A case study to explore how a national organisation works in partnership with people who have lived experience in a national mental health improvement programme

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Doctorate of Professional Health Studies

January 2025

Abstract

Working with people who have lived and living experience (PWLE) is acknowledged as a key component of healthcare improvement; however, there is limited understanding of how this happens in practice. The need to improve quality in mental health care is widely recognised and to address issues, there has been a significant effort to utilise Quality Improvement within healthcare as a means of delivering evidence-based care and improving mechanisms of care and clinical outcomes. Healthcare Improvement Scotland (HIS) is a national healthcare organisation whose purpose is to lead national improvement programmes, focused on supporting services to deliver improved health and wellbeing outcomes for the people of Scotland. National improvement programmes use a range of approaches to understand the system and to design, implement and evaluate changes – with PWLE central to this work. There has been limited research within national organisations, and findings from this case study have brought together existing evidence to explore partnership with PWLE within a national context.

A case study approach was used to understand how HIS worked in partnership with PWLE in a mental health improvement programme. This research explored how partnership working was described and demonstrated in practice in the Personality Disorder (PD) Improvement Programme, considering factors which influenced partnerships. Qualitative data was gathered from documents, participant observations, and semi-structured interviews. Thematic analysis was used to organise, find patterns, and elicit themes in the data. This improvement programme commissioned third-sector organisations to lead direct work with PWLE, and representation of PWLE through other organisations was discussed. Partnership working in the improvement programme was characterised by conflicting perspectives of power, different social processes, and high levels of conflict. A concept map is presented to articulate how key themes of mechanisms, identity and power were demonstrated in practice and how they influenced partnership working within a national context.

Statements

This thesis is original work and did not use any generative artificial intelligence software. The thesis was analysed by Turnitin to assess plagiarism.

Ethical approval

Ethical approval was granted from Healthcare Improvement Scotland's research oversight group, University of Stirling Research Ethics Committee (REC), and the Integrated Research Application System (IRAS – ID 4256) via the Queen Square Research Ethics Committee (for phase one – ID 318323); and Black Country Research Ethics Committee (for phase two – ID 309926).

Copyright declaration

Author contributions

This thesis was completed as part of the clinical doctorate programme at the University of Stirling, with the author as lead researcher and Dr Carina Hibberd Lead supervisor, and Professor Ashely Shepherd as supervisor. Both supervisors advised on the design, analysis and preparation of the thesis. Gordon Johnstone was a public partner who advised on the design, analysis and dissemination of this research.

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Acknowledgements

This research was completed with the support of a number of people whose contributions are gratefully and sincerely acknowledged.

Firstly, to my supervisory team Dr Carina Hibberd and Prof Ashley Shepherd – who I thank for their patience, kindness and wisdom throughout this process. Their insights and feedback helped my learning and development.

To Gordon Johnston who advised as public partner to this research, his patient and dedicated support was invaluable in ensuring I considered the needs of people with lived experience in designing and carrying out this research.

I would like to thank all of the participants who gave their time to this research. I am also indebted to Healthcare Improvement Scotland for supporting this research.

Finally, and most importantly, thanks to friends and family who have encouraged me throughout this doctoral programme. In particular my husband Steven for his tireless support, and our four boys – Hamish, Archie, Harry, and Johnny - for their patience, encouragement and understanding.

1. Introduction to the thesis

1.1. Introduction

Mental health services are facing unprecedented challenges which require creative solutions and improvement. In 2018 the Lancet presented a review of global mental health and sustainable development in which they recommended urgent action to transform mental health services with the 'full involvement with people with the lived experience of mental disorder' (Patel et al. 2018, p. 1591). Since publication of this report the COVID-19 pandemic – declared by WHO on 11 March 2020 - placed significant challenges and barriers to mental health care, and improvements to the mental health care system have been identified as priority in Scotland's transition and recovery plan (Scottish Government 2020). Healthcare Improvement Scotland (hereafter 'HIS') are the national improvement agency for health and social care in Scotland and recognise the importance of involving people who have lived or living experience (hereafter 'PWLE') by "placing the voices and rights of people and communities at the heart of improvements" (HIS 2023, p.12).

Despite this recognition, there has been limited research into how people with lived experience work within national improvement initiatives. To address gaps in knowledge, research was carried out to explore how HIS worked in partnership with PWLE in the national Personality Disorder (hereafter 'PD') Improvement Programme. Chapter 1 provides an introduction and overview of the thesis. Section 1.2 outlines the aims and objectives of the research; section 1.3 highlights the motivations for carrying out this research, and section 1.4 details the contributions this research offers to both knowledge and practice. The final section of this Chapter (section 1.5) provides an overview of the thesis structure to guide the reader through the systematic approach taken to present the research.

1.2. Research aim and objectives

This thesis describes the explanatory case study approach used to understand partnership working with PWLE in the national PD Improvement Programme, commissioned by Scottish Government and led by HIS. This research aimed to develop a greater understanding of how partnership working was described, defined, and demonstrated in practice, identifying factors which influenced partnership working within the national improvement programme studied. There were three key objectives used to guide the research which are outlined in this thesis:

Objective one: Critically analyse the current literature on working in partnership with PWLE in mental health improvement efforts, particularly in relation to national improvement initiatives

Objective two: Develop greater understanding of partnership working with PWLE to explain why and how sequences of events within this programme occurred and,

Objective three: Generate recommendations to improve partnership working within the study organisation, for other improvement interventions, and for future research.

1.3. Motivations for this research

There were academic, professional, and personal motivations to this research which was carried out as part of a clinical doctorate programme within the University of Stirling. Professional motivations are in line with my career development, which combines a clinical background with healthcare improvement. My professional background is as an Allied Health Professional (hereafter ‘AHP’) working as a Speech and Language Therapist in specialist services for people who have learning disabilities and mental illness for over 20 years. In 2020 I joined a national organisation (HIS) in a healthcare

improvement role. Developing the skills and research capabilities of the AHP community has been identified as a priority to help address the many challenges faced in the health care system (Scottish Government 2022) and the need to strengthen the evidence base for improvement is widely recognised (Portela et al. 2015; Dixon-Woods 2019; Batalden and Foster 2021). This research was informed by a desire to contribute to my AHP profession, and the evidence base for improvement.

Throughout my career I have worked closely with PWLE, their families, carers and supporters and have found this joint venture essential to providing high quality clinical care. In moving to a national organisation which does not provide direct clinical care, I have been acutely aware of the difficulties in ensuring the needs and experiences of people who use and need services are recognised and understood in this context. My personal motivation was to explore the issues around partnership working with PWLE to seek an understanding of this within a national organisation context.

1.4. Contribution to knowledge and practice

The findings from this research provide insights on working with PWLE which contribute to both knowledge and practice. For this research, I analysed data from documents, observations and interviews to provide insights into how partnership working happens in practice within a national organisation. This improvement programme commissioned third-sector organisations to lead direct work with PWLE and representation of PWLE through other organisations was a key focus of this research.

Analysis of data highlighted that actors representing PWLE may have made adjustments to enhance negative experiences, and the third-sector organisations did not represent a wide range of views of PWLE. There was a lack of oversight or evaluation of the work of the third-sector organisations in

this programme and therefore limited understanding of the work undertaken by the third-sector organisations to work in with PWLE. This research found there was a lack of clarity in definitions, processes and roles required to work in partnership with PWLE, and this lack of clarity influenced how people approached working in partnerships. Evidence presented found that partnerships were also influenced by organisational mechanisms, social processes, power and conflict.

The contextual factors which influenced partnership working which are articulated in a concept map (detailed in Chapter 6). This concept map provides an explanatory model of partnership working within a national context, is considered a unique contribution to knowledge, and may be used to explore how partnership working can be developed in both national organisations and in wider healthcare improvement initiatives to inform practice.

1.5. Thesis overview

This thesis is structured as a logical and systematic description of the research undertaken. Chapter 1 is a brief introduction to the topic of research, stating the motivations, aims, and objectives, highlighting how the findings from this case study contribute to knowledge and practice. Chapter 2 provides a more detailed analysis of the context of this research with a description of the context of mental healthcare, healthcare improvement and national organisations within a system of public service reform. Chapter 2 also outlines how the concept of partnership – central to this research – can be analysed and understood, detailing language used to describe partnerships, models of partnership, and key features of power and conflict associated with partnerships.

Chapter 3 details a systematic review of the literature carried out to analyse the current evidence base, highlighting gaps within the literature used to develop key research questions and inform the design of this research. The methodological approach and philosophical paradigm applied to this research are detailed in Chapter 4. The aim of this chapter was to ensure the research aims and objectives were addressed appropriately, considering the ontological, epistemological, and axiological positions adopted. The research design and methods used are outlined in this chapter, including discussion of the quality assurance and ethical considerations identified and addressed.

This thesis presents a qualitative case study research design in which I collected data from documents, observations, and interviews, and data collection is described in Chapter 5. Chapter 6 details the reflexive thematic analysis approach used and describes key themes identified from the data. In Chapter 7, I discuss how data was used to inform and develop findings for this research. Chapter 8 considers how these research findings contribute to knowledge, practice, and summarises recommendations for the study organisation, wider partnership working with PWLE, and future research. The thesis concludes in Chapter 9 with a discussion on the strengths and limitations of this research, and personal reflections on carrying out this research as part of the Clinical Doctorate programme.

Table 1 below summarises key terms used in this thesis

Table 1: Glossary of terms

Glossary of terms	
Term	**Definition and meaning**
Healthcare Improvement Scotland (HIS)	Healthcare Improvement Scotland (HIS) is an NHS national board whose purpose is to enable the people of Scotland to experience the best quality of health and social care.
Improvement Programme	Improvement programmes are key pieces of work led by HIS. The aim of an improvement programme is to support health, social care and housing partners to deliver improved health and wellbeing outcomes for people in Scotland, by applying appropriate methods to the design, implementation and continuous improvement of services.
Quality Improvement (QI)	QI is described as the application of a systematic approach that uses specific techniques to improve quality (Scot Gov 2018). Key features of QI are identified as the combination of a change (improvement) and a method (an approach with appropriate tools) while paying attention to the context to achieve better outcomes (Health Foundation 2013).
Partnership working	There is a lack of consensus in the literature around the definition of partnership working in relation to healthcare with terms such as involvement, participation, engagement, empowerment, and partnership being used interchangeably (Todd et al. 2020). This paper uses the term partnership working to describe joint venture with people who have lived experience.
People with lived experience (PWLE)	Patients, carers and people who have lived or living experience of healthcare.
HIS public partners	Public partners are volunteers who HIS train and support to provide a public perspective to their work.

2. Context

This research was carried out to provide a deeper understanding of partnership working with PWLE. This chapter describes the context in which partnership working occurs, which for this research was the mental health system in Scotland, described in Section 2.2, and healthcare improvement, outlined in Section 2.3. The case study was focused on a national organisation and this context is described in Section 2.4, considering the position of these organisations in a wider system of public sector reform discussed in Section 2.5. In addition to describing the context which partnerships occur, this research outlined facets of partnerships which were used to describe how partnerships could be explored in Section 2.6. This included consideration of language and descriptions of partnerships, models of partnership, and key features of partnerships – in particular power and conflict. This chapter describes the approach taken to develop a conceptual framework used to consider all factors that may influence partnership working and concludes with consideration of issues that require further investigation in Section 2.7.

2.1. **Mental health and mental health services**

2.1.1. What is mental health?

To frame the research study, it is important to define the current mental healthcare context in Scotland. This research focused on partnership working with people who have a diagnosis of PD and lived experience of mental health services. In this section I outline the current terminology used within mental health services – including an overview of mental health, and the diagnosis of PD. I then consider current service provision, and priorities for improvement in mental healthcare, and outline why partnerships with PWLE are key to addressing these challenges.

Mental health is integral to our general health and well-being and is a key social parameter relating to quality of life and human rights, as well as contributing to wider society in relation to economics, creativity, productivity and sustainable development (WHO 2022a; Samartzis and Talias 2020). Mental health is recognised as a global health priority and there is increasing evidence that mental health is a significant determinant of overall health (Scot Gov 2018) contributing to the burden of disease globally and is expected to rise in the coming years (Kilbourne et al. 2018).

In Scotland it is estimated that one in four people may be affected by mental health problems in any one year (Scot Gov 2018) and the COVID-19 pandemic has exacerbated these problems, with a reported rise of mental ill health globally (WHO 2022a). Mental illness contributes to the global burden of illness and is thought to account for 13 per cent of the total burden of illness from all disease (Samartzis and Talias 2020). There are varying terms associated with mental health and wellbeing which are thought to exist on a complex continuum which includes mental wellbeing, mental health, mental disorder, and mental illness. Mental illness is defined as a 'health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life' (Scottish Government 2023 p.12). A mental disorder is characterised by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour (WHO 2022b) and PD is described as a mental disorder (Pan and Wang 2024).

The term PD has been a source of discussion and debate with many people who have lived experience and some professionals expressing a preference to use different terminology to describe the range of experiences and symptoms (van Schie et al. 2024). The purpose of this research was not to consider the diagnostic terminology used; however, an outline of current evidence for diagnosis is thought to provide useful context for this thesis. PD is an enduring

and deeply engrained pattern of behaviour and inner experience, which affects thinking, feeling, relationships, and impulse control which can lead to significant functional impairment and distress. These patterns are often inflexible and long-lasting, affecting all areas of life and functioning (Royal College of Psychiatrists 2020a). There are a number of sub-types of PD and the updated diagnostic criteria outlined in ICD-11 (WHO 2022c) focuses on global and shared features, with diagnosis based on assessment of self and interpersonal functioning, cognitive, emotional and behavioural features, and psychosocial impairment and distress (Bach et al. 2022). Although PD is a common mental health condition there is evidence that PD may be underdiagnosed. There is a prevalence of six to ten per cent of the general population, which increases to 50 per cent of the general mental health population (Royal College of Psychiatrists 2020b). The impact of PD on the person and their families is significant as there is a high rate of self-harm and suicide associated with a diagnosis of PD, with up to eighty per cent of those with PD engaging in non-suicidal self-injury, and significant impairments in personal, family, social, educational and occupational functioning noted (HIS 2023). Despite these challenges, mental health services can provide specialist interventions and therapies which can offer considerable improvements to people with a diagnosis of PD (Ng et al. 2019). The need for quality mental health services is recognised; however, mental health services face a number of challenges which shall now be outlined, describing the need for improvement.

2.1.2. Mental health services

The presentation of PD is characterised by difficulties in interpersonal relationships which can impact on service approaches (Lothian and Read 2002) and there are recognised challenges in providing support and treatment for people with PD (Mental Welfare Commission 2018). Mental health services in Scotland have undergone radical change over the last three decades, with a shift from long-term care delivered in large institutions, to care delivered mostly in the community by multidisciplinary teams. In Scotland, support for mental

health ranges from self-help to support mental wellbeing in local communities, to primary care settings which provide help for mental health. Secondary treatment and care provide input for people who have longer term or complex mental health conditions that cannot be managed in primary care, and tertiary care settings offer highly specialised treatment for people who have complex mental illnesses (Audit Scotland 2023). Services for people who have a diagnosis of PD include working across different agencies and sectors, such as social care, housing, education, justice and physical healthcare (Royal College of Psychiatrists 2020b). There is an interdependency between community and inpatient services, and there can be many different services and organisations providing care and support for people with mental health problems. At times, due to challenges within mental health systems, the responsibility for looking after people with mental illness often falls to family members (Carbonell et al. 2020). There is considerable diversity and complexity within the mental health population and the relationship between health professionals and patients can be on a long-term basis, therefore close attention to relationships is central to service approaches.

2.1.3. Priorities for improvement in mental health services

The need to improve quality in mental health care is widely recognised in response to both longstanding problems and more contemporary pressures (Boland 2020; Carbonell et al. 2020; Care Quality Commission 2015; Gilburt 2015; Kilbourne et al. 2018; Patel et al. 2018; Ross and Naylor 2017; Samartzis and Talias 2020; Short et al. 2019; Strang 2020). There are a number of challenges within mental healthcare systems, which have been described as ‘typically deficient or non-existent all over the world’ (Carbonell et al. 2020 p.1366) and there is a recognised need to improve the quality of mental health care. In recent years there have been several reviews and investigations into the quality of care within mental health settings and a number of priorities for improvement have been identified including improved access to evidence

based care; reduced variation in service provision; improved clarity to expected outcomes; and improved leadership and culture within services (Crisp et al. 2016; Strang 2020).

There are also a number of structural and cultural challenges noted in mental health services. The health care system within Scotland (NHSScotland) is experiencing a prolonged period of turbulence and stress, with unprecedented pressures on the health and social care system. Challenges in mental health services are longstanding, and the COVID-19 pandemic placed further significant barriers and restrictions on mental health care, had a negative impact on services and people who require support, and may have left an enduring challenge for services (Preti et al. 2020; Abbas et al. 2021; Byrne 2021; Johnson et al. 2021). Recent reports by The Mental Welfare Commission (2018) and The Royal College of Psychiatrists (2020a) have highlighted significant variation in the provision of care which leads to inconsistent and inequitable outcomes for people who have a diagnosis of PD. In 2023 Audit Scotland's annual report of mental health services outlined significant issues across the system including problems with access to mental healthcare, fragmented services, and complex accountability resulting in difficulties understanding the quality of care or outcomes for people receiving care (Audit Scotland 2023).

The need to improve mental health services are recognised as a priority, outlined in Scotland's Mental Health and Wellbeing Strategy (Scottish Government 2023a) which describe nine outcomes centered around three areas of focus to promote positive mental health for the whole population, prevent mental health issues occurring or escalating, and providing mental health care and support. Previous changes to services have focused on risk management approaches and are thought to have resulted in a loss in relational continuity in mental health care (Royal College of Psychiatrists 2020b). Given the long term, relational nature of mental health care, and the

complexity of issues no single group will be able to address and improve these challenges. Working with others across agencies and sectors is key to understanding issues and identifying areas for improvement, and these collaborative approaches to change should involve PWLE. The involvement of PWLE is recognised in the Scottish Government's Mental Health Delivery Plan (Scottish Government 2023b) and is widely acknowledged within the literature (Carbonell et al. 2020; Scholz et al. 2018; Tindall et al. 2021; Vojtila et al. 2021: WHO 2022a).

2.2. Healthcare improvement

2.2.1. Development of healthcare improvement

The drive to improve the quality of healthcare services is not new, and efforts to improve healthcare have been established since the time of Hippocrates. There are well documented advances and improvements in care reported, including the use of triage in the American Civil War and the introduction of infection control credited to Florence Nightingale in the Crimean War (Dumitrascu et al. 2020, Hines et al. 2020). Over the past century efforts to improve healthcare have developed from a focus on standards of care, to the use of systematic approaches modelled on experiences in industries (Batalden and Foster 2021). There are a number of improvement focused approaches, tools and methods and the need to involve PWLE is recognised as central to all improvement (Backhouse and Ogunlayi 2020). Evidence of healthcare improvement interventions suggest they are sensitive to the context in which they occur and may even be considered context dependent (Bate 2014; Coles et al. 2020; Fulop and Robert 2015). In this section I discuss the context of healthcare improvement, describe systematic approaches to improvement, outline models and frameworks developed to support implementation, and highlight the need to involve PWLE in healthcare improvement.

2.2.2. Context in healthcare improvement

A key approach to improvement widely used in healthcare is referred to as Quality Improvement (hereafter 'QI') and is described as the application of a systematic approach that uses specific techniques to improve quality (Ross and Naylor 2017). There are several approaches adopted within QI including Lean, Six Sigma and the Model for Improvement (Kings Fund 2017). Key features of QI are identified as the combination of a change (improvement) and a method (an approach with appropriate tools) while paying attention to the context to achieve better outcomes (Health Foundation 2013). QI is widely used within healthcare organisations and is associated with narrowly defined approaches to improvement which does not reflect the broad approach to improvement demonstrated in this case study research. For the purposes of this thesis the term 'healthcare improvement' is used as recommended in the Standards for Quality Improvement Reporting Excellence Guidelines (SQUIRE-2.0) to describe 'any systematic effort intended to raise the quality, safety and value of healthcare services at a service level' (Ogrinc et al. 2016 p. 990).

Despite widespread use of healthcare improvement, evidence on the impact of improvement initiatives vary and there is growing recognition that the mixed effect and success rates of strategies are in part due to the different contexts in which the interventions are planned and implemented (Kringos et al. 2015). The SQUIRE 2.0 publication guidelines for reporting healthcare improvement research identifies context as a key component of improvement (Ogrinc et al. 2016). Context has been poorly defined (Bate 2014) and there has been growing interest in defining context for improvement in the literature. A simple approach defines context as all factors which are not part of the intervention (Ovretveit 2011) and may include the strategic, cultural, technical and structural components of the environment in which healthcare improvement intervention takes place (Bate 2014). SQUIRE 2.0 guidelines define context as 'the key features of the environment in which the work is immersed and which are

interpreted as meaningful to the success, failure, and unexpected consequences of the intervention' (Ogrinc et al. 2016, p. 989).

There are concerns that healthcare improvement initiatives can be fragmented and short term, therefore attention should be made to factors that support the implementation of healthcare improvement, so they can be embedded in healthcare systems (Kandesami et al. 2019). The question of do improvement efforts work is only of initial interest and focus should be on understanding how, where, when, and why it works most effectively (Kaplan et al. 2012). The following sections will consider these areas of focus in the context of this research.

2.2.3. Systematic approaches to healthcare improvement

There are multiple definitions of healthcare improvement, and it has been argued that it may be more beneficial to consider improvement not as a single method, but as a set of common principles found across definitions (Backhouse and Ogunlayi 2020). In addition to many definitions, the literature includes descriptions of healthcare improvement interventions, and the tools or approaches used to develop these interventions (Coles et al 2020) which at times are not clearly distinguished. This creates a complex description of improvement within the literature and is thought to contribute to improvement remaining largely in the domain of experts (Dixon Woods and Martin 2016). In order to support the wider use of healthcare improvement tools and approaches in practice there have been a number of heuristic guides, frameworks and models developed within healthcare settings in recent years which I will now summarise in relation to the Scottish approach to healthcare improvement.

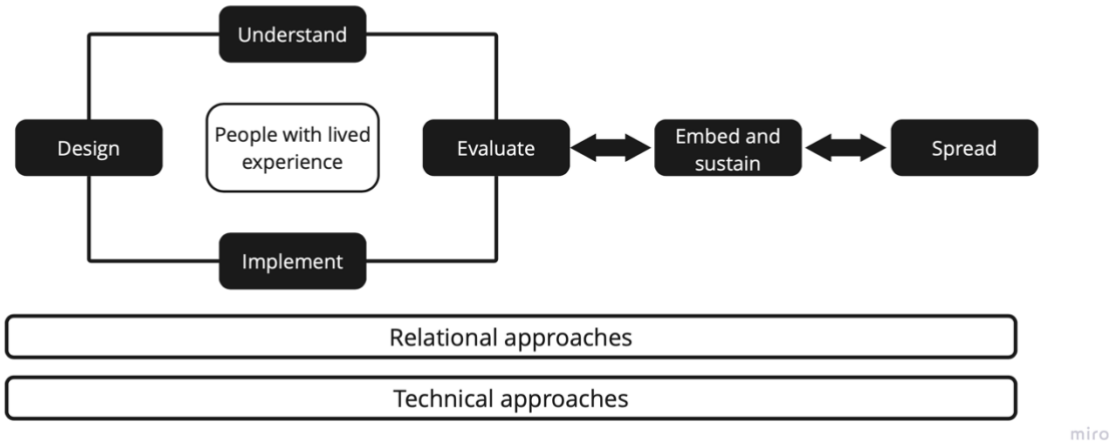
2013 – 3-Step Improvement Framework

In 2013, the Scottish Government developed a 3-Step Improvement Framework as a consistent model for change to be used across public services to deliver public service reform (Scottish Government 2013). The third step in this approach was the Model for Improvement which was developed by the Institute for Healthcare Improvement in the USA (Nelson et al. 1998). The Model for Improvement is based on the work of Edward Deming who described the 'system of profound knowledge' which identified four components (theories of systems, theory of knowledge, understanding variation, and psychology of change) which all should be understood to improve healthcare systems (Rohers 2018). The Model for Improvement combines measurement with test of small change cycles (plan-study-act-do) and provides a flexible range of tools which can be adapted to local contexts (Reed and Card 2016).

2016 – The Framework for Planned Improvement

The 3-Step Framework was updated in 2016 by HIS to include a broader range of theories, approaches and techniques which support improvement in health and social care. This model was developed as an internal organisational approach for HIS, was the approach used in HIS at the time of this research and is presented in Figure 1. The Framework for Planned Improvement outlines the stages of improvement work and is used as an overall common framework for improvement programmes within HIS. In the Framework for Planned Improvement, there is a focus on understanding the system, designing, implementing, and evaluating changes, with PWLE at the centre of this work. Following this, attention moves to embedding and sustaining successful change within practice and spreading the learning to other areas. Underpinning the Framework is the recognition of the importance of the relational aspect of change and the use of technical healthcare improvement approaches including the Model For Improvement.

Figure 1: Framework for Planned Improvement (HIS 2016)



2022 - The Scottish Quality Management Framework

Previous models for improvement had not led to the reliable delivery of high-quality care in NHSScotland (HIS 2022) and therefore an updated model was commissioned by Scottish Government and developed by HIS in 2022. The Scottish Quality Management Framework was designed as a single model for use across health and social care in Scotland and detailed QI as the implementation domain which should exist within a wider system of quality assurance, planning, and control. The importance of working with others was highlighted in the Scottish Quality Management Framework and described as relationships, co-design, and co-production. This framework was developed through a 90-Day Cycle which is a structured form of inquiry and improvement promoted by the Institute of Healthcare Improvement and has three phases to review literature, consult with stakeholders, identify and test changes and report findings (Institute for Healthcare Improvement 2018). There is no information on which groups participated in the consultation and therefore it is not clear if or how PWLE were involved in the development of this model. There was also no evidence of evaluation on the implementation of the previous models for improvement recommended to explore reasons for the lack of improvement noted. Given the complexity of models for improvement a 90-

Day Cycle is unlikely to have considered in depth the factors influencing lack of improvement within health and social care, and assumptions appear to have been made that updating a single preferred model would lead to improved outcomes.

2025 - The Scottish Approach to Change

At the time of writing there is a review of The Scottish Quality Management Framework with the next iteration of improvement frameworks described as “The Scottish Approach To Change”. This review was requested by Scottish Government to support NHS reform and is led by HIS. This draft model demonstrates how QI, service design, strategic planning, and engagement can be used together in a coordinated way to deliver high quality change (HIS 2024).

Although working with PWLE is recognised in all models for healthcare improvement developed, there is limited description of how this can be carried out. Healthcare Improvement Scotland have developed a Community Participation Toolkit (HIS n.d.) which is a list of methods and tools to support working with PWLE. These are not described in models for improvement but presented as individual tools, guidance and resources available for use in planning or community engagement activities in health and social care. There is no description of their use within healthcare improvement.

The frequency of changes and revisions to frameworks for improvement present challenges to those operationalising improvement efforts, can lead to a lack of co-ordination, lack of clear prioritisation, inconsistent implementation and a failure to consider the broader impact of change (Backhouse and Ogunlayi 2020; Batalden and Foster 2021; Dixon-Woods 2019). The revisions to models were based on observations that previous models had not led to sustained improvements in healthcare; however, there is limited evidence of

process evaluations carried out to understand how these models had been implemented in practice, or consideration of other factors that may have contributed to the lack of improvements noted. The focus on developing one model to inform healthcare improvement does not recognise the plurality of elements within healthcare improvement and the need for diverse approaches based on context. The development of updated frameworks did not include an implementation plan which would take into account how staff leading improvement would be supported to understand, use, and evaluate these models. It is of note that the frequent revisions to national frameworks for improvement present challenges to those working in improvement and also present challenges to evaluating and researching their implementation and impact.

2.2.4. Key areas for this research

Having considered a range of issues within healthcare improvement it is useful to summarise key issues that are pertinent to this research. The systematic efforts to improvement have been characterised by complex descriptions with a combination of principles, tools, methods, and approaches. The importance of context is emphasised as key to understanding the implementation and impact of improvement efforts. In order to support implementation of improvement, there have been a range of frameworks and models developed within NHSScotland. The aim of these frameworks is to describe one approach to improvement but does not recognise the importance of context and complexity of improvement approaches. Further to this, there have been frequent revisions and updates, with limited time to embed these approaches in practice, and limited evidence of critical analysis of the implementation of each model. A key principle of improvement recognised in the literature and within all models or frameworks is the importance of involvement with PWLE and this research is centred around how these relationships manifest in practice. The purpose of this research is not to explore implementation of specific improvement models

or approaches, but this context provides useful insights into challenges in designing and delivering healthcare improvement.

2.3. National organisations

Healthcare improvement takes place at various levels of the organisation and this research focused on an improvement programme within a national organisation. There are thought to be four main organisational contexts for improvement: national policy context (macro); organisational context (meso); the clinical microsystem (micro) and the stakeholder context (referring to individuals who change within the system which in the micro-organisational level) (Coles et al. 2020). This research was carried out in a national macro-organisational level, and the organisational terms used in this thesis are outlined in Table 2 below:

Table 2: Organisational levels

Organisational level	Definition
Macro-level	National level improvement such as system wide interventions, policy focused interventions or national improvement interventions
Meso-level	Organisational level improvement such as regional level improvement, or hospital wide improvement
Micro-level	Clinical level improvement such as individual healthcare teams

Traditionally, the clinical team who are closest to the problems have been considered central to applying an agreed set of tools and techniques to test, measure and learn, with improvement efforts focused at the micro-level of organisations (Backhouse and Ogunlayi 2020; Health Foundation 2013; Kings Fund 2017). Although change may happen at the clinical micro-level, it is

thought there is greatest impact of healthcare improvement when it is embedded within a coherent, organisation-wide approach (Batalden and Foster 2021; Coles et al. 2020; Dixon-Woods et al. 2012; Shah 2020). There has been a growing use of organisational wide approaches to improvement including the introduction of large-scale national improvement programmes which are thought to have potential to have broader and longer lasting impact (Health Foundation 2013; Greenhouse and Papoutsi 2019; Mannion and Davies 2018; Persson et al. 2021).

2.3.1. National organisations in healthcare improvement

There are several national organisations in Scotland with an improvement focus including: The Centre for Sustainable Delivery, Health and Social Care Alliance Scotland, Improvement Service, and HIS. Table 3 outlines key national organisations in Scotland working on improvement in NHSScotland, highlighting their purpose and focus.

Table 3: National organisations in Scotland

Organisation	Purpose
The National Centre for Sustainable Delivery	This national unit is designed to sustainably improve and transform Scotland's healthcare system through innovation, collaboration and clinical leadership. In relation to improvement, they aim to embed best practice by driving forward existing programmes proven to add value in improving health and social care.
Health and Social Care Alliance	National third-sector intermediary for a range of health and social care organisations.
Improvement Services	The national improvement organisation for local Government in Scotland.

Healthcare Improvement Scotland (HIS)	The national improvement agency for health and social care in Scotland.

HIS was established by the Public Services Reform (Scotland) Act (2010) and acquired responsibility for the function of NHS Quality Improvement Scotland. National improvement initiatives have been viewed as a key mechanism for delivering wider public service and healthcare reform. In locating this study, the wider social and political factors that influence the work of HIS will be discussed. To consider these factors I will briefly discuss the approach to public service reform in Scotland to position the work of national improvement organisations, I will then outline the operational framework for HIS which describes the agreed responsibilities and relationships with key stakeholders, and finally I will outline the challenges this context may pose to partnership working within the national organisation context.

2.3.2. Healthcare improvement within a system of public sector reform

The Christie review of Public Services in Scotland carried out in 2010 recommended substantial reform of how public services were delivered to make them “outcome-focused, integrated, and collaborative. They must become transparent, community-driven and designed around users’ needs” (Scottish Government 2011 p. 22). There is broad agreement that to implement recommendations outlined by Christie, structural reform would support closer partnerships between public service organisations (Mitchell 2025) by introducing coordinated organisational governance, systems and reporting. There has; however, been a lack of coordinated structural reform in Scotland which has resulted in structural complexities (Connolly and Pyper 2021). The current health and social care system in Scotland has been described as a

“cluttered national landscape” of improvement focused bodies with a lack of clarity over roles and responsibilities (Connolly et al. 2023; p.636).

Rather than implementing structural reform The Scottish Government adopted an empowerment focused approach to “inform and guide the discussion and planning of policy and services in Scotland” through the development of the National Performance Framework (NPF) (Scottish Government 2022, p. 10). The NPF was developed in 2007 and has a focus on local decision making centred around the delivery of high-level outcomes. A recent consultation highlighted several challenges experienced in implementing this framework in practice including a lack of policy coherence, complex reporting arrangements, difficulty identifying improvement and changes through the NPF, and dissatisfaction with current funding models (SPICe Spotlight 2024). The initial response to this consultation appears to be to revise the specified outcomes and there is limited detail of changes to organisational structures, governance, or accountability arrangements planned in health and social care.

National improvement initiatives take place within this complex structural and policy landscape where tensions exist between nationally arranged improvement activities, national performance measures, and local empowerment in health and social care. HIS is the national improvement organisation for healthcare in Scotland funded by Scottish Government and receives a combination of core funding and additional allocations which are granted in relation to specific projects or programmes (HIS 2023). HIS has an agreed duty to lead improvement in the quality of health care by carrying out a range of support, monitoring, and assurance of healthcare activities which are reported to Scottish Ministers. The funding and reporting arrangements may lead to considerable uncertainty in future programmes and creates a challenging relationship between HIS and stakeholders with a need to balance the needs of Scottish Government with the needs of staff working in the wider

healthcare system, and the needs of other stakeholders including third sector, and PWLE.

Skills required by staff working within national organisations include working with a range of stakeholders with a range of different value sets (Langley and Denis 2011). It has also been observed that understanding political structures and process are key for successful implementation of improvement programmes, particularly in a national context (Ovretveit and Klazinga 2012). In the current political landscape in Scotland these stakeholder relationships include working with others in different organisations with very different accountability and governance arrangements such as local government and the third sector (Scottish Government 2019). The third sector includes charities, social enterprises and community groups and receive funding through public sector contracts and grants, much of which is short-term (Scottish Parliament 2025). Such short-term funding creates organisational uncertainty and can result in time and resources being used to secure funding for programmes of work. This uncertainty and focus on funding may influence working practices and create tension between stakeholders operating within this landscape.

Partnerships within national improvement also involves working with PWLE. Working with PWLE in public service reform was recognised in the Christie Commission and is highlighted in the literature as key to improvement initiatives. Since the principles were outlined in the Christie Commission in 2011, there has been a degree of policy signaling in health and social care policy about the need for close partnership working, but a lack of clarity on how this could be achieved in practice (Mitchell 2025). This lack of clarity for partnership working with PLWE is also seen within the various models for improvement (outlined in section 2.2.1). HIS's operational framework states there is a commitment to "ensuring the engagement of people and communities are co-located with the delivery of improvement support" (Scottish Government 2019; p. 3). Connolly et al (2020) carried out a review of how co-production has

been implemented in improvement practice in Scotland (Connolly et al. 2020). This research analysed data from documents and interviews with staff within the health and social care context. Findings from this research highlighted a number of reported challenges within the national organisational context; however, it did not analyse how partnership working was implemented in practice at an operational level and there remains a lack of understanding of how partnership with PWLE happens in practice.

2.3.3. Key areas for this research

The context of national organisations are central to this research. Improvement efforts have been viewed as a key mechanism to deliver public service and healthcare reform in Scotland and national improvements play a significant role in this. Public service reform in Scotland have been influenced by principles outlined in the Christie Commission in 2011 and close working with PWLE and communities have been highlighted as a core feature of reform and improvement. In order to design and deliver national improvement efforts there needs to be an understanding of the wider policy context, identify appropriate improvement approaches, and a need to balance a range of stakeholder needs – including understanding how to involve PWLE in these efforts. There is limited evidence on how PWLE are involved in national improvement efforts and closer exploration of this is warranted. This case study was focused on one national improvement programme with an aim of understanding how partnership working happens in practice with a focus on the operational level of the national organisation.

2.4. Components of partnerships

A key principle to healthcare improvement is working in partnership with others in the system including other agencies, PWLE, and frontline staff. PWLE are

thought to have a central role to play in understanding problems and identifying solutions to ensure change delivers outcomes that make a difference (Alderwick et al. 2017). Batalden and Foster (2021) put significant emphasis on the need to work with PWLE and propose that the next phase of healthcare improvement will see improvement achieved through relationships with PWLE. This section details evidence supporting partnership working with PWLE in healthcare improvement, with a focus on working with PWLE in mental healthcare improvement initiatives. I then discuss key components of partnership including language used to describe efforts to work with PWLE, models of partnership which have been used to conceptualise partnership in health and social care settings, and key features of partnerships, in particular power and conflict.

2.4.1. Partnership working with PWLE in healthcare improvement

Working with PWLE in improvement initiatives is thought to have a number of benefits including offering unique insights and perspectives, creating a service more aligned to patient needs, responding to local needs and developing indicators to help improve care (HQIP 2017). Benefits of working with PWLE can be seen in terms of experiences, outputs, and outcomes, though there is a lack of consistency in how partnership working is measured (Nordin et al. 2023). Clarke et al (2017) presented an evidence synthesis of outcomes associated with co-production in improvement in acute settings, which is the micro-organisational level. This review concluded that when a systematic approach to co-production is used there are positive reported outcomes related to the process of participatory processes between staff and patients, improved generation of ideas for improvements, and improved patient experiences. This paper focused on studies that used a structured approach to co-production or co-design within an acute hospital setting so it is unclear if similar outcomes would be seen in partnership working in different contexts, especially a national improvement context. Another systematic literature review of improvement reported on research located within the meso-organisational level. This paper

highlighted that the level of patient engagement appears to influence the outcomes of service redesign and concluded that patient engagement can inform policies, service delivery and governance (Bombard et al. 2018). However, there was a particular focus on co-design in this review, and this paper only included studies which had followed a structured approach to patient involvement informed by specified models of participation. The evidence suggests that patient engagement contributes to improved outcomes when structured approaches to participation are used. It is unclear if similar outcomes are seen when less structured approaches to partnership working are used and there is limited understanding on outcomes of partnership with PWLE at a macro-organisational level including national improvement initiatives. Despite limited evidence at a macro-organisational level, evidence from studies at micro and meso-organisational level suggest that working with PWLE has a number of benefits, and the need to work with PWLE across all healthcare improvement is recognised in both models for improvement and in the wider public sector reform agenda.

In addition to evidence supporting why PWLE should be involved in healthcare improvement, research has considered how PWLE can best be involved, with some emerging evidence of involvement at a macro-organisational level. Recent research by Alliance Scotland (2022) identified key factors which support working with PWLE in a context of public service reform. Clarity of communication, goals and expectations, support and training, time, and resources were found to support partnership working in this context. This report recommended that working with PWLE in public service reform should ensure that all needs are represented, involvement happens at every stage and there is monitoring and evaluation of involvement. The findings of this research should be treated with some caution as they were based on a small number of participants (n=6) who were recruited directly through the Alliance and therefore may not reflect views of PWLE in the wider population.

Although factors that support involvement are described in the literature, there is recognition within the current evidence base of a number of difficulties and barriers to involvement with PWLE. There is a risk that involvement can be used to present a false appearance of inclusiveness, with a recent systematic review of reviews suggesting that patient involvement is often perceived as tokenistic (Ocloo et al. 2021). Some researchers have reported that at times patient involvement in healthcare has been viewed by participants as a way to legitimise already determined managerial or professional decisions (Entwistle et al. 2010). A recent paper published by patient partners reflecting on their experiences of involvement in healthcare describe negative experiences of patient involvement including examples of patient involvement being used in in a tokenistic way, bias towards individual patient partners at the exclusion of others, a lack of support for full inclusion, and a lack of recognition of the vulnerability of patients during involvement (Richards et al. 2023).

2.4.2. Partnership working in mental healthcare improvement

As this research focused on partnership working in a mental health improvement programme, consideration is also given to partnerships within contexts of mental health improvement. As outlined in Section 2.1.3 mental health services are based on relational approaches to care, and in clinical settings relationship between health professionals and patients can be on a long-term basis. This has led to greater partnership working observed at a clinical micro-organisational level (Todd et al. 2020) with partnership working embedded across mental health services. There has been a move from traditional models of care delivered to people, to a strengthening of rights-based approaches in which care is planned and provided in partnership with people (RCN 2016). There are; however, a number of challenges to partnership working in mental health services include tokenistic involvement and stigma associated with mental ill health (Scholz et al. 2018). There may be additional challenges when working with people who have a diagnosis of PD as the diagnosis is characterised by unstable relationships with other people, an

unstable sense of self, and unstable emotions, and symptoms can result in impulsive actions (Mental Welfare Commission 2018).

In addition to working with PWLE in clinical settings, it has been suggested that PWLE and their families should also be able to participate in the development of policies to improve and strengthen mental healthcare systems including improvement initiatives (Carbonell et al. 2020). Although working in partnership with PWLE in improvement initiatives at the macro and meso-level of organisations is recognised, there continue to be reported tensions between the ideology and practice of partnership working. Tindall et al. (2021) reviewed co-design practices in mental health settings and found that despite a commitment to working with PWLE, there are specific barriers in relation to co-design in mental health due to power imbalances, pressure to make fast-paced decisions, and previous experiences of mental healthcare, which may be unique to this population.

Although there are some examples in the literature of involving PWLE in local mental healthcare improvement within the micro and meso-organisational levels (Kings Fund 2017; Boland et al. 2020; Davies et al. 2020); there appears to be limited understanding in the literature of how partnership working with PWLE happens in practice in at a macro-organisational level within national organisations. The factors that support partnerships and barriers to involvement with PWLE outlined in the literature are descriptive in nature and do not appear to explore underlying assumptions, values, and perspectives of partnerships to offer a depth of understanding. This research explored partnership working with PWLE and the following sections describe key components and features of partnership to support more in-depth consideration of the concept of partnerships used in this research.

2.4.3. Language of partnership

Language used to define and describe partnerships provide crucial insights into individual and organisational beliefs, perceptions and conceptualisation of partnership. Language used in partnership includes definitions and descriptions of partnerships. Working with PWLE has been recognised across healthcare and there are several different terms and descriptions used to describe the involvement of PWLE in healthcare including engagement, involvement, collaboration, and participation. There has also been growing focus on co-production and co-design within healthcare improvement, with similar ambiguity noted in relation to concepts and definitions used (Masterston et al. 2022). This has been described as a cluttered landscape of definitions and approaches, which is happening alongside an ongoing debate as to what counts as meaningful involvement (Locock and Boaz 2019). Fumagalli et al. (2015) conceptualised working with PWLE as a development from basic delegation of tasks as involvement, to intellectual co-operation seen within collaboration, to joint venture demonstrated within partnership working. For this research, I have used the term partnership working as a broad term used to explore and provide a greater understanding of how PWLE were involved and included in national improvement efforts.

2.4.4. Models of partnership

Models or frameworks are used to structure and guide how various stakeholders may work together in different areas of public services including healthcare improvement. A seminal framework of partnership which is widely used in health and social care settings is Arnstein's 'Ladder of Participation' (Arnstein 1969). Arnstein's model of participation is represented in a metaphorical 'ladder' with each rung representing different levels or processes for participation. The initial stage of this model outlines processes which are described as non-participation, including forms of manipulation and therapy.

The second stage describes degrees of tokenism which includes informing, consulting and placation. The final stage in this model is defined as degrees of citizen power and includes partnership, delegated power and citizen control (Figure 2). Arnstein's ladder is based on a conceptualisation of participation as a form of power and each rung of the ladder represents a way for citizens to claim power against organisations or institutions (Collins and Ison 2006). This model does not reflect the complex and dynamic nature of participation (Carpentier 2016; Tritter and McCallum 2006) and views working with PWLE through a normative lens (Gathen et al. 2023) which risks bias and assumptions that any form of participation that happens within the early stages of the ladder is inherently less effective or appropriate. Despite these criticisms, the ladder of participation remains prevalent within the context of partnership, particularly within health and social care settings.

Figure 2: Arnstein's ladder of participation

Since Arnstein's publication there is a greater awareness of the complex, dynamic and non-linear nature of participation and further models have been proposed to consider forms of partnership working. More contemporary partnership models used in areas of public service and research include an engagement framework developed for patient involvement in healthcare, based on Arnstein's ladder of participation which describes a continuum of involvement from consultation to partnership (Carman et al. 2013), Hanley's Model of Involvement (2004) which describes three levels of participation, and the involvement matrix used to describe collaboration between researchers and patients (Smits et al. 2020). Although these models avoid conceptualising participation in hierarchical terms, they do not fully address the complexity of relationships and partnerships. There are risks that models of participation are viewed as tools, processes, and techniques to be followed with a lack of consideration of the values and beliefs which inform and shape partnerships.

The need to understand underlying values, power relationships and patterns of interest has been recognised as key to improvement initiatives (Langley and Denis 2011) and in this research a more reflexive and nuanced approach to understanding partnerships was preferred, taking into account the participatory processes that may be viewed in partnerships. Carpentier (2016) published a toolkit to support critical analysis of participatory processes within partnerships, describing four key dimensions of: field; actors; decisions; and power. Although this toolkit was not based around healthcare improvement, it outlines an analytical framework that can be used with a range of methods depending on the process being researched (Carpentier 2016).

Consideration of the concept of partnerships within this research included discussions with the public partner in this research and their preference was to include Arnstein's ladder of participation. A combination of the Carpentier and Arnstein's models of partnerships were used in a flexible way to support a deep engagement with the data and this model is presented in Chapter 5.

2.4.5. Power within partnership working

Power is recognised as a key factor influencing partnerships within healthcare, and careful consideration should be given to analysing the theoretical and methodological considerations underlying power in healthcare settings (Topp et al. 2021). Power can be complex to examine as expressions of power are context dependent and may be covert or hidden (Public Health Scotland 2021). Power is also thought to be manefested in complex and subtle ways (Greenhalgh et al. 2023). The World Health Organisation (WHO) have outlined components of power within a conceptual framework on the social determinants of health (WHO 2010) which identifies four different types of power:

- Power Over – where there is an ability to influence others
- Power To – where there is the ability to organise or change hierarchies
- Power With – where there is the power of collective action and,
- Power Within – where individuals have capacity to exercise power.

Power has been described in Miller's power matrix (Miller n.d.) which is presented to demonstrate the complex and dynamic relationships between forms of power and highlight relationships and interaction between categories of power. The power matrix was developed based on Gaventa's Power Cube (Powercube n.d) which provided a tool to help conceptualise power relationships in various contexts involving citizen participation. Miller's work illustrates how different aspects of power interact and describe examples of both the type of power and these may manifest in social contexts.

A combination of Miller's power matrix and the components of power (WHO 2010) was used within this research (Table 4). This framework was used to support analysis and reflexive approaches were also used throughout this

research to ensure deep engagement with the data and allow for emerging and developing understanding of the complexity of partnerships.

Table 4: Framework of power based on Miller (n.d.) and WHO (2010)

Type of power	**Mechanisms of power**	**How power is demonstrated**
Power Over	Powerful actors influence the actions and thoughts of relatively powerless actors.	Powerful actors control spaces, decision-making, and prevent others gaining power.
Power To	Where there is the ability to organise or change hierarchies.	Individual people make decisions and actions. There is some evidence of mutual support, and this may develop into a type of Power With.
Power With	Where there is the power of collective action.	Mutual support, solidarity, collaboration.
Power Within	Where individuals have capacity to exercise power.	Recognition of individual differences and respecting others.

2.4.6. Conflict in partnerships

Conflict is considered a key feature of human relationships and partnerships (Faculty of Public Health Knowledge n.d.) and in this research, conflict was a key consideration in understanding partnerships. Conflict within workplaces can lead to better judgement, decision making and recognition of others' opinions (Cosier and Dalton 1990) which may lead to improved team performance and team working (Tekleab et al 2009) and is a source of learning

or innovation (Eichbauam 2018). This positive view of conflict is not noted within NHS contexts. Although conflict is thought to be inevitable, in healthcare teams the response has been to avoid or manage conflict (NHS England n.d.; Bradley et al. 2013; Eichbaum 2018) with a goal of achieving harmony (Greenhalgh et al. 2023). NHS England have defined conflict as behaviour that is intended to obstruct the achievement of goals and considers conflict as negative or disruptive. This description uses emotive terminology and places negative attribution to those who may have different views or opinions. NHS Scotland's approach to conflict appears to be predominately focused within HR policies to resolve conflict within team relationships (NHS Scotland 2020) and there is little evidence of recognition of the possible constructive nature of conflict working in multi-disciplinary or collaborative contexts. Given the context within national organisations with the need to work with and balance the needs of numerous stakeholders across different agencies, the lack of consideration on the positive contribution of conflict is of note. The negative perspective of conflict seen may influence how actors work in partnership and respond to signs of conflict.

Kim et al. (2017) carried out a scoping review of healthcare conflict which identified three types of conflict observed within healthcare settings. This review did not address underlying beliefs and perspectives of conflict but described how and when conflict is seen in healthcare settings. This paper outlined individual conflict, interpersonal conflict and organisational conflict. Individual conflict happens when people's concept of self is threatened or when personal resources are depleted and is demonstrated by misinterpretation of others' motives, worldviews, abilities or integrity. Interpersonal conflict happens when there are communication breakdowns, power differentials or dehumanisation of others and is demonstrated by social distance or incivility. Organisational conflict happens in relation to tasks, procedures and use of resources and is demonstrated by professional disengagement. Although this scoping review did not consider conflict across different organisations – which may provide additional complexity to relationships, the descriptions of conflict

were viewed as appropriate to inform this research and a conflict framework was developed, outlining the type of conflict, when it happens and how conflict was demonstrated (Kim et al. 2017) and is outlined in Table 5 below.

Table 5: Framework of conflict

Type of conflict	**When conflict happened**	**How conflict was demonstrated**
Individual	People's concept of self is threated, or when personal resources are depleted	Misinterpreting other's motives, worldviews, abilities or integrity
Interpersonal	Communication breakdown, power differentials or dehumanisation of others	Social distance or incivility
Organisational	Conflict around tasks, procedures and use of resources	Professional disengagement.

Conflict within healthcare improvement has not been widely considered. In improvement programmes there are often efforts to build a 'shared vision' at the start of programmes which may not recognise or explore why people have strong conflicting views and in building such apparent consensus, less powerful voices may be silenced (Greenhalgh et al. 2023). The focus of a shared vision tends to be on the problem to be addressed and the outcomes of improvement, with a lack of consideration of the need to establish an understanding of different perspectives, expectations and experiences of working in partnership.

2.4.7. Key areas for this research

Partnership working with PWLE has been identified as a key component of improvement and public service reform. There are specific challenges that may present when working with PWLE in mental health improvement, specifically

within national improvement initiatives due to the position of these organisations.

In order to understand partnership working within improvement it has been recommended that research should be centred around how partnerships happen, by understanding the structures and processes used (Armstrong et al. 2013). Although this will be beneficial to improve methods or techniques for partnership, there is also a need to consider how partnership working is conceptualised and understood by participants. Consideration of the underlying beliefs of partnership will provide insights into how decisions about structures, processes, tools, and techniques are made (Collins and Ison 2006).

2.5. Conceptual framework in case study research

A conceptual framework is a visual or written representation of the expected relationships between concepts within a study and is used to help researchers organise their ideas, clarify the research problem and guide data collection and analysis. Conceptual frameworks are developed by researchers conducting the study and these can be based on the literature, their experiences and shared experiences of others (Luft et al. 2022). There are, however, concerns that the reliance on conceptual frameworks can "limit the potential of the researcher to remain open to the new and unexpected and tend to confine data into pre-determined categories and relationships" (Sale and Carlin 2025, p. 3). Nilsen (2015) also suggests that the use of frameworks may diminish the ability of qualitative researchers to remain open to wider and more nuanced interpretation of data. There is some concern that the field of healthcare improvement is "drowning in theories" (Oxman et al. 2005) which may have led to a reduction in their meaning or value, and it has been proposed that conceptual frameworks are most effective when used in a reflexive manner with description of their intended purpose and limitations (Hudon et al. 2014). The purpose of a conceptual framework in this research is to provide insights into

concepts pertinent to the phenomenon of partnership working with PWLE in a national mental health improvement context.

Partnerships were central to this research and were considered in relation to the context in which partnerships occurred and the concept of partnerships. The context in this research was mental healthcare improvement within a national organisation. Wider political and social influences have been described in this context but as this research is located at healthcare improvement design and delivery, they were not considered essential components of this research. The concept of partnership was considered in relation to language, models, and features of power and conflict. Models of partnership can be helpful guides to understand some features of partnership and a combination of Carpentier's model describing participatory processes in partnership, and Arnstein's ladder of participation was selected in collaboration with the public partner involved in this research. There is a risk that models do not address more complex and nuanced aspects of partnership. To consider key features of partnership I developed frameworks for power and conflict.

In this chapter I have outlined key concepts that were considered likely to influence partnership working with PWLE in the context of a national mental health improvement programme. The specific nature of how each concept may interact and influence each other was not identified at the start of research. The purpose of this chapter was to describe concepts pertinent to this research and bearing in mind the criticisms of over-reliance on conceptual frameworks my approach was to progressively develop these, understanding how they interacted and influenced each other throughout analysis.

2.6. Chapter conclusions

This chapter provided an overview of key concepts pertinent in this research. My approach to developing a conceptual framework was highlighted in this chapter describing the context within this research and features of partnership. The importance of context within improvement was discussed as this informed the decision to use a case study approach to research - which is outlined in Chapter 4, Methodology. Chapter 3 will now describe a systematic review of the literature carried out to further explore the evidence base informing this research.

3. Understanding the problem

3.1. Introduction

Chapter 2 outlined the context relevant to this research of mental health services, health care improvement, the role of the national organisation in leading improvement, and a central concept of working in partnership with PWLE. This was based on a broad review of the literature and personal experience of working in mental healthcare settings and in a national organisation. A systematic review of the literature was then carried out to carefully consider the current evidence base, examine gaps in the evidence and develop an appropriate research question. An initial literature review was carried out in 2021 to develop a research proposal (Robertson et al. 2024; detailed in Appendix 1), which was updated in 2024 to prepare this thesis.

Chapter 3 describes the literature review that was carried out in 2024 to understand the evidence base detailing the involvement of PWLE in national mental healthcare improvement. Section 3.2 describes stages of the literature review, outlining the search strategy the context appraisal, assessment of methodological quality, and content appraisal of selected studies. Section 3.3 then highlights the gaps identified in the literature which was used to develop an appropriate research question used to inform the research methodology and design.

3.2. Literature review

A literature search is a key step in the research process to help identify the research problem and formulate an appropriate research question. A literature search is a systematic and well-organised search from the already published data to identify high quality research in an agreed area of focus (Grewal et al. 2016). The purpose of this literature search was to understand the phenomenon of partnership working in the context of national improvement

programmes in mental healthcare settings. A PICo framework was selected as appropriate to support a structured literature search (Stern et al. 2014). PICo outlines the Population, phenomenon of Interest, and Context to develop a research question (Hosseini et al. 2024). For this research, the Population was PWLE in mental healthcare, the phenomenon of Interest was partnership working, and the Context was a national improvement programme. The research question was identified through an initial conceptual framework described in Chapter 2 and addressed by a systematic review of literature. The broad research question was: how does a national organisation work in partnership with PWLE in a mental health improvement programme? The conceptual framework helped identify key concepts to be addressed and in order to approach the research question I identified several questions which were explored in the literature search:

- How is partnership working with PWLE defined?
- At which level of organisations are PWLE in mental health services involved?
- What improvement focused interventions involve PWLE in mental health services?
- What are the factors that support working with PWLE?

Once the search question was identified, the next stage was to identify the search strategy which is now discussed.

3.2.1. Search strategy

In order to systematically review the literature, a Boolean search strategy was developed based on the key concepts within the research question including a combination of text words and medical subject headings (MeSH) terms, searched in titles and abstracts of studies. The use of truncation (*) was included in the search terms to ensure variation on terminology were included. Search terms were identified based on the PICo framework and are outlined in

Table 6 . The following databases were selected as most relevant: Medline (OVID); CINAHL; PsychINFO, and the Public Health Database available through the NHS Knowledge Network. Two studies were identified as centrally relevant and used as a sensitivity check within the literature search. A preliminary database search resulted in 431 papers available for screening title and abstract, but only five of these papers were identified as appropriate to include for full paper review. The excluded papers did not include a relevant context related to improvement programmes (n=177), were not related to mental health care settings (n=114) or did not refer to patient involvement (n=135). I therefore decided to update the search terms to exclude specific reference to mental healthcare settings as papers focused on healthcare improvement may be located across a number of healthcare settings, and relevance to a mental healthcare context would be considered during the screening process.

Table 6: Search Strategy

PICo search strategy	**Search terms / keywords**	**Related terms / Synonyms**	**Alternative terms**
Population	People who have lived experience in mental health services	Patient, client, service user, carer	
	AND		
phenomenon of Interest	Partnership working	Involvement, engagement, participation, involv*, particip*, engage*, collaboration co-production, partnership	
	AND		
Context	National healthcare improvement programme	Quality, improvement, national, programme, improv*Healthcare,	Service improvement

		health*, health service, health org*	

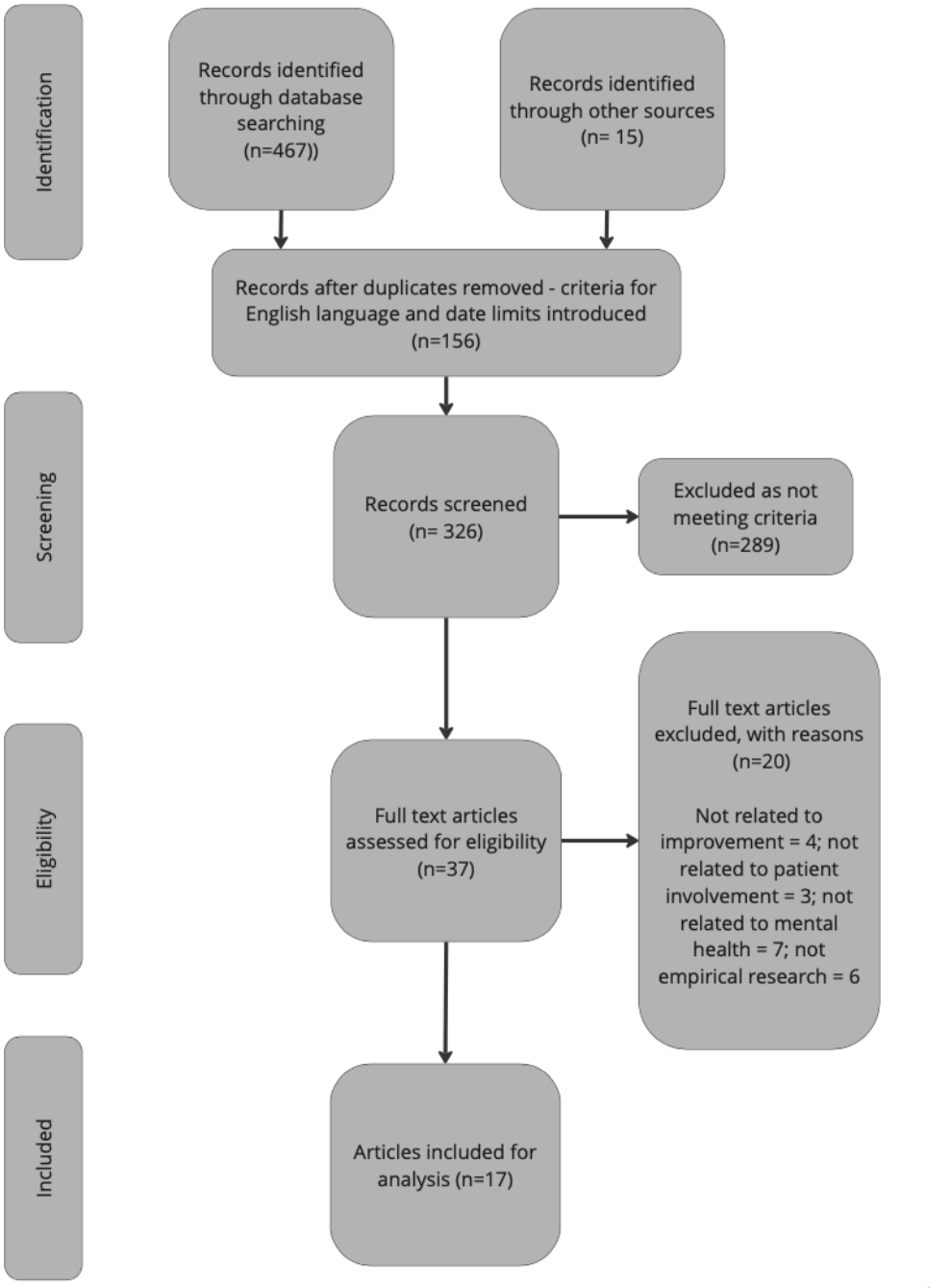
The second database search resulted in 467 papers identified and 15 papers identified through other sources including the first literature search and snowballing. Mendeley Reference Manager was used to check for duplicate papers and a search limit of English language papers from 2014 was set to ensure findings remain up to date and reflect the growing commitment to healthcare improvement thorough the formation of national bodies. This resulted in 326 papers identified, and an initial review of titles and abstract was carried out on these papers against inclusion and exclusion criteria. Papers which did not have specific references in the title or abstract to patient involvement, quality improvement, or improvement focused work within a healthcare setting were not included. I did not include papers that focused on patient involvement in direct care as this review of literature was centred on understanding patient involvement in healthcare improvement or system level improvement efforts. A summary of inclusion and exclusion criteria is outlined in Table 7.

Table 7: Inclusion and exclusion criteria

Inclusion	**Exclusion**
Quality improvement Improvement programme Large scale improvement Healthcare improvement Patient involvement / engagement / collaboration Patient partnership Empirical research English language Publication year 2014-2024	Mental wellbeing Patient involvement in direct care Patient centered care

Results from the search are detailed in a PRISMA flow diagram (Moher et al. 2009) in Figure 3.

Figure 3: PRISMA Flow Diagram



3.2.2. Context appraisal

A scoping review process was selected as appropriate to address this exploratory research question with an aim of mapping key concepts, types of evidence, and gaps in research related to partnership working with PWLE in national organisations (Amog et al. 2022). The first step in analysing the literature was to carry out a context appraisal of each study. At this stage I reviewed each study against key characteristics to understand if the papers were situated in a context relevant to this research. There were nine systematic reviews and eight qualitative research papers, and characteristics of each type of study were initially analysed separately. Data from systematic reviews was considered in terms of description of the approach used, number of studies analysed in each review, and contextual factors which would provide information on the healthcare system. The key characteristics of systematic review papers are documented in Table 8 below.

Table 8: Characteristics of systematic reviews

Author and date	Number of studies reviewed	Type of review	Setting	Organisational level	Country
Bergerum et al. 2019	18	Realist literature review	Various healthcare settings – mental health not specified	Various	Sweden
Bombard et al. 2018	48	Systematic review	Various healthcare settings including mental health	Various	Canada
Green et al. 2020	20	Systematic review	Various healthcare settings including mental health	Meso	Australia
Kjellstrom et al. 2024	73	Systematic literature review	Health care settings including mental health, policy and research	Various	UK and Sweden
Nordin et al. 2023	43	Systematic review	Health and social care settings including mental health services	Not clear	UK and Sweden
O'Brien et al. 2021	9	Scoping review	Adult mental health services	Various	Australia
Ocloo et al. 2021	42	Systematic review of reviews	Broad public services including healthcare	Various	UK
Robert et al. 2024	73	Narrative review	Various healthcare settings – including mental health	Various	UK and Sweden

Sandvin Olsson et al. 2020	34	Scoping review with thematic analysis	Various healthcare settings – including mental health	Various	Norway

The systematic reviews had appraised between 9 and 73 papers and were carried out from 2018 to 2024. From the information available, the reviews included papers ranging from 1990 to 2019 – this range is large and some of the earlier papers may not be representative of the growing body of research in this field. Robert et al. (2024) did not include information on the dates of papers reviewed as this was one report from a series of articles. It was unclear from the set of articles which papers were included in this narrative review. Each paper examined research from various clinical settings with seven papers specifying mental health settings. Five papers were described as systematic reviews, two were described as scoping reviews, one a realist literature review, and one paper consisted of a narrative review. A realist review assesses if the research was fit for purpose according to relevance and rigour, incorporating theory, research evidence and practical knowledge, as opposed to using a quality appraisal tool or framework (Coles et al. 2020). Scoping reviews are used to clarify concepts and key issues related to a concept and examine how research is undertaken in a specific field (Khalil et al. 2021). Narrative reviews are used to provide a meaningful synthesis of evidence that may be complex and require a broad description or interpretation of analysis (Sukhera 2022). All papers were thought to provide useful data to inform this review of literature.

Eight papers consisted of qualitative research and were reviewed in relation to the key characteristics of date, type of study, setting, organisational level, and country research took place in. These key characteristics are outlined in Table 9 below:

Table 9: Characteristics of qualitative studies

Author and date	Type of study	Setting	Organisational level	Country
Bergerum et al. 2020	Qualitative grounded theory	Hospital setting for patients with transient, chronic and / or parallel diagnosis	Meso	Sweden
Bjonness et al. 2024	Qualitative thematic analysis	Youth mental health services	Micro	Norway
Broer et al. 2014	Qualitative ethnographic design	QI collaborative for mental health services	Macro	Netherlands
Goodridge et al. 2018	Qualitative interpretative approach	Not specified – system wide approach to improvement	Unclear	Canada
Hackett et al. 2018	Qualitative interpretative phenomenological approach	Evidence Based Co-Design (EBCD) in mental health	Meso	Canada
Mulvale et al. 2019	Qualitative modified case study approach	Vulnerable and disadvantaged populations (including mental health populations)	Various	Australia

Persson et al. 2021	Qualitative content analysis	All healthcare settings – system wide approach to improvement	Macro	Sweden
Todd et al. 2020	Qualitative thematic analysis	Three NHS settings, Mental health trust, community health and acute hospital	Meso	UK

Various qualitative approaches were used in these studies which were carried out in various locations across Europe, Canada, and Australia. Eight papers were identified as appropriate to include in this literature review. Five papers specified mental health settings, one paper focused on various clinical settings in a hospital, and two reviewed a system wide approach to improvement so included all healthcare setting.

Following the context appraisal, an assessment of methodological quality was carried out for both systematic reviews and qualitative research papers which is now discussed.

3.2.3. Assessment of methodological quality

Analysis of methodological quality was carried out for both systematic reviews and qualitative research to ensure findings used to inform this research were from high quality papers. The Critical Appraisal Skills Programme (CASP) (2018 and 2024) checklists were selected as appropriate critical appraisal tools to analyse the quality of systematic reviews and qualitative studies against evidence-based criteria. This information was used to inform synthesis and interpretation of the results of the eligible studies. The CASP checklist for systematic reviews consisted of 10 questions to consider if the study results were valid, clear, and would help locally (CASP 2018). The CASP checklist for qualitative research (CASP 2024) also consisted of 10 questions to consider the validity, clarity and application of results. A summary of methodological assessments is detailed in Appendix 2.

The methodological quality of both systematic reviews and qualitative research was observed to be generally high. One paper (Todd et al. 2020) was considered to have insufficient detail on methodology, methods, and analysis and therefore was not included for further analysis. The next step in this

literature review was to review each paper to consider relevant evidence and findings to develop a greater understanding of gaps in knowledge.

3.2.4. Data extraction and synthesis

The aim of this analysis was to identify current evidence of when, how, and at which organisational level PWLE were involved in improvement focused work, outlining the context for working with PWLE. Each paper was reviewed to extract information on the definition of partnership working, level of organisational involvement and description of the type of involvement, including factors that support partnership working with PWLE.

3.2.4.1. Definitions of partnership

Definitions of partnership working were varied and used terms such as patient involvement (Bergerum et al. 2019, 2020; Bjonness et al. 2024; Ocloo et al. 2021), patient engagement (Bombard et al. 2018; Goodridge et al. 2018), patient participation (Broer et al. 2014; Sandvin Olsson et al. 2020), and co-production (Kjellstrom et al. 2024; Nordin et al. 2023; Persson et al. 2021; Robert et al. 2024). Four papers researched co-design (Green et al. 2020; Hackett et al. 2018; Mulvale et al. 2019; O'Brien et al. 2021) which is a specific approach used with PWLE in quality improvement. Many papers highlighted the lack of clarity in definitions used to describe work which involved PWLE, and three papers recommended that a generic term should be used to describe working with PWLE (Kjellstrom et al. 2024; Ocloo et al. 2021; Sandvin Olsson et al. 2020).

For this research, a generic term of partnership was identified to describe joint venture with PWLE, and a focus of the research would be to understand how partnership working was described in practice.

3.2.4.2. Level of organisation

The organisational level in which studies took place was considered using the definitions outlined in Section 2.3. There was variation in the level of organisation described with one paper located in the healthcare organisational micro level (Bjonness et al. 2024) four studies specifically focused on the organisational system meso-level (Bergerum et al. 2020; Green et al. 2020; Hackett et al. 2018; Todd et al. 2020), and two papers studied system wide or national macro-level interventions (Broer et al. 2014; Persson et al. 2021). These papers studied specific aspects of improvement work in a national context, Broer et al. (2014) analysed power relationships within a QI collaborative, and Persson et al. (2021) described the development of system wide co-production in QI at a national level in Sweden. Eight papers reported on improvement at various levels of organisations (Bergerum et al. 2019; Bombard et al. 2018; Kjellstrom et al. 2024; Mulvale et al. 2019; O'Brien et al. 2021; Ocloo et al. 2021; Robert et al. 2024; Sandvin Olsson et al. 2020) and two papers did not specify the organisational level within their papers (Goodridge et al. 2018; Nordin et al. 2023). This indicates limited evidence on working with PWLE at the national macro-level of organisations which is the focus of this study.

3.2.4.3. *Description of improvement*

There were various descriptions of the improvement work within papers with four papers specifying an approach to healthcare improvement, such as Evidence Based Co-Design (Green et al. 2020; Hackett et al. 2018), a national improvement collaborative (Broer et al. 2014), and rapid quality improvement workshops (Goodridge et al. 2018). Five papers highlighted an improvement focus but did not specify or describe the approach (Bergerum et al. 2019; Bergerum et al. 2020; Bjonness et al. 2024; Bombard et al. 2018; O'Brien et al. 2021) and the remaining eight papers described a broad approach to improvement including various approaches to improvement such as QI, service design, and participatory research (Kjellstrom et al. 2024; Mulvale et al. 2019;

Nordin et al. 2023; Ocloo et al. 2021; Persson et al. 2021; Robert et al. 2024; Sandvin Olsson et al. 2020). This review highlighted heterogeneity in the reporting of improvement efforts and a limited detail on descriptions of improvement focused work. Such variation has been recognised and to address this, guidelines have been published to provide a framework for reporting evidence on healthcare improvement. The original guidelines were published in 2008 and updated in 2016 (Ogrinc 2016). Despite publication of these guidelines there appears to continue to be variation in reporting of healthcare improvement. This variation is seen in this literature review as there were various descriptions, definitions and models of intervention reported described under the term improvement. This also reflects the broad approach to improvement adopted in HIS's Framework for Planned Improvement, discussed in Chapter 2.

3.2.5. Content appraisal

The final stage of analysis included a review of papers to identify key factors and context for involving PWLE in improvement focused work. Preparation for partnership working, roles in partnerships, process of partnership working, and challenges of partnership working were identified as key elements to explore the data reported in each paper and these will now be discussed.

3.2.5.1. *Preparation for partnership*

Several papers specified the need to prepare for working in partnership with PWLE and identified the need to adapt methods of improvement, establish appropriate representation and agree principles and approaches that support partnership working with PWLE (Bergerum et al. 2019; Mulvale et al. 2019; Sandvin Olsson et al. 2020). Persson et al. (2021) described preparation for partnership working in relation to organisational forms of setting expectations, identifying structures and tools, and social processes of facilitating conversations and relationships. Sandvin Olsson et al. (2020) described key

criteria for partnership working which should be in place before the improvement work begins including designing approaches to meet the needs of PWLE, identifying structures for partnership, allocating time and resources for partnership working, and securing senior leaders' support for partnership. Kjellstrom et al. (2024) focused on the role of leaders within the partnership process, and they reported on practices within partnership leadership which include social processes of developing and maintaining relationships and interactions among people. In relation to preparation, this systematic review found that leaders play a critical role in initiating co-production or partnership practices. Bjonness et al. (2024) described prerequisites for partnership working with young people who had experience of mental healthcare services. They identified the need to establish a sense of safety, provide accurate information, and develop partnerships between service users and providers in improvement work. They argue these pre-requisites are relevant at the individual (micro) and organisational (meso) level. This study also discussed the importance of addressing attitudes to partnership working with healthcare staff to support meaningful partnerships across organisational levels and highlighted the need to secure wide representation when seeking involvement with PWLE rather than relying on individual groups or organisations.

This review of literature describes that partnership working needs careful preparation at a micro and meso-level; however, there is limited research focused on how this happens in a macro-organisational level. The original literature search carried out in 2021 also identified the importance of preparation for partnerships which was described as an a priori theme of Mechanisms in this research. Mechanisms included analysis of organisational forms, social process and methods of working in partnership.

3.2.5.2. Roles in partnership

A number of papers discussed the range of roles and responsibilities people have within improvement focused work and identified the need to ensure clear roles and responsibilities in partnership working (Bergerum et al. 2019; Broer et

al. 2014; Mulvale et al. 2019; Robert et al. 2024). Bjonness et al. (2024) described various formal and informal roles that PWLE may have when working to improve healthcare, and lack of clarity on roles and expectations was highlighted by Bombard et al. (2018) and Ocloo et al. (2021) in their systematic literature reviews as a barrier to patient involvement. Bergerum et al. (2020) carried out interviews with patients who had been involved in improvement work and identified that a lack of clarity on expectations has the potential to lead to frustration within partnerships. Bergerum et al. (2019) carried out a realist literature review and generated a programme theory for patient involvement in improvement work, which recommended that clarification of roles and responsibilities 'must be outlined from the start' (p. 958). Although clarity of roles at the start of interventions is considered important, Sandvin Olsson et al. (2020) carried out a scoping review of literature which identified the need for ongoing clarification of roles during the process of partnership working. Leadership has a key role in organising and managing partnerships throughout improvement work, which was recognised in a number of papers (Bergerum et al. 2019; Bergerum et al. 2020; Bjonness et al, 2024; Hackett et al. 2018; O'Brien et al. 2021).

Roles were highlighted in the original literature search in 2021 and in both literature searches there was limited discussion of roles within macro-organisational level improvement. Roles were identified as an a priori theme in this research with analysis undertaken to explore how roles were identified, demonstrated, and understood in national improvement work.

3.2.5.3. Processes for partnership

Processes for working in partnership were highlighted in many papers, recognising the need for ongoing facilitation, support and management (Bjonness et al. 2024 and Hackett et al. 2018). Bjonness et al. (2024) carried out a qualitative study to understand young people's experiences of being involved in mental healthcare improvement at a micro-organisational level. Their study found that many PWLE found involvement in improvement

challenging as it required re-visiting memories of their experiences in healthcare, and this paper recommended that resources should be allocated to support and facilitate involvement of PWLE in improvement. Hackett et al. (2018) found the systematic process outlined in the Evidence Based Co-Design model helpful to involve PWLE. Another key process identified to work in partnership was described in terms of building and maintaining relationships (Bergerum et al. 2020; Bombard et al. 2018; Kjellstrom et al. 2018; Mulvale et al. 2019; O'Brien et al. 2021; Ocloo et al. 2021). There was also discussion on the need to recognise, respect, and balance different perspectives to support partnerships with PWLE (Bergerum et al. 2019; Kjellstrom et al. 2024; Persson et al. 2021). Another key element of balancing perspectives and managing relationships was identified as a form of understanding power within partnerships with PWLE. There were varied perspectives on power with many papers highlighting the need to reduce power imbalances (Bombard et al. 2018; Goodridge et al. 2018; Kjellstrom et al. 2024; Robert et al. 2024). Some papers challenged the assumption that there is a power imbalance within partnerships with PWLE in improvement work as Green et al. (2020) reported that power relationships are more equal in improvement focused work than in care relationships; however, the evidence supporting this finding was unclear. Broer et al. (2014) reported that both patients and staff can feel powerless in practice and professional staff were found to be concerned about the potential power imbalances which they reported to be a key difficulty in partnership working.

The first literature search carried out in 2021 identified the need to consider processes for partnership working in relation to: management strategies used, decision-making within partnerships, and power dynamics. A priori themes of Processes and Power were considered relevant to this research.

3.2.5.4. Challenges in working in partnership

Challenges to working in partnership were highlighted in the literature. Skills, knowledge and training of staff were identified in some papers (Bjonness et al.

2024; Kjellstrom et al. 2024). One systematic review paper reported that studies have found that although professionals recognise the need to involve PWLE, there was evidence in a number of papers that professionals did not know how to involve PWLE (Sandvin Olsson et al. 2020). This paper recommended a need to educate professionals on how to involve PWLE in service improvement. Ensuring meaningful partnership and avoiding tokenistic efforts was also identified as a challenge in partnerships (Bergerum et al. 2020; Hackett et al. 2018). Another challenge was reported to be in securing adequate and diverse representation (Goodridge et al. 2018; Mulvale et al. 2019). Bjonness et al. (2024) carried out interviews with young people who had experience in mental healthcare and had been involved in efforts to improve services. This study highlighted the need to exercise caution if there is reliance on single groups or organisation to represent the views and experiences of PWLE. These issues were considered in the a priori themes of Actors, and Challenges.

3.2.5.5. Working with PWLE in mental health settings

There were some challenges specific to a mental health context highlighted in the literature, including concern for the impact on people's mental health and wellbeing if previous experiences are revisited. Bjonness et al. (2024) and Mulvale et al. (2019) described a feeling of vulnerability reported when people were asked to describe their prior experiences in improvement work and evidence of difficulties with ongoing engagement with PWLE due to health concerns during improvement interventions. Some papers highlighted the benefits of involvement for PWLE in mental health settings. Hackett et al. (2018) described the use of a specified model for engagement in quality improvement and reported that this helped improve respectful collaboration in mental health service design. Bombard et al. (2018) outlined the use of a buddy system to support participation with PWLE in mental health improvement work and reported that mental health services were a frequent venue for patient engagement which they suggested may arise from the relational aspect of mental health services though evidence supporting this suggestion was not clear.

3.2.5.6. Future research recommendations

Papers analysed recommended that future research should focus on understanding models or tools used to support partnership working (Green et al. 2020; Mulvale et al. 2019; Nordin et al. 2023; O'Brien et al. 2021), processes for partnership working (Bombard et al. 2018; Broer et al. 2014, Ocloo et al. 2021), structures, systems and organisation of partnership working (Bergerum et al. 2020; Bjonness et al. 2024; Sandvin Olsson et al. 2020), and some papers suggested further understanding on how partnership working is viewed would be helpful to develop a deeper understanding on the context for working with PWLE (Goodridge et al. 2018; Robert et al. 2024).

3.3. Research question

This research synthesis helped identify gaps in the literature and was used to clarify the research question and inform the research approach used in this study. Variation in the description of partnership working and improvement was identified in papers and there was a consensus across papers reviewed that further research into the context of partnership working would be beneficial. There was limited evidence of research located in macro-level national organisations and limited understanding on how partnership working happens in practice. There was some evidence that mental health services work with PWLE and several papers outlined some key considerations for partnership working including preparation, roles, processes, and power differentials in partnership working.

A strength of this literature search is within the integration of qualitative papers and systematic reviews of partnership working within healthcare improvement. However, it is limited in terms of the scale of the research. This is a single researcher study and although academic supervisors were involved to reduce bias, analysis of papers were mainly conducted by the lead researcher. The

search strategy used may have excluded some relevant papers located within mental health settings.

3.4. Chapter conclusions

This chapter has described a literature search which was used to develop a research question which helped identify an appropriate research approach and outline areas for deeper exploration (Hosseini et al. 2024). The research question for this study was: how does a national organisation work in partnership with PWLE in a mental health improvement programme? Chapter 4 will now discuss the research methodology used to design an appropriate study.

4. Research Methodology

4.1. Introduction

The previous chapters outlined the problem and identified a research question as a focus for this research. This chapter describes the process used to consider research methodology, research design and ethical considerations – ensuring these were in line with the philosophical position adopted.

A qualitative case study approach was identified as an appropriate way to address the research problem identified as it enabled a holistic, multi-perspective examination of phenomenon within real life contexts (Carolan et al. 2016; Crowe et al. 2011). There is a lack of consensus on the design, conduct and reporting of case studies (Yazan 2016) and therefore a framework was used to structure the design of this research. The DESCARTE model (Carolan et al. 2016) was developed based on reviews of case studies within healthcare settings and was identified as an appropriate guide to inform this research design.

There are three stages to the DESCARTE model: situation of the research and the researcher; components of the case study design, and data analysis. The first stage of the DESCARTE model involved describing the situation of the research and the researcher which is detailed in section 4.2 where I outline research methodology, aims and objectives before describing the philosophical paradigm in this research. The second stage of the model involved determining the components of case study design which are detailed in section 4.3. The final stage of the model was to describe data analysis used in this research which is introduced in section 4.4.

4.2. Situation of the research and the researcher

In designing case study research, it has been recommended that the researcher states explicitly their informing philosophical approach, situation of "self" within the research and any ethical considerations, to outline the position of research and researcher (Carolan et al. 2016). I have approached this by describing research methodology, aims and objectives to provide a clear description of the research problem to be addressed.

4.2.1. Research methodology

The purpose of research is to acquire new knowledge using a systematic approach involving careful planning and interventions for discovery or interpretation of new gained information (Garg 2016). Planning involves consideration of research methodology to address research problems and ensure validity of findings (Swarooprani 2022). Methodology provides a description of principles and ideas that inform the design of a research study (Mills and Birks 2017) with a clear illustration of how the research was carried out, and methodological discussion should include the identification of the problem, aims and objectives of the research, study design and ethical issues within the study (Hyett et al. 2014). In describing the methodological approach in this study I will outline the research problem, highlighting the aims and objectives of the research. I will then describe the philosophical position adopted, outlining the ontology, epistemology and axiology which expresses the principles and ideas used to inform the research design.

4.2.2. Research aims and objectives

Chapter 2 described the context of national organisations, healthcare improvement in mental health settings, and involving PWLE in healthcare

improvement, and Chapter 3 presented a review of current literature used to identify the problem addressed in this research. Although partnership working with PWLE has been recommended across all healthcare services, there is an apparent lack of understanding of the expectation of partnership working at a national level (Connolly et al. 2020) and limited awareness in how to engage patients in the design and delivery of healthcare at a macro-organisational level. There are recognised barriers to partnership working in mental health services studied at meso and micro-organisational level (Scholz et al. 2018) and limited knowledge on how these barriers may be seen in macro-level organisations. A greater understanding of partnership working has been recommended to improve and strengthen improvement programmes (Bate and Robert 2006; Coulter et al. 2014; Robinson et al. 2019). Such understanding of partnership working includes analysis of culture, behaviours and practices that exist within organisations (Connolly et al. 2020). The aim of this study was to address these gaps within knowledge and contribute to a greater understanding of how a national organisation works in partnership with PWLE in a mental health improvement programme. The aims identified were used to guide decisions about research design including decisions about the philosophical paradigm adopted for research.

4.2.3. Research paradigm

Research paradigms refer to the philosophical position, beliefs and assumptions that demonstrate how the research has been designed and carried out (Erciyes 2020). There are four key components of a research paradigm: ontology, epistemology, axiology, and research approach.

4.2.3.1. Ontology

Ontology is concerned with the nature of reality and this research was informed from a constructivist paradigm. Constructivists believe individuals seek understanding of the world in which they live and work (Cresswell and

Cresswell 2018). Meaning is considered subjective and based on experiences, and researchers look for complexity of views rather than seeking to identify narrow meanings into a few categories or ideas. Constructivism maintains that individuals create or construct their own understanding through interaction between their beliefs and the ideas, events, and activities they experience (Ultanir 2012). From this perspective, individuals may perceive, interpret, and explain the same event or object differently. Partnership working is a complex phenomenon, and my philosophical position was that a greater understanding of partnership working would be developed by examining how individuals practise partnerships in real life contexts, and construct meaning from their experiences.

4.2.3.2. Epistemology

Epistemology is the study of knowledge and there should be coherence between the ontological position and epistemological approach (Bleiker et al. 2019). An interpretivist epistemological position was adopted for this research which aligns well with a constructivist ontology. An interpretivist position argues that researchers should seek to understand differences between humans in their role as social actors (Saunders et al. 2009). There is the assumption in this position that knowledge is constructed via interactions and interpretations of experiences and that different subjective interpretations of these interactions are possible. Using this epistemological position recognises that there may be different interpretations of the same experience by different actors and the aim of this research was to understand different perspectives of partnership working.

4.2.3.3. Axiology

The final component of the philosophical paradigm adopted in this research was the axiology, which reflects values and actions taken within the research. Aliyu et al. (2015) demonstrate the relationship between key components of a philosophical paradigm, describing these as a dynamic interaction between how a researcher sees and views the world and reality

(ontology), with how the researcher thinks about the world (epistemology) and how the researcher acts in the world (axiology), and there should be congruence between each of these positions. Axiology considers the values attributed to each aspect of the research undertaken including participants, data, and the intended audience of the results (Kivunja and Kuyini 2017). Within a constructivist approach there is acknowledgement that researchers are part of the reality being researched (Grix 2002) and therefore the researcher's values have impact on the research design, conduct, analysis and results achieved. For this research, each participant's views and perspectives were given equal value and therefore importance was placed on gathering data which provided insight into how actors perceived partnership, how actors demonstrated partnership working, and how actors reflected on their experiences to develop a better understanding of the phenomenon of partnership working.

4.2.3.4. Research approach

In order to address the research question in line with the philosophical position of the researcher, a qualitative case study was selected as an appropriate research approach. Qualitative research is located within a social context and considers how the social world is interpreted, understood, experienced or constructed. Qualitative approaches are used to address "how?" and "why?" questions and can provide a greater understanding of a phenomenon or context (Cleland 2017). A case study approach is used when: the focus of the study is on "how?" and "why?" questions; the behaviour of participants will not be changed; context is relevant to the phenomenon studied and when there are unclear boundaries between phenomenon and context (Baxter and Jack 2008). Case studies from a constructivist paradigm should consist of in-depth consideration of the nature of the case, historical background, physical setting and other institutional and contextual factors (Stake 1995). Partnership working sits within a wider context, and case study methodology is well placed to understand relationships between context and intervention (Grant et al. 2020). A case study approach therefore enables a holistic exploration of the complex social processes and mechanisms underpinning partnership working within an

improvement programme. The following section will now describe the research design process used, discussing how each element of the design aligns with the philosophical paradigm.

4.3. Determining the components of the case study

Case study research can have a level of creativity and flexibility, where the researcher may choose epistemologies and theories suited to their preferences, and the nature of the enquiry, clear descriptions of paradigm, theory and methods should be provided to demonstrate rigour (Hyett et al. 2014). The philosophical paradigm has been outlined in section 4.2, and in section 4.3 I will describe the theory and introduce methods used to determine the components of the case study which is the second stage of the DESCARTE model. Chapter 5 provides a more detailed account of methods used in this research.

4.3.1. Type of case study

A case study provides an in-depth exploration of a phenomenon in its natural context and case studies can be defined in a number of ways. There is a lack of consensus on the design and implementation of case study and there are two prominent typologies cited in the literature, one proposed by Robert Stake (1995) and the other by Robert Yin (2011). Stake (1995) describes three types of case study as intrinsic, instrumental and collective. Yin (2011) highlights three types of case study as descriptive, exploratory and explanatory. Thomas (2016) suggests that case study research can be defined using both Stake's and Yin's definitions, which provides a clear description of the purpose of the case study research and informs the design. Although different types of case studies were considered, this case study aligns with the definitions of instrumental and explanatory.

The PD Improvement Programme was of interest as it was an example of a national improvement programme working in mental healthcare settings, and it would provide insights into the phenomenon of partnership working with PWLE. This is consistent with the description of an instrumental case study approach. Explanatory case studies can be used to explain the links in real-life interventions that are too complex for surveys or experimental strategies (Baxter and Jack 2008). This approach is considered useful for addressing complex research issues and exploring relationships between concrete observations and abstract theoretical concepts (Blatter and Haverland 2012).The purpose of this research was to explore in more depth partnership working with PLWE in a national mental health improvement programme. The concepts within this research – described in Chapter 2 – are complex, context dependent, and abstract, and the use of an explanatory case study was designed to understand relationships and interaction between each concept within the context of national organisation. Explanatory case studies have been applied to understand complex, multi-factorial phenomenon in health services research (Guglielmin et al. 2022; Kjellstrom et al. 2019; Kreindler 2017) and therefore was considered an appropriate approach in this research. The focus of explanatory case studies is to explain why and how specific sequences of events occur or do not occur and aligns with a constructivist approach as the researcher attempts to understand a social phenomenon from individual perspectives (Priya 2021). In the analysis of this research, I identified a sequence of events to explain the phenomenon of partnership working and therefore, this case study is line with an explanatory approach as this research describes how the national improvement programme worked in partnership with PWLE.

4.3.2. Binding the case

The second component was to clearly define what the case was and set clear parameters or boundaries to ensure the study had a clear and reasonable

scope– a process referred to as binding (Yin 2011). The parameters of this study were determined by definition and context. For this research, the case consisted of the PD Improvement Programme within HIS. Early involvement of PWLE in the conceptual stages of improvement work has been highlighted in the literature to ensure meaningful involvement with influence and impact (Byrne and Wykes 2020) and preparation for partnerships was identified in the review of literature described in Chapter 3. The PD Improvement Programme was the first commissioned work for HIS to improve the understanding of the context of service provision for people with personality disorders across Scotland. The commission was from the Scottish Government and ran between June 2021 and March 2023. This case study followed the PD programme between October 2022 and July 2023 and the documentary analysis retrospectively covered earlier material, including the design of the improvement programme and preparation for working with PWLE.

4.3.3. Theoretical framework of the case

Establishing a theoretical framework that structures data collection in a case study is recognised as a key component in research design. In a broad sense, the theoretical framework provides a way to structure data collection to answer the research questions (Lauckner et al. 2012). As described in Chapter 2, I outlined a conceptual framework to shape and inform the research but did not intend to use this in a prescriptive way to remain open to new and unexpected findings (Sale and Carlin 2025). In case study design there should be a clear description of whether the research aims to test theory, construct new theory or contribute to existing theory. This case study aimed to understand how a national organisation worked in partnership with PWLE in a mental health improvement programme, therefore an explanatory approach was used to help develop or refine theory of partnership working in this context. As this research adopted an interpretative approach its focus would be on developing understanding of meaning through different perspectives and therefore could be considered to have a focus on theory-building (Crowe et al. 2011).

4.3.4. Methods

Case study methodology is research which involves an investigation in a real-life context of a particular phenomenon using multiple sources of evidence (Robson and McCartan 2016). The sources of evidence should be in line with the philosophical paradigm adopted and therefore from a constructivist perspective, methods should support the development of understanding based on social interactions, building on perspectives of individuals ensuring context is recognised. The research was designed in two phases – phase one collected data from documents and observations, and phase two collected data from interviews. This approach ensured ethical approval was granted in line with the improvement programme timelines so that observations could take place during the improvement programme and allowed time for the interviews to be developed in line with emerging findings from phase one. More detail on the methods used is described in Chapter 5.

4.3.5. Ethical considerations

Ethical approval was granted from HIS' research oversight group, University of Stirling Research Ethics Committee (REC), and the Integrated Research Application System (IRAS – ID 4256) via the Queen Square Research Ethics Committee (for phase one – ID 318323); and Black Country Research Ethics Committee (for phase two – ID 309926). This process ensured that a wide range of ethical issues was considered in advance of carrying out the research, including recruitment, consent, confidentiality, assessment of harm and risk, and management of data. Specific details on recruitment and consent process followed are described in Chapter 5, which outlines data collection for each phase of this research. Ethical issues of confidentiality, assessment of harm and risk, and management of data for this research are now discussed.

4.3.5.1. Confidentiality

Given this was a single case study, with a limited number of participants pure anonymity could not be guaranteed within observations or unstructured interviews. For this study, non-traceability was considered appropriate. Following transcription, all identifying data was redacted and individuals were assigned pseudonyms to protect the identity of participants. Once anonymised, data gathered was shared with the supervisory team and all information that could have been used to identify participants was removed.

4.3.5.2. Assessment of harm and risk

The overall risk was considered above the threshold of low risk measured against the University of Stirling's risk standards, as this research involved potentially vulnerable individuals, and anonymity could not be guaranteed. There was a possibility that some participants may be distressed or find recalling their experiences destabilising. There was also some risk to organisational reputation within HIS and with the third-sector organisations, and a risk to relationships between staff and PWLE working on the programme if there were differing views or experiences expressed. These risks were outlined in the participant information sheet in the recruitment phase and were reviewed throughout the research process. Discussion on any possible conflict of views was discussed with the supervisory team in advance of interviews, during the data collection phase and during analysis to ensure any bias was addressed.

4.3.5.3. Management of data

Data collected was digital and was stored in compliance with the UK Data Protection Act (2018) and GDPR (IOC 2017). Potential and actual participants were assigned a participant code (ID) to protect their identity, and all personal data was kept separate from research data. NVivo 12 was used to support management of data and to assist within and across case study analysis,

appropriate to case study research (Houghton et al. 2015). Data was stored in the University of Stirling's IT system and accessible only to the researcher and supervisory team. All data will be kept for a period of 10 years from last use, in line with the University of Stirling's Data management policy and following this period all data will be destroyed.

4.3.6. Sampling

Sampling is important in case study research and sampling should be relevant to the conceptual frame and research questions, produce reliable explanations of the phenomenon investigated and be feasible in relation to the scope and size of research (Priya 2021). The case had already been defined as the PD Improvement Programme within HIS, and a purposive sampling approach was applied to the three data collection methods. Purposive sampling identifies units for analysis (in this case documents, observations and participants) in a strategic way to ensure they are relevant to the research questions being addressed (Bryman 2016). Detailed descriptions of the sampling approach used are discussed in Chapter 5.

4.4. Data analysis

The final stage of the DESCARTE model was to describe the data analysis carried out. This section will provide a broad overview of the analytical approach adopted in this research, with more specific descriptions of the analysis process discussed in Chapter 5. The DESCARTE model recommends using three stances to describe data analysis in the design of case study research. The three stances are described as philosophical, strategic, and integrative (Carolan 2016). In this section I will outline each stance in relation to my research and outline quality assurance approaches used in this study.

4.4.1. Philosophical stance

My philosophical position is constructivist and analysis from this perspective should be considered in terms of pattern theories (Denzin and Lincoln 2003). Such analysis of data reduces large amounts of data into smaller analytical units, focuses later field work, and can provide insights to develop understanding by identifying common themes (Elo and Kyngas 2007). In this research, data analysis was used to organise, find patterns, and elicit themes in the data to help deepen an understanding of partnership working within the national PD Improvement Programme.

4.4.2. Strategic position

The purpose of this case study was to examine partnership working within a single case, understanding different perspectives and experiences. Thematic analysis was considered appropriate for this process due to its versatility (Morgan 2022). The are a range of approaches to thematic analysis described in the literature and Bruan and Clarke (2021) stated that “there is rarely one ideal method – or methodology – for a research project” (Braun and Clarke 2021 p. 38). In selecting a thematic analysis approach Willig (2013) recommends that the method used aligns with the the research purpose, the theoretical assumptions, research questions and methods are coherent, and the overall research design is logical. I selected an approach to data analysis described by Houghton et al. (2015) which provided a detailed account of strategies and steps used in carrying out analysis within case study research. The first steps of analysis considered all data sources separately before bringing them together to understand the whole phenomenon (Gadsby et al. 2023). Steps for data analysis was used to support thematic analysis of document data and outlined in Table 10.

Table 10: Steps of data analysis

Steps of analysis	Analysis strategy	Application in this research
Comprehending	Broad coding	This step analysed data to generate and develop codes. In this step, enough data was gathered to write a detailed and coherent, rich description of partnership working.
Synthesising	Pattern coding Development of themes Memoing	This step reviewed codes and a priori themes to identify patterns within the data to further develop themes. Memos provided summaries of key information for each theme which were used to develop executive summary statements at the end of phase one and phase two which were analysed in the theorising phase of analysis.
Theorising	Distilling and ordering Testing executive summary statements	Relationships between categories of data were examined, building a more integrated understanding of partnership working.
Recontextualising	Developing propositions	Concepts identified were synthesised to consider how the understanding of partnership working may be applied in different settings and identify research findings from the data. Analysis of propositions was carried out against all data collected.

This research was informed by a constructivist perspective which considers the researcher to be an integral part of the research process (Losantos et al. 2016). In order to position the researcher within the research and ensure their role in the research process is considered, I used the use of reflexive approaches at

each stage of thematic analysis. The reflexive approach adopted was informed by Green and Thorogood's dimensions of reflexive awareness (2018) which describes four dimensions of reflexivity, methodological openness, awareness of the social settings of the research, and awareness of the wider social context. A summary of the reflexive approach and how this was applied in this research is described in Table 11

Table 11: Dimensions of reflexivity from Green and Thorogood (2018)

Dimension of reflexivity	**Application in this research**
Methodological openness	Transparent description of decision-making during data collection and analysis
Theoretical openness	How theoretical influences shaped the research was considered in the design of research and during analysis
Awareness of the social setting of research	Discussion and reflection on the social setting, how this may impact on participants, and how this impact may be observed or described
Awareness of the wider social context	Awareness of the wider social, organisational, and political values influence this research.

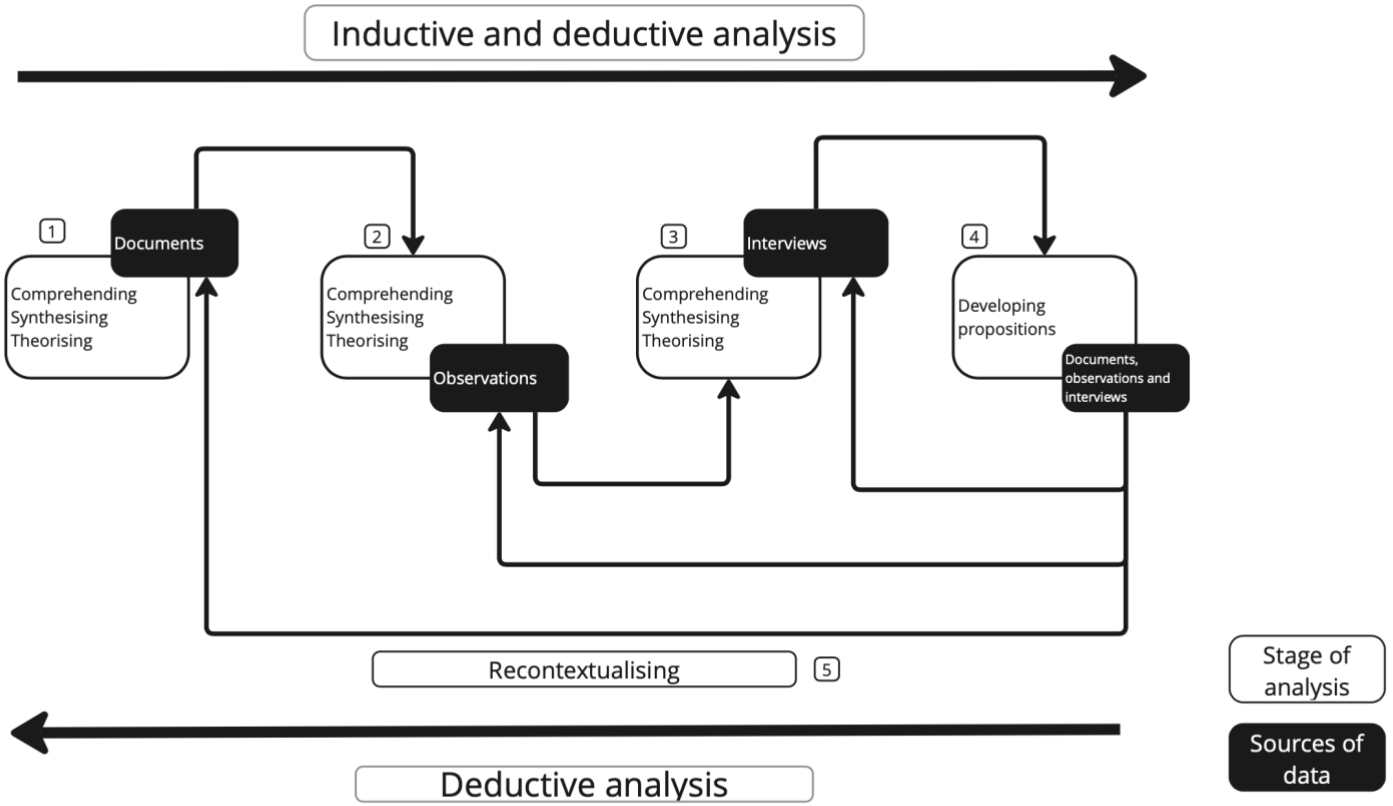
Methodological and theoretical openness were discussed and considered by completing a reflexive research journal, through discussions with academic supervisors, and discussions with the public partner. These were completed throughout the research design, during data collection, and analysis. I completed a reflexive journal before and after each interview or observation to describe my expectations and consider any assumptions made. I documented my feelings and response to any interviews or observations which were then used during academic supervision discussions. The social setting and context were discussed with the public partner who brough a perspective on the role

and context of third-sector organisations and PWLE to my reflexive process. My position within HIS and my assumptions about partnership working were key features of these discussions. Through this process these discussions supported me to appreciate the intersection between the role of national organisations, the role of third-sector organisations, and how these exist within a wider political context. The impact these organisational relationships have on how PWLE are represented and included within healthcare improvement was considered and discussed during the analysis process to ensure the findings and analysis was grounded in data collected during this research.

4.4.3. Integrative stance

In order to develop convergent evidence, a data analysis plan outlined in Figure 4 describes how data from all sources were analysed to strengthen the construct validity of this case study research (Yin 2011). There were five stages in this data analysis plan and each stage followed the steps of analysis outlined in Table 10 - comprehending, synthesising and theorising. The fourth stage considered data from all sources to develop propositions. The fifth and final stage of analysis analysed propositions developed to build a deeper understanding of partnership working. Approaches to thematic analysis traditionally use either inductive, deductive or abductive reasoning (Barrett and Younas 2024). In this research, data was analysed using a mainly deductive approach against a priori themes identified in the literature with acceptance and attention given to emerging themes and novel understanding within the data.

Figure 4: Data analysis plan



The use of different methods of data collection allowed methodological triangulation where each method of data collection was used to bring perspectives to the research questions.

4.4.4. Quality assurance

The final consideration in designing the case study approach used was planning strategies and approaches for quality assurance in this research. Qualitative research should ensure data analysis is trustworthy to establish credibility and reliability of findings. Ahmed (2024) describes four key elements of trustworthiness which were used in the design of this case study.

4.4.4.1. Credibility

Credibility pertains to the degree to which findings accurately reflect the reality that the participants experienced (Ahmed 2024). This can be achieved by extended involvement, researcher reflexivity, and triangulation of data sources. In this study, there was involvement with the PD Improvement Programme between October 2022 and July 2023, which provided an opportunity to build trust and rapport with participants over time. At the time of research, I was working within HIS and therefore was considered an insider researcher. Although this position may have supported access to naturalistic data and respondents, there was a risk of conflict between the researcher and participants who have professional relationships, and a risk respondents may change their behaviour or responses due to this relationship (Caruana 2015). This may increase the risk of bias within the research and strategies were used throughout the different stages of the research process to reduce these risks (Fleming 2018). For this study, strategies included planning the interview process; use of research diaries; reflection; and ongoing monitoring with supervisory team.

4.4.4.2. Transferability

Transferability is related to the degree to which research findings can be extrapolated to alternative contexts or situations (Ahmed 2024). As this research was conducted from an interpretivist perspective, findings were not intended to be generalisable or predictable in nature. The findings in this research are presented as an accurate reflection and understanding of partnership working in one national improvement programme. This research has provided comprehensive and detailed explanations to help determine if the findings may be applicable to similar populations or settings. This provides transferability in line with the philosophical approach taken.

4.4.4.3. Dependability

Dependability is achieved through careful and detailed documentation of research procedures and decisions made. In this study, I maintained a research log which detailed individual tasks required in data collection and analysis, and documented decisions made with a description of the rationale for each decision included. This provided an audit trail to build dependability of the research.

4.4.4.4. Confirmability

The final component of trustworthiness considered was confirmability, which relates to the impartiality and objectivity of the findings. A range of approaches was used in this study including participant validation, member checking and reflexive journalling. A public partner was involved in reviewing and discussing analysis of themes as a form of participant validation, participants were invited to check transcripts following observations and interviews as a form of member checking, and a reflexive field diary was maintained and discussed with academic supervisors to build trustworthiness in this research.

4.5. Chapter conclusions

This chapter has described the design of this case study in line with the DESCARTE model which has three stages: situation of the research and the researcher, determining the components of the case study, and data analysis approach. This model provided a useful framework to inform the case study design, ensuring key methodological considerations were described. I also included a more detailed discussion of the reflexive thematic analysis approach taken to enhance and strengthen the description of methodology in this Chapter. A detailed description of methods used, and data collection carried out is now discussed in Chapter 5.

5. Methods and data collection

5.1. Introduction

This chapter describes data collection used in this research. Section 5.2 provides a description of document data collected which was used to understand how partnership working was described. Section 5.3 outlines observations carried out which explored how partnership working was demonstrated in practice. Section 5.4 describes semi-structured interviews conducted with participants to understand their experiences of and factors which influenced partnership working. Chapter 6 then presents how this data was analysed in this research.

5.2. Phase one: Document analysis

This section describes the process and data collection of document data which was used to address the first research question. Data was collected from organisational documents to provide insight into how partnership working was described, defined and planned. Access to organisational documents was used to provide an understanding of plans, infrastructure and frameworks used to support partnership working with PWLE. Document analysis is recognised as a valuable research method which can complement other methods in case study research (Chopard and Przybylski 2021, Wood et al. 2020). Document analysis is a systematic procedure for evaluating written data which can also be used to provide context, gain understanding, generate questions, track change over time, and corroborate other sources (Bowen 2009).

5.2.1. Purpose of document analysis

Documents provide information, facilitate communication and interaction between organisational members (Osterlund and Crowston 2011) and are used in improvement programmes to monitor progress and track changes. Clear definitions are considered important in improvement programmes to provide a shared understanding and framework for implementation (Riley et al. 2010). In this research, document analysis was selected as an appropriate research method to provide insights into the phenomenon of partnership working and suggest questions or areas for further exploration in the later stages of this research. Documents were considered as objective sources used to reveal the interests or intentions of their authors (Karppinen and Moe 2011) in relation to the authors' plans for working in partnership with PWLE and therefore were aligned with a constructivist approach to research.

In carrying out document analysis, a clear explanation of the process followed - from data gathering to analysis – can be used to strengthen the validity of research and increase its impact (Karppinen and Moe 2011). I will now describe the systematic approach taken to build reliability within this research.

5.2.2. Process of document analysis

5.2.2.1. Defining documents

Once the purpose of document analysis was outlined, the next step was to clearly define what would be considered a document in this research. Although there have been various descriptions of what constitutes a document (Karppinen and Moe 2011), for this research, I used the simple definition that documents can be defined as a written text (Mogalakwe 2006), and written texts should include information on the PD Improvement Programme or

working with PWLE in HIS. Documents were considered to be any formal written texts prepared in the PD Improvement Programme in the agreed time period of research. Documents were not produced for research, but for specific purposes by individuals and groups during their practice and may be presented in a certain way or style (Payne and Payne 2004 cited in Mogalakwe 2006). Informal or personal notes were not available through the programme team and therefore were not included for analysis.

5.2.2.2. Access to documents

Following ethical approval, access to the PD Improvement Programme's shared folders via HIS's secure IT system. Documents were accessed within a three-week period (19 September 2022 – 13 October 2022) to ensure no changes or additions to documents were made, thus ensuring document stability (Morgan 2022). This period was chosen based on pragmatic grounds related to the timescales of the research.

5.2.2.3. Selection of documents

A total of 785 documents were identified from the PD Improvement Programme's IT folders and organisational folders. Duplicate documents were removed leaving a total of 649 documents which were screened against inclusion and exclusion criteria. Documents were excluded if they were not owned by HIS, if they included financial information, or were not relevant to the design or delivery of the improvement programme. Documents containing Human Resource (HR) information were not included due to ethical concerns. Exclusion criteria are outlined in Table 12 below and documents were excluded if they met any one of the criteria. Reasons for exclusion varied, with documents being excluded due to detail on planning events (such as distribution lists, planning emails n=307), HR documentation (including planning and performance or recruitment documents n= 5), and research papers (n=62).

Table 12: Inclusion and exclusion criteria

Inclusion criteria (must meet at least one)	**Exclusion criteria (documents excluded if they meet one of the following criteria)**
Design of the improvement programme	Human Resources Information
Delivery of the improvement programme	Not authored by HIS
Management of the improvement programme	Does not have sufficient detail on the PD Improvement Programme or working with PWLE
	Research papers

This resulted in 275 documents identified for full screening. Flick (2018) outlines four factors to address when making decisions around which documents to include in document analysis research and these factors were used to screen documents in this research. Flick proposes that documents should be included if they are authentic, credible, representative, and have meaning. For the purposes of this research each of these factors were defined in the following ways:

Authentic

Authenticity refers to whether the documents are genuine and from trusted sources (Mogalakwe 2006). For this research, criteria to determine authenticity were ensuring a document was owned by HIS and directly related to the PD Improvement Programme. A distinction was also made between primary sources and secondary sources of data, based on pragmatic grounds (Karppinen and Moe 2011). Primary sources were considered a written record directly relating to the PD Improvement Programme and secondary sources were considered to be written records or accounts of organisational approaches. Secondary sources such as publicly available documents relating

to partnership working within the wider organisation were included in this document analysis to provide insights into the organisational context for partnership working.

Credible

Credibility refers to the extent to which the document is free of errors (Morgan 2022). Given that some documents accessed included early drafts of papers that had not yet been finalised, there was some acceptance of errors within the inclusion criteria. In this research, credibility was identified by ensuring the document to be analysed was complete, with a date and author specified.

Representative

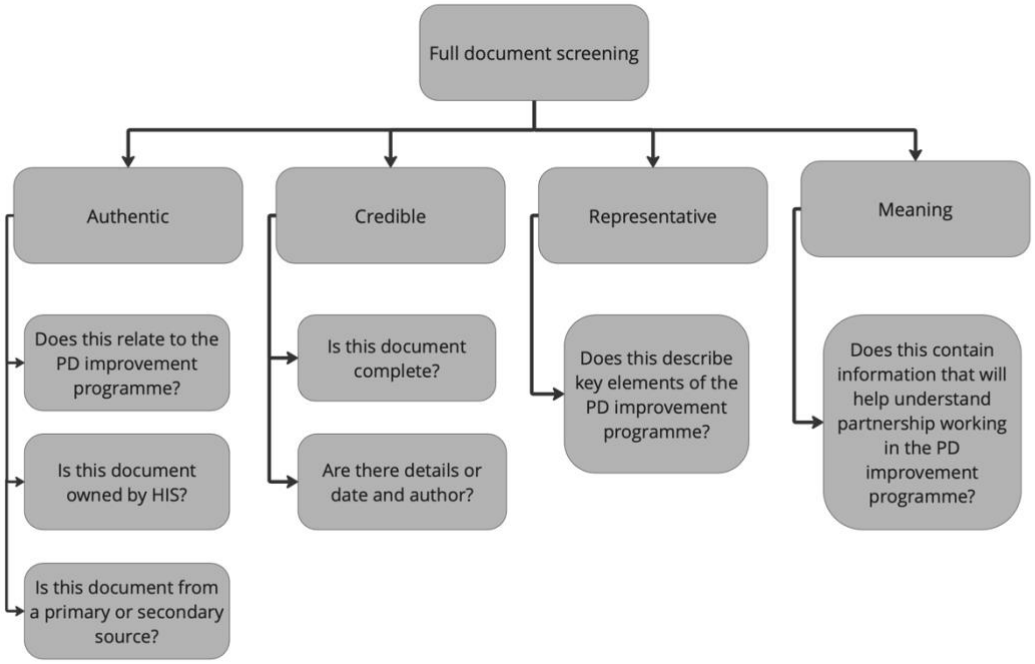
Documents considered representative based on how typical the document is (Morgan 2022). Documents in this research were identified as being representative by ensuring they described or detailed elements of the PD Improvement Programme. These elements could be the design of the programme, the intended outcomes of the programme, or the operational management of the programme.

Meaning

For documents to have meaning in this research, they had to contain information that would help understand partnership working within the PD Improvement Programme. Documents that detailed aspects of the programme but did not include specific details of partnership working were included for analysis, as the exclusion or omission of descriptions of working with PWLE may be an important aspect of the programme to explore within this research.

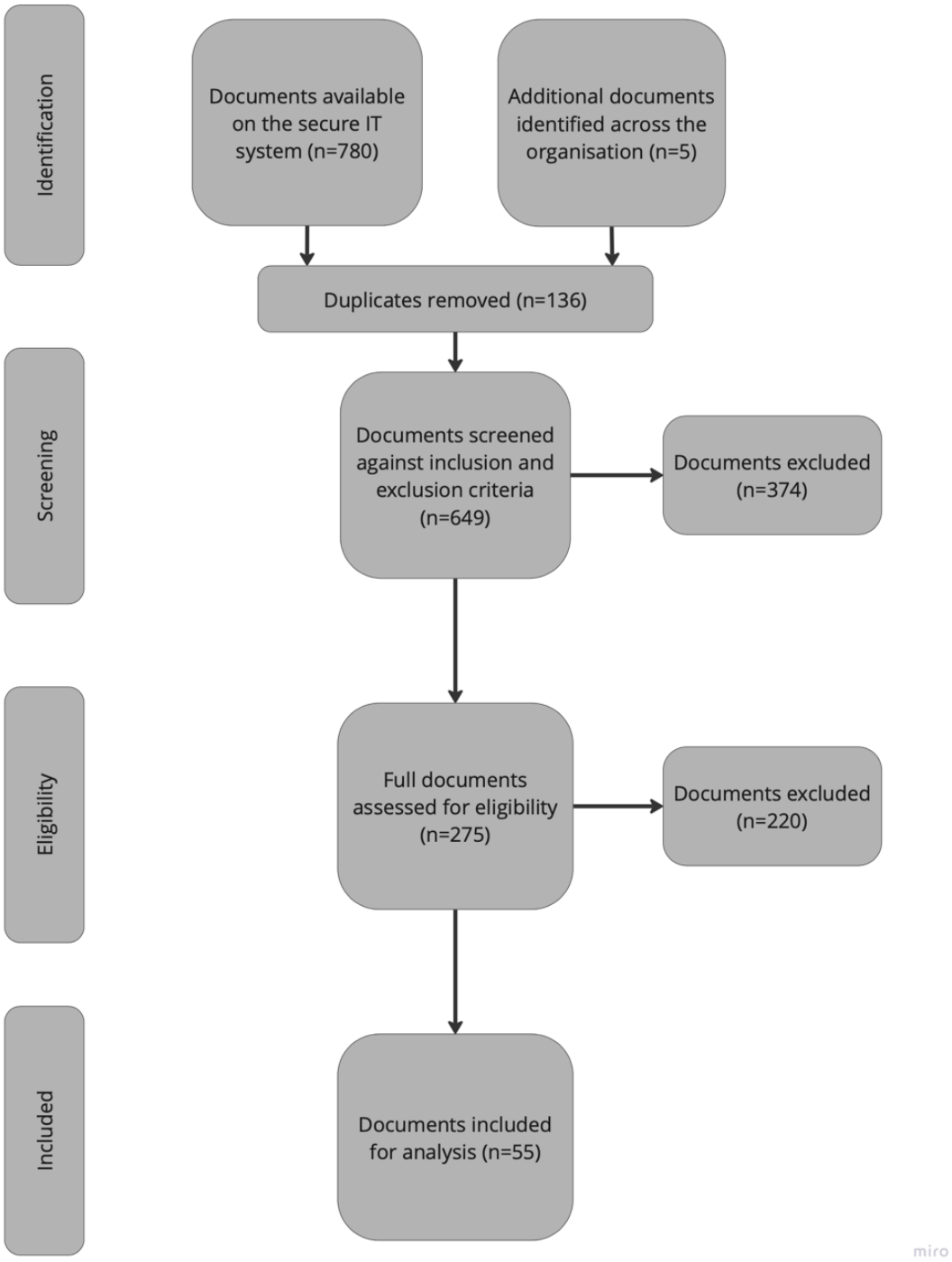
A summary of the full document screening is outlined in Figure 5 below.

Figure 5: Full document screening criteria



The 275 documents included were screened against four factors outlined in 4, and documents that met all four criteria were included for full analysis. At this stage 220 documents were excluded leaving 55 documents included for full analysis. Results from the screening and review of documents is detailed in a flow diagram based on PRISMA flow diagram (Figure 6) to ensure trustworthiness of this process (Page et al. 2021).

Figure 6: PRISMA flow diagram screening process



5.2.2.4. Overview of documents selected for analysis

Documents selected for analysis provided an understanding of plans, infrastructure and frameworks used to support partnership working. Documents included commission agreements; planning papers; minutes of key meetings; presentations or diagrams describing the programme infrastructure and partnership working in the programme. Dalglish et al. (2020) recommend selecting a combination of formal documents, 'grey' literature, and informal working documents such as meeting notes or presentations, when conducting document analysis. Types of documents included are outlined in Table 13.

Table 13: Types of documents

Type of document	Examples	Documents included in this research
Formal documents (n= 13)	Official policies Laws Strategies	Documents outlining the original proposal and business case. This included commissioning proposals and current literature informing the business case.
Grey literature (n=7)	Organisational materials Policies Reports Evaluations	Documents describing the organisational strategy or policies for working in partnership with PWLE.
Working documents (n=35)	Meeting notes Presentations Agenda	Documents defining the range, scope and plan for delivering and managing the programme. This included the Programme Initiation Document, evaluation proposals, project timelines, meeting agendas and minutes.

Formal documents and working documents are considered to have information specific to the PD Improvement Programme, and grey literature included organisational documentation. Understanding the perspective of the PD Improvement Programme and the wider organisation was beneficial to address the research question therefore analysis was conducted across all documents.

There is a possibility that organisational documents were developed to create a positive impression and there may be a difference in what the document contained and what happened in practice (Payne and Payne 2004). Such potential differences were central to this research and were considered by using a combination of document, observation and interview data and analysing these in interactive ways throughout the research (Goldstein and Reibolt 2004).

5.3. Phase one: Observations

Following document analysis, non-participant observations of improvement programme meetings were used to gather data on how partnership working in the PD Improvement Programme was demonstrated in practice. Observational evidence can be useful to gain an understanding of how complex processes work in practice (Weston et al. 2022) and can avoid problems inherent in self-reported accounts by allowing the researcher to see what people do rather than what they say they do (Mays and Pope 1995). Observation as a research method involves directly observing and recording phenomenon in the usual environment (Weston et al. 2022). The observer records how research participants behave within and relate to their physical and social environment (Morgan et al. 2017). Observation can provide insights into context, processes, the social and physical environment, and interactions within groups (Mulhall 2003). Such factors are key to exploring how partnership working is demonstrated in practice and therefore observation was considered an appropriate method in this research. There are varied approaches to observation and for this research a non-participant, semi-structured method was considered in line with the philosophical position of this research to provide data from multiple perspectives to seek an understanding of a complex phenomenon in a real-life context.

5.3.1. Purpose of observations

Observing people in real life settings can reveal insights not accessible from other data collection methods including structures, processes and behaviours (Morgan et al. 2017) all of which will lead to a greater understanding of how partnership working happens in practice.

5.3.2. Process of observations

The process of observations started with a review of events to select appropriate events for observation. A list of all events planned over a 4-week period was reviewed to provide sufficient events to select a purposive sample of observations. During this time, HIS operated a hybrid working environment with few events or meetings held face to face. The list of events included a range of team meetings, organisational meetings, large scale events, and preparatory meetings. Events were selected for observation based on the criteria outlined in Table 14 below:

Table 14: Inclusion and exclusion criteria

Criteria for Inclusion (must meet both criteria)	**Criteria for exclusion (excluded if any one criteria are met)**
Event central to the PDIP Near or near full consent (selected after consent process)	Education/ learning presentations Large scale events Previous observations of recurring meetings Focus on Finance / Human Resources Over 50% of participants who did not give consent

A total of 40 events were planned during this time and all were held online via MS Teams. No face-to-face events were planned during this time. A total of three events did not meet the selection criteria for observation as they were not central to PD Improvement Programme. Of the remaining 39 eligible events, 11 were scheduled as weekly or monthly recurring meetings, and the researcher was not available for 17 events. There were no events that directly involved PWLE and a total of five meetings involved staff from the third-sector organisations commissioned to work with PWLE. From document analysis of the improvement programme, the third-sector organisations are considered to have a role in representing views of PWLE, so were viewed as lived experience representatives for this research. Events that included people from the third-sector organisations were three recurring meetings, one large scale webinar and one meeting described as a 'pre-meet' with the purpose of immediate preparations for the webinar. The pre-meet with the third-sector organisation followed an internal pre-meet which did not include staff from the third-sector organisation. A total of eight events were selected to seek consent from potential participants.

A participant information leaflet (adapted from NHS Health Research Authority Guidance n.d.) outlining the research purpose (Appendix 3), and an invite letter (Appendix 4) was sent to those involved in the programme by senior staff within HIS. All potential participants were offered the opportunity to discuss the research in further detail either during an information sharing meeting or on an individual basis. Potential participants were asked to return a signed written consent form. The consent process generated a list of potential participants from a range of roles in the PD Improvement Programme and this was used to select observations based on those that had full or near full consent. At this stage, three events were excluded due to lack of consent.

Each participant's consent was documented within a written form they signed prior to the meeting. There was a separate consent form for staff within HIS

and for people external to the organisation adapted from NHS Health Research Authority Guidance (n.d.). Appendix 5 includes one consent form used. At the start of each observation, I provided a short introduction and explanation of research as a process of ongoing informed consent.

If there were participants within the meeting who did not consent, their contribution to the meeting was omitted during transcription in line with ethical approval. As meetings were held online, participants were offered the chance to turn their camera off during the meeting and use the chat box for contributions if required. This may have affected the understanding of the wider context of discussions and therefore efforts were made to observe meetings with full consent. All people who attended the meetings observed were given the opportunity to review both the MS Teams recording of the meeting and the transcriptions to ensure these were in line with consent received.

The participants who attended each observation are outlined in Table 15

Table 15 below. The prefixes are related to the groups of Actors identified in document analysis and includes the code used for third-sector organisations involved in this programme.

Table 15: Overview of participants and codes used

Participant code with prefixes **HNC = HIS Non-clinical** **HC= HIS Clinical** **P = PWLE**	**Overview of role within the programme**	**Overview of role within the organisation**	**Observations present**
HNC1	Member of staff within HIS with a senior role	Member of staff in HIS	1,2,3,5

HNC2	Member of staff within HIS with an admin role	Member of staff in HIS	1,2,3,5
HC3	Member of staff within the PDIP with a clinical background	No role in the organisation	1,2,3,5
HNC4	Member of staff with an admin role	Member of staff in HIS	1,2,3,5
HNC5	Member of staff with a non-clinical role	Member of staff in HIS	2,3,4
HC11	Member of staff with a clinical background	No role in the organisation	1,2,5
HNC12	Member of staff with an admin role	Member of staff in HIS	5
P1	Representing PWLE	No role in the organisation	4
P2	Representing PWLE	No role in the organisation	4
O1	Third-sector organisation	Commissioned to the improvement programme	-
O2	Third-sector organisation	Commissioned to the improvement programme	-

An overview of meetings observed is outlined in Table 16 below.

Table 16: Overview of observations

Observation No.	Purpose	Participant study ID	Lived experience representation	Participants who did not give consent
1	Weekly webinar workshop – a regular meeting to plan for the content and delivery of webinars. This was related to the learning system component of the PDIP.	HIS staff (HNC1, HNC2 HNC4, HC11, HC3)	None	1
2	Weekly catch up – smaller meeting to review current actions and tasks within the programme.	HIS staff (HNC1, HNC4, HNC5, HNC2, HNC5, HC3)	None	2
3	Monthly evaluation report progress meeting – to plan and develop evaluation report which brings together all key elements of the programme. The evaluation report was a requirement stipulated from the funders.	HIS staff (HNC1, HNC2, HNC5, HC3, HNC4)	None	1
4	Monthly meeting with O1 and O2 – regular	HIS staff (HNC5 –	Yes	1

	discussion with the third-sector organisations who were commissioned to lead engagement with PWLE for this programme	apologies from HNC1) Other staff (P1, P2)		
5	PDIP weekly catch up – a general overview of the operational progress of the programme.	HIS staff (HNC1, HNC4, HNC5, HNC2, HC3, HNC5, HNC12 – apologies from 1 member of staff)	None	2

Once events and meetings had been identified to be observed, the researcher arranged to carry out a test observation of a small regular team meeting in HIS to test the technology used in MS Teams, gain experience in using the observation guide and taking observation notes. A notes section was added to the observation guide following this test.

5.3.3. Considerations in observation research

The role of the observer, data collection tools and approaches, and process for data collection are key considerations when carrying out observations (Weston et al. 2022). Each of these considerations will now be discussed.

5.3.3.1. Role of the observer

Non-participant observation was selected as an appropriate method in this research to enable an understanding of how partnership working happens in practice. This allowed observation of the environment, language, non-verbal data and interaction in partnership working. The observer did not participate in any of the events and the role of the observer was known to all participants. Non-participant observation allows observation of the environment, language, non-verbal data – such as facial expressions, or tone of voice - and interaction between participants. The role of the observer in this research was to collect data by completing the observation guide (outlined in Table 17), completing notes during each observation detailing any notable interactions or discussions, and completing a reflexive research diary to document thoughts and reflections immediately after each observation.

5.3.3.2. Data collection tools and approaches

A semi-structured approach was used to combine elements of both unstructured and structured methods of observation. This approach can capture information that is descriptively independent but may influence the phenomenon of interest (Weston et al. 2022). An observation guide was developed from the conceptual framework outlined in chapter 2, the literature review discussed in Chapter 3, and document analysis carried out (Table 17). Although the use of this framework provided some structure to the observations, a form of semi-structured observation was also adopted to allow for some naturalistic observations (Simons 2009).

Table 17: Observation guide

Dimension of partnership working	Observation guide
Context	Where did the observation take place? Who was present / who was not present? What was the purpose of the meeting / event observed?
Process	How was partnership working planned for and what preparations were in place to support partnership working? How many events or meetings involved PWLE? Who was involved in setting the agenda and context for meetings?
Actors	Who attended meetings? What were their roles and responsibilities in the improvement programme? Was there agreement of roles and responsibilities between participants?
Decisions	How were decisions made? How were PWLE involved in decision-making?
Power	Who contributed to the event or meeting? What was the response to PWLE's contribution? What efforts were made to support contributions from PWLE?
Management	What methods were used in practice to support partnership working? What behaviours were observed in relation to PWLE and how did they relate to models of partnership working?
Mechanisms	How did the improvement programme work with commissioned third-sector organisations?

There was a possibility that the presence of a researcher would risk bias by changing the behaviour of participants and strategies were used to reduce this risk. Strategies included giving a clear explanation of the plan for observation and being aware of the position of the researcher to be as unobtrusive as possible (Cresswell and Cresswell 2018).

5.3.3.3. Data collection

Before each observation, I completed my reflexive research diary to prepare and document my expectations of the observation. During observations, I noted context including location, time, duration, participants, and purpose of the event. Immediately after each observation I completed the observation guide and a reflexive research diary, highlighting any key discussions or notable interactions, and considering any personal response I felt during the meeting. All meetings were recorded on MS Teams and following each observation, I completed a transcript of each meeting which captured the full text without paraphrasing or changing the meaning in any way. Notes were taken on non-verbal communication, the way the speaker communicated, silences and intonation if they were observed to affect the meaning of the text. Data from observation guides, diary entries, and transcripts were used to analyse observations.

5.4. Phase two: Interviews

The final method of data collection was semi-structured interviews with participants who were involved in the PD Improvement Programme. Interviews are a key source of data within case study research and can be used to provide insights into participants' perspectives of the case (Yin 2018). Interviews were used to gain an understanding of participant's experiences and perspectives of partnership working in this improvement programme.

5.4.1. Purpose of interviews

Interviews are used to understand experiences and perceptions of participants relating to the area of research (Naz et al. 2022) and are widely used within qualitative research (Bryman 2016). Interviews can be viewed as a process of socially constructing account of individual experiences and perspectives and therefore are in line with the constructivist paradigm in this qualitative case study (Neilson 2007). Semi-structured interviews are based on a list of questions and topics to be explored in an interview guide, which can be discussed in a flexible way responding to the interviewee's responses (Bryman 2016; Jamshed 2014). Interviewers can explore opinions and ideas of the interviewees and probe deeper into their responses for additional information and clarification (Naz et al. 2022). They are used when there is objective knowledge about a particular phenomenon but a lack of subjective knowledge (McIntosh and Morse 2015) and were chosen as an appropriate method to explore individual experiences in the PD Improvement Programme.

5.4.2. Process of interviews

Whiteley et al. (2003) outline key considerations when planning a qualitative research interview: interview schedule, interview plan (dimensions of the interview), and interview context. Each of these considerations were addressed in planning and designing the interviews carried out in this research. This section outlines the process used to provide a comprehensive explanation of interviews, which is a key criterion for ensuring quality in this qualitative research (Ahmed 2024). Section 5.4.2.1 details the interview schedule developed, section 5.4.2.2 describes the interview plan, which includes ethical dimensions, and in section 5.4.2.3 the interview context is considered.

5.4.2.1. Interview schedule

A systematic process should be followed when developing a semi-structured interview schedule to build trustworthiness in the research method (Kallio et al. 2016). For this research a framework proposed by Kallio et al. (2016) was identified as an appropriate way to document the process taken and decisions made to develop the semi-structured interview guide. This framework has the following five phases:

- Identify prerequisites required
- Utilise previous knowledge
- Formulate a preliminary semi-structured interview guide
- Pilot test the interview guide
- Present the interview guide.

Involvement of the public partner in the design of interviews was considered important to ensure the needs of PWLE were taken into account, and as a form of extended involvement and member checking to ensure credibility and confirmability of this research (Ahmed 2024). The public partner was involved at each phase of development of interviews.

The first phase of developing the interview guide was to identify prerequisites, which was carried out through evaluating the use of interviews as an appropriate method to address the research question. This evaluation consisted of considering the literature, discussion with the public partner, and discussions with supervisors. Semi-structured interviews were identified in the literature as an approach which can be flexible and responsive (DeJonckheere and Vaughn 2019; Naz 2022) and was considered an appropriate method to explore and build an understanding of individual experiences (McIntosh and Morse 2015).

I met with the public partner and academic supervisors to consider the use of semi-structured interviews with PWLE to identify and plan for any specific needs. The use of semi-structured interviews with people who experience mental ill health is thought to be valuable and there should be careful planning around ethical issues. The researcher should also ensure they develop strategies to establish an appropriate reciprocal relationship during the interview (Newman et al. 2017). Although interviews were only held with people who had worked directly with the PD improvement programme and did not involve PLWE, the same consideration was given to designing interviews as this programme was focused in a mental health context. The public partner and academic supervisors advised on rapport building and developing relationships in this research. Relationships were developed when agreeing consent as the researcher made direct contact with all participants who gave consent to arrange the interviews and discuss the process. Time was also allocated at the beginning of each interview for general conversations to continue to build rapport with participants. A distress protocol was agreed with the public partner and academic supervisors (Appendix 6) and was used as a guide to support individual participants during interviews.

The second phase of development involved using previous knowledge. In this research, themes for questions were identified from a literature review and from data gathered in the first phase of research. Themes were discussed with the public partner and academic supervisors during this second phase to consider how the these could be used to inform the interview schedule. The public partner advised that there should be some discussion on previous experiences and how people prepared to work in the PD Improvement Programme during interviews, and questions were added to include this discussion in the interview guide.

Following review of literature and themes identified in phase one, an initial interview guide was shared and discussed with academic supervisors and the

public partner. Byrne and Wykes (2020) highlight that researchers from traditional backgrounds do not understand the mental health experience, and meetings with the public partner were used to ensure questions were relevant and likely to receive meaningful responses. The interview guide detailed a combination of broad questions followed by more focused questions and possible prompts that could be used within the interview (Roberts 2020). The interview proforma consisted of five sections and is summarised in Table 18 below:

Table 18: Interview guide

Interview section	Purpose
Introduction	To provide participants with information on the research and confirm consent.
Background information	To build rapport and help participants feel comfortable in the interview. To understand participant's role in the PD Improvement Programme. To explore motivations for working in improvement within mental health.
Experiences of partnership working in the PD Improvement Programme	To understand management practices and social processes used to support partnership working in the PD Improvement Programme. To ask participants about their previous experiences working in improvement or working with PWLE.
Reflections on partnership working in the PD Improvement Programme	To explore participant's perspectives and experiences of partnership working within the programme. To understand the organisational forms used in the programme for partnership working. To explore perspectives on what worked well and what were barriers to partnership working. To understand how people prepared to work in the PD Improvement Programme.
Descriptions of partnership	To explore participants expectations on partnership working based on descriptions used within the PD Improvement Programme.
Closing questions	To provide participants the opportunity to discuss issues that had not been raised.

Debrief information	To ensure participants were aware of how to access support if needed.

The fourth phase of development consisted of pilot testing of the interview guide. The pilot test was completed with a member of staff within HIS who had previously worked in the Mental Health Improvement Portfolio but had not been involved in the PD Improvement Programme. The member of staff was asked to provide feedback on the format of the interview and questions asked, and the pilot test was used to identify how much time would be needed for each interview and how practical arrangements for the interview would be managed (Kallio et al. 2016). The interview guide was also discussed with the public partner as a form of internal testing (Kallio et al. 2016). Following these tests, one question was re-worded to improve clarity for participants, a structured introduction to interviews was developed, and an indication of how long each interview would last was included in the participant information. All interviews followed the schedule developed as an aide memoire and there was flexibility to adapt to each participant's response to allow exploration of emerging and reported experiences (Smith et al. 2009).

The fifth and final phase of development was presentation of the completed semi-structured interview guide. During this stage, an interview guide and the process used to develop this guide was prepared. The interview guide was presented as part of the ethics application and is included in this thesis in Appendix 7.

5.4.2.2. Interview plan

Following the development of the interview schedule, an interview plan was prepared which outlined the key objectives of the interview and described significant dimensions of the interview, including potential ethical issues during recruitment and consent. Ethical considerations including confidentiality,

management of data, and assessment of harm and risk were discussed in Chapter 4 and this section will focus on recruitment and consent for interviews. PWLE were not directly involved in the PD Improvement Programme and therefore there were no opportunities to interview PWLE in this research. Staff who worked in third-sector organisations commissioned to lead direct work with PWLE participated in interviews which was used to explore the experiences of partnership working in the PD Improvement Programme including involvement of PWLE.

A participant information leaflet was sent to all people working in the improvement programme to provide information on the research which invited them to participate in interviews. This ensured that all people working in the PD Improvement Programme had the opportunity to participate regardless of their involvement in phase one. Consent was documented for each participant, and potential participants were asked to sign a written consent form. Once consent was documented, the researcher selected a purposive sample of people who participated in interviews based on their role in the programme. All people who had given consent were contacted to discuss the next steps and interviews were arranged with participants to ensure they take place at a suitable time and setting. I was able to answer any questions from potential participants during this contact as a process of ongoing consent. Consent was also confirmed at the start of each interview.

5.4.2.3. Interview context

Elements of context pertinent to this research were proxemics, timing and status (Whiteley et al. 2023) which were considered during planning. All interviews arranged with participants who selected the time and location, ensuring factors such as privacy, distraction and environmental features were considered. Participants were offered interviews on MS Teams, face to face or by telephone so proxemics and timing of each interview would be in line with personal preference of the participants.

Status of participants within the PD Improvement Programme and status of the researcher were also considered. Participants were selected based on their role within the PD Improvement Programme to ensure there was a range of roles and perspectives operating at different levels within the organisation and within the programme. A purposive sample was selected from those giving consent to participate in the study, which was four staff in HIS, one person who had an advisory role to the programme, and one person from the third-sector organisation working in the programme to lead direct work with PWLE. These interviews would provide a range of perspectives from roles across the PD Improvement Programme. Interviews were carried out with participants from each group of actors identified in the first phase of research: HIS non-clinical, HIS clinical and PWLE.

The status of the researcher was also taken into account when planning interviews. The researcher was working within the organisation and although this position may support access to naturalistic data and respondents, there was a risk of conflict between the researcher and participants who have professional relationships, and a risk respondents may change their behaviour or responses due to this relationship (Caruana 2015). This increased the risk of bias within the research and strategies were used throughout each stage of the research process to reduce these risks (Fleming 2018). For this study, strategies included planning the interview process with the supervisory team and public partner; use of research diaries; reflection and ongoing monitoring with the supervisory team. Information shared with potential participants described my role in the organisation and my position as a researcher as part of a clinical doctorate programme in the University of Stirling. This information was also discussed at the start of each interview.

5.4.3. Interviews carried out

A total of six interviews were carried out with a range of staff from HIS, external staff and staff from the third-sector organisation commissioned to lead working with PWLE. All participants had been involved in the observations during phase one of research with the exception of HC9. A summary of participants is outlined in Table 19 below.

Table 19: Overview of interview participants

Interview number	Participant ID	Agreed description of role
1	HNC1	Internal HIS staff with a senior role
2	HNC4	Internal HIS staff with programme management focus
3	HNC5	Internal HIS staff with non-clinical focus
4	P1	A person running engagement programmes for people with mental health problems
5	HC3	A member of the PCIP team with a clinical background
6	HC9	A member of the PCIP team with a clinical and research background

All interviews were held on MS Teams and recorded using the MS Teams video recording functions. Interviews held online were audio-visually recorded via Microsoft Teams, in line with organisational policy (HIS 2021) and in compliance with UK GDPR (IOC 2017) and the Data Protection Act (2018), reducing the need for detailed note taking, allowing the focus to be on the conversation within the interview. The recordings were transferred to the University of Stirling's secure drive immediately after the interviews.

Transcriptions from interviews captured the full text without paraphrasing or changing the meaning in any way. The way the speaker communicated, silences and intonation were not transcribed in full but any non-verbal communications which appeared to affect the meaning of the text, were documented by the researcher in field notes immediately following the interviews. This included volume, tone of voice or facial expressions. Transcriptions of meetings were shared alongside the MS Teams recording for 7-14 days after the meeting and participants were asked to review and raise any concerns in this time, which had been agreed during ethical approval. Two participants asked for changes to be made – one participant requested that an informal conversation towards the end of the interview was redacted, and one participant added additional context to some of their responses – which were included in the analysis.

Reflexive journaling was also used as a form of confirmability to build trustworthiness in this research (Ahmed 202). I completed detailed notes on the interview proforma, and a reflexive research diary before each interview and then at the end of each interview summarising my expectations, initial thoughts on the interview, what was learned during the interview, any surprising discussions, and any emotional responses to the interview. This time for reflection was identified as a key dimension of reflexivity (outlined in Table 11) and considered an important component of qualitative interviews (Stake 1995; Roberts 2020). The combination of transcription data, field notes, and reflexive diaries were analysed, and the data analysis undertaken is now discussed in Chapter 6.

6. Data Analysis

6.1. Introduction

This chapter describes the data analysis carried out following the steps outlined in Table 10. Section 6.2 provides a description of the thematic analysis approach used in this research, 6.3 outlines analysis of documents, section 6.4 then describes analysis of observation data collected with section 6.5 detailing analysis of interview data. Themes developed are summarised in section 6.6 and this leads to Chapter 7 which describes recontextualising data across all sources to identify findings for this research.

6.2. Thematic analysis approach

The data analysis framework chosen was used to organise, find patterns, and elicit themes in the data to help deepen an understanding of partnership working within the national PD Improvement Programme. A structured approach to data analysis was detailed in Chapter 4 with each step described in Table 10 and an overview of the data plan articulated in Figure 4. Reflexivity was a key component of this analysis, and dimensions of reflexivity was outlined in Table 11. Each step of analysis was used for separate data sources, and during the final stage of analysis all data was brought together to provide a comprehensive understanding of the phenomenon of partnership working with PWLE in a national context.

6.2.1. Initial development of themes

A priori themes had been developed from the literature (Table 20) identified in the broad conceptual framework described in Chapter 2, and the literature review outlined in Chapter 3 to support a deductive analysis of data. Although many themes were developed a priori - NVivo nodes for emerging themes was used to identify any developing themes to ensure that findings continually informed when and how to interpret data (Dalglish et al. 2020). An inductive approach was also used in analysis to search for emergent themes that were not anticipated, and in this research, I identified codes within the data to identify novel and emerging insights. The deductive and inductive analysis was used to identify new themes, to identify themes most prevalent to partnership working in this context, and to develop a deeper understanding of a priori themes identified. As an example of this approach, the a priori theme of Actors initially considered the roles and responsibilities people had within the PD Improvement programme in relation to working with PWLE. Data indicated that partnership working was influenced by how people understood, perceived and demonstrated their role which is considered an expression of identity. Subthemes of Role and Identity were therefore added to the a priori theme of Actors. A further example of theme development is in relation to the a priori theme of National Organisations which had been anticipated to include evidence that the political, legislative or governance arrangements of a national organisation may influence partnership working with PWLE. There was no evidence of this in research and therefore this was not included in findings from this research.

Table 20: A priori themes

A priori themes	Description
Mechanisms	What mechanisms (such as organisational forms and social processes) were in place to support partnership working? Which models were developed, tested or applied to enhance partnership working?
Actors	Who was involved in the PD Improvement Programme, what was their role and responsibilities within the programme and within the organisation?
Process	How was partnership working defined, planned for, and carried out in the PD Improvement Programme?
Management	What were the individual and collective leadership and management beliefs and practices that enable partnership working in the PD Improvement Programme? How was partnership working led and supported in practice including allocating time or resources, setting priorities, clarifying goals, meeting objectives and communication?
Power	Power over – control of spaces, decision making and preventing others gaining power Power to – Individual people making decisions with some evidence of mutual support Power with – Mutual support evident, solidarity, collaboration Power within – Recognition of individual differences and respecting others
Conflict	Individual conflict – misinterpreting others motives, worldviews, abilities or integrity Interpersonal conflict – social distance or incivility Organisational conflict – professional disengagement.
National organisation	Legislative, political, or governance arrangements influencing working with PWLE
Mental health	Needs or considerations of working with people who have experience of mental ill health
Attitudes	How was partnership working viewed by participants
Challenges	Ensuring meaningful participation

	Representation of PWLE
Emergent	Themes not anticipated in advance

In addition to a priori themes, units of analysis – such as actors, stages of the programme, and type of documents, were designated as cases within NVivo12 to support future analysis across sources during this research. Cases of actors were separated into categories based on roles within the programme, stages were based on HIS's framework for planned improvement (2016) as this was the model of improvement in use at the time of the PD Improvement Programme, and type of document was based on categories from Dalglish (2020). Initial review of documents during comprehending highlighted that the purpose of the PD Improvement Programme was to understand the current service provision and therefore the design did not follow the stages of framework for planned improvement in order (outlined in Figure 1). The stages were aligned with the design of the PD Improvement Programme. The cases identified for analysis are outlined in Table 21.

Table 21: Cases for analysis

Cases	Description
Actors – HIS Non-clinical	People who worked within HIS and had a non-clinical role in the PD Improvement Programme. This included people who were senior leaders, improvement staff, researchers, project management staff or strategic planning staff.
Actors – HIS Clinical	People who worked within the PD Improvement Programme and who had a clinical advisory or lead clinical role.
Actors – PWLE	People who contributed to the PD Improvement Programme from a lived experience perspective. This included people who have lived or living experience, families, carers, or people who work in third-sector organisations,

	commissioned to work with the PD Improvement Programme.
Stage one – design	The initial phase of the PD Improvement Programme which involved the design of the programme to deliver planned outcomes.
Stage two – understand	The second stage of the PD Improvement Programme which focused on understanding the current system, problem and/or opportunity for improvement.
Stage three – evaluate	The third stage of the PD Improvement Programme which was to evaluate the programme to ensure there was a shared understanding of the current system and experiences, which would be used to inform future improvements.
Stage four – implement	The fourth stage of the PD Improvement Programme which was to implement changes with a focus on testing.
Type of document – Formal documents	Documents outlining the original proposal and business case. This included commissioning proposals and current literature informing the business case.
Type of document – Working documents	Documents defining the range, scope and plan for delivering and managing the programme. This included the Programme Initiation Document, evaluation proposals, project timelines, meeting agendas and minutes.
Type of document – Grey documents	Documents describing the organisational strategy or policies for working in partnership with PWLE.

6.2.2. Stages of analysis

During the comprehending stage I read through data gathered (documents, transcripts, field notes, observation schedules and reflexive diaries) to gain a broad understanding of the data, identify codes and emergent themes, and write a detailed description of partnership working against a priori themes. The synthesising step of analysis is considered the most difficult to describe and is dependent on the insight and judgement of the reviewers (Thomas and Harden

2008). During this stage of analysis, data was reviewed to identify patterns within the data and memos were used to provide summaries of key information against each theme. Samples of themes were shared with the public partner and discussed as a form of participant validation to improve scientific rigour (Crowe et al. 2011). The theorising stage of analysis involved identifying relationships between categories of data. To carry this out I returned to the research question and existing literature to identify interactions between themes identified to provide a deeper understanding of partnership working.

Data sources were first considered separately before bringing them together to provide a more comprehensive understanding of the whole phenomenon of partnership. In the following sections, I provide evidence from each data source to outline the analysis approach taken and describe how themes were developed with each data source. Chapter 7 follows with detail on how data sources were brought together to provide a more coherent description of themes and findings.

6.3. Analysis of documents

Analysis of document data identified that the main mechanism for partnership working was via a commission to third-sector organisations to lead direct work with PWLE, and there was limited evidence of plans to directly involve PWLE in the work of the PD Improvement Programme. Document analysis found a lack of detail on the processes used to work in partnership, with the focus on outputs of the programme, limited description of the purpose of the third-sector commission, and no documentation detailing how the work with PWLE would be monitored or evaluated. Having undertaken each step of analysis, key themes identified from document analysis were Mechanisms, Management, Actors, and Processes which will now be discussed.

6.3.1. Theme of Mechanisms

Formal documents, working documents, and grey literature were analysed to consider the theme of Mechanisms which had been identified as an a priori theme and was considered in relation to organisational forms, social processes, or models of partnership identified.

Mechanisms: organisational forms

The organisational form described for partnership working was a commission to work with third-sector organisations who would lead working with PWLE. The commission was described in various documents as a separate component of the PD Improvement Programme, and documents outlined the objectives, outputs and milestones of the commission. There was limited detail on how the commission would be co-ordinated or involved with other components of the programme and no detail on how the commissioned organisations would work with PWLE. The “Invitation To Quote” document outlined the role of the commissioned organisations as follows:

> - Engage with patient groups
> - Work in close partnership with the Scottish Personality Disorder Network, and other groups to foster and support lived experience insight to the PD Improvement Programme
> - Produce an independent report describing the engagement work conducted
> - Engage with the PD Improvement Programme Social Researcher and other team members in supporting the production of the insight report.
>
> PDIP Invitation to Quote, 22nd Feb 2022

The rationale for using separate organisations to work directly with PWLE was unclear in documents; and there was no evidence presented that this represents an organisational approach to partnership. There was some evidence of possible reasons to use a commission with PWLE within the PD Improvement Programme as in one document there was recognition around the potential difficulties of engagement when asking people to discuss previous experiences of mental health services, as can be seen in the following quote:

> Engagement with PDIP may be distressing for some participants in recalling past experiences and trauma.
>
> PD Improvement Programme phase one EQIA March 2022

One written comment in a meeting note may offer some further insight into the rationale for using third-sector organisations to lead work with PWLE.

> The programme needs to be careful and protective for those individuals
>
> Joint EIP and PD meeting notes Feb 2021.

Although this is a single statement found within the document analysis, a paternalistic or protective attitude of healthcare staff has been identified as a key barrier to partnership working in the literature leading to a potential power imbalance in relationships (Ocloo et al. 2021). These quotes were initially considered to be part of the a priori theme “Mental Health”; however, on discussion with the public partner these were interpreted as an indication of rationale for organisational forms used in this programme and suggest awareness of the skills and knowledge required to support PWLE would be better placed within a separate organisation. No specific documents were available detailing the commissioning process and decision-making or analysis

of submitted quotes to provide further insights into this theme from document data.

The use of third-sector commissions as the organisational form for partnership with PWLE, and lack of any direct involvement of PWLE within the PD Improvement Programme was unexpected and I reflected on the assumptions I had made within the research diary:

> "PWLE is a separate component of the programme and will be commissioned to a third-sector organisation. There seems to be a rationale that the third-sector org will be better placed to work with PWLE rather than the programme team. Does this reflect a value base within the organisation that working with PWLE is other people's responsibility? I wonder how this actually looks in practice as documents are only an indication of setting up – it can be difficult to explain complexity and nuance in writing, so I don't want to make assumptions at this stage. In reading through documents, I'm aware of the assumptions I have made – I am surprised at the lack of detail around working with PWLE in this programme and I had assumed there would be more consideration of this at the early planning. My experiences in HIS particularly in mental health programmes, is that there are strong working relationships with PWLE and this has been a central feature of the programmes I have been involved with. I'm not sure if this will be the case for this programme and am wondering if my experiences have been influenced by my preference for working directly with PWLE and my clinical background."
>
> Research diary 17 October 2022

Mechanisms: social processes

The theme of Mechanisms also included social process used to interact within groups and establish relationships to work in partnership during the PD Improvement Programme. Data from formal and working documents were

analysed to explore how social processes were planned and considered in the PD Improvement Programme. Grey literature was then analysed to explore how the organisation described social processes.

Analysis of formal and working documents demonstrated a focus on broad preparations for partnership working with all stakeholders and no specific information on how PWLE would be involved in the programme either through the third-sector commissioned work or directly with other components of the programme. Documents focused on all stakeholder relationships and described a 'relationship management' approach that would be taken for all partnership working within the programme:

> A stakeholder engagement and communication plan outlining how we will work with key stakeholders will be prepared as part of the core project governance arrangement
>
> PD business case August 2021

Stakeholder engagement is an approach used to understand the wider context of programmes and ensure that various perspectives are included in programmes of work. Stakeholder engagement can help with understanding people's experiences, obtaining views, prioritising questions, building consensus and identifying potential solutions. Central to stakeholder engagement is the development of collaborative relationships which requires effort at the beginning and throughout programmes of work to keep all stakeholders engaged (Skivington et al. 2021). There was no detailed description of what would be included in a relationship management approach in the documents analysed, and no documentary evidence of collaborative meetings with stakeholders to agree relationship approaches, so observations and participant interviews were used to further explore social processes within the PD Improvement Programme.

Grey literature did not include any description of social processes needed to build or maintain partnerships within improvement programmes. These documents are organisational policy and strategy documents, so may not be expected to include operational detail. It was thought to be useful to understand the strategic description of social processes to understand partnerships within the organisation. Analysis of grey literature highlighted the strategic aim of ensuring programmes would include “enabling the voices of traditionally marginalised individuals and communities to be heard and acted upon” (HIS 2022 pp16) and highlighted that “building effective relationships, built on mutual trust and respect, is vital for our success” (HIS 2016, p 9). These documents did not include detail on how PWLE may be included or social processes used to support such partnerships.

6.3.2. Theme of Management

Management of partnership working was defined as the individual and collective leadership and management beliefs or practices that enable partnership working in the PD Improvement Programme. The theme of Management explored how partnership working was led and supported in practice which included allocating time and resources, setting priorities, clarifying goals, meeting objectives and communication (Kjellstrom et al. 2019). Limited relevant information was found within grey literature, as these documents focused on describing strategic organisational objectives and policies. Document analysis of formal and working documents demonstrated evidence of clarifying goals and communication in relation to working in partnership with PWLE in the PD Improvement Programme.

Clarifying goals

Goals and outputs of the PD Improvement Programme were included in working documents. The main goals of working with PWLE in this programme were described to understand people's experiences, which would be used to propose future service improvements.

> The overall aim of the project is to understand the current state of service provision for people with a diagnosis of a personality disorder in order to identify the key opportunities for improvement and to then develop proposals to deliver those improvements in a potential phase 2 of the programme.
>
> PDIP Key Performance Indicators v0.1

Communication

Communication is the transfer of knowledge and information from one person to another and is a key tool of management functions within organisations (Ojokuju et al. 2012). Effective communication is critical to achieving successful healthcare improvement initiatives (Cooper et al. 2015) and is recognised as a way to build effective relationships and trust that facilitate partnership working (Li 2020). An effective communication system includes plans for the method, process and structure of communication (Odetayo et al. 2012) and can support participation within organisations.

Documents were analysed to understand plans for communication and identified descriptions of the structure of communication within the PD Improvement Programme. These documents highlighted that individual groups were required to take responsibility for communication within their own setting.

> Members will be responsible for ensuring timely communication between their organisation or peer group and the expert reference group (where their

function on the group is to represent the views or their organisation or peer group).

20220810 ERG TOR v0.4

This delegated responsibility for communicating with individual organisations or peer groups included the third-sector organisations who lead the work with PWLE. Document analysis therefore found evidence that third-sector organisations were expected to ensure good communication with PWLE to represent the views of PWLE within the PD Improvement Programme and there was no evidence of how practices of the third-sector commission would be monitored or evaluated identified within documents.

6.3.3. Theme of Actors

Actors were considered in relation to who was involved in the PD Improvement Programme, what was their role within the programme and their role within the organisation. There were three key groups of Actors in the PD Improvement Programme identified in formal and working documents, and these were described for the purposes of research as:

Actors – HIS Non-clinical: People who had a contract with Healthcare Improvement Scotland and who had a non-clinical role in the PD Improvement Programme. This group had a range of roles within the wider organisation.

Actors – HIS Clinical: People who had a contract with Healthcare Improvement Scotland and who had a clinical advisory or lead clinical role in the PD Improvement Programme. This group did not have a role in the wider organisation.

Actors - PWLE: People who contributed to the PD Improvement Programme from a lived experience perspective. This included people who have lived or living experience, families, carers, or people who work in third-sector organisations, commissioned to work with the PD Improvement Programme.

Documents included job descriptions for Actors who had contracts with HIS – and these were standard templates which used generic descriptions of working together such as “this role will involve working with senior clinicians and leadership teams in NHS boards, HSCPs, third-sector, people with lived experience and with key national partners, including Scottish Government” (National Clinical Lead Job Description 21/11/2021). Details of roles and responsibilities were included in some other documents – including the Business Case and the Project Initiation Document – and these documents provided information on role titles and how roles would contribute to the agreed outputs of the programme. These documents did not provide any detail on the role of Actors working in the third-sector organisations.

Analysis of grey literature highlighted that the description of key roles within improvement programmes consisted of scant information. This can be seen in the following excerpt:

> The main roles the improvement team fulfil or co-opt are:
>
> - Trusted advisor for example critical friend / coach / facilitator
> - Specialist advisor (subject matter expert) for example clinical advisor / social work advisor
> - Technical advisor for example improvement advisor / data analyst
> - Technical support for example programme co-ordination / administration support
>
> Our approach to supporting improvement, 2016

This lack of detail on the roles that people were expected to carry out within the programme was a key consideration in the theme of Actors and is thought to influence how people worked in partnership across the programme.

6.3.4. Theme of Process

The theme of Process included how partnership working was defined, planned for and carried out in the PD Improvement Programme. Document analysis highlighted a lack of clear definition of partnership across formal documents, working documents and grey literature. There was no identified model of partnership identified in documents and no evidence in documents of the processes used by third sector organisations.

Document analysis indicated that the PD Improvement Programme's processes for participation mainly referred to sharing information or sharing experiences from both PWLE and their carers, families or supporters.

> An insights report based on understanding the current experiences of people with a diagnosis of personality disorder and where they see the opportunities for improvement.
>
> ERG TOR August 2022

> What has been learned from the experience of those who provide social support to those with PD (carer's, family, partners, etc., what additional support is there for these individuals? What's missing/needed)
>
> PDIP evaluation framework April 2022

Sharing information in models of partnership – including the ladder of participation (outlined in Chapter 2), considered as a form of 'placation' as

people are only involved to demonstrate they are involved (Organising Engagement n.d.). Given the ladder of participation is a framework suggested by the public partner and thought to be a familiar framework for PWLE, the outline in documents of sharing information as the main focus of partnership working may be considered negative from a lived experience perspective. Perspectives of the process of partnership were explored in observations and interviews in this research.

6.4. Analysis of observations

Data from observations provided insights into how partnership working was demonstrated in practice within the PD Improvement programme and analysis of this data was used to build a more in depth understanding of themes identified from document data. Analysis of observations identified differing perspectives within the programme and high levels of conflict between staff working in HIS and staff working in third sector organisations. There was agreement on the mechanisms for partnership identified in documents but contrasting views on the rationale for these mechanisms and contrasting approaches to working in partnership identified. Analysis of observations identified key themes of Actors, Management, Mechanisms, Conflict and Power.

6.4.1. Theme of Actors

The theme of Actors was considered in relation to how roles were demonstrated in practice during observations. Analysis of observations demonstrate there was a distinction between actors working within the organisation, and actors working as part of the third-sector organisations. Staff working in non-clinical roles in HIS acted in a role of co-ordinating and

managing delivery of all component parts of the PD Improvement Programme. Staff working in clinical roles within the PD Improvement Programme acted in the role of providing clinical advice. These Actors were observed to have relaxed interactions and appeared to have close working relationships during observations. There were several observations that indicated mutual support between the HIS staff including the use of humour, and discussions of close relationships observed. Although mutual support is viewed as a form of 'Power With', if this exists within exclusive groups it may lead to a power imbalance for participants who do not experience the same relationships in the improvement programme. This is demonstrated in the observation guide from observation two:

> "There was a mention of close working relationships in this meeting – how team members can anticipate what each other might say and understand each other well. I'm not sure how this feels when there are other members in meetings – is there a similar balance or relationship?"
>
> Observation two: observation guide

The group described as PWLE - which were staff from third-sector organisations, commissioned to lead work with PWLE - did not appear to have such close working relationships and were observed to demonstrate signs of conflict. Their contributions appeared to demonstrate that their role was to represent the views of PWLE, although one participant was also observed to discuss negative views of the PD Improvement Programme, the organisation (HIS), and the wider NHS, which appeared to be personal views as can be seen in the following quote:

> “P1: And you've got support workers going into police cells into A&E. And they’re having A&E staff saying “you [third-sector workers] put us [NHS staff] to shame with your positivity and your enthusiasm, your hopefulness. You're looking at things completely differently”.
>
> P2: It’s so important, we don't look at it as individual flaws or something because it's definitely not. It's to do with the way the systems are set up.”
>
> P1and P2, Observation four

This quote highlights that P2 urged caution with P1s expressed views towards NHS staff and therefore this excerpt was interpreted as an indication that P1 was expressing personal views. The expression of personal views may be an indication of their perceived role within the programme. The theme of Actors was developed further with data from interviews to explore how participants understood and perceived roles within the PD Improvement Programme.

6.4.2. Theme of Power

The theme of Power was considered in relation to mutual support and collaboration which are demonstrations of ‘Power To’ or ‘Power With’, and control of spaces which is a demonstration of ‘Power Over’. There were differing observations of power observed across groups within the PD Improvement Programme, with staff working in the PD Improvement Programme demonstrating evidence of ‘Power To’ or ‘Power With’ through collaboration and mutual support, and staff working in third-sector organisations representing views of PWLE demonstrating evidence of ‘Power Over’ through explicit expressions of power.

One example of this was during a discussion on timescales for the completion of a report, P1 commented on a separate piece of work they had recently completed highlighting that they sent this to the Scottish Government Mental Health strategy team, who are funders for the PD Improvement Programme.

> “And if it's of any interest we launched the [REDACTED] report and podcast last week. And so me being my usual helpful self, sent it to everyone that I know and their dogs. I sent it off to the mental health Scottish governmental health strategy team because I keep them up to date with all our tit-bits”
>
> P1, Observation four

This was coded as an expression of power during analysis as it was not clearly linked to the context of the discussion, it specifically mentioned the relationship this actor had with funders, and the phrase “I keep them up to date with all our tit-bits” was to observed to be an implied threat and a way to control the meeting space. A further expression of power was:

> “But what was also nice is there was some people who I’ve done work with in the past in the NHS - in the good old days - actually got back in touch. I've noticed their names, but you can't easily private message people on [MS] Teams. And so there was some people I took their names and I got in touch to reconnect.”
>
> P1, Observation four

This was coded as an expression of power as P1 highlighted their long-standing relationship with staff in the NHS - who appeared to be senior staff within the NHS from the context of this discussion - which was interpreted as a way to imply senior connections and demonstrate power.

The observation of different expressions of power by groups of actors in the PD Improvement Programme required further consideration and interview data was used in the next phase of research to explore perspective and experiences of power within the PD improvement programme.

6.4.3. Theme of Management

The theme of Management was analysed in relation to how actors allocated time or resources and communicated within the PD Improvement Programme. Analysis of data from observations indicate that staff within HIS (Non-clinical and Clinical) allocated time and resources for partnership through the use of a commission to third sector organisations to lead direct work with PWLE. The structure of a commission to third-sector organisations was considered to be a separate component of the programme and was not given additional priority from staff within HIS. The lack of priority was evidenced in that HCN1 did not attend the monthly meeting with the third-sector organisations. This lack of priority may have contributed to conflict observed within the programme.

Management was also observed through communication between actors. A formal monthly meeting between HIS and the third-sector organisations was established to support communication. One of these meetings was observed (Observation five) and the purpose of this meeting was to receive updates from the third-sector organisations on the work they were doing with PWLE, and to keep the third-sector organisation up to date with progress in other components of the PD Improvement Programme. This approach to communication between the third-sector organisation and the HIS staff was observed to be difficult. The following quote was observed to be a sign that HNC3 believed there to be a difference in timescales between the work they were involved in with the third-sector organisations and other components of the PD Improvement Programme, indicating some challenges with communication:

> “I’m just going to check about the likely time scale of pulling together the strategic gap analysis stuff ... and what about the other part of O1 and O2 stuff – what is the time scale of **them** reporting back?”
>
> HNC3 Observation three

The emphasis in this quote was on the word “them” highlighting a belief that there were different timescales for reporting for the commissioned organisations.

Difficulties in communication was also observed in Observation four as P1 reported that they did not have information on other components of the PD Improvement Programme:

> “I feel that you know what we’ve been doing, but I’m not quite sure what’s been happening in the programme”
>
> P1 Observation four

There were also concerns observed from staff within HIS regarding how effective the management practice of communication between the commissioned organisations and the PD Improvement Programme as can be seen below:

> “hopefully O1 and O2 (third-sector organisations) will be doing a similar job with all their evidence and information, and we can lift and lay some of their summarised stuff into ours, we’ll link to their full thing”
>
> HNC1, Observation five

The use of the conditional word “hopefully” may be indicative of a lack of co-ordination between the third-sector organisations and the improvement programme. These observations were also considered to be indicative of signs of mistrust or conflict between actors.

Within the theme of Management there was evidence of a distinction between staff working in HIS and staff working in third-sector organisations. Further understanding of actor's perspectives and experiences of management practices within the PD Improvement Programme was gathered in phase two of this research to explore this theme in greater depth.

6.4.4. Theme of Mechanisms

The theme of Mechanisms explored organisational forms and social processes used to support partnership working in the PD Improvement Programme. The organisational form of the use of a commission to third-sector organisations had been identified in documents and had been described and planned as a separate component of the PD Improvement Programme. Observations indicated that this mechanism was viewed positively by staff working in HIS (non-clinical and clinical) who participated in this stage of research.

Staff working in third-sector organisations, representing PWLE, were observed to have negative perspectives of this mechanism as demonstrated in the following quote:

> "I'm a bit concerned that it's seen as a commercial transaction with us rather than a fully-fledged equal value part of the programme. I don't know if that's meant, but when I read in the expert reference group 'The Commmission' (said with emphasis). It didn't make me feel great. We are more than a commission"
>
> P1 Observation four

The mechanism for a commission had been outlined in documents at the start of the improvement programme and therefore the negative views expressed were interpreted as an indication of contrasting perspectives on the purpose of this Mechanism. There were no opportunities to observe PWLE in this research and therefore it was unclear if negative views expressed by the staff working in the third-sector organisations represented views of PWLE.

The theme of Mechanisms was also considered in relation to social processes observed. There were signs of conflict between groups of actors within the programme and some evidence of differing social processes used by groups of actors, with staff working in the organisation adopting collaborative approaches and staff working in the third-sector organisation working more independently with a lack of collaboration noted. This can be seen in the following example from Observation 4, when P1 was describing the approach they had used when preparing a report to the PD Improvement Programme:

> "I've asked a number of times what the deadline is and in the absence of any response, I've set one for 19th December. We were told it was needed by Christmas, and I've not heard back from you so I go on the basis that this is **my** deadline." (said with emphasis and tension)"
>
> P1 Observation four

This quote demonstrates that P1 made some decisions without fully understanding the needs of other actors within the programme. A further example of a lack of collaboration was noted in Observation one during a discussion reflecting on a previous webinar that had taken place:

> "We thought we had a process in place and P1 had said that they would respond directly in the chat to any questions that come up, but that didn't happen"
>
> HNC1 Observation one

Both examples indicate a lack of collaboration between staff working in HIS and staff working in the third-sector organisations.

Data from observations indicated a differing view of organisational forms, and differing social processes used by actors who worked in HIS and staff working in third-sector organisations. Individual perspectives of mechanisms within the PD Improvement Programme were further explored during interviews, to understand if participants had a clear understanding of the plans outlined of organisational forms in the programme before joining the programme, and to explore the reasons for adopting different social processes when working in the PD Improvement Programme.

6.4.5. Theme of Conflict

Analysis of data indicate the theme of Conflict was prevalent in this case with high level of conflict observed, particularly from one actor (P1). The main type of conflict observed was individual and interpersonal. An example of individual conflict can be seen in the following example in Observation four when P1 was observed to question the motives or integrity of staff in the NHS:

> “the NHS does far too much in mental health – not enough in a way, because it *should* do what it does well – but it *should* have the humility to say that some of these resources could be better spent by other people.”
>
> P1 Observation four

Although in this quote, P1 was speaking about the NHS as an organisation, it was interpreted as an indirect comment on individual staff within the NHS – and possibly staff working in the PD Improvement Programme. The use of “should” is a modal verb and is used when making recommendations. This quote was considered to be a suggestion from P1 that NHS staff were not doing their job well and were misusing resources, which was interpreted as an indication of individual conflict.

An example of interpersonal conflict was observed when P1 compared NHS with third-sector organisations as a way to establish a distance between these organisations:

> “I think it's too easy to say people are burnt out – well why are they burnt out in this part of the system [NHS staff]? They’re not burnt out in other parts of the system [third-sector] which are experiencing massive pressures as well”
>
> P1 Observation four

The reasons for such observations of conflict were not clear at this stage of research. Todd et al. (2020) found power to be a potential source of conflict and therefore, conflict was added as a subtheme of Power for future analysis. Phase two of this research developed a greater understanding of the nature of conflict and personal perspectives of the PD Improvement Programme to

explore how themes identified in phase one interacted and influenced each other.

6.5. Analysis of interviews

At the end of phase one, the thematic analysis structure was developed and used to analyse data collected during interviews. At this stage a greater understanding of the Themes of Actors, Power, Management, and Mechanisms were developing. The theme of Process – which was defined as how partnership working was defined, planned for, and carried out, was viewed as a subtheme of Management (in relation to definitions and preparation for partnerships) and Mechanisms (in relation to how partnership working was carried out in practice, including how PWLE were represented in the PD Improvement Programme). The theme of Actors was developed to include subthemes of roles and identity; and the theme of Conflict was considered a subtheme of Power with additional consideration given to responses to Conflict. Previously identified a priori themes of National Organisations, Mental Health, Attitudes, and Challenges had not been noted from document or observation data; however, as the purpose of interview data was to provide personal perspectives and insights these remained as part of the a priori themes for phase 2. A description of the themes developed for phase 2 are presented in Table 22 below:

Table 22: Themes developed for phase two

Themes	Sub-themes	Description
Actors	Identity Role	How actors understood, perceived and demonstrated their role within the PD Improvement Programme

Power	Type of Power	Power Over – ability to influence others Power To – ability to organise or change hierarchies Power With – power of collective action Power Within – individuals have capacity to exercise power.
	Conflict	Type of conflict (individual, interpersonal and organisational) Response to conflict
Management	Setting priorities Allocating time and resources Clarifying goals and meeting objectives Communication	Actors' perspectives and experiences of management practices and beliefs that enabled partnership working in the PD Improvement Programme.
Mechanisms	Organisational forms Social processes	Structure and design of the programme Representation of PWLE Ways in which social groups interact and develop relationships
National organisation		Legislative, political, or governance arrangements influencing working with PWLE
Mental Health		Needs or considerations of working with people who have experience of mental ill health
Attitudes		How was partnership viewed by participants
Challenges		Ensuring meaningful participation
Emergent		Themes not anticipated in advance

Data from interview transcripts, field notes, and reflexive diary entries were used during this stage of analysis. Interview data provided greater insights into individual perspectives and views of how partnership working happened in practice within the PD Improvement Programme. The following section discusses how interview data was initially analysed separately to develop themes. Chapter 7 then describes the recontextualising stage of analysis which considers data from all sources to build a more integrated understanding of partnership working and demonstrate how findings were developed. Key themes of Actors, Management, Mechanisms, and Power were identified from interview data and are now discussed.

6.5.1. Theme of Actors

Analysis highlighted that there was a lack of clarity on roles assigned to Actors in the programme and in the absence of clarity, Actors developed their own interpretation of the role they would have within the PD Improvement Programme. There is a distinction between roles that people are asked to undertake, and the roles people choose to undertake, which has been highlighted in the literature in relation to roles that PWLE demonstrate when working in partnership in health or social care settings. Miller et al. (2023) identified four roles that PWLE are asked or choose to undertake when working in partnership in health or social care settings. These roles are Community Builder, Improvement Expert, Disruptor, and Citizen Leader. Using these descriptions, P1 whose role in the programme was to lead the lived component of the improvement programme may have viewed their role as a Disruptor to the programme. The role of Disruptor is described as assertive, persistent while using radical strategies to ensure their voice is heard (Miller et al. 2023) and evidence from interviews suggests that P1 used these approaches in the PD Improvement Programme.

> “My role emerged, and I think there’s two reasons for that. I think HIS on the one hand, if I’m being honest, I don’t think they knew what to expect … and I think the mentality and the approach in HIS is ‘we are all powerful, we know everything’ and I decided to use that just to do what we want”
>
> P1 Interview

The phrase “I decided to use that just to do what we want” was viewed as indication that given the lack of clarity, this Actor used working in the PD Improvement Programme to follow a personal agenda. This quote may also indicate a pattern of working in isolation to others in the programme and may have also been influenced by the lack of evaluation or oversight of the work of the third-sector organisations which will be discussed in relation to the theme of Management.

The role of Citizen Leader is described as encouraging other people and professionals to connect intellectually and emotionally, reaching out to those who feel disenfranchised and representing the stories of others (Miller et al. 2023). Analysis of interviews highlights that other Actors perceived the role of staff working in the third-sector organisations as Citizen Leader.

> “If the programme were to be successful, it had to incorporate a whole lot of different strands of people’s lived experience with people who might have a diagnosis of personality disorder… and the broader piece of engagement with people with lived experience, that was theirs (the third-sector organisations) to deliver. ”
>
> HNC1 Interview

There was no evidence of P1 acting in this role as there was no description in any interviews of P1 connecting people to professionals and some concerns raised around how representative the work of the commissioned organisations was in practice. The planned and perceived role of third-sector organisations was to be a Citizen Leader and the distinction between planned, perceived and lived roles may have contributed to conflict observed in the programme.

6.5.2. Theme of Management

The theme of Management was defined as the individual and collective leadership and management beliefs or practices that enable partnership working. Interviews highlighted key elements of clarifying goals and objectives, and communication, were significant factors in the management of the PD Improvement Programme. Although factors such as time and resources had been highlighted in the literature as key to supporting effective partnerships (Giesen et al. 2024; Mulvale 2019; Persson et al. 2024; Pougheon et al. 2018) these were not discussed in any interview and therefore not considered a significant feature of the theme of Management in this research.

Central to the theme of Management are abilities, skills and capacity to build relationships and hold effective two-way communication (Davies 2016). Although the importance of a range of skills when working in partnership have been recognised there is a gap between theory and practice. Klatte et al. (2020) found that collaboration between patients and staff was complex and difficult to implement in practice. Principles and strategies for working with patients have been outlined in the literature (Klatte et al. 2023; Sundet et al. 2020) and include various strategies healthcare professionals use to empower patients to become collaborative partners. There was recognition of the skills needed to work with PWLE and the assumption that third-sector organisations are better placed to lead this work as can be seen in the following quote:

> "we really wanted to make sure that when working with people with lived and living experience that we were doing it justice, we were approaching it in the right way … and we commissioned a third-sector organisation"
>
> HNC4 interview

Given this programme did not work directly with patients but through third-sector organisations, strategies to communicate and build relationships may not have been given close consideration in this programme, as the commissioned organisation were viewed as professional partners. The literature on partnership working between professionals was therefore reviewed to provide insights into management strategies used in this programme.

Sundet et al. (2020) developed a heuristic model for collaborative practice which describes differences between patient/ professional collaboration, inter-professional collaboration and service sector collaboration. Strategies observed in the PD Improvement Programme and described in interviews by staff working in HIS appear to be in line with principles of interprofessional collaboration: developing mutual understanding (evidenced through communication between one member of staff from HIS and the third-sector organisations); negotiation (evidenced through descriptions of agreeing definitions); and working together (evidenced through the set-up of monthly meetings between HIS and third-sector organisations).

6.5.3. Theme of Mechanisms

The theme of Mechanisms was discussed in relation to the organisational form of a commission to third-sector organisations and social processes used to work in partnership. This theme also considered how PWLE were represented in the PD Improvement Programme. Analysis highlighted relationships between the theme of Mechanisms, Management and Power.

Organisational forms

Evidence from interviews highlighted that most participants were aware of the use of a commission to third-sector organisations to lead work with PWLE (HNC1, HNC4, HNC5, P1 and HC3). One participant was not aware of this organisational form (HC9), and they described their role in the PD Improvement Programme as an advisory role separate to the operational delivery of the programme. This lack of awareness is therefore thought to be related to their role within the programme. Interview data demonstrated that all other participants had similar perspectives on the reasons for the use of a commission to third-sector organisations. Key reasons described were in relation to skills and experience of staff in third-sector organisations in working directly with PWLE (HNC1, HC3, HNC4, HNC5, P1) and to provide ongoing support for PWLE (HNC1, HNC4, HC3, and P1).

Although there was agreement on the reasons for using a commission to third-sector organisations to lead direct work with PWLE, there were some key differences noted in perspectives of the separation of the third-sector organisations to other components of the PD Improvement Programme. Phase one of this research indicated there were different perspectives of this separation, with staff working in HIS viewing the separation as positive and staff working in the third-sector organisations expressing negative views on this organisational form. Analysis of interview data indicated that the separation was a deliberate decision made to provide the third-sector organisations full responsibility for leading direct work with PWLE and there was little consideration given to monitoring the work of the third sector organisations.

> “There was a degree of demarcation within the programme and I was conscious that I didn’t want to micromanage them (third-sector organisation).”
>
> HNC1 Interview

This supports the suggestion in phase one that this organisational form was considered by actors within HIS as a way to share power and is also further evidence of the lack of monitoring or evaluation of the work of the third-sector organisations. Such separation was recognised as providing autonomy for the third-sector organisations which was viewed as positive by staff in third-sector organisations, as can be seen in the following quote:

> “I think it is important that you know to talk about the extent to which we should be independent and do it independently. I think in this one it really worked.”
>
> P1 interview

There were also negative views expressed by P1 who perceived the separation between components of the programme as a form of control or a way to prevent full involvement of third-sector organisations. This can be seen in the following quote:

> “It was over there, and we were regularly described as ‘the commission’ which was separating us and diminishing us.”
>
> P1 interview

This view and description related to how the staff within the third-sector organisations perceived the separation between components of the programme and may not reflect views of PWLE. The differing perspectives of organisational form is considered an indication of perceived power within the programme.

Evidence from interviews found that some participants questioned if the third-sector organisations represented a wide range of experiences of PWLE in the PD Improvement Programme. Some participants raised concerns that the commissioned organisations did not support a representative range of views and appeared to seek negative views of services, with some suggesting that this may be a deliberate approach by the third-sector organisations commissioned to this programme. I have decided to share several quotes to demonstrate this view was shared by several participants:

> "I think maybe some of the people who engaged with the O1 and O2 work were people who really wanted to say, well that was a rotten experience for me"
>
> HNC1 interview

> "I would say be mindful that when you're working with third-sector commissions, they do have their own agenda … they have their own agendas, and they might not necessarily have positive experiences of working with the NHS either"
>
> HNC4 interview

> "one group that I worked in didn't get much information about what was going on – even though they were an identified group with personality disorder in the title. They felt that their views were a bit lost in the mix because they had a slightly different tone of views [with positive views on their experiences of healthcare] from the majority of views coming through that project"
>
> HC3 Interview

The use of third-sector organisations to represent views of PWLE is recognised in the literature with the role of third-sector organisations described as collaborators in health care development (Jones et al. 2021) or in a role consisting of translating knowledge to PWLE and representing the views of PWLE to health professionals and decision makers (Naslund 2020). There have been questions in the literature around how well third-sector organisations represent a range of views of PWLE and there have been some examples of adjustments or filters made by these organisations when communicating experiences to health professionals (Jones et al. 2021). Adjustments have been made so that information can be accessible to healthcare professionals (Blume 2017); however, in this case study, adjustments may have been made to enhance negative experiences to professionals. There have also been concerns in the literature about the use of others to represent views of PWLE, as there is a suggestion that to express experiences and views authentically PWLE should be directly involved in all levels of health services (Jones et al. 2021). The commission to third-sector organisations is central to the theme of Mechanisms and how this influenced partnership working with PWLE is considered further in Chapter 7.

Social Processes

The theme of Mechanisms also included social processes used. Observations carried out in phase one highlighted a different approach and different social processes used by actors who were members of staff in HIS, and actors who were staff in third-sector organisations. Analysis of interviews highlighted that staff within third-sector organisations used a less collaborative approach, and they described their approach as a way to ensure they had an opportunity to meet their needs, as can be seen in the following quote:

> "We saw this as an opportunity not to do what HIS wanted to do, but to do what we wanted to do … we based some of what we were doing on past

> experiences which is not to be so compliant … we got a wee bit more assertive"
>
> P1 interview

Again, it is of note that this appeared to be a personal view, and it was not clear if this represents the views of PWLE. P1 described their approach as assertive, and although assertiveness involves expressing ideas, feelings and boundaries while respecting other's rights, there are thought to be different views and practices described as assertive, with some that include aggressive and relationship damaging expressions (Pfafman 2017). This description supports observations that staff in the third-sector organisations did not use collaborative strategies and were observed to use confrontational approaches when working in the PD Improvement Programme.

6.5.4. Theme of Power

Power was considered in relation subthemes of Type of Power and Conflict. Interview data found evidence of differing perspectives of the Type of Power between staff working in HIS and staff working in third-sector organisations, and high levels of individual and interpersonal conflict noted.

Type of Power

The theme of Power was found to have a close relationship with the theme of Mechanisms. Interviews highlighted groups of actors viewed the organisational form in the PD Improvement Programme as a form of power. These perspectives of power were thought to influence social processes used by groups of actors in the programme. Evidence from interviews highlighted that staff working in HIS (HNC1, HC3, HNC4 and HNC5) viewed the use of a commission as a way to share power with PWLE and was perceived to be a form of 'Power To'. The strategies these participants used to collaborate were based on interprofessional collaboration. In contrast to this perspective, the

interview with P1 highlighted that they viewed the organisational form of the programme as a form of 'Power Over' and the use of a separate commission was used to withhold power. This actor used approaches to disrupt, which is thought to be a response to their perspective of power.

Conflict

Conflict was identified in observations and was discussed in interviews with all participants. Most participants acknowledged conflict within the programme (HNC1, HNC4, HNC5, HC3, and P1) and this was described as conflict between staff working in HIS and staff working in the third-sector organisations. During interviews there was evidence of individual and interpersonal conflict expressed by P1 – who was a staff member from the third-sector organisations. An example of individual conflict expressed is shown below:

> "I still don't know what their (HIS) deep down motive is other than we have to do it. For me this is all about transformation, revolution, change. I think HIS are doing it because they feel they have to."
>
> P1 interview

There were several indications of interpersonal conflict expressed during the interview with P1. During this interview there were examples of interpersonal conflict expressed in relation to other actors, organisations, approaches used during the PD Improvement Programme, and other approaches used to work with PWLE. The following examples demonstrate interpersonal conflict expressed:

> "[member of HIS staff] could be a bit – not difficult – but just strange to work with"

> “when we talked about the design of a conversation cafe with [HIS member of staff] they were very concerned, which I thought was hilarious because I mean, they were fairly new”
>
> “I’m not a fan of improvement and I think improvement is causing us lots of problems in Scotland because we’re just trying to polish the same old turd all the time”
>
> P1 Interview

Analysis of interview data did not provide insights into the reasons for the interpersonal conflict expressed, and given this was noted with only one actor, it may be that the conflict noted may be based on personal experiences or perspectives. There is; however, evidence that partnership working between staff in HIS and staff in the third-sector organisations was characterised by high levels of conflict.

The response to conflict was also considered in thematic analysis with contrasting approaches and responses identified. HC3 highlighted the response of accepting difference in views which demonstrated a response to high levels of conflict may have been to withdraw, as can be seen in the following quote:

> “There’s not much to be done about it because that was the direction they (third-sector organisations) were going in”
>
> HC3 Interview

A similar description of possible distancing or avoidance was also described by P1 and this was viewed as a response to the conflict in the programme. The distancing can be seen in the following quote:

> "(REDACTED – staff member) was completely absent – I think they turned up once or twice toward the end"
>
> P1 Interview

From evidence in interviews, it can be suggested that there were high levels of individual and interpersonal conflict noted by P1 and other actors in the PD Improvement Programme responded by withdrawing from ongoing attempts at collaboration. Such a response is outlined in the literature as although conflict is considered a source of learning or innovation, in healthcare there is thought to be a tendency to respond by eliminating conflict, rather than understanding issues underpinning the conflict (Eichbaum 2018). It is possible that healthcare professionals are not prepared or supported to understand or respond to power and conflict in partnerships. Given that national organisation's role is to co-ordinate work across a range of stakeholders, further consideration on the skills needed to manage these relationships is warranted to support effective partnership working with PWLE in future national programmes.

6.6. Review of themes

Analysis of data contributed to a greater understanding of previously identified and anticipated themes in this research with four prevalent themes developed, each with a number of subthemes. Key themes of Actors, Power, Management, and Mechanisms for partnerships were identified across all data sources and were considered relevant to understanding how the national PD Improvement Programme worked with PWLE. A priori themes of Process, Conflict, and Challenges were identified as subthemes in this programme, Process was considered a subtheme of Management, Conflict a subtheme of Power, Challenges were centred around the challenge of how PWLE were represented and considered a subtheme of Mechanisms. Although the a priori themes of National Organisations, Attitudes, and Mental Health had been anticipated,

these were not recognised within data collected. Analysis provided a deeper understanding of themes for this programme and an awareness that these themes were interconnected, and further analysis across all data sources was carried out to identify how themes influenced each other and interacted in this case.

6.7. Chapter conclusion

During data analysis key themes of Actors, Management, Mechanisms and Power were identified. Analysis considered each theme in relation to separate data sources and in line with literature helped strengthen and deepen an understanding of these themes in relation to this national programme. The final stage of analysis – recontextualising – was used to bring data across all sources together and develop propositions for each theme. These propositions were tested against all data and then used to develop findings of this research which is discussed in Chapter 7.

7. Findings

7.1. Introduction

This section details the process of recontextualizing data across all data sources to consider how the understanding of partnership working may be applied in different settings and build a more integrated understanding of events, processes and interactions in this case (Houghton et al. 2015). Propositions were written as statements related to themes identified and during the recontextualising a deductive approach was taken to analyse the propositions developed against all data collected. In section 7.2 I discuss each proposition to ensure that interpretations have been made in a credible manner describing how findings relate to the literature (Finlay 2021). These steps of analysis focused on ensuring data are converged from each data source to understand the overall case (Baxter and Jack 2008). Section 7.3 then describes how evidence was used from propositions to identify and develop findings of this research.

7.2. Recontextualising and development of propositions

7.2.1. Proposition one: actors

The first proposition stated that individual actors' perspectives of their role in the PD Improvement Programme influenced how they approached partnership working. The roles of actors representing PWLE were identified as significant during the first steps of analysis and therefore these roles will be discussed to analyse this proposition. Roles are defined as external attributes linked to social structure (Sirris 2019). As this proposition considered actors perspectives of their role, the concept of identity is also discussed. Identity is defined as an internal perception of self and is considered critical to how people behave in work situations (Sirris 2019). Ackerhans et al. (2024) describes the

concept of professional identity which influences how people act and is related to how people identify with roles and responsibilities in work situations. The concepts of both role and identity are considered key components in achieving partnership working with PWLE and a greater understanding of the roles PWLE are asked or choose to undertake can support more effective partnership working (Miller et al. 2023). Therefore, to reconceptualise the first proposition, I considered how actors representing PWLE perceived their role and identity within the programme, how other actors perceived this role, and how perspectives of identity influenced actors' approach to partnership working.

Data from documents, observations, and interviews were used to consider roles and identities of actors representing PWLE in the PD Improvement Programme in relation to role types outlined by Miller et al. (2023) described in Table 23 below. Although the descriptions are in relation to roles, they were considered appropriate as descriptions of identity for the purpose of analysis.

Table 23: Description of roles

Role and identity type	Description
Community builder	Community builders seek to find and connect people with similar interests and challenges to provide mutual support and shared representation.
Improvement expert	Improvement experts articulate relevant experiences to others, challenge different perspectives, and understand common approaches to analysis and sharing data.
Disruptor	Disruptors are assertive and persistent. They communicate to represent the perspective of others and at times adopting radical strategies to ensure voices are heard.
Citizen leader	Citizen leaders use stories to encourage people and professionals to connect intellectually and emotionally, actively reach out to those who feel most disenfranchised, and listen and represent the stories of others.

Analysis focused on P1 who participated in both observations and interviews which ensured adequate data was available. I analysed the roles that P1 had been assigned in the PDIP in documents, observations made of their approach to working with others in the PD Improvement Programme, and how this participant described the role they had in the programme, to understand their internal perspective of identity. From this data it can be argued that actors representing PWLE were assigned a role as Citizen Leader but perceived their identity and therefore acted in the role of Disruptor in the PD Improvement Programme.

Analysis of documents described the role of staff within the commission was to:

> "engage with patient groups, work in close partnership with networks and engage with team members to produce an independent report"
>
> Invitation to quote

The 'Invitation To Quote' document also highlighted examples of outputs anticipated from the commission including "undertaking consultation with those groups and individuals for example, focus groups, structured conversations, care journey capture". The role of the third-sector was described in documents as "leading work involving people with lived experience". These formal descriptions are in line with the definition of Citizen Leader.

Analysis of observations and interviews highlighted that P1 acted as a disruptor. Observations highlighted radical strategies used by P1 such as starting a programme of engagement using terms that contrasted with the agreed definitions in the programme and disclosing that they had shared reports with the funders of the programme without involving the PD improvement team. Observations also highlighted that P1 acted against agreed

processes during one external meeting - when the team had agreed that P1 would respond to any questions in the MS Teams chat during the meeting but failed to do this. This behaviour is viewed as a form of disruption.

In the interview, P1 described their role as:

> "We wanted to push the idea that lived experience was about what works and what doesn't about current services but that's a minor part of what we do … We saw this as an opportunity not to do what HIS wanted us to do, but to do what we wanted to do … So for me this is all about transformation, revolution, change."
>
> Interview P1

This quote demonstrates insight into P1's perception of identity as a Disruptor as they described planning to work in ways that were not in line with the agreed objectives within the commission. The use of the term "push" highlights their approach as assertive and persistent, and the use of the term "revolution" indicates an intention to use radical strategies, which are in line with the definition of Disruptor. Analysis of the data suggests that identity is a more significant factor in partnership working and therefore this proposition was changed to state that, partnership working was influenced by how actors representing PWLE in the PD Improvement Programme perceived their identity in the programme.

7.2.2. Proposition two: management

The theme of Management was defined as the individual and collective leadership and management beliefs and practices that enabled partnership working in the PD Improvement Programme. It included understanding how partnership working was led and supported in practice including setting

priorities, clarifying goals, meeting objectives and communication with all partners. The second proposition stated that management strategies of interprofessional collaboration were used by HIS staff working in the PD Improvement Programme. Interprofessional collaboration is defined as collaboration among professionals and among service sectors, and is characterised by mutual understanding, negotiation and working together (Sundet et al. 2020). To analyse this proposition, I reviewed data to explore strategies used by HIS staff (non-clinical and clinical) working in the PD Improvement Programme.

Formal documents between HIS and the third-sector organisations described the structure of the PD Improvement Programme and outlined an agreement between the organisations to work together – which was viewed as a way to develop mutual understanding. Data from interviews outlined an approach taken by HIS staff in the PD Improvement Programme to agree terminology used by the third-sector organisations which is viewed as an example of negotiation. Strategies outlined in documents and observed included setting up monthly meetings and identifying a named contact in the programme and are considered evidence of attempts to work together with the third-sector organisations. The data therefore supports the proposition that HIS staff working in the PD Improvement Programme used management strategies of interprofessional collaboration.

7.2.3. Proposition three: mechanisms

The theme of Mechanisms was defined as the organisational forms identified and social process used to support partnership working. Proposition three stated that the use of a commission to third-sector organisations in the PD Improvement Programme was intended to support partnership working with PWLE; however, the third-sector organisations did not represent a range of views of PWLE. There were two parts to this proposition so to analyse this

proposition, I reviewed data from documents, observations and interviews to understand the purpose of the structure of the programme and to explore how PLWE were represented in the programme.

To understand the intention of organisational form used in the PD Improvement Programme, I reviewed document data and interview data. Document data demonstrated that a commission to third-sector organisations was used to ensure that PWLE were supported in a skilled and sensitive way. Planning documents highlighted consideration of the needs of PWLE to support involvement in the programme as demonstrated in the quote below:

> "when it comes to engagement with people with lived experience, O1 have a number of well-developed skills and experience"
>
> Interim report on O1 event

The commission was agreed in formal documents between HIS and third-sector organisations and benefits of the commission were highlighted by participants from the third-sector organisation and HIS staff working within the PD Improvement Programme during interviews (discussed in Chapter 6). Data from documents and interviews supports the first part of this proposition that the organisational form used in the programme was intended to support partnership working with PWLE.

I then considered evidence to explore how the views of PWLE were represented in the PD Improvement Programme through the third-sector organisations. Formal documents highlighted the need for third-sector organisations to represent a range of views and engage with PWLE, but did not specify if there was a need to represent positive and negative views or experiences. Documents described approaches to engagement and gathering

views from the third-sector organisations that would include asking PWLE about positive aspects of their experience highlighted in the quote below:

> “O1 used an approach called “Conversation cafes”, asking people what keeps them well, what's worked well for them and why, and what recovery looks like.”
>
> Notes from O1 catch up

There was a contrast between the positive approach described in documents and organisations and the experience observed and discussed in interviews, when participants were concerned that only negative experiences were described by the third-sector organisations. There is an apparent difference in expectations from HIS staff working in the programme to staff representing PWLE. This difference may be attributed to a lack of detail on the process for partnership working. Data from documents highlighted a focus on structure and outputs but limited detail on the process which is thought to be a risk to partnership working (Greenhalgh et al. 2023). In this programme a lack of attention to process for working in partnership may have contributed to different expectations for the commissioned organisation.

The difference in expectations could be an indication that the third-sector organisation did not represent a range of views for PWLE in this programme. During interviews, several participants discussed that the third-sector organisations focused on negative experiences during the PD Improvement Programme (HNC1, HC3, HNC4 and HNC5). The following quote describes the view of some participants that the third-sector organisations may have focused on negative experiences of PWLE, with less focus on positive experiences:

> “I think one of the things that got lost were some of the positive experiences – there was something about the process that picked up a lot of the unhappiness. The group I work in has a mix of

> views about things to do with care they've experienced and the way services are set up and some of those are positive at times and it was really hard to find those voices coming through. I know they were expressed because I heard it back [from people who contributed] but it's though that got drowned out. I wonder what happens to the voice of people who might have more positive things to say."
>
> HC3 interview

It is of note that there was no evidence of HIS monitoring the work of the third sector organisations and scant information on how the third sector organisation worked with PWLE. However, from data available there was evidence to support the proposition that the third-sector did not represent a range of views from PWLE as P1 described their role in terms of what was important to them as an individual, rather than describe their role in representing a range of views of PWLE as is seen in the following quote:

> "So for me this is all about transformation, revolution, change."
>
> Interview P1

Concerns have been identified in the literature regarding how well third-sector organisations represent PWLE views and experiences in healthcare, with some examples of adjustments being made when communicating experiences to health professionals (Jones et al. 2021, Blume 2017). There is evidence in this research that actors representing PWLE may have made adjustments to enhance negative experiences to professionals and therefore data from this case study supports the proposition that the third-sector organisations did not represent a wide range of views of PWLE.

7.2.4. Proposition four: type of power

Proposition four stated that there were different perspectives of types of power within the PD Improvement Programme, and individual actors used strategies to work in partnership based on their perspective of power. There is evidence in the literature that people respond to power in different ways (Miller et al. n.d.) and evidence from interviews discussed in Chapter 6, highlighted a difference in perspectives of power and differences in strategies used to work in partnership between groups of actors in the PD Improvement Programme. To recontextualise this proposition, I reviewed data from documents and observations to explore if there was evidence of similar patterns of perspectives noted in phase one of this research.

Documents described the use of a commission to third-sector organisations to lead direct work with PWLE in the PD Improvement Programme. Evidence in documents highlighted that the commission was described and agreed as a separate component of the programme (outlined in the PID, Business Case, Invitation to Quote, and Expert Reference Group Minutes), and the third-sector organisations had documented agreement to engage with one member of the HIS staff (Invitation to Quote). These descriptions are in line with the definition of 'Power To' as the commissioned organisation were able to make decisions and influence the work of the programme. Observations and interviews demonstrated that the separation of the commission described in documents happened practice and different perspectives of this separation were noted.

During observations, actors who represented third-sector organisations expressed negative views about the use of a commission and appeared to view this as a way to limit access to power and therefore provided evidence that staff from third-sector organisations perceived the organisational form to be a form of 'Power Over', as can be seen in the following quote:

> "I'm a bit concerned that it's seen as a commercial transaction with us rather than a fully-fledged equal value part of the programme. I don't know if that's meant, but when I read in the expert reference group 'The Commission' (said with emphasis). It didn't make me feel great. We are more than a commission"
>
> P1 Observation four

The data therefore supports the proposition that there were different perspectives of power in the PD Improvement Programme.

This proposition also stated that individual actors used strategies to work in partnership based on their perspectives of power. Actors working in the third-sector organisations used confrontational approaches which was evidenced in observations and in interviews. Data indicated that HIS staff (non-clinical and clinical) used approaches to build relationships and build mutual understanding. The use of confrontation is thought to be a response to perceived 'Power Over' and the use of negotiating and working together are strategies used to respond to situations of 'Power To' (Miller et al. n.d.). Data from the PD Improvement Programme therefore supports the proposition that actors used strategies based on perspectives of power.

7.2.5. Proposition five: power and conflict

Conflict was identified as a subtheme of Power and proposition five stated that there was interpersonal and individual conflict in the PD Improvement Programme which influenced partnership working. To analyse this proposition, I will explore how conflict may have influenced partnership working in the PD Improvement Programme.

I returned to review documents to understand if there was any documentation on how to prevent or respond to conflict in the PD Improvement Programme. There was no description or discussion on conflict in formal documents or grey literature. Governance arrangements described in the Project Initiation Document described the establishment of 'robust escalation processes' but there was no detail on what this involved found in any working or formal documents. I also reviewed documentation to explore if there were any guidelines or information on either conflict or how to build positive relationships with others. There was recognition on the importance of building positive relationships across formal and grey literature, which can be seen in the following quote:

> "We recognise that building effective relationships, which are built on mutual trust and respect, is vital for our success"
>
> Our approach to supporting improvement, HIS 2016

Within grey literature there was also a participation toolkit which had been developed by HIS, which supports health and social care services to ensure that "people and communities are involved in planning and developing local health and care services" (Healthcare Improvement Scotland n.d.). This toolkit was highlighted in Chapter 2 and shares a range of practical resources for health and social care staff to use to work with PLWE within planning or community engagement activities. There was no evidence of the toolkit being referred to in the PD Improvement Programme and no recognition of potential conflict within the toolkit. Given the toolkit is not highlighted in any models for improvement used within HIS or described as a way to support improvement initiatives, the lack of description of use of these tools in the PD Improvement Programme is not unexpected. The lack of recognition that such engagement tools could be used within improvement initiatives within the organisation is of interest.

Analysis of observations and interviews identified conflict between actors with evidence of both individual conflict and interpersonal conflict. There were several examples of displays of conflict which were particularly noted in one actor, and characterised by misinterpreting other's motives, ability, or integrity. There was evidence that the response to this conflict from HIS Staff was to distance or withdraw. Given the position of national organisations and the need to balance a range of stakeholders needs (discussed in Chapter 2) this may account for the avoidance of conflict. Some participants discussed conflict and highlighted that they did not know how to respond as can be seen in the quotes below:

> "I think being able to maintain good relationships with people, allows for maybe sometimes conversations that might be more challenging otherwise, to be more effective. I don't know if there is any guidance in place just now about how we do that."
>
> HNC1 interview

> "I probably wasn't properly prepared for how I would feel about when I experienced difficulties in that relationship. How would I manage that? Because I'd never experienced that sort of thing before."
>
> HNC5 interview

These quotes highlight that conflict was noted by actors, that there was a lack of guidance found in documents, and a lack of recognition that conflict can be a source of learning or innovation. In this programme the conflict noted had an impact on how people worked in partnership. It is not clear if this conflict impacted on the approach third-sector organisations adopted when working with PWLE or the ability of PWLE to participate with the third-sector organisations.

7.3. Research findings

In this section, I describe how the evidence presented in this research has been used to identify key findings. The first finding is that there was a lack of clarity in definitions, processes and roles required to work in partnership with PWLE which is described in section 7.3.1. In section 7.3.2, the second key finding of this research is that partnerships were influenced by representation, social processes, power and conflict. In section 7.3.3, I present a concept map which is used to articulate how key themes of Mechanisms, Identity and Power were demonstrated in practice and how they influenced partnership working within a national context.

7.3.1. Language of partnerships

This research found a lack of clarity in descriptions of partnership in the PD Improvement Programme. Such a lack of clarity has been discussed in literature and this research has identified specific elements of definitions, processes, and roles, which I propose should be used to strengthen language used for partnership. In this section I will outline research findings that language used for partnership working can be improved by including clear definitions, descriptions of process, and roles. Evidence from this study and from literature indicates that clarity of language will support partnership working in practice.

7.3.1.1. Definitions

Data from documents found varying definitions of partnership between both the third-sector organisations and the PD Improvement Programme, and partnership between the third-sector organisations and PWLE. There was some superficial description of values for partnership found in documents – such as “valuing all contributions”; “trauma informed” - but these were in individual documents and were not used consistently across documentation.

There were some organisational documents outlining how clinical teams can support working with PWLE, but there was no recognition of the need for clear descriptions for partnerships, and these documents were not referred to in the PD Improvement Programme. Variation in definitions was also found in interviews as each participant described their understanding of the terms used to describe working in partnership in different ways and there was a lack of shared understanding of the description of partnership in this programme between all participants. All participants were unable to clearly articulate the definition of partnership, or the underlying principles and values that would support partnership within the PD Improvement Programme.

This finding aligns with current literature as although there is widespread recognition of the contribution of PWLE in healthcare improvement, there is a lack of explicit and precise definitions (Fumagalli et al. 2015) and variation in definitions is reported. Palmer (2020) recommended a unifying language to bring together the different ways that partnership functions in health care improvement and enable a common understanding between participants. Bergerum et al. (2019) suggested that there should be agreed definitions of concepts underlying partnerships when working with PWLE to provide greater understanding of how to organise partnerships and improve processes for partnerships. Although clarity of definitions or concepts have been recommended, a recent systematic review (Masterson et al. 2022) highlighted that concepts of partnership are evolving and therefore focus should be on clarifying principles and values underlying partnership working rather than on refining agreed definitions. Evidence from the PD Improvement Programme demonstrates there was a lack of clear description of definitions, principles or values needed to work in partnership with either the third-sector organisations or with PWLE. From the literature, and evidence presented in this research such lack of clarity is likely to influence the process of partnership, and descriptions of processes in the PD Improvement Programme will now be discussed.

7.3.1.2. Processes

Analysis of documents in this research highlighted that there was no detailed description of processes for working in partnership within the PD Improvement Programme. The main mechanism for involving PWLE was via a commission to third-sector organisations to lead the work with PWLE, and descriptions focused on the organisational structure and outputs for this commission. Data from observations and interviews also demonstrated a lack of clarity in processes, as participants expressed different views on the arrangements for partnership working with the third-sector organisations, and how this process would involve PWLE in the programme. There were no descriptions of how the commissioned organisations would work in partnership with the PD Improvement Programme, or how the commissioned organisations would work with PWLE. In addition to the models of partnership described in Chapter 2, there are several identified frameworks and toolkits describing processes for working directly with PWLE in healthcare improvement such as Evidence Based Co-Design (Point of Care Foundation n.d.). Toolkits include one developed by Healthcare Improvement Scotland – the Community Participation Toolkit (Healthcare Improvement Scotland n.d.)- to support working with PWLE. These frameworks relate to direct work with PWLE and are targeted at people working with PWLE in clinical settings, they do not outline processes of partnership working with a commissioned organisation and were not referred to in the PD Improvement Programme. The lack of use of formal approaches in this case may be attributed to the use of third-sector organisations to lead direct work with PWLE. It is of interest that there was no evidence that the third-sector organisation used formal frameworks to support their work with PWLE, and in the commissioning process HIS did not specify any formal approaches that should be used to support direct work with PWLE. There was also evidence of a lack of monitoring or evaluation of the work that was carried out directly with PWLE.

Evidence from the PD Improvement Programme demonstrates a lack of clear descriptions of processes to support partnership working, which is convergent with the current body of evidence. Evidence demonstrates there is a lack of

clear processes in relation to direct work with PWLE, or in relation to working with other organisations who may represent PWLE. In relation to working with PWLE, Bombard et al. (2018) conducted a systematic literature review which recommend the development of procedural evaluation for any work involving PWLE in healthcare improvement to clarify processes needed to support partnerships. Greenhalgh et al. (2023) also identified a lack of clarity on processes as a risk to partnership working in relation to working in partnership with others to address complexity in health care, with QI considered an approach to complexity.

The use of third-sector organisations in the PD Improvement Programme may have contributed to a lack of clarity regarding processes for working with PWLE. In a review of co-production and the third-sector in Scotland, Mazzei et al. (2020) found that there is an assumption that third-sector organisations effectively represent the views of PWLE. Although third-sector organisations are considered to have a role in representing views of people with lived experience in healthcare settings and there is increasing use of third-sector organisations to represent the views of PWLE (Williams et al. 2016), there are thought to be challenges and variation in how such organisations ensure effective representation of lived experience (Jones et al. 2021, Martin 2011, Wilson 2023). Evidence from this programme indicates that there was a lack of review of the work carried out by the third sector organisations with PWLE and assumptions were made that the third-sector organisations would effectively represent views of PWLE. These assumptions contributed to a lack of attention to specific details on processes for working in partnership.

7.3.1.3. Roles

In addition to a lack of detailed description of definitions and processes, there was found to be limited detail on roles within the PD Improvement Programme. Documents available for analysis did not include HR information – and therefore it is possible that the details of roles would be included in documents not analysed in this research. From documents available, descriptions of roles

for people working within the PD Improvement Programme consisted of generic NHS job descriptions. Descriptions of roles for people in the third-sector organisations - representing PWLE in this programme - focused on tasks and outputs. There was no evidence of detail on how each role might work with others – including PWLE - or contribute to the programme.

This lack of detail and understanding is recognised in the literature in relation to roles that PWLE are asked or choose to undertake in healthcare. Miller et al. (2023) described four roles that PWLE undertake when contributing to healthcare and proposes that more detailed descriptions of roles will enable appropriate support and will recognise the contribution people make when working in partnership. In addition to roles, the concept of professional identity is also recognised as an influence on how people act (Ackerhans et al. 2024). Rendeo et al. (2011) carried out an ethnographic study of participation in healthcare which found that there is no agreement in healthcare on the expected roles when working with PWLE, and identity in such partnership is constructed in a participatory process. Both clarity of roles and responsibility and the need to consider the participatory processes used to develop partnerships may therefore be particularly significant when considering how people work in partnership in healthcare improvement.

Evidence from this case study would suggest that clearer description of roles should include description of processes and how people will work together, including how and in what way PWLE will contribute to national programmes. Closer attention to language used may strengthen partnership working and support ongoing participatory processes to shape identity within programmes.

7.3.2. Representation, social processes, power and conflict

Evidence from this case study found that PWLE did not participate directly with the PD Improvement Programme, but third-sector organisations were

commissioned to lead direct work with PWLE. This case study also found that actors representing PWLE through the third-sector organisations, and actors working within the improvement programme demonstrated contrasting social processes and partnership working between these groups was characterised through expressions of power and conflict. In this section, I discuss key findings that partnerships were influenced by representation, social processes, power and conflict.

7.3.2.1. Representation

The PD Improvement Programme commissioned third-sector organisations to lead direct work with PWLE, and the commissioned organisations were the only contact PWLE had with the PD Improvement Programme. Analysis of data found that the third-sector organisations did not represent a wide range of views of PWLE and there was evidence that they emphasised negative experiences of PWLE in the PD Improvement Programme. This finding builds on current literature, as there is a body of evidence questioning how third-sector organisations represent PWLE and challenging the assumption that third-sector organisations are an effective proxy to involve PWLE.

Blume (2017) and Jones et al. (2020) both found that the third-sector can make adjustments when communicating experiences to healthcare professionals, though these studies reported that adjustments were used to “tame” lived experience and in this study, there is evidence that the third-sector organisations emphasised negative experiences. In studying representation of people in vulnerable situations, Gathen et al. (2023) highlighted that organisations who represent lived experiences have become increasingly professionalised and within organisations there can be a lack of representatives with lived experience, which leads to such groups being considered inauthentic and unrepresentative. Mazzei et al. (2020) also found variations in how third-sector organisations represent the views of service users in Scotland and proposed four scenarios to describe how third-sector organisations work with PWLE, ranging from PWLE being supported to participate, to situations where

the organisations demonstrate control and tokenistic participation resulting in limited voice of PWLE.

In this case study, the third-sector organisations did not promote direct involvement of PWLE within the PD Improvement Programme and focused on working with PWLE in separate groups. Evidence indicates that the third-sector organisations spoke on behalf of PWLE in the PD Improvement Programme, rather than supporting direct involvement of PWLE in the programme. The lack of monitoring or evaluation of the work the third-sector organisations carried out with PWLE is of interest and has contributed to a lack of understanding on how PWLE were represented in this programme of work. This study did not explore how the third-sector organisation was structured or the work they carried out directly with PWLE and there is also no evidence from PWLE who worked with the third-sector organisations. This case study therefore cannot provide evidence on the nature of representation in the PD Improvement Programme. There is; however, evidence that the third-sector organisations did not represent a range of experiences of PWLE and may have enhanced negative experiences within the programme. There is also evidence that the PD Improvement Programme did not evaluate or monitor the work carried out by third-sector organisations to represent PWLE.

7.3.2.2. Social processes

Another key finding identified in understanding how partnership working was demonstrated in practice was in relation to the social processes demonstrated in the PD Improvement Programme. Social processes, approaches to partnership working and ways in which actors interacted to establish relationships, were explored via observations and interviews. Data highlighted different approaches used by actors who were working within the organisation, and actors who were representing PWLE, to establish social relationships and work in partnership. Actors who worked within the organisation were found to use strategies of interprofessional collaboration, which were characterised by attempts to establish mutual understanding, negotiation and working together.

Actors who worked as part of the third-sector organisations to represent PWLE used strategies to disrupt which were characterised by being assertive and persistent, and at times adopted radical strategies to ensure their voice was heard.

These contrasting approaches to partnership working align with research on collaboration, power, and conflict. Sundet et al. (2020) propose a collaborative practice model which describes interprofessional collaboration as a domain of collaboration, informed by principles of mutual understanding, negotiation and working together. Evidence from this study suggests that actors working within the PD Improvement Programme used such approaches when working with the third-sector organisation. The use of this approach indicates that actors working in the PD Improvement Programme made the assumption that the relationship between the PD Improvement Programme and third-sector organisations was one of interprofessional collaboration.

In contrast to this approach, actors from the third-sector organisations adopted approaches of disruption when working in the PD Improvement Programme. The use of disruptive strategies is associated in the literature as a response to situations where there is a form of 'Power Over' - where powerful actors prevent others gaining power by controlling spaces and decision-making (Miller et al. n.d.). Perspectives of power and how these were demonstrated in practice will now be discussed.

7.3.2.3. Power

Power is widely recognised in the literature as a key component of improvement (Ocloo et al. 2020) and sharing power can help develop trust and achieve partnerships when working in healthcare (Greenhalgh et al. 2023). Perspectives of power in partnership working and how this was expressed was a key finding of this research. Power was demonstrated in different ways within the programme with actors working in the third-sector organisations displaying

control of spaces through explicit expressions of power, and actors working within HIS demonstrating mutual support and collaboration within internal staff.

Evidence from this research found actors had contrasting perspectives of power which influenced their approach to partnership working. Data indicated that people who worked within HIS had the view that the use of a commission was a way to ensure PWLE were able to make decisions and influence the work of the programme which is in line with a form of 'Power To'. However, those representing PWLE perceived the use of a commission as a form of controlling the programme and preventing others gaining power, which is a form of 'Power Over'. Perspectives of power may be related to how individuals conceptualise partnerships as outlined in Chapter 2; the model of participation preferred by third-sector partners was Arnstein's ladder of participation – which views participation as a form of power. These contrasting perspectives of power, and contrasting approaches to working in partnership, were found to contribute to high levels of conflict demonstrated in the PD Improvement Programme.

7.3.2.4. Conflict

Data from this research found that partnership working was characterised by high levels of interpersonal and individual conflict in the PD Improvement Programme. Individual conflict – where the concept of self is threatened, or personal resources are depleted – was found for most participants. One participant whose role was within the third sector organisation to lead work with PWLE demonstrated high levels of interpersonal conflict. The response to conflict from staff working in the PD Improvement Programme was found to be to eliminate or avoid conflict which data suggests exacerbated the view that there were efforts to withhold power.

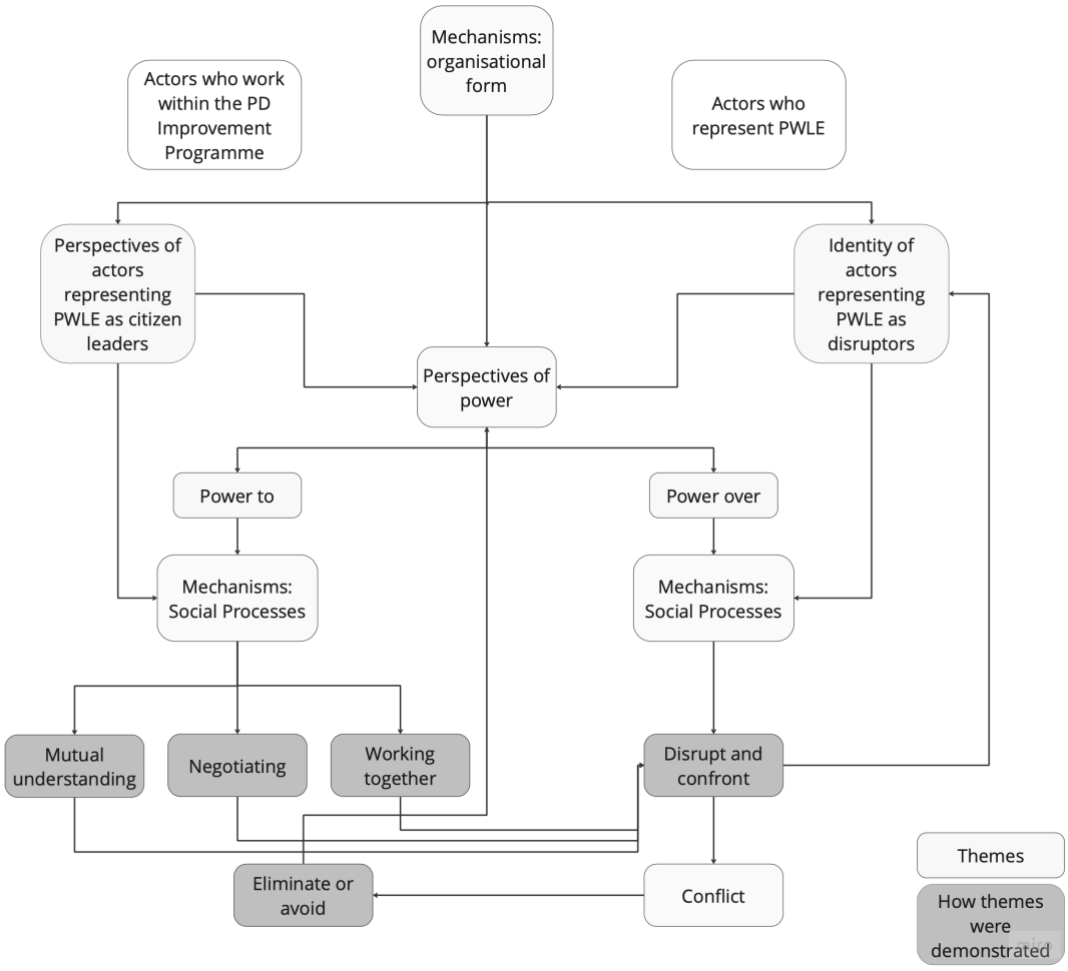
The finding that interpersonal and individual conflict was demonstrated in working relationships within the PD Improvement Programme aligns with current literature. Eichbaum (2018) reported that although conflict can be valuable as a source of learning, in healthcare there is a lack of attention to

understanding issues underlying conflict. Greenhalgh et al. (2023) also recognises that conflict can be “inevitable” and proposes that conflict should be viewed as a positive force when working in partnerships, with efforts made to understand differences to develop multifaceted approaches to achieve improvement in complex settings such as healthcare. There was limited evidence to demonstrate if actors within the PD Improvement Programme attempted to understand issues underlying conflict, and advice or guidance on managing conflict was not present within organisational or working documents. Further exploration of conflict and development of resources to support people to understand conflict and recognise the benefits of well managed conflicts when working in partnership within national improvement programmes may be beneficial.

7.3.3. Concept map of themes

Evidence from this research found three main themes of Mechanisms, Power, and Identity, which contributed to partnership working in the PD Improvement Programme. In presenting this research, I have developed a concept map (Fumagalli et al. 2015), which articulates how these themes influenced and were demonstrated in partnership working in the PD Improvement Programme (Figure 7).

Figure 7: Concept map of themes



The concept map highlights that the theme of Mechanisms had a significant influence on partnership working. The organisational form of a separate commission to lead work with PWLE resulted in no direct contact with PWLE in the PD Improvement Programme but actors in the third-sector organisations led direct work with PWLE and acted to represent PWLE in the programme. This organisational form was found to influence perceptions of identity and power within the PD Improvement Programme and contributed to conflicting perspectives, and conflicting social processes used to work in partnership. Evidence demonstrated a distinction between actors who represent PWLE and

actors who worked within the PD Improvement Programme which is highlighted in the concept map.

Actors who represented PWLE in the PD Improvement Programme perceived their identity as disruptors. Actors who represented PWLE perceived the organisational form of this programme to be a form of 'Power Over' which is defined as a way to withhold power from others. The perceptions of identity and power contributed to the social processes adopted – which were to disrupt or confront perceived power. These social processes contributed to the participatory process to further shape identity which reinforced their perceived identity as disruptors.

Actors who worked within the PD Improvement Programme perceived the identity of actors representing PWLE as citizen leaders – to listen and represent the experience of PWLE. They perceived the organisational form of a commission to lead direct work with PWLE as a form of 'Power To' where people were able to make decisions and influence the work of the programme. This perception of power contributed to the social processes of collaboration being adopted. These social processes contrasted with the social processes used by actors representing PWLE and I propose that the use of such divergent approaches contributed to conflict. The response from actors who worked within the PD Improvement Programme was to avoid and eliminate conflict which also may have contributed to the perception of the organisational form of the programme as a form of 'Power Over'.

7.4. Chapter conclusions

Key findings from this research were described in Chapter 7 and implications for future research, and how these findings may be applied in practice are now discussed in Chapter 8.

8. Contributions and recommendations from this research

The contribution of research and innovation is recognised as a way to identify new ways of working and transform services to better meet the changing needs and expectations of the population (National Services Scotland 2021; Scottish Government 2022). A key aspect of transformation is through research, and Watson et al. (2024) highlighted the value of doctoral level research in the AHP community, highlighting that post-doctoral practitioners actively contribute to and lead service improvements, evidence-based interventions, workforce development and organisational cultures of research in practice. This research has identified key findings which have implications for knowledge and practice which will be outlined in this section, highlighting direct recommendations for the study organisation which will contribute to developing new ways of working.

8.1. Contribution to knowledge

This research has strengthened the current body of literature on how a national organisation worked with PWLE in healthcare settings. The literature review highlighted that although working with PWLE is recommended across services, there is limited understanding of how this is demonstrated at a national level (Connolly et al. 2020), and a greater understanding of partnership working, including a greater understanding of the contextual factors enabling partnership working, is required to improve and strengthen healthcare improvement programmes (Bate and Robert 2006; Bombard et al. 2018; Coulter et al. 2014; Robinson et al. 2019). Previous literature had identified some factors that support partnership and barriers to partnership with PWLE, but these did not take into account underlying assumptions and beliefs about partnership from different perspectives. This research has provided insights into how partnership working is demonstrated in practice within the operational level of a national organisation, identifying contextual factors which influence partnership working,

and explored perspectives of partnership in this context. There has been limited research within the context of a national organisation and findings from this research have brought together existing evidence to explore partnership with PWLE within a national context.

In carrying out this research, I have identified how partnership working is demonstrated in practice in a national context and identified contrasting perspectives of the mechanisms and approaches used in partnership. The concept map presented in Chapter 7 is considered a unique contribution to knowledge and may be used to deepen an understanding of partnership working in relation to perspectives and beliefs about partnerships and explore how this understanding may be used in practice to improve partnership working in a national improvement context.

8.2. Contribution to practice

The findings described in this research provide opportunities to develop stronger partnership working in practice. The literature highlighted that there is a need for guidance and support for organisations to outline how to undertake working with PWLE – including clarification on terminology used in national policy documentation (Connolly et al. 2020). This research has identified how such clarification could be established by highlighting the need to consider language used to describe partnerships in relation to definitions, processes, and roles. Findings from this research may also be used to develop clearer guidance and support for partnership working. This research has identified some challenges when using third-sector organisations to represent the views of PWLE. The finding that the third-sector organisation may not have represented a range of views of PWLE, and there was a lack of evaluation of their work in this national programme offers insights to contribute to practice. This finding aligns with current literature and provides greater insights into some of the perspectives that may influence organisational decisions or

individual behaviours in partnerships. More in-depth consideration of the role of third-sector, clarification of the approach organisations takes to work with PWLE, and agreement on evaluation of any work with PWLE will be beneficial to develop practice in this area. This research can be used to enhance actors understanding of different perspectives and beliefs about partnerships which can be applied in practice when designing and delivering improvement programmes. Specific areas to apply in practice are now discussed.

8.2.1. Language for partnerships

This research found a lack of clear descriptions of partnership in relation to definitions, processes and roles. This lack of clarity may be related to assumptions made about the structure of the programme and the use of third-sector organisations to lead work with PWLE. The lack of clarify influenced the roles that people chose to undertake within this programme and contributed to different perspectives on the role of the third-sector organisations, and contrasting approaches to working in collaboration. This further contributed to conflict within the programme. The lack of clarity suggests that there limited understanding within the national organisation on the importance of establishing processes and roles for partnership working.

Given staff working within national organisations are required to work across a range of organisations with different value sets, governance arrangements, and accountability structures (Scottish Government 2019) I suggest that clarity in expectations for partnerships are of particular relevance in this context. From evidence in this case study, it is suggested that national programmes should provide greater awareness of the need for clarity and develop detailed descriptions of partnership in relation to definitions, process and roles. Development of heuristic guidance for partnership working in national improvement programmes, which includes how organisations and individuals

leading improvement programmes can develop clearer definitions, processes and roles required for working in partnership is recommended.

8.2.2. Representation

Mazzei et al. (2020) recommend that commissioners should better understand the organisations they work with to represent PWLE. Findings from this research supports this recommendation as there was a lack of understanding of how third-sector organisations worked with PWLE in this national improvement programme. Although the majority of participants highlighted in interviews concerns that the third-sector organisations did not represent a wide range of views of PWLE, there was little evidence of actions taken during the programme to address these concerns. Although meetings were arranged with the third-sector organisations they did not discuss how PWLE were involved and there were limited descriptions of the role of the third-sector and limited expectations on how they would represent PWLE. The evidence from this research suggests a need for greater attention to and evaluation of any arrangements made to support partnership working with PWLE, including the role of the third-sector. It would be interesting to understand the views of PWLE in relation to the use of third-sector organisations to represent their views, and their preference for contributing to national improvement programmes. Further research into the role of the third-sector to represent views of PWLE would be beneficial, and understanding PWLE's views is key to developing this research.

8.2.3. Social processes, power and conflict

Evidence from this research found that there were contrasting perspectives of power which contributed to different social processes used and high levels of conflict in partnerships. Although the literature has suggested that conflict within healthcare teams is inevitable and conflict within healthcare is viewed as negative (Eichbaum 2018), there has been limited discussion on conflict when

working with PWLE, how conflict may be demonstrated in practice, and the impact of conflict within partnerships for PWLE. Power and conflict within the context of national organisations which require management of a range of different stakeholders, with a range of different value sets, and different accountability or governance arrangements is central to understanding how such organisations work with others. This research provides evidence to develop an understanding of how management, power, and conflict interact within partnerships and provides insights into the different value sets across organisations as seen in contrasting perspectives expressed. The concept map presented in this research describes how these factors interact within one national improvement programme and may be developed to develop a deeper understanding of the complexity of partnerships and inform future practice.

This research was a single case study and further exploration of how people working with others in national improvement programmes recognise or manage power and conflict is recommended. Greenhalgh et al. (2023) propose the use of a frame awareness approach to build mutual understanding and improve working together despite differences in values and it would be beneficial to research the use of such an approach within national improvement programmes.

8.3. Recommendations for partnership working

Although this study was based in healthcare improvement within a national organisation, the findings have broader application. There are some specific recommendations identified to enhance partnership working in the study organisation and for wider partnership working in healthcare. These recommendations build on the discussion of contribution to practice and have been identified to specify how this research can be used to inform service development (Watson et al. 2024). There are three key recommendations:

8.3.1. Recommendation 1: Language of partnership

There was a lack of clarity in language used to describe partnerships in relation to definitions, process or roles. This lack of clarity influenced how people perceived partnerships, developed their role within partnerships, and the approaches individuals used to work partnership. Improving descriptions of definitions, roles and processes for partnerships may have provided greater clarity and improved partnership working in practice. Development of heuristic guidance for partnership working which includes clarity on how to describe partnership is recommended. The involvement of PWLE in developing such guidance would be key to ensuring a shared understanding and meaning is established.

8.3.2. Recommendation 2: Frameworks for partnerships

The process for partnership working is not only outlined in descriptions but developed through social and participatory processes. Evidence from this study suggests that themes of Mechanisms, Power, and Identity shaped such processes and are key factors to improve partnerships in practice. In considering how this finding can be applied in practice, learning from system thinking approaches to change may be beneficial. A recent paper by Gadsby and Wilding (2024) recommended a broad approach to partnership within system thinking approaches to change, which rather than focusing on prescriptive models uses a co-evolving form of partnership where those involved explore together, share perspectives, iterate and learn together. The broad approach advocates direct discussions and acknowledgement of many of the key themes identified in this research; however, there may be assumptions that there is a willingness to develop different approaches to partnership working with PWLE, and staff have knowledge, skills and understanding to apply co-evolving partnerships in practice.

Although I recognise the challenges of using prescriptive models of partnership, there is a need to describe recommended practices and a way to ensure these are applied appropriately in practice. A framework approach to partnerships would be beneficial to identify recommended practices and to ensure consistency of approaches to partnerships. This research recommends efforts to develop frameworks specific to partnership working and development of knowledge, skills, and support required to work in partnership with PWLE. An updated framework for partnership offers the opportunity to conceptualise partnership in terms of joint venture, rather than a form of power associated with traditional models of partnership – such as Arnstein's ladder of participation. Specific aspects of partnership highlighted in this research provide a more comprehensive understanding of how to work in partnership with PWLE and improve knowledge, understanding, skills and practices of managing complex partnerships within complex improvement initiatives. Evaluation of the development, application, and impact of frameworks to partnership should be carried out, with evaluation recommended to understand how such a framework may be implemented and engaged with in real life settings.

8.3.3. Recommendation 3: Role of third-sector

Finally, national organisations should review the role of third-sector organisations in representing PWLE. This research found a lack of detail and understanding of the approach the commissioned organisations used when working with PWLE and a lack of oversight or evaluation of the work carried out to represent PWLE. Building on the work of Mazzie et al. (2020), national organisations should review and plan how commissioning arrangements are managed to ensure meaningful representation of the views of PWLE. A retrospective review should include analysis of the commissioning processes undertaken in previous programmes to explore the expectations, agreement, monitoring and evaluation arrangements put in place to understand the work

carried out to represent PWLE. This research focused on a single national improvement programme and a review of how PWLE have been involved in other improvement programmes would be beneficial to explore alternative approaches to working with PWLE in future programmes. The views of PWLE should be central to such a review to understand their perspectives and preferences for contributing to national programmes. The lack of monitoring of the work of the third-sector contributed to limited data on the work carried out directly with PWLE and therefore greater focus on evaluation of improvement programmes – including any work that is carried out with PWLE in these programmes – is recommended for the study organisation.

8.4. Applying recommendations in practice

Case studies can contribute to practice by making prescriptions for future action (Mackie 2018) and there has been growing interest in recent years into how research findings can be translated in to practice and policy (Kent 2019). In this section I will describe key steps that can be taken within the study organisation to apply findings to practice and discuss how these may be applied in wider settings.

Within the study organisation there are key steps that I will proactively take to share the findings of this research, identify opportunities for implementation and plan wider dissemination. In 2024, Scottish Government identified the need for a “clear and coherent methodology” to underpin NHS reform and HIS are currently leading work to develop The Scottish Approach To Change (discussed in Chapter 2). A draft framework has been published and is currently open for consultation. This provides opportunities to share the findings of this research to ensure careful consideration is given to the complexity of partnerships and the need to give more careful consideration to individual perspectives, participatory and social processes within partnerships.

The concept map presented in this research clearly articulates this complexity and may be used to develop knowledge, skills, and practices for partnership working.

In addition to contributing to the development of The Scottish Approach to Change, I also have opportunities to share research findings within the AHP community of practice through professional networks and professional bodies to influence partnerships in other healthcare settings. I will endeavour to present this work to the annual Royal College of Speech and Language Therapists Conference and to the Scottish AHP Leads Network.

There are a number of potential barriers to applying this research to practice and a key consideration is the possible lack of agreement from various stakeholders which is pertinent in this study as there are a range of stakeholders across healthcare, social care, third-sector and political organisations. Research from a constructivist paradigm is thought to have indirect impact through influencing the knowledge and values of others, and such knowledge is intertwined with politics and persuasion (Greenhalgh et al 2016). To address these challenges the research findings will be shared and communicated in a way that supports stakeholders to reflect on their existing practices and assumptions, with collaborative work to determine how these findings can influence practice across different contexts. A further challenge to implementing recommendations in this research is ensuring that PWLE are meaningfully involved in reflecting on the findings of this research and implementation of recommendations. The use of participatory action research would be beneficial to ensure involvement of PWLE in future research, evaluation and implementation of changes to improve partnership working.

8.5. Recommendations for future research

The research carried out has raised a number of recommendations for knowledge and practice, all of which may benefit from further consideration. Based on the work carried out, I recommend that the following areas for future research to build on the findings presented in this thesis to continue the development of knowledge and understanding of partnership working with PWLE.

The first recommendation is to carry out work directly with PWLE to understand their views and perspectives on how they have been represented in previous national programmes, and how they wish to be involved in future programmes. This work could be carried out retrospectively or prospectively in the form of participatory action research in future national programmes working directly with PWLE.

This research identified that perspectives of identity impacted on how people worked in partnership within the PD Improvement Programme, and identity was influenced by mechanisms of organisational form and social process, and perspectives of power. These findings were interpreted from the data analysis process and were not discussed directly with participants. Building on this research, it would be beneficial to directly research perspectives of identity to explore Actors' perspectives on their roles and identity and identify factors that shaped these perspectives – particularly with Actors from third-sector organisations who identified as disruptors in this study. Exploring how the purpose of partnership working was understood, and perspectives of power may provide further insights into how Actors perceived their identity. Although this study did not identify political or organisational factors as an influence on partnership working, specific questions to consider these issues in future studies would be beneficial.

The concept map developed in this research describes the interaction and relationship between themes in relation to the PD Improvement Programme. The context of a national organisation may provide unique perspectives of Actors both within the organisation and external to the organisation. The interactions between key concepts are multi-faceted and complex and there were challenges in identifying a more detailed conceptual framework at the start of this research. This concept map may be used in future studies as a conceptual framework and applied in future research to understand if there is wider application of this model in different contexts to strengthen understanding of partnership working.

8.6. Dissemination plan

Various strategies will be used to support dissemination of this research to ensure findings can be used to influence practice, strategy and policy. This research has been published as a research protocol (Robertson et al. 2024) and disseminated within the study organisation. It is the intention to submit further articles for consideration for publication to ensure the impact of research can be realised. A publication will be prepared and summitted to appropriate research journals – such as BMJ Quality and Safety, International Journal of Quality in Healthcare, or Health Research Quality and Systems, and a report will be prepared and submitted to HIS with a summary of findings and recommendations. The researcher will prepare a presentation on this research which can be shared in appropriate professional forums and networks, including the Q Community, NHS Scotland Event, the RCSLT Professional Conference, and the Community for Allied Health Professions Research Scotland, and with professional and policy advisors working within the Scottish Government.

9. Reflections and conclusions

9.1. Introduction

This final chapter consists of reflections and conclusions for this research. Section 9.2 describes the strengths and limitations of this research, and section 9.3 provides a short reflection at the end of this research process, with a description of how the research will be used to influence practice. I will start this chapter with reflections on this research with a focus on carrying out research at the time of the Covid-19 pandemic.

9.2. Reflections

The PD Improvement Programme took place between June 2021 and March 2023 and data collection for this research took place between October 2022 and July 2023. During this time HIS operated within a mostly virtual environment using MS Teams as a way to undertake meetings and events. Occasional meetings within HIS could take place face-to-face during this time, but all meetings and events within the programme studied were conducted online. At the time of writing (March 2025) HIS operate a flexible work location in line with NHS workforce policies and staff work in a hybrid environment with many meetings, interactions and events taking place online. This approach is designed to ensure equity within the workforce and to ensure people living across Scotland have opportunities to engage and work within the national organisation. There appears to have been little consideration on the impact of hybrid working on partnership working within the organisation.

All observations and interviews in this study were conducted online using MS Teams which represented the work of HIS at this time. Online working had been in place since the start of the COVID-19 Pandemic in March 2020, and all participants reported they were comfortable with online interactions; however,

the sole use of online interactions may have influenced how partnership working happened within HIS. A review of research carried out prior to widespread use of virtual working due to the Covid -19 pandemic suggests that online interpersonal relationship processes show similar patterns as relationships as those developed in face-to-face settings but require a longer period of time to develop (Walther et al. 2005). Online interactions are more likely to be planned and formal with fewer opportunities for social interactions and informal communication with work colleagues which may result in difficulties in creating new group relationships (Blanchard 2021). A literature review of virtual teams published in 2020 reported challenges in establishing trust particularly during initial stages of collaboration (Morrison-Smith and Ruiz 2020). A number of additional factors were also considered in this literature review including nature of work, geographical distance and group configurations and therefore it is difficult to make clear conclusions about the impact of virtual working in the context of this research.

This research considered partnership working within this virtual environment and was representative of the working context of HIS during this time. My reflexive research diaries did note the lack of incidental and informal connection between actors in the programme and the use of formal MS Teams meetings to build working relationships. I was conscious that during observations efforts were made to have some informal discussions by participants which were considered an attempt to build relationships; however, I also noted the lack of interaction outwith the virtual setting which may have impacted on people's ability to identify or respond to early signs of conflict. Future studies could carry out a retrospective examination of partnership working prior to online working and given that HIS have moved to a hybrid model it would be of interest to review this way of working in relation to how this influences partnership working within the organisation and with external partners.

9.3. Strengths and limitations

There are strengths in the design of this research and in the findings developed. Case study research allows a level of creativity and flexibility; however, it has been criticised for lack of rigour. In this thesis I have outlined clear descriptions of paradigm, theory and methods used to demonstrate rigour. Data was collected from a wide range of sources to provide an in-depth exploration of partnership working within a single case study. Using diverse methods of data generation provided an account of practice situated within a specific context is viewed as a strength of the case study methodology (Flyvbjerg 2011; Miles 2015). The use of this approach developed a greater understanding of the practice of working in partnership in a national improvement programme. Another key strength of this study was the involvement of PWLE to inform the design and analysis of data. A public partner advised on the burden of intervention for PWLE in the study design, was involved in design of interviews, development of a distress protocol (Appendix 6), and advised on participant recruitment. In the analysis, the public partner was involved in reviewing and discussing themes developed as a form of participant validation to improve scientific rigour (Crowe et al. 2011). Finally, the data analysis framework outlined in Figure 4 described a detailed approach to data analysis to ensure development of convergent evidence and can be considered a strength of this research.

There are several limitations in this study in relation to scale and design of the study. The study was limited in scope and scale as it was a single research study. Further research of the themes outlined in this study would be beneficial to explore whether similar themes are present in other national programmes. The research was limited to recruit only people who were participating in the improvement programme which is a limitation to the study. There were no participants who had lived or living experience as PWLE were not involved directly in the improvement programme, and there were no opportunities to

explore why people may not participate in national programmes within this case study.

In relation to design, this study was led by an insider researcher which offer several benefits to the study as I had an in-depth understanding of the context which supports understanding and interpretation of the data, and the researcher is in a position to ensure research findings influence practice (Fleming 2018). There was a risk of bias in this approach and a risk of conflict between the researcher and participants who had professional relationships. This risk was reduced as I maintained clear boundaries between their professional role in the organisation and their role as researcher. I used strategies outlined in the design to reduce bias. These strategies included PWLE in the design and analysis, completing a reflexive research diary, and regular discussions with academic supervisors. I am confident that these mechanisms supported ongoing reflection and recognition of potential bias, so any findings are underpinned by evidence.

9.4. Thesis conclusions

"A bird doesn't sing because it has an answer,

it sings because it has a song."

- Maya Angelou

This thesis has described research carried out to provide a greater understanding of partnership working with PWLE in the national PD Improvement Programme. The concept map presented in this thesis does not provide an answer but proposes an explanatory model to understand how factors identified in partnerships influence each other. This thesis is submitted to build on previous research, and to contribute to future efforts to understand and improve how services include and work with PWLE. The findings discussed contribute to knowledge and practice within national organisations and may be applied wider to partnership working in healthcare.

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Appendix 1: Published research protocol

Robertson, C., Hibberd, C., Shepherd, A., & Johnston, G. (2024) How a National Organization Works in Partnership With People Who Have Lived Experience in Mental Health Improvement Programs: Protocol for an Exploratory Case Study. *JMIR Research Protocols*, *13*, e51779.

URL: https://www.researchprotocols.org/2024/1/e51779

DOI: 10.2196/51779

Abstract

This paper outlines a research proposal for a case study to explore how a national organization works in partnership with people with lived experience in national mental health improvement programmes. Quality Improvement (QI) has been considered a key solution to addressing challenges within healthcare, and over the past decade there has been a significant effort to utilise QI within healthcare as a means of delivering evidence based-care, improving mechanisms of care and clinical outcomes. In Scotland, Healthcare Improvement Scotland established the improvement hub (ihub) in 2016 whose purpose is to lead national improvement programmes. Each improvement programme focuses on supporting health, social care and housing partners to deliver improved health and wellbeing outcomes for people of Scotland. Improvement programmes use a range of theories and techniques to support teams and services through an improvement journey. Working in partnership with people who have lived experience throughout the improvement journey is recognized as a key component of improvement work however, there is little understanding in the literature of how this is demonstrated in practice in national organizations. In order to address the gaps in evidence and strengthen a consistent approach, a

greater understanding is required to improve partnership working in improvement programmes.

An exploratory case study approach will be used to address the proposed research questions in relation to the Personality Disorder Improvement Programme, led by Healthcare Improvement Scotland. This research will explore how partnership working is described and demonstrated in practice outlining factors influencing partnership working. The case study approach will be used to gather data from a wide range of qualitative sources – including document data, participant observations and semi-structured interviews. There will be two phases to this research – the first phase consists of document analysis and participant observation, the second phase will be semi-structured interviews. Data analysis will organise, find patterns, and elicit themes in the data to help deepen an understanding of partnership working within national improvement programmes.

Ethical approval has been granted from National Institute for Health Research (NICR) and the Integrated Research Application System (IRAS) for the first phase of this research.

1.0 Background

The need to improve quality in mental health (MH) care is widely recognised, in response to both longstanding problems and more contemporary pressures (Care Quality Commission 2015; Gilburt 2015). For a number of years, Quality Improvement (QI) has been considered a key solution to many healthcare

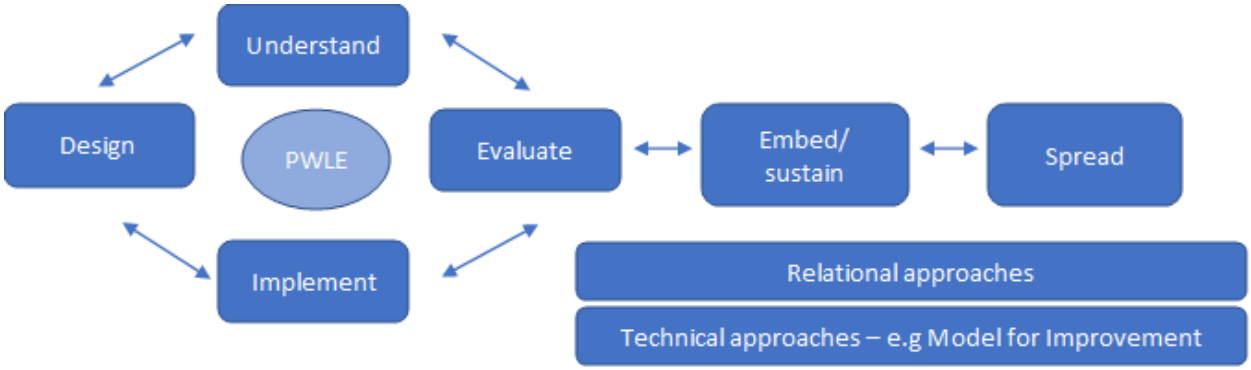
challenges, supporting the design and delivery of services. Over the last decade there has been a significant effort to utilise QI within healthcare settings including the introduction of national organisations to lead improvement programmes.

There are several national organisations in Scotland with an improvement focus including: The Centre for Sustainable Delivery; Health and Social Care Alliance Scotland; Improvement Service and Healthcare Improvement Scotland (HIS). In 2016 HIS established the improvement hub (ihub) whose purpose is to enable health and care systems to apply improvement methodologies to the design and implementation of changes that deliver sustainable improvements in the health and wellbeing outcomes of people in Scotland (HIS 2016). The ihub within HIS is uniquely placed with a focus on improvement support for those delivering health and social care across Scotland, including Mental Health services.

Work within the ihub is delivered through improvement programmes which use a range of theories and techniques to support teams and services through an improvement journey. National improvement programmes have an important role to play in healthcare however, there are challenges within centrally-led programmes which require sensitive understanding and management (Health Foundation 2013). Development of improvement programmes recognise growing evidence that the impact of QI in healthcare is mixed and of poor quality (Dixon Woods 2019), and there is a need to reconceptualise improvement efforts in response to the evidence base (Batalden and Foster 2021). In order to address some concerns within the literature the ihub have outlined a broad approach to improvement which form the basis of their improvement programmes. Core components of improvement programmes within the ihub are described in the Framework for Planned Improvement (figure one) which outlines the stages of improvement work. In the Framework for Planned Improvement, the initial focus is on understanding the system, designing, implementing, and evaluating

changes, with PWLE at the centre of this work. Improvement programmes then aim to embed and sustain successful change within practice and spread the learning to other areas. Underpinning the Framework is the recognition of the importance of the relational aspect of change and the use of technical QI approaches including the Model For Improvement.

Figure 1: Adapted from HIS's Framework for Planned Improvement (2016)



A key principle to improvement is working in partnership with others in the system including other agencies, people with lived experience (PWLE), and frontline staff. In Scotland, a seminal paper by Christie (2011) recommended the partnership working as a model of practice for national organisations across public services including those involved in healthcare improvement. There is a growing evidence base supporting the need to work with PWLE in healthcare improvement. PWLE have a key role to play in understanding problems and identifying solutions to ensure change delivers outcomes that make a difference to patients (Alderwick et al. 2017). Working with PWLE in improvement initiatives can strengthen and enrich the organisational agenda for improvement in healthcare (Ceo 2022) and should be seen as a core component of all improvement programmes. Within MH services, PWLE and their families should be able to participate in the development of policies to improve MH systems

(Carbonell et al. 2020) and should therefore be involved in healthcare improvement initiatives. Working with PWLE should be based on authentic, interdependent partnership working (Batalden and Foster 2021) which will improve the quality and value of services.

Despite the recognition that working with PLWE is central to improvement focused work there are a number of challenges and a lack of critical examination of partnership working within healthcare improvement literature (Palmer 2020). There is a lack of understanding of the phenomenon of partnership working including understanding the mechanisms of partnership working, organisational features supporting partnership working (such as leadership) and the impact and outcomes achieved from working with PWLE (Kjellström et al. 2019, Palmer 2020). There is also little understanding in the literature of how working with PWLE is demonstrated in practice in national organizations (Connolly 2020).

This research will explore how a national organisation works in partnership with people who have lived experience (PWLE) in mental health improvement programmes. This research will focus on one improvement programme – the Personality Disorder (PD) Improvement Programme within HIS' ihub. The PD Improvement Programme is a commissioned piece of work, funded by the Scottish Government to understand the current service provision in Scotland for people with a personality disorder and identify the key opportunities for improvement. This research will use a case study approach to explore how partnership working is planned, conceptualized, and demonstrated in practice within the PD Improvement Programme.

2.0 Objectives

The aim of this study is to better understand how a national organisation works in partnership with people who have lived experience in improvement programmes in mental health services, exploring people's experiences of partnership working in a national organisation. An exploratory case study approach will be used to address the research questions in relation to the PD Improvement Programme:

1. How is partnership working described in the PD Improvement Programme?
2. How is partnership working demonstrated in practice in the PD Improvement Programme?
3. What factors influence partnership working in the PD Improvement Programme?

This research will consist of two phases: the first phase will address the first two research questions through document analysis and observations of meetings within the early stage of the PD Improvement Programme. The second phase of research will carry out semi-structured interviews with participants to explore their experiences of partnership working, addressing the third research question.

2.1 Benefits to this research

It is anticipated that the findings of this research will contribute to an understanding of partnership working in national organisations and will be used to

identify a framework for partnership working so that partnership working can be improved across the organisation and other national organisations.

3.0 Methods and research design

In order to address the research aim, it is appropriate to use case study methodology. A case study approach is appropriate when: the focus of the study is on how and why questions; behaviour of participants will not be changed; context is relevant to the phenomenon studied and when there are unclear boundaries between phenomenon and context (Baxter and Jack 2008). Partnership working sits within the wider context, and case study methodology is well placed to understand relationships between context and intervention (Grant et al. 2020). A case study approach will enable a holistic exploration of the complex social processes and mechanisms underpinning partnership working within QI (Yin 2011). The case study approach will be used to gather data from a wide range of qualitative sources – including document data, participant observations and semi-structured interviews.

3.1 Case study design

The DESCARTE model (Carolan et al. 2016) will be used in this research to inform the design, conduct and reporting of the case study. There are three stages of this model: situation of the research and the researcher; determine the components of the case study design; and data analysis.

3.2 Components of the case study

Although case study research can have a level of creativity and flexibility – where the researcher may choose epistemologies and theories suited to their preferences and the nature of the enquiry, clear descriptions of paradigm, theory and methods should be provided to demonstrate rigour (Hyett et al. 2014). These will be described to outline the main components of the case study.

Binding the case

Firstly, it is important to identify what the case will be and set clear parameters or boundaries to ensure the study has a clear and reasonable scope– a process referred to as binding (Yin 2003). The parameters of this study will be determined definition and context. For this research, the case will consist of the PD improvement programme within HIS. Early involvement of PWLE in the conceptual stages of improvement work has been highlighted to ensure meaningful involvement with influence and impact (Byrne and Wykes 2020). The PD improvement programme is the first commissioned work for HIS to improve the understanding of the context of service provision for people with personality disorders across Scotland. The commission is from the Scottish Government and will run between June 2021 – March 2023. This case study will follow the PD programme during the current stage of the programme: creating the conditions and understanding the system. This stage will involve establishing the programme and working practices for working in partnership during the improvement programme.

Type of case study

Exploratory case studies can be used to explore situations in which the intervention being researched does not have a clear, single set of outcomes (Yin, 2003). Given the diversity within QI, and the complexity of partnership working, an exploratory approach is considered appropriate.

3.3 Methods

In phase one of this case study, data will be collected from organisational documents followed by non-participant observations of key programme meetings. This data will help explore how partnership working is described, defined, and demonstrated in practice. This will be followed in phase two with semi-structured interviews with key participants to explore their experiences of partnership working in the programme.

Phase one: Document data

In the first phase of data collection, access to organisational documents will be used to provide an understanding of plans, infrastructure and frameworks used to support partnership working with PWLE. It is anticipated that documents may include commission agreements; planning papers; minutes of key meetings; presentations or diagrams describing the programme infrastructure and partnership working in the programme. Further documents relevant to the study may emerge and will be included as appropriate. Access to these documents will be via the programme lead within HIS.

As there is no agreed definition of partnership working, documents will be analysed for any description of partnership which may include terms such as involvement, participation, engagement, empowerment. These will be recorded in the following template (Table one) noting the document, author, date, description of partnership working, and any actions taken or recommendations.

Table one: document data template

Document details (name, author, date)	Description of partnership	Actions or recommendations for partnership working

Findings from the document review will be used to inform the observation and interviews in the following phases of the research.

Phase one: Non-participant observations

Following document analysis, non-participant observations of improvement programme meetings will be used to gather data on how partnership working in the PD Improvement Programme is demonstrated in practice. Meetings observed will be chosen based on a purposive sample and there will be between three and six observations completed. I will ask the Portfolio Lead to provide a list of all meetings taking place in the early stage of the improvement programme which is likely to be within the first six – nine months of the programme. A sample of meetings most likely to demonstrate partnership working in practice (Simons 2009) will be selected to observe, such as planning meetings and advisory group

meetings. The meetings will be chosen by the researcher to address any potential bias and to ensure the appropriate independence of the research.

A framework for partnership working will be used to guide observations (Table two). This model describes four key dimensions of partnership: process; actors (identify and position); decisions and power relationships. Although the use of this framework provides some structure to the observations, a form of semi-structured observation will be adopted to allow for some naturalistic observations (Simons 2009).

Non-participant observation will allow observation of the environment, language, non-verbal data, and interaction in partnership working. General context will be noted for each observation including: location; time; duration; meeting roles and purpose of the event or meeting.

Table two: observation guide adapted from Carpentier (2016)

Dimension of partnership working	Observation guide
Process	How is partnership working planned for and what preparations are in place to support partnership working? How many events or meetings involve PWLE? Who is involved in setting the agenda and context for meetings?

Actors: identity; position	Who attends meetings? What are people's position within the organisation or programme?
Decisions	How are decisions in the programme made? How are PWLE involved in decision-making in the programme?
Power relationships	Who contributes to the event or meeting? What is the response to PWLE's contribution? What efforts are made to support contributions from PWLE?

There is a possibility that the presence of a researcher will risk bias by changing the behaviour of participants and strategies will be used to reduce this risk. Strategies will include giving a clear explanation of the plan for observation, and being aware of the position of the researcher to be as unobtrusive as possible (Cresswell and Cresswell 2018). Observations will be primarily descriptive and will provide the basis for interpretation of data obtained by semi-structured interviews in the final stage of data collection.

Phase two: Semi-structured interviews

The final stage of data gathering will be semi-structured interviews with participants from the PD Improvement Programme, including people across disciplines and PWLE. Interviews will be used to gain an understanding of participant's experience and perceptions of partnership working. Interviews will be held close to the time of the observations to ensure any observations made are

not misrepresentations (Simons 2009). A schedule for interviews has been prepared from themes developed from the document review and observations and will be piloted with PWLE working as public partners within HIS to identify any challenges. The interview proforma has been developed with PWLE to ensure questions are relevant and likely to receive meaningful responses (Byrne and Wykes 2020). All interviews will follow the schedule developed as an aide memoire however, it is important to allow flexibility to adapt to each participant's response to allow exploration of emerging and reported experiences (Smith et al. 2009).

The population within this case will include a purposive sample of between four and six staff and between two and four PWLE who are involved and contribute to the work of the PD Improvement Programme. Participants will be selected based on their role within the Improvement Programme and will include clinical and improvement staff working directly on the PD Improvement Programme operating at different levels of the organisation. This should ensure diversity within perspective gained from the interviews.

.

3.4 Data analysis

Data analysis will organise, find patterns, and elicit themes in the data to help deepen an understanding of partnership working within the national personality disorder improvement programme. A framework for data analysis is outlined in table three below:

Table three: data analysis plan

Steps of data analysis (adapted from Houghton et al. 2015)		
Step of analysis	Analysis strategy	Application for this research
Comprehending	Broad coding	This step will analyse data to generate and develop codes. In this step, enough data will be gathered to write a detailed and coherent, rich description of partnership working
Synthesising	Pattern coding Memoing	This step will review codes identified at the broad coding step and identify patterns within the data. Memos will provide summaries of key information for each theme which will be used in further development of propositions of the data
Theorising	Distilling and ordering Testing executive summary statements	Relationships between categories of data will be examined, building a more integrated understanding of partnership working from all perspectives and data sources
Recontextualisng	Developing propositions	Concepts identified will be synthesised to consider how the understanding of partnership working may be applied in different settings.

Effective organisation of data will be important to this case study to enable the tracking of data sources, notes, documents, narratives, and other data (Baxter and Jack 2008). NVivo 12 will be used to support management of data and to assist within and across case study analysis, appropriate to case study research

(Houghton et al. 2015). Data collection and analysis will occur concurrently as is practice within qualitative studies (Baxter and Jack 2008).

4.0 Discussion

This study will produce new knowledge on ways of working with people who have lived and living experience and will have practical implications for all improvement focused interventions. Though the main focus of the study is on national improvement programmes it is anticipated that this study will contribute to the understanding of how all national public service organisations work in partnership with people who have lived experience. The anticipated time for completion is 24 months. Information will be shared with key stakeholders on the progress of this research – including HIS and the University of Stirling and opportunities for presentation of this research will be sought. These may include at QI conferences and communities – including the Q Community, and NHS Scotland events. The findings will be completed with a thesis submitted to the University of Stirling and will be reported in an appropriate journal – such as BMJ Open Quality or Journal for Healthcare Quality.

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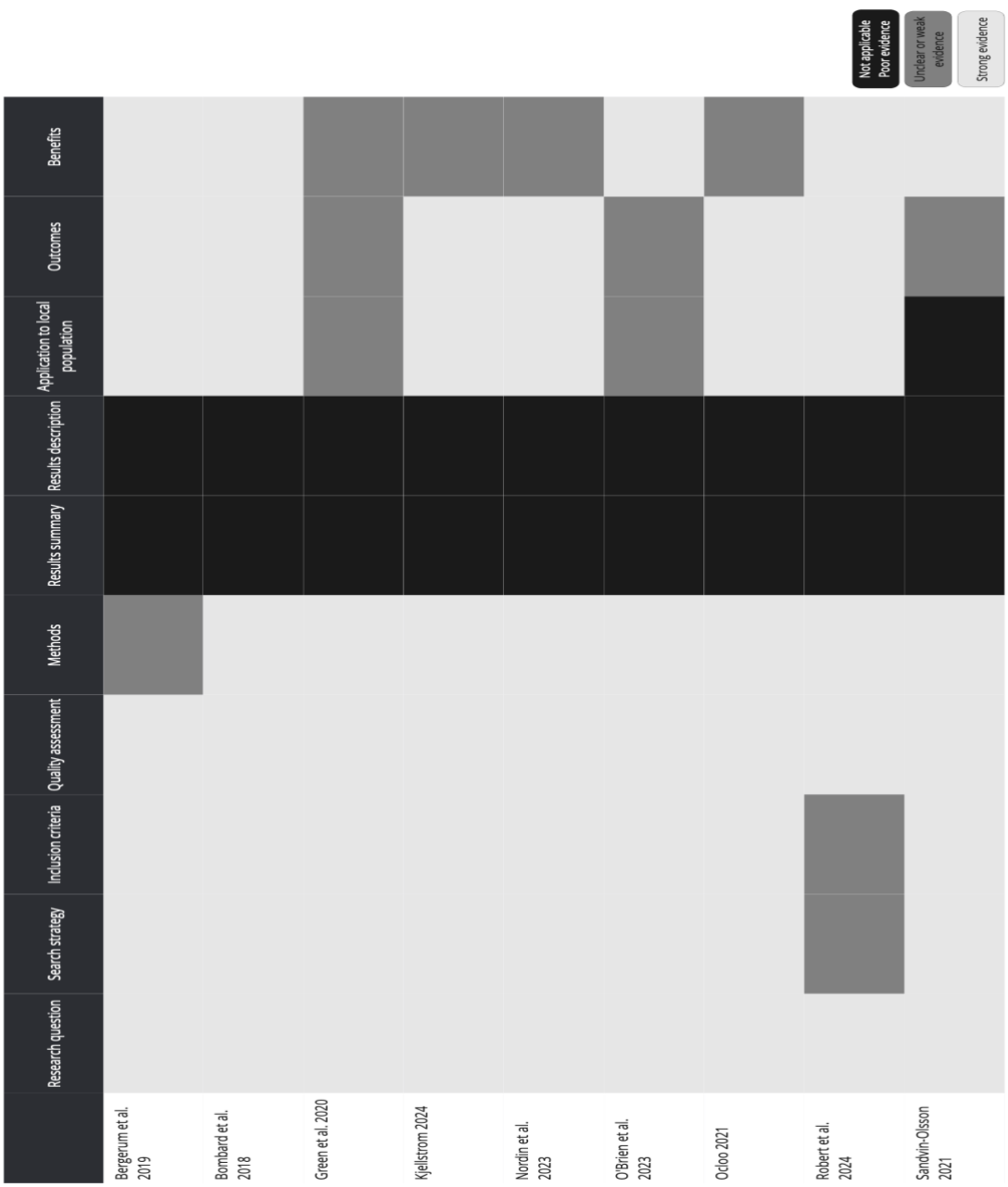
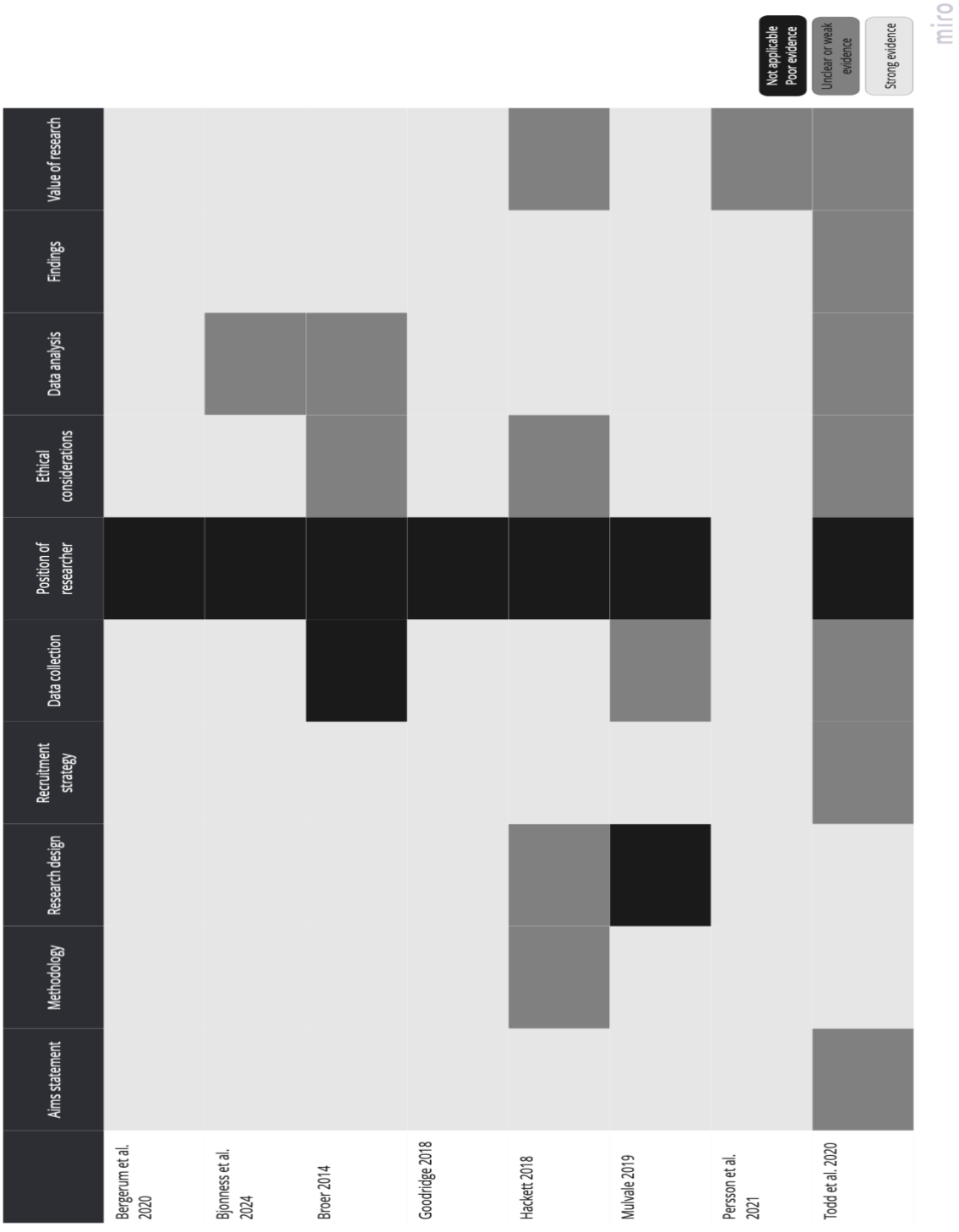
Appendix 2: Summary of methodological assessment

Critical appraisal of systematic reviews



Critical appraisal of qualitative studies



Appendix 3: Participant information leaflet

Participant Information Leaflet (for one-to-one interviews)

Study title

A case study to explore how a national organisation works in partnership with people who have lived experience in mental health improvement programmes

Researcher

Ciara Robertson, Improvement Advisor and Clinical Doctorate Student, University of Stirling.

Would you like to take part?

This is an information leaflet for phase two of a research project which is part of my clinical doctorate programme at the University of Stirling. My name is Ciara Robertson, and I am involved in this research as part of my doctoral studies. The research is led by an academic team based at the University of Stirling. I am also working as a senior improvement advisor in Healthcare Improvement Scotland (HIS) working in the primary care improvement portfolio. The research is focusing on partnership working in the Personality Disorder (PD) Improvement Programme in HIS. I am not directly involved in the PD improvement programme in HIS.

Phase one of this study included document analysis and observations of meetings. You may have been involved in this phase of the study. The study is now in the second phase and I will be carrying out one-to-one interviews with people who have been involved in the PD improvement programme. The interview has been developed in collaboration with a public partner in HIS who has represented the views and perspectives of people with lived experience in the design process.

I would like to invite you to take part in a one-to-one interview to explore your experiences of partnership working in the personality disorder improvement programme in HIS. Before you decide, it is important you understand why the research is being done and what it would mean for you. Please take time to read this information.

What and who is the study for?

Working in partnership with people who have lived experience is identified as a key principle of HIS's Clinical and Care Governance Framework and has been highlighted in the organisations Strategy for Supporting Better Care in Scotland (2017). Partnership working will be central to the work of the PD Improvement Programme. Although working in partnership with people who have lived and living experience in improvement programmes is recognised, there can be difficulties in putting this into practice. We can improve our practices around partnership working if we can understand the current practice and behaviour in organisations. This research will explore how partnership working is planned, viewed, and put into practice within the PD Improvement Programme. I hope that this research will lead to an understanding of partnership working in national organisations and will be used to develop a framework for partnership working.

What are you being asked?

If you agree to take part, you will be invited to attend a one-to-one interview. The interview will take approximately 60 -90 mins. The interview will be recorded and transcribed. You can ask to see the transcriptions from the interview you have taken part in.

Do I have to take part?

You do not have to take part in this part of the study. All participation is voluntary. If you do not want to take part, this will not affect your involvement in the personality disorder improvement programme. All data collected within this study will be anonymised and information about participation will not be shared with any staff in HIS.

What will happen if you agree to take part?

Consent

If you are happy to take part, please complete the consent form that was sent with this information leaflet. You can either send this back to me via email or via post. You can withdraw consent for this however, once the data is collected and anonymised you will be unable to withdraw consent.

If you are happy to take part, I contact you to agree the next steps. Depending on the number of people giving consent, I may not be able to interview everybody. I will interview people who have a range of different roles in the programme. The interviews will be arranged directly with participants. Interviews can be online via TEAMS, in real life at a suitable location for example, in one of the Healthcare Improvement Scotland offices, or by telephone. The interview will be recorded via teams (which collects video images) or via a digital voice recorder and then it will be transcribed.

Review of transcriptions

After the interviews have been transcribed I will send you a copy of the transcripts. This will ensure you are able to review to ensure they are an accurate reflection of our discussion. You can send comments back to me within a period of 14-21 days after the interview – after this no changes can be made to the transcripts and the original recordings will be deleted. Audio-visual recordings will be automatically deleted 60 days after the recording.

Confidentiality

I will be the only person listening to any recordings of the interview or meetings. During the transcription, I will remove any personal information and assign a pseudonym. The supervisory team at Stirling University will have access to anonymised transcripts of interviews, and all the recordings will be securely stored in the University of Stirling's IT system.

What are the benefits to taking part?

There is limited research into partnership working in national organisations in Scotland. This study will be used to understand and improve partnership working and your contribution to this will be extremely beneficial. This part of research will build a greater understanding of people's experience of partnership working in a national organisation. There is no payment for participating in this research.

Who will check the study?

Approval has been given by the Research Ethics Group for the University of Stirling, and the NHS Invasive or Clinical Research (NICR) Committee. This research has also been approved via HIS internal processes and is registered on the HIS internal research register.

Any other questions?

If you have any questions or concerns, then please get in touch through the contact details below.

What happens to the results of this study?

The findings from this study will be used during my clinical doctorate programme and the findings will be written up in a thesis. The main findings will be published in a scientific journal. You will not be identified in any written papers or reports. I will send you a summary of the findings at the end of the research.

Sharing the study

If you would like to read the published study when it is completed, then it will be available through the University of Stirling. I can email you the link to it in the future if you wish. As the study will be made public through the University of Stirling, it is possible that data from it will be used in future research studies.

Thank you for taking the time to read this and for thinking about taking part in this study.

Contact details

Researcher	Supervisor	Supervisor
Ciara Robertson Improvement Advisor and Student Healthcare Improvement Scotland	Professor Ashley Shepherd Deputy Dean University of Stirling	Dr. Carina Hibberd Lecturer University of Stirling
c.a.robertson@stir.ac.uk 07816285893	ashley.shepherd@stir.ac.uk	carina.hibberd@stir.ac.uk

If you want to speak to someone external to the study team, then you can contact:

Prof Jayne Donaldson (01786466345)
Dean of Faculty of Health Sciences and Sport, Stirling University
jayne.donaldson@stir.ac.uk

Appendix 4: Invite letter

28.11.2022

Invite letter to participants

Dear

Research within the Personality Disorder Improvement Programme – phase two.

A case study to explore how a national organisation works in partnership with people who have lived experience in mental health improvement programmes

I am writing to invite you to participate in phase two of this research. Information about this project and how you can be involved is included in the enclosed information leaflet, which gives and overview of the research and may answer any questions you may have.

You are not obliged to participate in the project and participation is entirely voluntary. If you are willing to participate, please read and sign the consent form which is also enclosed. If you would find it easier to this this electronically you

can take a photo of this consent form and send as an email attachment. The consent form should be sent or emailed to:

Ciara Robertson

c.a.robertson@stir.ac.uk

If you do not wish to participate and would like to let us know, you can do so by contacting the same email address. If we do not receive a response, we will contact you again in one week as a reminder.

Thank you for taking time to consider participation in this study. If you have any questions or require IT advice regarding completing the consent form, please contact Ciara at the above email address.

Many thanks

Rachel King

Portfolio Lead

Appendix 5: Sample consent form

Consent form 2 – for participants internal to HIS

A case study to explore how a national organisation works in partnership with people who have lived experience in mental health improvement programmes (adapted from NHS Health Research Authority guidance).

	Please initial box
1. I confirm that I have read the information leaflet dated..... for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	
2. I understand that my participation is voluntary, and I am free to withdraw before information is transcribed. I may be asked to give information on my reason for withdrawal, but I do not have to give this. This will not affect my participation with the Personality Disorder Improvement Programme or my employment within Healthcare Improvement Scotland.	
3. I understand that an audio-visual recording will be made of the interview I participate in.	
4. I understand that all data kept for this study will be anonymised so that participants cannot be traced. My name and role will be replaced with a participant code, and it should not be possible for me to be identified	

in any reporting of the data gathered. Specific roles will not be identified but there may be a broad category discussed – such as improvement staff, senior clinical staff. All data collected will be kept in the University of Stirling's secure IT system which only the nominated researcher and supervisory team have access	
5. I understand the results from this study will be published in appropriate journals and may be presented at conferences	
6. I agree to audio visual recording of an interview and the use of anonymised quotes in research and publications	
7. I agree to take part in this study	

Name of participant

Signature of Participant

Date

Researcher details	For internal use only
c.a.robertson@stir.ac.uk	Participant ID

Reference: Health Research Authority Consent and Participant Information Guidance (n.d.) Available at: http://hra-decisiontools.org.uk/consent/examples.html [accessed 24th November 2021]

Appendix 6: Distress Protocol

20/11/2022

Distress Protocol v 2.0

A case study to explore how a national organisation works in partnership with people who have lived experience in mental health improvement programmes

Recognition of distress

During phase two of this research, some people may experience distress during meetings or after the interviews. Participants attending interview may have lived or living experience of mental illness and therefore the researcher will be aware signs of poor mental health. The researcher is an experienced Speech and Language Therapist who has worked in Mental Health Services for over 20 years and will use this expertise to observe signs of distress in all interviews. This distress response policy has been reviewed by a public partner working in Healthcare Improvement Scotland, and mental healthcare clinical experts within Healthcare Improvement Scotland.

Signs of distress or poor mental health may include visible distress, a lack of coherence, extreme moods, or expressions of excessive fears or worries.

Distress Response

Should any participant express or display distress with the researcher at any point the following actions will be taken:

- The researcher will respond appropriately to the immediate situation. This may involve terminating the interview / phone call / discussion.
- The participant will be offered immediate support as appropriate and will be directed for further support as appropriate.
- For staff within Healthcare Improvement Scotland – there is support available via the staff wellbeing hub; HIS confidential contacts; management and HR
- For staff working in partner organisations support may be within their own organisation or via Healthcare Improvement Scotland via the staff wellbeing hub; confidential contacts, management or HR
- For people with lived experience, support may be via Healthcare Improvement Scotland programme staff or a partner organisation who have a remit to support people with lived experience such as VOX or Scottish Recovery Network. Information on national support organisations will also be given including Breathing Space, NHS 24, and The Samaritans.

I will contact all participants the next working day following their interview to check they are happy with the interview. For any participants who asked to stop the interview I will offer them the opportunity to continue the interview at a later date.

At the end of all interviews, participants will be given information on where they can go to for support if needed. Any distress will be documented and discussed with the supervisory team.

Ciara Robertson

University of Stirling

Appendix 7: Interview Guide

Interview Guide 28.11.2022

Participant information

Thank you for taking to be involved in this work, my name is Ciara Robertson, and I am leading this research into how national organisations work in partnership with people who have lived experience in a mental health improvement programme. This is part of my clinical doctorate programme with Stirling University. The aim of this research is to understand the experiences and opinions of people who have been working with the personality disorder improvement programme in relation to working with people who have lived and living experience.

I would like to understand your unique perspectives of working in the personality disorder improvement programme. I would like to know your opinion on what has supported partnership working in the improvement programme, where there may have been barriers to partnership working, and your thoughts on what could improve partnership working in the future. I will ask questions about your experience working in the personality disorder improvement programme, and I will ask questions about your opinion on other people's experience working in this programme – particularly people who have lived or living experience.

Our conversation will last around 45 minutes to 1 hour, and it will be recorded so that we can appropriately and fully understand and analyse what is said. The outcomes of these interviews will feed into a final report. Your name will be anonymised, and you will not be identifiable in any write up and analysis.

Confidentiality and the right to withdraw

If at any point during our conversations you would like to raise a point, mention something that comes to mind, or feel that you need to take a break for any reason, please feel free to do so. Also, if at any point you do not want to answer a question, if a question needs clarified or you would like it asked in a different way, please let me know. You have the right to withdraw from the interview at any time and for any reason.

Interview protocol

Background information

Aim: to build rapport and help people feel comfortable in the interview. To understand people's role and experiences in partnership working. To explore motivations for working in improvement within mental health.

Tell me a bit about yourself and your reasons for joining a national improvement programme.

Can I ask what your role is within the personality disorder improvement programme?

Is this what you thought the role was going to be?

Why did you become involved in the PD improvement programme?

Reflections on partnership working in the programme

Aim: to explore people's perceptions and experiences of partnership working within the programme. To understand the set up and design of the programme for partnership working. To explore what has worked well and what have been barriers to partnership working.

Can you describe how the PD improvement programme has worked with people who have lived or living experience?

Which aspects of the programme have PWLE been involved with?

Are there any aspects of the programme PWLE have not been involved with?

Can you tell me a bit more about your understanding of why this might be the case?

Is involvement of PWLE as you had anticipated when you joined the PD improvement programme?

In your opinion, what has worked well in relation to working with PLWE in the PD improvement programme?

Do you feel these has worked well for all people who have lived or living experience?

In your opinion, have there been any barriers to working with PWLE in the PD improvement programme?

Where there any surprises or things you did not expect in relation to working with PWLE?

Did you feel these barriers were similar to other people who have lived or living experience?

What recommendations would you make to improve working with PWLE in improvement programmes?

Experiences of methods used and support given for partnership working

Aim: to understand methods used to support partnership working and support offered. This may include different ways of communicating, flexibility, information, or training.

How did you prepare for the partnership working required in this improvement programme?

What did you hope to contribute to this programme?

What could have helped you prepare for partnership working?

Model of partnership working in the programme

Aim: to explore what partnership working means for each participant, and what partnership working looked like in the improvement programme.

The term "engagement" is used in this programme to describe working with people with lived experience.

Do you feel the term engagement is an appropriate way to describe the way the PD improvement programme has worked with PWLE?

Are there any other terms you feel would be more appropriate?

Have the team looked at or discussed models of participation / engagement?

Are you aware of different teams or programmes using different approaches to working with PWLE?

How would you like national organisations to work with people who have lived experience in the future?

Closing questions

Is there anything you would like to add or expand upon that has come up in our discussions today, or anything that you feel we haven't covered yet?

Based on your experience, what areas do you feel need to be explored further?

Debrief information

Thank you for taking the time to speak with me today, your input to this process and your insights on working with people who have lived and living experience in the personality disorder improvement programme.

I will make sure that your name is not included in any information, and you will be described in the report as *insert ID here.*

If you have found the interview distressing in any way, or feel you need support following the interview there are various places you can find impartial support. If you work in Healthcare Scotland you can contact the confidential contacts, speak with your line manager or contact HR. If you work with a different organisation there will be support available in your own organisation. The following organisations may also be able to provide support:

- Breathing Space – you can contact them at https://breathingspace.scot, or phone them on 0800 838587
- The Samaritans - you can phone them on 116 123
- NHS24 on 111

I shall contact you tomorrow to make sure you are happy with the interview and to answer any questions you may have.

If you have further queries or questions about the research that is being undertaken as part, or if you have any concerns or complaints, please feel free to contact my supervisory team at the University of Stirling.