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Title Integrating policy and practice in healthcare

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies.

Name Anthony Hostick

School of Health and Social Sciences

Middlesex University

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Summary / Abstract

There are national and local concerns about a policy-practice gap in healthcare services which bring into question the effectiveness of traditional mechanisms for policy implementation.

Using clinical governance as a focus, this report describes the rationale, development and evaluation of an alternative approach designed to integrate health policy with practice within a Mental Health and Learning Disability NHS Trust through a programme of social opportunities.

A number of methodological compromises were made due to the pragmatic nature of the project and limited availability of resources to undertake the evaluation. Not all disciplines and services were involved in the approach so different methods may be needed to engage these groups. However, the potential impact of the process for local policy, practice and aspects of practice culture has been critically evaluated using a framework for policy analysis and mixed methods for implementation, data collection and analysis.

The findings suggest that the intervention was successful in providing an opportunity for practitioners to meet, network and discuss policy and practice issues and virtually all attendees valued the opportunity to participate.

Contextually, the key focus was on meeting the needs of different client groups, i.e. working age adults, older people, children and people with a learning disability. Generally, all practitioners value the principles of user-centred, safe and effective practice that underpin national policy although some are valued more than others and practice in all areas can be improved. Personal responsibility is accepted and satisfactory levels of support are available and accessed.

However, culturally there is evidence of conflict created by perceived differences between practitioner and organisational values, increased workload without added value and a need for improved interdisciplinary working and better service integration. This is particularly evident in the adult community mental health services.

A theoretical model and process to integrate policy and practice is presented that needs embedding within an organisational approach to learning that provides supportive structures, processes and cultures requiring time, leadership and management commitment.

Recommendations are made for the dissemination of findings, further development and testing of the theoretical model and process.

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Chapter 1: Introduction

This report of my final project is submitted towards an award of Doctorate in Professional Studies in Health (Integrating Policy and Practice in Healthcare) through Work-Based Learning at the University of Middlesex.

The introductory chapter establishes the focus and context of the project and provides a rationale for my role as leader of the project.

1.1 Policy and practice in healthcare

Clinical governance (Department of Health 1997) is a strand of government health policy that provides an accountability framework for the quality of clinical services within the National Health Service (NHS). Within this framework each organisation (NHS Trust) has to establish systems that ensure that their services are user-centred, effective and safe. These principles underpin national health policy within a drive to modernise health services and practice (Department of Health 1997, NHS Executive 1998, 1999).

User-centred services ensure the involvement of service users in all aspects of healthcare planning and delivery, that services are designed to meet the needs of service users and information is readily available to the public (Department of Health 2000, 2003a, 2005a). Effective practice (Department of Health 1996) requires health service practitioners to; utilise research evidence, keep their practice up to date, participate in supervision, evaluate care and maintain good records. Safe practice (Department of Health 2001a) and a safer environment (Design Council and Department of Health 2004) aim to reduce the risks to service users, staff and the public.

In addition, there is a raft of condition-specific policy such as National service Frameworks (NSF). Guidance issued by the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) both incorporate implementation detail against which the performance of all NHS Trusts is extensively monitored by the Healthcare Commission (Department of Health 2004).

Traditionally, the implementation of national health policy occurs through the development of local policy which sets the boundaries for expected practice within a defined community of practice, in this case an NHS Trust ('the Trust'). Local policy is underpinned by national policy and incorporates local context, local need and evidence and identifies the means of achieving practitioner ownership (Lindsay 2005). However, the engagement of front-line practitioners to achieve practitioner ownership is variable. Post-incident reviews, local research (Hostick and Newell 2004) and audits of practice against standards (McLelland 1998, Pounder and Hostick 2001) illustrate that there are often gaps between policy and practice bringing into question the effectiveness of traditional mechanisms for policy implementation.

1.2 Project context

The Trust provides mental health and learning disability services in urban (locality A) and rural (locality B) localities to adults, older people and children. Services are both residential and community based including specialist forensic and substance misuse services.

The community of practice is defined as those practitioners providing secondary services to users who are registered with the Trust. Practitioners are from a number of disciplines including medical, nursing, psychology, social care, occupational therapy and physiotherapy.

The timeframe for the study was April to December 2004.

1.3 Project leadership

Previous projects within my doctoral programme have focused on user involvement in the planning of services, demonstrating that service users can effectively influence policy at national and local levels if the right conditions are established. If policy can also accommodate other elements of clinical governance such as effectiveness and safety and can be successfully integrated with practice this would go a long way towards assuring clinical governance.

As head of clinical governance within the Trust, I was responsible for the development of clinical governance systems across a variety of disciplines and services against a background of often competing agendas. This required demonstrable leadership capability and effectiveness within a complex, multi-cultural environment. Through the doctoral programme I have developed my theoretical knowledge of leadership and change to underpin my practice and this final project is a fitting culmination of this programme.

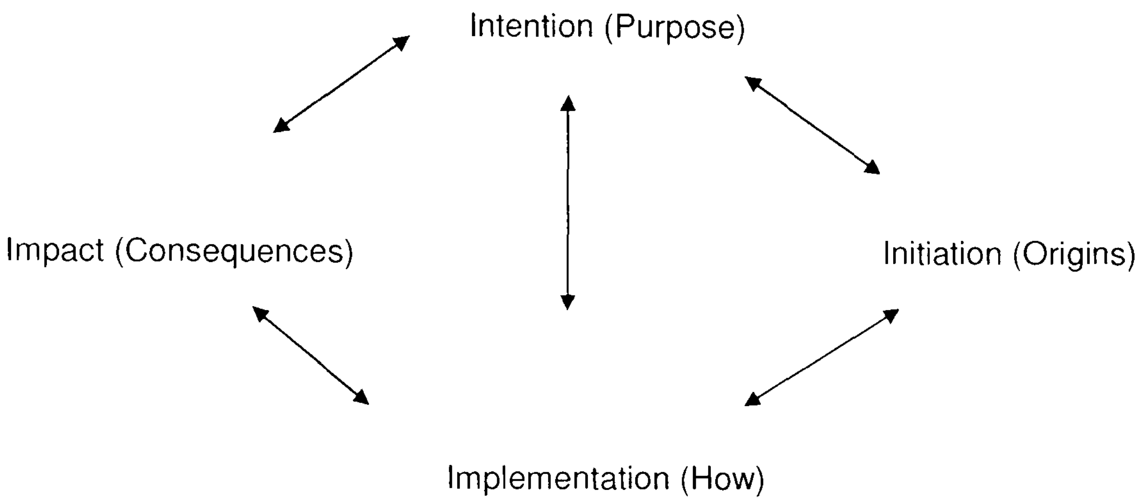
The main challenge was to find ways of integrating policy and practice within a defined community of practice. Subsequent chapters of the report outline the project's terms of reference and a literature review, describe the methodology, and present details of activity and findings with discussion and a critical commentary to develop theory. Finally, conclusions are drawn, recommendations are made and references and appendices are included to support the report.

Chapter 2: Terms of reference

Key elements of work-based projects in organisations are that activity is purposeful, focused, demonstrating leadership and above all collaboration within a 'community of practice' (Costley 2000). This chapter establishes the project's terms of reference, incorporating the project aim, objectives, research questions and literature review.

Portwood (2002) describes the inter-related stages of work related projects as intention, initiation, implementation and impact (Figure 1).

Figure 1 The inter-related stages of projects



The intention of a project may be: informative, reformative or transformative. The initiation stage requires an understanding of people including the ability to bring together ideas that conflict, imagination, design and building capability. These skills and abilities are often tacit and could be described as fitness of purpose. The implementation stage identifies the audience and the impact of a project is likely to be both positive and negative, both expected and unexpected.

The intention of this project is to provide information on perceptions of local policy and practice to inform an approach that has the potential to be reformative and transformative.

2.1 Project aim

To implement and evaluate an intervention to facilitate the integration of policy and practice within a defined community of practice.

2.2 Objectives

1. Design an intervention package to facilitate the integration of policy and practice.
2. Deliver the intervention package to groups of practitioners over a period of time.
3. Establish a baseline of current policy and practice integration and complete a cultural diagnostic
4. Evaluate the package and the potential impact of the package on policy and practice integration and culture.
5. Produce a project report incorporating critical commentary and theory on sustainable change management to improve practice quality.

2.3 Research questions

The main evaluative question in relation to the intervention package is 'what works for whom in what context?' and in relation to integrating policy and practice in mental health and learning disability services is 'what can work for whom in what context?'

2.4 Literature / policy review

The scope of literature to underpin this project is potentially vast; therefore any review must be selective and cumulative. An iterative search of published literature was undertaken to achieve a balance between the amount of available information (recall) and the proportion which is relevant to the study (precision). Free-text search terms included: policy, health and social care policy, quality, clinical governance and evidence-based practice combined with implementation and integration. These searches were focused predominantly on mental health and learning disability services in England over the past twenty years (1986 - 2006). Further searches on organisational culture, change, learning and leadership were undertaken of the international literature over the past fifty years (1956-2006).

Electronic databases relevant to the areas specified above were accessed through an internet gateway (ATHENS) at the University of Middlesex. Databases include those with management information (Proquest / ABI Inform), health information (King's Fund, Embase, Medline, Cinahl, Cochrane Library, Social Science Citation Index (SSCI)) and psychological information (Psycinfo).

The search strategy incorporated the reading lists from course material, directories including the National Electronic Library for Health which includes links to the Department of Health and the Research Findings Register (ReFeR) for yet-to-be-published research findings. Books, systematic reviews, academic papers, pre-publication research reports, appropriate evidence from local studies and policy documents were all utilised. Key journals were also checked by hand and reference lists and citations tracked to ensure a comprehensive search. References within the included material provided further sources that were found and incorporated up until the end of April 2006. A summary review of the relevant literature discovered is provided.

2.5 Public policy and the study of policy implementation

There is a lack of consensus on the definition of public policy although Birkland (2001) indicates that the elements common to all definitions of public policy are as follows:

> The policy is made in the name of the "public".
>
> Policy is generally made or initiated by government.
>
> Policy is interpreted and implemented by public and private actors.
>
> Policy is what the government intends to do.
>
> Policy is what the government chooses not to do. (Birkland p20)

Policy implementation studies developed out of two related concerns (Pressman and Wildavsky 1973). Firstly, the failure of bureaucracies to implement policy decisions constituted a failure of democratic authority. Secondly, it seemed that good policy ideas often foundered through administration. The development of the discipline of policy analysis can be tracked through the utilisation of compliance models, street-level bureaucracy models and analytic models.

Early policy studies sought to identify what interfered with the linear relationship between legislation and realisation, or compliance (Van Meter and Van Horn 1974, Sabatier and Mazmanian 1979). These studies provided advice on achieving greater allegiance between policymaking and policy delivery but there was increasing doubt cast on the authority that policy carried due to its ambiguity, discretion and complexity, and the complexity and autonomy of bureaucracies.

The study of street-level bureaucracies (Lipsky 1980) provided a template that virtually reversed the normative premises of a policy hierarchy through the identification of policy deliverers as policy makers. One of the main implications of this is that unless policy can be made simpler, then recommendations to increase command and control are less likely to succeed. Discretion needs to be incorporated as does a focus on methods for the development of implementation plans from the bottom up (Elmore 1979).

A third wave of implementation research, termed policy analysis, provides a general approach to issues in public policy that considers the policy making process, its context and the use and development of theory (Jenkins 1978, Hogwood & Gunn 1984, Parsons 1995). Some of its roots are in political science and assumptions that the social world is occupied by actors with different and sometimes conflicting interests and with differences in power relative to each other, and those institutional arrangements (government and organisations) are important mediators of the outcomes of these differences.

If government is taken to include local public agencies, a useful definition of the focus of policy analysis is what governments do, why they do it and what difference it makes (Heidenheimer et al 1990:3). This provides a conceptual framework for studying policy in Health and Social care services.

2.6 Health and social care policy

Contextually, the NHS was an administered rather than a managed system from its foundation in 1948 (Ham 1991) and quality was considered to be the domain of the healthcare professions within it (Donaldson and Gray 1998). In the early 1980's the main focus of government policy was on how to make the NHS more business-like and efficient. Griffiths (1983) described a lack of clear accountability and recommended that administrators should be replaced by managers who should be given performance targets and held to account. These recommendations were put in place and consequently general management replaced consensus management. The next significant policy development was the separation of purchaser and provider responsibilities (Department of Health 1989) to create an internal market in the NHS thereby improving quality by fostering competition. However there was little connection between management and professionally based quality initiatives resulting in fragmentation.

In the late 1990's a number of high profile cases illustrated this lack of a systematic approach to quality in the NHS. There was growing criticism about the effectiveness of professional self regulation and pressure to increase public access to the knowledge base of healthcare professionals (Sutherland and Dawson 1998). The government set out its vision to modernise the NHS and replace the internal market with integrated care and an approach to combine efficiency and quality (Department of Health 1997).

A government white paper (Department of Health 1998a) announced the failure of Care in the Community as planned in the 'NHS and Community Care Act 1990' (Her Majesty's Stationary Office) and an overhaul of mental health services alongside a review of social services (Department of Health 1998b). The white paper established plans to produce National Service Frameworks (NSF) for mental health of working age adults and a NSF for older people that would include mental health.

The NSF for adult mental health (Department of Health 1999) set out standards and service models to promote mental health and treat mental illness. Standard one addressed mental health promotion and the discrimination and social exclusion associated with mental health problems. Standards two and three covered primary care and access to services for anyone experiencing a mental health problem. Standards four and five covered effective services for people with severe mental illness. Standard six related to individuals who care for people with mental health problems and standard seven drew together the action necessary to achieve the target to reduce suicides as set out in *Saving Lives: Our Healthier Nation* (Department of Health 1998c). The policy acknowledged the challenging nature of the standards, which also included service models and performance assessment arrangements. The integration of the Care Programme Approach (CPA) (Department of Health 1991) and care management, carer's assessments, mental health promotion, stronger links with primary care, increased access to psychological therapies, 24 hour responsive services, assertive outreach, crisis services, liaison services, services to prisoners all had implications for providers of community mental health services in particular. The NSF was followed by a range of policy implementation guides detailing requirements for service models including assertive outreach services, crisis resolution and home treatment, personality disorder and dual diagnosis alongside a number of Clinical Guidelines published by the National Institute of Clinical Excellence (NICE) on schizophrenia, depression and anxiety, self-harm, managing violence and so on.

In contrast, the NSF for older people (Department of Health 2001b) had one standard relating to mental health in older people emphasising the need for health and social care integration although it also had a standard on person-centred care and single assessments. In terms of NICE guidelines there is a standard for falls prevention in older people and guidance on the use of anti-Alzheimer medication.

There has been a more recent policy 'Securing better mental health for older adults' (Department of Health 2005b) but this has been issued since the project finished.

Policy for learning disabilities was outlined in a white paper 'Better Services for the Mentally Handicapped' (Department of Health and Social Security 1971) with a focus on increasing community services, and 'normalising' the lives of people with learning disabilities (Wolfensberger 1972). The policy recognised that achieving change would 'require sustained action over many years', a prediction that proved to be correct. The long overdue follow-up policy document 'Valuing People' (Department of Health 2001c) is based on people having: their rights as citizens, inclusion in local communities, choice in daily life and real chances to be independent. Once again the policy recognises there are 'no quick fixes' but sets out issues to be addressed including families with disabled children, young disabled people at the point of transition to adult life, carers, choice and control, health care, housing, day services, social isolation, employment, minority ethnic communities.

It is argued that this policy approach reflects a shift to more centralised control than previously since the Labour government came to power in 1997 (Ham 1999). In support of this argument, Hurford (2003) summarised research that considered the way that policy has worked in mental health services and suggests that the macro level of policy formation has dominated the policy process. The conclusion is that a top-down approach to policy formulation is encouraging uniformity of service delivery and practice, but this may be stifling creativity with policy activity becoming less than the sum of its parts.

Different professional groups in mental health services have also felt the impact. Frank (2004) refers to a climate of excessive bureaucracy and risk management having a damaging effect on effective mental health nursing care and Barry (2006) identifies a context of massive demand and expansion underpinned by recent health policy developments when considering the clinical governance implications for psychological therapies.

Compounding this sense of pressure, Walker (2000) argues that government policy incorporates powerful political forces of inertia, expediency, ideology and finance and the current dominating force is clearly finance as outlined in the current operating framework for the NHS (Department of Health 2006). This pressure to deliver improvements to healthcare and an emphasis on financial control means that any quality improvements will need to be achieved within existing resources.

2.7 Quality and clinical governance

Clinical governance (Department of Health 1997) is a strand of government health policy that provides an accountability framework for the quality of clinical services within the National Health Service (NHS). However, the impact of clinical governance is still unclear due to a number of reasons. Quality improvement is complex (Pollitt 1996, Blumenthal and Kilo 1998) and it is difficult to evaluate any degree of reformative impact (modifying) or transformative impact (establishing new patterns) without follow-up over time, a point made by Walker (2000). Pascale et al (1997) and Vierling-Huang (1999) also illustrate how long it takes to effect transformational change in large organisations.

Quality is difficult to define and to measure (Ellis and Whittington 1993, Dale 1994) although it is necessary to be explicit about what it means in order to manage and improve it (Moss 1995). The clinical governance agenda can be summarised as a drive for ensuring user involvement in all aspects of healthcare and to developing services that are user-centred (Department of Health 2000, 2003a, 2005a), safe (Department of Health 1993, 2001a, Design Council and Department of Health 2004) and effective (Department of Health 1996, Walshe and Ham 1997). Clinical governance encompasses the establishment of organisational systems for clinical performance and appraisal and for delivering cultural change through transformational leadership.

Annual national surveys of mental health service users (Healthcare Commission 2003, 2004a, 2005a) and staff (Healthcare Commission 2004b, 2005b) are now undertaken which have the potential to measure the impact of quality improvements over time although the challenge of improving service quality remains.

2.8 Policy into practice

Walshe et al (2000) completed a study to explore and describe the development of clinical governance in one NHS region. They concluded that important progress had been made and that much of the machinery to support clinical governance was in place, however there has yet to be a real difference at the clinical workface and that the required changes in culture had not really begun to happen.

There is a specific concern with how to get evidence into practice (Nutley et al 2003) and whilst policy, evidence and research are not the same thing, policy often incorporates evidence that incorporates research and the challenge is similar, namely; how to address the research-practice gap (Institute of Medicine 1999) or what could be termed a policy-practice gap.

A range of approaches is available for getting evidence into practice as summarised in an annotated bibliography for clinical governance (Nuffield Institute for Health 2001). The evidence base is predominantly medical and an Effective Health Care Bulletin (University of York 2000) concludes that there are three critical requirements that need to be combined for success:

1. High quality evidence, which needs to be operationally defined and incorporate research, consensus, clinical experience, consumer experience

2. Context, which requires a diagnostic of culture (barriers / enhancements), priorities, leadership, evaluation systems (clinical, economic, satisfaction), resources (time / people)

3. Skilled facilitation including the roles and skills associated with evaluator / researcher, educator / facilitator, change management, expert / opinion leader.

These three critical requirements require further consideration. Traditionally, practitioners rarely rely on research to guide their practice (Rosen et al 1995) and there are a number of hierarchies of evidence. In biomedical science there is general agreement over a hierarchy. The higher a methodology is ranked, the more robust and closer to objective truth it is assumed to be as exampled by Sheffield Centre for Health and Related Research (2002). The social care evidence base, in contrast, is much more elaborate and much more contested. A key criterion of quality will be 'fitness for purpose' or the degree to which a given type of evidence addresses the question posed. In nursing and therapies practice other forms of evidence are acknowledged including the views of patients and carers. In organisational / management sciences, there is a lack of empirical evidence on decision-making in all industries - especially at the top management level (Harrison, 1999, p.345). Much of the literature consists of anecdotes, opinions and case studies that are difficult to collate or to theories or ideas produced by “gurus” that appear plausible but in the end have only anecdotal support – something noted by Iles and Sutherland (2001). It is therefore worth considering what different professions will accept or value as evidence as this is likely to have an impact on the uptake of evidence.

Research, evidence or policy can be taken as the ‘know about’ and the ‘know what’, an understanding of context and culture as the ‘know who’ and the ‘know why’ and facilitation or leadership as the ‘know how’ (Nutley et al 2003). The ‘know about’ and ‘know what’ are usually explicit in the form of research findings or policy documents. It is the other dimensions of knowledge and knowing that are more often tacit understandings and it is these understandings that this project is more concerned with.

There are many studies that identify difficulties with the implementation of evidence-based practice that are not related to the quality of the research or researchers. Local studies to identify barriers to getting research findings into practice for nurses and therapists (Closs and Lewin 1998, Griffiths et al 2001, Metcalfe et al 2001, Bryar et al 2003) have highlighted a number of obstacles. These include: insufficient time available to consider practice and improvement, and a lack of peer support. Other studies have identified high clinical workloads, lack of time and managerial support (Welch 2002) and a lack of organisational support (Thompson 2001). An exploration of the feasibility of implementing guidelines in routine practice highlights resource deficits in budgets, information and the system’s capacity to deliver sufficient educational activities (Whitty et al 2004).

Considering a lack of time and high workloads are major barriers then the guidance / guidelines that are now published by the National Institute for Health and Clinical Excellence (NICE) should be a real boon to busy practitioners. These are based on a systematic review of clinical and cost effectiveness and an emphasis on user involvement in clinical decision-making. However, the guidance issued by NICE (2005) on implementation is presented as a relatively simplistic stepped approach of: assessing the relevance; identifying an implementation lead; identifying an implementation group; completing a baseline audit; assessing costs and savings; developing an action plan; delivering training; communicating recommendations; improving access to services; monitoring and follow-up. The responsibility for achieving this is placed with the Chief Executive of each NHS Trust through clinical governance arrangements. This still depends on time and resources being available and is reminiscent of early approaches to the reliance on compliance as a means of policy implementation.

Similarly, a systematic approach to the development of local policy is described in detail (Lindsay 2005) but the section on implementation is limited to 'there needs to be rigorous systems for staff induction and training' (Lindsay 2005 p172). Clinical studies into policy implementation are relatively scarce. Early evaluation of detailed case studies on the implementation of National Service Frameworks (NSF) in Primary Care suggests that variable progress is being made although it is too early to assess the impact (Sheaff 2006). The mental health NSF is proving more difficult to implement than the one for coronary heart disease and many practices lack the necessary skills and information systems. A project with nurses in long term environments for older people (Tolson et al 2005) identified that key problems for accessing policy information were: little time available to keep up to date, compounded by communication inefficiencies and limited access to the internet. Outputs from focus groups with clinicians on policy implementation illustrated that clinicians have considerable discretion over whether and how particular policies are adopted and that their practices were not changing to the extent one might expect (Braithwaite et al 2003). Getting policy into practice is clearly not straightforward and attempts can be confounded by the organisational context of healthcare.

2.9 Organisational context

The NHS Trust in this study became a specialist mental health and learning disability Trust from April 2004 and the timeframe for delivering the study was April to December 2004. The Trust provides mental health and learning disability services in urban (locality A) and rural (locality B) localities to adults, older people and children. Services are both residential and community based and include specialist forensic and substance misuse services. The Trust is a relatively mature organisation locally. Despite its maturity, it is difficult to define the culture of the organisation (Garnett 2000) other than it being multi-cultural due to its complexity. The complexity is characterised by professional boundaries, local boundaries, client-group boundaries, boundaries between health and social care, health and welfare, health and education, health and ethnicity. There are organisational boundaries between Primary Care Trusts, Healthcare Trusts, Foundation Trusts, Local Authorities, the voluntary sector and the independent sector.

These boundaries pose challenges for communication and joint working between agencies as reflected in the national policy programme over the past ten years (Cooney and Wilson 2005). The NHS does not have a history of strong corporate culture and leadership. NHS Trusts are more likely to have complex formal and informal systems of clinical and managerial leadership with low cultural coherence and few shared cultural values (Walshe et al 2000) within which a number of different professional cultures dominate (Pollitt 1996).

Whilst the professions share responsibility for; care, improving services; reporting outcomes; leading and acting as role models; maintaining and increasing quality there are a number of differences that impact on the effectiveness of inter-professional working. Professional backgrounds are by definition different in terms of their education, status and financial reward (Vanclay 1997). Consultant psychiatrists have a legal responsibility in their role as Responsible Medical Officer as do Approved Social Workers under the Mental Health Act 1983. However, psychiatrists are not, as is often assumed, responsible for the practice of other disciplines within teams and services. Many nurses have not been used to assuming lead roles within organisations or even clinical teams (Ward 2005) and are more prone to using intuitive approaches to clinical decision-making (Cioffi 1997). Whilst some services, such as those for people with a learning disability, are committed to an explicit social model of disability, normalisation and daily living (O'Brien 1988) there is less adherence to an agreed approach in adult mental health services. The King's Fund London Commission (1997) pointed to systemic problems in inter-agency and inter-professional working within mental health services; including disagreements between professionals on what constitutes mental health and illness and the effectiveness of treatment approaches. Norman and Peck (1999) suggest that within in-patient services hierarchical relationships are more clearly defined with less jostling between professions whereas in many Community Mental Health Teams (CMHT) some powerful professions (consultant psychiatrists or clinical psychologists) exempt themselves from the workings of the team including the notion of accountability to the manager. Galvin and McCarthy (1994) suggest that the under functioning of CMHTs is due to a lack of clarity on purpose, role and relationships whilst Onyett and Ford (1996) suggest that either clinical staff do not respect or comply with requests from management or that management is weak. Using the Care Programme Approach (CPA) as a prime example many psychiatrists are reluctant to comply with what are perceived as centralised bureaucratic systems of service delivery fashioned by policy makers and managers not involved directly in service delivery (Peck and Parker 1998). Specialist teams have now been established with a clearer purpose and philosophy including those delivering assertive outreach, early intervention in psychosis and crisis resolution. However, CMHT's still exist as do models of general psychiatry delivered within sectors or localities.

These examples illustrate some of the power issues at play within NHS organisations with particular reference to community mental health services for adults. Power, or informal authority, can be defined as the ability of a person or group to secure compliance from another person or group. Authority, or legitimate power, is the right to seek compliance from others. Managerialism is an ideology that seeks to increase managerial power at the expense of clinical power in the NHS (Peck 1991) through the control of resources and conditions whilst clinical governance seeks to restore a balance in power through the development of clinical leaders. Leadership can be defined as the ability of an individual to exercise influence over and above the required mechanical compliance. However, the development of general management in the NHS over the past twenty years and top-down messages of performance management, expediency and efficiency do not necessarily sit comfortably alongside quality values (Firth-Cozens 2005).

Organisations are political systems (Morgan 1986) and politics are those activities taken within organisations to acquire, develop, and use power and other resources. Political behaviour is initiated to overcome opposition and if there is no opposition political activity is not necessary. This means that if the status quo is threatened there is an increase in organisational politics and an increased proportion of political over rational decision-making. Therefore, when change is required it may be perceived as a threat to the individual interests of both managers and clinicians (Povey 1996, Dawson 1992). This can create overt or covert resistance in order to maintain the status quo (Bate 1994) and there are concerns that sufficient attention has not been paid to conflicting interests within organisations (Thompson and McHugh 1995, Collins 1998, Buchanan and Badham 1999).

The national political forces of inertia, expediency, ideology and finance (Walker 2000) also operate at a local level and local research into service quality (Hostick 1995, 1998, McClelland 1998, Hostick and McClelland 2000, 2002, Hostick and Newell 2004, Walsh and Hostick 2005) has had relatively little impact on improving local services. The corporate infrastructure and processes to support clinical governance were well established and had received a positive review by the Healthcare Commission. These arrangements include the process for developing local policy that is underpinned by national policy, incorporating local context, local need and evidence and identifying the means of achieving practitioner ownership (Lindsay 2005). However engagement of front-line practitioners to achieve practitioner ownership is extremely variable. Post-incident reviews, local research (Hostick and Newell 2004) and audits of practice against standards (McLelland 1998, Pounder and Hostick 2001) illustrate that there are often gaps between policy and practice bringing into question the effectiveness of traditional mechanisms for the implementation of both policy and research findings.

Evidence suggests that mental health services were experiencing degrees of stress both nationally (Kelly 1998, Ford et al 1999, Davis 2002) and locally (Pounder and Hostick 2001) and this is likely to affect the quality of care delivered (Firth-Cozens 2001). Stress levels were found to be higher among healthcare staff than the general working population (Wall et al 1997), particularly for psychiatrists (Deary et al 1996) and mental health nurses (Fagin et al 1996). "Stress...can only be sensibly defined as a perceptual phenomenon arising from a comparison between the demands on a person and his ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the experience of stress and the stress response. Coping is both psychological (involving cognitive and behavioural strategies) and physiological." (Cox 1978 p25). This definition can be applied to both individuals and organisations. Palmer et al (2001) identify a number of potential hazards for employees including; culture, demands, control, role, change, relationships and support that can result in symptoms of organisational stress including increased irritability and negative emotions.

The organisational context is therefore complex. The growth of managerial power and the potential for problems in inter-professional and inter-agency relationships are key cultural issues that will impact on the integration of clinical policy and practice and can potentially generate organisational stress. If clinical governance is to have an impact there is a need for greater cultural change than previously achieved requiring the means for studying culture and influencing culture through politics and leadership.

2.10 Organisational culture

The study of organisations, culture and change is conceptually challenging but this challenge needs to be addressed satisfactorily if the project is to be successful. Morgan (1986) presents metaphors as images of organisations. Metaphors include organisations as machines, organisms, brains, cultures, political systems, psychic prisons, flux and transformation, instruments of domination and ultimately as a way of thinking. He then goes on to explore the strengths and limitations of each. Each has some appeal and can contribute to the design of this study particularly images of organisms, culture and political systems.

Bate (1994) argues that organisations are cultures rather than having culture, suggesting that organisational change and culture change are the same thing and there is a need for the cultural strategist to think culturally. It is argued that culture emerges from social interactions as the product of negotiated and shared symbols and meanings (e.g. jargon, verbal and non-verbal communication). The constant interaction between the individual and culture is fundamental to any study of culture or for that matter personality and provides us with a theory for studying both organisations and culture. The proposition being that 'an organisation or part of an organisation may be viewed as an association of individuals, and it is those individuals who develop the constructs that we categorise as structure and culture. Consequently the behaviour of individual actors is considered to be a key concept in the study of culture' (Stapley 1996, p12).

This offers great potential for the study of NHS Trusts which in systemic terms can be framed as organisations in their own right but are characterised by many micro organisations defined by boundaries of profession, client group, role, function, location and so on. By considering the values and behaviours of individuals within an organisation (practitioners within an NHS Trust) we can identify and therefore compare the culture at both organisational and practice levels comparing patterns within the system including thinking, behaviours, relationships, trust, values, conversation, communication, learning, decision-making, conflict and power (Capra 1996, 2002).

This in itself would be extremely useful to inform future actions but Stapley (1996) goes on to suggest that understanding the relationship between culture and change is necessary if we are to achieve constructive change in organisations. At the centre of the process are the individual members of an organisation, their mental processes and allegiances. Etzioni (1961, 1964) highlights that the type of involvement displayed by an employee is closely related to the form of power and authority used in an organisation. Culture is a construct, and the source of that construct is the human mind, therefore we need a means of interpreting the conscious and unconscious behaviour of the individual actors within various boundaried groups within organisations.

Clinical perspectives of management (Kets De Vries 1995) and psychodynamic theories of organisations (Stapley 1996) both have intuitive appeal for application in healthcare and especially the latter within mental health and learning disability services. Essentially, the members of an organisation(s) will produce forms of behaviour that will be psychologically advantageous to them under the conditions imposed by the environment. Ultimately if there is a basic trust in the 'holding environment' or organisation there is likely to be a task supportive culture. However, if there is no basic trust and the 'holding environment 'is viewed as being either socially, physically and/or psychologically 'not good enough' there is likely to be an anti-task culture. It is a dynamic and changing process (Stapley 1996).

In support of this line of reasoning it has been suggested that if change or policy is values-based and these values are in line with the values of those expected to implement change or policy this will lead to trust and increased chances of success (Nolan and Grant 1993, Fulford and Williams 2003). Forrester (1969) classified human services as complex social systems that have certain characteristics that engender resistance to planned reform and these characteristics reflect human tendencies. Kelman and Hamilton (1989) describe three processes of social influence that are fundamental to achieving sustainable change. Compliance: which is in response to rules and the behaviour is usually of short duration; identification which is in response to a role or relationship to another person or group (e.g. professional); and internalisation which means that people behave in particular ways that fit with their value system. A key point being that internalisation is internally driven whereas compliance and identification are externally driven.

Schein (1992) suggests that cultural analysis has aided understanding of situations when different subcultures and occupational groups must work with each other. Most organisational change usually involves some change in culture; leaders create and modify cultures and at times of disruption there is potential for culture formation.

2.11 Organisational change

Iles and Sutherland (2001) provide a review of organisational change and highlight a number of approaches that can be utilised from a number of sources, predominantly using a systems metaphor for organisations that may be useful in some parts of the NHS. Small-scale changes to practice have been demonstrated through Plan, Do, Study, Act (PDSA) cycles (Berwick 1998) and collaborative approaches (Northern Centre for Mental Health 2002). In quality improvement terms these potentially culminate over time to realise large-scale benefits.

However, Glouberman and Zimmerman (2002) identify important distinctions between simple, complicated and complex problems requiring different approaches. The application of systems thinking to simple or complicated problems means that simple problems lend themselves to a recipe approach, complicated problems are best dealt with using formulaic and expert-knowledge approaches, whilst complex problems, due to their nature, are likely to require different approaches altogether.

Healthcare and healthcare organisations can be viewed as complex, adaptive systems (Plsek and Greenhalgh 2001, Sweeney and Griffiths 2002). A complex adaptive system is a collection of individual agents who have the freedom to act in ways that are not always totally predictable, and whose actions are interconnected such that one agent's actions change the context for other agents. Complexity theory (Battram 1998, Wood 2000) supports the notion that any approach to change needs to consider the whole system, however defined.

Therefore if the context is complex it is unlikely that simple structures, tools or 'recipe' methods will have anything other than small-scale impact on parts of the health system and there are difficulties associated with 'implementation' through linear, rational management or establishing the 'correct' way to implement (Schwandt 1997). An alternative view is to allow people to work at the edge of chaos (a point between over-structured inertia and under-structured confusion (Connor 1998)) where a self-organising approach arises from chaos and the choices are to try and impose order or exploit the chaos by working within it.

An overview of conceptual frameworks that can inform the implementation of evidence-based practice is provided by (Nutley et al 2003) who review the literature on the diffusion of innovations, institutional theory, organisational change, knowledge management, individual learning and organisational learning. Davies et al (2000) identify a range of interventions that could be considered and Halladay and Bero (2000) identify the potential for clinical governance as a vehicle for developing organisational learning.

2.12 Organisational learning

Organisational learning (Dodgson 1993, Starkey 1996, Schmidt 2000, Stacey 2001, Collin 2001) requires both adaptive and generative learning (Senge 1990, 1999) to develop organisational fitness (Argyris and Schon 1996). The emergence of a knowledge economy reflects a shift in focus from training to education (Meister 1998) that requires an understanding of theories of knowledge and learning, soft methodologies, culture and values (Zuber-Skerritt 2005). Much of the clinical governance guidance refers to the development of both training and education which is driven by the need for continuous professional development, revalidation and appraisal (Stevens and Hettiaratchy 2005). Training is needed to develop competence and education to develop capability (Sainsbury Centre for Mental Health 2001). A major challenge is to develop multi-disciplinary programmes rather than uni-disciplinary as the requirements of each profession vary. This places extra demands on scarce resources therefore innovative approaches are needed and an organisational approach to learning that establishes supportive structures, processes and cultures to balance adaptive learning through a policy framework and monitoring with generative learning through opportunities for local invention and experimentation (Hargreaves 1998) could be utilised.

The literature provides a number of key elements that could be incorporated into such an approach, indeed the use of multifaceted interventions are more likely to result in favourable change than single interventions (Proctor 2004). Key factors for success are leadership, clarity of expectation, resources, support, training and education and planning for the sustainability of change (Redfern 2002, Bergen and While 2005).

More specifically, evidence suggests that wider national initiatives often have more effect on practice (Wright 2001) and that the influence of the Trust board is paramount (Williams 2000). There needs to be a clearly articulated vision, focus on shared purpose (Garside 1998) and evidence of commitment from the top (Klein and Sorra 1996) with the promotion of core values and actions to deliver strategic goals (Anthony 1990, Hackett and Spurgeon 1996).

Culture is a mediating variable (Hackett and Spurgeon 1999) and times of change are opportunities for culture formation (Schein 1992, Redfern 2002). There needs to be a perceived problem and the need for a new approach and potential adopters need to view the approach as offering some benefit or advantage (Rogers 1995) to be successful. The problem should be relevant to the practitioner, client, service system or community context (Schoenwald and Hoagwood 2001) and compatible with their values, beliefs and past experience (Henggeler et al 2002, Bergen and While 2005).

Any approach should be easy to understand and assimilate (Berwick 2003). A balance needs to be struck between the use of guiding principles and rules

(Wood 2000) as learning arises from taking risks and making mistakes (Grint 1997, Holt 1996) and an over reliance on rules often results in the discouragement of subordinate initiative and risk taking. Individuals tend to work on the minimum specification to get the work done and order is built from relationships rather than enforced by structures (Battram 1998, Wood 2000) so explicit trust in the motives and abilities of professionals (Davies and Lampel 1998) is required.

Collaboration and shared governance (Scott and Caress 2005) can be achieved through alliances with internal and external powerbrokers, involvement of multidisciplinary staff as actors not recipients and iterative approaches (Garside 1998). Team based approaches have particular potential (Beer et al 1990) as does social influence through informal approaches and networks that allow dialogue with peers, colleagues (McIntosh 2001) and opinion leaders (Rogers 1995, Grimshaw 2001). The development of consensus statements may be useful as internally produced evidence (Ferlie 2001a, Berwick 2003, Procter and Rosen 2004) and ideas are often more influential than data or systematic reviews (Lavis et al 2003).

A willingness to engage in dialogue about differences between academia, research and practice (Rogers 2001) and differences between managers and different disciplines (Degeling et al 1999) can provide the impetus for progress and the use of rewards and disincentives (Berwick 2003) and reminders (Institute of Medicine 2001) can increase success.

Many of these recommendations reflect an emerging worldview (Dent 1999) requiring an iterative approach (Garside 1998) rather than a traditional worldview. The diffusion of innovations is characterised as a nonlinear, dynamic system (Van de Ven et al 1999) that needs to be considered against the social and political context and the regulative, normative and cognitive aspects of the environment (Scott 1995). Sanderson (2006) calls for normative concerns to be embraced within practical rationality as an approach to achieve improvements within complex social systems. The means for balancing these polarised views is offered by Johnson (1996) through an approach to managing complexity in which he identifies polarities as dilemmas, or interdependent opposites to be managed, as distinct from problems to be solved. If policy and practice are interdependent opposites then polarity management provides a framework for managing both and the focus is framed as a process for achieving policy-practice integration rather than policy implementation requiring effective leadership.

2.14 Leadership

Heifetz (1994) distinguishes between technical or management issues and adaptive responses or leadership and differentiates between authority, or power derived from a formal role, and leadership, or power derived from an informal role. Despite the fact that the NHS is changing radically and leadership is now being encouraged rather than inhibited (Elgie 1995) the management of the NHS is still generally through hierarchies and traditional management approaches. Seddon (2003) is one critic of modernisation and performance management in the public sector as he claims there are no reliable methods for the setting of targets. He argues that traditionally managers manage work according to the work plan; the principal tools used are the budget and work standards hence managers become preoccupied with productivity measures.

A review of the literature on leadership and management styles (Stogdill & Bass 1981, Smith and Peterson 1988, Tomey 2000, Grint 2000, Bennis et al 2001, Pond 2002) provides theories of leadership and management which emphasise leadership attributes and skills. Traits theory, situational and contingency theory through to the development of transformational theory are discussed in an attempt to relate leadership theory to skills, practice and development and in particular to change. Contingency and situational models of leadership (Fiedler 1967, Adair 1973, Grant and Massey 1999) require leaders to develop a thorough understanding of position power, leader-follower relationships and the task structure.

Transformational leadership is described as leadership driven by the needs of followers (Stogdill and Bass 1981) and Bass (1985) asserts that leaders can transform followers by persuading them to subordinate their individual wants to the needs of the collective. The approach is a dynamic inter-relationship between leader's behaviours, follower's behaviours and situational factors that produces major change, higher effort by the followers, greater satisfaction and increased cohesiveness (Bennis et al 2001). Joynson and Forrester (1995) argue that the solutions to most organisational problems are already known to workers but formal leaders prevent them from implementing solutions. Change is predicated on the 'buy in' of managers, many of whom may not want to 'buy in' (Smith 2001) and without the will or commitment of both leaders and followers then any progress is likely to be minimal (Stewart 2001). Elgie (1995) recognises that leadership effectiveness is limited by the institutional structure within which leaders operate and that the appointment, monitoring, reward and accountability structures and processes all play some part in inhibiting and / or encouraging certain forms of leadership particularly in the public sector. Emotional Intelligence (EI) (Goleman 1986) which includes self awareness, self management, social awareness and social skill is viewed as being fundamental to achieving transformational change.

A literature review on leadership by the Performance and Innovation Unit (Department of Health 2003b) for the NHS provides a contemporary reference for public sector leadership and identifies guiding principles of self-supporting leadership teams, leadership institutions, cultural coherence, the use of principles, complexity, diversity, public service, acquired skill and deployed will and win / win negotiations.

Consideration of the unconscious aspects of work (Obholzer and Roberts 1994, Obholzer 1996) and the psychoanalytic contributions to authority and leadership also offer an understanding of some of the contextual relationship issues for aspiring leaders or agents of change. The influence of sentient systems within organisations is key and similar to the views of Egan (1993) who refers to the 'shadow side' of organisations. Other issues include containment, the effects of not being listened to, the importance of boundaries, the presence of task oriented work groups and basic assumption groups and the nature of envy.

2.15 Summary

To summarise, there is a concerted effort to improve health service quality through policy implementation. Policy studies differentiate between implementation / compliance models, street-level bureaucracy models and analytic models. Linear implementation models have limited impact on practice and pose significant challenges relating to context, culture and change. Contextually, the NHS can be viewed as a complex adaptive system as can NHS organisations and parts of NHS organisations. A psychodynamic view of organisations has appeal in that the culture of an organisation is formed by the personalities and interactions of the individuals within it. Moreover organisational culture can be studied. There are convincing arguments that leadership and cultural change are inextricably linked. Policy and practice can be seen as interdependent opposites or polarities that need to be managed and the literature emphasises the importance of the social context and collaborative approaches to effect change. A convergence of theoretical perspectives and available evidence provide the basis on which to develop a package to integrate aspects of local health policy with the needs of practitioners.

To evaluate the impact of this package a framework is needed that can: accommodate both the presentation of explicit norms and values and capture the tacit knowledge and personal values of practitioners; assist in the diagnosis of the pervading culture or cultures; and measure the potential for change in aspects of organisational culture and behaviour. This will inform the development of a theoretical model for achieving sustainable change management to improve practice quality.

Chapter 3: Methodology

Research methodology relates to an approach or way of going about research, a paradigm or worldview based on epistemology and ontology (nature and derivation of knowledge and what can be known) and theory or explanation of methods. Potentially, a wide choice of approaches can be adopted to study the organisation and delivery of health services and there are a number of considerations including: research type (paradigm); researcher role; focus on process or outcomes; role of context; issues of generalisability, reliability and validity; and the types of methods used (Fulop et al 2001). These considerations are addressed throughout this chapter.

3.1 Study paradigm

Four main paradigms can be summarised as; positivist, relying on objectivity and deductive approaches (hard, quantitative); interpretivist that relies on subjectivity and inductive approaches (soft, qualitative); pragmatic (Howe 1988) which argues that both approaches are compatible and indeed complementary; and critical that accepts the place of both hard and soft but emphasises the oppressing and inequitable nature of social systems. These paradigms are often presented as competing although all have practical applications dependent on purpose and the investigators personal beliefs and values (axiology).

The main driver for this project is, as illustrated through the literature review, a complex, practice problem (integration of policy and practice). This requires both social and political considerations of actor's behaviours within a community of practice and as there are conflicting interests a critical paradigm is adopted. An appropriate conceptual framework for studying the integration of policy and practice is policy analysis and a rationale for this approach is presented.

Within the framework it is likely that an appropriate design will be multi-methodological (Mingers and Gill 1997) due to the complexity of the study context. This is not to say 'anything goes' but does mean that 'we can explore more freely what does 'go, when and why' (Rosenhead 2001, pxiv).

The integration of policy and practice as opposed to the implementation of policy requires a formative approach and makes this explicit within the study design through action research (Meyer 2001) as the intention was to change practice through action. The action research element lends itself to the intervention process which also requires evaluating and 'realistic evaluation' (Pawson and Tilley 1997) incorporates measures of both context and processes which inform issues of generalisability, reliability and validity. Qualitative and quantitative methods of data capture and analysis are combined to capture aspects of the process, context and outcomes, and to strengthen the quality of the data. These elements need to be considered in more detail.

3.2 Policy analysis

Policy analysis, provides a general approach to issues in public policy that considers the policy making process, its context and the use and development of theory (Jenkins 1978, Hogwood & Gunn 1984 and Parsons 1995, Weimer and Vining 2005). It can take place at the level of local health care organisations implying some overlap with organisational studies. It overlaps with organisational studies in its interest in how policies are implemented at local level. Similarities between organisational and policy analysis include an emphasis on the study of decision-making, the importance of context, development of theory, the need to pay attention to values as well as facts. Key explanatory concepts are shared (agenda setting, non-decision-making, symbolic action) and whilst the focus of this study is on policy and practice rather than the organisation it still requires consideration of the organisation and its culture.

Policy analysis can be used to provide an analysis of key actors' values and perceptions of implementation and therefore the culture of the organisation. It can also be used to evaluate particular policy interventions and the comparative case study could be used to compare different contexts of policy implementation. Generalisation is through the development of theory (Harrison 2001, p91). It entails some notion of realism along with the socially constructed nature of problems and acceptable solutions, distinguishing between facts and values whilst acknowledging they are intertwined with each other and theory (Harrison 2001, p92). Its uses include policy or programme evaluation or what interventions 'work' in what conditions. The latter will often be social processes: those that aim to change the behaviour of social groups.

A framework for policy analysis is outlined in Table 1. As an approach it can, and indeed needs to, accommodate other methods. Case studies, for example, can be used to compare the different contexts of implementation (by profession, locality or client group).

Table 1 A framework for policy analysis

1. Policy is conceived as a process including several stages such as
    - Agenda setting
    - Defining what is thought to be problematic and what objectives would represent an acceptable improvement
    - Elucidating the causal structure of the problem
    - Elucidating measures that would intervene in this causal structure
    - Appraising the options for intervention
    - Implementation of selected options
    - Evaluation and feedback

These are not necessarily sequential or even all present and the behaviour of relevant actors is of interest as are unintended consequences, inaction, non-decisions, symbolic action and post facto rationalisations.

2. Action is seen as taking place within a context that can affect as well as be affected by the policy process.

3. Policy analysis is concerned with the use and development of explicit theory, not just the assembly of data. The assumption here is that all discussion of causal processes is theory-laden hence the only choice is between treating theory implicitly or explicitly, thereby encouraging the questioning of the taken for granted.

Harrison (2001)

General conclusions can be drawn as long as data about context, processes and policy outcomes are collected and analysed (Yin 1994) so that readers have sufficient information about the case context to be able to judge the replicability to other cases. The study of 'actors' or practitioners will require psychological aspects of behaviour, thoughts and emotions of individuals and groups (Arnold 2001) to be observed and 'realistic evaluation' (Pawson & Tilley 1997) in the form of 'outcomes result from mechanisms acting in context' provides a methodological strategy for evaluation and data relating to the intervention package, organisational and practice context, and outcomes were collected. The project can be described utilising the policy analysis framework (Table 1) to consider the project initiation, intervention and evaluation phases.

3.3 Initiation phase

In terms of agenda setting, a policy development process was in place within the Trust. National policy and guidance were considered and local policy developed through small groups of lead practitioners who established policy standards for practice. These were then distributed for wider consultation amongst practitioners, service users, carers and partner organisations. Following this consultation any implications of the policy for practice are considered by the Trust Clinical Effectiveness Policy and Audit Committee (CEPAC) and finally the policy is ratified by the Trust senior management team who consider any resource implications. The policy is then made available electronically and staff are notified through Trust communication channels that it is available. Therefore, there was an infrastructure and linear process in place for the dissemination of policy.

3.4 Integration problems

The next step was to define what was thought to be problematic and identify objectives that would represent an acceptable improvement (Rogers 1995). The process as described was effective at a developmental level with good engagement of lead practitioners and senior management. However feedback from practitioners through consultation was limited and post-incident reviews, local research and audits of practice against standards illustrate that there were often significant gaps between policy and practice.

The causal structure of why there were gaps was unclear but the assumption was that there were likely to be similar organisational or cultural barriers to those identified in the literature review. These can be summarised as a lack of clarity or access, insufficient time available to consider practice and improvement, a lack of organisational support and the unavailability of learning opportunities and skilled facilitation.

3.5 Large group interventions

Preliminary discussions with my sponsor, the Trust Chief Executive, supported the rationale for a project to evaluate an approach that would intervene in this causal structure and provide time and facilitation for practitioners to consider policy, practice and improvement (Redfern 2002, Bergen and While 2005).

I attended a workshop delivered by the eventual project manager who facilitated a session on clinical governance with a large group of staff (n=40c.) from Child and Adolescent Mental Health Services (CAMHS). CAMHS were experiencing a degree of upheaval in their services, losing several key staff and direction. Although not formally evaluated, the workshop was well received by the CAMHS staff and they were able to identify a way forward and formulate some actions towards achieving desired goals. This led to discussion with the facilitator and a project officer, who both worked within the Trust clinical governance team, on the potential for a Trust-wide initiative to integrate policy and practice utilising an intervention package with large groups called 'Practice Update Days'.

Principles of Large Group Interventions were adopted (Bunker and Alban 1997, 2006) including purposeful activity, connection before content, engagement, the use of dialogue, creative tension, time and space for reflection, public information sharing and decision making. The main goals of the intervention, including some of the expected benefits to staff were:-

- Making the core values of the Trust explicit.
- Offering clarity and direction regarding practice policy (Garside 1998).
- Providing the opportunity for staff to explore the implications of policy for practice and suggest ways forward.
- Providing time out for considered reflection.
- Opening up a dialogue between staff and policy developers.
- Providing the opportunity for staff groups to influence and shape the future development of practice policy (Battram 1998, Garside 1998, Wood 2000).
- Providing opportunities for networking and sharing of ideas (McIntosh 2001).

A number of evidence-based considerations went into the design of the content of the package. The 'Practice Update Days' were designed to engage practitioners through clinical governance as a national initiative (Wright 2001), to present local policy and Trust values (Anthony 1990, Hackett and Spurgeon 1996, Garside 1998) as well as more detailed policy relating to the needs of different cohorts of practitioners (Schoenwald and Hoagwood 2001, Henggeller et al 2002, Bergen and While 2005). Phases that were incorporated include the dissemination of policy principles (Wood 2000), a feedback loop (Degeling et al 1999, Rogers 2001) and the production of recommendations for policy and practice development (Ferlie 2001, Berwick 2003, Lavis et al 2003, Proctor and Rosen 2004).

3.6 Action research

The second criteria for policy analysis (Table 1) is that action is seen as taking place within a context that can affect as well as be affected by the policy process. Essentially, action research generates knowledge about a social system while, at the same time, attempting to change it (Meyer 2001). It is an approach, rather than a unique discipline or particular method that lends itself to adjustment in response to both unforeseen problems and emerging issues. There was potential for the intervention to be influenced by feedback from practice and for practice to be influenced by policy, or iteration (Garside 1998), thereby generating further theory that could be tested with subsequent groups, characterising the action research cycle.

A 'professionalising' action research approach as outlined in Table 2 was used to deliver the intervention process as each of the distinguishing criteria met the needs of the project.

Table 2 Characteristics of 'professionalising' action research.

Distinguishing Criteria	Professionalising type of action research
1. Educative base	• Reflective practice • Enhancing professional control and individual's ability to control work situation • Empowering professional groups; advocacy on behalf of patients / clients • Practitioner focused
2. Individuals in groups	• Professional and/or (interdisciplinary professional) group negotiated team boundaries • Shifting membership
3. Problem focus	• Problem defined by professional group; some negotiation with users • Problem emerges from professional practice experience • Contested, professionally determined definitions of success
4. Change Intervention	• Professionally led, predefined, process led • Problem to be resolved in the interests of research-based practice and professionalisation
5. Improvement and involvement	• Towards improvement in practice defined by professionals and on behalf of others
6. Cyclic process	• Research and action components in tension; research-dominated • Identifies causal processes that are specific to problem and/or can be generalised • Spiral of cycle, opportunistic, dynamic
7. Research relationship, degree of collaboration	• Practitioner or researcher collaborators • Outside resources and/or internally generated • Merged roles

Source: Hart and Bond 1995: 40-3

3.7 *Intervention phase*

The package was delivered through a programme of presentations and facilitated group work and the format for the days was:-

Morning: Clinical policy / Trust values overview; Practicalities of implementing clinical policy in practice settings.

The rationale for the approach was presented and consent obtained from participants to participate in evaluation.

An introduction to Trust clinical policy (what it is and what it says) was presented.

Small group work using case vignettes to explore the implications of Trust clinical policy implementation were facilitated.

Afternoon: Care Group specific policy – update and implementation issues.

More detailed aspects of relevant clinical policy based on identified care group need were presented.

Again, small group work using vignettes to explore the implications of Trust clinical policy implementation were facilitated.

Key messages on policy and the implications (e.g. *value conflict*, training needs, extra resources / service redesign etc,) were recorded as group outputs.

Time was offered for individual reflection and the completion of measures of practice values, awareness & understanding of clinical policy and its potential effect on future practice, satisfaction and further development needs.

The plan was to deliver 'Practice Update Days' to large numbers of multidisciplinary staff from each service area:-

Acute In patient
Rehabilitation and recovery
Adult Community
Learning disability
Forensic
Specialist Substance Misuse Services
Psychological therapies
CAMHS
Emerging services
Occupational Health
Older People

The project was managed using PRINCE2 methodology (UK Office of Government Commerce 1996) which is the NHS standard for structured project management. I was the project director working closely with the project manager and a Gantt chart outlining the project milestones is attached (appendix 1). A project board was established and as a member of the project board I presented a case to the senior management team of the Trust and through the local Clinical Policy Forum to gain top level commitment and support (Klein and Sorra 1996, Williams 2000). Information on the project was communicated through Trust communication channels and information sheets (appendix 2) were sent to all prospective participants.

3.8 Evaluation phase - realistic evaluation

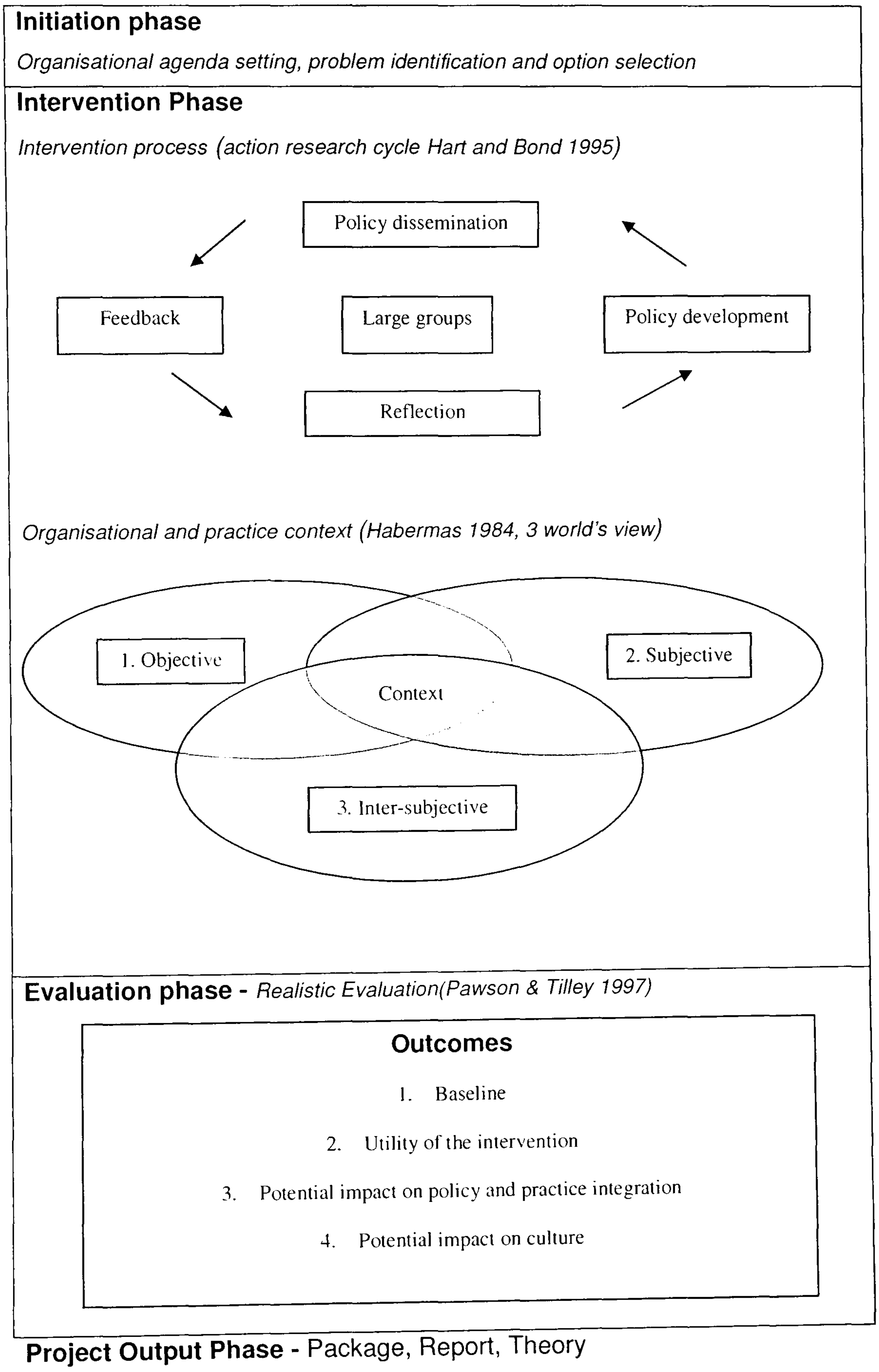
A key objective was to evaluate the utility of the package and the potential impact on policy-practice integration and aspects of practice culture with particular reference to establishing what could work for whom in what context (Pawson and Tilley 1997). In policy analysis terms the behaviour of relevant actors was of interest as were unintended consequences, inaction, non-decisions, symbolic action and post facto rationalisations (Harrison 2001).

Realistic evaluation can be summarised as "A theory of causal explanation based on *generative* principles which supposes that *regularities* in the patterning of social activities are brought about by the *underlying mechanism* constituted by people's reasoning and the resources they are able to summon in a *particular context* which gives research the task of *testing theories* of how program outcomes are generated by specific mechanisms and contexts" (Pawson & Tilley 1997, fig 9.1).

Realistic evaluation has been used to evaluate the impact of social programmes and as such it is an approach that meets the needs of the project purpose and accommodates both quantitative and qualitative methods of data collection and analysis.

The action research process was delivered to large groups within an organisational and practice context that needed to be described. Habermas (1984: 75-101, 1987) presents a structure for considering our relations to and interactions with three worlds; the material, the social and the personal. Thus, any real-world situation into which we are intervening will be a complex interaction of substantively different elements. Relatively hard and observer-independent aspects (context, structures, processes), socially constituted aspects (relationships, culture, practice, language, power) and individual beliefs, values, fears and emotions. The description of the 'real world' context needed to incorporate objective, socially constituted (intersubjective) and individual (subjective) aspects of culture at different levels within a community of practice. Figure 2 illustrates the project phases within a policy analysis framework.

Figure 2 Project phases within a policy analysis framework



Quantitative and qualitative data were collected so that concurrent mixed data analysis could be undertaken demonstrating fidelity to a parallel mixed model design (Tashakkori and Teddlie 1998). The methods for capturing contextual aspects were by survey using a structured questionnaire including general and specific questions (appendix 3), by recording the summarised outputs from facilitated work groups and facilitator observations in a project log, and through semi-structured, post-hoc interviews with the project manager and project officer.

The main identified outcome measures were to establish a baseline of practitioner perceptions relating to; their current practice and policy; personal responsibility and access to support; and any issues that had the potential to create cultural dissonance. The utility of the intervention package and the potential impact of the package on policy-practice integration and culture were evaluated.

This could then be extended in the future to answer 'what works for whom in what context?' relating to actual changes in culture and practice using longitudinal evaluation methods.

The outputs from the project were the intervention package and this report which incorporates a theoretical model for achieving sustainable change management to improve practice quality.

Details of the proposed project sample, variables and their measurement, procedures and data analysis and justification are presented below.

3.9 Project sample

The population or 'community of practice' under study was potentially all staff who deliver face to face clinical, therapeutic or care services (N=1000 c.) and who could be grouped by case (e.g. discipline, care group, locality).

The main quantitative analysis was undertaken on questionnaire responses to compare participant's perceptions using t-test for bi-variate analysis (gender, locality) and ANOVA's for groups (profession, care group, age). According to Cohen (1992), a t-test requires 95 cases in each group for a power of 0.8 and a medium effect size ($p < 0.05$), whereas to detect a large effect you need 38. Using ANOVAs for 3 groups requires 76 cases in each group for a medium effect size but only 30 per group to detect a large effect.

Therefore the aim was to obtain a minimum sample of 90 valid cases to detect any large effects from the questionnaire responses.

3.10 Variables and their measurement

Key aspects of clinical governance include user-centred practice and delivering safe and effective practice. One tool to measure barriers to research utilisation (Funk et al 1991) had been used in previous local studies. Whilst some of the findings were relevant (practitioner responsibility and access to support) the tool had some factor gaps (e.g. Information Technology) and domain gaps (user-centred practice and safe practice) for this exploratory study. The literature emphasises the importance of values in relation to change (Kelman and Hamilton 1989, Hengeller et al 2002, Bergen and While 2005) and therefore an instrument was needed to measure the perceptions of current values and practice as well as evaluate the potential impact of the intervention on these. Searches of the literature and discussions with my project supervisor and project consultant could not identify any appropriate off-the-shelf measures. So a questionnaire and measures were developed in collaboration with the project consultant who is a Professor of Nursing with extensive experience in the design and use of questionnaires. The questionnaire and measures incorporating the variables of interest listed in Table 3 were then piloted within the study.

Table 3 Study variables

Case characteristics

1. Profession
2. Grade
3. Locality
4. Care group (client group)
5. Gender
6. Age

Variables

7. How useful is the intervention perceived to be (intervention utility)?
8. How could the intervention be improved (intervention improvement)?
9. What is needed to improve integration of policy and practice (policy integration - enhancers)?
10. How user-centred is current practice and how user-centred should it be (policy integration - user centred practice)?
11. How involved are users in care decisions and how involved should they be (policy integration - user involvement)?
12. How safe is current practice and how safe should it be (policy integration - safe practice)?
13. Which areas of effective practice do practitioners acknowledge practitioner responsibility (perceived responsibilities)?
14. What aspects of support are available to practitioners and to what degree (perceived support)?
15. What aspects of support are inaccessible or inadequate (support gaps)?
16. Are there any strong feelings expressed (expressed emotion)?
17. What are the implications of policy for practice (implications)?
18. What are the potential improvements to policy (improvements)?
19. Are there any potential cultural differences between practice and organisation (dissonance)?
20. Are there any unintended consequences, inaction, non-decisions, symbolic action and post facto rationalisations (post-hoc issues)?

Case characteristics were collected through a structured questionnaire (appendix 3), variables 1-4 through text responses and 5-6 through tick-box choices. These were chosen to provide objective contextual data and the basis for comparisons between cases or groups.

The measures remained constant throughout the programme to illustrate the effects of the intervention in different contexts (cases), variables 7-15, were collected through a structured questionnaire (Appendix 3) to provide subjective data and variables 16-18 were collected through the project log to provide inter-subjective data.

Variables 7-9 were collected as free-text responses to open-ended questions to evaluate the outcome of the intervention. They were open-ended to allow the development of an evaluative framework from the responses through qualitative analysis to illustrate how useful the intervention was perceived to be (intervention utility), how the intervention could be improved (intervention improvement) and what was needed to improve integration of policy and practice (policy integration - enhancers). Variable 15 was also a free-text response to an open-ended question to allow a framework to be developed for considering any support gaps.

Variables 10-14 are ratings on a 5-point Likert scale between totally agree and totally disagree with statements relating to each variable. These variables were identified to illustrate perceptions of current and potential practice relating to user-centred practice (addressing the needs of service users, involving service users in decisions), effective practice (responsibility for utilising research evidence, keeping up to date, participating in supervision, evaluating care, record-keeping, care co-ordination), (access to support) and safe practice (reducing risk to users, staff and the public) providing a baseline diagnostic of practitioner values.

Variable 16 relates to the observed degree of expressed emotion and was captured by facilitators or observers if available within the group work.

Variables 17-18 are the qualitative outputs from group work. These illustrate the perceived implications for practice and suggest improvements for policy.

Variable 19 was identified through post-hoc interviews.

Variable 20 was developed through analysis of the qualitative outputs to highlight examples of potential dissonance between practice culture and organisational or management culture.

3.11 Procedures

Participant feedback on the implications of policy for practice were summarised and recorded on flip-charts during the intervention and transcribed into a project log allowing for concurrent member-checking of the data. The project log reflects potential aspects of practitioner conflict with espoused values, implications of policy for practice and potential improvements to policy.

The evaluation questionnaire (Appendix 3) was completed following the intervention during time allocated for personal reflection. It was anticipated that given time, encouragement and anonymity, practitioners would be willing to express their views. The questionnaire considered practitioner's current perception of the degree of impact of espoused values on practice and therefore required respondents to be aware of these. It also considered the degree to which values should inform practice, aiding evaluation of the potential outcome of the intervention and giving an indication of the degree of change required. The 'is / ought' aspect is an adaptation of Ulrich's critical heuristics (1983). The level of commitment expressed to integrating espoused values and practice establishes a proxy measure for any sustained effect. These were pragmatic choices limited by the collection of data at one point in time. If the questionnaires had been individually identifiable it would aid follow-up, offering the potential for future evaluations of changes to an individual's practice. The downside of identification was the potential for questionnaires not to be completed or for views to be tempered.

The outputs from the project log and questionnaires reflect explicit or recorded responses. It was more challenging to assess any implicit aspects of conflict between practitioner values and espoused Trust values or policy. The observer participants were asked to try and record the degree and type of emotion expressed whilst discussing various issues during the intervention. These records were transcribed into the project log to be considered at monthly project meetings, the content of which would also be summarised in the project log. Qualitative analysis of the group outputs also served to highlight any items that could create potential dissonance between practitioners and policy or the organisation.

3.12 Design considerations

Due to the pragmatic approach and limited resources a number of methodological compromises were made in relation to the design relating to reliability, validity, sensitivity and utility.

The combination of open-ended and closed-ended questions in the questionnaire is a compromise, as both types have strengths and weaknesses, but they are also highly recommended as they can offset the strengths and weaknesses of each other (Polit and Hungler 1995). Closed-ended questions are generally more efficient as they are easier to complete but may overlook some potentially important responses. Due to the potential for researcher bias, the use of open-ended questions is preferable when the area of research is relatively new.

Therefore open-ended questions have been used for the evaluation of the intervention and to identify any support gaps. Closed-ended questions have been used either to quantify practitioner values (user centred practice, safe practice) or to quantify aspects of a more developed construct (effective practice) that was based on previous research. Effective practice is a key construct as the successful integration of practice that is user-centred and safe relies on the characteristics and conditions required for effective practice (personal responsibility and access to support).

As this was a newly developed instrument incorporating qualitative data and a quantitative scale, issues of reliability, validity, sensitivity and utility required consideration through psychometric assessment.

Reliability refers to the stability of a measurement scale and how consistently a measurement scale measures what it is supposed to be measuring (Polit and Hungler 1995). Reliability can be assessed in different ways; test-retest reliability for stability, inter-item reliability for internal consistency and inter-rater reliability for equivalence. The project design did not allow for test-retest reliability or inter-rater reliability but inter-item reliability can be tested, using Cronbach's alpha procedure, for the responses relating to individual responsibility and support access.

Validity is concerned with whether something measures what it is supposed to measure. There are many ways of testing validity. Face validity and content validity are closely related and should be the minimum requirement for acceptance of a scale. Face validity is an assessment of whether a scale looks reasonable and relevant and if acceptable then it is more likely to have utility. It is not tested using statistical procedures but can be considered for relevance by subjects, experts, researchers and others. Content validity considers whether a scale has included all the relevant issues. It is usually assessed by a critical review by an expert panel or by comparing with the literature or both. Content validity is also not usually assessed using statistical procedures but should be carried out in the planning stage. The scale used was developed by the research team using available evidence, previous local research and policy drivers and checked with a Professor of Nursing with extensive experience in questionnaire design.

Criterion validity which incorporates concurrent and predictive validity can be assessed when there is already a valid criterion measure available for comparison. However, where this does not exist, the extent the scale correlates with the construct under investigation can be assessed (Polit and Hungler 1995) as construct validity. The constructs in question are user-centred practice, safe practice and effective practice.

Sensitivity is the ability of the measuring tool to make fine discriminations between objects with different amounts of the object being measured. Utility of the scale is also important and its practicality should be assessed. Consideration should be given to the time it takes to administer, ease of administration and ensuring the phrasing is clear (McDowell and Newell 1996) to achieve a balance between utility and sensitivity. For this reason the scale was set at five points and kept relatively brief. The measurement aspect of the questionnaire was limited for current perceptions of user-centred practice and safety as exploratory constructs with further corresponding questions for each construct on how their practice should be. Ten characteristics of individual responsibility and six conditions for access to support were included. The rationale being that these areas had been identified through previous research and were key in identifying any motivational obstacles.

Lincoln and Guba (1985) suggest four criteria for establishing the 'trustworthiness' of qualitative data: credibility, transferability, dependability and confirmability.

Credibility refers to confidence in the truth of the data. The likelihood that qualitative findings will be found credible can be improved through triangulation which is the use of multiple referents to draw conclusions. This incorporates triangulation of data, investigator, theoretical perspectives and methods (Denzin 1989). Triangulation of data collection, investigators, theoretical perspectives and methods were incorporated into the study design although this was not comprehensive for the data analysis due to resource constraints. Two further methods for establishing credibility are debriefing with peers and debriefing with informants. Debriefing with peers was incorporated into the study design although debriefing with informants was excluded as a further compromise.

Transferability of findings is mainly dependent on the investigator providing sufficient descriptive data so that consumers can evaluate the applicability of the data to other contexts themselves.

Dependability refers to the stability of data over time and over conditions. One approach is stepwise replication and requires the research team to split into two teams and conduct independent inquiries but maintain ongoing regular communication. A second technique is the inquiry audit where data and supporting documentation are scrutinised by an external reviewer.

Confirmability refers to the objectivity of the data such that there would be agreement between two or more independent people on the data's relevance. An inquiry audit can again be used to establish confirmability.

Neither stepwise replication nor inquiry audit were completed due to resource constraints although other checks of trustworthiness were carried out.

3.13 Data analysis

Quantitative analysis is the manipulation of numerical data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of relationships among variables (Polit and Hungler 1995, p651).

Qualitative analysis is the organisation and interpretation of nonnumeric information for the purpose of discovering important underlying dimensions and patterns of relationships (Polit and Hungler 1995, p650).

The data from the evaluation questionnaires were entered into the Statistical Programme for Social Sciences (SPSS©). Normative and ranked data were coded and entered as quantitative data and free text responses transcribed as qualitative data. Mixed data analysis was undertaken concurrently and descriptive statistics used to present the characteristics of the participants (variables 1-6) and frequencies of response to the tick-box questions (variables 10-14). Quantitative data analysis incorporated comparisons within and between groups using parametric tests to see if different values were ranked higher by locality, discipline or care group. Although the quantitative data are at ordinal level, the use of parametric tests is conventional with data of this kind (Bryman and Cramer 1990) and analysis of variance (ANOVA) in particular is a robust test. To avoid Type I error, which can occur when multiple comparisons are being made, a post-hoc Bonferroni test was used to determine which specific pairs of variables were significantly different.

The Bonferroni test seeks levels of significance that are equal to *0.5/x* where *x* is the number of comparisons being made. For example if three variables are being compared the significance (p) is 0.5/3 = 0.017. The responses were also compared between the 'is / ought' dimensions to identify which values (if any) require further work and the gap between current practice and desired practice.

Qualitative analysis of the quantitative data was also undertaken to inform how the qualitative analysis should be presented (i.e. any statistical differences found between groups, disciplines, localities were explored through the qualitative analysis).

Content analysis has been defined as a systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding (Berelson 1952). It provides a useful technique to discover and describe the focus of individual, group, institutional or social attention (Weber 1990). Krippendorff (1980) poses six questions to be addressed in every content analysis;

1. Which data are analysed?
2. How are they defined?
3. What is the population from which they are drawn?
4. What is the context relative to which the data are analysed?
5. What are the boundaries of the analysis?
6. What is the target of the inferences?

Content analysis of the free-text responses in the questionnaire and the project log was undertaken to identify and quantify data items, categories and themes. Further quantitative analysis was applied to these outputs by manually scanning identified categories and themes to identify differences and similarities between cases rather than applying statistical tests.

For the questionnaires, the technique used was to manually count the frequency of key words or phrases occurring syntactically within individual questionnaire responses. This manual count allowed words to be analysed in context. Once counted each occurrence or data item was then coded. Emergent coding of the questionnaire responses for the intervention utility (variable 7) and improvements (variable 8) and support gaps (variable 15) was developed between the project director and the senior project officer following a stepped approach. The approach included preliminary examination of the data, independent review of the material to form checklists, comparison and consolidation of the checklists and then coding was undertaken by the project director (adapted from Haney et al 1998). Triangulation of independent data analysis would have strengthened the technique but as resources were limited this was not undertaken. The unit of analysis was therefore individuals. The population was the project participants who were all practitioners and the context was healthcare policy and practice. The boundaries of the analysis apply to those disciplines involved and the target of the inferences is the community of practice.

For qualitative analysis of the project log, the technique was to code the outputs, as produced by the groups and facilitators to consider the emergent categories and themes within these. This meant that the unit of analysis was the work group outputs. The population was the project participants who were all practitioners and the context was healthcare policy and practice relative to a specific client group. The boundaries of the analysis apply to those disciplines involved and the target of the inferences is the community of practice.

A constant comparison method was utilised to develop substantive theory on policy-practice integration (Glaser and Strauss 1967) by comparing emergent data from group outputs to the categories and themes developed from the individual responses. Of particular interest were any reasons for potential dissonance between practitioners and policy or the organisation. The development of theory is a key output from policy analysis that has the potential to be tested in other settings.

3.14 Access and ethics

As I was involved as an 'insider' researcher there were methodological problems, particularly ethical and potential bias. Bell (1999, p45) identifies a number of methodological considerations that are summarised in Table 4.

Table 4 Negotiating access, ethics and problems.

• Clear official channels by formally requesting permission to carry out your investigation as soon as you have an agreed project outline.
• Speak to people who will be asked to co-operate.
• Maintain strict ethical standards at all times.
• Submit the project outline to head / principal, senior officer or ethics committee if necessary.
• Describe what you mean by anonymity and confidentiality.
• Describe whether participants will receive a copy of the project and / or see drafts or interview transcripts.
• Inform participants what is to be done with the information they provide.
• Prepare an outline of intentions and conditions under which the study will be carried out to hand to your participants.
• Be honest about the purpose of the study and about the conditions of the research.
• Remember that people who agree to help are doing you a favour.
• Never assure 'it will be alright'. Negotiating access is an important stage in your investigations.
• If you have doubts about the ethics of your research, consult your supervisor and decide what action to take.

(Bell 1999 p45)

To negate problems associated with some of these it was necessary to make my role and other's roles explicit within the project. Access was clarified through the planning and initiation stages and ethical considerations through application for ethical approval.

My role as *project director* was to establish the project aims and objectives, initiate the project, gain Trust approval and commitment, gain ethical approval, contribute to the design of the intervention and lead the evaluation including analysis of data with the two project facilitators and to produce a project report. In summary, to make the project happen.

The role of the two *project facilitators* (project manager & senior project officer) was to design and facilitate the delivery of the intervention at each session, collect and record data and to contribute to analysis and any redesign of the intervention. In summary; to deliver the intervention package.

Group facilitators were members of the project team who agreed to participate and facilitate at small group level during the intervention, they included clinical staff, trainers and service users who were able to take on the role. In summary; to support the delivery of the intervention package.

Participant observers were members of the project team who had experience and qualifications in psychotherapeutic approaches. They agreed to participate, observe and summarise their perceptions of any expressed emotion on the day and to facilitate the reflective sessions for members of the project team after each intervention and at each project team meeting. In summary; to observe any unconscious aspects of conflict that arose through delivery of the package.

Participants were staff who deliver face-to-face clinical, therapeutic or care services and who could be grouped by discipline, locality and client group (care group).

Anonymity occurs when even the researcher cannot link a subject with the information for that subject. In situations where anonymity cannot be guaranteed then a promise of confidentiality to subjects guaranteeing that any information provided by subjects will not be publicly reported in a manner that identifies the subject or shared without the subject's permission. The aim within this project was to achieve anonymity of subjects.

As the project involved members of staff, approval was sought from the local research ethics committee. The submission for ethical approval required documents detailing the application, my Curriculum Vitae (CV), a protocol, peer review, questionnaire and information sheet. This detailed my identity and background and included the main ethical issues as above for consideration. Interestingly, the ethics committee stated that the application need not have come to them as it was arguable as to whether the project was deemed to be research. However they did give approval for the project to commence. Cohen et al (2000 p71) provide an illustration of an ethical code for research in education that is summarised in Table 5.

Table 5 An ethical code for research

- It is important for the researcher to reveal fully his or her identity and background.
- The purpose and procedures of the research should be fully explained to the subjects at the outset.
- The research and its ethical consequences should be seen from the subjects and institutions point of view.
- Ascertain whether the research benefits the subjects in any way (beneficence).
- Where necessary, ensure the research does not harm the subjects in any way (non-maleficence).
- Possible controversial findings need to be anticipated and where they ensue, handled with great sensitivity.
- The research should be as objective as possible. This will require careful thought being given to the design, conduct and reporting of the research.
- Informed consent should be sought from all participants. All agreements reached at this stage should be honoured.
- Sometimes it is desirable to obtain informed consent in writing.
- Subjects should have the option to refuse to take part and know this; and the right to terminate their involvement at any time and know this also.
- Arrangements should be made to during initial contracts to provide feedback for those requesting it. It may take the form of a written resume of the findings.
- The dignity, privacy and interests of the participants should be respected. Subsequent privacy of the subjects after the research is completed should be guaranteed. (non-traceability).
- Deceit should only be used when absolutely necessary.
- When ethical dilemmas arise, the researcher may need to consult other researchers.

(Cohen et al 2000, P71)

I was known to many of the participants and my details were included in publicity material, information sheets and shared personally each day that I attended along with the purpose and procedures of the project. The risks and benefits to subjects and the Trust were considered and recorded. There were no anticipated risks to participants. However, due to the methods adopted there was potential for transference and counter transference within dialogue groups due to value conflict. The facilitators were trained and supervised to ensure that this could be managed appropriately.

Written consent was not sought due to the work-based nature of involvement although the nature of the approach and evaluation was described to all participants and participants were given the option to decline completing the measures. As Cohen et al (2000, p245) eloquently phrase it;

> "Questionnaire respondents are not passive data providers for researchers; they are subjects not objects of research. Respondents cannot be coerced into completing a questionnaire. They might be strongly encouraged, but the decision whether to become involved and when to withdraw from the research is entirely theirs".

The design, conduct and reporting of the research were all given careful consideration as described in this report. All data were anonymised and kept secure with the identities of individuals protected so that comments could not be traced to individuals. It was agreed that a summary of the findings would be made available to all participants.

One ethical dilemma did arise due to the nature of the project and my role within it. Anonymity was achieved for participants but the study involved some post-hoc interviews with co-researchers the outputs of which could be traced to them. They gave their approval to the outputs being included in the final report. Likewise the preliminary report was forwarded to the project sponsor for consideration prior to dissemination.

Chapter 4: Project activity and findings

4.1 Implementation

The project was implemented largely as planned. Ultimately, four Practice Update Days were delivered between July 2004 and December 2004 covering three 'care' groups, two to non-specialist, adult community mental health services (n=55), one to learning disability services (n=18) and one to older peoples mental health services (n=30). Whilst efforts were made to engage all practitioners this was not achieved but a stratified, non-random sample of sufficient size to demonstrate any large effects was recruited.

The case characteristics of the study sample are summarised in Table 6. Due to the sample being fewer than anticipated, the results by grade of staff would have resulted in cell sizes that were too small for analysis. Likewise compromises have been made in terms of grouping by locality rather than teams (Locality A and Locality B) due to the smaller sample, and discipline (nursing, social care and occupational therapy / physiotherapy combined) due to limited attendance.

Table 6 Case Characteristics of sample (n=103)

	Day 1 (n=22) Adult MH Community	Day 2 (n=33) Adult MH Community	Day 3 (n=18) Learning Disability	Day 4 (n=30) Older People	Totals
Nursing	13	22	11	25	**71**
Social Care	7	7	-	-	**14**
Occupational Therapy / Physiotherapy	2	4	7	5	**18**
Male	6	9	4	6	**25**
Female	14	22	12	22	**70**
Missing data	2	2	2	2	**8**
Locality A	16	16	7	15	**54**
Locality B	6	14	5	14	**39**
Missing data	-	3	6	1	**10**
≤ 20 years old	-	-	-	2	**2**
21- 35 years old	5	6	3	2	**16**
36- 50 years old	11	15	11	21	**58**
51- 65 years old	5	4	4	5	**18**
Missing data	1	8	-	-	**9**

Although there were a number of senior practitioners there was no representation from operational managers. It also proved difficult to engage medical staff and psychologists despite delivering presentations at their professional forums. Child and Adolescent Mental Health Services (CAMHS) declined the offer of a study day and managers of acute in-patient units felt they could not release staff and offers of alternative modes of delivery were not taken up.

The case characteristics summarised in Table 6 suggest that there were good levels of representation from nursing at all days, good levels of representation from social care at the adult mental health community days, some representation from occupational therapy / physiotherapy at adult mental health community days and good levels of representation from these disciplines at learning disability and older peoples' days. There was good representation from both localities, and participants were predominantly female (68% - 73.7%*) and over the age of 35 (73.8% - 80.8%*). * Range due to missing data.

The project outcomes are presented starting with the implications for policy and practice development by care group followed by individual's perceptions of policy into practice. These relate to: items that enhance the integration of policy into practice; access to support and support gaps; ratings of practitioner responsibilities and expressed practitioner values both current and aspirational.

Further analysis of questionnaire responses and group outputs to highlight any potential dissonance between the participants and the organisation is included. The themes from this are presented, followed by the analysis of results from the evaluation questionnaire and the responses to post-hoc interviews with the project manager and project officer. Finally, a summary of the findings is provided.

4.2 The implications for policy and practice development

What are the implications of policy into practice (policy improvements and practice development)?

The care group outputs are presented as themes by category in appendix 4. Categories are policy design, communication, practice development and support. These categories were established from analysis of the policy integration enhancers (Table 8). The outputs, as produced by the groups and facilitators were coded into one of these discrete categories and the numbers of outputs within each category were totalled and presented by policy by care group in Table 7.

A brief description of each policy is included in Appendix 6.

Table 7 Numbers of outputs by policy by category by care group

Adult Community Mental Health	CPA	Carers Assessments	Risk Plans	Advance Statements	Integrated notes	Supported Leave
Policy Design	13	8	9	4	8	14
Communication	2	1	0	1	1	0
Practice Development	9	0	0	5	0	5
Support	1	0	0	2	0	0
Older Peoples Services	CPA	Carers Assessments	Risk Assessment	Advance Statements	Challenging Behaviour	Capacity & Consent
Policy Design	2	4	4	3	2	3
Communication	0	0	0	0	0	0
Practice Development	4	0	1	3	1	3
Support	0	0	1	0	0	0
Learning Disability Services	CPA				Challenging Behaviour	Service Integration
Policy Design	8				4	8
Communication	0				1	0
Practice Development	5				7	5
Support	0				0	2

The outputs from each care group (Appendix 4) offer detailed areas for further action but analysis of the numbers of outputs by category can be used as a measure of the degree of policy impact experienced by practitioners. Overall it can be seen that the majority of outputs relate to policy design and practice development and although the two are interdependent, the emphasis on either policy redesign or practice development can be used to reflect the degree to which policy is acceptable and prioritise were the primary focus on further development should be.

Within the adult community mental health group it was policy on CPA along with supported leave that generated the most outputs and policy on carer's assessments, risk assessments and integrated notes also need a lot of work. The only policy that currently seems to have the potential for changing practice was policy on advance statements. The outputs from the older people's service group suggest that there were fewer outputs than other groups and that policy on carer's assessments and risk assessments again needed more work although the principles of CPA were viewed more positively with potential for benefiting practice. There was a strong emphasis given to the needs of older people being given special consideration and to the development of care pathways.

The learning disability service group considered fewer policies but the outputs were more detailed and views appeared to be more considered and developed than the other groups. CPA, challenging behaviour and service integration all require a significant focus on both policy design and practice development. A lack of clarity in Trust policy about how it relates to their service users and the need to distinguish the needs of users from the needs of carers was emphasised.

The differences in numbers of outputs from the groups strongly suggest that there is greater potential for dissonance within non-specialist adult community mental health services.

There are many recommendations for improvements that are also reflected within the outputs from the questionnaires. In particular there is a need to involve all staff to establish policy that is user and staff focused, giving clarity, standardising practice and improving communication. Opportunities and training should be provided to develop this requiring management support and resources.

4.3 Integrating policy and practice

The results from individuals questionnaire responses relating to items that enhance the integration of policy into practice, access to support and support gaps, ratings of practitioner responsibilities and expressed practitioner values both current and aspirational are summarised in Appendix 7.

The results were tabulated and any differences between variables where they are paired and any differences between care groups, gender, disciplines and localities are highlighted.

What is needed to improve integration of policy and practice (policy integration - enhancers)?

Participants were asked to identify what they need to help them put policy into practice. Content analysis was applied to the free text responses. 80 participants provided responses and 167 integration enhancing items were identified. The question relating to enhancers generated the most data of all questions and the responses were themed into categories and the major themes in terms of numbers of data items are presented in Table 8.

Table 8 Policy integration enhancers

Categories	Themes (data items)
Policy Design	clarity (10) standardised (9) staff-focused (8) client-focused (7) specific / concise / short / streamlined (6)
Communication	effective communication of policy (8) easily accessible (5)
Practice Development	effective training / induction (15) multi-disciplinary staff involvement (8) dedicated time for service improvement (6)
Support	more time (14) more resources (10) supportive managers (8) more staff (7) effective technology (7)

Items that enhance the integration of policy and practice are categorised under improvements to policy design, communication, opportunities for practice development and aspects of support. Many policy design items were identified although some were conflicting thereby posing a challenge for effective policy design generally. However, the main themes were for clarity, standardisation and a staff and client focus. There is a need for policy to be communicated and easily accessible. Practice development activity generally incorporates the need for opportunities for multi-disciplinary development with some specific recommendations for practice redesign requiring more time and resources to be generally available with some specific recommendations for supportive managers, more staff and effective technology. There were no discernible differences between the care groups.

What aspects of support are available to practitioners and to what degree (Perceived support)?

Participants were asked to identify, on a five-point Likert scale between totally agree and totally disagree, the degree to which they agreed with having access to adequate support. Aspects of support were categorised as information, management support, supervision, training and tools and resources in order to discharge their responsibilities. Response frequencies are presented in Table 9. There were relatively few missing data items therefore these have been excluded from the tables to aid presentation.

Table 9 Participant ratings for access to adequate support

Support category	Totally agree	Agree	Unsure	Disagree	Totally Disagree	Totals
Information	44	38	12	4	2	100
Management	48	34	10	4	2	98
Supervision	62	29	3	4	1	99
Training	40	35	13	9	1	98
Tools and resources	37	31	13	15	2	98

Generally, access to adequate information, management support and particularly supervision was satisfactory but there are some difficulties in accessing adequate training and adequate tools and resources based on the numbers that disagree.

Responses to all five aspects of support access were then combined into one variable and tested for reliability on 96 valid cases using Cronbach's Alpha scoring 0.864. This equates to high reliability of any of the five items as a measure of support access and this is predictable due to the skew in the data relating to these aspects.

The combined support access variable was then compared by care group (3), professional group (3) and age group (4) using ANOVA and by locality (2) and gender (2) using t-test for comparing independent samples. No significant differences (below 0.05) were identified and again this is predictable with the heavy skew in the data towards people agreeing.

What aspects of support are inaccessible or inadequate (Support gaps)?

Participants were asked to report what aspects of support were inaccessible or inadequate. Content analysis was applied to the free text responses. Only 30 respondents identified inaccessible or inadequate support and 50 support gap items were identified. The main themes are presented within categories relating to gaps in information, management, supervision, training and resources as presented in Table 10. The main gaps in terms of support were training and resources, which reflects the difficulties in accessing these.

Table 10 Support gaps

Categories	Themes (data items)
Information Gaps	often difficult to obtain (3) system failures (2)
Management Gaps	staff not consulted / involved (3) inflexibility (1) disjointed (1) too much change (1)
Supervision Gaps	not always possible due to staff shortages (1) could be better in Learning Disability services (1)
Training Gaps	unavailable (6) lack of specific training (4)
Resource Gaps	money (6) staff shortages (6) inadequate technology (4) time (3)

4.4 Practitioner responsibilities and values

For which areas of effective practice do practitioners acknowledge practitioner responsibility (Perceived responsibilities)?

Participants were asked to identify, on a five-point Likert scale between totally agree and totally disagree, to what degree they agreed with having responsibility for aspects of their practice. Aspects of practice were categorised as keeping knowledge up-to-date, participating in supervision, seeking appropriate training, assessing and managing risk, assessing need, providing evidence-based interventions, evaluating their effect, recording accurate activity data, providing effective care co-ordination and ensuring they are capable of discharging their responsibilities. These can be further categorised into personal aspects and practice aspects. Response frequencies are presented in Table 11. Again there was little missing data so these have been excluded from the tables.

Levels of perceived responsibility were extremely positive overall. However, when comparing the totally agree and unsure responses it can be clearly seen that there are differences between aspects. Responsibility for participation in supervision is rated more highly, as is keeping up to date and seeking training whereas overall personal responsibility is rated lower. Responsibility for assessing need (user-centred) and risk (safety) are more highly rated than evidence based practice, evaluation, collecting data (all effectiveness) and care co-ordination. This may reflect a higher value placed on user-centred and safe practice than effective practice.

Table 11 Participant ratings of responsibility for aspects of own practice

Practice Aspect	Totally agree	Agree	Unsure	Disagree	Totally Disagree	Totals
Keeping knowledge up to date	74	24	4	0	0	102
Participating in supervision	78	24	0	0	0	102
Seeking appropriate training	73	24	4	1	0	102
Assessing and managing risk	72	27	4	0	0	103
Assessing need	71	27	5	0	0	103
Providing evidence based interventions	58	34	8	1	0	101
Evaluating the effect of interventions	60	34	5	0	0	99
Recording accurate activity data	63	35	3	0	0	101
Providing effective care co-ordination	59	31	7	2	0	99
Discharging my responsibilities	63	24	11	1	0	99

Responses to all ten aspects of personal responsibility were then combined into one variable and tested for reliability on 91 valid cases using Cronbach's Alpha scoring 0.923. This equates to high reliability of any of the ten items as a measure of personal responsibility and again this is predictable due to the skew in the data.

The combined personal responsibility variable was then compared by care group (3), professional group (3) and age group (4) using ANOVA and by locality (2) and gender (2) using t-test for comparing independent samples. No significant differences (below 0.05) were identified, again as expected.

Comparisons between actual and potential practice

Participants were asked to identify, on a five-point Likert scale between totally agree and totally disagree: to what degree their practice was user-centred and to what degree it should be user-centred; to what degree they involved users in decisions about their care and to what degree they should involve users in decisions about their care and whether the safety of patients, staff and the public is paramount and whether it should be. Response frequencies are tabled below in Table 12.

Table 12 Participant ratings of actual and potential practice values

Practice Value	Totally agree	Agree	Unsure	Disagree	Totally Disagree	Totals
The needs of the service user are at the centre of all decisions I make about their care	35	48	11	9	0	103
The needs of the service user should be at the centre of all decisions I make about their care	74	26	2	1	0	103
I involve service users in every decision about their care	25	49	12	15	0	101
I should involve service users in every decision about their care	57	33	6	4	0	100
The safety of service users staff and the public is paramount	68	21	6	4	0	99
The safety of service users staff and the public should be paramount	81	16	2	1	0	100

Although many practitioners rated their practice as user-centred (mean 4.06) it is clear that there is still significant room for improvement as they felt it should be higher (mean 4.68). The results were compared by care group (3), professional group (3) and age group (4) using ANOVA and by locality (2) and gender (2) using t-test for comparing independent samples. A number of significant differences were found for user-centred practice. Locality B rated their practice as more user-centred than locality A (t -2.110, Sig. 0.038) and between care groups (F 9.504, Sig 0.000). Post-hoc analysis showed that the therapies rated their practice as more user-centred than social care (mean difference 0.984, Sig. 0.005). Both the older peoples group (mean difference 0.773, Sig. 0.003) and the learning disability group (mean difference 0.673, Sig. 0.002) rated their practice as more user-centred than the community adult mental health group.

Although many practitioners rated degrees of user involvement in decision making (mean 3.82) it is clear that there is still significant room for improvement as they felt it should be higher (mean 4.43). It is also clear that there is comparatively less enthusiasm for this than for practice being user-centred. The results were compared by care group (3), professional group (3) and age group (4) using ANOVA and by locality (2) and gender (2) using t-test for comparing independent samples. A significant difference was found between care groups (F 3.117, Sig 0.049). Post-hoc analysis showed the therapies rated their degree of user involvement higher than social care (mean difference 1.056, Sig. 0.005) and nursing (mean difference 0.845, Sig. 0.002). The learning disability group rated their degree of user involvement higher than the community adult mental health group (mean difference 0.649, Sig. 0.047).

Almost all respondents felt that the safety of service users, staff and the public are paramount (mean 4.54) but there is room for improvement (difference 0.26) as they felt it should be higher (mean 4.8). The results suggest that although safety considerations within current practice are generally a priority it is not paramount for a number of respondents (10.1% - 13%). The results were compared by care group (3), professional group (3) and age group (4) using ANOVA and by locality (2) and gender (2) using t-test for comparing independent samples. No significant differences were found.

4.5 Cultural dissonance

Cultural dissonance was assessed by considering expressed emotion in one of the groups and through qualitative analysis of the project outputs for potential conflict from a practitioner perspective.

Expressed emotion

During the group-work sessions held on the first adult community day, four of the group facilitators were asked to try and assess the degree of expressed emotion within the groups on a 19 point scale from 1 representing resentment / anger through to 19 representing enthusiasm / contentment with 10 representing a neutral mid-point.

Feedback on the use of this scale were that 'the rating scale was a bit 'woolly" and 'the rating scale was difficult to complete'. However, one facilitator reported that generally there was more discussion and focus on the negative aspects of services and not a great deal of enthusiasm for the positives. This is reflected in the ratings as summarised in Table xvi (appendix 4), with all issues rating a degree of anger / resentment apart from one, care pathways, which was rated as neutral.

Whilst the broad policy issues were discussed in the groups, specific issues were raised and recorded by the facilitators. These issues can be categorised by policy design, communication, practice development and support. The most anger and resentment were expressed specifically around the perceived shortcomings of control and restraint training which was the only identified support gap. Apart from two communication issues, there were twelve related to aspects of policy design, including five from the top seven, and seven related to practice development. Even the practice development needs were seen as the responsibility of the organisation, positioning the main source of dissonance from a practitioner perspective firmly with the organisation.

Potential for cultural dissonance

Any items or themes from the qualitative analysis of individual questionnaires and group outputs that could further illustrate the potential for dissonance between practitioners and the organisation were highlighted in the tables presented within the main report and Appendix 4. These were then themed and summarised in Appendix 5.

Table 13 illustrates the key themes with examples. The greatest potential for dissonance between practitioners and the organisation is where there is a perceived conflict between practitioner and organisational values, perceived increased workload without added value and a perceived need for improved interdisciplinary working or better service integration.

Table 13 Aspects of potential cultural dissonance

Themes	Examples
Values conflict (48)	"Trust Need to provide evidence of action taken" (8) "Trust Need to deliver follow-up days" (7) "Staff not consulted or involved" (3) "Nothing implemented fully or perfected"
Increased workload without adding value (19)	"CPA generates too much paperwork" "A back-covering exercise for risk"
Inter-disciplinary working (15)	"Need to involve other disciplines" (7) "Lack of communication between disciplines"
Service interface problems (12)	"All teams work differently" Where are the joint policies?"

4.6 The intervention

How useful was the intervention perceived to be (Intervention utility)?

Participants were asked to report ways in which the days had been useful. Content analysis was applied to the free text responses. 98 of the 103 participants provided a response of which only two respondents were explicitly negative. One respondent felt that it 'was not particularly useful...more a day for managers to get views from front line staff' (case 8 / group 1) the other negative response was 'not useful. What was the purpose of the day?' (case 33 / group 2).

Analysis of the 96 positive respondents identified a total of 185 useful items. The items were themed within categories relating to content, networking, sharing, time-out, positive outcomes and negative outcomes as presented in Table 14. Negative outcomes are items that were deemed to be useful because it confirmed negative aspects of the system.

Table 14 Intervention utility

Categories	Themes (data items)
Design	presentation of material (6) groupwork (6) good facilitation (2).
Activity	Sharing news / information / ideas / issues (37) networking generally(21) Sharing problems (15) Sharing good practice (14) networking with other professions (9) identifying areas for improvement (8) contributing to policy (7) reflection (5)
Positive Outcomes	anticipation of change (8) thought-provoking / stimulating / refreshing (7) increased knowledge of CPA (6) better understanding of policy (5)
Negative Outcomes	others are experiencing problems (6) widespread confusion / chaos (4) shared negativity (3) shared frustration (2) system inadequacies (1)

The main identified benefits of the activity were communicating / sharing with others and the opportunity to network. The main differences between care groups were that the learning disability service group identified CPA discussions as particularly useful (4/6), valued the networking with other professions the most (8/9) and made no reference to any negative outcomes. The older peoples service group only identified two negative outcomes (both shared frustration) meaning that most negative outcomes where identified by the adult community service groups (14).

How could the intervention be improved (Intervention improvement)?

Participants were asked to suggest ways in which the days could be improved. Content analysis was applied to the free text responses. 76 of the participants provided a response and of these 14 stated that the days were fine as they were. The remaining 62 respondents identified a total of 71 improvement items.

The items were themed into categories relating to design, activity, involvement and follow up as presented in Table 15.

Table 15 Intervention improvement

Categories	Themes (data items)
Design	clearer instructions for group activity (9) less presentations (3) better mix in groups (3) more representative title for the day (2) larger room (2) smaller groups (1) more handouts (1). better environment (1) more client carer centred (1) more practitioner centred (1) less jargon (1)
Activity	More time (13) to focus on specifics (6) to share practice (3) for feedback (2) more solution focused work (2) more group activity (1)
Involvement	Involving other disciplines (7) consultants / medics (3) ward staff (2) managers (1) psychologists (1) speech therapists (1)
Follow up	evidence of actions taken (8) follow-up days (7)

The main improvements suggested were to create more time for the activity, provide evidence that action had been taken based on the days, there was a need to have follow-up days and there was a need to involve all disciplines. The main difference between groups was that the need for clearer instructions for group activity (9) came exclusively from Adult Community services day two suggesting this was reflective of something specific to that day.

4.7 Post-hoc interview outputs

I think the main factor that assisted in the development and delivery of the project was being employed in the organisation that was hosting the project. I had access to resources to deliver the intervention and access to key people in the organisation providing the opportunity to influence.

The main hindrance occurred when I left the organisation to work in another Trust. The project faltered and it was extremely difficult to maintain links and access to the project team or data and particularly to influence key people. As policy analysis is also concerned with any unintended consequences, inaction, non-decisions, symbolic action and post facto rationalisations, a number of questions were raised. These were explored through interviews with the project manager and the project officer six months after the delivery of the final Practice Update Days. The questions posed and summary responses are presented:

Why were the anticipated numbers of update days not delivered?

Generally there was felt to be a loss of active leadership and authority for the project when the project director left the organisation that was not replaced within the project.

There was a sense that the project was no longer a priority and that some of the principles not being owned by Trust managers. The project board did not meet following the initial meeting.

Why were medics and psychologists not engaged?

One medic and one psychologist did attend the practice update days but neither completed an evaluation form. There was a sense of the project not being of interest to or a priority for these groups of staff.

Why were participant observers not engaged?

This is unclear. The participant observers had expressed their commitment to the project but apart from attending one project meeting did not attend due to other commitments.

How should the results be fed back to participants?

There was agreement that the summary findings should be fed back to participants because of ethical obligations and the strongly expressed desire of participants to see some impact from the days. However, despite sharing the results with the project sponsor and several offers to provide feedback to the Trust and participants these were not taken up.

4.8 Summary findings

In summary, three care groups covering adult community mental health, older people and learning disability services were included with good representation from nurses, social care, occupational therapy and physiotherapy. Psychiatrists, psychologists and operational managers were not represented.

There are many implications for both policy design and practice development which are interdependent. There are many recommendations for improvements, in particular there is a need to involve all staff to establish policy that is user and staff focused, offers clarity and standardises practice. Communication needs improving and opportunities and training should be provided to develop this requiring management support and resources.

Generally, access to adequate information, management support and particularly supervision is satisfactory but there are some difficulties in accessing adequate training and adequate resources.

Levels of practitioner responsibility were extremely positive overall although a higher value seems to be placed on aspects of user-centred and safe practice than user involvement and effective practice and there is room for improvements in all aspects.

Culturally, there is a degree of dissonance between practitioners and the organisation and from a practitioner perspective the main sources of this are conflict between practitioner and organisational values, increased workload without added value and a need for improved interdisciplinary working and better service integration. This is particularly evident in the adult community mental health services.

The intervention package was viewed extremely positively and the main identified benefits were the opportunity to network and communicate with others. Identified improvements include allowing more time for the activity, taking action, follow-up days and the involvement of all disciplines.

However, once I left the Trust the projected faltered, there was a sense that the project was no longer a priority and that some of the principles were not owned by Trust managers.

Chapter 5: Discussion

The *intention* of the project was initially to provide knowledge about local policy-practice integration, context and culture and secondly to be potentially reformative or transformative. Outcomes to evaluate 'what works for whom in what context?' in relation to the utility of the intervention package and 'what can work for whom in what context?' in relation to the *potential impact* of the project on policy-practice integration and culture are considered against previous work and a critical commentary is woven into the discussion.

5.1 Baseline knowledge

Policy Implications for Practice

Although the care groups considered a similar range of policies there are differences in how they were perceived. The policies under consideration carried different expectations and priorities. The sense of urgency and drive for policy implementation and the degree of impact on adult community mental health services is not as evident in older peoples and learning disability services.

Generally, there has been more policy issued affecting adult mental health services that includes more detailed guidance (Department of Health 1998a, 1998b, 1998c, 1999, 2001b, 2001c, 2005b). A formal care programme approach, for example, has been a policy imperative for working-age adult users of mental health services for many years (Department of Health 1991) whereas it has only recently being introduced for older people's services and is only recently being considered for learning disability services.

A number of studies have highlighted problems with the mental health system as a whole being under a great deal of pressure (Kelly 1998, Ford et al 1999). A local unpublished study (Pounder and Hostick 2001) concluded that the acute adult in-patient areas were experiencing a degree of stress on a par with community services (Galvin and McCarthy 1994, Onyett and Ford 1996, King's Fund London Commission 1997, Peck and Parker 1998, Norman and Peck 1999). Whilst the adult mental health NSF (Department of Health 1999) provided some clarity of purpose for specialist services, the participants in this study are still working in generic community mental health teams often with unclear roles and responding to a wide range of need.

Specifically, there are still problems with CPA provision in adult mental health services, as there were in the late 1990's (Peck and Parker 1998). Some commentators (Onyett and Ford 1996) were still suggesting that this was due to compliance failure requiring stronger management some fifteen to twenty years after the publication of evidence that traditional linear approaches to policy implementation were problematic (Van Meter and Van Horn 1974, Sabatier and Mazmanian 1979). It is clear that implementation approaches that are reliant on compliance are at best, marginally effective in the short term (Kelman and Hamilton 1989) or, at worst, create resistance (Forrester 1969) and detract from what needs to be done in practice (Schwandt 1997). Even now guidance still reflects a traditional linear (NICE 2005) or simplistic approach (Lindsay 2005) for policy implementation and if policy and practice integration is to occur then a different approach is needed.

Integration Enhancers and Support Gaps

The main identified enhancers to policy and practice integration were categorised as improvements to policy design, communication, practice development and aspects of support.

The main policy design enhancers were for all staff to be involved to develop clear policy that is standardised and focussed on the needs of service users and staff. Emphasis on the need for multi-disciplinary engagement and involvement is a key theme throughout the findings and is supported by recent studies (Garside 1998, Battram 1998, Wood 2000, Scott and Caress 2005) as is a focus on the needs of service users and staff (Anthony 1990, Rogers 1995, Hackett and Spurgeon 1996, Schoenwald and Hoagwood 2001, Henggeler et al 2002, Bergen and While 2005) to be successful. A key challenge for effective policy design is striking a balance between the use of guiding principles and rules (Wood 2000). Standardisation can help but if levels of detail and structure are increased it can lead to a lack of clarity. Therefore the development of local consensus statements may be more useful (Ferlie 2001, Procter and Rosen 2004, Berwick 2003, Lavis et al 2003).

It was suggested that effective communication and good access to information would enhance policy-practice integration and the use of technology has potential (Stacey 2001) but technology and technology support needs to be available and reliable. Informal approaches and networks that allow dialogue with peers, colleagues (McIntosh 2001) and opinion leaders (Rogers 1995, Grimshaw 2001) have proven to be effective so opportunities for these could be incorporated into more formalised approaches.

The need for practice development opportunities that offer effective training and education is supported (Sainsbury Centre for Mental Health 2001, Stevens and Hettiaratchy 2005) as is more time to consider service improvements (Closs and Lewin 1998, Griffiths et al 2001, Metcalfe et al 2001, Bryar et al 2003). A need for all disciplines to engage in dialogue about differences between policy and practice (Rogers 2001) and differences between managers expectations and different disciplines (Degeling et al 1999) was identified. Some of these differences are explored when considering reported practitioner values.

Support enhancers include the need for more time, more resources or staff, supportive managers and as previously mentioned effective technology. The participants felt that access to support including information, management and supervision was generally satisfactory although access to adequate training, tools and resources was relatively more problematic. However, as many other studies identify a lack of these supports as being a major barrier (Closs and Lewin 1998, Griffiths et al 2001, Metcalfe et al 2001, Thompson 2001, Welch 2002, Bryar et al 2003, Whitty et al 2004) and as these resources are predominantly controlled by managers it is essential that managers are engaged and involved in the process.

Practitioner Responsibilities

There were no significant differences found between the groups or disciplines in terms of perceived responsibility although this may have been different if medics and psychologists had been involved as professional backgrounds are, by definition, different in terms of their education, status and financial reward (Vanclay 1997).

The levels of perceived responsibility were generally high although some aspects were rated more highly than others. Levels of responsibility for personal development including keeping themselves up to date, participating in supervision and training were rated the highest followed by aspects of practice delivery that focus on safety and service user need. There was less emphasis placed on other aspects of practice delivery including evidence-based practice, data collection, evaluation, care co-ordination and overall responsibility which relate predominantly to effectiveness.

This suggests that certain aspects of practice are valued more highly than others: personal development is valued over practice development and user centred and safe practice is valued over effective practice and user involvement. Hence a values hierarchy seems to exist. Complexity theorists argue that logic and rationality are seldom the root cause of persuasion and that autopoiesis (self-regarding and self-making) is a characteristic of both organisms and organisations. Traditionally, practitioners rarely rely on research to guide their practice (Rosen et al 1995) and often internally produced evidence (Ferlie 2001, Berwick 2003, Procter and Rosen 2004) and ideas are more influential than data or systematic reviews (Lavis et al 2003). The role of values is key as essentially, the members of an organisation(s) will produce forms of behaviour that will be psychologically advantageous to them (Stapley 1996) and if espoused values are in line with the values of practitioners this will lead to trust and increased chances of success (Nolan and Grant 1993, Fulford and Williams 2003) and internalisation which means that people behave in particular ways that fit with their value system (Kelman and Hamilton 1989).

Effectiveness

There was less value placed on responsibility for aspects of effectiveness and although there were no significant differences found between participating disciplines this may not have been the case if medics and psychologists were involved as they may ascribe to different hierarchies of evidence. In biomedical science there is general agreement over a hierarchy. The higher a methodology is ranked, the more robust and closer to objective truth it is assumed to be as exampled by Sheffield Centre for Health and Related Research (2002) whereas other disciplines are more likely to use other forms of evidence and nurses are more prone to using intuitive approaches to clinical decision-making (Cioffi 1997). This reinforces the need for opportunities for all disciplines to engage in dialogue about these differences (Degeling et al 1999, Rogers 2001).

Previous local studies have highlighted a number of barriers to getting research findings into practice for nurses and therapists (Closs and Lewin 1998, Griffiths et al 2001, Metcalfe et al 2001, Bryar et al 2003). For therapists (Metcalfe et al 2001) the greatest barriers were understanding statistics (78%), literature not being compiled in one place (78%) and conflicting results (75%). For mental health nurses (Griffiths et al 2001) the greatest barriers were; insufficient time available to implement new ideas (74%), inadequate facilities for implementation (69%), statistical analyses not being understandable (66%). Other highly ranked barriers were perceived lack of authority to change practice, accessible and understandable research and a lack of peer support. The differences between nurses and therapists in terms of perceived time pressures suggest that some disciplines may feel under more pressure than others.

An action plan to overcome the perceived barriers to research utilisation had been implemented following the publication of the results from the barriers studies (Closs and Lewin 1998, Griffiths et al 2001, Metcalfe et al 2001, Bryar et al 2003). The findings from the current study suggest that whilst some barriers remain including insufficient time and accessible and understandable research (policy), there does seem to have been improvements in practitioner's perceptions of their authority to change practice (personal responsibility) and availability of peer support (access to support).

User-centred care

A number of significant differences were found for user-centred practice. Locality B rated their practice as more user-centred than locality A. The therapies rated their practice as more user-centred than social care. Both the older people's group and the learning disability group rated their practice as more user-centred than the community adult mental health group.

A study by the author on concordance with appointments (Hostick and Newell 2004) surveyed people's reasons for discontinuing contact with adult community mental health services in locality B. This was an early example of 'user-centred' research prioritised by users and carers within an earlier study (Hostick 1998). The main reasons given for discontinuation were dissatisfaction, although the reasons were varied and the interplay between variables was complex. Whilst the respondents were not apparently suffering from 'severe mental illness', there was a clear, expressed need for a service. The study concluded that, whoever provides such a service should be responsive to expressed need and a non-medical approach seemed to be favoured. If these needs are appropriately met then users are more likely to be engaged and satisfaction is likely to be improved. Although this in itself does not necessarily mean improved clinical outcomes, users are more likely to stay in touch until an agreed discharge. This conclusion is similar to the outcome of a Cochrane collaboration review of training for health care providers to be more 'patient centred' (Lewin et al 2001). Whilst training may improve communication in consultations and increase satisfaction with their provider's manner it is not clear whether this training makes a difference to health care use or outcomes.

In recent years the Healthcare Commission has commissioned national surveys of both staff (2003, 2004) and users of adult mental health services (2004, 2005). Although staff surveys do not cover constructs such as user-centred practice the user surveys do. The survey findings provide comparative perceptions of these constructs although only for users of adult services at the moment. Some related results from the national surveys are presented in Tables 16 and 17 for comparison. Users were asked to rate mental health services in relation to a number of questions and their responses were scored from 0 – 100 with 100 being the best possible score. Results from an adult mental health service user perspective in Table 16 show that aspects of user-centredness are rated consistently highly for all disciplines.

Table 16 Trust scores for user-centredness from national survey

Question	2004 Results	2005 Results
Did the Psychiatrist listen carefully to you?	82	83
Did the Psychiatrist treat you with dignity and respect?	88	89
Did the CPN (Nurse) listen carefully to you?	91	90
Did the CPN (Nurse) treat you with dignity and respect?	94	93
Did the Social Worker / OT / Psychologist listen carefully to you?	88	86
Did the person treat you with dignity and respect?	92	89

These results suggest that service users rate user-centred practice highly for all professionals but particularly nurses in adult services. The fact that older people's services and learning disability services rate their practice as more user-centred than adult services is of interest. This may be indicative of the greater policy pressure on adult services leaving less time for them to be user-centred or that older peoples and learning disability services (O'Brien 1988) are clearer about their purpose and contribution towards their service users.

User involvement

A number of significant differences were found for user involvement. The therapies rated their degree of user involvement higher than social care and nursing and the learning disability group rated their degree of user involvement higher than the community adult mental health group.

Work on developing user involvement has a relatively long history in locality B. Examples include user-led monitoring (McClelland 1998), mental health needs assessments using focus groups (Hostick 1995, 1998), a co-operative inquiry between nurses and service users (Hostick and McClelland 2000, 2002) and user-led research initiatives (Walsh and Hostick 2005). However, results from an adult mental health service user perspective in Table 17 show that user involvement is actually scored less than the previous year's survey. This suggests that user involvement in other activities, whilst benefiting the participants involved, does not necessarily lead to improvements in involvement in decisions about their own care. However, the higher rating for user-centred care by practitioners in locality B may be as a result of the user-centred research activity which involved nurses.

Table 17 Trust scores for involvement from national survey

Question	2004 Results	2005 Results
Do you have a say in decisions about the medication you take?	62	59
Were you involved in deciding what was in your care plan?	81*	67
Do you have enough say in decisions about your care and treatment?	68	66

* This question was phrased differently in 2004 survey as 'Were you given the chance to express your views at the last care review meeting?'

The survey findings show that although users do consider themselves to be involved in decisions about their care and treatment it is not as highly rated as aspects of user-centred practice. This could suggest a degree of deference to the professionals as the 'experts' or that professionals are more critical of their own practice.

The results presented in Table 16 and Table 17 also suggest that the intervention did not have an immediate effect on user ratings of user-centred practice or user involvement even though the intervention did take place in between the surveys. As the potential for improvement was identified by participants it will be interesting to see if there are any improvements in follow-ups of staff ratings or further user surveys.

The fact that learning disability services rate their levels of user involvement greater than adult services may again be indicative of the greater policy pressure on adult services or indeed a longer tradition of involving service users through normalisation (Wolfensberger 1972).

Safety

The results suggest that safety considerations within current practice are a priority although it is not paramount for a number of respondents. The ratings for practitioner's responsibility for assessing and managing risk were also relatively high. There were no significant differences between groups.

The staff surveys undertaken by the Healthcare Commission offer some quantitative results that relate to questions of safety. The survey for 2004 provides comparisons with other Trusts, comparisons against previous results (2003) and some comparisons by professional group, work patterns and demographics. The main related significant finding was a 7% decrease (from 35% to 28%) in the percentage of staff witnessing potentially harmful errors or near misses in previous 12 months. In fact this Trust was in the range for the best 20% of comparative Trusts. However, there were differences between professional groups within this finding; nursing (43%), medical staff (41%) and allied health professionals (12%). The results for nursing and medical staff are high compared to those of allied health professionals. This may reflect the fact that many errors relate to medicines management and as yet allied health professionals are not involved in this activity. It would be interesting to explore any differences between care groups in the future.

Cultural Dissonance

In the adult mental health group some of the issues that created more expressed emotion related to concerns about the safety of staff or users. The issue that created the highest levels of anger related to being unable to release staff for training and the lack of courses available for training to manage work related violence resulting in staff feeling vulnerable and unsafe.

The greatest potential for dissonance between practitioners and the organisation is where there is a perceived conflict between practitioner and organisational values, perceived increased workload without added value and a perceived need for improved interdisciplinary working or better service integration. This conflict between perceived demands and perceived ability to cope (for both practitioners and practitioner's views of the Trust) could be symptomatic of organisational stress (Cox 1978, Palmer et al 2001).

There is evidence that mental health services were experiencing degrees of stress both nationally (Kelly 1998, Ford et al 1999, Davis 2002) and locally (Pounder and Hostick 2001). There is also evidence of higher stress levels among healthcare staff than the general working population (Wall et al 1997), particularly for psychiatrists (Deary et al 1996) and mental health nurses (Fagin et al 1996). The staff survey for 2004 provides comparisons with other Trusts, comparisons against previous results (2003) and some comparisons by professional group, work patterns and demographics. The main related significant finding was an 8% decrease (from 43% to 35%) in the percentage of staff suffering from work related stress. Whilst this level is still high it is only just outside the best 20% of all comparative Trusts. There were differences between professional groups with nursing (40%), allied health professionals (31%) and medical staff (24%). The implication is that nurses as a group are indeed feeling more pressure, a point highlighted by Davis (2002) when commenting on the impact of incessant NHS change on nurses.

Aspects of potential conflict between practitioner and organisational values include: practitioner perception of ineffective management practice, a lack of practitioner involvement in organisational decision-making and inaction. There is national evidence to support some of these perceptions: Hurford (2003) concludes that top down policy implementation may be stifling creativity, Peck and Parker (1998) highlight a reluctance of practitioners to comply with systems developed by managers not involved directly in service delivery, Peck (1991) identifies increased managerial power at the expense of clinical power in the NHS through the control of resources conditions and Firth-Cozens (2005) argues that the development of general management in the NHS over the past twenty years and top-down messages / values of performance, expediency and efficiency do not necessarily sit comfortably alongside quality values. Galvin and McCarthy (1994) highlight under-functioning of some services due to a lack of clarity on purpose, role and relationships whilst Onyett and Ford (1996) suggest that either clinical staff do not respect or comply with requests from management or that management is weak.

The national political forces of inertia, expediency, ideology and finance (Walker 2000) also operate at a local level and local research into service quality (Hostick 1995, 1998, McClelland 1998, Hostick and McClelland 2000, 2002, Hostick and Newell 2004, Walsh and Hostick 2005) has had relatively little impact on local services. Certainly, the current dominating force is clearly finance as outlined in the latest operating framework for the NHS (Department of Health 2006).

In terms of a perceived increased workload without added value, Frank (2004) refers to a climate of excessive bureaucracy and risk management having a damaging effect on effective mental health nursing care and Barry (2006) identifies a context of massive demand and expansion underpinned by recent health policy developments when considering the clinical governance implications for psychological therapies.

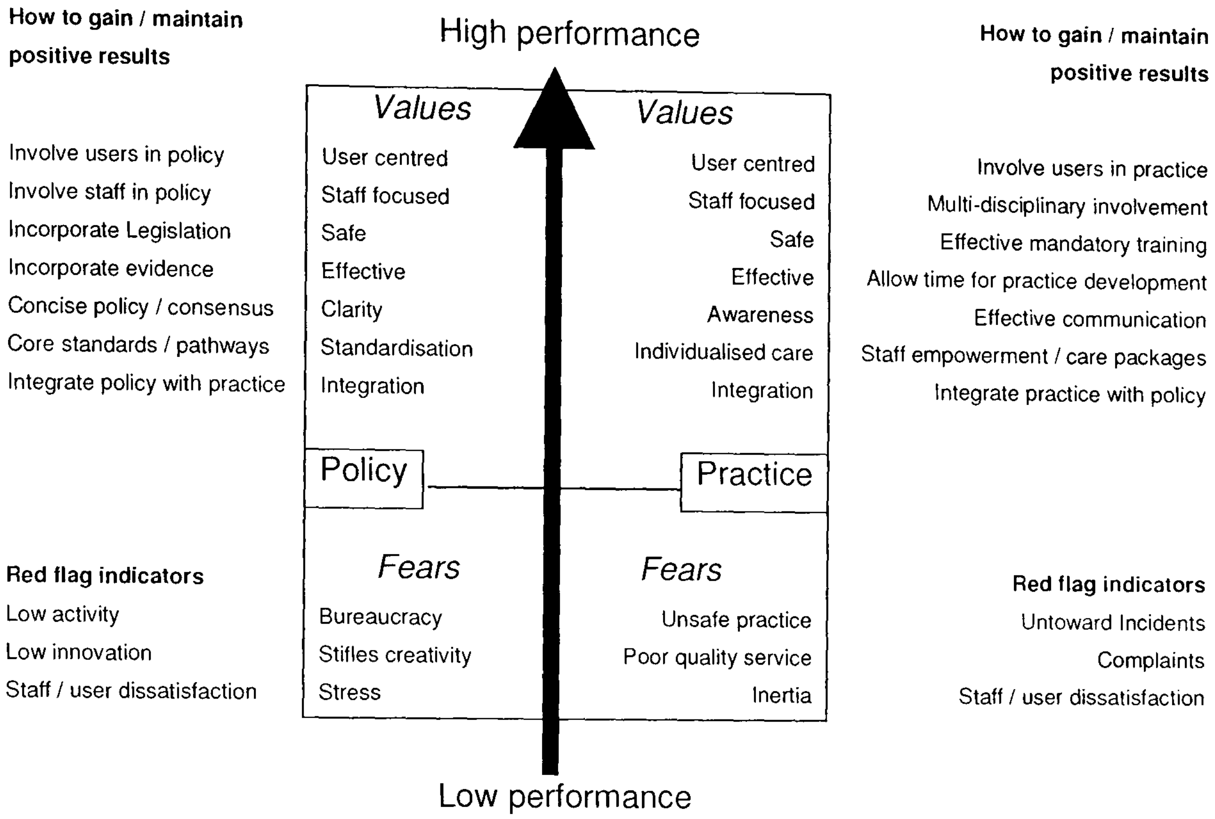
The perceived need for improved interdisciplinary working or better service integration is also reflected nationally, the King's Fund London Commission (1997) pointed to systemic problems in inter-agency and inter-professional working within mental health services whilst Norman and Peck (1999) suggest that some powerful professions (consultant psychiatrists or clinical psychologists) exempt themselves from the workings of teams including the notion of accountability to a manager.

5.2 The intervention

The intervention was evaluated in terms of its utility and ways in which this could be improved. Whilst generally perceived as positive, it is the opportunity to discuss issues with colleagues and network that is most highly valued. The focus on policy and practice issues that are real concerns to practitioners leads to practitioner engagement and a framework based on principles of clinical governance and the needs of different care groups means that the style of approach is predominantly patient-oriented (Davies et al 2000). Wood et al (1998) found that professionals collaborate in discussions and engage in practices which actively interpret the local validity and value of research within particular contexts and particularly with a focus on local ideas, practices and attitudes. It is clear that many people that did attend would like to see all professional groups represented and in policy terms it is essential if professional silos are to be avoided.

The policy–practice gap represents a polarity to be managed rather than a problem to be solved. Polarity management (Johnson 1996) was utilised implicitly throughout the project demonstrating flexibility and apparently providing the means to manage complexity. Polarities are usually ongoing phenomena with two interdependent alternatives. Another way of viewing this distinction is in terms of what Johnson (1996) refers to as 'either / or thinking', where the choice is between two alternatives, and 'both / and thinking' where equal consideration is given to both alternatives. This concept can be further applied to 'multarities' or many interdependent opposites composing complexity. Other examples of polarities that healthcare organisations need to manage include patient needs and staff needs, individualised care and standardised care, stability and change, quality and cost. These tensions were explored within the scope of the intervention package utilising polarity management (Johnson 1996) requiring the identification of and a focus on the advantages or 'upsides' of both polarities over time and a worked example of this is presented (Figure 3).

Figure 3 A polarity map for integrating policy and practice.



Template for map taken from Johnson (1996)

The main aim of policy and practice integration is to achieve higher performance and this requires actions to be taken to gain or maintain the things that are valued about both policy and practice. The initial drive can come from either policy or practice issues but momentum is accelerated by paying due attention to both. The map has been populated by the outcomes from the study but the mapping can be applied to any polarity in any context and culture. In this example many of the values are shared. Where there are differences, for example standardisation and individualised care, these may represent a further polarity requiring further detailed work. Likewise the things that would tell you that you were neglecting either policy or practice (fears) need to be monitored (red flag indicators).

The notion of 'managing' complexity is in itself paradoxical. Complexity theory (Battram 1998, Wood 2000) is based around a number of critical points including;

- Organisational life is systemic without being systematic - it is both predictable and unpredictable.
- Causal analysis is virtually impossible due to too many variables
- Diversity rather than homogeneity is a more productive base
- Order is built from relationships rather than enforced by structures
- Individuals work on the minimum spec to get the work done

This understanding means that if organisations are structured along the edge of chaos (a point between over-structured inertia and under-structured confusion (Connor 1998)) then a self-organising approach will arise from the chaos. Therefore the choices are to try and impose order or exploit the chaos by working within it.

However, the intervention accommodated both predictability and unpredictability and provided a framework for creating some order in parts of the system. Some causal factors were identified although by no means all. There were diverse contributions from the participants that provide the basis for dialogue and the activity was reliant on relationships albeit within a structure and participants worked effectively, given relatively brief instructions and limitations.

Halladay and Bero (2000) identify the potential for clinical governance in the United Kingdom to represent a systematic conceptualisation of the uptake of evidence and subsequent changes to practice. The intervention is an example of practice development to facilitate individual and organisational learning as a dimension of clinical governance. Recent emphasis on individual learning, lifelong learning and the role of self-directed and problem-based professional education regimes (Schmidt 2000, Collin 2001) and organisational learning requiring both adaptive and generative learning (Senge 1990) are needed to develop organisational fitness (Argyris and Schon 1998). Many organisations espouse their desire to be a learning organisation, including the host Trust, which was one of the supporting arguments for undertaking the project. The intervention package provided a framework for considering not only processes but also patterns within the system including thinking, behaviours, relationships, trust, values, conversation, communication, learning, decision-making, conflict and power (Capra 1996, 2002).

Halladay and Bero (2000) classify studies of this nature as a moderately complex strategy positioned between professionally based strategies that are lower complexity and whole system strategies that are of higher complexity. They identify four key success factors; thorough planning of interventions, leadership, a supportive cultural context and effective monitoring systems.

Planning

The planning of the intervention has been described in detail. The main suggestions for improvements, based on the frequency of participant response, were to provide evidence that action had been taken in response to the outputs from the days; there was an expressed need to have follow-up days and a need to involve all disciplines. The first two suggestions relate to follow-up actions, which ethically are desirable and were planned in the original proposal, but the key improvement to the intervention was the need to involve all disciplines. The feedback on the content and the facilitation of the days was extremely positive. There was good evidence of collaborative working but, as not all disciplines were represented, the scope of the approach was limited to those professions that did participate. Methods to engage all disciplines, particularly medics and psychologists, and operational managers need to be explored further.

Leadership

My role as *project director* required demonstrable leadership at a number of levels. Aspects of Emotional Intelligence (EI) (Goleman 1986) were applied including self awareness, self management, social awareness and social skill that are fundamental in achieving transformational change. These skills are often tacit but were made explicit through the project. Complexity theorists argue that logic and rationality are seldom the root cause of persuasion and that autopoiesis (self-regarding and self-making) is a characteristic of both organisms and organisations. Change must begin with establishing and appealing to the self-interests of the organisation and individuals as people may do what you want if their self interest persuades them to comply. Leadership may therefore be achieved by establishing what followers want, then satisfying this through some process of exchange in which both sides can win by negotiation rather than debate (Bass 1985). Leadership is viewed as a relationship between those who aspire to lead and those who choose to follow and applying these principles in practice required me to act as both leader and follower with both senior managers and practitioners.

Joynson and Forrester (1995) argue that the solutions to most organisational problems are already known to workers but formal leaders prevent them from implementing solutions. I was able to convince senior managers that the package would meet their needs of policy implementation but in order to engage practitioners I needed to emphasise the potential benefits of them being able to influence policy requiring effective negotiation.

Supportive cultural context

There was expressed top down commitment and expressed senior management support for the project as reflected in the establishment of a project board with project approval and access to resources granted.

However, the post-hoc interviews with the facilitators highlighted that once I had left the organisation the project lost leadership, organisational support and commitment. There were also difficulties in engaging the project sponsor in any form of follow-up to discuss these issues. There was a sense that the project was not a priority and the engagement of practitioners to consider policy and practice development was not valued by the organisation. If this was the case then some of the potential for dissonance between the practitioners and the Trust identified by practitioners may well have been realised. Elgie (1995) recognises that leadership effectiveness is limited by the institutional structure within which leaders operate and that the appointment, monitoring, reward and accountability structures and processes all play some part in inhibiting and / or encouraging certain forms of leadership particularly in the public sector.

In polarity management terms, manager's values need to be given equal attention. Walker (2000) argues that government policy incorporates powerful political forces of inertia, expediency, ideology and finance. These political forces also operate at a local level. The current dominating forces are finance, as outlined in the current operating framework for the NHS (Department of Health 2006), and expediency as characterised by the drive for modernisation. Whilst modernisation does incorporate an ideology of user-centredness, safety and effectiveness it is being driven through instrumental mechanisms for policy implementation with an overemphasis on performance monitoring that paradoxically can lead to inertia in practice.

Seddon (2003) is one critic of modernisation and performance management in the public sector as he claims there are no reliable methods for the setting of targets. He argues that traditional managers manage work according to the work plan; the principal tools used are the budget and work standards, hence managers become preoccupied with productivity measures. A traditional management culture still predominates within the NHS generally due to a focus on developing a management culture since the mid 1980's (Peck 1991) with the managerial qualities of individuals being valued more highly than leadership (Hostick 2006). Heifetz (1994) distinguishes between technical or management issues and adaptive responses or leadership and differentiates between power derived from a formal role and power derived from an informal role. Despite the fact that the NHS is changing radically and leadership is now being encouraged rather than inhibited (Elgie 1995) the management of the NHS is still generally operationalised through hierarchies and traditional command and control management structures.

This is also characteristic of the approach still adopted for national policy implementation which is at odds with the desire to be a learning organisation. Learning always occurs over time and in real life contexts (Senge 1999) and it takes time to achieve transformational change. Although there is great potential for transformational change, managers are being pressed for quick results and the aspiration may be too idealistic. Although the practice culture appears to be relatively conducive to the approach, the Trust culture as reflected by management behaviour was not. The priority for the Trust was to achieve a three star performance rating by ticking the right boxes. It is understandable that the project ultimately folded with these competing demands. In fact Senge (1999) suggests that resistance in the system as inevitable and identifies challenges such as; 'not enough time, no help, not relevant, not working, we keep reinventing the wheel'. If I had remained in post then perhaps these challenges could have been responded to.

Effective monitoring systems

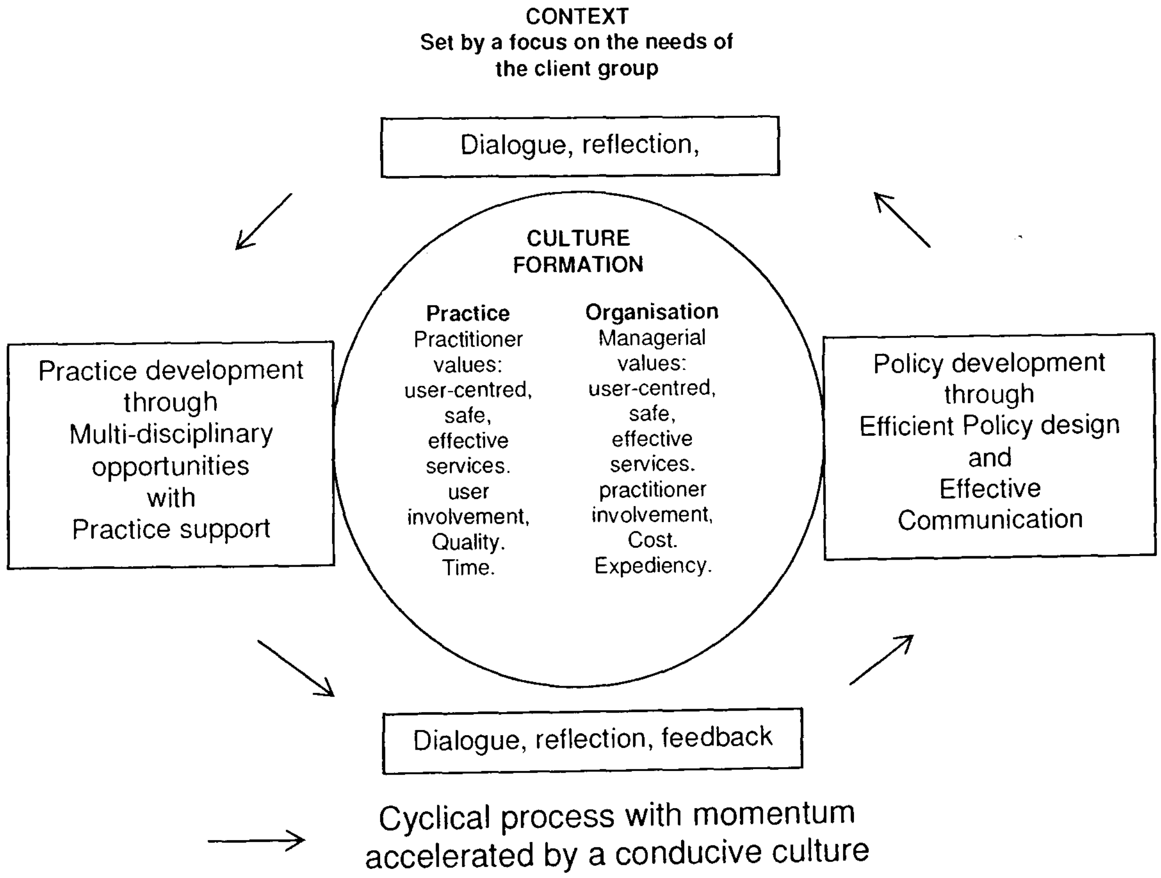
It is difficult to evaluate any degree of reformative impact (modifying) or transformative impact (establishing new patterns) without follow-up over time, a point made by Walker (2000). Pascale et al (1997) and Vierling-Huang (1999) also illustrate how long it takes to effect transformational change in large organisations. Whether the potential of the approach can be fulfilled remains to be seen. However, participants rated how they think their practice should be in terms of user-centred practice, user involvement and safety and by comparing these results with their ratings of their current practice it was possible to identify the potential impact of the intervention (i.e. has the intervention identified gaps in their practice). Potential impact is the difference between ratings and the higher the score for how practice should be reflects the degree of importance attached to the construct by practitioners.

Although many practitioners rated user-centredness, user involvement in decision making and safety considerations relatively highly for their current practice there was still room for improving all these. The potential for impacting on user-centred practice and user involvement is greater than for safety but safety is ranked as more important than user centred practice which is ranked higher than user involvement.

5.3 Potential impact on policy and practice integration

The intervention has definite potential. If evidence based policy is taken as the 'know about' and the 'know what' this can be developed through the intervention. Increased understanding of context and culture as the 'know who' and the 'know why' can also be established. The facilitation or 'know how' is in the form of a theoretical approach that requires further testing. The approach incorporates a process, a diagnostic and a model to balance adaptive learning through policy development with generative learning through opportunities for local invention and experimentation in practice (Figure 4).

Figure 4 A theoretical model for integrating policy and practice



To facilitate this cycle, policy and practice need to be considered equally through social opportunities, dialogue and reflection. The cycle operates at two levels; a practice level delivered within care-group focused opportunities, and an organisational level within a rolling programme.

Outputs should be produced and acted upon and the means to monitor the impact of the intervention over time needs to be developed. Measures of activity, innovations, untoward incidents, complaints and results from satisfaction surveys of staff and service users can be utilised.

5.4 Potential Impact on culture

Assessing the potential impact on culture is more challenging. Stapley (1996) offers a convincing explanation of culture developing in a similar manner to personality with reference to psycho-dynamic developmental theory (Obholzer and Roberts 1994, Obholzer 1996) and the inter-relatedness of the members of the organisation with the organisational holding environment as a psychosocial process that is influenced by conscious and unconscious processes (Egan 1993). Both the uniqueness of the collective, perceived view of the members of the organisation and the organisational holding environment results in a unique culture in every organisation and every part of an organisation. That is, each NHS Trust is different and each organisation within it (however defined) will be different. One of the main impacts of the adopted approach is that organisational culture is considered explicitly, thereby creating the potential to influence culture formation.

Organisational culture can be described as the personality of the organisation and as such can be measured, studied and influenced. As each organisational culture or personality is different then a 'diagnostic' of personality / culture is necessary and the project encompassed assessment of both conscious and unconscious elements. The conscious aspects were captured by the completion of tools and measures but in order to observe the unconscious aspects of organisational culture it is necessary to intervene, support and respond (as in a therapeutic relationship). Unconscious aspects of Trust culture were explored through analysis of: the outputs from the monitoring scale used to capture expressed emotion on the first day by group facilitators and analysis of individual and group outputs from the days reflecting any dissonance between practitioners and the Trust.

If there is dissonance or stress in a service created by negative perceptions of the organisation then staff may well be task resistant. This requires effective leadership which can lead to cultural change and staff becoming task receptive. It would be useful to compare the results of the staff survey to see if any significant differences in stress levels between care groups are lost through analysis at an organisational level.

The complex constitution of the community of practice means it is certainly multi-cultural and the results of this study support this premise by illustrating differences between services for different care groups, different professions and different localities representing a number of sub-cultures. Whilst the differences between localities are few and the differences between those professional groups that attended are potentially interesting, it is the differences between care groups that are of greater interest in this study due to the focus on the needs of service users rather than professional groups.

To succeed, any intervention should be context specific (defined by the needs of the client group), requires an understanding of the contextual parameters and needs to be encompassed within an organisational approach to learning that establishes supportive structures, processes and cultures. Without the will or commitment of leaders and followers then any progress is likely to be minimal (Etzioni 1961, 1964, Stewart 2001) and management commitment is unlikely to be offered unless the pressing performance demands of national and organisational priorities are also responded to or eased.

This was a major epiphany for me and the impact was significant. The learning from the project has been applied in my new role as Director of Clinical Governance in a different Trust. In my current organisation there is diverse experience, knowledge and expertise amongst the Senior Management Team and although finance and technical management are important these are balanced with concerns for quality and a concern for people. Trust services have been restructured into clinical directorates based on care groups and multidisciplinary forums for clinical governance established. The processes are still predominantly top-down and linear as there is still the need to deliver against national performance targets but we are developing more practice-led processes in parallel. In my current organisation I have support from the Chief Executive and colleagues in senior management and responsibility for developing a whole system approach to care pathways and care packages in the Trust. Initially the focus is on adult mental health services but the principles are starting to be applied to other care groups. The process has wide multidisciplinary and service engagement within the Trust and is part of a national project to develop Payment By Results (PBR) in mental health services. Although it is part of the national project the approach this Trust is adopting is very different to the one being developed nationally and rather than it being discounted its potential is recognised and receiving encouragement. The acceptance of diverse approaches to policy illustrates the changing culture of the NHS although there is still much to be done. I am functioning as a leader and expert practitioner and my activity will generate further learning, publications and presentations.

5.5 Effectiveness and limitations of design strategies

The overarching framework of policy analysis was appropriate and useful. Policy is conceived as a process including several stages. Agenda setting takes place that is informed by national drivers and local need. Consideration is given to the implications of policy for practice and potential solutions. The practice update days elucidate the causal structure of the problems and of measures that would intervene in this causal structure. The options for intervention still need to be considered but they have been identified. Once selected, options need to implemented and evaluated and the means to complete this have also been identified. The behaviours of relevant actors have been described as have unintended consequences, inaction, non-decisions, symbolic action and post-facto rationalisations.

Action takes place within a context that can affect as well as be affected by the policy process. This is seen not just by the policy under consideration but also by the implicit effect of previous and related policy. Explicit theory has been produced that does encourage the questioning of the taken for granted.

A critical view of social programmes being an approach of management control is provided by Alvesson (1993). This may well be one potential use of the approach but it could also be seen as an approach of practitioner liberation dependent on the underlying purpose. If the purpose of the intervention is managerial control or social management then a critical stance may be taken whereas if the intention is 'professionalising' or empowerment then a consensus approach can be adopted.

The adopted process for the intervention meets the criteria for 'professionalising action research' (Hart and Bond 1995). Reflective Practice was encouraged within the project and individuals were asked to record their reflections, albeit in a limited form, through an evaluative questionnaire. The project encompassed interdisciplinary policy, practice and participation within a defined community of practice and shifting membership between events. The focus was on quality, achieved by developing professional policy that was underpinned by user-centred values and emergent evidence from identified practice gaps. Due to the opportunities to influence policy, criteria were contested and determined by professionals throughout the project. The agendas were professionally led, informed by quality process issues and practice problems and although limited due to pragmatic constraints there is real potential to improve defined practice for the benefit of service users. Both research and practice components operated in tension, and although research-dominated for the purposes of this report there is potential to continue the process with practice-domination. Specific causal processes were identified throughout and reported elsewhere and the process as described was cyclical, opportunistic and dynamic. The project was reliant on the effective collaboration of researchers and practitioners at all stages with some merging of roles and most of the resources were internal there was some utilisation of external academic resources.

The main limitation of the action research approach was being unable to complete the high level cycle and evaluate the actual impact of the project on practice. However, there is scope for improvement in all aspects of practice and a willingness to work towards this. The methods have the potential to enhance both the professional and individual's control within the project by providing a framework for policy consideration and feedback.

The mixed methods approach to 'realistic' evaluation (Pawson and Tilley 1997) of 'what works for whom' and the collection of quantitative and qualitative data provides the basis for describing both the practice context as defined by the objective, subjective and inter-subjective elements of Habermas's '3 world's view' (1984), and the outcomes of the intervention.

It seems from the responses that participants value the social aspects of these types of event, regardless of the focus of the day, and there are other potential benefits such as improving morale and team building. The practicalities and logistics of organising and delivering large-scale events need consideration. Some services such as those for acute in-patient care find it very difficult to release numbers of staff at the same time due to work pressures. Likewise it is challenging for some smaller services to take time out if they have to provide essential services. One of the risks, again, is the creation of service silos unless all services are engaged. The process can be applied but alternative modes of delivery need to be considered, such as smaller sessions focused at team level or task groups working with services or the use of technology to create opportunities for all staff to be involved. A shift from 'same time, same place' technologies such as events / meetings to 'any time, any place' technologies such as on-line discussions, virtual teams, networks and e-learning could be considered.

A major limitation of the approach is that the project did predominantly focus on practitioners and practice culture. The approach works at this level if there is an opportunity to adopt it. However, fundamentally, any effort needs to be encompassed within an organisational approach to learning that establishes supportive structures, processes and cultures to balance adaptive learning through a policy framework and monitoring with generative learning through opportunities for local invention and experimentation (Hargreaves 1998) in order for potential to be realised.

Such an approach requires management support at corporate and operational levels and the rationale for using polarity management implicitly requires further clarification here. Firstly, I had received negative feedback on its utility having earlier tested the approach explicitly with a large group of senior managers in the Trust. Secondly it took longer (two days) to develop the approach explicitly than was available to deliver the intervention process (one day). A series of *Improvement Leaders Guides* (Department of Health 2005c) have been published based on the work of the NHS Modernisation Agency which set out a range of approaches including a reference to polarity management. However the successful application of these is predicated on the 'buy in' of managers, many of whom may not want to 'buy in' (Smith 2001). The feedback I received from senior managers poses a question about the acceptability of explicit approaches to service improvement in the NHS. This combined with the perceived differences in practitioner priorities and Trust priorities and the results of the post-hoc interviews suggest that although the approach had been initially sanctioned by senior managers they had not in fact bought into it.

5.6 Limitations of methods

The nature of the inquiry, the mixed model design and combination of quantitative and qualitative methods posed a number of methodological dilemmas or 'polarities' (Johnson 1996) requiring pragmatic decisions. Methods for capturing policy and practice issues, utilising the best of quantitative and qualitative design, data collection and analysis, can be viewed as polarities or interdependent opposites that require effective management to provide a richer picture of the complexities involved. This is not to say there is no room for problem-solving approaches, but that these should be applied appropriately. Johnson offers four lenses that can be applied that differentiate between polarities and problems.

Polarities are usually ongoing phenomena with two interdependent alternatives, requiring you to identify and focus on the advantages or 'upsides' of both over time. This approach was adopted throughout the study to successfully consider not only methodological and ethical dilemmas and to develop a theoretical model and process but also less successfully to ensure support for the project.

The methods adopted within the approach do have limitations. The inability to recruit medical staff and psychologists to the project needs further exploration. It is clear that many people that did attend would like to see all professional groups represented and in policy terms it is essential if we are to avoid professional silos.

The collection of the qualitative outputs from the sessions was done by different people for each group on each day. This meant that the style and content varied from one word responses, through short phrases to coherent paragraphs. Therefore whether this reflects the activity and outputs of the sessions or the skills of the scribe is not clear. Standardisation of the output formats would assist data analysis.

The piloting of the evaluation questionnaire and rating scale demonstrated further potential. The constructs of user-centredness, safety and effectiveness within the questionnaire could underpin the development of a cultural diagnostic tool but this will need to be separate and distinct from the evaluation of policy / practice integration. Incident data and national surveys of staff and user perspectives can provide better measures of impact evaluation.

Participant observers, although initially engaged and interested, did not actually participate. The reasons for this are unclear but seem to relate to the absence of the personal influence of the project director once the programme was running. The main role of the participant observers was to develop a sense of any underlying dissonance during the days. Whilst the completion of a rapidly developed scale to assess expressed emotion was able to offer some measure of this it was extremely limited. However the concept of culture in relation to change and how those who are expected to change perceive it is a key consideration and has great potential. If there is suspicion or scepticism of organisational motives then there is likely to be task resistance rather than task responsiveness if the culture is perceived more positively.

These observations seemed to capture dissonance very well compared to the questionnaire outputs but because the measure for capturing this was undeveloped and difficult to apply it was not continued. Therefore qualitative analysis of the group and individual outputs was used to highlight any issues that had the potential to create dissonance.

5.7 Confidence of the results and statistical treatments

It is clear that compromises have been made due to the complex nature of the project and resource constraints.

The qualitative data collected were in a summary form in both the questionnaires and the outputs from the workshops. Recording audio and / or video outputs of the sessions could have collected more detailed data and, more importantly, respondents' tone and inflection to assess dissonance. However, this is one of the compromises that were made and by collecting and analysing the high level summaries it is likely that we have captured the important points that people want to make. If more time and resources were available then either recording and / or non-participant observation would complement the approach, particularly in picking up more of the unconscious responses to the activity.

Triangulating quantitative and qualitative methods for data collection and analysis strengthened the emergent coding of the data.

Content analysis as a method of qualitative analysis does have limitations including the need to effectively take account of the use of synonyms and the meanings of different words in different contexts. This was considered and where different words were merged into themes each word was included within the theme and manual counting was undertaken to take account of context.

When considering the four criteria for establishing the 'trustworthiness' of qualitative data: credibility, transferability, dependability and confirmability (Lincoln and Guba 1985) there are grounds for confidence in the results. In terms of credibility, triangulation of data collection, analysis, investigator, theoretical perspectives and methods did occur as did debriefing with peers within the project although debriefing with informants did not. Sufficient descriptive data has been provided so that readers can evaluate the applicability of the data to other contexts themselves. It was not possible to split the research team to conduct independent inquiries or undertake audit trails although the data and supporting documentation have been scrutinised by second party reviewers who were independent of the intervention but linked to the project. This approach offers a degree of confirmability of the relevance of the data.

For the quantitative analysis the recruited sample was not as large as anticipated but was large enough to detect large effect sizes in the applied tests. If more subjects had been recruited then medium sized effects may have been detected. However for an exploratory, mixed-method study of this type we were particularly interested in large effects.

The measurement scale has inter-item reliability relating to individual responsibility and support access although further work is needed to develop the constructs used for user-centred practice and safety, indeed this remains a challenge globally. The scale was developed from available evidence, previous local research and policy drivers and checked with two experts, supporting face validity and content validity. Whilst a valid criterion measure could not be found for comparison, construct validity for user-centred practice, user involvement, safety, individual responsibility and access to support could have been assessed predictively. A pragmatic balance was achieved between utility and sensitivity as most people completed the questionnaire and the results did detect large differences.

The measurement of expressed emotion had a degree of face validity as it was developed by members of the team but was difficult to use in practice. However, the construct does have potential for further development based on the outputs of this measure and the findings from qualitative analysis.

Chapter 6: Conclusions and Recommendations

6.1 Conclusions

There are concerns nationally and locally about a policy-practice gap in the NHS. National health policy not only establishes what needs to be done but increasingly the detail of how this must be implemented. This approach to policy implementation through traditional, linear, rational target setting, performance monitoring and technical management is currently replicated throughout much of the NHS and many NHS Trusts.

Paradoxically, there is also a drive to develop leadership within the NHS and contemporary leadership theory contradicts the traditional management approach that is being adopted. In particular, complexity theorists argue that logic and rationality are seldom the root cause of persuasion. Change must begin with establishing and appealing to the self-interests of the organisation and individuals as people may do what you want if their self-interest persuades them to comply. Leadership is achieved by establishing what followers want and satisfying this through some process of exchange in which both sides can win requiring negotiation rather than debate. This applies to both practitioners and managers.

This project has utilised theory on leadership and change within a policy analysis framework to develop, implement and evaluate an approach that treats policy and practice as interdependent opposites or polarities that require managing to ensure due attention is paid to both. An intervention was delivered through a social programme using a professionalising type of action research with large groups of mental health and learning disability practitioners over a period of six months.

The impact of the intervention on policy, practice and aspects of practice culture was critically evaluated using mixed methods for implementation, data collection and analysis in the form of realistic evaluation.

In terms of the intervention the main evaluative question was 'what works for whom in what context?' Virtually all the attendees valued the opportunity to participate, in particular to meet, network and discuss policy and practice issues with other practitioners. Contextually, the differences between professions and localities are interesting. However the key focus should be on meeting the differing needs of the client group, i.e. adults, older people, children, learning disability. Services delivered to these client groups are defined as care groups and a diagnostic of the cultures of care groups can establish the degree of compatibility between the needs and expectations of practitioners and the needs and expectations of policy and the organisation (NHS and NHS Trust).

Generally, practitioners value the principles of user-centred, safe and effective practice that underpin national policy although practice in these areas can be improved. A values hierarchy is evident and personal development is valued over practice development and user centred and safe practice is valued over effective practice and user involvement. Personal responsibility is accepted and satisfactory levels of support are accessed. Policy needs to be clear, based on principles rather than detail, and standardised with a staff and client focus. Policy should be accessible and effectively communicated and multidisciplinary forums established to consider policy issues and practice improvements. Practitioners are able to develop plans to achieve improvements rather than being given solutions that are often contextually and culturally at odds with their experience.

Practice culture is conducive to the approach but organisationally there is some evidence of service stress compounded by a number of factors. Factors include an imbalance between the perceived needs and priorities of practitioners and the perceived needs and priorities of NHS managers, underdeveloped inter-disciplinary working and service integration and the degree of change being driven through health services over a number of years, particularly in non-specialist, community based adult mental health services.

The intervention has definite potential and the approach incorporates a process, a diagnostic and a model to balance adaptive learning through policy development with generative learning through opportunities for local invention and experimentation in practice. Policy and practice need to be considered equally through social opportunities, dialogue and reflection and the process operates at two levels; a practice level and an organisational level. To succeed the process needs the 'buy-in' from operational managers and embedding within an organisational approach to learning that establishes supportive structures, processes and cultures. One of the main strengths of the adopted approach is that organisational culture is considered explicitly, thereby creating the potential to influence culture formation through change.

The means to monitor the impact of the intervention over time needs to be developed to include measures of activity, innovations, untoward incidents, complaints and results from satisfaction surveys of staff and service users.

The intervention was not wholly successful as medical staff, psychologists and operational managers were not engaged and some services were not able or willing to create the opportunity. Acute in-patient services in particular were too busy to release staff. Therefore different methods need to be considered to reach these groups including a focus on their needs and values and the potential of any-time, any-place technology.

Methodologically a number of compromises were made due to the pragmatic nature of the project and limited availability of resources to undertake the evaluation. These were predominantly in the development of tools and measures and in methods for qualitative analysis.

6.2 Recommendations

The recommendations can be grouped in terms of recommendations to the host Trust, recommendations for potential further study and recommendations for dissemination and development.

Host Trust

1. The findings should be communicated to participants.
2. The Trust should consider the identified implications for policy.
3. The Trust should consider ways of creating time and opportunity for practitioners to network and consider policy.
4. The Trust should consider ways of engaging operational managers, medical and psychology staff and other services in this process.
5. The Trust should consider providing focused leadership particularly into the non-specialist community adult mental health services and into organisational learning and practice development.
6. The Trust should consider further monitoring of policy / practice integration utilising the findings from incident reports and surveys of staff and service users.

Further Study

1. The measurement of constructs of user-centred practice, user involvement, safety should be developed further.
2. Cultural diagnostics using a range of methods to capture objective, subjective and inter-subjective aspects of culture need further development.
3. Different approaches need testing within different contexts to deliver the process.
4. The utility of 'any time, any place' technology for policy and practice development should be tested.

Dissemination and Development

This report will be developed into a number of articles for submission for publication in peer reviewed journals and the project will be presented at the summer conference to be held by the University of Middlesex in 2007.

The model and process will be integrated within my current organisation through a programme of practice development days delivered by care group on a regular basis.

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APPENDICES

Appendix 1 Time frame and milestones for final project

FINAL PROJECT (IPH 5180)	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05
Trust commitment & approval obtained															
Policy-making mechanism established															
Project proposal approved															
Ethical approval obtained															
Intervention programme delivered															
Report produced															

Appendix 2 Sample Information Sheet

Practice Update Days – Information Sheet

The clinical work of all our care staff is governed or should at least be influenced by the various policies, guidelines and protocols in circulation to ensure the delivery of best practice. Examples of these might include various integrated care pathways (ICPs), NICE / NIMHE Guidance and Trust policy such as CPA, supervision, observation etc. With the introduction of clinical governance the Trust has a responsibility to ensure the delivery of high quality services which demonstrate the following core values:–

- User / carer involvement: choice, decision making & consultation
- Safety – of staff, patients & public
- Effective practice
- Effective staff
- Access to and appropriate use of information to guide and inform practice

If the above values are communicated to all staff, reflected in all of our clinical policies and then fully integrated into practice we can be more or less sure about delivering on clinical governance. The recent Healthcare Commission (Formally CHI) report identified many areas of good practice, found our clinical governance arrangements to be in relatively good order but also identified significant problems regarding the communication and delivery of clinical governance at practice level. Incorporating the above Trust core values into clinical policy and integrating the same into practice poses a number of challenges but by far the greatest of these is the actual integration of policy and practice.

Practice Update Days, which will bring together large numbers of multidisciplinary staff from each service area to address the practical issues of implementing clinical policy, have been given the full backing of the Trust as a way forward and forms part of our CHI action plan. All staff involved with the delivery of care to patients will be invited to attend at least one practice update day per year and each day will be attended by staff from the same service area. Service areas involved will be:-

Acute In patient
Rehabilitation and recovery
CMHTs
Learning disability
Forensic
Older People
Psychological therapies
CAMHS
Emerging services
Occupational Health
SMS

What is the purpose of Practice Update Days?

As previously mentioned the main aim on these days is to address some of the implementation issues of clinical policy. For instance we all know the importance of involving service users and their carers in clinical decisions, and we have policy to guide us in this (New Dawn). In reality though the feedback from care groups is that in practice settings user involvement is more often tokenistic than meaningful and sometimes difficult to achieve at all, for a variety of reasons. Similarly we know that although there is a huge emphasis on risk assessment within the Trust, the safety of staff, patients and the public is often compromised. Practice Update Days alone will not solve issues like this overnight but it is a start and signifies a different approach to the development of clinical policy; one of listening to the issues and barriers to implementing clinical policy and a focus on solutions rather than problems. The main aims then, including some of the expected benefits to staff of Practice Update Days are as follows:-

- Makes explicit the core values of the Trust
- Offers greater clarity and direction re. Clinical policy
- Opportunity for staff to work with clinical policy, explore the issues and suggest ways forward
- Provides time out for considered reflection
- Opens up a regular dialogue between staff and policy developers
- Opportunity for staff groups to influence and shape the future development of clinical policy
- Provides opportunities for networking and sharing of ideas

Format of the days

The format for each day will be the same and basically looks like this:-

Morning: Clinical policy / Trust values overview; Practicalities of implementing clinical policy in practice settings - addressing the issues & looking for solutions.

The rationale for the approach will be presented and consent obtained from participants for participation in evaluation.

An introduction to Trust clinical policy (what it is and what it says) will be presented.

Small group work using case vignettes to explore the implications of Trust clinical policy implementation will be facilitated.

Afternoon: Care Group specific policy – update and implementation issues; Personal reflection and evaluation

More detailed aspects of relevant clinical policy based on identified care group need will be presented.

Again, small group work using vignettes to explore the implications of Trust clinical policy implementation will be facilitated.

Opportunities to feedback any key messages on policy and the implications (e.g. *value conflict*, training needs, extra resources / service redesign etc,) will be offered and recorded in a programme log and actioned appropriately.

Time for individual reflection and the completion of measures of impact on values, awareness & understanding of clinical policy and its potential effect on future practice, satisfaction and further development needs will be offered.

The main focus of the events will be on group work and we have a team of facilitators to assist with guiding and supporting groups on the day.

Further Information: Please contact Tim Ward (Project Lead)

Appendix 3 Practice Update Day Evaluation Questionnaire

Personal Details

Profession

Grade

Locality

Care Group

Gender:	Male	○
	Female	○

Age Group:
<20 ○
21-35 ○
36-50 ○
51-65 ○

General Comments

Please tell us in what ways you have found today's Practice Update session useful:

Please tell us how you think the Practice Update session could be improved:

Please tell us what you need to help you put policy into practice:

Trust Clinical Policy in Practice

Please tell us how much you agree or disagree with the following statements.
Shade the circle that best reflects your opinion, using the following categories:

5 Totally agree
4 Agree
3 Unsure
2 Disagree
1 Totally disagree

	5	4	3	2	1
The needs of patients are at the centre of all decisions I make about their care and treatment	○	○	○	○	○
The needs of patients should be at the centre of all decisions I make about their care and treatment	○	○	○	○	○
I involve patients in every decision about their care	○	○	○	○	○
I should involve patients in every decision about their care	○	○	○	○	○
The safety of patients, staff and the public are paramount	○	○	○	○	○
The safety of patients, staff and the public should be paramount	○	○	○	○	○
I am responsible for;					
keeping my practice knowledge up-to-date,	○	○	○	○	○
participating in supervision,	○	○	○	○	○
seeking appropriate training,	○	○	○	○	○
assessing & managing risk in practice,	○	○	○	○	○
assessing need,	○	○	○	○	○
providing evidence-based interventions,	○	○	○	○	○
evaluating their effect,	○	○	○	○	○
recording accurate activity data,	○	○	○	○	○
providing effective care co-ordination.	○	○	○	○	○
I am responsible for ensuring I am capable of discharging my responsibilities.	○	○	○	○	○
*To enable me to discharge my responsibilities I have access to adequate;					
information,	○	○	○	○	○
management support,	○	○	○	○	○
supervision,	○	○	○	○	○
training,	○	○	○	○	○
tools and resources.	○	○	○	○	○

*If you feel any of these are inaccessible / inadequate please provide details below

Thank you for taking the time to complete this evaluation questionnaire.

Appendix 4 Care group outputs on integrating policy and practice

Table i Integrating policy and practice - CPA

• Needs review to realise patient benefits. • Six monthly reviews are often too often • Documentation needs reviewing – very repetitive and boring • Hospital discharges are always enhanced but documentation states otherwise. • Generates too much paperwork for each review. • Another document with little meaning and lots of stress. • If the client chooses not to maintain contact what can we do. • Care co-ordinator does not have power, resources and authority to meet needs by care management. • The monitoring is a complete waste of time and resources. • Principals of CPA are sound. • Needs standardising • Need to be clear about care co-ordination, Roles, Responsibilities • Most clients would benefit from annual reviews.	Policy Design
• Confusing standard / enhanced – meaning each individual worker appears to have their own interpretation. • Needs communicating.	Communication
• Difficulty in getting all parties involved in reviews. • Issues around having them typed and signed. • Often, unit staff do not fill in documentation. Then request CMHT worker to sign. • No uniformity in practice. • Co-ordinator role. Not shared with other professionals – all teams work differently • Consultants take on role but do not complete paperwork. Clients often find reviews stressful. • Too formal, too many people, clients often lack assertive skills to contribute. • Encourages medical model as we tend to work round consultant out patient clinics. • Emphasis may be on completion of documentation rather than actual client need.	Practice Development
• Collation of electronic information is very poor	Support

Table ii Integrating policy and practice – integrated notes

• Good in theory but not in practice, Needs more work • Are clients informed that notes are being integrated? • Lack of clarity about session divisions – maybe better if each discipline had its own section. • Policy suggests unqualified staffs notes are countersigned – implications impractical for social care staff. • Collaboration in clarification	Policy Design
• Let service users know who has access.	Communication
• Policy is only implemented in a few areas. • Issues of confidentiality on case files due to previous local authority agreements. • Notes not always immediately accessible in order to make a contemporary entry.	Practice Development
•	Support

Table iii Integrating policy and practice – risk relapse plans

• Out of date. • As clinicians we do not consider this is a client led need. • It is a repetitive exercise which often increases anxiety and reinforces the negative rather than positive for the client. • A back covering exercise for risk. • Risk/relapse plan is trying to perform too many functions i.e. Patient alert(staff awareness and safety), Advanced directives, Solutions to relapse • Do we need it if advanced directives are in place? • A more effective client centred tool and process could be developed. • Change Terminology. Suggest Safety Plan. – Newcastle clients often write them. • Feel separate documents and processes are needed to have more meaning to clients and staff. If more meaning then likely to be more valued by all.	Policy Design
•	Communication
•	Practice Development
•	Support

Table iv Practice implications and policy improvements – advance statements

• Negative aspects of policy can demotivate staff • Where is best place to keep directive • Only as good as the content and ownership • Fear of litigation – everyone protecting own corner – self preservation leading to excess administration and bureaucracy/duplication.	Policy Design
• Users need information and support.	Communication
• Wishes might be compromised by events (i.e. Law) • Pressures of large caseload. • Need to reduce duplications to be able to manage paperwork and have the time to discuss local patients charter. • Empower service users in the decision making process. • Information from Service Users has the ability to improve quality of care.	Practice Development
• Staff need training. • The way it's applied is key (training and support)	Support

Table v Integrating policy and practice – carer's assessments

• Not an integrated policy? • What is a carer? • What is a carer's care plan? • Where do they fit into integrated notes? • Issues of boundaries and confidentiality. • Requires definition • Requires clarity of roles and increased awareness • Incorporate into care co-ordinators role	Policy Design
• All staff not aware of policy	Communication
•	Practice Development
•	Support

Table vi Integrating policy and practice – supported leave

• Misses the point and is outdated. • Out of hours support can cause difficulties – clients under the influence – alcohol/narcotics – causing vulnerability for staff members. • Weaknesses in guidelines i.e. what to do when no relatives to inform. • Quite controlling – should we be more empowering? • Length of agreed leave can easily be broken – informal • When difficulties occur how to access secure / safer areas, who to call on? • Understandable, however written for use in 'ideal world'. • Only a blueprint for what to do when things go wrong (not about prevention). • Confusion around who should fill it in when inpatient/first time user of the service. • Care co-ordinator role can be changed when patient is admitted – without consultation. • Needs to be purpose of leave-led. What is the leave achieving? • In and out reach. Sharing and liaison between unit and community staff. • Client responsibility within a plan. • MDT, care co-ordinator has to be involved with the leave process	Policy Design
•	Communication
• Difficulty encouraging patients to go on leave. • Informal clients wanting to do own thing. • Different practices in different teams. • Keeping them up to date can be a time consuming task – depends on good paperwork management – skills, and other pressures. • They should be accessible to all involved in patient care.	Practice Development
•	Support

Table vii Integrating policy and practice – advance statements (OP)

• The policy appears to be regarded as lengthy, legalistic and not very user friendly though practice guidelines are better • The use of a care pathway would ensure completion though the use of prescriptive timescales may lead to failure of the policy due to issues of appropriate timing. • A need to reform the policy for older adults and a more open timescale for discussion are required.	Policy Design
•	Communication
• The fear of insensitivity and an appropriate moment to introduce were important as initial contact has overarching issues for discussion with the individual. • Concerns about capacity for understanding and the related issues for older adults are of importance also. • The use of the directive by a carer needs to be discussed and assessment of carer needs should be completed.	Practice Development
•	Support

Table viii Integrating policy and practice – capacity and consent (OP)

• These assessments should be issue specific and the client's ability to understand the consequences and being aware of the risks are both input and outcome related. • Should be gathered by the professional who knows the person best of all and who also has the skills and knowledge as it cannot be assumed that the presence of a Mental Health problem dictates lack of capacity. • A standard statement of which tools should be utilised, and a process map of action to be taken to carry out this task and its frequency is essential.	Policy Design

•	Communication
• All professionals should be aware of factors and have training to assess for capacity. • Practically, the issue of lone working is difficult and whether two people should assess for capacity or consent. • Maintain respect and dignity for client even if they don't have capacity and re-assessment should occur regularly to take account of episodes of change in mental functioning.	Practice Development
•	Support

Table ix Integrating policy and practice – carer's assessments (OP)

• Currently there are two discipline specific policies, for which there is a lack of clarity regarding responsibility for completion and extended roles. • The policy currently neglects some intrinsic factors to older people and there is ambiguity regarding financial burden or realistic expectations from services. • Recommendations are for a single, all service policy that is either solely for Older people's use or is designed in partnership with adult services. • Within the health assessment a care pathway should be designed which will allow for the capturing of carers' needs and difficulties.	Policy Design
•	Communication
•	Practice Development
•	Support

Table x Integrating policy and practice – challenging behaviour (OP)

• A realistic and achievable, person-centred, older person specific policy and pathway needs to evolve. • Collaboration between services, disciplines and users will help design pathways for individuals which address training needs of staff of all agencies allowing for problem solving, professional support systems which safeguard a failsafe mechanism for extended crises.	Policy Design
•	Communication
• Reaction to challenge should be based upon assessment and understanding of an individual's own bio-psychosocial systems.	Practice Development
•	Support

Table xi Integrating policy and practice – risk assessment (OP)

• Information is not consistent with other teams' expectations, uploading information is difficult • Sainsbury's risk assessment and the frequency of use and update is unclear; it was suggested that the tool should be linked with risk and relapse guidelines. • Responsibility for update of the risk and relapse plan is unclear, as policy does not encompass leave for the client group. • Guidelines and policy required regarding updates of information and the presence / location of advanced directive.	Policy Design
•	Communication
• The quality of information is also variable, on file vision often tick boxes left blank.	Practice Development
• Increase access to PCs for risk/relapse plans.	Support

Table xii Integrating policy and practice – CPA (OP)

• Documentation and supporting policy is difficult, often restricting practice as opposed to enhancing. • More clarity and definition of care coordinator role required.	Policy Design
•	Communication
• Variation between services and the recorded care co-ordinator – often nurse led - creates difficulties. • Priorities and timescales are different. • A lack of understanding regarding use of data • There is a need for the teams to be integrated with joint paperwork and training.	Practice Development
•	Support

Table xiii Integrating policy and practice – CPA (LD)

• CPA requires a robust usage structure. • Lack of staff awareness and management of their roles and responsibilities within CPA feeds into a perceived and potential impact upon organisational planning around the limited resources available within the current services. • That CPA can be accessed, reported from and fed into systematically. A lack of formal monitoring of out of area patients has created situations whereby staff teams receive potentially complex cases with very little historical information or ongoing service involvement. • Who should be on or benefit most from CPA? • There is a conflict of interest issues between client and carer. Who is the client? • Shared care protocols could be a solution and fuller links between Health and Social Care practitioners should be fully considered. • Some clients already well managed under local agreements, so why do they need to be in CPA? • The process should focus upon operational practice and clarity for specific professionals.	Policy Design
•	Communication
• Patient registrations being both complete and accurate. • Currently different professions and the individuals therein have problems completely defining their understanding of CPA and its uses. There is felt to be a lack of ownership of the system by the LD Services that creates difficulties in its facilitation needs. • If implemented in this Trust, will CPA reflect workloads both accurately and similarly to other areas in the country? • Training in CPA standards, interpretations, usage, costs and consequences (for both service and 'conceptually') for staff is important. Elements such as the reduction of duplication and attributable practice enhancement are felt to be the most important. • Identify other models from external Trusts addressing communication, support and timely discharge closure.	Practice Development
•	Support

Table xiv Integrating policy and practice - challenging behaviour (LD)

• There is a need for structure around the management of physical interventions. • Learning Guidelines different and require (British Institute of Learning Disability) BILD approved training. • Accurate representation of LD practitioners on the policy workgroup, thereby feeding directly into national directives will allow for both 'push-up' and 'pull-down' approaches to environmental appraisal for the purposes of managing violent incidents. • A theory base should be established identifying the most appropriate approach to intervention – de-escalation or Control and Restraint techniques.	Policy Design
• The use of the clinical debriefing team should be communicated to all.	Communication
• Placing skills training within the focus of control and restraint does not impress upon staff the need for de-escalation and non-aversive interventions; similarly should the events allow for supportive, reflective practice and its associated skills to be addressed. • There is some expressed feeling that the units are not the most able areas to offer this type of therapeutic intervention, effectively limiting opportunities to respond in a manner other than through physical management. • Theoretical training regarding Managing Challenging behaviour is available through the training department although some of the incidents may be avoided through raising awareness of the use of care-plans to which new staff members can refer. • The need for pro-active responses raised to a higher point in the processes as currently the documentary responsibilities currently take up the post-event time. To create an environment of feedback and review, clients and staff should be offered the opportunity to appraise units, teams and services. • Honest dialogue between staff and managers requires a change in culture, which in turn can eliminate stress and sharing ideas and good practice. • The training should be more regular and based around implementation of learning plans that are not yet shown to be in place. • Communication of care plans is essential alongside a formalised debrief and supervision process otherwise opportunities to learn are lost.	Practice Development
•	Support

Table xv Integrating policy and practice – service integration (LD)

• There is a conflict between the actual and perceived needs of patients and carers with all involved. • Isolation for staff over weekend and the lack of a safe house for patients in crisis. This is especially apparent for people with challenging behaviour and physical disabilities. • A lack of clarity for patient / carer as to 'Whose need [for a service]?' compromises prescribed strategies for intervention. • There is felt to be a clear lack of planning reflected in different working practices and core values. • Careful planning of communication, operational and environmental strategies were felt to be important so as to minimise the variations and the use of a joint business plan would be the enabling factor. This was felt to be the most productive way to ensure that risk could be managed alongside enabling a 'smoothing' process that would remove any negative perceptions held by practitioners about the other service. Additionally, a proactive approach to planning as opposed to reactive approach would be beneficial. • Shared values and policies should be developed. • Clarifying roles around practice and responsibilities would also depend upon individuals feeling that the governance requirements should be met through a representative framework, accessible to everybody. This should also encompass both user and carer beliefs and knowledge around the integrated team. • Issues surrounding Section 31 and communication need to be managed. All need to be involved from the Executive boards to the front line staff and users.	Policy Design
•	Communication
• Communication issues between services, leads and practitioners were raised as a main factor for this topic. • Differences between services were apparent through the concerns around record-keeping, training and supervision requirements all of which were felt would lead to a change in how services are delivered within the community. Minor concerns about case note locations were expressed from a 'travel-time' perspective and also the loss of single team identities. • The lack of awareness and poor knowledge networks arising from GPs feeling distanced from the service [for reasons unknown] lead to incidents of boundaries being flexed for patient and carer. This may lead to reactive responses that are not based upon a full understanding of the individuals' needs. The Learning Disability Services' relationship with carers is felt to be both unique and complex. • Marrying two sets of policies creates queries of who leads the service. • Currently staff / carer / client involvement is felt to be tokenistic and does not enhance good working relationships. The lack of integration of case notes Health and Social Services is probably an example of this and creates fear and anxiety amongst professionals.	Practice Development
• Education and support for parents regarding their own expectations should be an integral part of all professionals' intervention framework. • Establish a 'safe house' facility alongside a review of the limited respite care currently available.	Support

Table xvi Issues ranked by degree of expressed emotion

Degree of emotion	Most intensively discussed issues	Specific Issues discussed (Themes)	Category
1	Control & Restraint training	Staff unable to be released. No courses available. Staff feel vulnerable and unsafe.	Practice Support
3	Emphasis on 'scoring' patients	If patients do not get the right score, they do not get a service	Policy design
4	Discharge of Patients	Discussed policy of referring back to GP if patient misses 2 appointments. Concern particularly with new patients who may not receive a service when ill. Time pressures cause this practice.	Policy design
4	"If nothing goes wrong, nothing changes"	Staff are so busy they are only able to react to crisis, some clients do not get a service. Trust turn a blind eye until something goes wrong, then reacts	Policy design
4	Taking part in time-out days	Nothing implemented fully or perfected (tokenism)	Practice Development
4	Lack of staff awareness about the carers assessment - for example what it entails, who's responsible	It's a social services policy - as an integrated service how do health staff access these policies - were health involved in drafting the policy?	Policy design
4	Carers assessment policy is a Social Services policy - a lot of health staff had not seen it	Now an integrated service: why are health/social care staff not aware of each other's policies? Where are the joint policies?	Policy design
5	Focus on diagnosis	Too much focus on diagnosis - often used as a means of passing/moving someone elsewhere. Not enough emphasis on concentrating on the patient's level of distress which should be the focus of the intervention.	Policy design
5	Fulfilling the Care Co-ordinator role (Responsibilities)	The importance of role. Implications if things go wrong. Attitudes. Lack of communication between disciplines.	Policy design
5	Integration	Not true. Integration ambiguous - roles, procedures	Policy design
5	Multi Disciplinary Team	MDT meeting - still are not true MDT approach. Limited time	Practice Development
5	Communication between units, community teams and consultants	Problems - not all areas are doing the same	Communication
5	Lack of working knowledge of policies	Levels of knowledge differ - some find it difficult to put these in practice	Communication
5	Capacity - don't feel able to take on more work	Staff feel they are at full capacity, have run out of ideas to be more creative	Practice Development
5	Confusion about roles and responsibilities for both health and social care staff	Confusion about roles etc, not just with regard to carers assessment but other policies etc,.	Policy design
5	Carers assessment policy states assessment officer undertakes it or someone (professional) who knows carer well	Doesn't address the issues of conflict between client and carer, leading to an impact on therapeutic relationship	Policy design
5	Confidentiality and boundaries when working with client and carers	Where documentation about carer should be filed. How health professionals would log contact with carers.	Policy design
6	No lateral thinking	People are often precious about their specialism. Not prepared to share skills/knowledge and work together in the interest of the patient	Practice Development
7	Teams become obstructive	If patient does not meet a specific criteria they are often passed around the service	Practice Development
9	"Wherever there is a bed"	Not patient led. Not considering needs of patient. Very frustrating for practitioners.	Policy design
9	Caseload numbers/skill mix	Work needs to be done on skill mix, different teams have better than others. No set numbers for CPNs on caseload	Practice Development
10	Care pathways have been developed but are not working	Good idea, but not always workable in practice due to time, staff morale	Practice Development

Appendix 5 Themes of potential cultural dissonance

Inter-disciplinary working (15)

- Encourages medical model as we tend to work round consultant out patient clinics.
- Lack of communication between disciplines.
- Confusion about roles and responsibilities for both health and social care staff
- MDT meeting - still are not true MDT approach.
- People are often precious about their specialism. Not prepared to share skills/knowledge and work together in the interest of the patient
- Communication issues between services, leads and practitioners were raised as a main factor for this topic (LD)
- Care co-ordinator role. Not shared with other professionals – all teams work differently
- Consultants take on (CPA) role but do not complete paperwork.
- Need to involve other disciplines (generally) (7)

Service interface problems (12)

- Different practices in different teams.
- Care co-ordinator role can be changed when patient is admitted – without consultation.
- It's a social services policy - as an integrated service how do health staff access these policies - were health involved in drafting the policy?
- Now an integrated service: why are health/social care staff not aware of each other's policies? Where are the joint policies?
- Variation between services and the recorded care co-ordinator – often nurse led - creates difficulties (OP)
- Differences between services were apparent (LD)
- Integration ambiguous
- Often, unit staff do not fill in (CPA) documentation. Then request CMHT worker to sign.
- If patient does not meet a specific criteria they are often passed around the service
- Confusion about roles etc,
- Problems - not all areas are doing the same
- Work needs to be done on skill mix, different teams have better than others. No set numbers for CPNs on caseload
- system inadequacies (1)

Value conflict (48)

- Trust need to manage effectively;
    - others are experiencing problems (6)
    - widespread confusion / chaos (4)
    - negativity (3)
    - frustration (2) (OP)
    - inflexibility (1)
    - disjointed approach (1)
- Trust need to provide evidence of actions taken (8)
- Trust need to deliver follow-up days (7)
- staff not consulted / involved (3)
- Nothing implemented fully or perfected (tokenism)
- Staff feel vulnerable and unsafe.
- Trust turn a blind eye until something goes wrong, then reacts
- Honest dialogue between staff and managers requires a change in culture (LD)
- The policy currently neglects some intrinsic factors to older people (OP)
- An older person specific policy and pathway needs to evolve (OP)
- There is felt to be a clear lack of planning reflected in different working practices and core values (LD)
- Currently involvement is felt to be tokenistic and does not enhance good working relationships (LD)
- Care co-ordinator does not have power, resources and authority to meet needs by care management.
- Not patient led. Not considering needs of patient. Very frustrating for practitioners.
- Doesn't address the issues of conflict between client and carer, leading to an impact on therapeutic relationship
- Too much focus on diagnosis
- If patients do not get the right score, they do not get a service

Increased workload without adding value (19)

- Too much change (1)
- (CPA) Generates too much paperwork for each review.
- Another document (CPA) with little meaning and lots of stress.
- Emphasis may be on completion of documentation rather than actual client need.
- The monitoring is a complete waste of time and resources.
- As clinicians we do not consider relapse plan is a client led need.
- It is a repetitive exercise, which often increases anxiety and reinforces the negative rather than positive for the client.
- A back-covering exercise for risk.
- Negative aspects of policy can demotivate staff
- Need to reduce duplications to be able to manage paperwork
- Fear of litigation – everyone protecting own corner – self preservation leading to excess administration and bureaucracy / duplication.
- (supported leave) misses the point and is outdated.
- Quite controlling – should we be more empowering?
- Only a blueprint for what to do when things go wrong (not about prevention).
- Keeping them (plans) up to date can be a time consuming task
- Staff are so busy they are only able to react to crisis, some clients do not get a service.
- Time pressures cause this practice.
- Staff feel they are at full capacity
- Documentation and supporting policy is difficult, often restricting practice as opposed to enhancing (OP)

Appendix 6 A brief description of policies discussed

Care Programme Approach (CPA)

This is a formalised framework for assessing, planning, evaluating and reviewing services provided to service users based on their needs. Reviews are held regularly and ideally involve users, carers and significant others. It has two levels, standard CPA for uni-disciplinary involvement and enhanced CPA for complex cases and multi-disciplinary / multi-agency involvement.

Integrated Notes

These are held in a shared case file for all mental health and social care documentation relating to an individual user although separate sections maintained.

Risk / Relapse Plans

These are an individual's risk, relapse signature and management plan that is readily available to identified care providers at any time.

Advance Statement

This is a written statement that allows the user to have greater influence upon their care and treatment. Enables a user, when well, to record their preferences for treatment and any practical arrangements to be made should their mental health deteriorate.

Carer's Assessments

Carers of people in receipt of mental health services are entitled to an assessment of their own needs and each carer should be offered an assessment.

Supported Leave

This is the planned provision of supported periods of leave from in-patient care based on multi-disciplinary agreement.

Capacity and Consent

This is an assessment of an individual's capacity to make informed choices.

Managing challenging behaviour

These are agreed approaches to behaviour that is inappropriately challenging to other people and services to maximise the safety of the service user and others.

Risk assessment

This is the formal assessment of all aspects of risk relating to an individual user's circumstances.

Service Integration

This describes the integration of health and social care services.

Appendix 7 Frequency Tables from questionnaire responses

Table i Ratings for adequate information

I have access to Adequate Information

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Totally disagree	2	1.9	2.0	2.0
	Disagree	4	3.9	4.0	6.0
	Unsure	12	11.7	12.0	18.0
	Agree	38	36.9	38.0	56.0
	Totally Agree	44	42.7	44.0	100.0
	Total	100	97.1	100.0	
Missing		3	2.9		
Total		103	100.0		

Table ii Ratings for adequate management support

I have access to Adequate Management Support

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Totally disagree	2	1.9	2.0	2.0
	Disagree	4	3.9	4.1	6.1
	Unsure	10	9.7	10.2	16.3
	Agree	34	33.0	34.7	51.0
	Totally Agree	48	46.6	49.0	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Table iii Ratings for adequate supervision

I have access to Adequate Supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Totally disagree	1	1.0	1.0	1.0
	Disagree	4	3.9	4.0	5.1
	Unsure	3	2.9	3.0	8.1
	Agree	29	28.2	29.3	37.4
	Totally Agree	62	60.2	62.6	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Table iv Ratings for adequate training

I have access to Adequate Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Totally disagree	1	1.0	1.0	1.0
	Disagree	9	8.7	9.2	10.2
	Unsure	13	12.6	13.3	23.5
	Agree	35	34.0	35.7	59.2
	Totally Agree	40	38.8	40.8	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Table v Ratings for adequate tools and resources

I have access to Adequate Tools and Resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Totally disagree	2	1.9	2.0	2.0
	Disagree	15	14.6	15.3	17.3
	Unsure	13	12.6	13.3	30.6
	Agree	31	30.1	31.6	62.2
	Totally Agree	37	35.9	37.8	100.0
	Total	98	95.1	100.0	
Missing		5	4.9		
Total		103	100.0		

Table vi Rated responsibility for up to date knowledge

I am responsible for keeping my practice knowledge up to date

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unsure	4	3.9	3.9	3.9
	Agree	24	23.3	23.5	27.5
	Totally Agree	74	71.8	72.5	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Table vii Rated responsibility for participating in supervision

I am responsible for participating in supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	24	23.3	23.5	23.5
	Totally Agree	78	75.7	76.5	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Table viii Rated responsibility for seeking appropriate training

I am responsible for seeking appropriate training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.0	1.0	1.0
	Unsure	4	3.9	3.9	4.9
	Agree	24	23.3	23.5	28.4
	Totally Agree	73	70.9	71.6	100.0
	Total	102	99.0	100.0	
Missing		1	1.0		
Total		103	100.0		

Table ix Rated responsibility for assessing & managing risk

I am responsible for assessing and managing risk in practice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unsure	4	3.9	3.9	3.9
	Agree	27	26.2	26.2	30.1
	Totally Agree	72	69.9	69.9	100.0
	Total	103	100.0	100.0	

Table x Rated responsibility for assessing need

I am responsible for assessing need

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unsure	5	4.9	4.9	4.9
	Agree	27	26.2	26.2	31.1
	Totally Agree	71	68.9	68.9	100.0
	Total	103	100.0	100.0	

Table xi Rated responsibility for evidence based practice

I am responsible for providing evidence based interventions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.0	1.0	1.0
	Unsure	8	7.8	7.9	8.9
	Agree	34	33.0	33.7	42.6
	Totally Agree	58	56.3	57.4	100.0
	Total	101	98.1	100.0	
Missing		2	1.9		
Total		103	100.0		

Table xii Rated responsibility for evaluating impact of practice

I am responsible for evaluating their effect

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unsure	5	4.9	5.1	5.1
	Agree	34	33.0	34.3	39.4
	Totally Agree	60	58.3	60.6	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Table xiii Rated responsibility for recording activity data

I am responsible for recording accurate activity data

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Unsure	3	2.9	3.0	3.0
	Agree	35	34.0	34.7	37.6
	Totally Agree	63	61.2	62.4	100.0
	Total	101	98.1	100.0	
Missing		2	1.9		
Total		103	100.0		

Table xiv Rated responsibility for care co-ordination

I am responsible for providing effective care coordination

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	2	1.9	2.0	2.0
	Unsure	7	6.8	7.1	9.1
	Agree	31	30.1	31.3	40.4
	Totally Agree	59	57.3	59.6	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Table xv Rated responsibility for personal authority

I am responsible for ensuring I am capable of discharging my responsibilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.0	1.0	1.0
	Unsure	11	10.7	11.1	12.1
	Agree	24	23.3	24.2	36.4
	Totally Agree	63	61.2	63.6	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Table xvi Rating of user centred practice - actual

The needs of the service user are at the centre of all decisions I make about their care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	9	8.7	8.7	8.7
	Unsure	11	10.7	10.7	19.4
	Agree	48	46.6	46.6	66.0
	Totally Agree	35	34.0	34.0	100.0
	Total	103	100.0	100.0	

Table xvii Rating of user centred practice - potential

The needs of the service user should be at the centre of all decisions I make about their care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.0	1.0	1.0
	Unsure	2	1.9	1.9	2.9
	Agree	26	25.2	25.2	28.2
	Totally Agree	74	71.8	71.8	100.0
	Total	103	100.0	100.0	

Table xviii Rating of user involvement - actual

I involve service users in every decision about their care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	15	14.6	14.9	14.9
	Unsure	12	11.7	11.9	26.7
	Agree	49	47.6	48.5	75.2
	Totally Agree	25	24.3	24.8	100.0
	Total	101	98.1	100.0	
Missing		2	1.9		
Total		103	100.0		

Table xix Rating of user involvement - potential

I should involve service users in every decision about their care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	4	3.9	4.0	4.0
	Unsure	6	5.8	6.0	10.0
	Agree	33	32.0	33.0	43.0
	Totally Agree	57	55.3	57.0	100.0
	Total	100	97.1	100.0	
Missing		3	2.9		
Total		103	100.0		

Table xx Rating of safety consideration - actual

The safety of service users staff and the public are paramount

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	4	3.9	4.0	4.0
	Unsure	6	5.8	6.1	10.1
	Agree	21	20.4	21.2	31.3
	Totally Agree	68	66.0	68.7	100.0
	Total	99	96.1	100.0	
Missing		4	3.9		
Total		103	100.0		

Table xxi Rating of safety consideration - potential

The safety of service users staff and the public should be paramount

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	1.0	1.0	1.0
	Unsure	2	1.9	2.0	3.0
	Agree	16	15.5	16.0	19.0
	Totally Agree	81	78.6	81.0	100.0
	Total	100	97.1	100.0	
Missing		3	2.9		
Total		103	100.0		