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i. Title:

Building collaborative leadership: a qualitative evaluation of the Australian Collaborative Pairs trial

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i. **Title:**

Building collaborative leadership: a qualitative evaluation of the Australian Collaborative Pairs trial

ii. **Abstract**

The need to reorient the health system to ensure greater involvement of consumers in health care has, in recent years, been highlighted as a priority in both literature and policy. This change requires renegotiating power relations between health organisations, health professionals and health consumers. This paper presents findings from a trial of a program designed to foster collaborative relationships between clinicians and consumers of health services in the Australian setting. The King's Fund Collaborative Pairs program is a leadership development program that brings together a consumer, patient or community leader to work together in pairs with a service provider clinician or manager to develop new ways of working together.

The trial involved 88 participants paired together undertaking one of seven programs conducted from October 2018 to August 2019. Participants were guided through a series of activities in five face-to-face sessions run by facilitators trained by the King's Fund. A qualitative evaluation was undertaken via semi-structured interviews (n=40) with organisations involved, facilitators and participants. A brief review of program documentation was also included. Thematic analysis was undertaken to evaluate program acceptability, implementation and to identify program impacts.

The evaluation, although limited in scope, found the program changed the way some participants understood the nature of consumer and provider relationships and how collaborative working relationships could be developed. The impact of the program on organisations sponsoring

participants was less evident as numbers of participants from each organisation were limited and the time required for cultural change to develop is typically longer than the evaluation period allowed for. We highlight key recommendations addressing program recruitment, facilitation and format to inform future iterations of the program.

iii. Key words

- collaborative practice
- co creation
- consumer
- leadership
- health system
- consumer engagement
- consumer involvement

iv. What is known about this topic and what this paper adds;

What is known about this topic?

- Where consumers are actively involved in the healthcare system improvements are seen in healthcare processes and outcomes
- Shifting to a patient centred system is slow due to the difficulty of the cultural and behavioural changes required
- The change to a more patient centred system requires patients and health professionals to think and act in different ways

What the paper adds

- The King's Fund collaborative pairs trial was found to be relevant and applicable to the Australian context
- The trial demonstrated variable impact on participant understanding and experience of collaboration

- Care must be taken in recruiting participants, marketing the program to ensure realistic participant expectations and coaching facilitators and participants in new collaborative practices

v. **Main text;**

Introduction

Consumer involvement in improving healthcare quality has been a focus in literature, policy and healthcare practice for over two decades (Bombard et al., 2018; Brett et al., 2014; Gardner, Dickinson, & Moon, 2019). Placing consumers at the forefront of the healthcare system involves renegotiating power relations between health organisations, professionals and consumers. While this is a significant undertaking, evidence suggests that where consumers are actively involved, we see improved health outcomes, overall efficiency gains, increased patient choice, increased trust, reduced patient and health system costs, increased use of medical research, and increased patient satisfaction and treatment compliance (Coulter, Roberts, & Dixon, 2013; Hibbard, 2013).

Although in many developed health systems there is political will and public demand to put patients at the centre, actually making the shift has proved challenging (Foot et al., 2014; Gold, Hossain, & Mangum, 2015; Weissman, Millenson, & Haring, 2017). Gardner et al (2019) argue slow progress is largely due to the cultural and behavioural changes required in breaking down vested interests and long-established ways of thinking and doing. Patients and health professionals alike need to think and act differently (Foot et al., 2014; Gold et al., 2015; Weissman et al., 2017).

This paper reports on a program evaluation that seeks to drive cultural change and renegotiate relationships between health service providers and consumers. The Consumers Health Forum of Australia (CHF) in collaboration with the King's Fund (UK) and four Primary Health Networks (PHNs) in New South Wales (NSW) and Victoria undertook an Australian trial of the King's Fund Collaborative Pairs (CP) program. CP is a leadership development program that brings together a consumer, patient or community leader with a clinician or manager to develop new ways of working together. The program supports development of practices that underpin a culture of shared leadership and collaboration (CHF, 2017a) and improvement in service delivery (CHF, 2017b).

This paper first provides an overview of consumer involvement and then outlines the approach to program evaluation. Key findings are then presented in terms of program relevance, acceptability, and impact. How program benefits could be extended to more participants with refinements in program marketing, recruitment and format are discussed. The paper concludes the program differs from existing consumer engagement mechanisms and has an impact in changing some participant attitudes to collaboration.

Consumer involvement: existing and new concepts

A range of terms are used to describe consumer involvement in healthcare. A useful framework to understand these, developed by Carman et al (2013), outlines both levels and degrees of involvement. Consumers can be involved in direct care delivery or micro level, at the meso levels in organisational design and governance or the macro level in policy making. At the micro level, consumers are partners in clinical processes and actively engaged in their own treatment planning and decision-making (Lloyd & King, 2003). At the meso and macro level consumers contribute to planning, evaluation, reform and policy processes that shape the way services operate for a larger group of consumers (Lloyd & King, 2003). The involvement at each level can vary from consultation, involvement, partnership and shared leadership. This reflects a continuum from low to high involvement depending on 'how much information flows between patient and provider, how active a role the patient has in care decisions, and how involved the patient or patient organization becomes in health organization decisions and in policy making' (Carman et al., 2013 p. 224).

The aim with healthcare consumer involvement has been to shift to higher forms of engagement at all levels. Concepts of collaboration and leadership, integral to the CP program, are similar to the partnership and shared leadership descriptor in the Carman et al framework and reflect higher forms of consumer engagement.

Collaboration is defined in this paper as two or more individuals and/or organisations working together to create or achieve the same goal/outcome. Contemporary literature expands on the nature of collaboration through the concept of co-creation where consumers are active participants in services, rather than passive receivers of goods (Vargo & Lusch, 2004). This approach acknowledges that patients or consumers are the only people who experience the full extent of their health problem from symptom development to the services they receive (Elg, Engström, Witell, & Poksinska, 2012). Co-creation requires strong relationships and mutual trust to enable consumers and providers to share information, and align and define value sought from collaborative activities (Joiner & Lusch, 2016).

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Consumer leadership is a nascent term and has been defined in multiple ways that include references to purpose, roles, capacity and processes (Stewart, Scholz, Gordon, & Happell, 2019). Common elements in the literature include moving beyond tokenistic 'participation' (Ocloo & Matthews, 2016), away from restrictive concepts of consumer representation not normally associated with leadership (Happell & Roper, 2006) to embrace concepts such as developing leadership capacity, dedicated roles and responsibilities (Scholz, Bocking, & Happell, 2017), application of lived experience, exercising influence, collaboration, and promotion of supportive, inclusive cultures (Stewart et al., 2019). Consumer leaders are seen as necessary to drive a culture shift from seeing consumers as 'users and choosers', to being valued as 'makers and shapers' of health services (Janamian, 2016).

This paper presents evaluation findings of a program that aims to promote higher forms of consumer engagement in healthcare, through partnerships or shared leadership between service provider leaders and consumer leaders. The CP program has a focus on change at the meso level and aims to shift organisational culture to support new forms of consumer and provider working relationships to improve healthcare quality. The findings provide an insight into the complexities of creating culture change to support higher forms of consumer engagement in healthcare.

Collaborative Pairs

The shift to a more consumer focused system requires investment in building both consumer and provider capacity. The CP program, developed by the King's Fund, aims to enable '*cultural change and a new relational paradigm for consumers and health care professionals*' (CHF, 2017a). In 2015, the King's Fund ran a series of CP programs in England. While no formal program evaluation was undertaken, a summary of learnings indicates the potential benefits of investing time to enable collaborative learning and relationships to develop and embedding this activity within existing organisational systems (Seale, 2016).

The stated objectives of the Australian program were to build skills in developing partnerships, and to break down the cultural barriers that often exist between those providing the services and those receiving them (CHF, 2017a). The underlying program assumption is that consumers, managers and service providers are all equal in an effective health system.

The principal features of the Australian CP program were:

- Program facilitation by both a consumer lead and a clinician/manager lead who received King's Fund supervision
- Participants were managers, clinicians and consumers paired together to form a manager/clinician-consumer partnership
- Five one-day face-to-face sessions with three to six weeks between sessions
- Each program included theoretical, experiential learning and reflection in relation to communication, conflict resolution, partnerships and collaborative working
- Pairs identified and worked on a service improvement project ('the project') as a vehicle for exploring collaborative working relationships
- Clinicians were sponsored by their employer organisation
- Consumer participants were remunerated in some programs

Table 1 gives an overview of the type of projects undertaken by pairs.

Table 1: Summary of project categories

Local variation existed in program delivery reflecting a flexible approach to facilitation. Facilitators tailored programs to meet local needs through selecting appropriate resources from a range of material provided during facilitator training.

Facilitator pairs were recruited through an expression of interest process. Pairs underwent a five-day training program in the UK in March 2018. Facilitators were engaged by CHF to deliver two programs auspiced by four participating PHNs in a range of urban, regional and remote contexts. PHNs, the funders for CP, are regional commissioning primary health organisations located throughout Australia designed to improve efficiency, effectiveness and coordination of care to patients through identifying need, and assisting local practitioners and organisations (Department of Health). Facilitators were primarily responsible for program delivery while PHNs and CHF were primarily responsible for recruiting participants, provision of venue and other program administrative issues. CHF held a session with PHN staff and facilitators to prepare for program implementation. Participants were invited to apply for the program by their PHN as a consumer and health service 'pair'. Figure 1 outlines the different stages of the CP program

Figure 1: Stages of the Collaborative Pairs trial

Methodology

Having set out the project background, we now turn to the methods used to generate data. The evaluation objectives articulated by CHF were to:

- Assess program's relevance and acceptability in Australia;
- Assess program's effectiveness in building collaborative relationships that impact on practice and lead to system changes in the way health services are designed, developed and implemented;
- Inform further implementation of the program and;
- Build the evidence base on collaborative practice, leadership and transformational change.

The evaluation, funded by the Australian Commission on Safety and Quality in Health Care, was undertaken independently and was relatively small scale permitting only limited evaluation. Program impact was evaluated with a focus on participant perspectives on the changing nature of relationships. To evaluate program impact on system change a broad range of data, a larger number of participants from each healthcare setting and a longer timeframe would be needed. The program's relevance and acceptability were evaluated through participation data and interview findings. Findings informed recommendations about further implementation.

The evaluation used qualitative methods, primarily through semi structured interviews supplemented with documentary analysis. Semi-structured interviews are typically used to gain a detailed picture of a respondent's beliefs or perceptions of a particular topic (Smith, 1995). Interviewers used an interview schedule with questions addressing drivers for involvement in the program; what the program had delivered; what worked well; improvements needed; whether the program fit in the Australian context; and, changes needed for future program iterations. 40 people were interviewed either during or after the program by three of the authors, with no involvement in the program delivery. Interviews conducted during program implementation allowed interim findings to improve implementation. A range of perspectives were sought through interviewing key organisational stakeholders from all PHNs, all facilitators and some program participants. The evaluators aimed to interview one consumer and manager/clinician participant from each program. Participants were selected based on the first available consenting interviewee. Interviewees were sent a plain language statement and consent form. The interviewee profile is shown in Table 2.

Table 2: Stakeholder interviews

Interviews were audio-recorded and transcribed. Thematic analysis was undertaken using *a priori* codes related to program relevance, acceptability, delivery and impact. Data was analysed by three authors to identify themes. Thematic analysis is a widely used method for identifying, analysing and reporting themes from data (Braun & Clarke, 2006). Interview data was supplemented with a desktop review of program documents including participation data, project descriptions and participants and facilitators notes summarising knowledge development from each session. Documents were analysed to calculate program demographics, project types and learnings. The project received ethical approval from the UNSW Human Research Ethics Committee ((HC180329).

Findings

Findings are presented under the first two evaluation objectives, namely: relevance and acceptability and program impact. Key challenges emerged in recruitment, the ability to articulate program purpose and the program format - all influencing program acceptability. Program impacts are explored in terms of the degree to which the program succeeded in rebalancing power relationships between clinicians and consumers and the benefits cited.

Relevance

All interviewees were overwhelmingly positive about the need for and relevance of the program in fostering collaborative relationships. Participants commented that 'collaboration is vital' (interviewee #6) and 'definitely the way the health system needs to go and health practitioners need to practice these relational skills' (interviewee #3). This participant explains,

I know that programs like this work. They change clinician behaviour, they change consumer behaviour and ultimately change the way people behave at the bedside (Interviewee #8)

Most provider participants had previous experience working with consumers and wanted to 'do it better' (Interviewee #11). Interviewees felt the program approached consumer leadership and collaboration in a new way. An interviewee contrasted CP to one-off consumer development programs workshops that were usually restricted to theory and often had little substantive consumer involvement.

Program participants saw the program content as relevant and 'really strong' (Interviewee #8). A few participants identified the need to situate course examples to the Australian context, including references to Aboriginal and Torres Strait Islander perspectives. Most participants supported future program implementation; however, all noted the need to address changes to program delivery to improve acceptability.

The course content is really strong and if could use to full effect this would be great (Interviewee #8)

Acceptability

Acceptability was evaluated through participation data and program delivery feedback. To complete the program a consumer and manager/clinician pair were required to participate in most or all five sessions. Table 3 presents an overview of pairs commencing and completing the seven programs conducted. Eight pairs were the maximum number suggested for each program.

Table 3: Program commencement and completion

As Table 3 shows, most programs experienced some difficulties in recruiting pairs as well as pair attrition, due to change in employment, work/family commitments, or illness. Overall, there was a 70% completion rate.

A key theme was the lack of clarity regarding the program's purpose. Many participants reported they had difficulty initially understanding what the 'program was, based on the description' (interviewee #2). Some interviewees suggested it was difficult to articulate how this program differed from existing consumer involvement activities. One PHN manager explained:

People [participants] felt like it was what they already did. 'I already engage with consumers, I already work with clinicians, I'm on a consumer advisory committee, I don't understand why this is different'. [it was] hard to describe a process when people are used to outcomes. [So I] Started to talk about it in terms of leadership development (interviewee #23)

Several interviewees said it was easier to explain the program to consumers than it was to clinicians, given that it represents a significantly different way of working for clinicians.

There was also confusion about the role of the project. Some participants felt the project was of greater benefit than developing the pair relationship. This was seen as problematic by facilitators and PHN representatives who viewed this as a misunderstanding of the program intention. Most facilitators acknowledged marketing to participants needs to further emphasize the relational building process of the program.

The inability to clearly articulate the program objectives and format led to many participants finding it 'quite confusing initially' (interviewee #10). This confusion cleared for many after program commencement:

'Realised when started it was about learning how to work with people who might have different opinions (Interviewee #5)

However, for some the confusion remained:

I could never understand what we were hoping to achieve in the end ... it was assumed that that was known by each pair before we went there and we didn't (Interviewee #6)

Lack of clarity regarding program objectives influenced perceptions of program acceptability for several participants due to unmet expectations.

Challenges were experienced in recruiting consumers. 55% of participants were clinicians or managers, which meant several pairs were made up solely of clinician/manager pairs. Recruitment relied largely on the provider participant identifying their consumer pair. A clinician explains their decision not to participate in their regions first cohort was related to needing to find a consumer pair, a requirement relaxed in the second cohort,

We did try and engage a consumer...[Facilitators] encouraged us to get a consumer... well how do we sell that to them, how do we get 5 days of their time, how do we pay for that, how do we get them to come and talk about their health journey. We didn't know how to do that (Interviewee #11)

No pairs in the first SEMPHN program completed. These participants were exclusively from mental health and/or drug and alcohol services. This was seen as a positive in terms of their non-

traditional insights on health and welfare. However, there were challenges for consumers in this program. Many consumers were currently receiving services and the CP program was an additional stress which hindered completion. Several consumers were in therapeutic relationships with their clinician pair. This brought an existing power imbalance between consumer and clinicians that facilitators and participants reported as being unhelpful in changing the relationship dynamics.

Concerns were expressed about stresses placed on participants either through clinician/manager participants struggling to support their consumer pair or consumers struggling to understand the program and manage the commitment.

We had a woman who was really, really enthusiastic but because of her medication couldn't turn up until a certain time and then had to leave early because her concentration...she just couldn't manage the full day (PHN staff, interviewee #22)

Interviewees felt that greater facilitator and PHN involvement in consumer recruitment may have assisted in selecting suitable consumers, such as past rather than current recipients of mental health services. This may also assist with challenges experienced by clinicians in finding consumer pairs and avoids clinicians being gatekeepers of consumer recruitment and potentially biasing consumer selection to those they already work well with.

An additional factor influencing both recruitment and completion was the support provided by organisations sponsoring participants. Strong sponsoring organisation engagement with, and understanding of, the program is important in recruitment and enabling staff to attend all sessions.

One facilitator described this,

We talked about the three-legged stool, the pair in the room is only two legs of the three-legged stool, the missing leg or the absent leg is the sponsoring organisation. Some of them weren't really that supportive (interviewee #18)

Interviewees were asked about program facilitation and format. Facilitators were seen to vary in their approach to group engagement, with participants describing a 'lecturing style' to more interactive approaches, with the latter being more valuable. Participants also described differences in facilitator's ability to identify and support participants having problems or difficulty understanding theory. Where facilitators did not pick up on individual issues, their pair felt they were left to manage and negotiate issues alone.

Participants from a couple of programs consistently remarked on the ability of facilitators to model an effective collaborative relationship.

Really dynamic, really great pair together... very engaging and very knowledgeable... delivered it in a way that wasn't bland (Participant, interviewee #9)

Several interviewees remarked these facilitators had more experience of group work and facilitation. Facilitator pair relationships need dedicated time to develop and reflect on, above and beyond that provided in supervision, and this occasionally suffered as the demands of program organisation took priority. Facilitator pairs benefitted from being able to meet easily to discuss and reflect on progress. This was more difficult for facilitator pairs who delivered programs outside the region they lived and worked.

Facilitators reported not being allocated adequate time to undertake all tasks required. Clinician facilitators found it a challenge to find time beyond the allocated time. Because of this, some consumer facilitators reported any slack typically fell to them. While some consumer facilitators had fewer time pressures than clinicians, extra time spent on tasks was not remunerated. This situation is problematic as facilitators were essentially modelling processes they are aiming to elicit in participants. If consumers were seen to pick up any slack that clinicians could not manage this sent a particular message to pairs.

Participants felt the program format required changes. All-day sessions were too long and this was physically and mentally demanding for some:

The content was really good but it could be cut back, didn't need to be so drawn out (Interviewee #6)

Others commented the interval between sessions was too long and momentum was lost in developing pair relationships. As participants had variable understandings of the project role this influenced their comments on timing. Some participants who thought the project was a major focus were disappointed their project did not progress as far as anticipated. These participants were not expecting the amount of out of session time required to progress their project and had difficulty managing this. Other program participants had a clearer understanding;

The process was important... the process is the relationship and developing the relational skills and breaking down the power dynamics and barriers, and the project was the mean by which you do that (Participant, interviewee #3)

Between-session facilitator support of participants was seen as useful. However, only some facilitators offered this.

They [facilitators] had strong communication between sessions, mainly via e mail, which was perfect for me (Participant, interviewee #11)

Between-session support was a way of checking in with participants and reviewing their relationship and understanding of key concepts. Similarly, facilitator supervision provided by the King's Funds was seen as essential in supporting facilitators to strengthen their own and their pairs collaborative relationships.

Program impact

Program impact was evaluated through a focus on immediate benefits articulated by participants. While all participants suggested improvements to program processes and format, most were positive about the program's ability to change dynamics between consumers and providers. Benefits were expressed in terms of new skills, thinking and approaches to communication, collaboration and partnership.

The program was seen to 'open doors to new ways of thinking' (interviewee #5). A provider participant explains:

It has changed the way I think about service design and service delivery and having consumer representation on committees and advocating for that
(Interviewee #3)

A clinician/manager commented:

Made us realise we had to take a different approach to project development, collaborate more widely and listen, ask the right questions (interviewee #11)

Provider participants expressed benefits in terms of being more 'open to more opportunities for collaboration' (interviewee #9) and confident to undertake collaborations with consumers. A facilitator comments:

So many of the consumer engagement attitudes in organisations, in hospitals, in particular, position the consumer as the problem and the clinician and service provider as naturally having the skills to do that work... this program is definitely more transformational for the clinician/service provider half, especially when you get experienced consumers coming into the program because these issue of power, conflict and influence and how you actually make things happen in a

challenging hierarchical bureaucratic system are things that consumers working in consumer representatives roles are thinking about all the time (Interviewee #17)

Consumers reported they were applying lessons learned more broadly:

Learned some really great skills around collaboration that am now using in other areas of my life to advocate for myself and for others (Interviewee #7)

Several attributed the change in their approach to relationship building and a greater understanding of and ability to address power imbalances between clinician/manager and consumers. For consumers this gave them greater confidence to speak up: 'Has given me confidence that what I have to offer is valuable' (Interviewee #1).

The program included various mechanism for participants to reflect on and capture their learnings. At the end of each session facilitators collected participant feedback about what to keep, discard, amend or create from the program. Key themes from the knowledge capture from all sessions and programs are presented in Table 4 and highlight the shift in understanding from knowledge and behaviours to discard and those to keep, amend or invent.

Table 4: Summary of key knowledge capture themes

Not all, however, had a positive response to the program. One provider participant explained:

I kept thinking each time I went and leaving...that was horrible. I thought it was just my own process but by the last session ...two other people turned up ...that were in different states of distress. I thought, I don't think this is just me, I think this has been a really difficult process (Interviewee #6)

The program impact on organisations was unclear. Benefits were reported at one organisation, which sponsored several participants and developed mechanisms to incorporate program learnings and generate broader organisational discussion. Many believed organisational benefits would emerge over time as participant numbers from individual organisations undertaking the program increased with future program iterations.

Some questioned the fit of the program with PHNs. PHNs were described as being 'bureaucratic' organisations with high staff turnover. This proved, challenging for some facilitators in communicating and progressing with program implementation. PHNs ability to recruit effectively was questioned as commissioning organisations perceived as being not close enough to health care

providers. Hosting organisations being direct service providers, rather than PHNs would potentially ensure organisational commitment and a greater number of staff from an organisation attending to *'get the momentum for culture change and construct an ongoing community of practice'* (facilitator, interviewee #17).

Discussion

As outlined in the introduction, the program aimed to trial the King's Fund CP approach in Australia. The evaluation objectives were to determine the program's relevance, acceptability and impact to inform future implementation. The program was seen to be relevant and addressing a need to foster healthcare collaboration in Australia. However, all interviewees identified changes to program delivery prior to future implementation. Challenges were identified in program marketing, recruitment and delivery, which influenced program acceptability.

The inability to clearly articulate the program to participants was a fundamental barrier to realistic program expectations. Given this, program promotion needs to clearly articulate program objectives, highlight its experiential nature, and the time and commitment required in and between sessions. This along with careful recruitment, involving facilitators to model and explain program objectives, may help ensure suitable participants with expectations aligned with program intent.

This evaluation indicates the importance of support mechanisms for facilitators and participants. How facilitators work together as a pair appears to be crucial. If pairs do not model an ability to balance power relations, this does not set up an expectation that pairs will be able to do this. It is therefore important that facilitators pay attention to these issues, while also delivering a detailed program with limited time and resources dedicated to this. It was evident that facilitators with greater group work and facilitation experience were perceived to be more effective. Recruitment needs to consider facilitator experience as the program requires intensive exploration of beliefs, assumptions and attitudes which at times is confronting for participants. Additional support for participants in the form of between session participant coaching is also needed. This may allow session length to be shortened.

The findings further suggest that it is crucial to think about how the program is supported and by whom. Some interviewees suggested that PHNs may not be the best hosts if the program is to drive change across the health system. As commissioners of a limited range of services across primary

and community care, some felt that these organisations might be too young and too removed from service delivery to be able to have a significant impact. In the English program, the organisations involved have tended to be service delivery organisations, such as hospitals or other secondary care institutions.

The CP program with its focus on new ways of working requires organisational support for change to be embedded. Organisations sponsoring participants need to have clear objectives for involvement, fully support participant engagement in all program aspects and have mechanisms to incorporate learnings and support further action. These are key cultural change considerations to ensure organisational impacts are realised and could be assessed at the point of organisational recruitment and supported throughout the program.

Given the limited evaluation scale and scope we were not able to capture measures relating to meso level changes in health service use, patient experience or efficiencies. We cannot therefore make statements about whether this program was able to drive organisational benefits that have been noted in the literature (e.g. Janamian, 2016; Ocloo & Matthews, 2016). However, our findings show most interviewees believe a program like this is needed and are broadly supportive of the need to rebalance power relations between consumers and clinicians. There was less agreement relating to the degree to which the program achieved this.

It was evident the program had an impact on some participants approach to provider and consumer relationships. They reported learning new ways of listening, communicating and collaborating and were more open to new perspectives. Communication as a tool for creating change is not a new idea (Ford & Ford, 1995). Models such as generative dialogue, conversations allowing learning and new knowledge, enable participants to develop trust and mutual respect and work towards a common goal (Petta, Smith, Chaseling, & Markopoulos, 2019).

Some participants felt it was too early to determine whether the nature of the collaborative relationship had changed. Working in new ways such as this represents a culture change in the ways that professionals interact (Mannion, Davies, & Marshall, 2005). It is, therefore, possible that it is too early to tell whether the program will have a positive impact. This does point to the importance of developing mechanisms to support these relationships after program completion. A few PHNs and facilitators spoke of an aspiration to develop communities of practice to support pairs beyond the program in order to sustain benefits over the longer term.

Program impacts were perceived to be greater for clinicians than for some consumers, already adept at navigating health system hierarchies. At the same time, provider participants tended to be more critical of the program, possibly reflecting resistance to challenges to the status quo. Clinicians are required to relinquish power and honour different forms of knowledge in undertaking collaborative relationship with consumer leaders.

There were a few negatives responses to the program and this highlights the 'dark side of co-creation' (Heidenreich, Wittkowski, Handrich, & Falk, 2015, p. 279). Heidenreich et al demonstrate that high levels of co-creation can lead to high levels of dissatisfaction when the resulting service performance is less than expected. While program participants had not yet experienced the service improvements they were co-creating through projects, the dissatisfaction of a few with their collaborative experience and the program was evident. Participants considered they were investing considerable time and effort and had expectations regarding the benefits they would receive that were not always realised.

This evaluation provides limited evidence of program impacts on the clinician and consumer relationship. However, the investment required to engage in co-creation and the associated risk of dissatisfaction highlight the need to attend carefully to program marketing, recruitment and delivery. The learnings from this study may assist in realising these benefits to more participants in the future.

A limitation of this evaluation was the lack of measures of change in collaborative relationships. There are several collaboration measurement tools that exist that could be trialled to determine their usefulness in assessing short term program impacts. The exploration of meso level benefits at sponsoring organisations needs to be a focus of future research.

Conclusion

This paper reports on the evaluation of the Australian trial of the King's Fund CP program. The ultimate aim of this program is to renegotiate power relations between health organisations, health professionals and health consumers. The literature suggests that improving consumer and clinician

collaboration can lead to several positive outcomes in terms of health services effectiveness and efficiency.

Drawing on documentary analysis and 40 semi-structured interviews, the paper finds mixed perspectives regarding the degree to which the trial has achieved its aims. The program differs from existing consumer development programs, promoting participation, by directly fostering higher forms of engagement through shared leadership and collaboration via experiential learning. A number of areas are identified as being important to the program veracity. These include the need to foster clear program expectations, careful recruitment of facilitators and participants, the facilitators role in modelling collaborative behaviours and supporting participants, ensuring program delivery is tailored to participants and the time it takes to establish change across systems and cultures.

Conflict of Interest Statement

The academic team (Professor Helen Dickinson, Professor Susan Robinson and Dr Alison Brown) were contracted to deliver the evaluation.

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Table 1: Summary of project categories

Project Categories
<ul style="list-style-type: none"> • Encouraging feedback from service users • Developing patient and family education on specific health/welfare issue

- Involving consumers in program evaluation
- Understanding patient/consumer perspectives on health/welfare issues
- Developing and effective working with peer support networks
- Consumer involvement in incident review
- Developing new models of care
- Consumer centric approach to service commissioning
- Connecting with vulnerable communities
- Consumer perspective on clinician roles
- Supporting peer workers
- Supporting informed consumer decision making in preventative health activities

Table 2: Stakeholder interviews

Interviewee type	Number of interviews during program implementation	Number of interviews post program implementation
REDACTED	1	-
King's fund	-	1
PHN	10	-
Facilitators	6	8
Participants	-	14*
Total	17	23

*9 clinician/provider participants and 5 consumer participants

Table 3: Program commencement and completion

PHN	Groups	No. of Pairs commenced	No. of pairs completed
South East Melbourne PHN (SEMPHN)	Group 1	6	0
	Group 2	8	6
North West Melbourne PHN (NWMPHN)	Group 1	8	6
	Group 2	7	6
Western NSW PHN (WNSWPHN)	Group 1	5	4
	Group 2	5	5
Western Sydney PHN (WSydPHN)	Group 1	5	4
Total		44	31

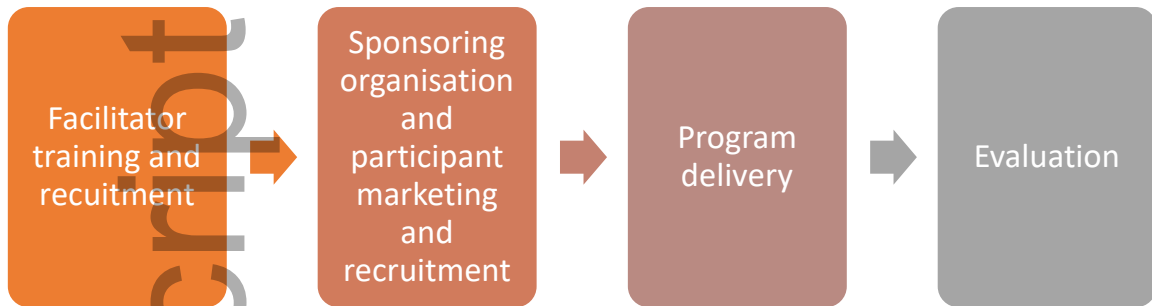
Table 4: Summary of key knowledge capture themes

Keep	Discard	Amend	Invent
<ul style="list-style-type: none"> • dialogue/discussion /listening conversations • 'why' questions • reflective practice • draw on others experience • respect • different ways of conflict resolution • ladder of inference • walk and talk 	<ul style="list-style-type: none"> • self-doubt • impatience • being in control/ownership • assumptions • judgement/bias • competition • talking too much • fear of conflict/differences • ego 	<ul style="list-style-type: none"> • more time on understanding problem • more time and approach to questioning • listening • speaking up more • more brainstorming • valuing others contribution 	<ul style="list-style-type: none"> • new ways of working/engaging/communicating and reflecting • opportunities for new perspectives/engaging different voices • pair feedback processes • create learning environments

<ul style="list-style-type: none"> • world cafe • sharing/being open • valuing unique perspectives • open mindedness • honesty/fun/friendliness • strengthening relationship • regular catch up • prompting people to share • revisiting objectives and expectations 	<ul style="list-style-type: none"> • needing to act quickly • being task focussed • equating education with power • inward focus 	<ul style="list-style-type: none"> • continually review relationship • address power imbalance • regular time together • define engagement • language used • time for reflection 	<ul style="list-style-type: none"> • ways of addressing power imbalances • how to share learnings • new project • inclusive and culturally respectful leadership • build stories and examples of collaboration • access to new resources and tools for collaboration • keeping connected to share learnings
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Figure 1: Stages of the Collaborative Pairs trial



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