall priorities have been identified focusing on:

- Maximising opportunities for Children and Young People - through the provision of accessible and affordable activities at a local neighbourhood level;
- Tackling crime and fear of crime;

- Working for a good quality housing and street environment for all residents.

Lower Broughton – Gwen Rolfe
The Area
The majority of the area is currently the focus of the City's SRB 2 regeneration programme in partnership with Manchester City Council under the Cheetham & Broughton Initiative until March 2003. The area is designated a Priority Area for Regeneration by the City Council requiring major change and continued investment to tackle the deep rooted problems which exist, particularly in the Broughton area. A major study is underway to determine the long term vision for the area. Significant opportunities exist in the Blackfriars area with the Chapel Street Initiative attracting substantial private sector interest and investment.

Key Issues Facing The Community
The area is characterised by high levels of deprivation, particularly in the Broughton Ward. The Index of Deprivation places the area's problems within the worst 7% nationally. Crime levels are high and educational attainment at secondary level is below national average. Both social and private sector housing in the area is deteriorating rapidly and there is a high number of lone parent families. The problems facing the area are acute. However, the area is characterised by a strong and vocal community and voluntary sector supporting the regeneration programmes in place.

Community Priorities for Action
- Helping the community by supporting the Broughton Trust and the local Community Development Trust, and securing long-term funding for the Broughton Community Resource Centre.
- Helping to combat crime and disorder by developing projects to prevent secondary school pupils from exclusion; identifying crime hot-spots and trying to find ways to identify the people involved and tackle the problems; continuing the funding to provide two additional police officers to work in the local area; providing play opportunities through the Broughton Blackfriars Play Development Project and improving the security of local businesses.
- Tackling health issues by coordinating and developing out-of-school and leisure facilities for young people and establishing a Community Development Worker focusing on Health.
- Working with young people by continuing to develop projects to help and work with children excluded from school; ensure help is available to children in school when they need it; continuing the development of North Salford Youth Centre and planning and supporting projects to create holiday activities through the Play Development Project.
- Finding people jobs and training by reducing unemployment in the area by working with the Lower Broughton Job Shop, the New Deal Programme and the Employment Charter; raising standards and achievement in education and training; providing access to education, training and advice; supporting and encouraging community economic development and community enterprise and providing advice and support to local businesses.

- Working with local businesses by providing professional advice and support to businesses in the area; reducing the impact of crime towards businesses through a practical support and improving industrial/commercial premises by using environmental grants.
- Improving the environment by improving and redeveloping a number of open spaces in the area; improving the appearance of the housing stock and the environment, particularly where residents have reported problems; developing a solution to the Marlborough Road and St Thomas' Schools site problems; cracking down on people dumping rubbish in the area and prosecuting anyone caught doing it and improving education on environmental issues.

Charlsestown – Kevin Coakley

The Area

The area is characterised by different neighbourhoods. Higher Kersal, encompassing the Broughton Park area, is mainly residential and home to one of the largest Orthodox Jewish communities outside London. The Precinct area is the most densely populated area of Pendleton Ward. It is characterised by Local Authority-owned high rise blocks and also the Salford Shopping City. The Precinct Forum has been developed and provides a focus for resident involvement in the area. Lower Kersal and Charlestown form the central area of the Pendleton and Kersal Wards.

Key Issues Facing The Community

Across the Community Committee area, crime rates are higher than the City average and overall crime is considered the biggest concern. Despite good results within primary schools in the area, educational attainment at the secondary level is well below the City and national averages. Health problems are particularly evident with the Standard Mortality Rate in Pendleton almost twice the national average.

Community Priorities for Action

The main priorities focus on:

- Supporting the New Deal for Communities programme for Charlestown/Lower Kersal. The Charlestown/Lower Kersal Partnership has secured £53 million over the next 10 years to; reduce crime, help children and young people, improve the physical environment, improve health, reduce unemployment and raise standards of educational achievement and skills;
- Sustaining the environmental, social and economic improvements that have resulted through the City's SRB 1 programme;
- Developing methods of working with the Jewish Community that appreciate and complement their culture;
- Continuing to develop community capacity through the Community Committee.

Appendix12

REGIONAL STATISTICS
NHS users: the silent majority

Most people (76%) have never been asked about what they want from local NHS services

North East 74%
Yorkshire and Humberside 71%
East Midlands 77%
Eastern 76%
South East 74%
Scotland 79%
London 82%
South West 77%
West Midlands 67%
North West 78%
Wales 75%

90% of the public agree that local people ought to have a say in how health services are run

North East 99%
Yorkshire and Humberside 94%
East Midlands 93%
Eastern 87%
South East 90%
Scotland 84%
London 86%
South West 86%
West Midlands 93%
North West 88%
Wales 98%

Many people (50%) feel that they have no power to influence what happens with their local NHS services

North East 47%
Yorkshire and Humberside 50%
East Midlands 47%
Eastern 50%
South East 51%
Scotland 44%
London 41%
South West 53%
West Midlands 59%
North West 53%
Wales 58%

26% of people saying that they think it is a waste of time to involve ordinary people in the first place.

North East 31%
Yorkshire and Humberside 25%
East Midlands 20%
Eastern 25%
South East 23%
Scotland 27%
London 20%
South West 28%
West Midlands 31%
North West 30%
Wales 32%

Three out of four people (74%) would like to have a say in how their surgery is run.

North East 73%
Yorkshire and Humberside 75%
East Midlands 79%
Eastern 78%
South East 71%
Scotland 65%
London 73%
South West 69%
West Midlands 69%
North West 81%
Wales 84%

Three out of four people (74%) would like to have a say in how their local hospital is run.

North East 70%
Yorkshire and Humberside 76%
East Midlands 75%
Eastern 77%
South East 77%
Scotland 72%
London 77%
South West 71%
West Midlands 72%
North West 69%
Wales 83%

References

ABALOS E, CARROLI G, MACKEY ME, BERGEL E. 2001, *Critical appraisal of systematic reviews:* The WHO Reproductive Health Library, No 4, Geneva, The World Health Organization,(WHO/RHR/01.6).

ALLISON, B, 2006, *Action Learning and the process of Research and Development, Outline of a projects life.* Unpublished paper.

ARGYRIS, C., PUTNAM, R., & MCLAIN SMITH, D. 1985, *Action science: concepts, methods, and skills for research and intervention*, San Francisco: Jossey-Bass.

ARNSTEIN, S, 1969, *A Ladder of Participation.* American Institute of Planners Journal, 1969;35: 216-224.

ATKINSON, P., HAMMERSLEY, M 1994. *Ethnography and Participant Observation.* In Norman Denzin and Yvonna Lincoln (Eds.), Handbook of Qualitative Research. Thousand Oaks: Sage, pp.249-261.

AUDIT COMMISSION. 1996 *What the Doctor Ordered? A Study of GP Fundholders in England and Wales.* HMSO, London.

BANDURA, A, 1997. *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall, Inc. pg227.

BAQUER,A., 2002. *A comparative in depth study of disabled and non disabled girls in an urban slum of New Delhi.* Un published paper.

BARNES, M., 1999. *Users as Citizens: Collective Action and Local Governance of Welfare.* Social Policy and Administration 33 (1), Pgs.70-80.

BARNES M. & McIVER S. 1999. *Public Participation in Primary Care.* HSCM University of Birmingham, Birmingham.

BARTON, R., 1976. *Institutional Neurosis.* 3rd ed. Bristol: John Wright & Sons. Pg.2.

BATTRAM. A, 1998. *Navigating Complexity, The Essential Guide to Complexity Theory in Business and Management*, The Industrial Society. Pg63.

BENTLEY, T., 1998a. *Introduction.* Learning Beyond the Classroom. 2nd ed. Routledge, pg1.

BENTLEY, T., 1998b. *The Challenges.* Learning Beyond the Classroom. 2nd ed. Routledge, pg 9.

BENZEVAL. EDS., JUDGE, M., WHITEHEAD, M., 1996a. *Tackling Inequalities in Health – An Agenda for Action.* King's Fund

BENZEVAL. EDS., JUDGE, M., WHITEHEAD, M., 1996b. *Tackling Inequalities in Health – An Agenda for Action.* King's Fund

BOOTH, A, 2006, *Lifting The Curse of the Effectiveness Review: Challenging Assumptions about Systematic Review Methods.* Available at:
http://www.joannabriggs.edu.au/services/2006CochSymp/pdfs/AndrewBooth_July11.pdf
[Accessed 26th May 2009]

BOTHAM, D., VICK, D., 1998. *Action Learning and the program at the Revans Centre*, Performance Improvement Quarterly, (11(2) pgs. 5-16)

BOTHAM, D. MORRIS, J., 1998. *Botham Morris Triangle.* Revans Centre Publication, Link-Up 2002. Pg.5.

BOTHAM, D., 2000. , *Workshop on Making Improvement Happen: Sustaining Action Learning.* National Primary and Care Trust Development Programme.

BOURNER, T, 2000, *Practitioner Centred Research and the PhD,* New Directions In Action Learning, Seminar Series, The Revans Institute for Action Learning and Research, University of Salford.

BOURNER, T, SIMPSON, P, 2005, *Practitioner Centred Research and the PhD,* Action Learning, Research and Practice, Volume2 Number 2, September 2005, pg 141, Routledge.

BOYDELL T, BLANTERN. C, 2007 , *Action Learning as Relational Practice.* Action Learning Research and Practice, Volume 4, No 1. April 2007, Pg 97. Routledge.

BRECHIN, A. (1993) *Sharing, in Reflecting on research practice. Issues in health and social welfare,* P. Shakespeare, D. Atkinson and S. French (Eds), Open University Press, Buckingham, UK, pp70-82.

BRENNAN,J., 2000a. *Learning to make a difference.* Link-Up, July – September, Vol 1, No10, pg.5.

BRENNAN, J., 2000b. *Learning to make a difference.* Link-Up, July – September, Vol 1, No10, , pg 5.

BRENNAN, J., 2000c. *Learning to make a difference.* , Experiences in action learning, Link-up, July – September, Vol1, No10, Pg5

BRENNAN,.J., 2001a. *What has been achieved*? Link-Up, Special Feature, , January – March, Pg 2.

BRENNAN,.J., 2001b. *What Has Been Achieved?* Link-Up, Special Feature, January-March, Pg2.

BROOKS, F. 2008 *Nursing and public participation in health: an ethnographic study of a patient council,* International Journal of Nursing Studied, 45(1): Pgs 3.13.

BRYMAN, A, 2008. Social Research Methods, Oxford University Press, Pg 433.

CABINET OFFICE, 2006. *The UK Governments Approach to Public Reform.* Prime Ministers Strategy Unit.

CIVIL RENEWAL UNIT., 2005. *Together We Can.* Unpublished paper, Home Office.,

CIVIL RENEWAL UNIT., 2006. *Active Learning for Active Citizenship.* Civil Renewal Unit, Active Communities, Home Office

COAKLEY, K., 2005. *Notes from an Interview by Young S.* Unpublished notes.

COGHLAN, D, PEDLER, M, 2006. *Action learning dissertations*, Action Learning Research and Practice, Volume 3, Number 2, September 2006, pg 128, Routledge.

COLGAN, S, DR., 2003. *Letter Confirming Research Approval and Conditions.* Unpublished paper, Medical Director, Bolton Salford and Trafford Mental health NHS Trust.

COOK, D., 2002. *Consultation, for a Change? Engaging Users and Communities in the Policy Process.* Social Policy and Administration, Volume 36, Number 5.

COULTER, A, *Paternalism or partnership? Patients have grown up and there's no going back,* BMJ Volume 319 18 September 1999 pp719-20

CUNNINGHAM, I, 2000, *The Importance of Learning, What should we be learning? The Case of the Warrior and the Sage,* [on line]. Available at: WWW.selfmanagedlearning.org/IansReport/IansReport.htm.
[Accessed 27th July 2007]

DABBS, C, 1999, *Salford Social Entrepreneurs Programme 1999-2000, Report on the Development Phase,* Unpublished report,pg.37

DABBS, C., 2000a. *SSE Report November.*,1999 to January 2000, pg4.

DABBS, C., 2000b. *SSE Report November.*,1999 to January 2000, pg5.

DABBS, C., 2000. *Salford Social Entrepreneur Programme, Report on the Pilot Programme,* 1999 – 2000, Pg2.

DABBS, C., 2002. *Brighter Sparks, SSE Programme Progress Report.* Pg 46.

DEARNLEY, C, 2005, *A reflection on the use of semi-structured interviews,* Nurse Researcher, Vol. 13 Issue 1, p19-28, 10p

DEEGAN, P., 1993. *Recovering our sense of value after being labelled mentally ill.* Journal of Psychosocial Nursing and Mental Health Services, 31:7 – 11.

DEEGAN, P., 1998. *Recovery: the lived experience of rehabilitation.* Psychosocial Rehabilitation Journal, 11:11-19.

DEVELOPING PATIENT PARTNERSHIPS, 2006. *NHS Users – The Silent Majority.* [on line]. Available at:
WWW.dpp.org.uk.
[Accessed 30th March 2006]

DENZIN NK, LINCOLN YS 1994, *Handbook of Qualitative Research.* Sage, Thousand Oaks CA.

DENZIN, N.K., LINCOLN Y.S., 2000 *The Handbook of Qualitative Research,* Chapters 1, 2, 3, 6 and 7, 2nd Edition, London, Sage Publication

DEPARTMENT OF HEALTH AND SOCIAL SERVICES, 1983. Griffiths.R, *NHS Management Enquiry.* London: HMSO. pg12.

DEPARTMENT OF HEALTH, 1998. *Modernising Mental Health Services: safe, sound and supportive.* London: HMSO, pg7.

DEPARTMENT OF HEALTH, 1990. *NHS and Community Care Act.* London: HMSO.

DEPARTMENT OF HEALTH, 1994. *Capital Investment Manual.* London: HMSO

DEPARTMENT OF HEALTH, 1999. *Health Act.* London: HMSO.

DEPARTMENT OF HEALTH, 1999. *Saving Lives: Our Healthier Nation.* London: HMSO.

DEPARTMENT OF HEALTH, 1999a. *National Service Framework for Mental Health.*: London: HMSO.

DEPARTMENT OF HEALTH, 1999b. *National Service Framework for Mental Health,* London: HMSO, Pg14.

DEPARTMENT OF HEALTH, 1999c. *National Service Framework for Mental Health.* London : HMSO. Pg115.

DEPARTMENT OF HEALTH, 1999d. *National Service Framework for Mental Health.* London, HMSO: Pg14.

DEPARTMENT OF HEALTH, 1999e. *National Service Framework for Mental Health,* London: HMSO, pg9.

DEPARTMENT OF HEALTH, 1999f. *National Service Framework for Mental Health*, London: HMSO.

DEPARTMENT OF HEALTH, 2000a. *The NHS Plan – A Plan for Investment, a Plan for Reform*. London: HMSO.

DEPARTMENT OF HEALTH, 2000b. *The NHS Plan – A Plan for Investment, a Plan for Reform*. London: HMSO, pg88.

DEPARTMENT OF HEALTH, 2000c. *The NHS Plan – A Plan for Investment, a Plan for Reform*. London: HMSO.

DEPARTMENT OF HEALTH, 2000d. *The NHS Plan – A Plan for Investment, a Plan for Reform*. London: HMSO.

DEPARTMENT OF HEALTH, 2000a. *Making it Happen – A Guide to Mental Health Promotion*. London: HMSO.

DEPARTMENT OF HEALTH, 2000b. *Making It Happen - A Guide to Delivering Mental Health Promotion*, London: HMSO. Pg 25.

DEPARTMENT OF HEALTH, 2000c. *Making it Happen – A Guide to Delivering Mental Health Promotion*. London: HMSO

DEPARTMENT OF HEALTH, 2001a., *Health and Social Care Act 2001*. London: HMSO

DEPARTMENT OF HEALTH, 2001b., *Health and Social Care Act 2001*. London: HMSO

DEPARTMENT OF HEALTH, 2001c., *Health and Social Care Act 2001*. London: HMSO

DEPARTMENT OF HEALTH, 2001. *Shifting the Balance of Power within the NHS: Securing Delivery*. London: HMSO.

DEPARTMENT OF HEALTH, 2001a. *Strengthening Accountability, Involving Patients and The Public, Policy Guidance, Section 11 of the Health and Social Care Act*. London: HMSO.

DEPARTMENT OF HEALTH, 2001b. *Strengthening Accountability, Involving Patients and The Public, Policy Guidance, Section 11 of the Health and Social Care Act*. London: HMSO.

DEPARTMENT OF HEALTH, 2001c. *Strengthening Accountability, Involving Patients and The Public, Policy Guidance, Section 11 of the Health and Social Care Act*. London: HMSO.

DEPARTMENT OF HEALTH AND THE NEIGHBOURHOOD RENEWAL UNIT, 2002. *Health and Neighbourhood renewal*. London: HMSO. pg34.

DEPARTMENT OF HEALTH, 2003. *Health and Social Care Community Health and Standards Act*. London: HMSO.

DEPARTMENT OF HEALTH, 2003a. *Fair for all personal to you, Choice, responsiveness and equity in the NHS and social care, A national consultation*, London: HMSO. Pg3.

DEPARTMENT OF HEALTH, 2003b. *Fair for all personal to you, Choice, responsiveness and equity in the NHS and social care, A national consultation*, London: HMSO.

DEPARTMENT OF HEALTH, 2004. *NHS Improvement Plan-Putting People at the Heart of Public Services*. London: HMSO.

DEPARTMENT OF HEALTH, 2004. *Patient and Public Involvement in Health: The Evidence for Policy Information*. London: HMSO. pg1.

DEPARTMENT OF HEALTH, 2004. Patient and Public Involvement in Health: The Evidence for Policy Information. London: HMSO. Pg7.

DEPARTMENT OF HEALTH, 2004a. *Choosing Health, Making Healthy Choices Easier*. London: HMSO.

DEPARTMENT OF HEALTH, 2005a. *Creating a Patient – Led NHS, Delivering the NHS Improvement Plan*, London: HMSO. Pg 3.

DEPARTMENT OF HEALTH, 2005b. *Creating a Patient-Led NHS, Delivering the NHS Improvement Plan*. London: HMSO.

DEPARTMENT OF HEALTH, 2005c. *Creating a Patient-Led NHS, Delivering the NHS Improvement Plan*. London: HMSO.

Department of Health, 2005d. Creating a Patient-led NHS, Delivering the NHS Improvement Plan. London: HMSO.

DEPARTMENT OF HEALTH, 2005. *Commissioning a Patient-Led NHS*. London: HMSO.

DEPARTMENT OF HEALTH, 2006. *Our Health, Our Care, Our Say: a new direction for community services*. London: HMSO.

DEPARTMENT OF HEALTH, 2006, *Government response to "A stronger local voice*". London, HMSO

DEPARTMENT OF HEALTH, 2007, Commissioning framework for health and well-being, London, HMSO.

DEPARTMENT OF HEALTH, 2008, *Real Involvement*, London, HMSO.

DEVELOPING PATIENT PARTNERSHIPS, 2006. *NHS Users – The Silent Majority*. [on line]. Available at:

WWW.dpp.org.uk.
[Accessed 30th March 2006]

DIXON,N, 1998, *Dialogue at Work*, Lemos and Crane. Pg63.

DONALDSON R.J, DONALDSON LJ. 1998. *Essential Public Health Medicine*, LibraPharm Ltd. London, pg320.

FALK, I., GUENTHER, J. 2006. *Generalising from Qualitative Research: Case studies from Vocational Education and Training*, [on line]. Available at: www.avetra.org.au/publications/10-Guenther.pdf
[Accessed 24th June 2009]

FORSTER, R, GABE, J, 2008, *Voice or Choice? Patient and Public Involvement in the National Health Service Under New Labour*, International Journal of Health Services, Volume 38, Number 2, Pages 333 – 356, Baywood Publishing.

FRIER P., 1970. *Pedagogy of the Oppressed.* Seabury Press, New York.

GREEN, K. 1999, *Defining the Field of Literature: a personal approach*, Educational Action Research, Volume 7, No.1.

GREENHALGH, T. and PEACOCK, R. 2005, *Effectiveness and Efficiency of Search Methods in Systematic Reviews of Complex Evedence: audit of primary resources,* British Medical Journal 331: 1064-5

GUBA, E.G., LINCOLN, Y.S. 1994.. *Competing Paradigms in Qualitative Research. Handbook of Qualitative Research.* N.K. Denzin & Y.S.Lincoln. Thousand Oaks, U.S.A., Sage: p.107.

HAMILTON, D., 1994a *Traditions Preferences and Postures in Applied Qualitative Research*, Chapter 3, in Denzin NK, Lincoln YG, (1994a), The Handbook of Qualitative Research, op cit. 1st ed.

HAMILTON, D., 1994b *Traditions Preferences and Postures in Applied Qualitative Research*, Chapter 3, in Denzin NK, Lincoln YG, (1994b), The Handbook of Qualitative Research, op cit. 1st ed.

HAMMERSLEY, M. 1990. *Reading ethnographic research*, Longman, New York.

HANDY,.C., 1995. *Work.* Cities of Pride. Cassell, Pg92.

HAWKING, S., 2002. *Standing on the Shoulders of Giants.* The Great Works of Physics and Astronomy. Running Press. Pg ix.

HEALTH ACTION ZONE, MANCHESTER HEALTH AUTHORITY, SALFORD AND TRAFFORD HEALTH AUTHORITY, MANCHESTER CITY COUNCIL, SALFORD CITY COUNCIL, TRAFFORD METROPOLITAN BOROUGH

COUNCIL. 1998a. *Health Through Action – A Health Action Zone for Manchester, Salford and Trafford.* pg 2.

HEALTH ACTION ZONE, MANCHESTER HEALTH AUTHORITY, SALFORD AND TRAFFORD HEALTH AUTHORITY, MANCHESTER CITY COUNCIL, SALFORD CITY COUNCIL, TRAFFORD METROPOLITAN BOROUGH COUNCIL. 1998b. *Health Through Action – A Health Action Zone for Manchester, Salford and Trafford.* pg 2.

HEALTH EDUCATION AUTHORITY, 1999. *Social Action Research Project - Tackling Inequalities in Health.* London

HEALTH CARE COMMISSION, 2005. *State of Health Care.* [On line]. 2005. Available at: http://www.healthcarecommission.org.uk/nationalfindings/stateofhealthcare.cfm [Accessed 22nd July 2005].

HEER, B., WOODHEAD, D., 2002. *Promoting Health, Preventing Illness: Public Health Perspectives on London's Mental Health.* London: King's Fund

HERON, J., 1981. *Philosophical basis for a new paradigm*, in P.Reason and J.Rowan (eds), Human Inquiry: a source book of a new paradigm research. Chichester: Wiley.

HOGGETT. P, STEWART.M. RAZZAQUE.K, BAEKER.I, 1997. *Urban Regeneration and Mental Health in London.* Centre for Mental Health Services Development, King's College, London.

HOLMAN & LORIG, 2000. *Patients as partners in managing chronic disease*, British Medical Journal; 320: 526-7.

HOTHI, M. 2008, *Neighbourliness + Empowerment + Wellbeing, Is There A Formula For Happy Communities?* The Young Foundation.

HULL, J., 2005. *Notes from an Interview by Young S.* Unpublished notes.

JOINSON, A N, *Internet behaviour and the design of virtual methods,* In Hine, C (ed) Virtual Methods: Issues in Social Research on the Internet. Oxford: Berg, 2005, Pgs 21-34.

JONES, S., 2003. *Action Learning Proposal, Building and Sustaining Action Learning Across the North West.* National Health Service University. pg1.

JOWELL, T., 1998. *A Third Way for Public Health.* [0n line]. Nye Bevan Memorial Lecture. Available at: http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4024652&chk=IU47aV [Accessed 1st July 1998]

KENDRICK, T., BURNS. T., GARLAND, C., GREENWOOD, N AND SMITH, P. 2000. *Are specialist mental health services being targeted on the neediest*

patients? – the effects of setting up special services in general practice, British Journal of Clinical Practice, 50, 121, - 126

LEE, R., 1999. *School for Social Entrepreneurs Project for Salford People*, Unpublished Letter. Mental Health Services of Salford NHS Trust.

LEE, R., 2000a. Written Response to a proposal, Bolton Salford and Trafford Mental Health NHS Trust.

LEE, R., 2000b. Written Response to a proposal, Bolton Salford and Trafford Mental Health NHS Trust.

LEE, R., 2000c. Written Response to a proposal, Bolton Salford and Trafford Mental Health NHS Trust.

LEE, R., 2001. *Centre for Community Learning proposal*, Trust Board Paper. Bolton Salford and Trafford Mental health NHS Trust.

LEE, R., 2001. *Memo to Trust Directors*, Bolton Salford and Trafford Mental Health NHS Trust.

LEE, R., 2001a. Chief *Executives Objectives 2001 to 2002*, Bolton Salford and Trafford Mental health NHS Trust.

LEE, R., 2001b. Chief *Executives Objectives 2001 to 2002*, Bolton Salford and Trafford Mental health NHS Trust.

LOIS, M, BARTUNEK, J 1992, Insider/Outsider research teams: collaboration across diverse perspectives, Journal of Management Inquiry, ! (2): pg101-110

MANCHESTER EVENING NEWS, 2000. *Straw praises the crime-hit estate which came clean*, July.

MANCHESTER HEALTH AUTHORITY, SALFORD AND TRAFFORD HEALTH AUTHORITY, MANCHESTER CITY COUNCIL, SALFORD CITY COUNCIL, TRAFFORD METROPOLITAN BOROUGH COUNCIL. 1998b. *Health Through Action – A Health Action Zone for Manchester, Salford and Trafford*. pg 2.

MAYS N., GOODWIN N., KILLORAN A. & MALBON G. 1998, *Total Purchasing. A Step Towards Primary Care Groups*. King's Fund, London.

McDERMOTT, E, GRAHAM, H, HAMILTON, V, 2004, *Experiences of Being a Teenage Mother in the UK: A Report of a Systematic Review of Qualitative Studies*. [on line]. Available at: http://www.sphsu.mrc.ac.uk/Evidence/Research/Review%2010/SR%20Executive%20Summary.pdf
[Accessed 12th July 2009]

McGILL, I., BROCKBANK, A. 2004. *The Action Learning Handbook; powerful techniques for education, professional development and training*. London:Rouledge Falmer.

MEGGINSON, D., 2001. *Research as Personal Unfolding*, New Directions in Action Learning, Revans Institute, pg3.

MENTAL HEALTH SERVICES OF SALFORD NHS TRUST AND CITY OF SALFORD COMMUNITY AND SOCIAL SERVICES DIRECTORATE, July 1997. *Mental Health and Community Strategy.* Trust Board Paper.

MENTAL; HEALTH SERVICES OF SALFORD MENTAL HEALTH NHS TRUST. 1999. *Job Description.*

MIND. 1994. *Breakthrough – Making Community Care Work*, Pg9.

MINGERS, J. 2001 *Combining IS Research Methods: Towards a Pluralist Methodology.* Information Systems Research, Vol. 12, No.3, September 2001, Pg. 240-259

NATIONAL INSTITUE FOR MENTAL HEALTH ENGLAND, 2004, *Improving Mental Health and Well-being*, pg3.

PARSTON.G., 1998. *Preface.* Civic Entrepreneurship, Public Management Foundation, DEMOS, pg7.

PEARCE, U., 2006. *Audit on Labours Reforms.* The Guardian, March 2006.

PEDLER, M., COGHLAN, D., 2006 *Action Learning Dissertations: structure, supervision and examination.* Action Learning Research and Practice. Routledge. pg 133-134

PENNINGTON, J., 2005. *Notes from an Interview,* S Young

PFIFFERLING, J.H., 1980. *A cultural prescription for medico centrism.* In Relevance of Social Science for Medicine (eds L. Eisenberg & A. Kleinman), pp197-122. Dordrecht: Reidel.

PHILIPS, E., PUGH,D.S. 1994. *How To Get A PhD, A Handbook for Students and Their Supervisors*, University Press

PIDD, F., NEWBIGGING, K., 2002. *Public Health Information Report, Mental Health.* North West Public Health Observatory, Lancashire and Cumbria Zone. Pg 2.

POPAY, J., 1999. *Social Action for Health: Hopes, Expectations and Progress. Perspectives from Salford,* Report of a Seminar held November 1999.

POPAY, J., Picken, C., 1999. *Salford Social Action Research Project*, Salford and Trafford Health Authority.

POPAY, J., Picken, C., 1999. *Tackling Health Inequalities: The Salford Social Action Research Project, Phase 1.* A Proposal from Salford and Trafford Health Authority, Salford City Council, The University of Salford.

QUEENDOM.COM, *Classical Intelligence Test. Tests, tests and more tests.* 2006. [0n line]. http://www.queendom.com/tests/iq/classical_iq_r2_access.html [Accessed April 2005].

RAELIN, J.A, 1999, The action Dimension in Management: Diverse approaches to research, teaching and development. Management Learning 30, Number 2:115-125.

RAELIN, J.A. 2001, *Public Reflection as the Basis for Learning*, Management Learning, Volume 32(1) 11-30, Sage Publications.

RAELIN, J.A. 2001, *Public Reflection as the Basis for Learning*, Management Learning, Volume 32(1) pg 16, Sage Publications.

RAPPAPORT, J., 1981, *In Praise of Paradox: A social policy of empowerment over prevention.* American Journal of Community Psychology 9(1):1-24.

REASON, P. 1998, *Human Inquiry in Action, Developments in \new Paradigm Research,* Sage Publications

REASON, P., & BRADBURY, H. (2001). *Inquiry and participation in search of a world worthy of human aspiration.* In P. Reason & H. Bradbury (Eds.), *Handbook of action research: Participative inquiry and practice* (pg. 1-14). London: Sage.

REASON, P. 2006, *Choice and Quality in Action Research Practice.* Journal of Management Inquiry, Vol. 15 No 2, June 2006, pg187-203.

REASON, P., 1986. *Innovative Research Techniques*, Complementary Medical Research, 1(1): 23-29

REASON, P., HAWKINS, P., 1998. *Storytelling as Inquiry.* Human Inquiry in Action. Developments in New Paradigm Research. P. Reason. London. U.K. Sage. p 79-101.

REPPER, J., PERKINS, R., 2003a. *Social Inclusion and Recovery, A Model for Mental Health Practice*. Bailliere Tindell, p21.

REPPER, J., PERKINS, R., 2003b. *Social Inclusion and Recovery, A Model for Mental Health Practice*. Bailliere Tindell, p13.

REPPER, J., PERKINS, R., 2003c. Social Inclusion and Recovery, A Model for Mental Health Practice. Bailliere Tindell, p13.

REVANS, R.W. Action Learning in a Few Hundred Words. Found in the Revans Archive, Unpublished paper. University of Salford, no date recorded, Pg iv.

REVANS, R.W., 1980a. *Action Learning, New Techniques for Management*, Blond and Briggs Pg 297

REVANS, R.W., 1980b. *Action Learning, New Techniques for Management*, Blond and Briggs, Pg 228.

REVANS, R.W., 1982a, *Origins and growth of action learning*, Bromley, Chartwell-Bratt, Pg 247

REVANS, R.W., 1998a. *The A.B.C. of Action Learning, A Review of 25 Years of Experience*, The Revans Centre for Action Learning and Research, Pg11 (iii).

REVANS, R.W, 1998b. *The A.B.C. of Action Learning, A Review of 25 Years of Experience*. The Revans Centre for Action Learning and Research, Pg11 (iii).

REVANS, RW, 1998c. *The ABC of Action Learning, A Review of 25 Years of Experience*, The Revans Centre for Action Learning and Research, pg25.

REVANS, RW, 1998d. *The ABC of Action Learning, A Review of 25 Years of Experience*, The Revans Centre for Action Learning and Research, pg6.

REVANS, RW. 1998e. *The ABC of Action Learning, A Review of 25 Years of Experience*, The Revans Centre for Action Learning and Research, pg10.

RITCHIE, J, ZWI, A, BLIGNAULT, BUNDE-BIROUSTE, A SILOVE, D, 2009, *Insider-outsider positions in health-development research: reflections for practice. Development in Practice*, Volume 19, Number 1, February 2009, Routledge

ROLFE, .G. 1999. *Notes from Action Learning set meeting*, S Young, 21st December.

ROLFE, G., 2005. *Notes from an Interview, S.Young.*

ROSE, D. 2001, *Users' Voices, The perspectives of mental health service users on community and hospital care*, Sainsbury Centre for Mental Health, pg 7.

SANDELOWSKI, M., DOCHERTY, S., & EMDEN, C. (1997). *Qualitative metasynthesis: issues and techniques*. Research in Nursing and Health, 20, 365-371.

SALFORD PARTNERSHIP, *Community Plan, Our Vision for Salford, 2001 – 2006*. Strategy and Resources, City of Salford.

SANG, W., 1988. *Relocation Now, A Strategy for the Development of Prestwich Hospital*, Salford Area Health Authority.

SARACENO, B., 2004a. *Prevention of Mental Disorders, Effective Interventions and Policy Options*, Summary Report, Unpublished Report World Health Organisation. Pg4.

SARACENO, B., 2004b. *Prevention of Mental Disorders, Effective Interventions and Policy Options*, Summary Report, World Health Organisation.

SCHOOL FOR SOCIAL ENTREPRENEURS., SSE Programmes: [0n line]. via http://www.sse.org.uk/contact.php
[Accessed April 2002]

SCHRATZ and WALKER, 1995, *Research as Social Change*, London: Routledge, pg.24)

SCHWANDT, T.A., 2000 *Three Epistemological Stances for Qualitative Enquiry: Interpretivism*, Hermeneutics and Social Constructivism in Denzin NK, Lincoln YG, 2000, The Handbook of Qualitative Research, 2nd Edition op cit.

SEFFRIN, 1997. *Proximal and Distant Causes Of Illness and Premature Mortality,* Journal of Health Education, September – October.

SENGE, 1990. *The Fifth Discipline:The art and practice of the learning organisation*, Century Business, London.

SMITH, P, 2003, *Tinkering could swamp foundations in red tape.* Health Service Journal 2003; 113:5

SOCIAL EXCLUSION UNIT., 1999. *"What's It All About"* [on line]. Cabinet Office Website. Available at:
WWW.cabinet-office.gov.uk/se/index/faqs.html
[Accessed November 1999]

SOCIAL EXCLUSION UNIT., 2000. *Neighbourhood Renewal: National Strategy Action Plan..* London: Cabinet Office.

STANSFIELD., J., 2004, *Proposal for the Development of Health Promoting Mental Health Services, North West Pilot Site.* North West Mental Health Development Centre.

STEUER, N. & MARKS, N, 2008. *Local Wellbeing: Can We Measure It?* The Young Foundation. Pg.11.

STREET, JM, BRAUNACK-MAYER, AJ, FACEY, K, ASHCROFT, RE and HILLER, JE (2008) *Virtual community consultation, Using the literature and weblogs to link community perspectives and health technology assessment.* Health Expectations, 11, Pages 189-200

TAYLOR, E.W, 1997, *Building upon the Theoretical Debate: A Critical Review of the Empirical Studies of Mezirow's Transformative Learning Theory*, Adult Education Quarterly 48(1):34-59.

THOMAS, P., ROMME, M., AND HEMMELLINJK, J., 1996. *Psychiatry and the Politics of the underclass.* British Journal of Psychiatry 169, 401-404.

TILFORD, S, DELANEY, F, VOGELS, M. 1997, *Effectiveness of mental health promotion interventions: a review*, Health Education Authority, pg53.

TOMA, J. 2000, *How Getting Closer to Your Subjects Makes Qualitative Data Better*. Theory Into Practice, Vol 39, No 3, College of Education, The Ohio State University. Pg 177-184.

WEINSTEIN, K.1999.,*Action Learning:a practical guide*. 2nd ed. Aldershot:Gower.

WEIR, K, & SUTCLIFFE, K, 2003, *Hospitals as Cultures of Entrapment: A Re-Analysis of the Bristol Royal Infirmary,* California Management Review, Volume 45, Number 2.

WHITEHEAD, M., 1996.*Tackling Health Inequalities-An Agenda for Action*. Kings Fund, Pg.xvii.

WOODWARD, V., 2004. *Active Learning, Active Citizenship*. Report by the Civil Renewal Unit, Home Office.

WILLIAMS, B, CATTELL, D, GREENWOOD, M, LeFEVRE, S, MURRAY, I, THOMAS, P, 1999, Exploring 'person centredness':user perspectives on a model of social psychiatry, Health and Social Care in the Community, 7(6), 475-482.

WORLD HEALTH ORGANISATION, 1986. *The Ottawa Charter*.

WRIGHT, B., 2002a. *About Me* [on line]. School for Social Entrepreneurs Web Site, Available at:
http://www.sse.org.uk/people/bernadette.wright
[Accessed April 2004].

WRIGHT, B., 2002b. *About Me* [on line]. School for Social Entrepreneurs Web Site. Available at:
http://www.sse.org.uk/people/bernadette.wright
[Accessed April 2004].

WRIGHT, B., 2002c. *About Me* [on line]. School for Social Entrepreneurs Web Site. Available at:
http://www.sse.org.uk/people/bernadette.wright
[Accessed April 2004].

YOUNG, S., 1996, *Capital Funding Proposal, Democratic Therapeutic Community Service*, Unpublished Business Case, Mental Health Services of Salford NHS Trust.

YOUNG, S., 1996, *Learning Journal Entry*, January 25th & 26th.

YOUNG, S., 1998. *Mental Health and the Creative Living Centre*, The Royal College of Nursing Journal Mental Health Practice. Vol 1, No 6, pg16, 17, 18.

YOUNG, S., 1998a. *Managing Without Shoes*. MSc Thesis. University of Salford.

YOUNG, S., 1998b. *Managing Without Shoes*. MSc Thesis. University of Salford, Pg107.

YOUNG. S., 1999. *Learning Journal Notes.*1st March 1999

YOUNG,S., 2000., *Notes from Action Learning Set Meeting.* 21st Jan.

YOUNG, S., 2000. *Learning Journal Entry.* 21st January 2000

YOUNG, S., 2000. *Learning Journal Entry.* February 2000

YOUNG, S., 2000. *Notes from Action Learning Set Meeting.* 22nd August.

YOUNG, S., 2002. *Notes from Action Learning Set Meeting.* 24th January.

Bibliography

BAGGOTT R. 2008 *Healthy Democracy: the future of involvement in health and social care,* Health Expectations. 11(2):202-203

BELL, J. 1993 *Doing Your Research Project*, Open University Press.

BENINGTON, J. 2000 *The Modernization and Improvement of Government and Public Services*, Public Money and Management, April-June 2000. COPFA.

BOTHAM, D, 2000. *IFAL- Action Learning News*, Vol. 19 No1.

BROWN, I. 1999. *Patient participation groups in general practice in the National Health Service,* Health Expectations. 2 169-178.

BROWN, I. 2001. *Organizational values in general practice and public involvement: case studies in an urban district,* Health and Social Care in the Community 9 (3). 159-167.

CAHILL, J. 1998. *Patient participation – a review of the literature.* Journal of Clinical Nursing, 7 119-128.

CARTER S.M, JORDENS C.F.C., MCGRATH C. and LITTLE M, 2008, *You Have to Make Something of All That Rubbish, Do You? An Empirical Investigation of the Social Process of Qualitative Research,* Qualitative Health Research 18(9):1264-1276

CHARLES C, DEMAIO S, 1993, *Lay Participation in Health Care Decision Making: A Conceptual Framework.* Journal of *Health Politics, Policy and Law,* Vol. 18, No. 4.

CHECKLAND, P. 1999. *Systems Thinking, Systems Practice*, Wiley

COOTE A, ALLEN J, WOODHEAD D, 2004, *Finding Out What Works Building knowledge about complex, community-based initiatives.* King's Fund Publication.

DELBANCO T, BERWICK D, BOUFFORD J, EDGMAN-LEVITAN S, OLLENSCHLA ÈGER G, PLAMPING D, ROCKEFELLER R, *Healthcare in a land called People Power: nothing about me without me.* 2001 Health Expectations, 4, pp.144-150. Blackwell Science Ltd

DEMOS, 1998. *The Good life*, DEMOS

DIXON A, LE GRAND J, 2006. *Is greater patient choice consistent with equity? The case of the English NHS.* Journal of Health Service Research and Policy, Vol 11, No3.

ELDH A, EKMAN I, EHNFORS M, 2002, *Considering patient non-participation in health care.* Health Expectations 11, pp.263–271. Blackwell Publishing Ltd

FAIRBAIRN, G and WINCH, C 1996, *Reading Writing and Reasoning, A Guide for Students,* Open University Press.

HANDY, C. 1994 *The Empty Raincoat,* Arrow Business Books

HOGG C, 2006, *Patient and public involvement: What next for the NHS?* Health Expectations, 10, pp.129–138, Blackwell Publishing Ltd.

JENSEN, M.C. 1997, *Non-Rational Behaviour, Agency Costs, and Organisations*, paper presented at the Boston-Cambridge Seminar on Economics of Organisations, Harvard Business School, Boston.

KINGSFUND, 2007, *Engaging Patients in their Health,* Report from the Sir Roger Bannister Health Summit, Leeds Castle, King's Fund Publication.

LAMA, D. 1999. *Ancient Wisdom, Modern World. Ethics for a new Millennium,* Little, Brown and Company.

LEADBETTER, C and GOSS, S, 1998. *Civic Entrepreneurship*, DEMOS

MANN, R, G. 1985. *Why patient participation groups stop functioning: general practitioners viewpoint,* British Medical Journal. 290. 209-211.

MURIE, J., & DOUGLAS-SCOTT, G. 2004, *Developing an evidence base for patient and public involvement,* Clinical Governance 9 (3). 147-154.

PEDLER, M, *Action Learning for Managers*, 1996,Lemos and Crane

PAINE, T. 1983, *Survey of patient participation groups in the United Kingdom*, British Medical Journal Clinical Research Edition. 286 768-772.

PRATT, M, GORDON, P, .PLAMPING, D, 1999, *Working Whole Systems*, Kings Fund Publishing

REVANS, R 1998, *ABC of Action Learning. Empowering managers to act and to learn from action*, Lemos and Crane.

ROBERT G, HARDACRE J, LOCOCK L, BATE P and GLASBY J 2003, *Redesigning mental health services: lessons on user involvement from the Mental Health Collaborative.* Health Expectations, 6:60-71.

ROWA-DEWAR N, AGER W, RYAN K, HARGAN I, HUBBARD G and KEARNEY N. 2008, *Using a rapid appraisal approach in a nationwide, multisite public involvement study in Scotland*, Qualitative Health Research. 18(6):863-869

ROWE R, SHEPHERD M, 2002, *Public Participation in the New NHS: No Closer to Citizen Control?* Social Policy and Administration, Vol 6. 36, N0 3. 3, Pgs. 275–290

SARA K. ABELSON J, AND CHARLES C, 2005, *From rhetoric to reality: including patient voices in supportive cancer care planning.* Health Expectations, 8, pp.195–209, Blackwell Publishing Ltd.

SOCIAL EXCLUSION UNIT, 1999, *"What's It All About"* [on line]. Cabinet Office Website, Available at:
WWW.cabinet-office.gov.uk/se/index/faqs.html
[Accessed November 1999]

STANISZEWSKA, S. HERRON-MARX, S, MOCKFORD, C, 2008, *Measuring the Impact of Patient and Public Involvement: the Need for an Evidence Base. International Journal for Quality in Health Care Volume 20, Number 6: pgs 373-374. Oxford University Press.*

TAYLOR, G., BROWN, K., CALDWELL, K., GHAZI, F., HENSHAW, L., and VERNON, L. 2004, User Involvement in Primary Care: A case study examining the work of one Patient Participation Group attached to a primary care practice in North London. Research Policy and Planning. 22 (1). 21-30.

THORNTON H. 2008, *Patient and public involvement in clinical trials,* [Editorial] BMJ. 336(7650): 903-4

WALSH M, GRANT G and COLEMAN Z. 2008, *Action Research—A necessary complement to traditional health science?* Health Care Analysis. 16(2):127-144

Wykurz G, Kelly D, *Developing the role of patients as teachers. BMJ* 2002;325;818-821