

**Professional change and knowledge translation in mental
health nursing: case study of the integration of a health policy
into practice**

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ABSTRACT

This investigation aims to explore the area of change and knowledge translation in professional practice by using a case study to investigate the integration of a health policy into clinical mental health nursing (MHN) practice. It will address the research question of ‘*What factors influenced the integration of Choosing Health (2006) and the Well-being Support Programme (WBSP) at the Trust*’ by exploring how mental health nurses and managers of mental health services constructed and operationalised the recommendations of this policy into mental health services 2007-2008. A case study design and constructivist grounded theory methodology were used and the participants were taken from two groups who both worked in the Trust: registered mental health nurses (MHN) (n=28) and clinical managers of mental health services (n=18). Data were collected from the reflective accounts of the participants’ experiences of implementing the *Choosing Health (2006)* policy recommendations over a six month period during 2008. The Trust in this study was a large mental health and social care Trust in the South-East of England. Data were deductively analysed using a modified version of Lewin’s (1946) change theory which found six minor themes representing the factors that affected the implementation of *Choosing Health (2006)* in the Trust. The factors were common to both practitioners and managers and were: resources; policy and procedures; leadership in change; personal and professional development: support; motivation and innovation. The relationships between the six minor themes were examined further using inductive analysis producing three key themes that answered the research question of this study which are: organisational factors; professional factors and individual factors. This thesis argues that professional, as defined by Dopher (2012), influence in health policy both individually and strategically is weak, indicating deficits in professional influence, specifically in relation to organisational influence and professional representation. Further, shortfalls in professional influence at both local and national level were identified, resulting in under representation of the professional values, beliefs, codes of conduct and culture of mental health nursing (MHN). It is proposed that groups representing MHN should provide a higher profile advising on and developing mental health policy to improve the *translation* of policy into practice instead of its *interpretation* into practice. It also recommends that there should be an increased involvement in critically evaluating the professionally relevant evidence pertaining to the policy and an means of interpretation policy implications in terms of the practitioners related roles and responsibilities.

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Chapter 1

INTRODUCTION AND BACKGROUND

1.1 Physical health and well-being of people with severe or serious mental illnesses (SMI).

In 2006 the Department of Health (DH) produced the health policy and best practice guidance *Choosing Health: Supporting the physical needs of people with serious mental illness - commissioning framework* (DH 2006a). The policy stemmed from a growing body of evidence from authors such as Leucht et al (2003); Haddad (2005); Wieck and Haddad (2003) pointing to the grave physical health issues being experienced by people with a severe or serious mental illness (SMI). The outcomes of these physical health issues were linked to premature deaths among people with a severe or serious mental illnesses (SMI); with people in this group likely to die fifteen years earlier compared with the general population (DH 2006a). However despite the recommendations in *Choosing Health*, (DH 2006a), Gatineau and Dent (2011) and the Royal College of Psychiatrists (RCPsych) (2010) found that morbidity has increased and life expectancy for people with a SMI is twenty-five years less than the general population.

Initial concerns regarding increases in morbidity and mortality, summarised by Marmot and Wilkinson (1999) focused on issues related to SMI, however subsequently other mental illnesses and disorders such as depression and chronic anxiety states have also been linked to poor physical health, as noted in the policy *No Health without Mental Health* (DH 2011d). Depression is linked to increased mortality from the following diseases; 67% from cardiovascular disease, 50% increase from cancer, two-fold increase mortality from respiratory disease and threefold increase from metabolic disease (Manderscheid 2010; RCPsych 2010). Depression approximately doubles the threat of developing coronary heart disease and chronic psychological distress and is associated an 11% increased risk of stroke. Depression also predicts later life onset of colorectal cancer, back pain and irritable bowel syndrome (Sainsbury Centre for Mental Health 2010; RCPsych 2010).

1.2 Personal and professional background and motivation for the study

As a registered mental health nurse since 1981 and an educator and academic in this field since 2000 I find my overarching professional purpose is concerned with supporting change of one description or another with the intention of helping people achieve their potential. Both my clinical and academic roles enable me to create the opportunities, support, and guidance and knowledge that motivate people to learn and develop. I imagine this as a journey for those

involved where I could be seen as a navigator of this passage. My role enables me to use my empathy and trustworthiness to enable those concerned to feel safe enough to take on an often risky step into the unknown so they can reach their potential, improve their lives and feel fulfilled emotionally, educationally and intellectually.

In both of these roles I have specialised in the care and management of people with a SMI, such as schizophrenic disorders and bi-polar disorders. This care has always included a holistic approach of psychological, social and physical health elements. However, despite being of equal importance, the psychological aspects of care seem to be uppermost in the mind of most mental health nurses; followed by social aspects, and then lastly physical health aspects. This situation has unwittingly led to a health crisis among people with a SMI in terms of the neglect of their physical health needs and the consequential impact on their morbidity and mortality compared with the general population. It is this predicament that has motivated me to embark on this study as it has professional resonance for both my clinical and academic practice.

In 2003 I was shocked to learn that the service users in my care were likely to die 10-15 years earlier than a person without a SMI. I was disturbed even further to find out five years later that this situation had not improved, and had actually deteriorated to the extent that the predicted life span for people with a SMI was now 15-25 years shorter. As a means to address this problem I arranged and undertake training days within a range of NHS Trusts for mental health staff in order to raise awareness about this issue and to develop their knowledge and skills regarding the care of the physical health aspects of health. I also developed and introduced a mini syllabus across the three-year mental health pre-registration curriculum relating to physical health and nursing care which is still active. Furthermore in 2008 I also created the course 'Physical Health and Well-being' which is part of the Psycho-social Interventions (Thorn approved) Programme and carries 30 credits at level 6. These activities increased my interest in why, if training and resources were available, why mental health nurses (MHN) were not all fully engaged in physical health assessment and care.

It was this question that directed me towards trying to discover why this situation was continuing, despite health policy and recommendations. In a so-called Cinderella service, mental health struggles to find a voice among other more notable and seemingly important services, and physical health issues were even more neglected. I found that the physical health problems experienced by

people with a SMI were not of great interest to researchers (2006), and the literature identified that this was an under-researched area. This made me determined to discover why this situation could possibly be allowed to continue and created a passion in me to identify the underlying reasons.

I feel professionally responsible and personally motivated to change and develop areas outside of the students and service users' realms of power such as the high rates of morbidity and mortality among people with a SMI. If I can discover the reasons for the shortfalls in care and can offer suggestions to address them, and make a difference by suggesting ways that people with a SMI can live longer and more healthily.

The plethora of health policy, guidance and recommendations regarding the precarious physical health and well-being of people with a SMI over the last twenty eight years has done little to change the increasingly high morbidity and mortality rates in this group (Gatineau and Dent 2011; Brown et al 2010; McEvoy et al 2006; Greening 2005; Brown et al 1999; Kane 1996). Further, a systematic review of the literature regarding interventions to improve the physical health of people with a SMI undertaken by Samele et al (2006a) proposes that service users with a SMI are also greatly concerned with the physical health risks they face and are not satisfied with the associated current health service provision. Implicated in these points, but significant additional concerns in their own right, are that individual practitioners such as MHNs are typically given insufficient time to acquire an adequate understanding of new health policy recommendations, their implications for practice and the resultant additional roles and responsibilities expected of them. The professional concerns raised by the issues outlined make it relevant to me as a MHN practitioner and educator to investigate the reasons why health policy continues to fail to improve the physical health of people with a SMI.

1.3 Professionals' Responses to Physical Health Morbidity

Mental health nurses and other professionals were becoming increasingly aware of the escalating risk to their service users of premature deaths due to physical health reasons. The Chief Nursing Officer (CNO) (2006b) stressed the value of MHNs undertaking physical well-being interventions with their client group. Nevertheless adopting new practices related to physical health such as: additional knowledge and skills; developing a focus on health promotion; dealing with the tensions between doctors both in the mental health field and primary care, were recognised as being a challenge for some MHN (Eldridge 2011, Nash 2010, Gourney 2005). Therefore the extra

responsibilities and competencies required for well-being interventions would add another dimension to the already complex care required by people with a SMI, and delivered by WBSP MHNs within an inter-professional system (Brimblecombe et al 2005; Gourney 2005). In addition, it is also well documented in reports such as the National Confidentiality Inquiry (Appleby et al 2012) that fragmented and disorganised care is common in mental health cases. This is due to the complexity of the service users' needs and the poor levels of communication between multi-agency professionals regarding health risks and interventions (DH 2004c).

1.4 Setting of the study

The Trust in this study was selected because it was one of the *first wave* Trusts to implement the Choosing Health (2006) agenda and the well-being support programme (WBSP) following the initial pilot sites in 2003. The Trust was generally as representative as could be expected within the NHS as a secondary mental health service provider to a population of 1.6 million in the South East of England. At any given point there are approximately 25,000 open cases and around 4,000 members of staff employed in the Trust. Demographically, the Trust covers both rural and urban areas, including a large coastal and boarder area with some of the richest and poorest areas in the UK. The Trusts area also incorporates several of Her Majesty's Prisons however the healthcare provision in them is not the primary responsibility of the Trust. The Trust therefore manages a diverse and complex demographic which is possibly unlike a typical inner city NHS Trust, but similar to many other mixed urban and rural ones. The Trust provides mental health services for a full range of mental health disorders such as: acute working age adult and older adult mental health in-patients and generic community services; substance misuse; child and adolescent; forensic; rehabilitation and early interventions series.

This Trust was also chosen because prior to implementing the WBSP, there was minimal specific physical health care provided to service users in the Trust an aspect which was representative of most mental health service providers at that time. Nevertheless, there was considerable debate within its clinical teams, management groups and the executive team about how to address the physical health needs of service users using Trust services. Despite the lack of hard evidence from clinical trials, practitioners in the Trust that had attended presentations about the WBSP were keen advocates of the programme. Support from clinicians and subsequent endorsement by the Department of Health (DH 2006a) convinced the Trust to implement the programme. The WBSP training in the Trust was initially backed financially and practically by one of the drug companies

that produce one of the major atypical antipsychotic medications; a group of drugs held partly responsible for the physical health issues experienced by people with a SMI. The training scheme was an ambitious project which offered a three-day training event for 25 people every week for two years. The content of the training was a mixture of practical clinical skills, reading and interpreting clinical reports and knowledge regarding morbidity and mortality issues concerning SMI.

Importantly, a number of adaptations to the WBSP were made by the Trust prior to implementation:

1. Mental health practitioners (MHNs) in routine practice (not Nurse advisors) would deliver the program;
2. Service users would be offered four and not six face to face *Well-Being* sessions;
3. The length of the programme would be reduced from two years to one year;
4. MHNs would receive three days training delivered by the Nurse Advisor who had worked on the Smith et al (2007) project;
5. MHNs would deliver the programme directly to patients on their caseload;
6. Adherence to each of the five steps of the programme would not be monitored.

Adoption and implementation of the WBSP represented a considerable financial investment by the Trust and to justify this cost it was argued that it was important to determine whether service users engage and benefit from the programme. Practitioners only delivered the programme to service users on their caseload, limiting the number of patients that could access the programme. To reach more service users more practitioners needed to be trained. A rolling programme of training was developed with help from a pharmaceutical company in terms of training resources and costs, and practitioners could apply to attend the training which was allocated on a *first come first served* basis. By the end of 2008, 212 mental health workers were trained. The well-being support service was established in September 2006, and by September 2008 each worker had engaged an average of four patients; approximately 1 in 4 of an average practitioners' caseload; numbering 754 service users, representing around 3% of the service user population in the Trust services.

The Trust was also receptive to facilitating my research and the Research and Development Department recommended I was provided with a Trust 'buddy' with whom I met every month to discuss my role and responsibilities, and also to maintain my accountability to the Trust. This

'buddy' also supported and guided me in navigating the Trust's personnel and systems (App 5). The Trust also required me to provide evidence of the National Research Ethic Service verification of 'favourable ethical approval' (App 3) and University Research Ethics Committee approval. My request to use this Trust was then presented and subsequently approved by their Research and Development committee with the proviso that I submitted annual progress reports for the duration of the study and undertook my monthly meetings as outlined above. I then was given an honorary contract with the Trust as a Researcher, provided with Trust identification credentials and a Trust email account.

The early innovation stage of the Trust in terms of the Choosing Health (2006) agenda was appropriate for this study as it was on the verge of implementation. I also wanted my work to have professional relevance and currency to MHN and that my findings and recommendations would be relatively representative and potentially transferable to other NHS mental health and social care Trust in the UK.

1.5 Research aim and research question

The research aim of this study is to understand why health policy may not become fully integrated into clinical practice, and the reasons that prevent it. It will investigate issues regarding 'professional change' and knowledge translation concerning MHN in relation to the integration of a health policy into clinical practice. Therefore as a case study this investigation will explore how one NHS Trust managed to implement the physical health policy (*Choosing Health 2006*) into practice and asks: '*What factors influenced the integration of Choosing Health (2006) and the Well-being Support Programme (WBSP) at the Trust?*'

Chapter 2

REVIEW of the LITERATURE

The Review of Literature in this chapter is presented as three separate sections:

2.1 – Background to mental health care 1942-2011

The first section of this chapter provides a background by chronicling the related policy development to mental health care in two historically significant periods; 1942-1992 and 1993 - 2011. It examines the historical health policy related to people with a SMI between the periods of time 1942-1990, and 1991-2012 highlighting the failings in health care for this group and provides a background to the current unstable health situation they face. To preserve the historical context, and reflect the circumstances and status of those individuals with a SMI at the given time, a number of different terms such as patient, client, and service user will be used. It will also define the term Severe or Serious Mental Illness (SMI), outlining the features and prevalence of disorders within this definition

2.2 - Change and innovation in mental health nursing practice

The second section provides a systematic and critical review of contemporary research related to the implementation of physical health and well-being initiatives across the UK and the consequences for the role of MHNs. It identifies four key themes which provide an evidence base to inform this investigation and also establishes the extent of similar research in this area.

2.3 - Theoretical perspectives of change

The final section provides a critical overview of Change Theory within the context of this study, using *Change Theory* paradigm proposed by Lewin (1946) to frame analysis; the Open Systems approach to conceptualised change in a professional context (Bevan et al 2008; Plesk 2001; Plesk and Greenhalgh 2001) and Dopher (2012) work which will inform the intellectual debate concerning the specific nature of change relating to clinical and professional practice (Dopher 2012; 2008; 2004).

2.1 Background to mental health care 1942-2012

The first part of this section examines the period 1942 – 1990 which saw the decline of institutional care; the development of early community services; the devolution of financial responsibilities from central government to local health and social care authorities and the impact of antipsychotic medications on non-institutionalised care. The second part discusses the period 1991 - 2011 when community-based mental health care largely replaced institutional care of the SMI and examines the consequences of these changes to service users, particularly in terms of their physical health. The DH sequence of responses to persistently high levels of morbidity and mortality of people with SMI from 1991- 2011 are also charted culminating in the recommendations of *Choosing Health* (2006). Finally, a critical discussion compares how the Royal College of Nursing (RCN) (2010) failed to provide nurses with direction and advice about the consequences to their practice brought about by *Choosing Health*; unlike the Royal College of Psychiatrists (RCPsych) (RCPsych 2010; RCPsych 2009) who presented its members with detailed scoping and guidance concerning their professional responsibilities arising from the *Choosing Health* (2006a).

2.1.2 Severe or Serious Mental Illness (SMI)

There are two main groups of disorders associated with SMI; Bi-Polar Disorders (BPD) and Schizophrenic Disorders. The onset of these disorders are associated with significant deterioration in quality of life, with 34% of people with a SMI rating their quality of life as poor, compared with 3% of those without mental illness (NICE 2011; McCrone et al 2008). Recovery from SMI can however result in dramatic improvement in quality of life; only 9% of sufferers continuing to report poor quality of life when recovered from mental illness (Shepherd et al 2008; Care Services Improvement Partnership, Royal College of Psychiatrists, Social Care Institute for Excellence 2007).

2.1.2.1. Bipolar disorders (BPD)

Bi-polar disorder (BPD), also known as *manic depression* or *manic-depressive illness*, refers to disorders that have serious episodes of on-going mood disturbance that affect the individual's mental state. The World Health Organisation (WHO) (WHO 2010) states that a definitive and universally agreed classification of BPD is difficult to achieve. However, the terms mania and serious depression are used in the International Classification of Disease (ICD-10) and within clinical practice to describe the signs and symptoms of BPD (NIME 2007).

The National Institute for Clinical Excellence (2006a) (NICE) maintains that BPD affects up to 1% of adults. The signs and symptoms of mania or hypomania include grandiose ideas; increased feelings of self-importance; uncharacteristically irresponsible, risky or inappropriate behaviour such as a loss of normal social inhibitions; excessive spending and sexual promiscuity (Ch. V, F30-39 WHO 2007). These states can alternate with depressive phases when a person experiences symptoms such as an extremely low mood, insomnia, poor concentration, low self-esteem and self-confidence, negative evaluations of self and shamefulness, a pessimistic outlook and sometimes suicidal thoughts and actions (Manderscheid 2010; WHO 2010). NICE guideline 38 (2006), states that the pattern of mood swings in BPD varies between individuals and that some people have a few episodes in their lifetime, whereas others experience frequent and regular periods of illness. BPD can occur at any age but often develops in people between 18-24 years of age, affecting both males and females equally (Kessler et al 2005).

Treatments for BPD include medications such as *Lithium Carbonate* (a mood stabiliser) and atypical antipsychotic medications (AAM) such as *Olanzapine*, *Clozapine* and *Respiridone*. A range of psychological interventions and therapeutic support are also thought to be effective particularly if undertaken in conjunction with atypical antipsychotic medications AAM (NICE 2006). BPD carries an increased risk of physical morbidity and mortality particularly thyroid disease; migraine headaches; heart disease; Type 2 diabetes; obesity and associated diseases (NICE 2011; NICE 2006; Kessler 2012; Kessler et al 2012; Kessler et al 2005).

2.1.2.2. Schizophrenic disorders

The ICD10 code (WHO 2010) states that the signs and symptoms of schizophrenic disorders can be categorised into two main areas known as positive and negative symptoms. The NICE guidelines for schizophrenia describe positive symptoms as hallucinations, often known as '*the voices*' which are false perceptions of any of the five senses (visual, auditory, tactile, olfactory, or gustatory) without an outside stimulus or certainty of their authenticity (NICE 2010). Positive symptoms can also include fixed false beliefs known as delusions of various types such as *paranoid*, *grandiose* or *nihilistic in nature*. Characteristically, negative symptoms of schizophrenic disorders include a flattening of affect which presents as a seemingly depressed state where the person cannot derive any pleasure from their life; inability to initiate or maintain any activities, and experience poor social, interpersonal and verbal communication. They can also result in individuals becoming unmotivated and neglectful of their basic needs giving an incorrect

impression of laziness (Ryrie and Norman 2009). Negative symptoms are a less overt part of the disorder and can be mistaken for other mental and physical conditions such as depression, hypothyroidism or diabetes. Behavioural changes can also be seen in individuals due to the person being unable to distinguish psychotic thoughts and feelings from reality (NICE 2009). It should be noted that mistaking one symptom in this way is based on assumptions about the patient or lack of proper assessment, known as *diagnostic overshadowing*, can be responsible for the mistaken or overlooked differential diagnosis between physical and mental illnesses (Jones et al 2008; Seymour 2003). This is a problem for accurate diagnosis and treatments and will be discussed in detail later.

Schizophrenic disorders can be permanent or intermittent, with either increasing deterioration or complete, or incomplete, remission. (WHO 2010 Ch V 20-29). Men and women are equally affected by schizophrenia; men usually developing schizophrenia between 15 and 30 years of age; women, between the ages of 25 and 30. WHO (2011) estimates that fifty million people globally have schizophrenia which imposes a significant burden of illness for MH service users, the carers and society. There are direct costs to society from frequent hospitalisations and long-term psychosocial and economic support, also indirect costs such as life-time lost productivity (Alonso et al 2013; Centre for Mental Health 2010; WHO 2008).

People with schizophrenia have an approximately 50% higher rate of morbidity and mortality compared with the general population. This is partly attributed to an increased incidence of suicide in people with a SMI; 10% die of suicide and violent death however, it is predominantly physical health problems such as cardiovascular disease, Type 2 diabetes mellitus, and obesity (British Medical Association and NHS Employers 2009; National Collaborating Centre for Mental Health 2009). Kilbourne et al (2007) and Osborn et al (2007) both identified that cardiovascular disease (CVD) is the leading cause of death for people with schizophrenia. The third most common is diabetes, following after suicide and epilepsy. DeHert et al (2009) highlights the dangerous compounding comorbidity effect of Metabolic Syndrome when three or more of the following diseases are experienced by an individual: CVD; diabetes; obesity; high levels of low density cholesterol and high levels of triglycerides as reaching epidemic proportions and being expected rather than an exception in people with long-term mental illness (DeHert 2007).

2.1.3. Treatments for SMI

Various treatments that combine pharmacological management with specific recovery approaches such as psychosocial interventions have proved valuable in enabling people with a SMI to live a fulfilling and integrated life in the community (Gamble and Brennan 2006). Psycho-social interventions promote therapeutic alliances and collaborative working with service users, challenging negative assumptions about recovery in mental illness; promoting positive attitudes towards mental health issues among service users, their families, professionals and the public (Gamble and Brennan 2006). Treatment advances in pharmacology have also been remarkably effective in the management of psychological distress and psychotic disorders. Drugs used to alleviate these symptoms are known as conventional antipsychotic medications (CAM) and AAM (as highlighted earlier). Modern mental health provision makes extensive use of both types of antipsychotic medications, with the AAMs being the drugs of choice over the last ten years for the effective treatment of so-called refractory or treatment-resistant psychosis (Tuunainen et al 2003; Wahlbeck et al 2003). AAMs contribute to the reduction of acute symptoms and relapse in SMI and help reduce time spent in hospital (Woodall et al 2004). However, latterly the side effects from AAM causing long term diseases such as Type 2 diabetes; hypertension; CVD and hyperlipidemia have become apparent (McEvoy 2005; Ryan and Thakore 2002).

NICE guideline 38 (NICE 2006a), states that people with a BPD receiving AAM can be equally susceptible to these side effects as people with Schizophrenic disorders and that monitoring of these problems are not taken sufficiently seriously by many health professionals. However, The Prescribing Observatory for Mental Health (part of the Royal College of Psychiatrists work with a number of NHS Trusts to improve practice with regard to mental health prescribing. They have produced a card for users entitled 'Looking after your physical health', to encourage people who are taking antipsychotics to have regular health checks and keep their own record (RCPsych 2010).

2.1.4. Development of Mental Health Care

The development of care for people with, what is now known as, mental illness and mental disorders in the UK can be traced back to religious and pastoral origins such as the *Priory of St Mary of Bethlehem* and the *York Retreat*. The *Priory of St Mary of Bethlehem* established in 1247 was probably the first formal public establishment in England to provide care for people with both mental and physical illnesses. The York retreat opened in 1796 as a place

where members of the *Quaker* group who were experiencing mental distress could recover in an environment that would be both familiar and sympathetic to their needs (www.theretreatyork.org.uk: 2/12/12); It was not until after the *Reformation* in 1647, that the organisation *The City of London* formalised care in the five ‘Royal’ hospitals. The Bethlem Royal Hospital was one of these and it remained the only public institution for people with mental illnesses until the early 17th century.

Over time, a range of different locations hosted the Bethlem Royal Hospital but always focussed on short-term or acute mental problems; discharging patients after 12 months even if they had not recovered. The hospital in the 1850s was situated at the St Georges Field site Southwark and during this period the general conditions for in-mates improved and the use of ‘restraints’ were abolished (Bethlem Royal Hospital Archive 1810-1885). However, the site also accommodated a new State Criminal Lunatic asylum for the criminally insane in two detached wings built, maintained and managed by the Home Office. This was a very unpopular arrangement with the Royal Bethlem medical staff and the facility eventually relocated in 1846 to a newly built Broadmoor Hospital in Berkshire (Bethlem Royal Hospital Archive 1810-1885). A further development was that in 1845 the ‘pauper patients’ in the South East of England, had until then were treated in hospitals like Bethlem Royal Hospital were admitted to in the newly built *County asylums* that were located in what was then the countryside, and remote from cities or towns for example: Cane Hill Hospital, Coulsdon, Surrey; Long Grove Hospital, Epsom, Surrey; Hellingly Hospital, Sussex and Stone House Hospital, Dartford, Kent.

The subsequent widespread development of *County asylums* and private madhouses across the UK led to increasingly systematic and often disreputable institutional basis of MH care. During the early 1900s, psychiatric hospitals began using treatments now thought to be barbaric such as electroconvulsive (shock) therapy, surgical lobotomies and insulin-induced comas to treat mental illnesses (Scull 2005). Socio-economic, sociological factors, and a poor understanding of mental illness continued this trend until Mental Hospitals reached their peak in the UK during the 1950s with on average over 2,000 patients in each institution (Nolan 1993). Policy relating to the mentally ill can be traced to the post World War 1 period and the Report of the Royal Commission on Lunacy and Mental Disorder (Royal Commission 1926). This report was notable for promoting voluntary admission to mental hospitals and identified

mental illness as a public health problem (Royal Commission 1926). This change of attitude led to mental healthcare becoming part of mainstream medicine and encouraged the development of outpatient clinics and aftercare services for its patients. This led to replacing a mental healthcare system predicated on detention with one based on prevention and treatment.

Changes to the care and treatment of the mentally ill and the decline in institutional care continued. However community services did not adequately accommodate the associated problems of SMI, such as poverty, isolation, stigma and homelessness. The Beveridge Report (1942) guided the subsequent development of the UK Welfare State to address the socio-economic issues experienced by people with a SMI and other disadvantaged groups (Abel-Smith 1992). The principles of a Welfare State supported a forward looking approach to revolutionary initiatives and development of provision of Social Insurance, the War on Want and collaborative approaches to health and social care between the patient and the state (Beveridge 1942). Four years later the National Health Service (NHS) Act (1946), heavily influenced by the Beveridge report, transferred responsibilities for the mentally ill from locally based *County asylums* to the central management of the newly formed NHS. The NHS inherited over 100 mental hospitals, each one having an average patient population of 1,000 – 2,000 patients. However, soon after transfer to the NHS these numbers dropped rapidly due to legal and policy changes in terms of the mental health act (MHA) (MHA 1959) which reduced the numbers of compulsory new admissions and promoted the early discharge of existing patients (Nolan 2001).

Mental health services were also driven by changes in social, legal, political and philosophical attitudes which all culminated to form a critical opinion of an institutionalised approach of the care of the mentally ill. The Percy Report (1957) marked the official change to community-based systems of mental health care suggesting the use of viable alternatives such as the relatively newly developed General Practitioners (GPs) and other community-based services. The ‘*Water Tower*’ speech delivered by the then Health Minister Enoch Powell in 1961, made a powerful critique of asylums and envisioned a ten year plan for community care (Holloway 2008). Foucault, the French philosopher and psychologist also offered a comprehensive critique of psychiatric institutions arguing that locking up people with mental illnesses only served to provide the medical profession with cases to experiment upon; usually with ineffective treatments (Foucault 1967).

The condemnation of large asylums or mental institutions can be seen from a number of perspectives. The anti-psychiatry movement, exemplified in the notable works such as *Asylums* (Goffman 1961); *Stigma: Notes on the Management of Spoiled Identity* (Goffman 1963); *The Divided Self* (Laing 1960); *The Self and Others* (Laing 1961) and *Sanity, Madness and the Family* (Laing 1970), were also influential in challenging the traditional methods of psychiatry and called for a greater rights for the 'patients'. These authors rejected the idea that the institutionalisation of people with mentally illness was ethically acceptable and challenged its usefulness to individuals when dealing with their mental distress. They argued that mental illness is an artifice, a sociologically constructed phenomenon designed to relieve the social inconveniences of certain kinds of non-conforming behaviour and a process that unjustifiably stigmatizes those labelled as '*mentally ill*'. In response to the favourable public opinion of community based mental health care, the mental health act (MHA) (1959) for England and Wales was also revised, the new 1983 MHA legislated for why and how a person could be detained for compulsory treatment, it also placed additional legal controls regarding certain treatments, particularly psychosurgery, insulin therapy, narcosis therapy and electroconvulsive therapy (ECT). Further, legal obligation under Section 117 of the MHA (1983) made it statutory for local health and social services authorities to provide appropriate aftercare for people with SMI on discharge from hospital.

In 1962, the *Hospital Plan for England and Wales* stated that all large psychiatric hospitals should be closed and local authorities should develop community services (Ministry of Health 1962). However during the transition from institutional care to community care in the 1960s and 1970s a number of scandals regarding practices in some of the large psychiatric hospitals were uncovered which accelerated the closure of mental hospitals. The White Paper *Better Services for the Mentally Ill* (1975) laid a foundation for care in the community recommending small psychiatric units set within District General Hospitals (Gilmore 2007). The concept of care in the community has a long established history provided in the non-statutory and pastoral ways. The Mental After-Care Association (MACA), now known as *Together*, established in 1879 and still provides short-stay residential homes for discharged psychiatric patients in the Greater London area (Mind 2011). It also offered a range of services to meet the holistic needs of people with mental health related issues on the recovery principles including accommodation, day and community support, providing advocacy and work with courts and probation services (Mind 2012).

In 1981, the Green paper *Care in the Community* went further by suggesting ways of reallocating financial and care responsibilities from the centrally managed NHS to local councils, and voluntary associations. The aim was to enable people with serious and ongoing mental health problems to live as independently as possible. It is interesting that the very opposite recommendation was the vision of *The NHS Act* (1946), when mental health care was moved from the local areas to a central Government department. In 1990, the NHS and *Community Care Act* (*NHS and CCA*) (DHSS 1990) was announced, motivated by a range of considerations including financial, medical, legal and sociological (Butler committee 1975). The *NHS and CCA* (1990) also enacted the decentralisation of financial and practical responsibilities from central government to regional and district authorities. A more locally determined and appropriate services such as NHS Trusts, Family Health Services Authorities and Fund-holding practices (Butler committee 1975) were recommended. The NHS and CCA had major implications to the care of patients with mental illness particularly where and how it would be provided. The expectations of MH staff also changed in terms of day-to-day clinical practice, and the expectations of the personal and professional development necessary to undertake a more autonomous and evidence based approach to interventions (Nolan 2001). The former measures, introduced immediately in 1990, contained, for example, the legal basis for NHS Trusts and fund-holding GPs. The community care sections of the Act delayed implementation until April 1993. Writing at the time, Thornicroft (1994) discussed how the key focus of the act was on allocating the main coordinating responsibility, (lead agency) to local social service authorities. They were required to conduct ‘needs assessments’ on existing patients and patients presenting with MH problems and establish the level of care they needed

2.1.5. Development of Mental Health Care and Policy - 1991 – 2012

Devolution of responsibilities, both financially and medically following the NHS and CCA (Butler committee 1975) meant that remaining long-stay mental patients in the county asylums became the responsibility of the geographical borough or area from where they originated. Patients involved often found this to be an alien and frightening experience (Scull 2005; Nolan 2001). Despite the arguments regarding the negative aspects of institutional care, it should be noted that the benefits of hospital life for the patients included the attention to their physical health through regular medical and nursing care such as yearly ‘physicals’; regular consultation with doctors including medication titration and physical assessments; 24 hours-a-day nursing care; balanced diet and a reasonable standard of shelter. The local NHS Trusts were financially

responsible for providing the services for these individuals following the NHS and CCA (1990) discovered that the costs of long-term hospital care far outweighed other options such as residential care, group homes or hostel provision often with few staff usually unqualified in mental health care. Unfortunately for the patients, cheaper options were often chosen, and the people who had formerly suffered under the injustices of the asylum institution now found themselves in unknown and bewildering surroundings, facing stigma and distrust from the community in which they lived (Scull 2005).

Following discharge from mental hospitals some ex-patients were found living an isolated existence, in poverty and facing discrimination from the public and professionals alike which all contributed to a decline in the ex-patients physical health (House of Lords Debate 15th May 1996). Having spent most of their adult life in mental hospitals, some individuals with mental illness found it difficult to access care in the community and despite being entitled to a GP and other forms of primary health care found them reluctant to offer their services (Mehta et al 2009, House of Commons 1993). This was a challenge to most GPs who, up to this point, had rarely been required to care for people with serious and chronic mental illness (DH 1990).

The first report of the House of Common Health Committee (1993) titled *Better off in the Community?* examined the transition from mental health institutions to community alternatives and evaluated the degree to which the alternatives had met the needs of MH patients. The committee asked ten questions that were concerned with the effectiveness of community care for the mentally ill. These included the key ingredients for the successful or unsuccessful closure of psychiatric hospitals, the benefits and disadvantages of the reprovision of services, and links of hospital closure to homelessness (House of Commons 1993). They found that ex-patients had serious problems with appropriate accommodation; homelessness; poor continuity of care with mental health and primary care services, and an uneven and compromised approach to their physical and mental health care. Further, service users with a SMI who had never had treatment within a large mental illness institution but who were recently diagnosed and part of the community care philosophy, also experienced fractured care pathways and often ‘slipped through the net’ of MH care provision (Nolan 1991).

Some headline cases highlighted the risks and dangers of *mental patients* creating increasingly negative attitudes to mental health community care (Mehta et al 2009). These attitudes were

reinforced by reports of high risk patients committing homicide whilst in untreated psychotic states (Swanson et al 1999). One notable case was that of Christopher Clunis, a man with a long history of paranoid schizophrenia who killed Jonathon Zito in an unprovoked attack because Clunis thought Zito was ‘putting an evil-eye’ (a ‘spell’) on him (Ritchie et al 1994). Following the Ritchie (1994) report and others similar, changes to the mental health act were made including Supervision Registers (Holloway 1994) which were intended to improve MH community/in-patient care transitions and prevent relapse. However, the crucial part of Supervision Registers was contingent on the service user’s cooperation which was difficult to gain if the person was in an acute psychotic state, or the care coordinator was not known to them (Bindman et al 2000; Holloway 1994). Following the issues being identified the committee recommended two targets outlined in Health of the Nation Outcomes for Mental Health (HoNOS MH). These aimed to reduce the suicide rate nationally and to significantly improve the health and social function of mentally ill people (DH 1996). They also initiated the concept of national standards to address the inconsistencies of care for people with mental illness across the U.K. Seven years later the National Service Framework (NSF) for MH (1999) set standards for mental health, among other health targets supported by additional funding of £700 million over a three year period in the NHS Plan (DH 2000). The NHS plan argued the NHS was operating a 1940s system in a 21st century world which:

- lacked national standards
- showed old-fashioned demarcations between staff and barriers between services
- lacked clear incentives and levers to improve performance
- over-centralised management and disempowered patients. (DH 2000:2)

To ‘fast forward’ the NSF and secure the introduction of new services an additional £300 million was provided. The promise was that the treatment of illnesses such as cancer, heart disease and mental health services – the conditions that kill and affect most people will improve with:

- big expansion in cancer screening programmes
- an end to the postcode lottery in the prescribing of cancer drugs
- rapid access chest pain clinics across the country by 2003
- shorter waits for heart operations
- hundreds of mental health teams to provide an immediate response to crises.

(DH 2000:8)

As an outcome from the NHS plan (DH 2000), community mental health teams, services for early intervention in psychosis, and crisis resolution teams became a common part of mental health care services (Edwards and McGorry 2002).

2.1.6. Contributing factors to high levels of Morbidity and Mortality in SMI

2.1.6.1 Antipsychotic Medication

Other advances in terms of treatments that led to more effective management of the signs and symptoms of SMI began in the 1950s with the discovery of conventional antipsychotic medication (CAM). CAM such as Chlorpromazine, Thioridazine, and Haloperidol were used for several decades as the mainstay drug treatment for psychotic disorders. These medications had considerable beneficial effects on both positive and negative psychotic symptoms of psychosis for many patients and contributed to managing the symptoms of people with a psychotic illness in the community thus avoiding hospital care (Robson and Gray 2007). However, despite being largely effective in psychoses they also produced distressing and unpleasant side effects for patients such as tremors, hyper-salivation and tardive dyskinesia (Davis et al 2003, Leucht et al 2003, Umbricht and Kane 1996). In response to these issues, a new generation of drugs known as atypical antipsychotic medications (AAM) were introduced in the 1980s.

The AAM drugs were promoted as being not only more effective in the treatment of positive and negative symptoms, but also as having less distressing side effects than CAMs (Keltner and Johnson 2002). The success of community care for people with MH problems was partly due to the increasingly wide spread use of AAMs indeed some doctors considering them as a panacea for managing psychosis (Davies et al 2007). The widespread evidence promoting AAMs led to the NICE Health Technology Appraisal (HTA) No 43: *Guidance on the use of atypical antipsychotic drugs for the treatment of schizophrenia* (NICE 2002) endorsed their usage. Positive findings from randomised controlled trials of AAMs, service users and health professionals' views and experiences showed these newer antipsychotic medications were more efficacious and safer than their predecessors (NICE 2002). However, the side effects and complications of AAM were not so benign, for example the drug Clozapine can produce agranulocytosis; an abnormally low white blood cell count which can lead to a potentially fatal condition and also produced such huge weight gain in short periods of time that can lead to Type 2 diabetes (Tosh 2010). Other groups of AAMs have side effects including the development of metabolic syndrome which is a cluster of metabolic and cardiovascular abnormalities that can lead to serious physical health problems and

early death (Toalson 2004). Despite the serious consequences of metabolic syndrome, it is often overlooked, or its consequences are underestimated by medical and nursing staff (Eldridge et al 2011). This is despite NICE guidelines for Schizophrenia (NICE 2009) and the NICE guidelines for BPD (2006) both recommending screening and monitoring for these problems (NICE 2009, NICE 2006). Holt et al (2010) note that, although there are explicit guidelines, there is still high prevalence of undiagnosed metabolic syndrome in people with SMI and screening rates for metabolic abnormalities in people with SMI remains low. Consequently, Holt et al called for improved screening of physical health complications and better identification and treatment of metabolic syndrome however they do not explain exactly how this will be achieved (Holt et al 2010; Meltzer 2005).

2.1.6.2. *Contributing factors to poor physical health*

Considerations that can lead to poor physical health are generally associated with socio-economic issues leading to a poor diet, high in saturated and low in unsaturated fats, low in fibre, vitamins and minerals. As many MH Service users are in this situation this adds to the other risks experienced by people with a SMI (Filakovic et al 2012). Furthermore, a study undertaken by Brown et al found people with SMI were less likely to engage in physical exercise; with 36% of the male participants and 32% of the female participants reporting they took no exercise at all (Brown 1999). Negative symptoms as noted earlier, can also lead to limited motivation, lethargy and lack of interest in engaging in healthy life style choices such as exercise, healthy diet and seeking health advice (Ryrie and Norman 2009).

Osborn et al (2007) reported an increased risk of death from stroke and coronary artery disease in people with SMI; conversely differences between co-morbid cancer and SMI compared with the general population were not found. Their conclusions were consistent with other studies that established that people with SMI have an increased risk of death from coronary heart disease (CHD) and stroke as a result of multiple factors including antipsychotic medication; smoking; limited exercise; poor access to primary care; social deprivation and finding accessing primary health care challenging (Viron and Stern 2010).

A retrospective study from 1998-2003 of 63 service users in a Recovery Living Hostel setting using medical and nursing notes was undertaken by Greening (2005). The participants were males (n = 45%) and females (n = 55%) who all had a primary diagnosis of a psychotic disorder; with

the exception of two who had obsessional compulsive disorder and one with a personality disorder. All medical examinations including vital signs, blood tests, urinalysis and weight were reviewed in the five year period from the notes. Greening (2005) found that physical health screening for service users was very poor, despite some obvious indicators that would require interventions, such as weight gain and breathlessness. Although this study was limited to the hostel setting, there were some interesting recommendations made for healthy life style interventions. Unfortunately, it was only when staff became *well-being practitioners* and began implementing the programme that they became aware of the issues.

A survey by Pansesar (2006) investigated the outcomes of well-being assessments conducted with people with SMI living in a group home setting. He found that the participants (n=39) were given a full physical screening, with specific attention to *well-women* or *well-man* issues. Findings showed there was an extremely high incidence of obesity with (30) participants being overweight; of these 53% of the group were obese and 10% were very obese (Pansesar 2006). The study also found that seven of the (39) service users were hypertensive; five undiagnosed. The researchers also undertook a range of urinalysis tests and found over 21% of the service users had abnormalities. The recommendations from the study suggest that: more attention should be made to regular physical health assessments; staff should be provided with well-being awareness training to help this be achieved; skills should be developed in health promotional activities to improve the service user's physical health status. However, specific recommendations as to how this could be achieved were not made explicit. Gatineau and Dent (2011) representing the National Obesity Observatory (NOO) argues that mental disorders can be a cause of obesity for a number of reasons including unhealthy lifestyles and use of food as a coping strategy. Obesity can also occur for biological reasons such as side effects of medication and psychological explanations including low expectations of weight loss attempts and poor support from family and friends (Gatineau and Dent 2011).

Problems identified by Osborn (2006) coupled with poor access to health care, stigma and (non-MH) professionals' fear of mental illness added to the difficulties experienced by people with a SMI has a direct impact on the high morbidity and mortality rates in this client group (Osborn 2007). Filik et al (2006) report that uptake of health seeking interventions for people with SMI were lower than the general population having conducted a two year observational study comparing the respiratory and cardio-vascular condition of participants with a SMI, with the

general population. All participants that volunteered were largely representative of a cross section of UK mental health service users. The data collection instruments were reliable and valid, but other variables such as pre-existing medical conditions such as diabetes were not discussed. This omission raises questions about the amplifying effects of co-morbid disease and disorders. One year later 20 participants (80%) remained with ten (12%) having spoiled results. Nevertheless, the group was still largely representative with the exception of 20 (65%) being smokers in the original set as opposed to ten (48%) in the remainder. Further, patients with SMI were more likely to experience cardiovascular problems compared to the general population and less likely to be referred for procedures such as heart catheterization or placed on cholesterol monitoring to diagnose heart disease (Filik 2006).

The necessity to improve the health of this susceptible group of people through health interventions and health promotion is well established. Tosh et al (2011) evaluated the effectiveness of the health advice on physical health outcomes of people with SMI by reviewing all randomised controlled trials available in 2009 (n = 884); of which only five were selected using a random-effects model for analysis. The authors describe an increasing emphasis on providing healthy life style advice to people with a SMI by different professional groups involved in the studies reviewed (Tosh et al 2011). Both outcomes that were positive and those that made no difference were discovered in the participant group of people with a SMI in terms of their health outcomes. The authors concluded that some of the participants' groups may benefit from accessing services to promote physical health, leading ultimately to improving the existing morbidity and mortality rates. However, they also found that practitioners could unknowingly be offering ineffective health promotional advice, despite an earnest amount of time, effort and money being spent (Tosh et al 2011).

A critical systematic review to establish the motivators and barriers of service users engaging in healthy lifestyle interventions (HLI) undertaken by Roberts and Bailey (2011) is also of interest. The review included searching eight electronic databases (1985 – 2009) and hand searches for qualitative, quantitative, and mixed-method studies. No studies were discovered that explicitly investigated what helped and hindered the uptake of lifestyle interventions for people with a SMI. Service users' incentives to engage in HLI included symptom reduction; support from peers and staff; increase understanding of issues; personal skills and active participation of staff. Negative factors included were symptoms of illness: side effects of treatments: poor support and negative

staff attitudes (Roberts and Bailey 2011). The authors conclude that further research would be necessary to establish service users' motivators and barriers and that nurses should consider these when undertaking health promotional activities. The implications of these findings are that although there are inherent advantages in engaging in HLIs there is still little understanding discovered in this review about what factors help or hinder this engagement.

The discovery of increased morbidity and mortality rates among people with SMI due to physical illness is relatively recent, however the physical wellbeing for this group has arguably been undervalued for decades (Lawrence and Kisley 2010; Brown et al (2008); Brown et al 2000; Dixon et al 2000; Lader et al 2000). Health professionals were gradually beginning to realise both the seriousness of these side effects of medications and the implications of the emerging evidence that life expectancy may be reduced by 15-20 years for people taking these drugs (Robson and Gray 2007). Unfortunately the evidence not only continues to highlight these problems but it also suggests a year by year deterioration in the health and wellbeing of people with a SMI.

2.1.7 Policy and Best Practice Guidance

Various reasons for the increasingly poor levels of physical health among people with a SMI since the move to community care have been proposed, including so-called life style choices made by service users (Osborn et al 2010; Osborn et al 2007). Added to these issues are problems for service users in accessing primary care and getting regular physical health checks which increased their propensity towards illness and disease compared with the general population as seen in the National Psychiatric Morbidity Survey (Jenkins et al 2008). The NSF MH standards 2 & 3 make it mandatory for people with SMI to receive reliable advice and assistance about physical and mental health matters (DH 1999). To this end the recommendations were made that primary care staff should work collaboratively with mental health care coordinators to provide effective physical health care for service users (DH 1999). However, five years later Louis Appleby, the National Director for Mental Health, addressing the Annual General Meeting of the All Party Parliamentary Group on Mental Health expressed concern about the on-going problems for people who have a SMI living in the community (Appleby 2004b). These concerns included social exclusion, poor employment prospects, stigma, discrimination and inequalities in accessing proper health care due to socio-economic or occupational factors (DRC 2006). The DH also argued that health promotional activities can inadvertently exacerbate inequalities and disadvantage people in lower socio-economic groups (DH 2000).

2.1.7.1 *Choosing Health*

In response to reports of increasing morbidity and mortality among people with SMI the Department of Health (2006a) commissioned an experimental pilot project of nine different MH services in the UK. The pilot project explored whether the physical health screening and monitoring of people with SMI could improve their physical health status (DH 2006a). The practitioners involved were predominantly experienced MHN who had additional training regarding physical health and well-being interventions associated with SMI, and were keen to develop this aspect of their clinical work. The outcomes were that the physical health and well-being interventions for people with a SMI provided overwhelmingly positive outcomes in terms of service user satisfaction and reduction of physical health risks (Smith et al 2007; DH 2006a). Success of this project motivated the development of the commissioning policy *Choosing Health: Supporting the physical needs of people with serious mental illness - commissioning framework (Choosing Health)* (DH 2006a). This policy was introduced across the UK heralding the well-being support programme (WBSP) (DH 2006a) as best practice guidance and recommending its interventions should be on offer to all people with a SMI. To support its implementation additional revenue was provided to a number of primary care Trusts (n=88) in 2006/7 and 2007/8 equating to the cost of approximately two lead - nurses for integrating the WBSP in each Trust. It is this policy and its recommendations that this study will focus on to uncover the reasons for the success or failure of health policy implementation.

One of the final initiatives of the previous government was to introduce the policy *New Horizons: Confident communities, brighter futures: a framework for developing well-being* (DH 2010b). This marked a shift towards the prevention of the development of mental health problems and the promotion of positive mental health and well-being across the UK population. However, these aims were not realised due to the change of government. The current coalition government has nevertheless followed this direction and has published several policies such as, *No Health without Mental Health: a Cross-Government Mental Health Outcomes Strategy for People of All Ages* (DH 2011d); *Healthy Lives, Healthy People: Our strategy for Public Health in England* (DH 2010a); *Our Health and Wellbeing Today* (2011e) which all reflect the Coalition Government's three main guiding principles of, freedom; fairness; and responsibility; emphasising the interrelationship between physical and mental health, particularly early interventions (DH 2011d).

2.1.8 Interagency Collaboration

Making a Difference (DH 1999) recommended the most effective means to deliver care to people with complex needs is through interagency collaboration. This concept was further promoted with the publication of The NHS Plan (DH 2000), a ten-year programme of practice reform that has been instrumental in shaping the way in which inter-professional working is viewed and implemented today. It is increasingly accepted that inter-professional team decision making regarding patient care improves with greater sharing of information and knowledge, particularly when service users have complex needs. The DH has issued guidance for psychiatrists working within multi-disciplinary teams (DH 2004c). However, despite clear directions and remuneration, the NSF for Mental Health: Five Years On (DH 2004a) had to reiterate the roles and responsibilities of GPs in the management of physical health care of people with SMI. Unfortunately, this was also limited in effect, as *Choosing Health* (2006) found it necessary once more to reinforce the role of GPs should play in decreasing the risks of high morbidity and mortality rates of people with SMI (DH 2006). Some GPs complied with the *Choosing Health* recommendations, whereas others considered it was not their responsibility to screen, monitor and advise on physical health issues to people with a SMI. The latter group believed that the physical health problems associated with SMI were generally attributable to either the mental illness itself or the side effects of medication treatments initiated by MH services, and therefore their responsibility (Citrome 2005).

Choosing Health recommended that the physical health care of people with SMI should be a collaborative undertaking between MH services, GPs and other primary care agencies, thereby providing the means to respond to the wide ranging and complex needs of people with SMI (DH 2006a). According to the DH (2006a) this recommendation was not successful due to several reasons including, lack of flexibility in GP services; GPs interpersonal skills; reluctance for GPs to develop specific mental health knowledge and an unspecified role for GPs in terms of the physical health care of people with a SMI (DH 2006a). To address this problem, an item of Quality and Outcomes Framework (QOF) was introduced, which entitled GPs to receive payment for conducting physical health reviews on people with SMI (British Medical Association and NHS Employers 2009). Reviews were to include details of prescribed medication, physical health and co-ordination arrangements with secondary care recorded in the preceding 15 months (British Medical Association and NHS Employers 2009).

Recognising the conflicts and differences of opinion between GPs and MH services regarding the responsibility for physical health issues is important in understanding why the physical health of people with SMI generally remains neglected. Phelan et al (2001) argues that the poor uptake of primary health care by people with SMI causes their poor physical health and recommends that they should register with a GP who would assume responsibility for that person's physical health care; including the provision of a routine annual check and health promotional advice. Roberts and Bailey (2011) however, established that GPs still paid little attention to treatments for somatic co-morbidity of MH service users and failed to understand the importance of their role in screening and monitoring physical illnesses commonly found in patients with a SMI. Another reason for the difficulty in bringing about the required change in GPs' attitudes and practice is partly reflected in problems within the service user - GP relationship. Oud et al (2009) found GPs could identify several factors that influenced their attitudes to providing care for patients with psychotic disorders. These included the lack of knowledge and skills to deal with behavioural factors, presented by MH service users including aggression and drug abuse; both of which were perceived as difficult and threatening for the GPs (Oud et al 2009). The influence exerted by these difficult-to-manage behaviours resulted in GPs giving sub-optimal care, being inflexible about appointment arrangements and undertaking inappropriate or hasty referrals back to MH services despite obvious cardio-vascular risks (Oud et al 2009; Hippisley-Cox and Vinogradova 2007).

Currently mental health services contribute to addressing physical health problems related to SMI as outlined in the updated NICE guidelines for the treatment and management of schizophrenia (2009) and bipolar disorders (2006), whilst liaising with GPs with varying degrees of success. In simple terms, this seems a good solution to the breaches in care for people with a SMI. Unfortunately, multidisciplinary and interagency working can be problematic due to general long running hierarchical rivalries between professionals and agencies, reflecting differences in their fundamental beliefs regarding what constitutes health, illness and wellbeing (Reeves et al 2010). Within each profession involved in collaboration there is a tendency towards insularity which results in a poor understanding of one another's roles and undermines the inter-professional synthesis of care (Reeves et al 2010).

This year the Health and Social Care Act 2012 (c. 7) is set to enact an extensive re-organisation of the NHS in the UK. The outcomes for the mentally ill and their physical health as a result of these changes are uncertain. However, historically the relationship

between GPs and the care of SMI has been problematic so caution and careful evaluation of service provision would be advisable.

2.1.9 Conclusion

This chapter has explored the historical context of the influential health policy concerning mental health services and service users and explored the development of mental health care and policy 1942 – 2012. It also examined strategic health policy decisions and other factors contributing to the deteriorating physical health status of people with SMI. This led to specific emergent themes such as: increasing morbidity and mortality rates related to SMI from physical health problems; disease and disorders; on-going and frequent changes to health policy to augment previous shortfalls in health outcomes; problems with interagency collaboration concerning the complex needs of people with a SMI. These themes are indicative of the factors that affect both the complex activities required to integrate new approaches in clinical practice in particular the WBSP and reinforces the necessity to ask the research question of this study which is: ‘What factors influenced the integration of *Choosing Health* (2006) and the WBSP at the Trust?’. The specific nature of these factors and their interrelationships as found in this investigation will be explored in depth throughout the rest of this chapter. Chapter 2.2 will go on to examine theoretical perspectives in relation to organisational and professional change and offer an insight into the factors that impact on the development and integration of change in clinical practice.

2.2 CHANGE AND INNOVATION IN MENTAL HEALTH NURSING

Introduction

Choosing Health (DH 2006a), the Chief Nursing Officer's (CNOs) review of MHN (DH 2006b), the NICE guidelines for Schizophrenia (NICE 2009) and the NICE guidelines for Bi-polar disorders (NICE 2006) specifically recommend that individuals with a SMI should receive regular physical health checks and mental health nurses should be competent in undertaking these clinical procedures. However, as discussed in earlier chapters, the issues involved in changing clinical practice to accommodate such recommendations are complex and challenging which leads to the research question in this case study: 'What factors influenced the integration of *Choosing Health* (2006) and the *WBSP at the Trust*?'

This section of the literature involved a systematic search and a critical appraisal of the current literature regarding the implementation of well-being interventions and the changes this additional role made to mental health nursing practice. Aveyard (2010) refers to systematic literature reviews as 'original empirical research' as they review primary data, which can be either qualitative or quantitative. The search included the Cochrane centre, RCN library, computerised database such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), British Nursing Index, ERIC, Medline and Science direct. It also included hand searching of journals in the University of Greenwich, the Royal College of Nursing (RCN) on line journals, books and other mental health sources such as the Centre for Mental Health, Re-think and the Royal College of Psychiatrists (RCPsych). Electronic searches of the main health science and research databases were conducted using the following academic databases; SwetsWise, EBSCOhost, MEDLINE, PsychInfo and sciVerse Science Direct, accessed through the academic library resulting in direct access to relevant academic journals and literature. 2,125 search modes were identified originally by using the keywords search terms: *physical well-being, policy led change, physical health, severe mental illness, psychotic and bi-polar disorders, metabolic syndrome, co-morbidity, attitudes to physical health, change in mental health practice, mental health nurses and physical health*. By introducing the terms 'nursing' and 'clinical', using the Boolean operator 'AND' to ensure both terms entered were searched for, reduced the results to 1,048. The Boolean operator 'OR' was not used, because this lengthened the search results. By adding an additional keyword; change' AND 'practice' 23 papers were found and 7 of which were appropriate to the research questions and investigation of this study. A critical appraisal of the selected papers found four main themes

which were: MHN roles and responsibilities towards the WBSP; attitudes towards WBSP work; inter-professional WBSP responsibilities, and personal and professional development which will be examined in turn. The self imposed parameters of the search were primary research, contemporary in nature so less than five years old and primarily research undertaken in the United Kingdom published in English language.

2.2.1. MHN roles and responsibilities towards the WBSP

The CNO review of MHN in England (DH 2006a) stated that all MHNs should have the skills to ‘refer on to medical or other primary care staff in response to evidence of unmet physical health need’, or be able to ‘arrange for further investigations themselves’, emphasising the need for MHNs and develop their knowledge and skills regarding physical well-being for their service users by improved assessment and health promotion activities. The role of a MHN to provide holistic care, and the frequency of contact with service users provides several opportunities to address their physical health needs (Robson and Gray 2007). However of the seven primary articles critiqued, four identified role ambiguity as a reason why MHNs are unable to identify the physical health needs of people with a SMI.

Shuel et al (2010) found that MHNs do not perceive physical health care as being part of their role or responsibility, that it is time consuming and adds extra expectations to their present workload. They used a qualitative evaluation method of semi-structured interviews with nine MHNs regarding their views in using a physical health assessment tool called the Health Improvement Plan (HIP) to arrive at this finding. The strength of using this method is that it allows in-depth interviewing and the exploration of the “insider perspective”, capturing the MHNs’ own words, perceptions and experiences (Taylor 2005:39) allowing spontaneity for the MHNs to elaborate on their responses (Serry and Liamputtong 2010:47). However, Shuel et al (2010) found only four of the eight MHNs that consented and participated in the semi-structured interview expressed concerns regarding the additional workload and time spent using the HIP to screen for physical health; problems or confusion about whether this task is part of their role and responsibility as a MHN.

These findings are similar to those identified by Eldridge et al (2011) inasmuch as six WBSP participants expressed initial pessimism about incorporating physical health interventions into their role. Brown and Smith (2009) found that eleven of the mental health key workers (MHKW)

(19) that were recruited from the community mental health team (CMHT) in their study failed to participate in the study mainly because they felt overworked and believed the WBSI interventions were not their responsibility. Unlike Shuel et al (2010), Eldridge et al (2011) failed to produce verbatim quotes from the six participants regarding their pessimism about taking on this role and responsibility, thereby reducing the credibility of their findings (Greenhalgh 2010:172). Brown and Smith (2009) inclusion and exclusion criteria for participating as a MHKW are not clear; although it appeared that a convenience sampling method was employed. As Serry and Liamputtong (2010:20) suggest, this sampling method is often used when it is difficult to specify a criteria and any available participant with specialised knowledge of the study area is used. It is worth noting that CMHTs consist of various mental health professionals with a range of knowledge and skills such as MHN; social workers; occupational therapist; support workers; psycho-therapist and Psychiatrists (Gask and Khanna 2011). In Brown and Smith (2009) study it was not made clear if the eleven non-participants MHKW gave genuine reasons for not taking part, such as physical health interventions not being their direct responsibility, or if they just preferred to avoid this type of care despite being a mental health professional with relevant knowledge and skills. Therefore it is difficult to draw conclusions from this non-participation.

The findings concerning role ambiguity and workload from sample sizes of eight from Shuel et al (2010), eight from Brown and Smith (2009) and six from Eldridge et al (2011) may suggest limited generalisability to the wider population of MHNs. Serry and Liamputtong (2010) suggest there is no formula to determining representative sample size so long as the participants supply data that addresses the research aims and objectives. Therefore there may be opportunities to develop transferability of the key points as indicated in qualitative research. Howard and Gamble (2011) used a sample size of MHNs (n=37) and found that all participants felt it was important to address the physical health needs of people with a SMI in their care, although they felt little support for this role. Howard and Gamble (2011) went further to tabulate the exact number of participants that did not perceive specific physical health assessment and care management activities to be the role and responsibility of MHNs. For example, nine of the participants (n=37) perceived that *measuring body mass index* is not the role of a MHN, 24 participants did not perceive that *checking if a female patient is up to date with mammogram screening* as their role, while 20 participants felt that *referring for medical review* is the role of a MHN (Howard and Gamble 2011). Howard and Gamble's (2011) study used descriptive analysis to elicit the answers to each question in the questionnaire. This research method was appropriate to measure perceived

roles and responsibilities of MHNs because the questionnaire sets out to investigate the views and practices of MHNs in physical health assessment and care management (Greenhalgh 2010). The analysis answered the research question which found that MHNs do not perceive physical health interventions as their role or responsibility. Further, these studies illustrate that there is a lack of a reliable or standardised tool for screening the physical health needs by MHNs. Many authors (Eldridge et al (2011); Shuel et al (2010); Brown and Smith (2009); Smith et al (2007)) all investigated intervention tools and the benefits of these tools in addressing the physical health needs of people with a SMI. Howard and Gamble (2011), and Robson and Haddad (2012) looked at views and attitudes of MHNs in screening the physical health needs of people with a SMI.

Howard and Gamble (2011) discovered little evidence that MHNs were addressing and documenting WBSP activities. They noted there was limited consideration for physical activities, dietary intake and sexual health interventions and furthermore little documented evidence of care plans for health promotion activities. Assessing case notes provides in-depth information on MHNs documentation and identifies relevant missing clinical data which can lead to improving professional practice (Nilsson et al 2007). The NMC (2008) stress the importance of keeping clear and accurate records of care delivered. However, Howard and Gamble (2011) identified that a limitation in their study was that they only audited the case notes of MHNs and no other mental health professionals who could have been addressing and recording WBSP activities. Nevertheless, Hall and Dearmun (2008) argue that auditing case notes is a useful tool in reviewing and monitoring change, and encouraging MHNs to reflect on and improve it. Therefore, training MHNs to improve their documentation skills that reflect their care can encourage competency, confidence and positive attitudes towards the physical health care of people with a SMI and may ultimately help to reduce the high levels of morbidity and mortality experienced by this group (Robson and Gray 2007).

2.2.2. MHNs attitudes towards WBSP work

Robson and Haddad (2012) found that MHNs' attitudes towards physical health screening affected their practice, clinical behaviour and willingness to adopt new ways of working. The participants in the study were MHNs recruited from a NHS Mental Health Trust (UK) human resource records, irrespective of their clinical background, age, gender or years of experience; data analysis was undertaken using descriptive statistics. Robson and Haddad (2012) investigated MHNs confidence and attitudes towards physical health screening and found that MHNs were

competent and confident with high attitude scores in undertaking physical health checks; vital signs such as blood pressure; pulse, temperature; respiratory rate; weight and height, but limited confidence in the assessment of sexual and women's health. Robson and Haddad (2012) claim those MHN participants who had undertaken some physical health training and those MHN that initially trained as adult nurses, were more confident and scored higher on the physical health attitude scale compared with MHN colleagues with no additional training.

Robson and Haddad (2012) employed a quantitative research method using postal questionnaires that yielded a total 585 of 1130 (52%) completed questionnaires. Although this response rate appears low, it is not uncommon with MHN surveys as suggested by Baker et al (2005). Nevertheless, it should be acknowledged that low response rates can bring about bias as described by Polit and Beck (2009) and Denscombe (2007). The response rate could have potentially been improved if the researchers had presented themselves face to face with the participants, but this may have caused logistic difficulties considering the numbers involved (Aveyard 2010).

The validity of their newly developed attitude scale for their study was established by evaluating the population's variables and its readability was indicated to be understandable by an average person 14-15 years old. They also suggest that these findings cannot be generalised to a wider population of MHNs, as data was collected from just one mental health trust. However their analysis showed some statistical significance with a probability value of $p > 0.063$ although generally statistical significance for social sciences is usually $p > 0.005$ therefore their suggestions related to these findings that previous physical health training or adult nursing education has some effect on MHN confidence. Further, it may also affect their attitudes to physical health work and help formulate their practices to facilitate suitable interventions and contextual knowledge may be important (Serry and Liamputtong 2010). This may be attributed to nurses unconsciously or consciously limiting themselves to assessing situations or conditions that they feel able to manage, because assessing other areas will bring with it expectations outside their scope of expertise.

Robson and Haddad (2012) found rather surprisingly, that there was limited statistical significance that training in physical health work influenced the MHNs' attitudes towards this kind of care. Howard and Gamble (2011) found similar results in their questionnaire survey investigating MHNs' views and practice of physical health assessment and care management of

SMI adults in an acute in-patient setting. They found that MHNs are confident when checking vital signs including weight; height; blood glucose levels; dipstick urinalysis; assessing lifestyle factors and health promotion but less confident in conducting electro-cardiogram's (ECGs); assessing sexual and women's health, and using formal medication side effects assessment tools. Their findings suggest that MHN in their study did not perceive physical health interventions as part of their role or responsibility and thus answered their research question. The lack of standardised physical health assessment processes, clear guidance on the documentation of issues found, and instructions regarding the formulation of this information into care plans were found to be a difficulty by the participants in the study (Howard and Gamble 2011). Howard and Gamble (2011) saw evidence of the study's participants being willing to undertake physical health assessments and interventions, but were restrained by inadequate structures and processes. The researchers suggested the lack of means was one of the reasons why the participants felt unable to be involved in this aspect of clinical work and were therefore not addressing the physical health needs or offering health promotional advice to their service users.

In obtaining these results, Robson and Haddad (2012) and Howard and Gamble (2011) both used quantitative research methodology, and descriptive statistics to analyse data. Robson and Haddad (2012) used postal questionnaires and Howard and Gamble (2011) used a descriptive self-report questionnaire from a census sample of MHNs from six acute wards located in three different geographical sites within a mental health trust in the UK. Both studies recruited participants irrespective of their age, gender and years of experience with a substantive employment contract using an audit of case notes. An advantage of using quantitative method is that it allows information to be collected from a large group of people with no direct involvement between the researcher and the participants (Aveyard and Sharp 2013). Howard and Gamble (2011) used a relatively small participant group and failed to state how the 37 of 78 potential respondents (47%) obtained and returned their completed questionnaires. This can affect the quality of the data as it can introduce bias if participants of the returned questionnaires have different clinical area speciality, years of professional experience, qualification and 'banding' status to those that did not respond. Richardson (2004) argues there is no control over who completes the questionnaire therefore a low response rate of 52% and 47% in the studies discussed, together with the issue that the data in both surveys were collected from individual Trusts, indicates that although the findings may be transferable, they are probably not generalisable to a wider population of MHNs.

The benefits of a brief health promotion delivered by mental health key workers (MHKW) were evaluated by Brown and Smith (2009). They found that eight of the 19 MHKW participants recruited from a CMHT were more confident in delivering physical health care to SMI service users. This was thought to be because they had either been trained in physical health and wellbeing, or were adult/general nurses. This is despite all participants having undergone two-hour training at the beginning of the study, and supervision and support throughout the study period. Likewise, Smith et al (2007) UK study found that MHN employed as nurse advisors, after undergoing WBSP (DH 2006) training became more competent and confident in providing physical health interventions, and increased motivation in this respect. However, Smith et al (2007) failed to note the exact number of MHNs trained as WBSP nurse advisors and how they were recruited or if this was irrespective of their clinical expertise, age, gender or years of experience. Nevertheless they stated that the seven MH Trusts that took part in the study each had a MHN trained as a WBSP nurse advisor; implying seven were WBSP nurse advisors. Smith and Brown (2009) also did not indicate if MHKW were recruited irrespective of their years of experience, age, gender or expertise for instance, if the MHKW were MHNs, support workers or social workers. The omission of MHKW and WBSP nurse advisors recruitment criteria in the studies by Brown and Smith (2001) and Smith et al (2007) reduces the likelihood of replication and therefore the findings may have limited generalisability (Serry and Liamputtong (2010). Although, Brown and Smith (2009) used a randomised controlled trial (RCT) in their study, this method only applied to the (26) individuals with a SMI involved in the WBSP and they did not clarify how the MHKW were assessed and selected to have arrived at their findings.

Smith et al (2007) used a quantitative service evaluation methodology to examine the WBSP and its impact on physical health of people with a SMI. They excluded the physical health aspects of sexual and women's health therefore the WBSP nurse advisors may not have gained confidence and competence in addressing sexual and health of women with a SMI. Unlike Smith et al (2007), Eldridge et al (2011) and Brown and Smith (2009) both used mixed methods involving a quantitative approach with 212 community MHNs trained as WBSP practitioners to understand the strengths and weaknesses of the WBSP, going on to interview six of them for a further 10 – 20 minutes.

Shuel et al (2010) found similar results to Brown and Smith (2009), Smith et al (2007) and Eldridge et al (2011), in that some training in physical health knowledge and skills built

confidence, competence and optimistic attitudes in practitioners to assess the physical health of people with a SMI. Shuel et al (2010) found that before the HIP training, MHNs were less confident in assessing physical health, particularly the sexual and women's health; but became competent and more confident after the training and were able to make physical health care plans for this group. Shuel et al (2010) employed a qualitative evaluation using semi-structured interviews with nine MHNs' about their views in using the HIP, in a community mental health practice in Scotland. A possible bias within this study could be the 'Hawthorne effect' as Greenhalgh (2010) suggests that staff tend to work harder when change is aimed at improving performance and there is increased attention from colleagues, superiors or clients. In this case data were collected by the author who was the line manager to some of the participants using a newly developed tool of her own design which raises questions about the objectivity of the evaluation because the participants were keen to provide positive feedback to their 'boss'.

On the whole, there are variable levels of confidence, competence and attitudes amongst MHNs to physical health related knowledge and skills as evident in this review. Robson and Haddad (2012) concluded that the attitudes of MHNs potentially impact on the outcomes of physical health care. Competence in undertaking physical health monitoring is an essential skill for all nurses as recommended by the CNO (DH 2006b) and also included in the Essential Skills Clusters for pre-registration nursing programmes (NMC 2007). As a result, it is suggested that MHNs need to conceptualise behaviour and contextualise their knowledge in order to facilitate professional competency, increase confidence and integrate physical health care skills into their current practice. This could improve their care of people with a SMI and provide clarity concerning this role.

2.2.3. Inter-professional WBSP responsibilities

The responsibilities for the physical health of people with a SMI are the subject of debate between primary and secondary care practitioners in the UK. However, the general agreement is that shared care among them is largely ineffective (DH 2006a). Osborn et al (2010) explored the impact of nurse-led interventions to improve screening of key physical health risk factors for clients within the primary and secondary care service by comparing the annual screening of CVD from Jan 2000 - Dec 2007 among clients with schizophrenia, with those without a CVD, in a primary care setting in the UK using The Health Improvement Network (THIN) assessment protocol. The study included GPs (n=420) across the UK with patients aged over 18 years of age

who had a diagnosis of schizophrenia. Clients with, and without schizophrenia were compared using regression model to analyse age group, sex, social deprivation to consider the influences of these factors on the differences between the screening of non schizophrenic and schizophrenic clients. Clients with pre-existing CVD and those with no further records were excluded. The findings showed the four risk factors of CVD were not assessed in people with a SMI despite NICE guidelines (NICE 2006; NICE 2009) recommending this should be undertaken in the annual CVD risk screening for these groups.

Osborn et al (2010) study used a collaborative approach between primary care and MH services were developed to increase the screening of people with a SMI by working collaboratively with GPs. They went on to encourage MH clinicians in the community teams to pursue the issue of screening people with a SMI with GPs if they were not seen by the GP after three months. Time constraints meant the effectiveness of interventions could not be measured and risk factors reassessed (Osborn et al 2010). The RCT methodology used had a poor response rate which undermined its rigorousness and ability to fulfil its aim of establishing whether physical health interventions can reduce related risks (Lincoln and Guba 1985). Recruitment time was also limited as a consequence of funding and therefore further comparisons such as with other diagnosis, antipsychotic drugs and demographics were not made. This undermined the quality of the findings and transferability of their results (Aveyard 2010). Ethical approval was sought by the authority and a large number of clients with schizophrenia (n=18,696) and without schizophrenia (n=95,512) participated. The whole UK was included therefore factors that could predict screening inequalities such as the deprivation scores and consultation rate were controlled. Data on each person diagnosis, CVD risk factors, referrals, prescriptions and the local deprivation determined by postcode, were included by THIN (Osborn 2010).

Osborn et al (2010) found that GPs felt uncomfortable about being asked by MHN to carry out physical health tests on clients. Nevertheless, the requirements of the Quality Outcomes Framework (QOF) (BMA and NHS Employers 2009); the Maudsley Prescribing Guidelines (2007) and the NICE guidelines for Schizophrenia and Bi-Polar Disorder (NICE 2009; NICE 2003) all recommend that physical health care for people with a SMI should be shared between primary and secondary care providers. This is supported by the NSF for MH (DH 1999) which recommends that primary care should have the proper organisational structure and skills to facilitate physical health checks and support for people with a SMI. Since the introduction of the

Quality Assurance Framework in 2004 and the SMI register, the situation has improved and approximately 30% of people with a SMI are now in touch with their GPs.

2.2.4 Personal and professional development

The DH (DH 2006a; DH 2006b) identified that MHNs should have the skills, knowledge and attitudes to improve the physical well-being of people with a SMI, however in 2011 Howard and Gamble found that the thirty-seven MHN participants in their study showed little confidence when undertaking physical health screening. Twenty seven nurses reported they felt they had not received adequate training regarding physical health care and the majority of the MHNs were not familiar with their Trust or NHS guidelines or policies relating to the physical health needs of people with a SMI (Howard and Gamble 2011). These findings highlight the general implications for MHN practice and the specific issues related to sexual health training which they suggest could be commissioned from higher education institutions. The tool used to investigate MHNs views of physical health assessment was developed for the study and reviewed by a panel of experts consisting of a consultant nurse with responsibility for developing the Trusts *physical health policy*, a mental health lecturer, a doctoral student and a senior statistician. The study was approved by the Trusts Research Ethics Committee, the Trusts Research and Development Committee and piloted to improve reliability and validity. However, Howard and Gamble (2011) did not discuss the pilot study outcomes, and failed to clarify whether those participants were representative of the final study's participants which leaves some unanswered questions in this regard (Greenhalgh 2010).

Robson and Haddad (2012) investigated the development and validation of a tool to measure the attitudes of MHNs in caring for the physical health needs of people with a SMI. Their outcomes support Howard and Gamble (2011) study in finding it necessary to target MHNs for training and education. They also suggest that further measuring of MHNs attitudes would establish interventions suitable to modify their attitudes towards physical health care of people with a SMI. Robson and Haddad (2012) stated that a limitation to their study is in the development of the new scale which could not be compared to an accepted 'gold standard'. Polit and Beck (2009) suggest that a scale lacks criterion validity if there is no correlation to another *gold standard* scale that is widely used in the field of study. It is worth noting that a correlation could not be made as there was no existing scale to guide exploration of this area of study. However, the concurrent validity of the scale was established by comparing staff variables that were judged. The comprehension of

the questionnaire has a readability index of 55.5 and reading grade level of nine using Flesch-Kincaid readability test therefore indicating understandable level of the questionnaire to be the equivalent of a 14-15 year old person.

Brown and Smith (2009) argued that because of the frequency of contact with this client group, using a low intensity intervention delivered by eight MHKW, following a two hour training session could enhance their skills and improve their position to deliver health promotion interventions and identify the need for further training in WBSP activities. Although they stated that a RCT methodology was used it was not clearly described in the paper. Furthermore, the data collection methodology was not described and the findings that led to the conclusion of MHKW needing additional training were not explicit. A qualitative interviewing methodology may have improved understanding i.e. an in-depth MHKW perspective on this matter, as it produces verbatim quotes that illustrate the issues in question in more depth as in the studies by Shuel et al (2010) and Eldridge et al (2011). The disadvantages of this methodological choice is its time consuming nature, accessing participants may be slow and they may also be less forthcoming seeing the interview process as being burdensome (Coombes et al 2009).

Brown and Smith's (2009) study determined whether WBSP could modify lifestyle factors that have a negative impact on the physical health of people with a SMI. They used a quantitative service evaluation approach to monitor the physical health of SMI service users (n=764) in secondary care over a two year period. They found that there was a significant reduction in the level of cardiovascular risk factors and improved self esteem in the participating service users. They concluded that basic nurse-led training in programmes like WBSP which provide physical health checks can reduce cardiovascular disease risk factors and increase self esteem in this service user group (Brown and Smith 2009).

Shuel et al (2010) investigated the impact of training MHN (n=9) participants to use the HIP assessment tool and found similar results to the studies by Brown and Smith (2009); Howard and Gamble (2011); Robson and Haddad (2012), and Smith et al (2007) that MHN additional training in the physical health of people with a SMI would be beneficial. Shuel et al (2010) argued that MHN require further training to develop competencies and confidence in addressing physical health needs, including sensitive subjects like sexual and women's health. They also found that competency concerning engagement of service users to facilitate them providing accurate health

information when completing assessment tools required development. In addition to this, Eldridge et al (2011) study also recommends that further training for MH practitioners be given to improve their interpersonal skills in engaging sensitively and eliciting information from service users about their lifestyle behaviour and physical health.

The participants in the studies by Smith et al (2007), Eldridge et al (2011) and Shuel et al (2010) all consented to participate and their anonymity was maintained. Smith et al (2007) argued that ethical approval was not required in her study because the WBSP is not an intervention but the provision of a service relevant for MH service users in secondary care. Eldridge et al (2011) also commented that ethical approval was not required for their study, and Shuel et al (2010) identified that the study did not meet the criteria of research according to the National Patient Safety Agency National Research Ethics Service and was approved as an audit and service evaluation. Nevertheless, Polit and Beck (2009) recommend that research involving human participants should be reviewed and approved by an independent committee before commencing the study to protect the safety, well-being, rights and dignity of participants. Smith et al (2007), Eldridge et al (2011) and Shuel et al (2010) all claimed that their studies were service evaluations and therefore did not require Research Ethics Committee approval. However this was debatable as participants were involved, and in terms of the studies discussed, their role, their safety, well-being, rights and dignity were not addressed (Central Office for Research and Ethics Committees 2005).

In essence, this review has identified that education, knowledge and training in physical health care and screening impacts on MHNs' competence, confidence and attitudes; thus nurse training should include knowledge around links between mental and physical health about the higher prevalence of physical health risks associated with SMI such as the association of the side effects from anti-psychotic medication which includes: weight gain, high risks of developing diabetes and heart disease (Hamilton et al 2008; Hamilton et al 2007; Osborne 2010). Brown and Smith (2009), Smith et al (2007), Eldridge et al (2011) and Shuel et al (2010) all found that physical health assessment training prior to use of the HIP improved the reliability of the HIP outcomes; made an improvement in their practice in this area; acknowledged the physical health issues of the service users. Howard and Gamble (2011) and Robson and Haddad (2012) recommend that in terms of physical health care of people with a SMI, MHNs should be more knowledgeable, have more positive attitudes and be cognisant of the relevant guidelines and policies.

2.2.5. Conclusion

The key themes that emerged from this literature review were: MHN roles and responsibilities; attitudes and skills towards WBSP work; WBSP inter-professional responsibilities and increased user engagement; personal and professional MHN development. Although issues in their own right these areas also have common characteristics, for example uniform procedures were necessary to undertake a reliable form of physical health assessment and subsequent interventions. Additionally, education, knowledge and training in physical health care and screening impacts on MHNs' competence, confidence and attitude; thus nurse training should include knowledge around links between mental and physical health about the higher prevalence of physical health risks associated with SMI. These include the association of the side effects from anti-psychotic medication including weight gain, high risks of developing diabetes and heart disease (Hamilton et al 2010). Also, making decisions regarding assessment findings were improved by having the relevant physical health knowledge which in turn also improved the practitioner's confidence and competence. MHNs' levels of expertise led to a degree of certainty in terms of the relevance of well-being work and the clarity of their role within the primary and secondary care interface. The complexities of providing well-being interventions to service users can be reflected in the underpinning operational process that facilitates them. The literature in this subject area has grown immensely in the last five years. However, to date, the specific research question this study seeks to answer of 'What factors influenced the integration of Choosing Health (2006) and WBSP (at the Trust) is not represented in the literature discovered.

The following section of the review of literature will extend this critical and systematic review and offer a critical overview of the theory of change linked to the issues in this investigation and offer ways that these perspectives can suggest regarding addressing the answer to the research question of this study.

2.3 THEORETICAL PERSPECTIVES OF CHANGE

2.3.1. Background

In 1998 Diane Plampling then Co-Director, Urban Health Partnership, Primary Care Group, King's Fund, London wrote:

“The NHS is 50 years old. Every government since 1948 has re-invoked its founding principles, but there is less agreement about how services based on these principles should be organized. Alongside remarkable stability in the espoused purpose of the NHS there has been almost constant structural change. Health action zones and primary care organisations are the latest offerings. There is a paper mountain of advice on reforms, restructuring and managing change. Yet many behaviours do not change. The puzzle is why the NHS has been so unchanging, given the barrage of attempts to 'reform' it”.

(Plampling 1998:69)

This quote exemplifies the on-going tensions in the NHS produced by a fundamental need to provide a service that maintains its original purpose proposed in 1946, whilst managing the constant external and internal influences necessary to maintain these aims. Sustaining equilibrium in any field can be a challenge that requires constant change, adjustment, compensation and dynamism (Lewin 1946). Apparently simple tasks may in reality involve complex activities and significant change to be successful. In this study the policy Choosing Health (2006) recommended that people with a SMI should have at least an equitable level of physical health care compared with the general population, and that their life expectancy should not be significantly shorter. No-one could argue with the sentiments of this policy however achieving them is another matter. This review will examine the issues related to change in the NHS and particularly examine how commonly used change theory and management may not be suitable for the multifaceted organisational, professional and individual issues health professionals face when changing clinical practice is concerned.

2.3.1.1 *Lewin-Field Theory of Change and Motivation*

Lewin's theory of change is a good example of a planned change theory, albeit often in a transformational way (Lewin 1946). Lewin's seminal work used group dynamics and Gestalt psychology to offer a theoretical basis to change in beliefs, behaviour or feelings (Lewin 1946;

Lewin 1943). He proposed that psychological needs presupposes field theory which is a tension between a system in relation to another surrounding one and the tendency for change to be towards this direction to achieve equilibrium between them (Lewin 1943). Lewin's work was based fundamentally on earlier experiments by his colleague Zeigarnik. Bluma Zeigarnik, a psychologist and a psychiatrist by profession, was also a member of Berlin School of experimental psychology (Yasnitsky 2011). Her experiments led to the discovery the so-called *Zeigarnik effect* which proposes that individuals remember that which they were unable to complete to a satisfactory level with greater clarity than those tasks which they were able to complete suitably (Zeigarnik 1967; Zeigarnik 1927).

Zeigarnik's early experiments measured levels of *will power*, and proposed that the affect of an intention is equivalent to the creation of an inner personal tension (Lewin 1946). The first assumption is that the intention to reach a certain goal, or to carry out an action to reach a goal, corresponds with a tension in a system with the observable syndrome known as 'intention'. The second assumption is that tension is released if the intention is achieved. Assumption three is that the need for intention to correspond with force acting on the person causes a tendency of 'locomotion' toward the intention. This last assumption defines a causal relationship between need and locomotion (affect and behaviour) and proposes a construct of tension in the person and the construct of force for locomotion in the environment. A further sub-section of assumption three, proposes that a need leads not just to a tendency of locomotion towards a goal, but also to thinking about this type of activity; therefore the force is not just dependent on behaviour, but also on cognitive processes (Van Bergen 1968).

Zeigarnik's experiments to prove these assumptions were ground breaking, serving as the underpinning of most subsequent motivational theories. She reported that one experiment showed that there is a greater tendency to recall interrupted activities, compared with completed ones, due to the assumption two and three. The data indicated that participants may not necessarily have had more negative experiences than positive experiences, but they re-call these more vividly, therefore the perception of the number of negative ones is greater (Lewin 1946). There was also an assumption of dynamism in the 'field' between the systems to ensure different degrees of tension were maintained. Lewin transferred these psychological principles into the workplace and developed what he called a 'social democracy theory' (Lewin 1947). Lewin's theory of change is a fundamental approach for analysing, managing and evaluating change. He uses a transition

process known as a Force-Field Analysis (FFA) to illustrate his theory, which seems to superficially imply a linear approach (Fig 1). However, Lewin proposes that the FFA undergoes a series of repetitions in a spiral model to drill down to the real issues defining and re-defining the problem and its solution concerning the change in question. FFA has sometimes mistakenly been thought to describe a situation that was held in place, therefore, unchanging, by a ‘force field’ concept in a somewhat fictional scientific conceptualisation such as in magnetism or electricity. This may be understandable as the diagram often used to illustrate a FFA does seem to have force field type objects in place (Fig 2). However, the force field Lewin referred to was actually related to his proposal that ‘field theory’ “that was probably best characterized as a method: namely a method of analysing causal relations and of building scientific constructs” (Lewin 1946:45). All behaviour, including action, thinking, wishing, striving, valuing, achieving are all perceived as a change of some state of a field in a given unit of time. The maintenance of equilibrium is dependent on the relationship between the driving and the restraining forces in the field remaining the same. Any transitional processes require the ‘power’ of the forces to be altered either intentionally or unintentionally. If for example the ‘driving’ factors are increased/ enhanced/ improved they will become more forceful than the ‘restraining’ factors a transition or as Lewin refers to it, ‘motivation’ and overwhelm the forces of the restraining factors. This will result in a change from a theoretical point A to a point B (Lewin 1946). At this stage Lewin had not fully associated the contemporary associations of ‘motivation’ which include not only physical movement towards an object but the emotional need to do so. In addition Lewin recognised that

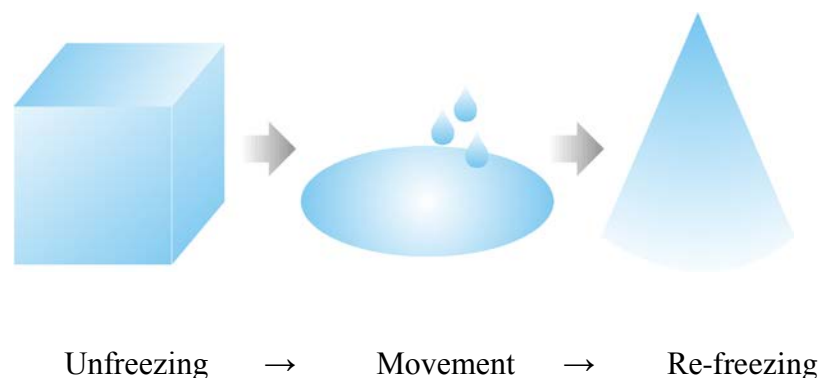


Fig. 2.1 Three elements of transition (Lewin 1946)

increasing the forcefulness of, in the case of cited example, the driving factors was not a simple matter and that further measures were required to facilitate this, particularly in unmotivated, intransigent and challenging situations where change is being strongly resisted. In response to this issue Lewin proposed that a three stage process of transition was also necessary to achieve change: the unfreezing; movement; re-freezing stages

The unfreezing phase involves the forces that are maintaining the status quo being weakened, diminished or reduced and, therefore, conceptionally ‘un-frozen’, allowing free Movement (transition). Motivation for change is the main driving forces and must be generated in sufficient force before change can occur. One of the important points of this model is the Re-freezing phase which is proposed to be the maintaining and sustaining phase that considers that undertaking the first and second parts alone will not be sufficient to ensure permanent change. Therefore, ‘Refreezing’ prevents a retrograde step to the original position, and the transition will be permanent (Lewin 1946) (Fig. 1). However, Lewin (1947) argues that situations are rarely static and that additional or new factors to an existing FFA will alter its dynamics, thus requiring a re-evaluation of the situation.

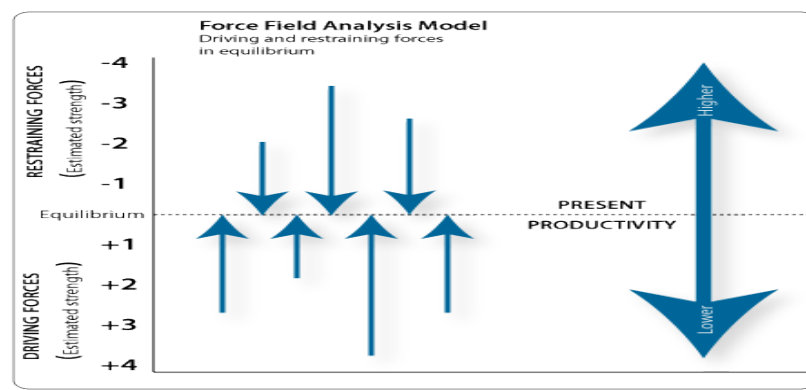


Fig. 2.2: A Force - Field Analysis Model (Lewin, circa 1946)

Lewin’s work is used as a theoretical framework in this study for two reasons. The first is that Lewin’s theory is arguably a major contribution to all subsequent change theory since its inception, and its reliability and validity are underpinned by rational, scientific evidence. The second reason is that the aim of this study is to investigate the integration of a health policy, prima facie indicated a transitional change which is reflected in Lewin’s approach (Lewin 1946). Davies et al (2000) and Bellman (2003) both discussed change from a variety of perspectives usually related to the NHS. They have built on the basic principles proposed by Lewin, adding a more contemporary application to issues such as national and local politics, social policy, and diversity. This study will use Lewin’s work to identify the field factors that impacted on the integration of *Choosing Health* at the Trust.

2.3.1.2. Emergent change

Emergent change (Holman 2010) is a result of inductive or intuitive approaches that detect evolving patterns or discover effects that do not follow an obvious plan. Despite this, change will nevertheless take place in a developmental, transformational, or transitional way (Holman 2010).

Emergent change occurs in situations where apparently unrelated decisions are made which ultimately result in change. There is a drift into change as compared to change occurring as a result of planned events (Holman 2010). Although the decisions may appear superficially unrelated, they may be based on assumptions or covert understandings about the situation or the organisation according to Mintzberg (1989). Therefore, the change appears to be a drifting process rather than deliberately planned events.

This type of change is characteristic of a situation being influenced by external and uncontrollable factors that result in emergent elements, even in a planned change. In a dynamic and unstable environment change is arguably one of the most important issues facing organisations. This is particularly relevant as there is evidence that although some projects are successful, others fail. Price Waterhouse Cooper (2007) found that over 60% of unsuccessful projects were related to internal project problems such as missed deadlines or poor resources. They found the three top reasons for 50% of project failure were poorly estimated and missed deadlines; scope changes; insufficient resources Price Waterhouse Cooper (2007). Therefore, it is critical for organisations to select the correct approach to resolve their problems and lead to healthy organisational development (Davis et al 2000). Since 1984, the previously popular emergent approach appears to have replaced the more planned approach. As an organisation the NHS is a complex, multi-faceted and has many influences, all of which may lead to uncertainty. Therefore although emergent change may not be the model of choice, it may be inevitable in times of uncertainty or fast changes (Kotter 1996).

2.3.1.3. *Developmental, transformational and transitional change*

Akerman (1997) proposes three change models comprising: developmental, transformational and transitional. Developmental change is frequently associated with an improvement or modification that will lead to a better service or product. It can be emergent or planned and is so-called 'first order' in nature, which means it is deliberate and incremental. Transformational change is radical and 'second-order' in nature and involves shifting attitudes and beliefs held within the organisation by its workforce. These factors cause a change in the organisational philosophy and fundamentally alter its nature into one that has the capacity to constantly learn, adapt and develop (Akerman 1997). Transitional change alternatively is concerned with altering or developing an existing situation or behaviour, generally with the purpose of improvement. It is said to be second order change possibly episodic, but generally planned. Many models of transitional change such

as those proposed by Moss Kanter (1983) and Nadler and Tushman (1989) have their origins in the work of Lewin (1946).

2.3.2 Organisational reasons for Change: Systems approach

Many models of change and quality improvements are available, often responding to the failing integration of change within an organisation. However, change remains a well debated topic and mastering it effectively remains exigent. DH offered assistance with the policy document concerned with NHS Sustainability Model and Guide which suggests a three systems approach to integrated change comprising of: staff; process; organisation (NHS Institute for Innovation and Improvement 2010). Although it offers some principles the evidence of a high failure rate, up to 70%, of organisational change highlights the challenge faced with change in a large organisation such as the NHS (Daft and Noe 2000, Beer & Nohria 2000a; Beer & Nohria 2000b). Change occurs for a range of reasons as outlined before but generally the fundamental purpose of change is concerned with improvement, development and progression (Kotter 1996). The development of practice in relation to health care is not fully understood despite the constant emphasis on its importance (McCormack 2004). Nevertheless, the development and inevitable changes in clinical practice are intrinsically linked to health care provision and integral to its quality assurance, clinical effectiveness, and its evidence based, accountability and modernisation (Manley 2004). The process of change is often portrayed as tidy, organized and controlled; however, it can also be challenging, confusing and result in unexpected outcomes as outlined in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2009b revised).

2.3.2.1 *Systems Approaches*

The complexity of change within an organisation such as the NHS may be explained through a systems approach. This approach was originally based in the disciplines such as engineering and biology but was developed further in organisational theory in response to the failure of reductionism to provide a satisfactory account for a whole and complex phenomenon (Senge 1994). The scientific approach of the 3 R's of reduction, repeatability, and refutation (Popper 1972) analyses problems by separating those into component parts to easier understanding. However it fails to account for the effects found when parts are reconstituted. Systems alternatively can have qualities that are not directly traceable to the systems' components, but instead to how those components interact (Laughlin 2005).

A system is said to be formed by a group of parts functioning together as an integrated whole which are interdependent and effective on each other which leads to feedback that can be negative or positive. This is a complex arrangement that is not just a case of cause and effect (Senge 1994). This can be illustrated by the systems of the human body such as the cardio-vascular system or the central nervous system which are constantly relying on each other to work effectively to achieve equilibrium and homeostasis in the body. Similarly, this model also applies to families, cultures and organisations whereby the influencing forces of the individual parts can be either detrimental or complementary to the functioning of the whole system (Plesk and Greenhalgh 2001). Systems are often described as being closed or open in nature. Closed systems are independent and self-regulating of other influences, whereas an open system interrelates with the external environment. When considering a change in relation to a systems approach it is important to account for the system as a whole including the connected and unconnected parts; the effects of the environment on the system; a system in which status quo will only change if dynamic effects are introduced and perspective of the system from the individuals within it (Plesk 2001).

2.3.2.1.1 Whole systems thinking

Clinicians and managers in the NHS often use whole systems thinking (WST) when considering the management of organisational change (Plesk 2001). WST recognises that the NHS is a highly complex organisation which requires a collaborative and seamless approach. It also facilitates the concept that highly developed professionals with different views, values and knowledge can function together in a complementary fashion in the interest of their patients (Plesk 2001). WST, however, in the NHS makes change challenging due to the dynamic expectations of the internal and external forces: the numerous stakeholders involved; developing technology; independence and interdependence of staff; lack of control regarding outcomes. Ywye and McClenahan (2000) proposed that change in the NHS is not straight forward and often has unpredictable outcomes.

2.3.2.1.2 Application of Open Systems Approach to the NHS

Smith et al (2007) undertook an extended case study using an ethnographic methodology to investigate the then current situation in the NHS as regards patient safety, using a systems model. She described the 'macro level' as being the global or international arena, and the 'micro level' as representing national and local issues. She used these to illustrate the role of emotions in creating a safety culture at both individual and organisational levels (Smith 2007). The macro system components in health systems have been described as being comprised of various multifaceted

elements (WHO 2000) although Yalden and McCormack (2010) argued that health services and systems are arranged in a hierarchical way at a number of different levels. However, he largely dismisses the middle system between macro and micro levels ('mezzo' / meso) levels as simply a sub-set of macro level systems, giving examples of mezzo level being services or organisations that cross over other organisations (Yalden and McCormack 2010). They continue by refocusing on the micro level in more depth offering a definition from Dartmouth Hitchcock Medical School (Nelson et al 2007). This definition suggests that micro-systems are related to those on the front-line of health care, where the staff and patient interface, clinical decisions are made and care delivered. The Institute of Innovation and Improvement (2005) supported this view and propose that the micro-level systems are the most influential on service users / patients experience and consider it is where the most effective change can occur (Barton 2010). Stranks (2007) argues that the micro level culture is crucial because strategic operational change and development can be influenced by the micro level, and influences it as well.

Plampling (1998) discussed how the management of change in the NHS has often been comprised by trying to "control behaviour by changing the organisational structure" and suggests that 'control' can be replaced with the development of 'guiding principles' which represent the values and purpose that professionals attribute to practice (Plampling 1998:69). This alternative method of developing practice might be achieved by applying the guiding principles to new ways of working that facilitate "professionals coming together from a range of different perspectives; spending enough time together to move beyond first impressions; engage in conversations that generate possibilities but don't start with problem solving" (Plampling 1998:69).

2.3.3. Professional Perspectives on Change

Dopfer et al (2004; 2008) explain that although the macro and micro parts of an open system demonstrates the organisation and the individual respectively, neither explicitly represent the rules and regulations specific to a profession or its knowledge base, values or standards. He claims these elements are found in the meso level of the system and are demonstrated by the legal, ethical and values of the profession. Dopfer (2012) proposes that the *meso level* is the backbone of professional change and change will only occur if the professional rules and values of the meso system support a process where the knowledge based and values set or activity undertaken are explicit and understood by its members.

The micro part of open systems model is where the individual and smaller activities are based and principles are undertaken. It is the previously noted strategic framework of the organisation where the two former elements can function (Dopfer 2004). However, to view the macro, meso, micro (*MMM*) open systems framework as simply a hierarchy with macro at the top, micro at the bottom with the meso middle ground would undervalue its complexity. Dopfer (2012) argues that professionally developmental processes are determined by the meso system (professional) factors or rules, not the macro (organisational) or micro (individual) factors. The departure from the traditional ‘top down or bottom up’ analyses of change is clear, and Dopfer et al (2004) contends that an alternative perspective is necessary to explain and improve the understanding of how change is developing in professional settings.

Transferring Dopfer’s concepts to this study from the economic discipline is an interesting proposition which can remind professionals of the importance of professional values in all aspect of practice, not least change and development. In the field of nursing, Morse identified six concepts proposed to reach those aims including concept development; concept delineation; concept comparison; concept clarification; concept correction (Morse 1995). Nevertheless, nearly ten years later Manley (2004) was still trying to grapple with the development of practice by examining the intricacy of introducing change in health care and the difficulties related to achieving its sustainability. She maintained that professional emancipation is ultimately an empowering experience although not without its challenges. McCormack et al (2002) reflected a more contextualised perspective for practice development suggesting that collaborating with providers and service users to create systematic approaches appropriate to day to day practice would improve care (McCormack 2009). These concepts imply a greater context related perspective towards the development or change in practice with more opportunity for nurses to achieve. The RCN developed their ideas considerably since 2002 and in 2011 have re-focused on a greater degree of person-centeredness and more confidence in the value of nursing practice recently as outlined below (RCN 2012).

Principles of Nursing Practice: What to expect from nurses and nursing

Principle A - nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

Principle B - nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and families and carers of their patients, and in a way that meets the requirements of help to keep everyone safe in the places they receive health care (RCN 2012:7).

These principles probably have more relevance in day to day nursing practice than earlier versions and seem to recognise the importance of professional and individual knowledge, skills and values, instead of a greater emphasis on evidence and research. This recognition should be reassuring for nurses working in a face to face patient role; however, there still remains a necessity to develop knowledge from a relevant evidence base for the profession.

2.3.4. Individual reasons Change – Personal and Professional Development

On an individual level, Prochaska and Di Clemente (1986) and Prochaska et al (1994) propose that the ability for an individual to initiate change in their ‘Cycle of Change’ model is dependent on several successive factors. These include an initial awareness of harm or benefit of a specific behaviour, a subsequent desire to change this behaviour, and finally the successful actualisation of this change in behaviour. An intricately related construct to this model of behavioural change is Rotter’s locus of control which is concerned with the person’s belief about the extent to which they can exert control over events that affect them (Rotter 1989; 1954). The combination of the Cycle of Change (Prochaska and Di Clemente 1986) and the Locus of Control (Rotter 1989; Rotter 1954) can be suggested as a means to improve the self determination of an individual practitioner and develop a greater sense of motivation in them which could increase confidence when about to embark on change ventures.

In terms of nurses as a group with their own social norms and expectations both explicit and implicit social learning theory considers change to be determined by the social group of which the individual is a member. In terms of professional practice, social learning theory may suggest that a practitioner will only embark on a specific practice if they are cognisant of the specific reinforcers and if they believe that changes in practice will lead to these reinforcers being instigated (Wallston and Maides 2006). With respect to professional development, an individual will seek to embark on a change in practice if they both value the rationale for introduction and believe that the change in practice will improve their patient’s health or well-being. Practitioners

with a high internal locus of control feel more empowered to bring about this behavioural change independently, whereas those people whose locus of control is located in powerful others or in chance (external locus of control) feel less empowered to bring about such behavioural change (Wallston & Maides 2006).

MHNs and other clinical practitioners are expected to initiate a great deal of change by integrating the expectation of health policy recommendations into their practice. However, there seems little additional support for them to develop knowledge, skills and attitudes or to develop a locus of control about their new professional expectations. As noted earlier, the DH had anticipated that MHN involved in the introduction of *Choosing Health* would need to enhance their knowledge and skills in screening and monitoring physical health. The CNO review of MHN (DH 2006b) also recognised these deficits and stated that MHN must develop physical healthcare assessment skills and actively engage in health promotion strategies with service users (DH 2006b). The CNO's review also recommended that these competencies be integrated in pre-registration programmes and continuing professional development to help MHN to acquire positive attitudes towards people with SMI that have physical health problems (DH 2006b). In addition to the CNO's review, the NMC also identified core competencies and capabilities for MHN students at the point of registration, including the physical health care of people with a SMI. The Nursing and Midwifery Council (NMC) also insisted that nursing students satisfy a required level of proficiency in performing nursing skills. This includes those identified in the *Essential Skills Clusters* such as competencies in providing a holistic assessment that encompasses physical, psychological and social health needs (NMC 2007). The DH also produced standards of professional skills and knowledge in the *Ten Essential Shared Capabilities* which were intended to underpin the development of workforce capabilities for socially inclusive practice. However, it had a limited impact and is seldom used now (Hope 2004).

As a consequence of these multiple expectations MHNs were challenged by competing demands such as: developing new areas of expertise, skills and responsibilities concerning the physical health care of people with SMI; how they teach student nurses these new skills and knowledge; and in their own capacity as registrant MHNs (Eldridge et al 2011, Howard and Gamble 2011). MHNs were struggling to make sense of health policy in terms of how it should affect their practice. They needed to be considered as a much more significant part of any systems model used to integrate change and be advised by their professional bodies regarding their expectations,

role and responsibilities in initiatives such as *Choosing Health* and its expectations of change in practice. The reason for an individual practitioner's decision to change or develop is complex. The ideas outlined above are just a small selection of different concepts that illustrate this.

They are not definitive, but simply illustrate the multiple and complex factors involved in individual change as suggested by Scott (2002).

- Facilitation
- Leadership
- Developing person centred approach
- Using and developing evidence from practice
- Evaluating effectiveness
- Influencing and determining policy (Scott 2002)

These concepts imply a greater context related perspective towards the development or change in practice. These principles identified by Scott (2002) have more relevance to day to day nursing practice than earlier versions and seem to recognise the importance of professional and individual knowledge, skills and values instead of simply a strong emphasis on evidence and research. This recognition should be reassuring for nurses working in a face to face patient role however there remains a necessity to develop a relevant evidence base for the profession.

2.3.5. Conclusion

This three-section chapter critically reviewed the literature from three different perspectives: the background regarding mental health policy 1991 – 2012: research regarding the role of MHN in terms of physical health and wellbeing of people with a SMI and the theoretical approaches to change. This offered a comprehensive account of the factors that contributed to the current issues concerning the morbidity and mortality rates of people with SMIs. The first section critically examined the plethora of health policy that has affected people with mental illness over a number of years, identified the shortfalls in consistency and longevity of policy and the constant changes in policy recommendations and expectations. The second section identified four key themes from the literature: MHN roles and responsibilities towards WBSP; MHNs attitudes towards WBSP work; Inter-professional WBSP responsibilities; personal and professional development which highlight some of the issues experienced by MH professionals related to introducing physical well-being assessments and interventions across the UK. These themes provide a sound basis for

this study to develop further ideas in this field and also confirm that no other published studies discovered have asked the research question of this study. The third section discussed a range of change theory and its practical application. It also identified a number of specific approaches applicable to this study such as Lewin (1946), Plesk (2001) and Dopfer (2010). It also went on to apply these theories to mental health clinical practice and note the shortfall of commonly used change theory in the context of clinical change in MHN. The next chapter will now critically present the research design and methodology that facilitates the emergence of the key findings in this investigation.

Chapter 3

THEORETICAL DESIGN AND METHODOLOGY

3.1 Introduction

This chapter provides a critical discussion of the chosen design and methodology of this investigation which seeks to understand the impact of health policy on the clinical practice of mental health nursing (MHN). The research question asks: ‘What factors influenced the integration of Choosing Health (2006a) and the WBSP at the Trust?’ A constructivist epistemology is offered as an appropriate perspective for this study. A case study (Stake 2005) is critically discussed as the chosen design for this study and constructivist grounded theory (CGT) as the appropriate methodology (Bowers and Schatzman 2009, Charmaz 2005). The collaborative role of the researcher in this study is also presented as is the relevance and utility of the *reflection* model suggested by Gibbs (1988) as a means of data collection. A critical examination of the data analysis methodology used in this investigation will then follow identifying a *deductive thematic analysis* to construct six minor themes informed by the principles of *change* (Braun and Clarke 2006; Lewin 1946). Following on the six deductively determined themes were then developed further and constructed into three main systems which were: organisational; professional; individual. An original interpretation of Lewin’s model which emerged from this study is then outlined and its reliability and validity is discussed. Finally, this chapter discusses the themes that emerged and how these were further developed into a conceptual framework adapted from a theory emanating from the economics discipline originally proposed by Dopfer (2004). To ease readability the two participant groups in this study will be referred to as *the managers* and *the nurses*; the NHS Trust where the study is sited will be known as *the Trust*.

3.2 Epistemology

This study is embedded within a constructivist epistemology and an interpretive theoretical perspective (Crotty 1989). The reason for this choice is because such a view of knowledge, justification and their relationship to the natural world seemed particularly appropriate to this investigation which is concerned with identifying and understanding the factors that influence the impact of health policy on the clinical practice of MHNs for a number of reasons including social constructivism and the adoption of a critical position. Social constructivism incorporates the epistemological commitment that knowledge is socially constructed by the researcher and research subjects (Burr 2003). In this study the researcher plays an active and personal part in data collection for both participant groups. Although a constructivist epistemology accommodates a

range of methodologies it essentially subscribes to four key tenets (Burr 2003). These are: the adoption of a critical position about knowledge taken-for-granted; consideration of knowledge as socially, culturally and historically specific; an appreciation of social processes instead of empirical validity in producing and regulating knowledge; the belief that knowledge and social action are related (Burr 2003).

The study demonstrates these beliefs by critically revisiting the existing and ‘taken for granted’ positions on the ineffectiveness of health policy in changing the physical health outcomes, and the morbidity and mortality rates of people with a SMI (Gatineau and Dent 2012). It also challenges the current thinking regarding the role of the MHN in relation to the physical care aspects of people with a SMI. In doing so, it also critically evaluates the historical background of mental health care and MHN in terms of the ontological dualism, often referred to as *Cartesian dualism* (Hart 1996). This dualism dominates the ways physical and mental health is dealt with separately in health services both historically and currently. It also illustrates the philosophical duality between mind and matter that assumes they are fundamentally two separate kinds of substances and that their ontological distinction lies in the differences between properties of mind and matter and furthermore that mental predicates cannot be attributed to physical predicates (Hart 1996).

A social constructivist view also challenges the notion that structuring nebulous ideas and principles will not enhance the understanding and meaning of data, and lead to practical methods of data collection and data analysis. This study takes a relatively nebulous and under researched area pertaining to the relationship between health policy and MHN practice and constructed an open systems model that represents the inter-relationship and dynamic between the themes found. Such an approach is compatible with research questions of this study which seeks to uncover the factors that influenced the integration of *Choosing Health* recommendations into clinical practice by using a CGT methodology. The constructivist epistemology provided a useful paradigm to distil a theory from the ephemeral ideas, ideologies and intuitions offered by the participants in this case study. It also complements CGT by prioritising the interpretation of data and events based on the participants’ knowledge and experiences (Charmaz 2006). Social constructivism reasons that the meaning and knowledge of reality are products of social and linguistic processes bound both historically and socially. The nurses and WBSP managers in the study constitute sub-groups that have their own professional perspectives on nursing and nurses which are characterised by a vocabulary relevant to MHN. The social construction of MHN is as a discrete

entity that has its own rules, values, expectations commonly held beliefs and norms that differ from other fields of nursing (RCN 2012, NMC 2008b). The prominence of these perspectives in their respective vocabularies, social structures and commitments to theory suggest that social constructivism provides an appropriate epistemological basis for this study.

3.3 Research Design

A qualitative case study design was used in this investigation to facilitate an in-depth investigation that provides insights into the complex issues concerning the implementation of health policy, particularly on clinical MHN practice. Stake (2005) describes case study as an in-depth investigation of a case which uses various methods to investigate a phenomena. It also enables more than the application of rigid, formal scientific rules and focuses on issues concerning personal experience, observations and reflection (Stake 2005, Yin 2002, Yin 1999). The case study centred on how one health policy was integrated into MHN nursing practice in a single NHS Trust in the South-East of England. Exworthy et al (2012) argues that any meaningful study of health policy in the NHS can only be done effectively using a large number and range of case studies to evaluate outcomes in a collective and longitudinal way. These definitions were all appropriate to this study by considering a holistic and dynamic analysis of *changing* with a focus on context and processes of change (Pettigrew et al 1992). Huberman and Miles (2002) propose the *case* itself should be at the centre of the study and the unit of analysis. In this study the case in question was the interpretation of the perceptions of mental health professionals and their experiences during the implementation of *Choosing Health* into the Trust.

3.4 Research Methodology

The research methodology selected for this study is CGT (Charmaz 2006) because it facilitates an in-depth exploration of the perceptions of its participants and encourages the development of new theory based on those outcomes. However, unlike its closely related methodology grounded theory (GT), CGT does not expect that data finds its own form or lead to new understandings without a means of constructing it (Charmaz 2000). Charmaz (2006) argues that new interpretation of data are more meaningful and transferable if constructed within, or supported by frameworks that can be conceptual, actual, formal or flexible and that will enhance the understanding of the findings particularly if it merges from the data itself. This study anticipated the construction of new knowledge and concepts concerning the issues that arose during the integration of the recommendations of a health policy on MHN clinical practice, as none were

discovered in the literature. It also examined whether the lack of success in changing practice was because particular approaches to change are necessary in the case of clinical and professional change as opposed to those commonly used and organisationally led approaches.

3.4.1 Critical review of Constructivist Grounded Theory

A review of the literature was undertaken to investigate the outcomes of utilising a Constructivist Grounded Theory methodology together with a Case Study design. The following terms appear interchangeably in various formats ; case study; case studies; grounded theory; constructivist grounded theory; health; nursing; mental health by using the university e-library and Athens search engine. The search results via the EBSCO host Health Sciences Research Databases for Boolean/Phrase 'case study' between dates 2007 – 2013 yielded 293, 869 results. Modifying the original search to 'health and case study' reduced this to 61,271 results and although by adding 'grounded theory' this reduced the yield to 297 A specific search of 'constructivist grounded theory', 'case study' and 'health' and resulted in 21 papers from academic journals. These were all reviewed individually and only one article contained constructivist grounded theory and case study related to a health subject which was McGeorge (2011). Another search replaced 'health' with 'change' which found seven results but only two are health related. They are Matthew-Maich et al (2013) and McKeown et al (2005).

McGeorge (2011) investigated the 'unravelling the differences between complexity and frailty in old age' using the findings from a constructivist grounded theory study (CGT) (Charmaz 2000). This study was designed to understand the differences between the related constructs and definitions of 'frailty' and of 'complexity' that had hitherto been used interchangeably in the mental health field of caring for people with mental health issues in their older age. This paper describes how McGeorge (2011) selected CGT as a methodology with the aim of developing new constructs concerning the two terms, and establishing a shared meaning. She also aimed to undertake an investigation that would bring forth and suggest definitions, and identify the differences between 'frailty' and 'complexity' in this particular clinical area. The choice of CGT was made by McGeorge (2011) because this methodology emphasises the value of insider knowledge and the co-construction of conclusions and theory and does not insisting on *distancing* or *bracketed* from the area of investigation as discussed by Charmaz (2000); when comparing this approach to Grounded Theory (Strauss and Corbin 1990; Glaser and Strauss 1967). McGeorge (2011) also argues that philosophy or paradigm influences the choice of methodology and they

must be aligned and that her relativist and subjectivist perspectives were in concordance with CGT. The areas identified as positive features of CGT by McGeorge, and ones that had resonance with my study included the sense of involvement and collaboration between the researcher and the participants; the complimentary underpinning beliefs systems between the study and CGT, and the wish to develop a much clearer conceptualisation for hitherto unexplained and under-researched areas. The aspirations of McGeorge (2011) were also those in this study, which investigated an under-researched area regarding the integration of health policy in a mental health setting. As with McGeorge, it was thought unsatisfactory to attempt to resolve an important clinical matter in a piecemeal way and that a wide reaching and overarching framework was necessary.

The study conducted by Matthew-Maich et al (2013) also used CGT as their research design and methodology. The background to Matthew-Maich et al (2013) study were similar to this study in that they found inconsistencies in the objectives of guidelines being achieved, albeit in their case related to the area of breast feeding. Matthew-Maich et al (2013) suggested that the shortfalls in uptake of the guidelines into clinical practice were related to them not being properly understood and that outcomes would improve and become more reliable if they were. The issues that Matthew-Maich et al (2013) identify and discuss have resonance with this study in terms of issues related to the implementation of policy recommendations, as does their use of a purposive sample. The design used by Matthew-Maich et al (2013) were criterion-based, theoretical and negative case sampling and not a case study as in this Study They choose CGT as did this study because their subject was an under-researched area and they wanted to develop a clearer perspective on their issue focus.

As with this Study the authors found that three similar and important areas were constructed from the data which they argued would guarantee the requisite uptake: individual attitudes and beliefs; organisational, inter-organisational and inter-professional partnerships. Unlike this Study, Matthew-Maich et al (2013) recommended what they called 'frontline leaders' as the means to develop an increased adherence of the *Best Practice Guidelines*. This study refuted this approach due to its personal and professional consequences on those leaders at the forefront of this type of leadership as described by Greenwood (1999). Nevertheless, Matthew-Maich et al (2013) do refer to issues related to 'knowledge translation' (McKibbin et al 2013; Kitson 2009) in terms of recommendations as does this Study, particularly the developmental processes required to reduced an overly interpretive approach to understanding policy and guidelines.

The study conducted by McGeorge et al (2011) shows the use of CGT produced good outcomes in terms of identifying the underlying issues concerning the poor uptake of policy recommendations. The CGT method facilitated the construction of three main areas of concern and drew conclusions from them. The recommendations that followed provided clear direction and suggested both traditional and novel solutions to the concerns raised. They did not undertake a full critique of their study compared with another methodology which would have provided a balanced perspective of the advantages of using CGT.

Emancipatory practice development through life-story work and changing care in a memory clinic in North Wales was investigated in this third paper by Keady et al (2005). This study also used a constructivist grounded theory to develop new assessment and diagnostic sharing practices. The methods used included 'biographical life-story work' based on a systematic review by McKeown et al (2005) to understand the experiences for nine clients of being diagnosed with dementia. The constructivist grounded theory method facilitated the developments by providing a means to formulate the clients' accounts using a three stage process: practice reflection; practice modification; practice transformation. The study recommends that the use of constructivist grounded theory in relation to emancipatory practice is an important development in mental health care.

Hunter et al (2011) attempted to conceptualise his choice of grounded theory as opposed to CGT. He first explored Glaser and Strauss (1967) and then the CGT methodology with help from Mills et al (2007; 2006) who argue for a constructivist approach to GT. Hunter et al (2011) suggests that this approach is well suited to research related to collaborative healthcare issues and therefore his background as a mental health nurse trained in cognitive behaviour therapy and his research area. Hunter et al (2011) quotes Mills et al (2007; 2006) in proposing that constructivist approaches allows researchers to:

1. Ensure reciprocity between themselves and participants therefore consequently, the theory generated is grounded in the participants' experiences;
2. Address power imbalances between participants and themselves, resulting in theory that reflects participants' experiences;
3. Develop theory that stems from the researchers' rendering of participants' data.

Charmaz (2006; 2000) supports the idea that collaborative approaches such as those noted above can be useful in the development of mutual understandings between researcher and participant. However, Hunter et al (2011) questioned the ideas proposed by Charmaz (2000) as being less successful than originally thought, particularly the principle of the theory that derives from the co-construction of meaning. Hunter et al (2011) also argues that Charmaz fails to offer instruction regarding how the co-construction of meaning and theory development can be achieved. Hunter (et al (2011) go on to suggest that the notion of equal partnership in research is unrealistic and the consequential uniqueness of the outcomes is difficult to contextualise. Williams and Keady (2008) agree with this point and had developed a novel descriptive methodology to meet the requirements of their research. Therefore, whilst collaboration in research suggests it being philosophically principled, CGT as a research methodology may be considered more appropriate to experienced researchers who wish to develop unique concepts and new meanings.

The arguments raised by Glaser (2002) regarding the viability and validity of CGT as discussed before have been refuted by Bryant (2003) by stating that Glaser's approach is essentially positivist in nature while Charmaz proposes that CGT emanates from a primarily objectivist tradition. In defending CGT Bryant (2003) provided a sound case for why developing forms of grounded theory such as CGT require due consideration. Hunter et al (2011) concludes by reflecting that the main reasons for selecting GT as opposed to CGT were based on Glaser's claim that the researcher should maintain an on-going evaluation of data to facilitate the emergence of themes or categories. He also suggested that because he was a novice researcher GT was more attractive proposition due to its long and well documented history and examples of the methodology in research papers thus providing a range of examples and schemes to follow for his work. Hunter et al (2011) also considered that the certainty and flexibility of grounded theory (Glaser 1992; 1978) made this approach more attractive but added that underpinning constructivist perspective offered by CGT (Charmaz 2006) and Straussian GT promotes a collaborative commitment with participants and the dynamic participation of the researcher in the advance of theory.

3.3.2 Constructivist epistemology and ontology

GT with its constructivist epistemology provides the opportunity to combine *free flowing* qualitative data to the point of 'data saturation', to be discussed in detail later in this chapter, whilst being aware of constructionist opportunities that emerge from the data (Charmaz 2009). CGT methodology was developed from traditional (Morse et al 2009) theory (GT) and whilst it still

shares some of its basic assumptions, it has developed in its own right in several respects (Morse et al 2009). GT has three commonly used versions; first is Classic GT that originating in the work of Glaser and Strauss (1967). According to Glaser (2007; 2002; 2001) this methodological approach represents GT in its purest form, stemming from his original work in the 1960s. The second is the Straussian GT which was developed from classic GT (Corbin and Strauss 2008; Strauss and Corbin 1997; Strauss and Corbin 1990). Constructivist GT is considered the third approach and the most recent re-modeling of the GT approach (Charmaz 2006, 2000).

Facilitating and formulating the participants' contributions were undertaken in this study by me becoming part of the reflective groups. I was subsequently involved in the participants' reflective accounts and responses to the challenging situations faced whilst integrating the WBSP. These witnessed accounts provided a deeper level of understanding in line with Charmaz (2006: 524) who argues "Data (alone) does not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts". She maintains that such a view of the world and our relationship to it does not rely on "radical subjectivism or individual reductionism" and argues that constructivism can be achieved by locating the research in its relative field (Charmaz 2006: 134). This investigation sought to construct the meanings which emerged for its participants' experiences, make sense of them by being empathetic with the data and their situations and construct conceptual frameworks that can describe the findings to interested others.

CGT is ontologically concerned with a relativist perspective and epistemologically based in an interpretive and constructivist viewpoint, as opposed to traditional GT. Consequently the reciprocity between the researcher and the participants provides a collaborative relationship which enables the construction of meaning and theory grounded in their experiences (Clarke 2005; Charmaz 2006). Mills et al (2006) reiterates by describing the researcher as author of the phenomena under study, rather than a distant observer trying to interpret meanings presented by participants (Mills 2006). This had particular personal resonance with clinical MHN skills which include the assessment and interpretation of a patient's experiences and feelings. MHN use active listening skills and specific techniques of summarising, paraphrasing, reiterating and mirroring in the humanistic and phenomenological Rogerian style. This approach facilitates understandings and interpretations of the patient's experiences, thoughts, and feelings (Rogers 1980; Rogers

1961). The insights are formulated within the most appropriate therapeutic paradigm such as psychotherapeutic, counseling, cognitive or medical models to form the basis of care and treatment. Anecdotally my observations are that experienced MHNs will respond to the complex needs of a person with mental health problems by formulating their needs into an eclectic model build from appropriate elements of different therapeutic approaches. This more clinically sophisticated and intellectually intricate skill is usually associated with intuitive and experienced nurses who have the capacity to create their personal patient version of a specific clinical paradigm rather like CGT.

Glaser (2003) claims that despite CGT being a legitimate methodology, it is not a re-conceptualisation of GT or a pathway in its own right; it is just another way to undertake GT within the existing inclusive, philosophy of GT. Mills et al (2006) agrees with this perspective in part and points out that traces of constructivism as well as interpretation can be found in the work of Glaser and Strauss. Therefore although the origins of a constructivist approach can be detected in GT it does not facilitate the constructivist paradigm. Whereas, a CGT constructivist epistemology and subsequent design is in all stages of the investigative processes and one that encourages the formulation and construction of findings, possibly improving their transferability (Charmaz 2005).

3.4 Sampling

The research question of this study asks '*what factors influenced the integration of Choosing Health (2006) and the WBSP at the Mental Health Trust?*' and to answer this, the study sought the expert opinion of the people closest to the aforementioned integration. This comprised the managers responsible for the strategic implementation and the nurses responsible for the practical implementation. One could argue that other people could also help to answer this research question such as service users, carers, GPs or non-statutory service user based groups like 'Re-think' who could all offer an important opinion. However, when this project began, the Choosing Health policy and the WBSP were new and generally unheard of by people other than those interested in health policy or responsible for this particular policy's implementation. Nevertheless the groups mentioned could have made a contribution to the issues relating to the physical health difficulties concerning to SMI in terms of their own particular perspective and had this study been focused on those issues these opinions would have been imperative. This study however, did not

wish to focus on these areas as it was seeking to discover the fundamental and underpinning issues regarding the success or failure of integrating health policy into clinical practice.

A purposive sampling technique was therefore used because the participants needed to have expert knowledge and experience in the specialist area of implementation of the WBSP (Given 2008). In preparation for the study, I participated in several of the newly developed WBSP implementation groups where orientation to the culture of the Trust and the aims of the groups were developed. Over a period of four months I had begun to comprehend the aims and objectives of the WBSP implementation group and the processes being undertaken to reach its proposed aims.

It soon became apparent that the managers on the WBSP steering committee and the WBSP trained nurses were the two main groups at the forefront of implementing the WBSP project and therefore were the appropriate purposive sample for this study. Consequently a specific subset of people was accessed who had direct involvement with the WBSP in the Trust. Staff who do not fit this particular profile such as individuals with no direct involvement in implementing the WBSP: non-clinical or clinically unqualified staff; nurses without WBSP training; managers without any specific responsibility to implement WBSP, were rejected. The purposive sample in this study included two different groups who were involved with implementing the WBSP: firstly, qualified clinical MHN practitioners, predominantly MHNs who had undertaken additional WBSP training and are known in this study as *the nurses*; secondly, senior clinical managers who were members of the WBSP implementation group, *the managers*.

The National Research Ethics Service (NRES) specified further constraints regarding the expectations of the participants which limited the subsequent recruitment processes. A full account of the study's compliance with NRES requirements is detailed in the section on ethics below.

3.4.1 Access to participants

Agreement to undertake this investigation within the Trust is given by the Trust's research and development (R&D) committee (App 5) following formal ethical approval by the National Research Ethics Service (NRES). The Trust's Head of Nursing and the Assistant Head of Nursing

(AHN) also approved, facilitated and supported access to the WBSP personnel which, as an outsider to the Trust, was helpful.

3.5 Data Collection

3.5.1 *WBSP nurses groups*

The nurses were invited to attend the reflective groups through information provided by myself and the AHN. The NRES had stipulated in their approval letter that the participants could not be asked personally to attend groups or be expected to agree to 1:1 interviews due to possibly coercion. Consequently, these limitations changed the original data collection methodologies from a direct invitation to participants to join to an informal alternative. The changes involved included issuing a broad and informal invitation to attend a series of six reflective groups on a monthly basis for one hour on each occasion, at a range of locations. This led to twenty-eight of the eighty-five trained nurses who self selected attending at least one group. This resulted in a random, self selecting sample from a wide range of clinical and demographic areas throughout the Trust comprising Forensic, Child and Adolescent, Acute In-patient, Rehabilitation, Community and Older Adult services, from urban and rural areas.

3.5.2 *WBSP managers*

The WBSP managers were also subject to the same methodological restraints imposed by the NRES committee. The semi-structured interviews originally planned were replaced with an open invitation to attend a series of reflective groups following each WBSP implementation group meeting. The rationale for this was aimed at reducing disruption and enabling them to reflect upon their experiences of implementing the WBSP. The managers group comprised representatives from nursing, a pharmacist, occupational therapy and social workers, clinical governance and one person from the drug company funding the WBSP training. All the members were primarily concerned with the strategic and managerial aspects of introducing the WBSP initiative and were purposively sampled due to their particular role in the WBSP implementation. The NRES insistence on informality in the recruitment of participants together with the need to select a purposive group resulted in a relatively small group and therefore a high risk of having too few participants. The methodological challenges experienced in recruiting participants in this group as an outcome of the NRES restrictions of data collection made it uncertain whether a purposeful sample would be achieved. However, thirteen of this group attended at least once, with a mainstay of six attending regularly; those six were all nurses by background.

3.6 Participants' reflective accounts

The participants' accounts in this study were captured through their reflection of how they experienced the implementation of the WBSP. The reason reflection was critically selected was due to both epistemological and methodological reasons. Dewey (1933) first discussed the concepts underlying reflective practice within an educational paradigm. His approach suggested that critical and objective accounts from an individual concerning the matter in question would be followed by a more subjective examination of the effects of the event presenting both the rational and subjective perspectives (Bolton 2012). From this account the individual carefully and thoughtfully considers what has happened and attempts to draw conclusions from these insights. Following on, the individual is expected to develop new insights from the experiences from the period of reflection and that as a result they will increase their understanding concerning the issues raised and from these new understandings will emerge and *learning* will happen. White et al (2006) suggests that critical reflection in health and social care underpins the transformative potential of critical reflection and provides practitioners, students, educators and researchers with the key concepts and methods necessary to improve practice.

Reflection on, and in, practice either for personal or educational development reasons is central to maintaining high standards of care and on-going enhancement of personal and professional practice is outlined by Jasper (2003), and the NMC in terms of pre-registration education for nurses (NMC 2011). Reflection comprises both affective and intellectual processes that facilitate not only the examination of experiences, but also their reinterpretation (Kolb and Kolb 2005; Boud et al 1985). Kinsella (2010) identified four central epistemological themes found in reflective practice that have a resonance to CGT. These are the broad critiques of technical rationality and view professional practice as artistry and not a totally scientific position: the constructivist assumptions being that theory are developed from and through practice. She observes that personal diaries recording critical incidents in practice and within clinical group supervision have been the most popular form of reflection over the last 20 years, included in preparatory professional programs and continuing professional development (Kinsella 2010; Kinsella 2012).

Despite common use of reflection in practice and education, as a research method it is rarely used. However there is an emerging trend towards its use in research. O'Connor and Murphy (2009) propose that using reflection served as an effective research approach as well as an educative and

personal developmental tool. They use reflection in focus groups in their descriptive qualitative study to establish perceptions, beliefs and professional values about a preoperative procedure that had previously only been investigated using quantitative medical research (O’Conner and Murphy 2009). Guided by these innovative methodologies it was decided to utilise reflections in this study to provide familiar processes to help participants to explore, describe and reach conclusions regarding their experiences of integrating the WBSP.

The reflective model that guided the data collection in the study is the Gibbs six stage cycle (Fig 3) which is commonly used in MHN. This approach was discussed at the beginning of each group informally to establish the participant’s knowledge and familiarity of the processes that this model proposes. All participants in both groups understood this model (Gibbs 1988) and had experience of using it either academically and/or in practice supervision. Nevertheless, a simple handout was provided to remind them of the stages and prompt them during their accounts if necessary (App 2). The groups were all audio-recorded and transcribed verbatim and these quotes are used to underpin and contextualise the data analysis (App 7). The participants were invited to read the transcripts where it did not breach any confidentiality issues concerning the different participants’ membership of the group at each occurrence.

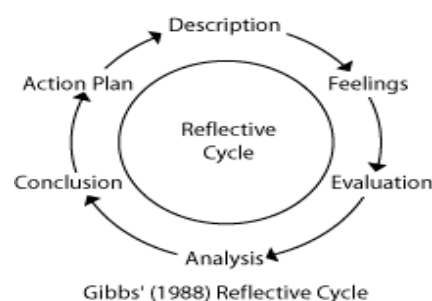


Fig 3.1: Representation of the Gibbs (1988) Model of Reflection

Participants tended to construct their accounts in a reflective way by describing experiences, formulating an analysis, drawing conclusions and finally offering an alternative or new perspective. Alternative approaches to data collection such as semi-structured interviews or questionnaires would not have captured the quality of data developed by the use of reflective accounts such as drawing conclusions and realising what they learned from the experience. Therefore the limitations imposed by NRES may have been fortuitous in ultimately facilitating a richer source of data.

The researcher's role in CGT is to engage in a collaborative relationship with participants whilst, acknowledging the possibility of compromising objectivity (Mills et al 2006). The researcher's role in this study within both groups was as a participant observer and not a formal leader. The prompt that started each group was to the effect '*Hi everyone and welcome. Shall we find out how you have been getting on with the well-being work since we last met?*' This appeared to be all that was necessary to start the discussion and the dynamic of the groups led the order of participants' accounts and length of time spent reflecting upon them. The groups' dynamic in this study led to highly personal accounts regarding the positive and negative experiences of implementing the WBSP. As a MHN myself, I could not claim complete objectivity regarding issues that were raised by fellow MHNs. Schatzman (1991) argued (with qualifications) that this level of subjective perspective can be a positive phenomenon in qualitative research, suggesting that researcher subjectivity can help to develop themes. Charmaz supports this idea and argues that a collaborative approach to the co-construction of data with participants avoids the researcher's sole interpretation (Charmaz 2006, 2009). She also claims that collaboration is important to CGT as it recognises the subjectivity of the participants' practice, the researcher's value system and the relationship between them.

3.6.1 Researcher empathy

The position I took in this study was neither subjective nor objective in the sense discussed by Charmaz (2009) or Schatzman (1991) but was *research empathetic*. Empathy is described as the ability to understand and share the feelings of another without experiencing pity or distress (Carkhuff 1982). I was able to transfer and utilise my clinical MHN practice and psychological intervention skills to achieve high levels of empathy used with service users to engage the participants within the study (Carkhuff and Berenson 1978). Carkhuff (1982) suggest the key factors in developing a relationship are empathy and respect. These skills were used in this study to facilitate humanistic principles of client-centeredness avoiding using direct questions, and allowed the participant to tell their story whilst maintaining respectfulness, genuineness and empathy (Rogers 1980). Ethically these actions were to ensure the participants did not experience any harm and thereby demonstrated the ethical principle of non-maleficence (Seedhouse 1991). Further, counselling-type techniques such as summarizing, reflecting, offering conclusions and checking interpretations helped develop properties, categories and core themes from the data. Empathy allowed me to have a deep level of understanding of the situation without becoming unhelpfully subjective or compromising the boundaries of a qualitative researcher Nevertheless,

as a MHN there was the potential that I may aligning myself with the nurse participants rather than the managers. Anticipating this, I took precautionary measures to ensure that I maintained a balanced approach to the views of each group. This included close discussions with the thesis supervisor regarding objectivity and an even handed approach towards interpretation and coding; use of reflexive and reflective methods to increase self-awareness about my feelings and myself in relation to the participants.

3.7 Ethical Considerations

As a responsible researcher I was mindful of the emotional well-being, safety and respect that the participants in this study were entitled to expect. I sought to practice from a value base of non-maleficence and beneficence (Seedhouse 2005). As NHS staff were going to be involved in the research, it was necessary have permission from the National Research Ethic Service (NRES) which was finally given in November 2007 after a scrupulous interrogation of my research proposal by a committee of 12 professional and lay people . The eventual agreement stipulated that the original intention to interview each steering group member individually was not permissible due to the possible coercion of the participants, particularly the managers group in that they could feel that they should agree to be interviewed (App 6). This would be both unethical and could interfere with the accuracy and honesty of the data. As a data collection methodology was changed to using reflective groups attendance was optional basis gained NRES approval. A further issue raised by the NRES committee was that participant information in terms of the leaflet designed to be given to WBSP practitioner participant should follow the standard NRES template; the additional work was undertaken and subsequently approved (App 3).

The NRES process was an educational process for me as the strictly implemented regulations and mission is to rigorously and formally safeguard NHS staff and patients from research exploitation. This highlighted the care and compassion expected from researchers and influenced my attitude to participants henceforth. Having gained NRES permission (App 3) my proposal underwent scrutiny by the University of Greenwich Research Ethics Committee (UREC) and also the Research Degrees Committee who, following equal scrutiny for both ethical practice and research rigour, both granted permission to precede. Following on, the proposal was then presented to the Trust's Research and Development Committee who also agreed but with a stipulation that regular reports were submitted concerning progress of the study. This process took approximately seven months in total to complete.

3.7.1 Informed consent process

The participants were invited to attend in writing via email to join the study (App 4) and informed in writing using information designed for this study and approved by NRES in a 'Participants Information Leaflet and Consent Form' (App 6). They were also informed verbally and in writing that they had access to the data that they had provided with confidentiality caveats and were also assured about the limitation of any data collected (App 6). They were also told that they had the right to withdraw from the study at any stage without recrimination. Assurances in writing and verbally that research participants will receive information that becomes available during the course of the research relevant to their participation (including their rights, safety and well-being) were given. Furthermore it was made clear to the participants that any data gathered during the study would be held securely on a password protected computer and destroyed as advised by the University and NRES guidelines. In addition, provisions for receiving and responding to queries and complaints from research participants or their representatives during the course of the research were undertaken; all transcripts were rendered anonymous in order to ensure that neither names nor locations could be detected. Following these written and verbal explanations, reassurances and safeguards, each participant signed a consent form (App 6).

3.8 Outsider Replication and Verification

As a qualitative study, this investigation was aware of the criticisms made concerning reliability and validity. Hierarchy of levels of evidence produced with RCT's usually taking first and second place in the listing; followed by experimental studies, non-experimental studies and lastly opinion based on clinical experience or descriptive studies (Holm 2000, Madjar and Walton 2001). Proving reliability and validity such as that applied to randomised control trial (RCT) for instance, is not appropriate in research such as constructivist grounded theory per se. Nevertheless, this study made a point of discussing issues concerning reliability and validity in an on-going way throughout the study, and in particular in the design and methodology sections of this chapter. As a result, possible reliability and validity issues relating to sample, data collection, and data analysis were considered and rebutted within the methodological discussions.

One area in this study however that did require the provision of a reasonable degree of critical argument was that concerning the adaptation the original work of Lewin through the development of the two extra categories to the existing *helping* and *hindering* factors of a. *what can improve the helping factors* and b. *what can reduce the hindering factors*. *Insider verification* is a method

that requires the data and those involved in the study check its understanding repeatedly. This approach was not appropriate for this study because I was the only researcher. *Outsider replication and verification* however was appropriate to test the two newly developed categories as they had not been used in the field before this study. As such it provided the means to check that the interpretation of the participants' quotes that I made using the four categories were reasonably accurate and free from researcher bias (app 7). The testing involved for the introduction of a '*significant disinterested colleague*' (SDC) to examine the data 'blind' and comparisons made with my critical decisions regarding categorisations (Barton-Cunningham 1993 in Morton-Cooper 2000) (App 1). This process was undertaken and resulted in some amendments and improvements being made to the category descriptors and an insight into the importance of quotes being read in the context of the reflection. Details can be found in the handbook used for the *Outsider Replication and Verification* process (App 1).

3.9 Data Analysis

Qualitative case studies are typically concerned with the in-depth study of a single unit of investigation. This study focused on the perceptions of two groups of participants from the same Trust regarding their experiences of integrating the recommendations of one policy; a case study was adopted as a suitable design (Stake 2005). Traditionally GT is considered written properly when "silently authored", demonstrating a position of "distant expert" (Charmaz 2000: 513). However, exposing the researcher as the author of a co-construction of experience and value is a noteworthy development in CGT research. According to Mills (2006) all CGT studies involve the researcher tackling some common features in handling the data which include: "theoretical sensitivity, theoretical sampling, treatment of the literature, constant comparative methods, coding, the meaning of verification, identifying core categories and the measure of rigor" (Mills et al 2006:3). The researcher's moral obligation in terms of analysing findings is to "describe the experiences of others in the most accurate way possible" (Munhall 2001:540). Therefore adaptations to the existing model proposed by Lewin (1946) suggested the development of two further categories to the usual helping factors and hindering factors categories of the *force-field analysis* of his model. This four-category frame of reference provided the structure to facilitate the CGT necessity to saturation the data and a model for future replication. The two additional categories were associated with the originals and were of second order in nature.

The original two are:

- *helping factors* and *hindering factors* of change (Lewin 1946)

The two additional categories are:

- *what can **improve** the helping factors*
- *what can **reduce** the hindering factors*

The nature of the original factors was primarily statements of fact that were generally not modifiable such as ‘not enough support’ or ‘too few resources’. The extra categories found in this investigation related to modifiable statements made by participants that would alter the integrity of the originals in the case of helping factors making them even more forceful. In relation to the hindering factors, making them less powerful or hindering such as ‘being creative when faced with poor resources’ or ‘seeking out support from unusual sources’. This can shift the dynamic of a situation and alter its status quo. The modifiable factors found were of particular interest to this study as they could provide the key to motivating prospective change projects, instead of merely providing a retrospective analysis. The intention was that this investigation would classify data using both Lewin’s original forces and the newly developed forces found in this study that suggested the non modifiable and modifiable factors involved in changing clinical practice and capture the real issues involved in changing practice as a result of health policy recommendations for MHN.

3.9.1 *Data coding*

The processes of data analysis in this study were assisted by an NVivo8 qualitative research package using a tree-node analysis to undertake open and axial coding (Charmaz 2006). Substantive coding; categorisation were developed using deductive thematic analysis using the previously discussed four categories inspired by Lewin (1946). The identification of properties within the constructs was achieved through an inductive thematic analysis (Braun and Clarke 2006) and suggestive of theoretical saturation (Charmaz 2005)

Six themes were identified:

1. Policy;
2. Resources;
3. Leadership;
4. Personal and Professional Development;
5. Support;
6. Innovative practice.

These were re-conceptualised into an open systems model (Plesk 2001) with three systems:

1. *Organisational* - **Macro system**
2. *Meso system* - **Professional**
3. *Individual* – **Micro system**

The transcripts taken from all recorded group meetings from both groups were exhaustively examined “to ensure detailed theoretical coverage” (Cormack 2000:157) and analysed the properties within the categories for similarities and differences which identified conditions in which the properties occur (Cormack 2000). This resulted in the identification of properties described by participants as helping factors or ‘hindering factors’ and their properties. Although frequency across the whole body of data is a phenomenon in its own right, the assignment of a numerical value to properties was inappropriate for this study. CGT methodology in this study extended the parameters beyond an account of the investigation into transforming perspectives, interpretations and understandings in order to illustrate new ways of knowing and thinking. Charmaz (2009) suggests that conceptualisation of core categories can be meaningful in developing an abstract account of an experience with the rich participant narrative.

3.10 Deductive Thematic Analysis: Construction of Themes

The first level of thematic analysis compared and contrasted the data from both participants groups utilising a deductive thematic analysis resulting in four categories as discussed before (see fig. 4 below for illustration). This was then constructed for both groups and went on to establish the themes ranking in terms of frequency and consequently compared them to main data categories. Across category analysis exposing clues to similarities and differences between participants groups and between categories. Coding the data in this way facilitated its categorisation and exposed significant connections and patterns between themes. The initial interpretations found both similarities and differences between the two groups, shown by the frequency with which topics were expressed in their quotes (App 7).

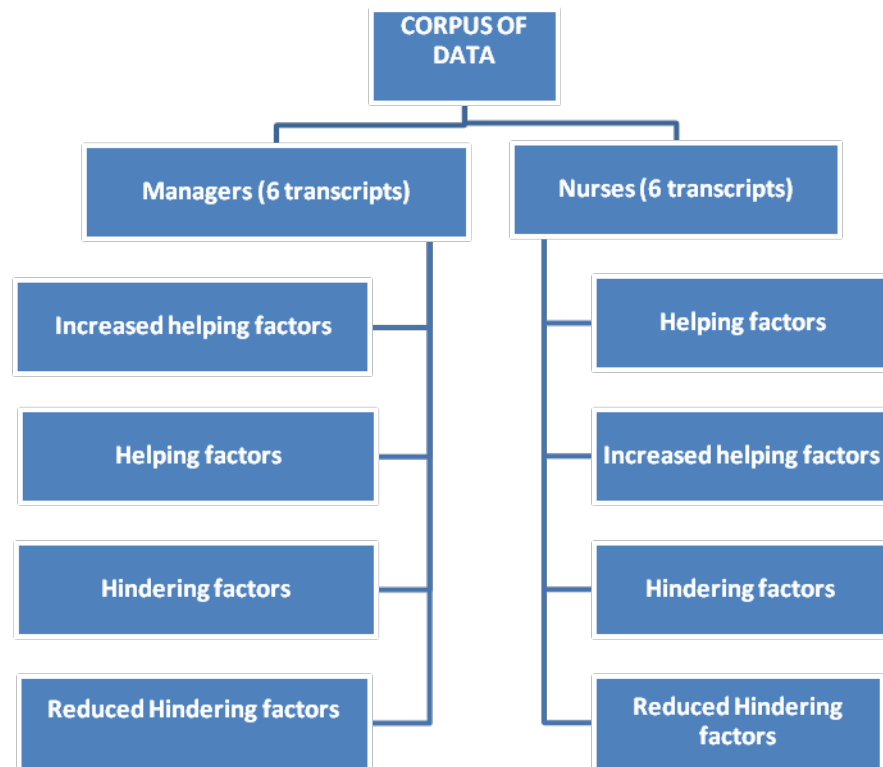


Fig 3.2 Illustration of deductive data analysis format

Following the initial deductive analysis and comparisons there were commonalities of themes across the two groups. However, there were major differences between the weighting in terms of frequency of discussion and also the perspectives of these discussions. Therefore, inductive thematic analysis was conducted to explore these issues and provide total saturation of data (Simons 2009). The outcome of deductive and inductive thematic analysis led to the formation of six minor themes, five of which were shared by both managers and the nurses.

3.10.1 Inductive thematic analysis: Construction of Meanings

The development of six initial minor themes a further level of analysis led to the subsequent emergence of three overarching major themes which provided headings for the minor themes. These were the *organisation*, the *professional* and the *individual practitioner* perspectives and are the basis of answering the study's research question of *what factors influence the implementation of the Choosing Health policy and the integration of the WBSP?* The open systems approach inspired by Plesk (2001) conceptualised the inter-relationship between the themes and provided a holistic perspective to this question.

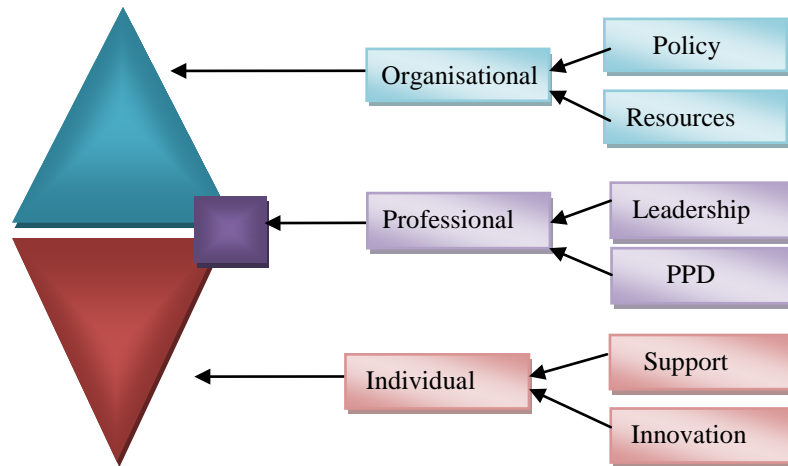


Fig. 3.3 Illustration of the CURRENT relationship between organisational, professional and individual systems (Personal and Professional Development – PPD)

Further, the open systems approach as proposed by Plesk (2000) drew attention to the shortfalls in the professional perspectives which were both underrepresented and largely negatively perceived in the data, despite their proposed value in determining professional practice. The weakness of professional perspectives as perceived by the participants in this study was of concern and suggested that this deficit played a crucial role in the degree to which practice changes as a result of health policy recommendations (Fig 5).

The scarcity of attention paid to the professional issues in changing practice in this study such as: leadership and personal-professional development coupled with a dearth of change theory related to professional change gave rise to the exploration of literature outside of the health or MHN. This led to discovering the work of Dopfer (2012) based in the economics discipline, which partly addresses the shortfall identified in health literature by identifying the ‘professional’ component as the critically fundamental and central constituent of professional change. He claims this provides the back-bone of professional practice and is fundamental to its change or development. This insight into the significance of professional perspectives and influence led to the conceptualisation of the three-part open systems model including ‘professional’ as a key system in the context of change in MHN.

The framework adopted Dopfer’s key tenet in that professional values are essential for professional change, such as changes in clinical practice in the case of MHN in this study.

However he does not conceptualise them further in a practical sense. Therefore this study drew together his ideas with an open systems approach reflecting a three part open systems model of *organisation*, the *professional* and the *practitioner* respectively and suggesting the meso-level/professional could be one system within the proposed Macro, Meso and Micro (MMM) approach thus offering a suggestion to reduce the shortfall identified in professionally suitable change theory. The findings suggests that the synthesis of change theory principles of Lewin (1946), Plesk (2001) and Dopfer (2012) can provides a viable alternative to currently ineffective theories of change for professional/clinical situations and offer an approach that is relevant to change issues related to health care professionals.

The following descriptions are the result of the synthesis of the three main theoretical perspectives used in this study: Dopfer (2012); Plesk (2000); Lewin 1946) represented in the context of this study.

The Macro system– The Organisation – views the practitioner as part of an organisation, such as an individual NHS Trust, that has policy and resource influences that fit in with wider or global expectations of it.

The Meso system – The Profession – views the practitioner as part of a group that has expectations of professional behaviour, values and knowledge base; professions are prepared to engage in a relationship with individual and organisations but ultimately have the responsibility for professional standards, ethical practice and the development of future registrants.

The Micro system – The Individual practitioner– considers the practitioner’s relationship with her/his own beliefs, motivations, needs and vocation that results in the wish to improve, develop, solve problems and integrate improvement and change into practice.

(after Dopfer (2012); Plesk (2001); Lewin (1946))

3.11 Conclusion

This chapter has outlined the epistemology, design and methodology used in this study. The overall design of this study was selected specifically as the most suitable to answer the research question. The question is concerned with investigating which factors contribute to the implementation of *Choosing Health* (DH 2006a) into clinical MHN practice in the Trust.

Therefore a qualitative case study was presented as the most appropriate means to achieve this and a rationale for choosing it was given. Deductive and inductive thematic analysis was proposed as suitable methods to extrapolate the meanings of the participants' experiences, explore their rich accounts and interpret and consolidate the overall findings. In doing so, the research question of this study of what factors influenced the implementation of the *Choosing Health* policy and the integration of the WBSP into the Trust is to be addressed. Theoretical constructs evolved in this study through linking smaller properties together that had a number of common features or portrayed a similar position or situation. Synthesis of the change theory principles of Lewin (1946), the Open Systems model (Plesk 2001) and a specific focus on the impact of professional values on clinical change (Dopfer 2012) can provide a viable alternative to present ineffective theories of change for professional or clinical situations and suggest ideas more relevant to change issues related to health care professionals.

Chapter 4

FINDINGS

4.1 Introduction

This chapter is divided into two sections: A and B: Section A presents and discusses the initial deductive thematic analysis, using a modified framework based on the change theory formulated by Lewin (1946); Section B presents the subsequent inductive thematic analysis (Braun and Clarke 2006). Coding data initially from a deductive perspective and then going on to explore data further using an inductive method provided an ideal opportunity to use the constructivist principles fundamental to CGT and develop transferable principles (Charmaz 2005). The detailed analysis consistent with a case study design also facilitated detailed examination leading to the identification of significant connections and patterns. The deductive analysis categorised data from both participant groups using four categories is explained in Fig 3 p 81. The initial outcomes of these insights and interpretations found similarities between the two groups themes present in all four categories developed for this study and inspired by Lewin (1946). The subsequent inductive thematic analysis in section B explores each minor theme in detail using the researcher's cognitive and intuitive processes concerning the subject and the data. It explores the rich accounts of the participants' experiences, consolidating and interpreting the factors that influenced the implementation of the *Choosing Health* policy and integration of the WBSP into MHN practice in the Trust. In doing so, the six minor themes in section A and the detailed analysis in section B led to three main themes that offer answers to the research questions of 'what factors influenced the integration of *Choosing Health* (2006) and the WBSP at the Trust?

The outcome of these analytical processes led to the formation of six minor themes, five of which were found in both the managers and the nurse's data. Although the evidence from this study found the managers and the nurses had identified similar themes regarding what helped and hindered the implementation of the WBSP, it was also clear that their perspectives within each theme differed. In some cases there was a polarity between the groups in terms of the frequency of discussion which if interpreted as significant; it could suggest opposing views or values between the groups. The quotes to support these analysis can be found in (App 7)

4.2 SECTION A - Deductive Thematic Analysis

A deductive thematic analysis categorises data into meaningful parts which are usually determined by a pre-existing theoretical approach (Braun and Clarke 2006). The study extended Lewin’s original two categories by adding two further categories explained in detail in chapter three. The two additional categories were associated with the originals and were of second order in nature.

The original two are:

- *helping factors* and *hindering factors* of change (Lewin 1946)

The two additional categories are:

- *what can **improve** the helping factors*
- *what can **reduce** the hindering factors*

Data from both the managers group and the nurse’s group were categorised into four areas as outlined. The data in table 1 shows *helping factors* from both groups had the fewest references; with *hindering factors* having a similar percentage from both groups. The areas that were discussed mostly by the managers were what *increased helping factors*; the nurses discussed *hindering factors* most.

Table 4.1: STAGE 1 Open Coding:

Nurses’ and managers’ field factor frequencies and comparisons

| | Nurses | | WBSP managers | |
|----------------------------------|-----------------|------------|-----------------|-------------|
| <i>Helping factors</i> | 4 th | n=59 19% | 4 th | n=49 13% |
| <i>Hindering factors</i> | 1 st | n=98 – 32% | 2 nd | n=98 – 32% |
| <i>Increased Helping factors</i> | 3 rd | n=61 – 20% | 1 st | n=111 – 34% |
| <i>Reduced Hindrances</i> | 2 nd | n=89 – 29% | 3 rd | n=64 – 21% |

4.2.1. Nurses Group: Deductive Thematic Analysis

The deductive thematic analysis was undertaken using the descriptions identified in the reliability and validity section of methodology chapter. The findings were that each four categories frequently had a similar theme, albeit from different perspectives as illustrated in Table 2.

Table 4.2: STAGE 2 – Axial coding:

Nurses’ groups field factor categories in frequencies ranking order

| Increased helping factors 3 rd ranking | Helping factors 4 th ranking | Hindering factors 1 st ranking | Reduced hindering factors 2 nd ranking |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Being supported -9 Flexibility - 9 Creativity - 7 Being realistic - 4 Recognition - 4 Resourcefulness - 4 Service Users care 4 Determination - 2 Enthusiasm - 2 Job satisfaction - 2 Team effort - 2 Confidence - 2 Negotiation – 1 | Flexibility - 9 Service user’s Benefits - 7 Support for WBSP - 4 Policy - 4 Manager’s support - 4 Feel good factor For WBSP - 3 Training - 2 Team support - 2 Personal attributes - 1 Dedicated resources - 1 | Poor resources - 23 Poor team support - 19 Skills - 12 Expectations - 9 Confidence - 8 Workload -6 Stigma outside MH services - 6 Awareness of WBSP - 6 Different views - 5 Service users reluctance- 3 | Having support - 20 Organisational skills -9 Resources - 8 Creativeness - 8 Persistence - 8 WBSP - 8 Problem solving - 5 Flexibility - 5 Professionalism - 5 Patient care - 5 Acknowledgement 1 |

Several themes were clear such as *support*, *flexibility* and *resources* whilst others less obvious including *personal skills*. In addition, what increased helping factors and reduced hindering factors could be interpreted as ways in which the nurses managed to implement professional or clinical change. Themes such as *enthusiasm*, *confidence*, *resourcefulness* or *job satisfaction* seem to have an obvious connection to each other indicating motivational aspects and assumed to be of importance.

Support and *resources* of varying types were dominant in themes among the nurses group; *resources* were extrinsic or intrinsic to the practitioner and *support* was overt and covert in nature. Although less quoted, helping factors also included *support*, *WBSP policy*, *job satisfaction*, *personal attributes* and, *training* and *resources*. Themes identified as increased helping factors included *service user care*, *motivational aspects*, *confidence* and *team effort*. Hindering factors went on to include *stigma of mental illness*, *service users reluctance*, *general awareness of the WBSP* and *different views*, whereas *cognitive skills*, *professionalism* and *patient care* were quoted as way to reduce hindering factors. There was scant attention to how the Trust assisted the nurses to implement the WBSP or the role of their professional bodies including Royal College of Nursing (RCN), (NMC) and the CNO’s position in terms of advice or guidance, or their position on validating the innovation.

Findings therefore indicated that the nurses group frequently had similar themes in at least one other field category, and often had multiple cell representations. Based on this, those themes were

merged and re-coded to develop feasible, coherent, well grounded larger themes which were appropriate to the case study. This is illustrated in table 3 below.

Table 4.3 - STAGE 1i- Open coding:

Nurses' themes based on field factors regarding WBSP

| Trans- field themes | Helping factors | Increased Helping factors | Hindering factors | Reduced Hindering factors |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Support | Managers & team support for WBSP | Support for WBSP, team effort, recognition | Not being supported Poor awareness of WBSP | Having support for WBSP work |
| 2. Resources | Dedicated & flexible resources for WBSP | Resourcefulness, creativity, flexibility, negotiation, being realistic concerning WBSP work | Lack of resources & increased expectations for WBSP | Having enough resources, creativeness & flexibility to implement WBSP |
| 3. Motivation | Feel good factor Nurses doing WBSP work, motivation & personal attributes to improve implementation WBSP | Increased job satisfaction from doing WBSP work. Determination, enthusiasm confidence to integrate WBSP | Workload too high to assimilate WBSP. Confidence to undertake WBSP work | WBSP increased feelings of professionalism and Acknowledgement. Having good organisational and problem solving skills. Being persistent and tenacious |
| 4. Policy | | WBSP Policy in the Trust | Different views regarding WBSP roles | |
| 5. Service users | | WBSP benefits to MH Service users | Service users reluctance to engage in WBSP | Improvements WBSP brought to service users care |
| 6. Personal & professional development | WBSP training | | Underdeveloped skills for WBSP work | |

The greater importance in this study has been assigned to those themes that are represented in all four field categories. For example, the nurses indicated that *support* was an influencing factor in implementing the *Choosing Health* (2006) policy and integrating the WBSP by discussing it specifically on sixty-two occasions and support is found in all four categories. Their discussions indicated the nurses felt that support had been a helping factor, particularly from team colleagues in their clinical teams and their managers. They also indicated that the helping factors for them in integrating the WBSP were further enhanced by general *support* for the WBSP. They also felt that recognition of the work involved in integrating additional roles and responsibilities that arise from undertaking WBSP activities indirectly, but importantly, supported them in their endeavours. However the nurses also reflected that they were largely *unsupported* on a regular or long-term basis; due to a lack of wide spread awareness of the important nature of the WBSP interventions.

The ways to overcome these shortfalls were expressed as having a more formalised *support* from a clinical leader of some influence in the initiative which would underline the value and responsibilities of their new role.

4.2.2 Managers' deductive thematic analysis

The managers' data was analysed using same methods as the nurses' data to deductively develop the four field categories.

Table 4 shows that the areas concerned with increased helping factors and hindering factors were raised as themes on a far greater number of occasions compared with helping factors or reduced hindering factors. At face value this could indicate a general emphasis towards the more negative aspects of implementing the WBSP. However, the discussion of a positive area was often followed by a critical discussion and then a reflection on what could reduce the restraints and increase the helping factors of the issue in question.

**Table 4.4: STAGE 2 – Axial coding:
WBSP managers field factors – ranked frequency**

| Increased helping factors | Helping factors | Hindering factors | Reduced hindrances |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PH assessment 34 Training 30 Change 23 Embedding to Practice 18 Research 15 Communication 10 Policy 9 Implement success Empowerment 6 Skills 5 Attitudes & Knowledge & enthusiasm 7 I-P issues 3 | Training 9 Policy helping factor Knowledge & Skills 6 Attitudes 4 Flexible 3 Formal Procedures 3 Service users 3 Support 3 Leadership 3 Communication 3 Empowerment 1 Access to resources | Putting into Practice 39 Responsibility -37 Poor knowledge & Skills 21 WBSP 20 Available resources 17 Clarity 8 Resistance to change 8 Communication - 8 Change in roles 6 Lack of consistency 4 Training & education 4 Lack of support 1 Lack of creativity 1 | Exploiting systems Positively 12 Education & training 8 Communication 7 G.P's role 6 Creativity 5 Increased awareness 4 Leadership 4 Motivation 3 Developments 3 Providing resources 1 |

The overwhelming emphasis in all four areas from the managers' groups' data was related to what increased helping factors such as, *policy*, *procedure responsibilities* and *training*. The *WBSP assessment process* (actual clinical activity of service user's health screening) was quoted 34 times in terms of increased helping factors references and *WBSP training or instruction* was raised 30 times in same category. The main hindering factors identified by the managers were *WBSP training* with nine references and *policy*, and *knowledge & skills* both on six occasions.

Themes identified as helping factors by the managers' groups were primarily concerned with *putting the WBSP into practice* discussed on 39 occasions and the *responsibility for undertaking WBSP assessments, co-ordination and communication outcomes* were discussed 37 times. *Lack of knowledge and skills* followed in the ranking with 21 quotes, *exploiting existing systems* which were thought to reduce hindrances were mentioned twelve times and *education & training* was quoted on eight occasions by the managers.

It appears that the managers' groups had serious concerns regarding making the WBSP operational particularly in terms of which professional group had appropriate clinical skills and who should take on particular roles and responsibilities in this respect. However the group considered *WBSP training* and *embedding the WBSP into practice* as ways to ameliorate these issues. In addition the group thought the *WBSP assessment process* was a huge helping factor, together with training for *skills development* and a firm *physical health policy* position. The remaining themes were largely concerned with inter-personal type issues such as *communication, leadership, motivation* but were marginal by comparison to themes discussed above. The most important to the nurses across all fields were *resources* and *support*; which were mentioned on fewer occasions by the managers.

Similarities between the managers and the nurses can be found in the general main theme headings such as: *training; resources; roles and support; policy* and *service users*. However the differences occur in the number of references the two groups made within each theme and their respective interpretations of the themes. *Training and education* for example was discussed at great length by the managers, but mentioned just once by the nurses. *Policy and procedure* was discussed on many occasions by managers but once again, the nurses raised it only on a few occasions. Conversely, support was a key theme for nurses but hardly discussed by managers. On this evidence, one might conclude that the two groups did not share a common understanding of purpose or values base. However, the interesting finding is that despite a question of different prioritisation, the themes between the both groups are almost identical.

The establishment of a hierarchy of themes in both the managers and nurses provided an understanding of their ranking importance and served to illustrate the difference of opinion between the groups. The managers, like the nurses, had themes that were present in all four field categories which was important in understanding its full perspective. In addition, the total

frequencies of quotes were used as an indication of what was essential to the WBSP managers, in the same way as the nurses. The value of these findings lay in the weighting that can be attributed to helping factors overall when the four field categories are utilised in this way. Three of the four categories were essentially positive and solution focussed and just one was concerned with a negative perspective, *hindering factors*. The data presented an emphasis towards positive as described before, was framed using Lewin's proposition of a force-field analysis (FFA) (Lewin 1946) (Table 4.5). This area has been discussed earlier in relation to nurses. But to reiterate, this framework can provide the means to analyse situations in order to unfreeze the status quo and facilitate movement towards change by providing a greater positive force than negative force thereby producing motivation (Lewin 1946).

Table 4.5 STAGE 1ii – Open Coding: WBSP managers' field findings and themes

| Trans-field Theme | Helping factors | Increased Helping factors | Hindering factors | Reduced Hindering factors |
|--------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1. Training & education | Training provided for WBSP work; increased knowledge and skills | Sufficient training available for WBSP skills | Limited uptake of training opportunities led to poor knowledge skills generally | Training taken up by motivated nurses who cascade knowledge & motivation to increasing awareness |
| 2. Communication | Communication about WBSP across the Trust | Attempts to communicate with staff WBSP | Poor communication channels re WBSP roles, policy and expectations | Communication nurses; support groups led by lead nurse |
| 3. Resources | Access to resources, equipment | Resources to Manage WBSP work | Availability of resources | Providing resources e.g. time, equipment and support |
| 4. Change & leadership | Leadership shown in practice re WBSP | Change required assimilate WBSP | Resistance to change and changing WBSP roles | Leadership provided for WBSP e.g. lead nurse |
| 5. Professional roles | | Good inter-professional relationships with primary care | Uncertainty about WBSP led change in nurses roles; blurred responsibilities | GPs role clarification and agreed joint WBSP protocols |
| 6. Clinical policy & procedure: application to practice | Formal WBSP Policy & procedures | Physical health Policy assessment Process. Embedding WBSP into practice | WBSP lack of consistency. Clarity, putting into practice | Exploiting existing systems to ensure success CPA and existing clinical procedures |
| 7. Attitudes & creativity | Flexible attitudes to integrating WBSP into practice | Better knowledge & attitudes, enthusiasm about WBSP's importance | Lack of creativity or vision implementing WBSP | Creativity and innovative practice from motivated WBSP nurses |
| 8. Support | Support for nurses through groups | | Poor support for WBSP in practice | |
| 9. Service users | Service users benefits | Positive feedback from service users | | |
| 10. Empowerment | Empowerment of nurses do WBSP work | Acknowledgement of WBSP work by peers leading to professional empowerment | | |

Table 4.5 shows *leadership* was considered enhanced by *creativity*, *enthusiasm* and *recognising success*; *policy implementation* was improved by *exploiting existing systems* and *embedding the new WBS into existing practice*. *Communication* regarding the WBS programme was thought to be improved by *increasing awareness*, *developing inter-professional relationships* and *utilising service user feedback*.

It was found that the WBS managers' themes frequently occurred in at least one other field category. Themes concerning *training*, *communication*, *leadership/change*, *resources* and *positive attitudes* all had representation in each of the four field categories. *Policy*; *knowledge and skills*; *inter-professional roles*; *embedding WBS into practice* and *policy/procedure* all had three field category representations; *Support*; *Service Users*, *research* and *empowerment* each had two. Further analysis found that some of the trans-field themes were quite similar, such as '*policy*'/'*application to practice*'/'*clinical procedures*'; *education & training / knowledge and skills*; *attitudes/creativity*. The most complementary or similar themes were merged to develop fewer but more complex themes and recoded to reflect the new richer perspective. For example, the clinical managers on the subject of *support* as illustrated for the nurses group earlier did not identify *support* as a major issue with only four quotes. Three of the quotes were seen as helping factors and the lack of *support* was mentioned once as a hindering factor. The lack of reference to *support* explicitly by the managers is an issue in the context of implementing a health policy in terms of failing to recognise it as either an important factor and that it did not warrant discussion as a shortfall. The opposite perspective emerged from the nurses who discussed *support* in all four categories on 62 occasions reiterating this deficit.

The example of themes given from the nurses and the managers show that a theme can have quotes in all four categories or in just two, and that there is some importance assigned to this in terms of the importance of the themes dependant on the amount of quotes. The examples also show that although there can be apparent similarities between the two groups of participants the likeness is generally superficial since underlying the heading the differences are quite clear.

4.2.3 Consolidation of themes

The themes in table six indicate the number of different contributions in each trans-field themes, in order of the total number of contributions in each one. When compared, the managers and the nurses show shared themes such as *policy*, *support*, *resources*, *professional development* and

personal skills and *motivation*. However, the weighting as indicated by the degree of incidents of discussion in the original data, differs greatly.

Table 4.6 Conditional Matrices

Nurse’s & Manager’s trans-field themes: comparative rankings

| Managers | Nurses |
|-------------------------------------------------------|----------------------------------------------------------------------|
| 1 st - Policy & procedure | 6 th - Policy |
| 6 th - Support | 1 st – Support |
| 7 th - Resources | 2 nd - Resources |
| 3 rd - Personal & professional development | 4 th - Training |
| 5 th - Innovative & inter-personal skills | 3 rd - Personal attributes, motivation & job satisfaction |
| 2 nd - Leadership in change | 0 - Leadership |
| 0 – Service users | 5 th - Service user issues |

4.2.4 Summary

These findings demonstrated that although there were apparent similarities of the key themes between groups this could be misleading if taken at face-value, and false assumptions could be made without a clear understanding of the diverse facets from each group. *Support* as a theme was the area most discussed by nurses, but least by managers. Equally polarized was *policy*; the theme most discussed by managers and least by the nurses. These relationships were unexpected and have wider implications particularly in this case study, which is exploring a public health policy implementation (House 1980:25). The main issues are the differing perspectives and values concerning apparently similar themes as evidenced by the participants’ quotes. It is not the intention of this study to analyse these issues statistically or to assign meaning to the emerging themes according to statistical significance, however the qualitative differences can be suggestive of certain issues such as a divergence between the two groups and indicative of the flimsy and ambiguous middle ground between the ‘top down and bottom up’ model of change which Dopfer (2008) suggests should be the fundamental care of professional practice.

4.3 SECTION B. INDUCTIVE THEMATIC ANALYSIS

To provide the context for the following section B, a brief reiteration of the literature review will now be provided. The scarcity of attention paid to the professional issues concerning changing practice in this study such as leadership, and personal and professional development in this study was consistent between both groups. Further, a review of change theories and relevant research found there was a shortfall in evidence regarding the role that professional agenda plays in this area. This deficit led to extending the searches to disciplines outside the ‘health’ arena and the discovery of the work of Dopfer (2012).

Dopfer (2012) believes that the professional component plays a critically fundamental and central role in changing professional practice. This insight into the value and influence of *professional* perspectives led to conceptualising a three-part open systems model adopting Dopfer’s tenet to represent *professional* values as the backbone of professional change together with the *organisation* and the *individual practitioner*. The result is the Macro, Meso and Micro (MMM) approach which reflects the three open systems elements of the *organisation*, the *professional* and the *practitioner* respectively.

Part B of this chapter discusses the findings of the six minor themes of: *policy and procedure: support; resources: personal and professional development: innovating inter-personal skills: leadership in change* under the headings of *organisation, professional and individual practitioner* respectively in order to offer an answer to the research questions of this study. This will be followed by a discussion concerning the relevance on an *open systems model* to illustrate the relationships between the systems as illustrated in Fig. 3.3. As the shortfalls of influence in clinical change are mostly related to the *professional* system, particular attention will be paid to how this deficit can be improved in terms of the limited impact of health policy on clinical MHN practice.



Fig. 4.1: Illustrating the relationship between major and minor themes

4.3.1 MACRO SYSTEM: ORGANISATIONAL THEMES

4.3.1.1 Policy

4.3.1.2 Resources

Macro system level; Organisation system views the practitioner as part of an organisation, such as an individual NHS Trust, that has policy and resource influences that fit in with wider or global expectations. Theoretical constructs in this category were resources and policy.

4.3.2.1 Policy

The theme of policy in this study included three main areas which were an awareness of the Trust's Physical Health policy; assimilating WBSP to pre-existing procedures: the relationship between the physical health policy and practice.

4.3.2.1.1 Awareness of the Trust's Physical Health policy

The Trust's *Physical Health* policy including the *Choosing Health* policy recommendations was developed in 2008 introduced across the Trust by senior clinical staff. This introduction aimed to provide a detailed explanation of the policy and answer any queries regarding its implications. This approach was unusually personal and systematic indicating the policy's importance, an eagerness to ensure its widespread introduction and endorsement by the senior clinical staff involved. This quote from a lead clinician explains how this was done:

We have run awareness sessions around the Trust for the first year so once a month A and I would go to a different place across the Trust and run a session and repeat it twice more so that people could come to a morning session, a lunchtime or an afternoon and we raise the awareness about the physical health policy, the well-being service and what it was all about and we get them to do a quiz which was quite fun and it got them all interactive, so that was raising awareness and it covered a large area and a large amount of staff, and now we just do awareness sessions when they're wanted because then their staff attend sessions if they actually want them to come rather than us saying they're coming, so that's still ongoing and the people are requesting an awareness session (242).

The approach described was designed to decrease the hindering factors associated with introducing change in practice such as lack of awareness, poor understanding, and concerns about its impact on individual practitioners thereby improving its likelihood of success. This level of publicity should have guaranteed the awareness level of the policy and well-being work in the Trust being reasonably high. However, a survey undertaken in one of the three boroughs in the Trust during the same time period, found that approximately half of the clinical staff knew

nothing about the Physical Health policy and WBSP. The managers group did not find this particularly surprising, despite all the efforts to 'launch' the *Physical Health* policy across the Trust. This point was discussed by two of the managers group:

This[question in the survey] is under the knowledge and awareness section, so here we asked these questions specifically about 'are they aware of the physical health policy in the Trust?' and also the well-being support programme, and this is kind of quite split really in that 147 people said 'yes' and 132 have said 'no'. I guess it doesn't really surprise me because I think people aren't always aware of them (policies) (243)

I agree with you, they'll [staff] only go to it [the policy] if they need it or if they think they'll need it (244)

And that's more of an issue. If they think they need to look at it they'll go and look at it, ... there are some instances where people don't go to the policy that would have given them the guidance that they're actually looking for because they haven't recognised that they needed to do that (245)

These quotes present two issues: the first is whether nurses accessed the *Physical Health* policy at all; the second, inconsistency in its use. The principles underpinning the issues illustrate similar concerns discussed by Kitson (2009) and Kitson et al (1998) regarding accessing and translating knowledge. These works proposed that individual interpretation of externally created evidence, and I would suggest policy, is problematic because the version that emerges is affected by the perceptions of the individual or team. This can lead to a poorly translated version of the original. The nurses did not use the *Physical Health* policy as a means to help them with their specific practical concerns in this area. This example was one of many that describe how individual teams decided on procedures to help their practice. For example, ensuring the viability of the WBSP by integrating it within existing clinical procedures such as admission systems:

What we said, what we were going to do was incorporate it [Physical assessment] with our admission policy so that's there so everybody's got to do it, and on our handover sheet we've got, we've incorporated physical obs (9)

The implication in the last quote is that nurses may only seek out an evidence base when they experience some difficulties, such as not having previous experience of the clinical situation or there is a difference of opinion regarding a procedure. Nurses are unlikely to read a new policy immediately it's published and critically evaluate its significance to their practice. This quote from lead clinical well-being nurses demonstrates this point:

What I've been doing since the awareness [roll-out programme] stopped in December is actually saying to teams "ok well look, none of you came to the awareness session, are you aware of the 'well-being': are you aware of the 'physical health' policy? Can I come to your team?" Some people are moaning that they haven't been involved or invited to stuff [such as the Physical Health policy launch] and yet we sent out invites constantly ... (246)

It was evident that the nurses in this study were, on the whole, unlikely to use the policy as a practical means to help them conduct their well-being practices. Instead, the trained WBSN nurses acted as informal clinical teachers and role models for other nurses they worked with. This apprenticeship-type model for developing skills in nursing is not uncommon; indeed it is the model of choice in pre-registration nursing programmes (NMC 2011).

The inherent dangers of this approach are that the *apprentices* will learn a modified version of the knowledge and skills, affected by the nurses' perceptions, values and pre-existing knowledge developed during their WBSN training; a type of so-called *Chinese-whispers* effect. This unreliable translation of the original knowledge and skills could lead to inconsistencies in practices. The trained WBSN nurses were also expected to be role models in respect of seamlessly incorporating the WBSN work into their existing responsibilities. This model and its assumptions asked a lot of the average ward or community nurse already facing cut-backs in staffing and increased case loads. A WBSN nurse described a colleague who had taken on the responsibilities of being a WBSN nurse:

I think one lady [WBSN nurse] at D town runs it all by herself which I can't think is very good for her at all. Well it will be alright until something happens, like everything, and then it will be well because no-one else wants the responsibility of it. That's what it is! But I think the responsibility is there through the policy, regardless.....for everybody yes (268)

The clinical lead for the physical health agenda tried to approach the issue of policy guidance by explaining the professional and clinical responsibilities in terms of the prescription of atypical anti-psychotic medication as recommended in the Maudsley Prescribing Guidelines (Taylor 2012 11th eds):

'... safety measures that were put in place from the pharmaceutical company which then said that we [must] promise that these [physical health] checks will be made as this drug is prescribed, and then each Trust, or each foundation, or each Trust then that started using the medication developed their own, produced their

own policies on running WB clinics and we have a policy that states very clearly these are the checks that you must do.’

This approach demonstrates the serious critical nature of the well-being assessments and interventions in terms of the morbidity and mortality problems experienced by people with a SMI. As a professional group MHN may have been influenced by this argument if it was offered as a reason for following the physical health policy. It was surprising that the following perspective in this quote was not raised more in the study as a means to encourage nurses to engage in the changes in practice that were necessary to assimilate the well-being work:

And so if you're a professional, and it's up to that nurse who's taking on the responsibility of running a WB [well-being] clinic, she's a professional within her own right, she should find out before she says yes that she can do all those things and that she's confident and competent to actually run that well-being clinic as it should be run (247)

However, it was not detected much in this study, and other limitations concerning professional considerations will be discussed at length later.

4.3.1.1.2 *Linking WBSP to pre-existing procedures*

A way of embedding the WBSP into practice using already robust systems in the Trust was suggested in the managers group. The approach in question was the care programme approach (CPA) (DH 1991). The CPA is a well established national mental health policy that legally and clinically requires that all people with a SMI have a regular assessment of psychological, social and physical health needs. Since its introduction in 1991 the CPA has become fully integrated into all aspects of mental health care and is the framework for a multi-disciplinary approach across the UK (Kingdon 1994).

The proposal was that the WBSP work could be assimilated into the CPA requirement to undertake a physical health assessment on a regular basis. Arguably embedding the WBSP expectations into a rigorous pre-existing system could augment the deficits in policy awareness and well-being clinical procedures. The following quote highlights an early debate when coming to conclusions regarding the integration of the WBSP requirements into the CPA, showing the developmental processes involved such as resistance to change:

I don't know whether this would work, but rather than presenting this to GPs with

a new system [WBSP] can we tinker with the CPA policy and process as it stands at the moment, slicing this [WBSP] into it, enriching the assessment, the physical health assessment and monitoring into the CPA as it stands at the moment, building that up, making people aware of that change and that the emphasis is now much stronger (towards physical health care) (97)

Institutionalising change in this way was described by Whelan-Berry and Somerville (2010) as an intrinsic part of the organisation's structure (Cummings and Worley 2004). This idea reflects Lewin's concepts of unfreezing in terms of using the acceptability of an existing system to incorporate a new idea. It also has some resonance with the *re-freezing* phase which is concerned with sustainability and is fundamental in maintaining a change (Lewin 1946). There was some agreement to the proposal of integrating the WBSP activities to the CPA but objections were also made, as quoted here by a WBSP manager:

The problem is we can't tinker with the CPA process because that isn't just our Trust, it's not a policy just for our Trust, it's VVVV social services policy as well, and they've just undergone a review and it took about a year just to get it back where it is now, so to say "well we'll pop this in it" that's not going to happen until their next review. But what we can do is what you said earlier on P about latching it on to CPA (98).

Whilst institutionalising the WBSP activities into the CPA could offer a sound basis for its success the problem was that there were no specific physical health assessment structures or processes within the CPA. This reflects the emphasis of psychological interventions and highlighting the need for an appropriate assessment instrument.

One instrument known as the Schizophrenia Health Improvement Plan (SHIP) was recommended by a manager. However, although the SHIP was suitable and apparently reliable, it had been commissioned by the pharmaceutical company that produces one of the main atypical antipsychotic medications that contribute to the physical health issues experienced by people with a SMI. Therefore, some managers had ethical difficulty in accepting the SHIP as an instrument of choice particularly if the drug company were to insist on their explicit and obvious patronage. However, these complex issues were set aside to tackle the more practical considerations. The first was the SHIP was a new assessment instrument playing an important part in well-being policy and procedure but was also unfamiliar to the practitioners. Secondly, the SHIP was only available as a paper document therefore could not be incorporated into the electronic patient records system. Also the SHIP had no specific Trust-wide instructions, procedure or training making it potentially difficult for nurses to be confident about how and when to use it. The

following conversation exemplifies these issues:

The thing I wanted to raise was a physical well-being policy. I think this is something that we missed out on when we set up the training and I think that's probably because maybe the physical well-being policy came out after we started rolling the training out, and the issue is that in the physical well-being policy there is a form that needs to be completed and should be filed in patients notes, and the information on the form is very similar to what the well-being people would be collecting anyway, and of course in terms of the training we've been focusing and encouraging people to collect information so it can go onto the database and we missed the point that really they should be completing that form in the physical well-being policy (248)

Reflecting on the apparent dilemmas and complexity of this proposal another participant of the managers group suggested a solution:

Could you not, I'm just thinking about people are going to start complaining about having to fill in the two things, if you've got the form that should be completed as part of the physical health policy, they've got a print out for what's on the Audit Tool, can you not just staple the two together so that you actually have got the outputs?(249)

The original speaker outlined the actions already taken to resolve the issues:

When I talked to D about it when we finally realised this by talking with JS the pharmacist, the information is there it just needs to be put on a piece of paper and followed in order, and they're not that dissimilar. I think there are just 1 or 2 areas that are missing, for example, it's about blood tests, the actual physical policy checklist says about blood tests, we're not just being awkward, and of course the well-being person may not necessarily do that at the first consultation, they may do it at the second, we need to get them to start thinking of doing it the first consultation. So you're right, it's bundling it together so we do not have to duplicate it (250).

In response to this lack of clarity another of the managers group offered the following suggestion:

We've got an opportunity to start tweaking the form that's in the policy to fit in, so that people aren't duplicating, and I think that's what you were wanting (251)

Further implications of introducing the SHIP were concerns about more 'paperwork' and potential duplication of information. When hindrances such as this were identified by participants in this study they often also provided solutions too. The following conversation reflects an open minded problem solving approach to this particular issue:

How does the HIP or the SHIP [physical health assessment tools] fit into that? Is that the third piece of information? (252)

That's the third one. It partly overlaps but partly other information which would be relevant and useful to bring in, but at the moment we're not going to be doing anything with the SHIP in relation to the training, they're still distinct aren't they, I guess we'll see the policy in the physical health policy's reflected very much with what's in the well-being Audit Tool (253)

The managers group were concerned with practitioners complaining about having to complete numerous documents that all contain similar information and a lead nurse realised the opportunity for merging documents and maintaining their auditability:

So you're right, it's bundling it together so we do not have to duplicate it. And we've got an opportunity to start tweaking the form that's in the policy to fit in so that people aren't duplicating, and I think that's what you were wanting. The problem is obviously because this has happened it's very difficult to audit the policy. It's possible but it's not as easy as we'd like it to be because the information is scattered (254)

Nevertheless, the SHIP or HIP assessment tool would be yet another document, despite its role in providing a reasonably good assessment tool (Hardy and Gray 2010).

This discussion shows that policy recommendations such as those made in Choosing Health need to be incorporated or considered in parallel to existing clinical practices to improve their quality overall and not simply produce a profusion of seemingly unrelated policy requirements as quoted here:

Is there a procedure kind of thing in the physical health policy? (255)

No. No, we've never had.... (256)

So you do need a sort of clinical procedure really (257)

Yes, and maybe that's something that we can do (258)

However, this level of assimilation can be challenging clinically and professionally when many different demands such as NICE guidelines for Schizophrenia and Bi-polar disorder, Choosing Health, professional demands and organisational targets are being made. Another participant in the manager's group reflected that an opportunity was missed concerning introducing the Trust's *Physical Health* policy during the W BSP training:

I wanted to raise an issue about the physical well-being policy. I think this is something that we missed out on when we set up the training and I think that's probably because maybe the physical well-being policy came out after we started

rolling the training out (135).

This omission had meant the WBSP trainees did not have a policy to refer to during training to contextualise and guide their newly acquired skills. To recover this situation and offer an alternative in the absence of clear guidelines, a method of embedding the WBSP into practice was proposed by a nurse. Communication was not discussed explicitly by the nurses, but it was the sixth topic in frequency ranking in the manager's contributions relating largely to policy issues and showing a fairly even distribution between helping factors and hindering factors. Communication with staff was quoted ten times and the following example from a manager considered clarity between GPs and MH services in providing WBSP activities:

All we're asking for really is that communication, aren't we? That they [GPs] know what we're doing and we know what they're doing and that we actually share so that the patient/client isn't having the same done in both primary and secondary (234)

The issues highlighted in this quote are some of the most difficult to overcome, as seen in the history of health policy for the mentally ill chronicled earlier in this study. The lack of communication between health workers has been noted as contributing factors in the mismanagement of complex care management cases in both the National Confidential Inquiry (DH 2007) since the *Ritchie* report (1994) and more recently in the *Laming* report (2007) as the most significant and avoidable contributing factor to major incidents and mistakes in health care. In every day practice communication difficulties between different professional staff groups, patient – staff and carers and staff persist despite efforts to improve them such as educational and role modelling leadership initiatives (RCN 2010). In terms of the WBSP Vasudev and Martindale (2010) found that there is an increasing recognition of the role that GPs play in terms of the physical and mental health of their patients and note that the Quality Outcomes Framework (QOF) has played a significant part in formalising the GP's role. However, the vulnerability of people with SMI remains an issue from the perspectives of being high risk for physical disease and also being able to successfully negotiate the primary care systems designed to assist them (Vasudev & Martindale 2010).

4.3.1.1.3 Relationship between the physical health policy and practice

One policy implication for both the managers and nurses found in this study was the question of the logistics of what, where, when, how and often why physical health interventions should be undertaken. However, had there been a policy or procedural guidance on this matter the

misconception of only being able to proceed with well-being interventions in a purpose built environment or *WBSP clinic* could have been reduced. This quote is an example of the confusion:

One of our nurses has said, that someone above her has said that we should be seen to be having a 'clinic'. But it seems a bit useless really, if we can't actually do anything and get there and do it; it's much better surely to be doing things on a one-to-one (65).

Whilst in the managers group this issue was discussed as follows:

In the network meetings and link meetings people (WBSP nurses) are finding that sometimes because the service have said that's the way it is and then they've been given that one day the service is adapted to meet the needs of the individual by creating them and holding onto that day, and some managers are very good at doing that and of course with the change of managers sometimes that's lost but I think it's just naturally evolves depending on the service make up (14)

These quotes highlight the breakdown in communication regarding the implementation of the WBSP. It shows how the nurses demonstrated flexibility and were prepared to undertake well-being assessments wherever it was most appropriate for the service user such as their own home, rather than depending on a particular clinical environment. Views about this level of flexibility differed between the nurses and the managers however. The following quote from a manager criticises the lack of consistency of approach in undertaking WBSP assessments and interventions, highlighting the effects of no definitive guidance on implementing the WBSP. She also suggests a more formal strategy should be taken to address this:

I think it's probably more a reflection when I say in my directorate in the West of the Trust I've got two or three teams where they have well established well-being programmes. Clients are encouraged to think about their physical health coming along to that opportunity to have that reviewed. I've got other teams where they're struggling to get that message across to other team members that this is something that they need to do. Staff have done the training, but they haven't yet got them well established so therefore it looks as though this inconsistency is across the directorate as to what is happening and I think that the fact that at the moment you could be being supported by a team in one area and actually not have that available to you within that team, you'd have to rely on the primary care service actually delivering that for you. If you were ten miles down the road and actually being supported by another team you would be encouraged to get involved in the programme (131)

These kinds of tensions were discussed by Lewin (1946) as an inevitable and probably necessary part of the transition towards change. He identified that tensions between a system and those systems surrounding it, and the propensity for change towards equalisation between them, would

produce *motivation* towards a given objective. However the lack of a full and agreed assessment procedure made it difficult for nurses to know if they were carrying out the WBSP activities correctly and consequently nurses created their own systems:

I've done it with one or two [WBSP assessments] and I've also done one when I spent the whole day taking someone to a pre-operative assessment and then the whole day's sitting in a hospital with them so they didn't do a runner to have a biopsy taken, and it was a huge commitment and a huge time out of my caseload (148).

Another nurse also discussed a proactive or preventative approach which was not set out in by the Trust in any formal policy or procedure:

Well I suggested that it (WBSP assessment) should be done for everybody rather than leaving someone to faint and fall on the floor before they take their BP, because then we've got a picture of what their BP's doing (66)

These quotes suggest the nurses were trying to develop a locally agreed protocol for undertaking the WBSP assessments in the initial absence of a formal physical health policy; a phenomenon acknowledged by Exworthy et al (2012). He suggests that practitioners will often use discretion in selecting the parts of policy they can achieve and adapt other expectations in line with their capacity. This is an important point when considering the size of NHS Trusts and the distance practitioners find themselves from the source of the recommendations in terms of interpretation and socialisation of the expectations (Exworthy et al 2012).

The lack of consistency in the implementation the well-being programme led to different modes and standards of care delivery in this regard across The Trust. This would generally be considered a problem however the WBSP managers reflected that not having a clinical procedure for WBSP activities was a positive despite the criticism of a lack of consistency from the practitioners:

I think it's (the WBSP) not implemented uniformly, and I think that's a good thing, because it's such a big Trust and the areas are so different; but I don't know what they're talking about in the actual consistency element (130)

However, nurses were unclear about whether well-being interventions should be restricted to people who have obvious or existing significant physical health problems or offered as an on-going part of recovery and maintenance of health. The difference between these two approaches were important to nurses as there are implications concerning practice between them such as, different skills sets, appropriate knowledge and levels of theoretical understanding about both physiological mechanisms, and current and effective health promotional techniques. This

confusion was understandable as the DH (2006a) originally recommended focussing on people with a SMI based on the robust research base concerning the seriousness of co-morbid physical disease and SMI. It was thought to be particularly important when atypical anti-psychotic medications are used based on the Maudsley Prescribing Guidelines (Taylor 2012 11th edn). However, the emerging body of knowledge indicates that physical health problems are also associated with depression, stress and anxiety in adults and children. Since 2009 it has been a protocol for psychiatrists to undertake a physical examination of all service users admitted to mental health services in the UK regardless of their diagnosis or chronic nature of their illness (RCPsych 2009).

4.3.2 Summary of Policy theme findings

Awareness of the Trust's Physical Health policy and the Choosing Health recommendations were at the time of this study approximately 50% amongst MHN in the Trust. The lack of understanding about both policies, and the implications of not trying to address the issues they raise would have had long-term effects on the morbidity and mortality rates of the people with a SMI using the services of the Trust. However, the time period of this study was early in the overall development of the well-being programme locally and nationally, and it would be hoped that as an organisation the Trust would continue to support professional development, on-going training and full integration of the WBSP into practice.

In terms of the research question of this study: 'what factors influenced the implementation of Choosing Health (2006) and the integration of the WBSP at the Trust?' the policy issues raised such as lack of policy at the out-set of implementation, inconsistencies in implementation and ad hoc locally assumed procedures all had a predominantly negative effect on the early success of implementing the well-being agenda and the Physical Health policy in the Trust. As an organisation the Trust did not emphasise the professional reasons and codes of conduct for undertaking these new practices which could have offered some professional motivation for implementation. However, the lack of professional advice and guidance forthcoming from the professional bodies concerning the well-being agenda was negligible, maybe accounting for this shortfall.

The assimilation of the physical health and wellbeing work into pre-existing procedures such as the CPA, admissions procedures and psychiatrists assessment protocols is a well established idea

endorsed by theorists such as Lewin (1946) and more recently Exworthy (2012). However, there was an initial reluctance in adopting this approach possibly due to Trust politics involved in a recent Health and Social Care services merger. Despite this subsequently physical health and well-being assessments and care plans did become a well established part of the CPA and remains so today. As a factor influencing the implementation of *Choosing Health* recommendations and the integration of the *WBSP* the assimilation of well-being into the CPA could have been exploited much sooner in the overall process. This could have prevented the problems of well-being being seen as yet another professional responsibility to the already overwhelming workload of practitioners and promoted it as an improvement to an existing shortfall in the required CPA physical assessment. Perhaps a strategic vision can sometimes be seen somewhat radical in the midst of change, but arguably it can ultimately reduce arduous circumnavigation and short cut change processes that are at risk of becoming weakened by a lack of momentum.

Relationships between the physical health policy and the related practice were tenuous at best and at worst, absent. This study found that there were too many different messages being received by the nurses engaged in delivering specific physical health care because of their different interpretations of the messages from the *WBSP* training. Also, the evolutionary nature of the *WBSP* implementation and its training programme lead to on-going changes in the knowledge and skills levels of individual practitioners who had undertaken it. However, because the training was rolled out opportunistically, the knowledge and skills was reaching different practice areas at different times with the result there was an inequity of *WBSP* skills and knowledge across the Trust. This resulted in a range of alternative interpretations of the *WBSP* and the role and responsibilities it brought with it depending on the 'generation' of training that the *WBSP* practitioner had undertaken. Rather surprisingly the managers did not feel it necessary to be strategic about offering guidance on a particular framework or approach for the assessment and development of interventions regarding physical health issues following the *WBSP* or manage a planned approach to implementation determined by criteria such as either particular clinical speciality services or geographical area. This ill-defined style and 'organic' process of implementation may have worked in a smaller Trust or where a borough of a Trust is involved. However this approach was probably rather too ambitious for the Trust as it left the nurses to develop their own frameworks leading to inconsistency across the Trust. This worked out well for some nurses and their team, whilst others were left feeling unsupported and overwhelmed by a change in practice they did not completely understand or know how to manage. Therefore a poor

relationship between the health policy and practice was a contributing factor in hindering the wide-spread success of implementing *Choosing Health recommendations*, and was a negative factor in the integration of the WBSP in the Trust.

Balfour and Clarke (2001) maintain that the disturbance caused by changes in practice can result in resentment, not unlike a sort of bereavement. The questioning of assumptions, implications that existing practice needs improvement and exposure of underlying flaws can be perceived as threatening to individuals and teams. This may be understandable as the very things that claim to make a team cohesive such as established rules, clarity of roles and responsibility and agreed team goals are compromised by change and this could be a determinant of the success of the initiative in question.

The CPA should have been an obvious choice in serving as a host for the WBSP care outcomes from the outset. However, signing up to this in principle was not immediate:

Well [the WBSP assessment is] in there in a sense. Obviously all our risks certainly come through CPA and it's in there around self neglect, but it's not really physical health (119)

People [staff] don't necessarily tie in physical implications of people not looking after themselves. The overt ones they probably pick up, but some of the others that they perhaps don't drill down far enough in to it (120)

The researcher offered a suggestion that the WBSP be imbedded into CPA as a way of encapsulating it in an existing successful process. The argument against this from a manager was:

I mean, I recognise where you're coming from, the CPA it's extremely important and maybe the backbone of this, but I think let's get this right, let's get it out there, and then we start merging it into CPA. Because at the moment we've got people in the Trust specifically trained around delivering this and the CPA covers every clinician who may not be involved in this, and I know the argument could be well they should be, and yes that's fine, but we haven't got to that stage yet so I think that's why it's... to me...[better left to] a later stage (53)

This may have been sound strategic thinking however there was a danger that political posturing and risk avoidance could result in policy change being a way of managing a complicated policy agenda and avoiding the repercussions of any errors. Minstrom and Norman (2009) maintain that although political agenda can be an exasperating barrier to radical change, steps can be taken to provide an eventual position which has the same outcome as the radical change, the results will not be substantially different. However, the strategy should not lose momentum in its overall aim

and those involved should sustain a functioning coalition to ensure its integrity. Two years on, the WBSP has been integrated fully into the CPA and the Trust's electronic patient records systems. It was argued by a manager in the study that this merger was best left until the WBSP had established its own identity. Conversely, integration of the WBSP activities into the CPA at its inception could have provided the WBSP a powerful medium in which to develop and consolidate itself into every day practice.

Advice offered by McKenzie and Manley (2011) would have provided important structures to include in a WBSP procedure and would have been represented thus:

1. Linking and networking with commissioner of healthcare and important political stakeholders
2. Aligning WBSP with the Trusts vision and demonstrating how it can facilitate the vision.
3. Demonstrating the role of WBSP in achieving evidence based practice.
4. Showing skills of individuals in negotiating, liaising and influencing.

(McKenzie and Manley 2011)

From the WBSP manager's perspective the enhancement of policy as a driving force was fundamentally dependent on nurses being fully aware of the policy, despite it not existing at the initial training sessions. Thus, the subsequent distribution of policy was an issue of crucial importance. One method of addressing this issue was the 'global' distribution of emails to everyone in the Trust simultaneously: one quote highlighted this process as a way to ensure distribution and awareness of the WBSP agenda:

Emails come out that say what new policies are now available ... managers will pull off a hard copy of the policies which have a direct reference to work that individuals are doing and will make sure that it's discussed in their teams meetings of new policies (63)

However, there was no evidence that WBSP policy was being integrated in this way, and the motivation for which policies are 'pulled off' could reflect the WBSP managers' own motives or agenda. For instance, one group of nurses found their enthusiasm for WBSP was not shared by their manager, who came from a non-clinical, social work background. Shaw et al (2008) found that it may be necessary to check the cultural norms of a team possibly using instruments such as 'values clarification' or 'claims, concerns and issues' as the values espoused by a group are not always those which its members express in practice (Guba and Lincoln 1989).

Awareness of the WBSP and the issues related to the physical health of people with SMI generally was discussed. An in-patient nurse was concerned about the state of people being admitted to her ward and said:

I'm also quite concerned about people who come in from residential care into depots clinics and what their health care checks are (63)

Despite efforts to promote physical health and raise awareness about the morbidity and mortality rates of people with SMI there remained a level of ignorance on the subject. The researcher heard two students recently discussing this. One said:

Well, if a person dies of a heart attack it is considered natural causes isn't it'

Her friend said:

'I don't think there is anything 'natural' about having a heart attack, especially if you are only 45 years old!'

This hopefully indicates both a shift in perception related to the inevitability of early death in SMI, and a change in attitude towards the fundamental rights that people with a SMI have in terms of effective care concerning their physical health. As the public profile of WBSP within The Trust grew, it added legitimacy to the activities, time and resources the project required. Certainly, protected clinical time for WBSP activities, network meetings, events promoting the WBSP and internal Trust publicity all added to increasing credibility and its consequent ability to attract resources. But they were also time-consuming. A WBSP practitioner said in relation to her role:

Service have said that's the way it is and then they've been given that one [protected] day the service is adapted to meet the needs of the individual by creating them and holding onto that day, and some managers are very good at doing that and of course with the change of managers sometimes that's lost but I think it just naturally evolves depending on the service makeup (109)

Implementation success was another way participants recognized the reinforcement of existing positive forces. For example:

I think it's a great achievement and I'm not trying to knock it (166)

Putting the well-being initiative into practice was seen as a restraint by the WBSP managers with this argument that Lewin (1946) would refer to as the re-freezing stage:

I mean the embedding and getting it consolidated so there's no slippages is what people say is the hard bit, you know, because the initiative is the kind of exciting bit (87)

Sustaining motivation to ensure permanency is often a problem in integrating change. Kotter (1995) refers to this permanency as ‘institutionalising’ new approaches (for similar characterisations see Kanter et al (1992) and Luecke (2003). Lewin (1946) also explores this issue, particularly the connection between motivation and action. He maintains that having motivation alone does not lead to change, as that assumes a relationship between motivation and action. He claims that a decision connects motivation to action which has the required ‘re-freezing’ effect on change in terms of his *unfreezing>movement>refreezing* model of change (Lewin 1943). Lewin adds that the ‘re-freezing’ process is the commitment of the group to making the change permanent. However, he notes that this commitment may be weakened by other external individual factors such as personal interests, financial reasons, or promotion at work (Lewin 1935)

The Trust’s physical health policy was being used as the benchmark for clinical implementation of a new initiative, particularly within the inter-professional arena. Bellman (2003) identified policy as a means of modifying change factors in terms of long-termism. However in the case of the Trust the policy was unknown to the majority of nurses and therefore was limited in terms of its influence in integrating the WBSP changes. The following quote from a manager highlights this issue:

I know that just within the west of the Trust; I’ve got it well developed in some areas and fledgling in the others and it’s trying to get cross pollination at the moment, trying to give encouragement to those that are just starting out in pursuing it and keeping that momentum going (167)

4.3.3 Summary

Policy as a theme in this study showed helping factors and hindering factors emanating from both participant groups. The main issues related to a fundamental difference of opinion regarding the necessity for a clinical procedure relating to WBSP assessment, screening and monitoring. The managers were divided in their opinions about this; however the managers were clear about the need for proper professional guidance on this matter. The next issue was how to integrate the WBSP interventions into practice without a widely distributed read or understood policy and procedure.

The suggestion of attaching WBSP interventions to pre-existing established procedures (like the CPA, for example) was rejected, for largely political reasons. Despite these issues the nurses used different styles to implementing the WBSP but despite their ingenuity and creativity they were

uncertain about whether their interventions were appropriate or correct. These tensions created a critical divergence between the WBSP nurses and WBSP managers in terms of the necessity for a useful clinical guidance which could not only facilitate new nurse's competence and confidence but also offer a means to standardise high quality care and share this message with mental health service users.

4.3.1.2 Resources

Resources as a theme had substantially fewer comments from the managers compared with the nurses and were the single most commonly discussed area from the nurse's point of view in regard to both helping and hindering factors. The nurses discussed resources in such terms as 'lack of', 'access to', 'dedicated', 'provision of' or 'availability of' time, equipment or environment

Time

The issue of time was related to protected time for WBSP which was offered to keen, selected nurses who had undertaken the appropriate WBSP training designated nurses to undertake physical health assessments. Some other nurses used the opportunity to run a WBSP clinic, whilst others integrated the time evenly across the week depending on their pre-existing commitments. A manager said:

Instead of having a protected day of seven hours [to undertake WBSP activities] the (WBSP practitioners) might have an hour here and an hour there (181)

However a WBSP nurse seemed less clear about the appropriate use of the WBSP protected day per week:

I'm not sure how we're going to do it unless we do it on a one-to-one basis with the clients really. I don't know. I mean, D was saying maybe we could catch these people when they come to the depot clinic and things like that, because rather than trying to...you could actually... But it's just you have to have a parallel clinic running with the depot clinic. We haven't got...there isn't the room, there's only one (81).

Many initiatives in the NHS are introduced without any extra resources in terms of staff or equipment however as mentioned earlier the WBSP did have considerable financial support. Some used this as a clinic-style time whilst others integrated the time evenly across the week depending on local specific requirements. The funding for a number of nurses to have one protected day a week in the early stages of the WBSP implementation was not provided by the DH but by a drug company which produces one of the atypical antipsychotic medications who

also paid for the three-day WBSP training (Eldridge and Dickers 2007) . The conflicting ethical tension this created did not go unnoticed by the nurses. However their pragmatism and the potential benefits to the service users made them take a philosophical approach. This was considered a considerable investment and seemed to imbue the WBSP with some degree of value for the nurses. However this was a limited resource and after one year the WBSP nurses resumed normal responsibilities. Despite this, some retained their involvement in the WBSP activities in addition to their usual duties and a far greater workload for the individual practitioners. Nevertheless, by now they understood the consequences to the services users in terms of their increased physical health risks and the significance of the interventions provided by the WBSP nurses and felt morally obliged to continue with them. A nurse recounted how she tried to manage to fit the increased workload produced by the WBSP into her existing caseload commitments:

My clinic yesterday was two home visits, that's all I could fit in because of my workload, my well-being clinic for this week was two home visits yesterday afternoon (58)

Another nurse commented on how difficult it must be for ward-based nurses to integrate the WBSP expectations reflecting on the conditions on a recently visited acute psychiatric admission ward:

It's very frantic isn't it? I was horrified, I went to meet A [the WBSP leader on the ward] at the computer desk - and it's all changed since I last worked on the ward! (59)

To high expectations as a hindering factor this quote referred to the competing demands and high expectations from colleagues regarding the WBSP work and day to day mental health work. The feeling in the group is illustrated in this quote:

But I do feel quite pulled in all different directions and I...you know.... It's really difficult to fit it in (46)

A tension was created in the nurses as they felt guilty for not responding to colleagues' demands but feeling passionately about pursuing the WBSP work. Another nurse described how she had to undertake a well-being assessment under unusual circumstances to ensure it was done whilst simultaneously undertaking another intervention:

It was quite interesting the other day; I took a lady to A&E and actually did a well-being assessment while we were there because we were there ages (90)

In terms of an appropriate clinical environment to undertake WBSP interventions the following quote shows how a nurse was excited and proud of what she and her colleagues had achieved in preparing a suitable milieu for WBSP activities:

...a room that's been dedicated for the well-being service now and it's all nicely transformed, it's stable, and we've got leaflets and everything, handouts for all the people to come in for the consultations. We have a dedicated day and it's operated by two members of the staff now (19)

This important level of resources devoted to WBSP was quite rare but when in place made the nurses feel valued and their work seen as important. This view however was not shared by the managers' groups who preferred a rather more esoteric interpretation of a WBSP clinic. This quote was from a WBSP manager reflecting on a complaint from a practitioner that she could not get a designated clinical area to do WBSP activities and proposed:

... nurses were thinking about a well-being clinic as a sort of bricks and mortar arrangement rather than a virtual arrangement. So when they talked to the others in the group they realised that a 'clinic' may be these ten people [but] that they may not all be in the same room together, they may do them at home (86)

One nurse described her current situation of not having a formal clinical setting for WBSP activities and that she thought she required to have one to undertake interventions properly. She was not aware of the different viewpoints regarding venues and flexibility of service provision outlined by the managers. Feeling clinically compromised her solution was to revert to a 1-1 basis arrangement with her clients in lieu of proper amenities:

At the moment it would be D town and I think we need to make the service local so we need to start looking at local facilities somewhere where we could actually have a room for the day really. Yes, we do have an access to G hospital but it has CPA's most afternoons and they have limited availability there as well and I'm not sure how we're going to do it. If I was honest, I think we need to deal with our own patients individually on a one-to-one level, [and assess] our own patients initially but I understand that we should be seen to be having a clinic at the moment (79).

Change management literature appears to be rather vague on the issue of practical resources. The literature pertaining to the commitment to change includes: Neubert and Wu (2009) on employees attachment to change and implementation of new rules or policies; Herold (2008) on effective

reasons to change; Armennakis and Harris (2009) three-stage employees' commitment to change. Most of these theories examine psychological factors for change and are essentially based on classical cognitive, affective and behavioural processes (Beck 1975, Rogers 1980, Skinner 1938). This review found no theoretical approaches that specifically identify resources as a necessary component of successful change despite the rather obvious notion that money, time and equipment all being prerequisites for change.

Equipment

Equipment as a resource was discussed often and the following quote from a manager exemplifies the essential concepts:

CPN's (community psychiatric nurses) have bought a set of scales in T's store and kept them in the back of their car, you know, and they have all these genius ways around things (43)

All participants agreed that they enjoyed the feeling of professionalism that establishing the WBSP brought. They felt that it was contributing to their personal development and also playing a real and tangible part in the health of their patients. Creativity was often used to reduce hindrances as shown by a nurse:

I think what they seem to do is like most of the health professionals and nurses they will be quite creative with what they can do and they will use clients own stuff (144)

4.3.1.2.1 Summary

Resources are generally underrepresented in the change management literature, and rarely mentioned on the list of key considerations offered by authors such as: Moss-Kanter (2009: 1983); Kotter or Luecke. Slater et al (2009) among others reviewed the achievements reached through practice development and outlined items including developing learning cultures, new services, staff empowerment, and role clarity and competency frameworks. However, she typifies other writers who do not discuss resource allocation, costs involved, either financial or emotional (DH 2001). And yet it is axiomatic that adequate funding is a necessary component in securing the success of any project.

Initiatives such as Nurse Development Units had initial success in the UK and Australia however their eventual demise was attributed to the removal of financial support and leadership burn-out (Happell 2008; Greenwood 1999). Therefore, schemes that produce excellent quality outcomes and involve highly trained and experienced staff, good facilities, proper resources and support will always be costly (Greenwood 1999). *Choosing Health* states that GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year. This expectation was supported by allocating designated Quality Outcomes Framework (QOF) performance related funding to GPs to undertake this intervention. However, similar expectations were made of the mental health services without the same remunerations from the DH. In spite of this rather obvious point, policy and change are often proposed and pursued without recognition of the associated cost implications. Yet resources are important to the nurses in this study, although the managers seemed to be less concerned. In terms of the WBSP, the nurses did not protest at the innovation or ideology of the WBSP project in itself, but to the real or perceived lack of resources to undertake the innovations in a meaningful way.

4.2.2.2 MESO – SYSTEM: PROFESSIONAL THEMES

4.2.2.2.1 Personal and Professional Development

4.2.2.2.2 Leadership

The Meso system; the ‘Professional’ themes, views the practitioner as part of a group that has expectations of professional behaviour, values and knowledge base; professions are prepared to engage in a relationship with individual and organisations but ultimately have the responsibility for professional standards, ethical practice and the development of future registrants. The theoretical constructs in this category were education and leadership, and personal and professional development (PPD).

4.2.2.1.1 Personal and Professional Development

The PPD theme in this study was of greater concern to the managers group with predominant issues including the skills and knowledge regarding WBSP activities: training issues: Higher Education involvement. In contrast, there were just two quotes from the nurses which related to training.

4.2.2.2.1.1 Skills and knowledge

The skills theme yields three key areas of concern. First, primary skills development; secondly the use of existing skills (for example interpersonal or communication skills) alongside newly acquired physical health skills, and thirdly acquisition of professional decision-making skills to know when to use skills in the first two areas to best effect. As in other areas of this study there was a discrepancy between the WBSP managers and the WBSP nurses opinion concerning knowledge and skills pertaining to well-being work. The managers believed the nurses had sufficient knowledge and skills to undertake basic physical health check-ups; this was challenged by the results of a survey undertaken by the Trust. The survey of all clinical staff had a limited response rate but nevertheless the results showed that approximately half of respondents who were clinical staff, had never carried out a physical health assessment and the other half reported they could not do simple physical health examinations such as measuring vital signs and calculating a person’s body mass index. One manager said:

The first [question in the survey] is ‘have you ever undertaken a physical health assessment?’ and the response is even between the yes’s and no’s to that question and [to the further question the same level of response] ‘can they take blood pressure and calculate the body mass index’ as well? (105)

The following quotes are part of a further discussion by managers concerning inter-personal skills surveyed:

This one [question] was about which skills are important; you've got verbal communication and non-verbal communication, non-judgemental attitude and respect, and dignity, and as you can see most people agreed that in order to do all of those things there were hardly any no's and I think a couple of people said 'don't know' and there are a few no responses but most of it is people said yes to that so that is good (100)

In response to this shortfall a manager accepted that the noted skills may not be part of a MHN's current portfolio of skills due to the emphasis on psychological interventions and highlighted the importance of the specific WBSP training to address this issue:

... unless they've been trained as part of their well-being [WBSP training] they wouldn't necessarily have had it [training regarding vital signs and BMI calculation] (106)

The implications of this situation appear to not be considered too grave in this quote and reflected the generally poor levels of knowledge and skills regarding physical health issues among MHN in relation to the WBSP activities in 2008. The shortfalls in physical health skills in 2008/9 remained withstanding despite the CNOs review (2006b) recommending a clear and explicit role for MHN in undertaking physical health assessments and interventions (DH 2006a). This point made by a manager reflects the on-going developmental process of integrating the WBSP into practice:

we've certainly got people trained up [WBSP training] that are very, very effective in their workplaces and they're being asked to go to other areas and start implementing it [WBSP] where they haven't really staff as yet to deliver so, there's a huge interest and the skills are out there (129)

Lack of skills was found to be hindering factors for the nurses because the success of the WBSP was dependent on the development of new physical health assessment skills and the confidence to use them. Despite this, the nurses reflected that although they needed help with developing physical health skills, they had other well-developed skills, particularly inter-personal expertise. However, a viewpoint common in mental health nursing highlights a prejudice which considers well developed inter-personal skills as being more valuable than formal qualifications and training. A nurse in this study highlighted this issue:

... because you'll get individuals as well that are naturally good at it (providing care) and then you get someone that's got all the qualifications under the sun but they are patronising and it's very difficult sometimes to get that balance isn't it ?(47)

The growing interest from practitioners is the realisation of the responsibilities involved in having to manage the outcomes of uncovering serious physical illnesses and disease which had not been fully realised by MHN. One nurse said:

It's not just taking the blood pressure, it's also recognising when someone is hypertensive (259)

Furthermore, nurses were finding that there were new areas of skills and knowledge to acquire such as lipid levels which were not so rigorously checked until the use of atypical antipsychotic medications:

I think historically that blood glucose has been talked about or associated with SMI for many years whereas the links with cholesterol has probably become more prominent in the last 5 years (260)

A manager drew attention to whether the WSBP nurses have the necessary depth of knowledge to be sufficiently reliable enough in interpreting the outcomes of physical health assessments and developing the correct management plan for the findings:

I think the biggest issue is around the increasing number of clients with high cholesterol and the huge impact that stopping smoking has on the levels of cholesterol in somebody's system (if taking atypical antipsychotic medication) and a lot of staff are actually not aware of the impact of clients from stopping smoking (110)

The context of this quote was a discussion about a shared care approach to WSBP between MH services and GPs, which for reasons outlined earlier (in Chapter 2) were causing difficulties. The MH managers preferred MHN undertake the physical health assessments of the MHN service user group because the service users preferred it that way for a number of reasons related to skills, knowledge and attitudes. However, the MHN wanted to be permitted to refer any serious, complex or unmanageable problems found in an assessment to the GP for treatment. However, although this method of care management was common in mental health services between psychiatrists and MHN, GPs were reluctant to accept the professional opinion of a MHN in these physical health matters and were reluctant to assimilate this way of working into their practice.

The acquisition of relevant physical health knowledge and skills was necessary for MHN to be safe practitioners in this area. However, it was also necessary for practitioners to develop positive attitudes toward the importance of physical health to service users, their capacity to develop competence and confidence in undertaking well-being interventions, and realigning their existing priorities toward psychological interventions. A manager reflected on these areas:

It's really about the staff's attitudes and knowledge around physical health and implementing well-being etc because I think that the thinking was is that if you don't tackle that (attitudes and knowledge) you can ask as many service users as you want but if they're not getting the service it means nothing (172)

The critical balance between physical health and psychological skills was the main aim of the WBSP and the evidence suggests that if either one is practised in isolation the outcomes will be ineffective in providing good standards of care are for people with a SMI. However, the development of the additional knowledge and skills regarding the WBSP activities were challenging, particularly to those MHN who were considered highly competent and confident in psychological interventions.

4.2.2.2.1 Training

The participants were all qualified practitioners but mostly MHN who were self selecting based on interest of the subject and implementing the WBSP agenda. The result of this approach was a broad roll-out of the WBSP across the Trust instead of a strategic prioritisation of training to a particular service or geographical area. The staffing numbers (November 2007) were reported by one manager:

we've got just under 4000 (staff in the Trust) and we've got just over 1000, I think it's 1200 that are within the nursing profession, 900 of those are qualified nurses and the reason I know this is because I'm on the HR committee for the Trust so I get all the details (261)

On this matter another manager asked:

Just to help me, how many total staff would you want to be trained and what percentage have already been trained?(262)

The response was:

.... well there are 150 professionals trained up and like you said earlier we've got social workers and our first two social workers are trained up and OT's and nurses mainly and we're now doing the training to qualify down unqualified

people so the training needs to be pitched at a level that suits everyone. If that works and we all send in train-the trainers in addition, obviously you've got the three lead nurses that are doing it in their own boroughs, but if it works for them to have the involvement of some senior practitioners for example to deliver some of the training and that might be something to think about in the future then maybe that's a way of actually increasing the cascade (263).

The cascade approach to training and awareness is quite common in the NHS and fits in with the predominantly hierarchical managerial approach of the organisation approach to integrating the WBSP is not surprising. This approach was illustrated in the following quote:

We've certainly got people trained up that are very effective in their workplaces and they're being asked to go to other areas and start implementing it where they haven't really staff as yet to deliver so there's a huge interest and the skills are out there(264)

Furthermore the training was going to be also offered to practice nurses in primary care settings using the same approach as discussed by a manager:

One of the things from a primary trust perspective that we are looking is to see whether we can actually do the WBSP kind of training with the practice nurses (265)

However, given problems discussed earlier in the Policy theme, regarding *interpretation* rather than *translation* the accuracy or consistency of the training may be compromised using a cascade approach; particularly as training was seen as substitute for policy and procedure in the early days of the project. The nurses commented that they found the training meaningful and that it had given them the skills and knowledge necessary to undertake the WBSP activities. They discussed the knowledge and skills in relation to physical health checks, how to understand the relevance of blood test results and also to act upon them. They also benefited from the aspects of change management skills included in the three day training relating to the implementation of the WBSP. The training was challenging for the nurses to undertake as it was three consecutive days in same week. A nurse commented:

I feel like I haven't done any training on anything like that for a really long time and I would like to feel more confident in it [WBSP assessments] (56)

Despite the WBSP training being voluntary, attendance was good and attrition almost nonexistent. Education and communication are said to be among the commonest ways to defeat opposition to change as it helps to communicate the why of change not simply the what, where, when, how and who of change. Understanding why is necessary to facilitate a cognitive shift which forms part of

an overall decision making process that ultimately steers an individual towards motivation and action (Lewin 1946; Buonocore 2004). Many of the nurses in this study cited job satisfaction as a helping force in its own right, and also as enhancing the effect of other helping forces. One nurse expressed her enthusiasm for the WBSP generally and how it effects her working day:

I love working 9-5 and I love what I'm doing as well because just different (14)

This demonstrates not only the level of professional satisfaction in and meaningfulness of the WBSP activities. This so called 'feel good factor' was very important to the nurses and led them to feel their efforts to meet the challenges they faced were all worthwhile. However, despite a great deal of training opportunities sometimes changes in staff resulted in clinical areas without any trained WBSP nurses, Also, as time went by the WBSP training was a less urgent than the raft of mandatory training necessary for the Trust to be successful in its bid for NHS Foundation status. The following quote illustrates this:

They did have two people trained up from that unit from that particular ward, but one person had to be transferred because she was pregnant and another person emigrated and they just say that because of the staffing situation they just haven't been able to release anyone to do the training, and of course everybody does have to do mandatory training before this, you know, before well-being so what some the managers say is no you can't go to the well-being until you've actually gone to every single mandatory training (60)

Although a substantial 150 staff were trained it only accounted for approximately 8% of the total number of clinical staff in the Trust. Training places were available to rectify this situation; however shortages of staff and other competing priorities prevented practitioners being released from work to take them up. The lack of training was given as a reason for being unable to implement the WBSP strategy as practitioners were reluctant to undertake WBSP clinical work unless trained to do so. In addition the practitioners were asking for remuneration for the extra work and responsibilities that undertaking WBSP work involved. A manager was shocked by this and said:

They [WBSP practitioners] are saying they need to be trained and have extra money, do they really know what we we're asking for? (132)

The tenor of this comment suggests the manager considered the WBSP practitioners were being unreasonable in their expectations and had possibly overestimated the extent of their importance.

Nevertheless, the WBSP practitioners had added many extra facets to their original skills and knowledge repertoire since the beginning of the well-being programme so the anticipation of added remuneration was possibly not unreasonable but almost certainly unrealistic in the economic climate of the NHS in 2009.

In terms of education, I offered the position of WBSP knowledge and skills input into pre-registration MHN training and post qualifying education programmes at my University:

I think it's really getting properly into the pre-reg programme at the University, and we've just finished mapping the core areas into the new curriculum which will include it (WBSP), so yes. In post registration, we've now got that pathway right from the beginning when you (pre-registration) train right through to when you register (as a MHN), and further in to the mental health work programme (131).

The Framework for Lifelong Learning (DH 2001) proposed that developing the capability and confidence to engage appropriately and effectively with service users is an essential element of effective leadership and positive service users experiences have been linked to leadership behaviours. Training and development can address some of the confidence issues in relation to knowledge and skills but it is also necessary to support nurses through a regular system of supervision to fully develop and integrate newly acquired skills. The Northern Ireland Practice & Education Council for Nursing & Midwifery (NIPEC) states:

‘Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety’

(NIPEC 2006: 25).

Placing an emphasis on enabling staff to lead and manage in the NHS and organising services around the needs of individuals were ambitions set out in the Darzi report (2008). Despite acknowledgement of the value of supervision the evidence from the NIPEC Workforce survey (2006) showed the supervision activity for registrant nurses was just 33% regionally. Even Department of Health, Social Services and Public Safety (2004) Best Practice Guidelines recognised the value of supervision. However, the expectation was to improve this situation; every registrant nurse should have regular supervision starting from April 2009. This has yet to be formally evaluated. ‘Reflective groups’ that ran on a monthly basis were set-up to support the

WBSP nurses in the Trust. In this study these were principally conducted as group supervision sessions and showed that nurses were enthusiastic about the WBSP because it provided opportunities to develop and demonstrate their new professional skills, knowledge and attitudes.

Summary

This theme was concerned with personal and professional development. It also provided the findings and interpretation regarding the knowledge and skills regarding the WBSP, training issues and higher education. These areas show that this theme was of far greater importance to the managers group than the nurses. This is a surprising finding as nurses are accustomed to training and personal development as being part of a changing practice.

4.2.2.2 Leadership

A review of the related literature coupled with my experience as a mental health nurse led me to believe that leadership and change would be major themes in this study for both the nurses and the managers. However, this was not the case, and factors concerning change or leadership were not mentioned explicitly by the nurses at all. The managers reflected on leadership on just seven occasions predominantly related to processes, actions or strategy rather than to attitudes, beliefs or values involved in making changes. The relative lack of interest in leadership issues from nurses in this study may suggest that the nurses were probably more concerned with other factors to help them implement the WBSP such as *resources, support or problem solving skills*. Alternatively, it could also indicate that the nurses relied largely on intrinsic personal leadership skills and integrated leadership qualities such as *creativity, determination, professional values* based actions, use of *evidence based practice* and a sense of *nurturing change*. Alternatively they may have no concept of the need for leadership or its benefits if they are unaccustomed to the leadership experience. It's also possible the nurses did not value leadership as a constructive experience and perhaps they had experienced poor or destructive leadership. This level of data collection was not part of this study so a detailed analysis cannot be undertaken. Nonetheless, it is of interest that the nurses in this study did not discuss leadership in either a positive or negative way.

The reasons for this deficiency can only be suggested; however the dearth of available leadership from the professional nursing bodies such as the Royal College of Nursing (RCN) and the Nurses & Midwifery Council (NMC) for MHN both generally and specifically in this case can be

evidenced. Leadership is said to be one method of supporting individuals in the embryonic phases of their career or projects to provide positive formative experiences. Therefore a lack of appropriate leadership, advice and guidance regarding the changing role and responsibilities related to the WBSP and the necessity to develop relevant knowledge and skills indicate a lack of support and negative formative experiences. Jackson (2010) considers the complexities that leaders face in the contemporary workplace including reflectivity, powers of discrimination and emotional capacity to change. The main leadership influence for implementing the WBSP came from a senior nurse who also led the WBSP steering group and represented it at Trust Board level. However, at the end of the steering groups second year she reluctantly relinquished her direct involvement in the WBSP. However, maybe due to the absence of consistent formal hierarchical leadership, the nurses in this study appeared to develop a way of undertaking WBSP activities resembling a collegiate approach. This was demonstrated by them joining voluntary networking groups where they shared quite formally with their peers in an equalitarian way taking responsibility for new work-streams and initiating innovative evidence based practice.

This move towards collegiality suggests that the absence of a specific leader to pilot nurses through implementing the WBSP in this study developed alternative means to gain inspirational support by developing their own integrated and self determined personal/professional leadership values, beliefs and expectations. The means they utilised to achieve the capacity for intrinsic leadership was by utilising transferable principles from their respective psychological or therapeutic training and practice. For example, a cognitive behaviour nurse therapists led by focussing on challenging the negative assumptions about challenging situations; counsellors took a 'client' centred approach to leadership issues and solution-focused practitioners undertook their leadership role by being systematic and problem solving. The success of this model of leadership could be partly attributed to professional training, clinical autonomy and clinical success in using the given approach, mixed with personal traits, values and beliefs.

Given the size and diversity of the Trust a collegiate approach could have been an ideal solution to integrating the WBSP, particularly as the selection of a single manager for a transformational change can be problematic. The two issues identified by Doyle (2002) were that the complexities of change in an organisation contradict the selection of a single leader and can be based on generic leadership or management skills, rather than specific competencies in the arena of change (Doyle 2002). Doyle warns that change exposes leaders to a range of pressures such as political

and behavioural influences that can outrun their professional expertise (Doyle 2002). He suggests that the effects of these pressures and lack of expertise in coping with them will eventually affect the change process negatively resulting in under-performance and de-motivation of the leader. Ironically, although these people are usually the brightest and the best they run the risk of damaging their credibility and also possibly their career prospects by being selected for the unrealistic expectations of the role (Doyle 2002).

In contrast, the Royal College of Psychiatrists (RCPsych) undertook an independent scoping project including a review of the relevant research and recommendations regarding the WBSF (RCPsych 2009). As a direct outcome of this professional review recommendations were issued regarding good quality general healthcare for psychiatric patients with potential physical health problems offering guidance on the assessment and monitoring protocols for community settings and in-patient care (RCPsych 2009). *No health without public mental health, the case for action* (RCPsych 2010) also noted that many psychiatrists lacked the skills required to provide for the general healthcare of people with mental illnesses and suggested this was due to psychiatrists specialising in mental health issues whilst considering physical healthcare as the responsibility of other physicians. There were also reference to the need for clarity regarding their responsibilities concerning general healthcare; improving working relationships within partnerships with other related health professionals and collaboration with primary healthcare and other specialist colleagues (RCPsych 2009).

4.2.2.3 *Summary*

Whilst the publication by the Royal College of Psychiatrists (2009) was three years after *Choosing Health* (2006a), it did provide a well considered review of the relevant literature and comprehensive guide for psychiatrists relating to their responsibilities in general healthcare of their patients. It also outlined the parameters of collaborative working, partnerships with primary healthcare and other specialist colleagues in terms of the physical health of mental health service users (RCPsych 2009). Although it is reassuring that psychiatrists have been given professional guidance on this serious health agenda, it is of concern that MHN have yet to receive the equivalent professional guidance. This is regardless of the consequences of the *Choosing Health* recommendations on MHN practice and the serious concerns about morbidity and mortality rates among people with a SMI in the UK. It is suggested that strategic and collaborative leadership

interventions from the professional nursing bodies such as the RCN and the NMC, together with the CNO could have been very helpful in relation to supporting the integration of the WBSP. The current situation is that these representative groups do not offer guidance, advice or support in any meaningful way to nurses at any level who are responsible for the integration of health policy into clinical MHN practice.

As seen in earlier chapters of this study, the development of physical health care for people with SMI is littered with failure for many reasons, despite a catalogue of related health policies. Nevertheless, the implicit expectation of change and improvement in clinical practice as a result of health policy remains the mainstay of the NHS in the UK. The shortfall in achieving effective outcomes of health policy may be due to their poor construction, nebulous nature and all too frequent amendments and additions. However, the lack of professional, as opposed to organisational, guidance and help with contextualising the application of health policy into mental health practice may also contribute to their limited success.

4.2.2.3 MICRO SYSTEMS–INDIVIDUAL PRACTITIONER THEMES

4.2.2.3.1 Support; 4.2.2.3.2 Innovation and motivation

Micro system – The Individual practitioner themes – considers the practitioner’s relationship with her/his own beliefs, motivations, needs and vocation that results in the wish to improve, develop, solve problems and integrate improvement and change into practice. Theoretical constructs in this category were support and individual attributes.

4.2.2.3.1 Support

The theme of *support* was discussed by both the nurses and the managers’ groups indicating it was an important factor in implementing the Choosing Health agenda and integrating the WBSP. In as much as using the frequency of occurrence as an indication of the relative importance a topic has for a group, the evidence suggest that support was a minor concern for the managers with the fewest quotes of any from the managers. In contrast, support was the most important for the nurses as shown in many statements that suggest they found support a helping factor and the lack of support a hindering factor. The support theme consisted of three main elements which were peer support, manager’s support, and support through leadership.

4.2.2.3.1.1 Peer Support

Peer or team support was discussed by the nurses groups and the lack of team support was the second most referenced hindering factor overall for the nurses. The following contribution conveys the general tenor of these comments with one practitioner expressing difficulties with lack of team support for WBSP activities in her absence and frustrations about the lack of consistency during her absences from the unit:

I can get it going, but it’s difficult to get it carried on when I’m not there, so that’s my struggle at the minute (45)

The next practitioner was particularly distressed to think her colleagues were convinced that the initiative, as well as all her efforts, would fail regardless of her enthusiasm:

I’m finding it a real struggle. I’ll start on the negative stuff and end on a positive note. But what I’m finding is that, actually don’t get me wrong the staff are lovely, they all work with me but the attitude that is portrayed is “oh bless, isn’t she eager” sort of attitude or the other one is “oh it’s another project that will

fall by the wayside” and so I find it really hard to get the support of the team. Now I know you came to the last one and my manager came and “oh we must start weighing everybody. J, can you sort that out” which I did. The charts that we’ve got for temperature, blood pressure etc are stuck in weight charts integrated on the back so we do that, turn over, do the weight. I said to ask that when everyone’s having their meds on the weekly basis I’d have it set up, BP machines, scales etc so they’re there and they’re not having to go back and forth, but we are...I’m not there every Sunday because like the Sunday wasn’t a weekly time it hasn’t been done since, and so I’m struggling to get everyone else to keep doing...(266)

This reflection typified the struggling emotion common among the nurses in relation to their experiences of integrating the WBSP into practice, being more common among in-patient nurses. A qualitative, critical, feminist exploration undertaken in Australia by Ward (2011) investigated mental health nurses working in mental health inpatient services. The nurses, who were asked about their stress and professional well-being, unequivocally supported the view prevalent in contemporary literature that mental health nursing is stressful. The study identified, as did this study, that nurse participants’ stress management was intrinsically linked to their job satisfaction. The major theme showed that participants' ability to manage busy acute mental health wards was decreased by lack of manager support and improved by teamwork, diversity, and creativity (Ward 2011). This point was highlighted by a nurse in this study:

I’m confident because I know the team I’m working with, they are, I mean I have to say they are a fantastic team and I’m confident that they will continue to do that (17)

Another nurse found the WBSP support groups a helpful resource as well:

This is why these link groups are so supportive really because I think sometimes it does feel like you’re banging your head against a brick wall (69)

Support was illustrated by the following quote which highlights the importance of peer support to improve motivation and innovative practice. A nurse reflected upon activities she had discovered in a particular unit that had organised an inter-ward WBSP network:

... they’ve (WBSP nurses in an acute unit) only just told me that they all meet up on a regular basis as a group to do what I’ve just said, you know, that they inspire each other they keep, you know, “have you tried this? Have you tried that?” (21)

Peer support for nurses was highlighted by the managers in terms of the value of peer support and sharing ideas:

So that's a very good example, isn't it, of why the link meetings are so important and it just envisions [inspires] people doesn't it? (8)

In terms of team or peer support as highlighted above, Lewin argues that although they can experience difficulties, team ventures are more likely to be more successful than those of a lone individual or of many uncoordinated solo activities. This is due to the supportive dynamic between members of a group producing a motivational energy which tends to be missing in isolated activities (Lewin 1935). Whilst Lewin acknowledges that joint ventures can lead to tensions for various reasons such as professional beliefs, values and attitudes, he proposes that a degree of tension or stress is productive in a system. Furthermore, he suggests a lack of dynamic energy due to either too much fluidity or too little tension in the system will result in poor motivation and outcomes (Lewin 1946).

4.2.2.3.1.2 *Manager's support*

Manager support was necessary for the success of the WBSP as it is a major facilitative factor in change. Equally, the lack of support or an inconsistent approach can hinder change and this was the experience of the majority of nurses in this study. The following advice was given from one nurse to another:

... if your manager has asked you to do all of this and then is not actually backing you up on it, you need to go back and say "I really do need your support" and that's not confrontative, and that's saying "I really want to do what you've asked me to do but I need your support here" (74)

Another nurse who was experiencing inconsistency in support with her WBSP responsibilities was supported by a peer group member as follows:

I think if you simply say to your manager "you've given me this job and I want to do it really well can you suggest to me, can you help me now with how to make it work so that when you're not on duty it still happens" (12)

However, there were some examples of supportiveness experienced by the nurses involved in the study. One said: such as:

So I suppose I'm lucky that I've got support and people can see how good it (WBSP) is (7)

The appreciation of manager support for the well-being initiative was demonstrated by an in-patient practitioner when she said:

I'm so lucky that I've got the modern matron that recognises the importance of it all and C.D. as well, my ward manager" (11)

4.2.2.3.1.3 Support through leadership

Support is an important issue in most ventures, not least when change is involved. A nurse in a leadership position played a big part in this role and often offered her support and encouragement. She often offered help and advice but also tried to contextualise the nurses efforts and results in terms of the broader picture. She would focus on the recognition of achievement as a means of support and one particular quote embodies the overarching philosophy of professional support:

Whatever you do achieve, acknowledge it, don't just think oh well that's only a bit of what the bigger picture is, actually that's a huge step and an achievement for the whole team and you're not just taking the glory yourself (31)

This approach encourages the adoption of a generous, sharing attitude that values the efforts and outcomes of a team effort rather than only recognising a few prominent individuals and isolating those who did not, or could not contribute. Such inclusive praise validates the success of the team as a whole. Acknowledgement was also shown by remarks such as this one from a manager:

Just to let you know I have entered it [the Trusts implementation of the WBSP] again in to the Nursing Times award (37)

However despite the good intentions raising the profile of the WBSP in this way could lead to WBSP work becoming a *specialist* activity undertaken by an elite group of nurses and in so doing inadvertently excluding others who saw themselves as unskilled in this area.

4.2.2.3.2 Summary

The theme of support included peer support, managers' support and leadership support, and examples of these have been given. Challenging existing assumptions regarding practice can be a daunting prospect which nurses need to be empowered to undertake as outlined in the RCN's *Integrated core career and competence framework for registered nurses* (RCN 2010). It appears that the managers assumed there to be enough existing support for the nurses and therefore the issue did not require special attention. Alternatively the managers could have been unaware of the nurses' feelings on this issue. Either way, managers failing to recognize the significance of this issue are a major problem in a project depending on their collaboration with nurses. The managers might have benefited from considering Buonocore (2004) views that it is not only important to support nurses with changing practice, but also the changes within themselves to ensure sustainability of the change in question. As noted support was a far bigger issue for the nurses than the managers which was related to their perceptions of their own competencies and confidence concerning their WBSP interventions. Although the notion that the nurses in this case study had mixed feelings about the level of support, often referring to lack of support particularly when faced with difficult situations may not be surprising or new despite its relevance. However the data that show that the nurses needed significant interpretive skills to synthesise the policy and professional expectations in the real world of service users' care is unique and a proposal that the high volume of items in the 'support' section reflects such a shortfall of skills in those who are less able or experienced is new. In terms of the research question, support was one of the factors that influenced the implementation of *Choosing Health* (2006) and the integration of the WBSP at the Trust.

4.3.2.3.3 Innovation and motivation

This theme consists of a number of small but important areas that affected the integration of the WBSP in the Trust such as personal attributes, determination, persistence, enthusiasm and motivation. The following quotes offer a brief overview of these areas. A nurse in a lead nurse position encouraged a fellow nurse by saying:

Your team, your ward manager should acknowledge your keenness, your enthusiasm, and say the staff needs to get behind you and maintain that because you're leading up on this you know (36)

Organisational skills were discussed by a nurse as a way of improving helping factors by describing how she managed to get service users to partake in a WBSP clinic:

It may be that we could organise transport to take people up to D town to get them to go to the well-being clinic and get them involved in the well-being interventions (75)

Determination and motivation are linked and both are necessary to overcome obstacles to the improvement of whatever existing positive scenarios are present. The DH (1999b) National Service Frameworks for mental health insists that all staff should be engaged in shaping services and in planning and delivering change, with incentives to alter both attitudes and practice. Strong leadership, with clear commitment to target resources and a willingness to promote learning were stated as being essential to secure and sustain change (DH 1999a). These factors were crucial to WBSP practitioners in terms of organisational responsibilities and professional perspectives.

Persistence and determination were identified by the nurses and this quote represents an implicit sense of determination:

I'll keep going. I think they think I'm just quite quiet but actually I'm quiet but I keep going, I keep going and I will get there (18)

Persistence as a characteristic of importance was exemplified by these thoughts:

Perhaps persevering more with GPs to get things looked at, rather than just accepting it's the side effect of a mental health medication or something else (85)

A nurse reflected thus:

So they're persisting with their manager, it's a journey you know it's a process and about not giving up (33)

Determination and persistence are essential characteristics for these nurses in their clinical practice, as it primarily involves engaging with and caring for people with intractable mental illnesses over long periods of time (Gamble and Brennan 2006, DH 2006a). It seems that the nurses were cognitively and affectively hard-wired to manage and cope with difficult and enduring problems from their clinical work and they apparently transferred these skills to implementing the WBSP.

The managers also reflected on personal attributes when they considered attitudes and creativity as skills that were important to the success of the WBSP. Subgroups of these two themes included notions of being flexible, enthusiastic and a positive attitude towards overcoming obstacles faced in implementing the WBSP. Flexibility was discussed in terms of interpretation of policy guidelines to match specific working environments. A manager said:

And that's the whole point of the well-being training is that we're meeting NICE guidelines. But if it works in your team best that it's done in your caseload that you offer a well-being service to clients in a one-to-one that's OK (23)

A nurse exemplified flexible attitudes to undertaking WBSP interventions by saying:

In the community all that gets out the window, which I love, and say this is your home, if you want to sit there in your dressing gown and talk to me, if you want to sit out in the garden, if you don't want to open the front door but you want to talk to me out of the window, that's fine, that's ok (267)

A slightly different context is exemplified here by one of the nurses:

Sometimes it's better to be flexible because on the Thursday, when I run well-being, sometimes there isn't anybody that's well enough to engage but there might be someone who's really crying out on a Sunday night when the ward is more settled (24)

This quote exemplifies the flexibility of mental health nurses' attitudes:

I think that's important isn't it, different people ready to engage with it at different stages of their recovery, you know, so some people will engage with it on the ward, some people when they get back home maybe (2)

Flexibility was also discussed in relation to being able to maximise existing, and sometimes restricted, resources or opportunities to reach objectives:

To me, with the environment you work in, if you can manage to get base line obs done and record them and then raise any issues and concerns you sort them out before discharging them (3)

A WBSP manager reflected on attitudes and knowledge thus:

It's really about the staff's attitudes and knowledge around physical health and implementing well-being etc because I think that the thinking is that if you don't tackle that, you can ask as many service users as you want, but if they're not getting the service it means nothing (172)

A different means to achieve the successful implementation of the WBSP was the empowerment of the nurse to undertake the WBSP activities and gain acknowledgement of their work. An example of acknowledgement was portrayed by one manager explaining:

I've encouraged her to write up her approach to the well-being and the prison in-reach and actually then AD would help her write an article, or you guys can from Lilly [drug company], but that would be a brilliant piece of work, she could have an article published before she leaves prison in-reach (95).

Creativity and ingenuity were illustrated by the following quote offered by a nurse who was leading the WBSP implementation:

The other positive thing is that they're being incredibly creative about how they implement this [WBSP], in all the different areas they've all got different stories and they're fantastic and the ingenuity is just outstanding. They're not going to be stopped in doing it (80)

A nurse cited job satisfaction as a 'helping factor' in its own right, and also as enhancing the effect of other helping factors forces. This so called 'feel good factor' was very important to the nurses and led them to feel their efforts to meet the challenges they faced were all worthwhile. The evidence from participants' quotes in this theme shows that by being organised, having problem solving skills, being persistent, having determination, showing enthusiasm, confident and maintaining a professional attitude, changing practice can be achieved. This inevitably invites the question, what is the outcome if the individual does not have well developed skills in this area, if confidence is low and personal attributes limited?

Hindering factors in the theme of personal skills and attributes included issues relating to a lack of confidence primarily focussed on the practicalities of undertaking a well-being assessment or clinic. A nurse said:

I don't know whether it's confidence, whether people don't do it because of confidence or [lack of] time (55)

However there was also a suggestion that reluctance could be masked by nurses claiming it was a time issue or a lack of other resources.

Enthusiasm, motivation and determination all contribute positively to any new initiative and have been proposed as a major characteristic of leadership and change management (Price 2009). Speaking at the 4th International Stigma in Mental Health Conference (2009) the Minister of State for Care Services stated

‘If you’re serious about creating fair, resilient, healthy communities, you can’t stick your head in the sand. You have to show leadership. You have to make it happen in your area’

Confidence is concerned with power, judgement and ability and was quoted in relation to care giving skills as well as professional behaviour. However, a lack of confidence and competence can be quite undermining and destructive for an individual. This comment from a nurse in the study provided some reassurance:

And they’re not going to do any harm, because a lot of people are quite reticent when they think they might do more harm than good, you know like talking to patients when you’re a student, you might upset them or make an error (37)

4.3.2.3.3 Summary

The combination of flexibility in approach, reflexivity in undertaking clinical intervention and the confidence to interpret routines will increase what Exworthy et al (2012) have called local interpretation of policy or local governance. The response to a weak top-down pressure can lead to locally negotiated rules and innovation driven from the bottom-up (Exworthy et al 2012). Experienced and expert nurses will often show a more sophisticated approach to challenging situations by being reflexive and intuitive in relation to their practice (Benner 1984). Schon (1983) proposes that a reflective approach to practice allows nurses to reach new understandings through critical evaluation either individually or as a community. In addition the professionals will exercise a substantial degree of discretion in the interpretation and application of a policy, despite formal origins (Pettigrew et al 1992).

Lyneham et al (2008) study of decision-making in nursing used a reconstruction of Benner’s *expert stage*:

Cognitive intuition, where assessment is processed subconsciously and can be rationalized in hindsight

Transitional intuition, where a physical sensation and other behaviour enter the nurse's awareness embodied intuition when the nurse trusts intuitive thoughts

(Benner 1984).

4.3.2.4 Current Policy Pathways

Currently the main two systems involved in health policy and related practice are the organisational and the individual ones (Fig. 3). This previously described approach of *top down* or *bottom up* has been criticised ever since *Shaping Strategic Change* (Pettigrew et al 1992) when managerial and market reforms were producing turbulence, confusion and instability in the NHS; also in many classic policy studies including the 'garbage can' model proposed by (Cohen 1972) and noted by Pettigrew (1992). The consensus from Pettigrew was that:

“top-down” pressures were likely to be too weak to change locally negotiated rules of the game; ‘policy’ was being constantly renegotiated at the periphery; innovation was likely to be bottom up and professionally driven; human services organisations were likely to be ‘frontline’ services where professionals exercised substantial discretion irrespective of formal policy”.

(Pettigrew et al 1992:32 In Exworthy et al 2012)

Pettigrew et al (1992:32) identified a high level of cynicism regarding the effectiveness of top-down organisational change. They suggested a middle ground of 'substantial variability' can be detected in a range of organisations that studied as cases longitudinally. They found that through the wide range of cases it was evident that a *focus on impact* such as the amount of strategic change, *focus on context* including long relationships, historical factors and management styles and a *longitudinal approach*, would be the best way to evaluate the degree and resilience of the change in question and more importantly, the amount of *changing* necessary to achieve it (Exworthy et al 2012). In a cross-case analysis of numerous NHS cases they found eight key areas necessary to create an amenable context for change. These were not unlike those found in this study and included: the need for a high quality of policy; key leaders in change; long-term environmental pressure; supportive culture; good clinical–managerial relations; cooperative inter-organisational networks; simple aims and priorities that fit with the change agenda from the overarching organisation (Exworthy et al 2012). Nonetheless, Pettigrew's research does not

include the fundamental areas of professional power and influence in clinical change found to be essential in *professional change* in this study.

The research aim of this case study was to understand what influences the integration of health policy recommendations into clinical MHN practice. This was achieved in this case study by specifically answering the research question through the six themes that emerged. They were also worthwhile in illuminating areas not commonly included in change theory checklist such as ensuring there are adequate and available resources, and the important, but underestimated in this case study, role of service users. It is important to acknowledge that further interpretation of the themes would bring forth a deeper level of understanding concerning the positive and negative influences on the successful integration of policy into practice. Furthermore, additional exploration covering the relationship between themes could give rise to wider implications concerning the creation of an environment for clinical change. These ideas will be pursued further in subsequent chapters by re-constructing the six minor themes using an open systems approach to present the findings, identify shortfalls in current approaches to changing practice through policy recommendations and thereby drawing broader conclusions regarding the subsequent implications.

4.3.2.3.3 Conclusion

Initially this chapter critically discussed the data analysis undertaken in this investigation and the theoretical methodological reasons for selecting thematic analysis of both a deductive and an inductive nature. It then went on to provide a detailed examination of evidence from the participants about how each group regarded the helping and hindering characteristics of the consolidated themes. After this an overview of the construction of themes that emerged from the data and their development into a modified open systems model was discussed . The second part of this chapter presented an overview of the findings from both participant groups demonstrating the deductive and inductive findings. The frequency and ranking of the issues that the nurses and the managers in this study reflected upon were also highlighted as were the similarities and differences between the groups. The findings were interpreted and illuminated by a range of evidence to support the trustworthiness of the data and their research findings in this study. As a case study investigating the implementation of a health policy into the NHS UK there was close attention to the political, social and professional contexts in an effort to optimise the understanding of the influencing factor.

The research aims and research questions of this case study were answered in the following ways: six minor themes of *policy; resources; leadership; personal and professional development; support and innovative practice*; three overarching systems of influence, *organisational, professional and individual*. The six minor themes suggested an uncommon combination of factors for *change* and its management in relation to clinical nursing practice, compared with most organisationally and professional lead proposals. For example it included *resources, policy and education/training*, but it also included *professional leadership, support and innovative practice*. A model of change that included this mixture of factors which particularly emphasised professionally important aspects was not discovered in the literature and therefore it appeared appropriate to construct one which reflected them.

The choice of model to illustrate these six themes and the subsequently developed three overarching principles was difficult. However after careful consideration, an open systems model was thought to be the most representative as discussed before in chapter three of this study and outlined below and illustrated by Fig. 3.3 below.

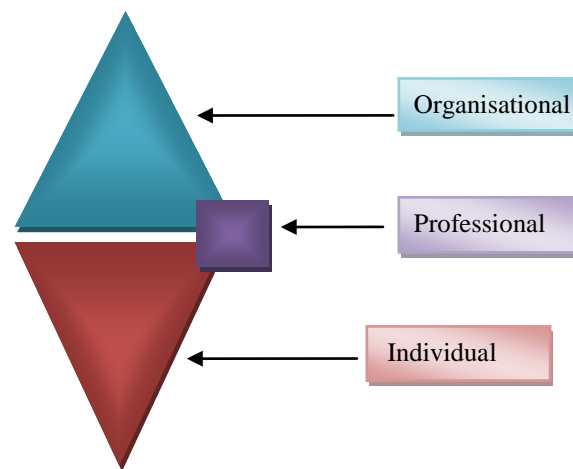


Fig. 3.3 Illustrating CURRENT relationships between Macro, Meso and Micro systems

| Systems | Themes |
|-----------------------|---------------------------------------------------------------|
| <u>Organisational</u> | <u>Policy; Resources</u> |
| <u>Professional</u> | <u>Personal professional development; clinical leadership</u> |
| <u>Individual</u> | <u>Support; innovative practice</u> |

This model conceptualises and illuminates the suggested relationships between the three systems of organisational, professional and individual and shows proposed shortfalls in the significance of the professional system in clinical change found in this investigation.

Chapter 5

DISCUSSION

5.1. Introduction

This chapter will discuss the findings and propositions of this case study. It will also explore how the open systems model (Plesk 2001), change theory (Lewin 1946) and principles of professional influence can be synthesised to suggest an innovative approach to *change* in professional clinical practice (Dopfer 2012). This chapter will then examine the themes that emerged in the study from a systems approach: the macro –organisational system; meso-professional system and micro-individual system. It will go on to discuss the shortfalls in the meso-professional system in terms of its influence in affecting professional and clinical change and how this can be addressed, particularly in MHN. Following this, the transferability of these ideas will be examined in relation to other situations where policy recommendations and clinical practice interface. In doing so, it will offer answers to the research questions in this study.

5.2 Reconstruction of existing approaches to change

To progress this case study from a position of competing versions of reality to a point of critical re-generalisation, a re-conceptualisation of existing approaches to change is needed. This investigation found six themes representing the factors that impacted on the implementation of *Choosing Health* policy and the WBSP at the Trust, which were not hitherto discovered in the literature. However, the differences between the themes in this study and others reviewed were they included practical areas as resources and specific individual practitioners' qualities for example, innovation and motivation. *Resources* were one of the significant issues for the nurses, together with *Support*; largely due to the lack of both. *Motivation and innovation* were thought of as the main reason for the successful aspects of implementing *Choosing Health* and the WBSP by nurses, whilst being unrecognised by the managers. The remaining themes: support; leadership; policy and personal/professional development are found in many 'change management' checklists as suggested by author such as Cormack (2004) and Manley (2004).

Kitson (2009) proposes that knowledge translation can play a vital role in organisational change which is highly relevant to this case study as seen in earlier chapters. However her focus is on the translation of knowledge and evidence into clinical practice as distinct from health policy as in this case study. Nevertheless, if policy is seen as knowledge, arguably the principles she outlines have currency. She also maintains that successful innovation and effective knowledge translation

is fundamentally dependant on local autonomy and innovation. This study found that areas were present but struggled without support and adequate measures during policy development at the professional and organisational levels to facilitate reliable translatability. Kitson (2009) identifies five emerging hypotheses which also reflect some of the findings in this study such as: levels of participants understanding; informed autonomous practice; negotiating roles; resources. However, the suggested means to achieve these was through locally based *expert facilitators* or change agents (Kitson 2009:218). This study suggests a more strategic and professional means to create and translate knowledge, in this case the knowledge within the *Choosing Health* policy. This concordance may not be surprising due to the underpinning nature of this study being concerned with nursing practice and reassuringly indicates this study has some resonance with the work of well known writers on nursing. However, the literary review in this investigation found existing change theory quite piecemeal in nature and weak in capturing the more fundamental and quintessential ideology concerning professional/clinical change.

An approach commonly used is known as a ‘top-down-bottom up approach’. This approach is generally offered as being all encompassing as it includes using ‘top down’ (deductive reasoning) and ‘bottom-up’ (inductive reasoning). However, deductive reasoning and inductive reasoning tend to suggest divergent paradigms; therefore the rationale for amalgamating them is questionable. Indeed, the big issue in this study is the weak gap between the ‘top’, in this case in terms of the organisation, and the ‘bottom’ representing the individual practitioners in this investigation.

Existing change theories as discussed earlier tend to be based on linear, spiral and systems models and offer some utility in examining, explaining and illustrating the issues in this case study (Kitson 2009). The linear and spiral approach (Lewin 1946) was useful in organising data and establishing themes whilst the systems model explains the relationships between the themes (Plesk 2001). The open systems approach used flexibly in this case study, provided an overarching perspective and illuminated the relationship between the organisational, professional and individual systems. The open systems approach did encapsulate the six minor themes and provide an additional system, that of professional, to the common focus on either the organisational or the personal perspective. However, it was apparent that the professional system held the themes of Leadership, and Personal and Professional Development (PPD) because they are not dependant on the organisation but are fundamental to the practice, motivation and

development of an individual practitioner. However despite the recognition and suggested value of the professional system, a full rationale for its significance was necessary.

5.3 Discovering a professional perspective for change in practice.

A review of the literature regarding the relationship between the philosophy, beliefs, values of professional nursing and change in clinical practice found no specific published work in this area. The search was therefore extended to include other disciplines which discovered the work of Dopfer who offered a very interesting perspective to this case as it argues that there is an important and dominant middle-layer in professional practice which holds the components that underpin the quintessentially professional values, beliefs, codes of conduct, moral behaviour and professional regulation (Dopfer 2012). He proposes this fundamentally central area is flanked by the organisational layers and individual professional layer. This middle or meso layer is said to be the backbone and driving factor for professional practice and responsible for individual professionals' behaviour in terms of change and development.

These ideas were used to support the argument for acknowledging that a professional perspective is necessary addition to the existing organisational and individual practitioner perspectives to fully achieve change in professional practice, critically to mental health nursing. Therefore the findings of this case study were constructed within this proposed three part open system model with the justification of the professional system being that it is essential to achieve clinical change for reasons supported by concepts proposed by Dopfer (2012).

This proposal underpins the 'big idea' of this case study in that the integration of health policy is dependant not only on the practical, rather piecemeal, considerations arising from the six minor themes: *resources; policy; personal and professional development; professional leadership; support; motivation and innovation* but also on the conceptual construction of them into three key inter-related systems. In this case, professional system was concerned with leadership and personal and professional development which was greatly underrepresented therefore influencing the successfulness of implementing *Choosing Health* and the WBSP in the Trust. Arguably in other situations the professional system may be sound, and one of the other systems may be compromised thereby needing attention. It is suggested however, that in nursing this is unlikely, as there is little to suggest that this case differs appreciably from other attempts to apply policy recommendations in to clinical practice.

The synthesis of the systems approach with change theory, and values within the professional perspectives provided a construction that was helpful in illustrating the complex issues that emerged in this study in three ways. The first highlighted the distinction between the organisational, professional and individual systems and the existing poor interrelationship between them. Second, this study showed that the professional area is currently neglected, and the model shows how this could be significantly improved through professional guidance and support. The professional area is also deliberately positioned centrally and strategically between the organisation and the individual. This indicates its function as a central mediating component with a facility to filter, interpret, scope and advise on processes between the organisation and the individual. The third reason is that the model presented below (Fig. 6) was designed to illustrate and differs from (Fig. 5) insofar as it suggests conceptually how the professional system can be developed, redesigned and reconstructed to provide a more reliable way of facilitating change in clinical mental health practice.

The extreme top and bottom of the model shows the DH and also the individual practitioner respectively; both relatively isolated, making key autonomous decisions and initiating clinical change. To this end, it is recommended that the construction of a model that accentuates the professional system in the current organisational systems and individual system will provide the missing key element in the successful integration of health policy into clinical practice. The discussions and conclusion that follow will explore the professional value-base necessary for practitioners to engage or disengage with changes in clinical practice set against the more traditional explanations for change. These insights will offer the answer to the research question; *what factors influence the integration of health policy by defining three areas; organisational; professional and individual?*

Hitherto un-chartered territory of the professional organisations' responsibilities in acting as a conduit or catalyst for change means that the gap between the top down and bottom up scenarios will begin to be understood. If involved in a meaningful and strategic way the professional bodies could increase the nurses, and possibly the clinical managers' comprehension, confidence, courage and competencies concerning the extent, implications and responsibilities of new practices that health policy recommendations bring to them. However, it is acknowledged that there could be benefits in locally developed, autonomous and innovative interpretations of Trust or NHS policy. Bellman (2001) and Kitson (2009) propose this type of initiative should only

follow a total comprehension of the policy and its full implications for practitioners and their service users. It should not be the result of lack of policy; under-resourced facilities; poor education or training; little leadership; scant support or ‘making do.

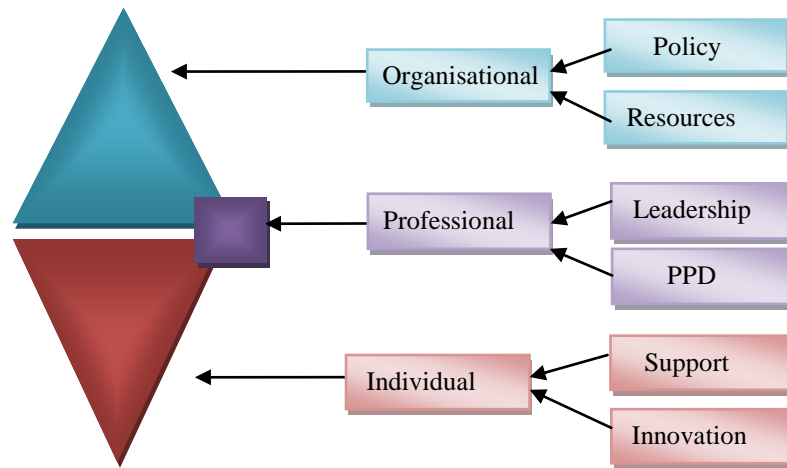


Fig 3.3: The MMM model: Illustrating CURRENT conceptual inter-relationship between the Organisational, Professional and Individual systems involved in change of professional (MHN) Practice

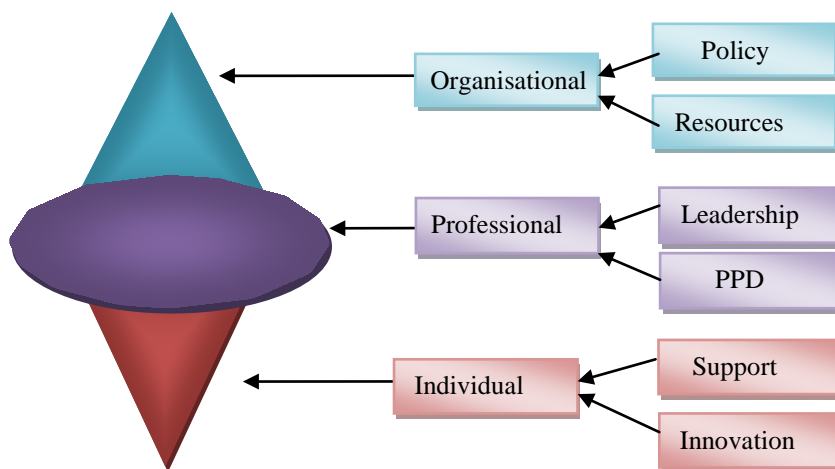


Fig 5.1: The MMM model: Illustrating PROPOSED conceptual inter-relationship between the Organisational, Professional and Individual systems involved in change of professional (MHN) Practice

5.4 The MMM model in context

This three part open systems model consist of parts that will be known as Macro (organisation), Micro (individual) and the fundamentally necessary and hitherto unrepresented part in the context change management, the Meso (professional) part, referred to hereafter as the MMM model (Fig.

5). These titles were selected based on the proposal by Dopfer that the influential professional element which is central to change and development is the meso element. Extending this idea, this study considered it would be appropriate to title the other two areas correspondingly and call the organisational system, the *macro system* and the individual *the micro system*. The three systems in what will now be referred to as the MMM model each contain two of the six themes developed from the data in this case study. A critical discussion will now provide reasons for why each particular theme was allocated to the system in question, and examine the interrelationship between the themes and the systems. One of the main concerns raised by the findings in this case study is the shortfall of professional input into the developing and implementing health policy. However, this phenomenon in itself is significant and, this case study will argue, if the professional leaders had a more explicit and tangible role in the development and implementation of the policy such as *Choosing Health (2006)* policy may have been more effectively integrated into practice.

5.4.1 Organisational MACRO – system

The organisational, or macro, system in this case study was viewed as part of the interrelated system presented before which includes the professional system and the individual system. The organisational system is identified as being managed by the Department of Health and the Trust who had policy and resource influences locally and also have wider or global expectations (Dopfer 2012). The Macro - organisational system provides services based on a balance between policy expectations and varying amounts of resources. *Policy* was assigned to the organisational/macro system because local Trust policy is usually determined by DH directives and recommendations which are passed on to the NHS Trusts to develop local interpretations and deliver outcomes related to the objectives of the health policy. In the Trust the local management of national health policy was the responsibility of senior clinical managers who participated in this study including Assistant Director of Nursing, Senior Pharmacist and Senior Occupational Therapist. Therefore the main purpose of policy in the Trust was the organisation and management of care. However, as seen in the findings of this study, the lack of clarity regarding the Trust's physical health policy and its activities made it difficult for the nurses to fully appreciate and therefore develop their roles and responsibilities in terms of physical health assessment and monitoring.

The lack of initial guidance concerning health policy coupled with no clear procedure resulted in uncertainty among the nurses regarding the expectations placed on them concerning well-being interventions. The outcomes of this dissonance lead them to feeling concerned and uncertain about their levels of competence and confidence in this area. The managers in this study, however, spent a considerable amount of time discussing the shared-care physical health policy between the Trust and primary care; which was proving to be a political minefield. Had the managers been more cognisant of the internal Trust inconsistencies regarding policy and procedures they may have developed clearer and timelier guidance for the WBSP practitioners. The lack of a visible policy and procedure for the WBSP impeded its integration into practice and indicates that health policy should be available and understood by those responsible for its implementation prior to its expedition. Consequently, the lack of clarity concerning roles relating to well-being activities interfered with the nurses' confidence and comprehension vis-à-vis their responsibilities.

This case study advocates that national health policy should always be supported and interpreted by clear local policy and procedure, and the practitioners should fully understand its political and clinical implications. It promotes the idea that all health policy should be accounted for accurately in term of time, clinical environments, equipment and developmental strategies. This would be a departure from the current situation in the NHS which expects change to be absorbed and integrated within existing budgets with an inconsistent approach to professionally and locally interpreted policy. In spite of this rather obvious point, policy led change, such as *Choosing Health*, is often proposed and pursued without recognition and allocation of the associated resources. Furthermore, if so called value for money improvements are not improving at the rate required to bridge the gap between resource funding and demand, then access to and quality of care, are likely to deteriorate as outlined by the Institute for Fiscal Studies (Kelly and Tetlow 2012).

Resources as one of the macro-organisational themes also illustrated huge differences in opinion between the nurses and the managers. The nurses blamed the lack resources as their primary reason for having difficulties implementing the well-being activities and quotes limited time, no available or suitable rooms for examination, no proper clinical equipment and not enough trained WBSP staff. The managers did not attribute the same degree of concern regarding resources and mentioned them rarely, usually in the context of training. The allocation of enough money to staff

one nursing post per Trust was given by the NHS in the initial stages but after two years that funding ceased. Therefore it was apparent to the nurses that there had been little regard for how they would integrate the additional responsibilities and tasks of the WBSP into their practice and possibly assumption that there would be no need for further resources. Unfortunately, if this was the case it gives a message to the nurses of the value and importance of their work and themselves and highlights the problems with a top-down and bottom-up approach where the meeting point between them is tenuous.

5.4.2 Professional MESO system

The issues outlined in the previous section are largely representative of the key themes situated in the meso or professional system which is where the 'rules' of the profession together with its expectations, culture and power by which every health care professional group is bound and regulated. According to Dopfer (2012) the meso system is also responsible for setting the professional 'rules', agenda or accepted boundaries for the change. Therefore the opinion and validation involved using the professionally determined parameters would be more powerful motivators for change than those of the Trust or Department of Health. As this constitutes and expresses a professional culture rather than an overt political agenda, it consequently defines a perspective distinct from that of the Trust or Department of Health. According to Dopfer (2012) expectations of professional behaviour, values and knowledge base are fundamental and in this study they are found within this system. Professional groups and regulatory bodies are expected to engage in a relationship with individual and organisations but ultimately have the responsibility for professional standards, ethical practice and the future of the profession. The most significant themes that emerged this system were *Theme 4 Personal and Professional Development*, and *Theme 5 Professional Leadership in Changing MHN Practice*.

Professional regulation is enacted by bodies such as the NMC (2011) and GMC (2006) who insist on evidence that practitioners have undertaken personal and professional development and demonstrate clinical and professional leadership (Weir-Hughes 2011). The professional expectations are essential for influencing the development and change of practice as it represents the views and approval of its members. However, the lack of discussion concerning these issues by the participants in this study draws attention to the poor representation of their professionally driven motives for integrating the WBSP into practice. Additionally, whilst the NHS has similar

expectations regarding these standards it is not accountable for ensuring they are achieved, nor has the power to remove a practitioner from their professional register.

Collaboration and co-operation between bodies such as the RCN, CNO, NMC and the DH are desirable and beneficial. One example is the increased morbidity and mortality of people with SMI and the WBSP where the NMC (2011), the DH (2006a) and the Chief Nursing Officer's review of MHN (2006b) who all issued their own but nevertheless compatible directives on this matter. This fortuitously unified perspective ensured more success on introducing measures to rectify the situation than previously isolated policy recommendations. However, examples of unified approaches to the development of mental health policy are uncommon as chronicled earlier. Further, although the professional bodies expressed their expectations they did not provide any guidance or support in undertaking the new practices. It may be that leaders of the profession of nursing may have misjudged the extent of the changes necessary to accommodate the new practices involved in assessing and developing strategies for the physical health of people with SMI. If the scenario had been reversed and, for example, nurses on surgical or medical wards were required to undertake a mini-mental state examination (NICE 2006a; Folstien et al 1975) and mental health nursing interventions on all their patients who had a history of mental illness, I would argue it would have probably been received with complete disbelief or absolute refusal from the Adult nurses.

Discrepancies in the competencies of MHNs in relation to the WBSP are partially due to lack of resources, proper guidelines and skills as discussed but also due to inter-professional politics and having a firm grasp of the implications of leadership and change at a personal and organisational level. Generally both the nurses and the managers had refined problem-solving skills and generally coped well with the difficulties in integrating the WBSP. However, the influence of the professional nursing bodies was unacceptably underrepresented in the development of mental health policy translation and this I suggest accounts for some of the difficulties found in integrating the WBSP into clinical mental health nursing practice. These bodies also failed to provide MHNs with the necessary understanding of, and leadership about, relevant health policy associated with clinical practice despite the *Choosing Health* policy recommendations and the serious nature of the high levels of morbidity and mortality rates among people with a SMI in the UK.

In terms of this case study, one assumption was to be that the nurses and less so, the managers, would seek out their professional position related to the implications of their new roles and responsibilities regarding the clinical expectations of the WBSP. However, they did not express any inclination in this regard. The reason for this could be they knew there to be no such support for them based on past experiences or believed a professional rationale and supportive leadership would not be forthcoming unlike that offered by professional bodies such as Royal College of Psychiatrists (RCPsych 2009) or General Medical Council (GMC). Therefore the question is why the bodies that professionally represent MHN such as the RCN and NMC do not offer the same support, advice and leadership as given to our medical colleagues?

Historical factors involved in the development of physical health care for people with SMI are littered with failure for a number of reasons as discussed in earlier chapters of this study. If this is to be addressed, mental health nurses must be fully supported advised and guided by their professional bodies and have professional clinical leadership in health policy matters. If provided, this will offer the means to fully develop the cognitive, emotional, behavioural, ethical, and thereby professional aspects of individual practitioners. This study found that an obvious and deliberate consideration of the professional standpoint would be essential before deciding on the nature of a proposed clinical change.

The Meso system representing professional expectation is responsible for leading change initiatives, with close support and assistance of the organisation at the macro level, and practitioners in the micro level. Nevertheless, it could be worth considering the amount of currently proposed change that fails to be implemented successfully. No doubt, disagreements will emerge between professionals and these will present challenges, not least in reconciling the different paradigms of health, illness and care they recognise. Nevertheless, the dynamic of difference which can describe the creative propulsion which can emerge from conflict, can add to the value of inter-professional ventures and may be worth trying.

5.4.3 Individual MICRO system

This system considers the practitioner's relationship with her/his own beliefs, motivations, needs and vocation that results in the wish to improve, develop, solve problems and integrate improvement and change into practice (Cormack 2004; Smith 2007). In the present study the individual system was concerned with sub-systems developed and used by front-line health care

professionals. It is where the staff and service users interface, where clinical decisions are made, and care and treatment is delivered (Manley 2004). The individual system culture is vital in clinical nursing practice because it provides the means to affect and react to practice and its development through service user opinion, reflexivity and application of evidence (Bevan et al 2008, RCN 2007). It is at this level that nurses implement the systems of the organisation and interpret the recommendations of the professional groups with reference to their own knowledge, skills and values.

The theoretical constructs in this category were support, motivation and innovation which were designated to this system as they represented the personal needs of the mental health nurses in the study. Support systems were seen as lacking from several accounts of the nurses, although the managers did not recognise or acknowledge this shortfall. Some nurses however did note they were supported and also stressed how important this was for them to carry on in a positive and motivated way with WBSP activities. Despite the inconsistencies in getting support both the managers and the nurses were expected to integrate the WBSP into practice despite issues such as poorly presented policy, limited resources, underdeveloped or unsupported leadership and limited longer term personal and professional development. According to Kitson (2009) knowledge translation in terms of research and evidence will bridge the gap between what is known by the researcher and how this knowledge assimilated into practice by research users. If this notion is re-interpreted as WBSP policy recommendations instead of research, perhaps the knowledge translation promoted by Kitson (2009) is imperative to successful understanding of the evidence; and that knowledge translation and transfer is a multidimensional process. It also involves knowledge generators, synthesis of knowledge, implementers of the research recommendations and users of research to make sense of introducing new ideas into existing practice. Graham and Tetrow (2007) propose *knowledge to action* processes that could also be re-interpreted in terms of *policy to action* processes as in this case study. The stages they identify are knowledge translation, transfer exchange, research utilisation, implementation, innovation, dissemination and diffusion (Graham and Tetrow 2007).

5.5 Transferability

It is vitally important to acknowledge that although organisational, professional and individual systems are concerned with the specific issues found in this investigation, the principles of the three systems are transferable to other circumstances similar to those in this study. Further, the six

key themes that emerged from this investigation also not be exactly generalisable to all circumstances or different periods of time in a single process of change but could too have transferable currency. The trustworthiness of findings in this investigation and the subsequent claims of transferability of its findings can be made because the data were analysed in the context of participants' quotes to underpin the meanings of their experiences. It also does so by using a methodology which has been explained systematically and critically in detail to provide steps for replication of this investigation. Therefore the three-system MMM model should be generalisable to other cases that involve the introduction of a policy into clinical (MHN) practice.

5.6 Conclusion

This chapter concluded the interpretations of findings and in doing so, the aim of understanding the affects of health policy and best practice guidance on clinical practice was achieved and the research question of this study *what factors influenced the integration of Choosing Health policy and the WBSP into mental health nursing practice* were addressed. The main findings regarding this research question are the influences of the strategic policy on clinical decision making. However at individual system there is no clear indication that nurses makes a conscious decision to elect to use DH policy initiatives to guide their practice.

A critical interpretation of the findings in this study were undertaken from both the WBSP managers and nurse participants, supported by quotes and interpreted through a range of theoretical perspectives and political positions. This twin perspective of managers and nurse provided an invaluable insight into the factors that impacted on the integration of health policy into MHN practice from a so-called top-down and bottom-up viewpoint. A critical discussion in this chapter explored the organisational, professional, the individual perspectives of these themes. The three perspectives were constructed into a model that exemplifies their concepts and the inter-relationship between them. The data and subsequent findings from the managers and nurses optimised that of the researcher's giving a dual insight into the case study in question by understanding the participants' unique perspectives. The systems in this case study included the managers and the nurses, but within each of these: what were the factors that influenced the implementation of the *Choosing Health* policy and the integration of the WBSP in to the Trust and within those, what were the themes that the participants generated?

This chapter also highlights the findings that the paucity of professional considerations in the suggested category of professionally developed and led change in clinical practice in this case study the physical health of people with a SMI. The historical evidence provided in earlier chapters, shows that previous attempts to implement and sustain changes in practice through health policy through a so called *top-down* or *bottom-up* approach have been ineffective and thereby not fully addressing the reduction of high morbidity and mortality rates of people with a SMI. The shortfalls in this approach were critically discussed and other ways of addressing the problem of effecting clinical change, by adding a professional dimension, were considered. Dopfer's (2012) model provides useful insights into the importance of a professional dimension in relation to organisational and individual elements of change. His proposal concerning the meso-professional system helps to answer the research question of this study by pointing out the fundamental importance of professional values, guidance, advice, rules, and codes of conduct, beliefs systems and values related to changes as a result of the integration of health policy into clinical MHN practice. Dopfer (2012) contends that the potential of professional influence on change in practice is not always given due consideration thereby resulting in change not being fully and satisfactorily achieved. This perspective coupled with the concepts of knowledge translation (Kitson 2009, Graham 2008) explain some of the issues that emerged in this study and included could have been useful in implementing the WBSP in the Trust.

Chapter 6

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

The NHS is a service with extremely visible practices and public expectations of high standards of care, therefore innovation, improvement and high standards are on-going. Nevertheless, the plethora of health policy, guidance and recommendations regarding the precarious health and well-being of people with a SMI over the last twenty five years has done little to decrease the morbidity and mortality issues they experience; indeed there is well documented evidence of an increase in the physical health difficulties they experience. Health policy in the NHS serves to articulate recommendations, expectations and to provide frameworks for their dissemination. Of particular concern is that individual practitioners such as MHN are typically not given sufficient time to acquire an adequate understanding of new health policy recommendations; their implications for practice; the professional issues that may be related to their integration and inevitably the additional roles and responsibilities to practitioners. In other words MHN need to develop the skills and be offered the support through clinical leadership to enable them to translate evidence, policy and research and critically integrate it into their clinical practice. Therefore, it was professionally relevant to me, as a MHN and my profession to explore the reasons why health policy had not improved the physical health outcomes of people with a SMI by asking: *What factors influenced the integration of Choosing Health (2006) and the WBSP at the Trust?*

6.1.1 *Addressing the research question*

This case study set out to identify the factors that influenced the integration of *Choosing Health* (2006) and the WBSP at the Trust: specifically how mental health practitioners and managers of mental health services constructed and operationalised the integration of physical health care into mental health services. Case study design and constructivist grounded theory methodology were used to analyse the impact of health policy recommendations on clinical practice in a NHS Trust concerning the introduction of *Choosing Health: Supporting the physical health needs of people with serious mental illness (Choosing Health)* (DH 2006). The participants in the study were two groups: MHN (n=29) and clinical managers (n=18) who all had responsibilities for implementing *Choosing Health* and the WBSP either strategically or practically and were working in the mental health trust in this study. Data were collected from the reflective accounts of the participants' experiences whilst implementing the *Choosing Health* over a six month period. The results found

six themes common to both groups: *resources; policy and procedure; leadership; personal or professional development; support; motivation and innovation*. These six themes were merged to develop three main systems of an open systems model which represented an **Organisational system**, a **Professional system** and the **Individual Practitioner system**. This overarching framework connected three systems and investigated the relationships between themes and also the shortfalls in representation.

Theoretical concepts focused mainly on concepts of change provided the main theoretical basis for this study, fundamentally that of Lewin (1946); the Open. Systems theory (Plsek 2001) was also helpful in guiding the construction of an inclusive framework; Dopfer (2012) proposals regarding the influence of professional perspectives on change in clinical or professional practice were also highly influential. Findings showed the three inter connecting systems were dominated by the organisational influences and the professional representation and were weak, indicating deficits in the professional influence, both individually and strategically in health policy.

6.1.2 Open systems solution

This study found that the factors that influenced the implementation of the WBSP into the Trust were related to six main areas which were: resources; policy; leadership; professional and personal development; leadership; personal and professional development; support; motivation and innovation. The six themes discovered were common to both the participants' groups; the managers and the nurses but the emphasis and degree of importance between them was quite different. However, if these six themes are simply viewed as a rather piecemeal list of themes there would be a danger of over-simplifying the complexities involved in expecting health policy to change practice in a meaningful and sustainable way. Lewin (1946) proposed that the *whole* is more than just the sum of its parts sum and that the phenomenon of Gestalt (Brownell 2008) should be applied to complex and dynamic systems. Therefore, the research question is also answered in a more strategic way by applying the themes to an open systems approach.

In this case study the aforementioned six themes were the constituents of the three part open systems model consisting of three systems: *professional system* which included policy and resources; the *organisational system* which included personal professional development and leadership; the *individual system* that included personal innovation and motivation, and support. The system with the most significant shortfall, but also arguably the most important is that of the

professional system. Although the organisational and individual systems are important in change as they represent the place and the people who implement change, the unique nature of professional clinical nursing practice means that without a professionally determined beliefs and values base, critically regulated peer lead standards, sound clinical leadership and higher education change in clinical practice is compromised. An individual affected by this epistemology does not simply respond to organisational wishes but makes their own clinical and professional decisions due to the responsibilities they have to their professional awarding and regulatory bodies for their practice. Previously noted deficiencies in this system demonstrated this and lead to the conclusion in this study that additional considerations concerning change in clinical practice could be helpful.

6.2 Professional representation in clinical change expectations

This investigation found that the organisational (*policy & resources*) and individual (*support and personal attributes*) relationships were generally compatible. *Policy* could arguably include provision for support systems for the practitioners when they implement it. Also, *policy* could explicitly encourage and maintain personal attributes such as *innovative practice or motivation* by making provision for locally driven autonomous developments. Equally, sufficient *resources* may provide the opportunity for the time and space for the practitioners to seek *support* from their peers, managers and colleagues which would, as seen in the nurses' quotes to reduce their stress and possible burn-out. The relationship between *resources* and *personal attributes* is somewhat more complex and could have both positive and negative outcomes. Just as *resources* will nearly always be helpful to a situation, *inter-personal skills and attributes* may flourish with extra attention, development or education. Conversely this study found the lack of *resources* seemed to lead to the nurses being more creative, flexible or resourceful to accommodate the shortfall, and may indicate that within certain thresholds resources do not always materially affect outcomes. If you have got just about enough to do the job, then you *can* do it; if you've got a surplus of resources then these may lie idle, or be wasted. However, despite the generation of interesting parallels and connections as a pre-change checklist of features it would have simply resulted in a possibly useful, but rather predictable inventory.

Bellman (2001) and Kitson (2009) propose the type of initiative in this study should only follow a total comprehension of the policy and its full implications for practitioners and their service users. It should not be the result of lack of policy; under-resourced facilities; poor education or training;

little leadership; scant support or 'making do'. Further, the evidence in this study suggests that there must be a greater provision of sufficient fundamental requirements such as resources in terms of time and finances; education and support for practitioners; sound clinical leadership in the translation of the evidence and implications of policy; guidance and support with policy driven change in practice and encouragement of innovative practice among individual practitioners to maintain motivation and reduce burnout.

The prospective planning and accounting for the six areas found in this study comprise the key constituents of successful change from both managers and nurses' perspectives: policy; resources; leadership; professional development opportunities; support and innovative practice. When the key themes are considered as a whole within an open systems model the systems are seen as being represented by the *Professional* (Meso system), the *Organisational* (Macro system), and the *Individual practitioner* (Micro system) perspectives. This study identified that there is currently a shortfall in the essential professional knowledge, skills and attitudes exemplified by leadership, guidance, interpretation and support necessary to influence the integration of health policy (Choosing Health 2006). Therefore the findings from this study suggest that there should a greater emphasis on the clinically and professionally acceptable reasons for change as they have more resonance with the professional groups as opposed to the organisational reasons. Furthermore, organisationally dominant *models of change* currently favoured in the NHS do not take into account the importance of the professional aspects and therefore there is a need for a model that does.

6.2.1 *Current assumptions about change in clinical practice*

Current assumptions that organisational reasons for changes in clinical practice are the most influential are disproved in this study. Therefore, groups representing professionals such as mental health nurses should have a higher profile in advising on and developing health policy, increased involvement in scoping the evidence, and interpreting health policy implications for practitioners. Hitherto un-chartered territory of the professional organisations responsibilities in acting as a conduit or catalyst for change means that the gap between the top down and bottom up scenarios will begin to be understood. If involved in a meaningful and strategic way the professional bodies could increase the nurses, and possibly the clinical managers, comprehension, confidence, courage and competencies concerning the extent, implications and responsibilities of new practices that health policy recommendations bring to them.

The literature shows change theory to be generally generic in its concepts and proposed applications, with no specifically developed relevance to professional situations such as nursing, medicine or others where the professional values and beliefs are so influential to the individual practitioner. Therefore the clear and deliberate consideration of the professional standpoint would be critical in deciding the nature of a proposed clinical change. Professionally lead reasons for change are arguably quite different to those of the organisationally lead reasons and in the case of MHN may be more concerned with rationales such as research or evidence, policy or procedure and professional codes and guidance. Developing the themes further into an open systems models raised the fundamental distinction that accounts for dynamism in the change between systems. Thus, this model can be adapted depending on the context and circumstance regarding the issues relating to Choosing Health (2006) and the WBSP can be useful in future analysis of change or if this case study was reviewed in the future.

The recommendations in relation to this finding is that the application of an open-systems approach such as the MMM model (Fig. 5) results in a change that is professionally successful whilst also developing new concepts and theory. The NHS and the DH could disagree with this analysis as the 'whole is often more than the sum of its parts' and professional influences may not solely account for the totality of work of a NHS Trust. Nevertheless, the influence of the professional bodies representing the values, belief and practices of its members may be considerably underestimated and underutilised in terms of their role in policy translation, guidance, support and advice.

Within the three systems identified in this investigation the significance of the professional meso system was the most important as it is here that the principal drivers for professional change are sited. It is also the area which challenges traditional concepts of a top-down approach and affords the opportunity to develop a new way of thinking about change, particularly in relation to the clinical practice. If this system, which is responsible for setting the professional 'rules', agenda or accepted boundaries for the change was prioritised, it may result in professionally determined parameters, rather than those of the organisation, NHS Trust or DH. In terms of the micro system there were also some important considerations concerning motivation and innovation that relate to the individual practitioner. Recommendations in this regard include the importance of allowing MHN the opportunity to be reflexive, innovative and creative in their practice when introducing or developing new practises.

Harnessing and celebrating innovation and other personal and inter-personal MHN skills that develop the individual MHNs intrinsic leadership, attitudes and values also underpin professional development and clinical change. In terms of the individual MHNs professionalism, maintaining motivation and innovation in practice by being properly supported, supervised and personally developed is crucial. This can be achieved by professional bodies and key nurses facilitating motivational leadership in MHN that supports and develops their profession and encourages the dissemination of good practice. Further, it is important that individual MHN practitioners feel that the clinical teams and managers support initiatives based on policy recommendations; that there is recognition for innovation, good work and achievement and that peers and colleagues have non-judgemental and helpful attitudes towards clinical change.

6.2.2 *The MMM Model of professional change*

The research question in this study is also answered by the additional consideration of the professional system in the context of organisational and provides this currently missing ingredient. The literature shows change theory to be generic in its concepts and proposed applications, with none specifically developed that have relevance to professional situations such as nursing, medicine or others where the professional values and beliefs are so influential to the individual practitioner. This study found that obvious and deliberate considerations of the professional standpoint would be an essential condition for any proposed clinical change. The overall outcome of this interpretation was that the professional perspectives of health policy concerning the WBSP and clinical change have a limited affect on the practice of MHN. However, if the three systems in the MMM model are carefully considered and the key themes identified in the study are managed well when introducing health policy generally, practitioners will be able to translate its recommendations professionally leading potentially to an improvement in service users' care.

The meso system representing the professional issues found in this investigation equates to the rules of the profession together with its expectations, culture, knowledge and powers to which health care professionals are bound and regulated and was identified as the most influential in the development of professional change. Therefore, the views and validation of the professional bodies such as the NMC, RCN for nurses, and GMC, RCPsych is the most decisive factors in driving clinical change. In this study, the two themes within the meso professional system were leadership, and personal and professional development indicating that these areas were the most

professionally important to the participants in this study. Dopfer (2004) proposed that the micro system also found in this study is where individuals carry out 'so-called' rules and expectations of the organisation and the profession and where nurses engaged in the interpretation, integration and execution of professional conduct based on professional expectations. The macro system alternatively represents organisation, in this case the NHS Trust, which in turn represents the DH whose principle function of this part of the open systems model is to provide policy and recommendations that are intended to determine practice within the allocated resources.

Collaboration and co-operation between bodies such as the NMC and the DH is essential but nevertheless a shift in power and emphasis in favour of the professional arenas would be beneficial in engaging nurses in integrated health policy in a meaningful way. Explicit clinical MHN representation in the development of policy at local and national level could provide a meaningful conduit between the DH and day to day practice. An example of this is the introduction of well-being interventions to address the increased morbidity and mortality of people with SMI where the NMC (2007), the DH (2006a) and the CNO's review of MHN (2006b) who issued directives on this matter. This fortuitously unified perspective ensured more success on introducing measures to rectify the situation than previously isolated policy recommendations; however, examples of an explicitly shared approach are uncommon.

6.2.2.1 Translation and formulation

Implicated in the MMM models meso – professional system but also important in its own right is the level of proficiency concerning the accurate and full translation of evidence, such as health policy in this case, but also research and other evidence by MHNs. A clearer understanding by MHNs regarding their role and responsibilities in relation to the WBSP would increase the likelihood of MHNs in the Trust understanding both the professional rationale and practical expectations of them. Further, health policy which necessitates change in professional practice is introduced with such frequency that it is often difficult to review and consolidate implications for practice.

The lack of interpretative and synthesis skills which facilitate the translation and formulation can compromise the assimilation of abstract knowledge, information or skills into clinical practice. In this case that information was the *Choosing Health* policy and the WBSP. As a result MHNs in this study were found to depend on their own or others potentially unreliable interpretations or

incomplete renderings of the many sources of evidence including health policy recommendations and related research which expected them to instigate changes in their clinical practice. This shortfall in nursing leadership, education and training over decades could be responsible for not preparing nurses appropriately to extrapolate key concepts from sources of information such as research or policy directives. This resulted in the loose interpretation and second guessing the meaning of the policy recommendations in question rather than its translation thereby compromising the reliability of the recommendations. Although individual practitioners are accountable for their own professional development including knowledge transfer or clinical formulation, there is also a responsibility on the part of the professional bodies to act on behalf of individual and groups of practitioners. They play a key role in directing research, defining professional roles and offering support and guidance concerning the execution of health policy in a professionally acceptable way as illustrated in this study. In doing this it also offers an approach that fully captures the aspects necessary for change in relation to clinical practice by encouraging professional bodies and nurses to develop effective knowledge translation abilities (Kitson 2009). The overall outcome of this interpretation is that the professional perspectives of health policy concerning the WBSF and clinical change have a limited affect the practice of MHN due to the shortfalls in professional guidance and leadership at a range of different levels.

In my experience, MHNs often struggle with the notion and practise of formulating data such as, clinical assessment data into a conceptual or theoretical framework not fully comprehending, valuing or identifying the outcomes or realising their implications. This results in MHNs depending on possible unreliable interpretations or incomplete renderings of policy led initiatives. This has implications in terms of the responsibilities of a MHN to disseminate good practice to other health care professionals and be engaged in raising awareness confidently throughout the profession, not only in mental health, but also in other fields of nursing and primary care where the needs of people with mental disorders are also met.

An important objective is that nurses develop critical and professional translation skills enabling them to understand and translate policy and recommendations into practice applicable to both current and future situations. It is proposed that this shortfall must be addressed if health policy is to be integrated effectively in to clinical practice in MHN, as it is the professional values, beliefs, codes of conduct and culture that determines the ways professional practice. The recommendation in this respect is that education and training programmes go beyond the teachings of the last 30

years in terms of *the nursing process* to include the more sophisticated skills of *knowledge translation and formulation* necessary for contemporary 21st century MHN. Further, that qualified nurses are encouraged to understand the clinical and professional contextual application of policy (and research) via peer group and MDT action learning sets; clinical supervision; critical incident reviews and on-going personal and professional opportunities. These activities will support MHN in developing skills in the translation of relevant policy, guidance and research into practice and ensures correct application in the clinical context.

To illustrate these points the figures below (Fig. 3.3 and Fig. 5.1) show the existing and the proposed differences conceptually if the suggested changes were integrated.

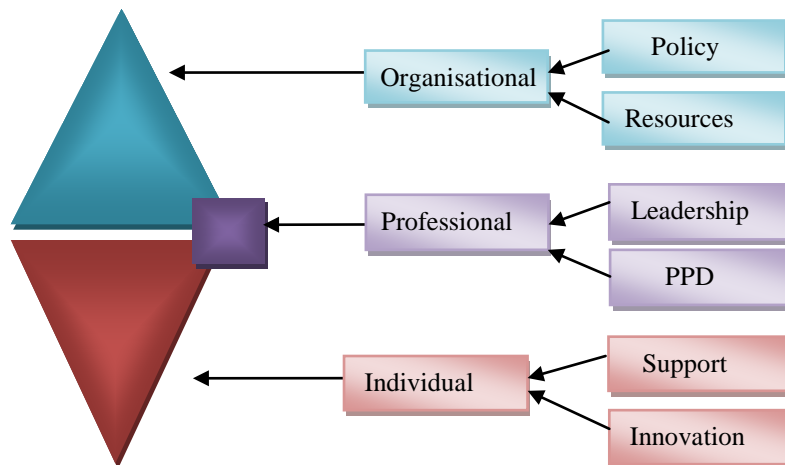


Fig 3.3: The MMM model: Illustrating CURRENT conceptual inter-relationship between the Organisational, Professional and Individual systems involved in change of professional (MHN) Practice

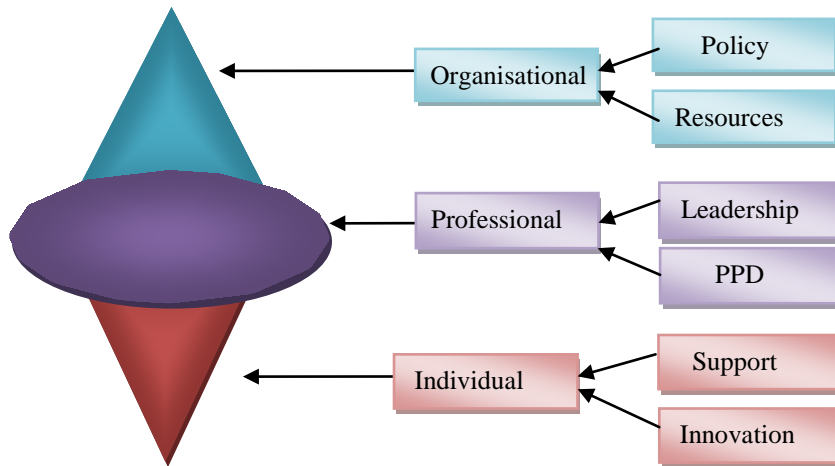


Fig 5.1: The MMM model: Illustrating PROPOSED conceptual inter-relationship between the Organisational, Professional and Individual systems involved in change of professional (MHN) Practice

6.3 Testing theory through dissemination

The concepts espoused in this study concerning professional responsibilities have hopefully made a clear case for consideration as is the purpose of a case study. However, I felt it was necessary to test the ideas to prove to myself that they had purpose and value to the body of knowledge in this field. To achieve this I undertook three activities which were a presentation of my findings at the 4th International Conference, of Health and Wellbeing, Chicago, USA in March 2012 where I presented the initial findings of this study. I also presented a paper concerning the findings, implications and recommendations to the RCN International Psychiatric Nurses Conference, Keeble College, Oxford in November 2012 and negotiated a secondment as a consultant nurse to a mental health Early Interventions Service (EIS). The intention of these activities was to ‘test my theory’ of the shortfalls in professional leadership at a range of different levels in the organisation and the professional groups that represent MHNs, with a critical audience. It was a challenging and risky endeavour but I knew I would not feel satisfied or confident until they were undertaken. The outcomes of this challenge were very rewarding and each one provided me with a new confidence about my findings and conclusions. As a direct outcome of the RCN conference the chief nursing officer for Mental Health at the RCN has suggested the findings and conclusions of this study would usefully contribute to an RCN initiative concerning professional practice. The International conference in the USA has forged networking links internationally and significantly to the ‘Chicago School’, the birthplace of grounded theory. Probably most important was my

clinical work in the EIS as a clinical nurse consultant specifically associated with physical health and wellbeing. This service provided the assessment and care for individuals aged between 16-35 years who are experiencing their first onset of a psychotic disorder. The services users were often young, vulnerable and in crisis so it was challenging to engage and sustain therapeutic relationships with. However, the physical health aspects of their lives were very important to them and despite their often chaotic lifestyle they were keen to stay healthy. Here, I worked with the manager, the inter-professional team and the service user in a flexible and collaborative way, offering insights from this study to improve delivery and management of physical health care by offering leadership in supporting the translation of the *Choosing Health* policy and the Trusts physical health policy into their particular clinical context.

6.4 Limitations

The limitations of this study can be viewed from methodological and professional perspectives. Methodological limitations included the NRES recommendations regarding the data collection methodology of interviews which had to be reviewed due to the committee's concerns about possible coercion of participants. Consequently, these limitations changed the original data collection methodologies from a direct invitation to participants, and resulted in an informal alternative being developed that involved a broad and informal invitation. The second limitation, but also an opportunity, was that I was not a member of staff at the Trust in question which made it necessary for me to work quickly to appreciate the culture and methods of the organisation, the politics and power issues involved at both strategic and grassroots levels. However, the objectivity I brought, together with me having no particular allegiances or personal motivation or responsibility to anyone was liberating and permitted me to research in an unhindered way. Further limitations of the study are the usual caveats regarding the mobility of findings and conclusions in qualitative research. In this case, efforts were made to improve the transferability of the research findings by continuing with theoretical saturation beyond establishing the six initial minor themes and by adopting an open systems model to offer fundamental considerations that were removed for the particular situation-the case-and into the generic application of the principles in the MMM model.

6.5 Contribution to knowledge

Changes and developments in practice must be fundamentally and profoundly influenced by the core determinants of the profession it relates to because this will appeal to and influence the

professional group. In practical terms I would recommend the following be available in order to support the effective knowledge translation of policy into clinical MHN practice. The contribution that this study made to the body of knowledge has included the generation of new understanding demonstrated with respect to the following areas.

6.5.1 *Professional contribution to knowledge*

The main contribution to knowledge was the findings indicating that traditional, organisational models of change are inadequate in representing the type of experience found in professional or clinical settings by health professionals. The contribution this study made to the body of knowledge included generating new understanding of change and identified that when change is to be related to clinical work, it needs to be reconstructed to include the missing professional element. The open systems approach in this study developed a model that represented the overarching professional perspectives of change regarding the integration of health policy recommendations into clinical MHN practice. This model was constructed from three tiers of influence which were related to the organisational, the professional and the individual components of professional change.

6.5.2 *Clinical contribution to knowledge*

The clinical contribution to knowledge this study offers is fundamentally concerned with how the findings can ultimately improve MHNs ownership and understanding of health policy via their professional representation leading to greater standard of quality care due to a consistent and unambiguous approach to implementing health policy across the UK. Further, a collaborative approach to health policy will provide realistic and achievable outcomes resulting in better care for MH service users.

6.5.3 *Methodological contribution to knowledge*

6.5.3.1. Case study and health policy

A case study design investigates the impact of a national health policy on the clinical practice of MHNs a single Trust. The implications regarding the professional influence in changes in practice due to health policy can be added to the growing body of knowledge on this subject. Exworthy (2012) proposes that the accumulative knowledge from developing case study evidence base is the best way to implement policy into practice. A systematic review of the literature reveals that currently no other studies using this combination of elements to answer the research question this

study asks. Similarly, a systematic review of the literature reveals that currently no other studies were discovered that has this combination of elements to reach the aims and answer the research questions in this study or any other perspective of MHN.

6.5.3.2 Peer-group reflections as a means to facilitate data collection.

The use of critical reflection in professional practice is becoming increasingly popular across the health professions as a way of ensuring on-going scrutiny and improved concrete practice - skills transferable across a variety of settings in the health, social care and social work fields. This familiarity provided a comfortable and informal milieu for the participants to be forthcoming about their experiences (Rolfe 2001). The recent advice from the Chief Nursing Officer Ms Cummings suggests that *courage* should be one of the so-called 6 C's and I would argue that critical and supportive reflective practice in research would afford the nursing profession with the courage to challenge problems in practice and address the shortfalls.

6.5.3.3 The use of a case study design, CGT methodology framed by Change theory and Open Systems theory and literature

The synthesis of these theories and methodologies was an innovative approach to the investigation a MHN issue concerning the integration of health policy into clinical practice. In addition the study also provided an analysis of MH policy UK and its integration into clinical practice. This contribution led to providing an understanding of the level of effectiveness of health policy in changing practice. It also offers a new perspective on the issues that this investigation found to be imperative to implementing change successfully in MHN practice.

6.5.3.3.1 Peer-group reflections as a means to facilitate data collection

The use of peer-group reflections as a means to facilitate data collection provided an opportunity for MHNs to critically reflect on their experiences improved the quality of the data in terms of the participants formulating it during their narrative rather than simply asked questions. Critical reflection provided by this study is increasingly popular across the health professions as a way of ensuring effective health policy led change in practice is rarely used as a means of formulating stories told by research participants in case studies.. Using a reflective approach created familiarity a comfortable and informal milieu for the participants which encourages them to be forthcoming about their experiences (Webber and Nathan 2010; White et al 2006).

6.5.3.3.2 *The modification of Lewin's model of change*

This novel approach led to the development of two additional categories. Lewin refers to two factors essential for motivation of change, namely a, what helps and b, what hinders change. Although this investigation found these factors in the data, when these were extrapolated a large amount of data remained. Therefore, these two extra categories were used to support and add dimension to the original helping factors and hindering factors, namely increasing helping factors and reduced hindering factors.

6.5.4 *Historical analysis of Mental Health care provision*

The provision of an original historical analysis of Mental Health within a wider health policy in the UK context between 1942 and 2011 provided insights into the level of general effectiveness of health policy in changing clinical and MHN practice.

6.6 Post Script Reflection

In the beginning of this study I noted that as a registered mental health nurse and educator my fundamental role is that of facilitating, encouraging and enabling change and motivating people to reach their potential. My belief that individuals can achieve emotional, educational and intellectual fulfilment still holds true, and guides my practice. At the time of sharing that sentiment I had not anticipated or realised that five years later it would be applicable to me despite now, on reflection, it being fairly obvious. Nevertheless, it describes my journey through the construction of this study and its eventual conclusion. Someone told me once the two rules to undertaking a doctorate are to 'start it' and 'finish it'. At the time I was amused by this 'joke', now I recognize it is far from being funny and the message in it has been raised in my consciousness at times of distress and hopelessness. The 'risky step into the unknown' that I described five years ago in relation to others, I now see was also a hidden message to me and with the help, support and empathy of those who took the time to care 'it' has been started and finished.

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APPENDICES

Appendix 1

Outsider Replication and Verification

Training Handbook

Reliability and Validity

Ed.D. Dissertation

Outsider replication

HANDBOOK

**Guidance training notes and tests for outsider
replication and validation**

Pat Allen

January 2009

Outsider Replication and Verification' training handbook

This research identified the shortfalls in the deductive approach which originally used an idea that explain the forces which maintain the status quo in any given situation, namely the helping and hindering forces (Lewin 1951). Within the categories described it was not the intention to explore what factors underlie the text i.e. what is said and what was not said but to categorisation of the factors that were responsible for maintaining the status quo in this particular situation. To understand these sub-categories that describe what *increased* the drivers and *reduced* the restraints were created by the researcher. These too were complimentary and matching pairs of concepts to each other and to the original two factors. They would provide the category by which the data relating to the real management of change can be explored.

Outsider Replication and Verification

As a qualitative study, this investigation was aware of the criticisms made concerning reliability and validity. Hierarchy of levels of evidence produced with RCT's usually taking first and second place in the listing; followed by experimental studies, non-experimental studies and lastly opinion based on clinical experience or descriptive studies (Holm 2000, Madjar and Walton 2001). Proving reliability and validity such as that applied to randomised control trial (RCT) for instance, is not appropriate in research such as constructivist grounded theory per se. Nevertheless, this study made a point of discussing issues concerning reliability and validity in an on-going way throughout the study, and in particular in the design and methodology sections of this chapter. As a result, possible reliability and validity issues relating to sample, data collection, and data analysis were considered and rebutted within the methodological discussions.

One area in this study however that did require the provision of a reasonable degree of critical argument was that concerning the adaptation the original work of Lewin through the development of the two extra categories to the existing *helping* and *hindering* factors of a. *what can improve the helping factors* and b. *what can reduce the hindering factors*. *Insider verification* is a method that requires the data and those involved in the study checked its understanding repeatedly. This approach was not appropriate for this study because I was the only researcher. *Outsider replication and verification* however was appropriate to test the two newly developed categories had not been used in the field before this study. As such it provided the means to check that the interpretation of the participants' quotes that I made using the four categories were reasonably accurate and from researcher bias. The testing involved for the introduction of a '*significant disinterested colleague*' (SDC) to examine the data 'blind' and comparisons made with my critical decisions regarding categorisations (Barton-Cunningham 1993 in Morton-Cooper 2000). This process was undertaken and resulted in some amendments and improvements being made to the category descriptors and an insight into the importance of quotes being read in the context of the reflection. However, as new tools they had to be examined for reliability and validity and this is how it was done.

Reliability – the criteria for the success of reliability but absolute reliability would be impossible in true CGT due to the unique and specific to context nature of the study. In fact the exact qualities of a CGT studies are its individualistic nature and nuances. Therefore a more sensitive approach to the participant's engagement, the projects collaborative and co-operative nature is themselves the measures of reliability and cultural validity (Morton-Cooper).

Having said that there may be parts of the project that can be tested in parts for validity and one of these is the accuracy of the data collection even if it is just one observer. *Insider verification* requires the data and its understanding to be checked repeatedly by those involved in the study. *Outsider replication* alternatively asks for the introduction of a 'significant disinterested colleague' (SDC) to examine the data and decide if they agree or not with the findings. It is the latter of these that was used in this project. A colleague with a background in mental health and higher education was recruited and instructed in to the role of examination or moderating the data.

Following supervision advice, a sample of 4 paragraphs, with one from each of the categories, was selected from each of the five nurses' reflective groups and six managers' reflective groups' transcripts. This produced 44 paragraphs that exemplified the categories in question. These were transferred to plain text throughout and the SDC was asked to read them and categorise them herself using the prepared criteria which were used by the researcher originally.

However, in order to provide adequate preparation the SDC was given a training exercise to familiarise herself with the type of transcripts used, the categories and the criteria for allocation into the four different groups. A set of 12 paragraphs containing 3 from each of the 4 categories were presented to the SDC and compared with and mapped against the criteria. These paragraphs were overtly coded into the 4 categories as explained before. The reasons for why each was put into the different categories were explained in detail and there was the opportunity for the SDC to ask questions and check any queries. Following this exercise the SDC was presented with an experimental set of 8 plain text paragraphs that were 2 from each category. When she had completed this it was discussed and reviewed with any further questions or checks being undertaken.

Once the training had been completed the SDC was given the 44 paragraphs and asked to allocate them into one of the 4 categories of driving, resisting, and increased driving and reduced resisting forces. These were then checked against the original coding for correlation.

Force – Field Analysis

According to Lewin (1956) things are held in a status quo due to opposing helping or driving forces and hindering or restraining forces. If you wish to change the status quo by introducing a change or innovation, you have to increase the helping forces and diminish the hindering factors. This will weaken one side of the force-field and strengthen the other, so there will be a natural movement towards the change proposed. Clearly this can work in the

opposite way and if the hindrances are stronger than the helping forces and the change will not be implemented.

Its often show as so –What I want to analyse from the transcripts of the focus groups are the events or comments the participants describe as being positive/helping/driving forces; negative/hindering/restraining forces.

However, I also want to look for factors they describe that improved/ assisted/ enhanced the positive forces and also the things that they say diminished the negative forces. There is clearly a fine line between these so judgement has to be used and a certain amount of personal interpretation. This is alright as it's unavoidable but I have drawn up a set of criteria that can help and guide together with a few examples to illustrate the criteria. However, it may not be possible for an exact match, and this is OK.

1. Driving Forces
 2. Factors that improve or enhance the driving forces
- AND
3. Restraining Forces
 4. Factors that reduced the restraining forces.

Taxonomy of Force-Field Analysis Forces

1. Driving Forces eg the positive factors that assist, help, improve, benefit, encourage or aid situations, resources, people, attitudes, opportunities etc that were positive/helping/driving forces which assisted the goals being achieved . These can also include having training, time, being allowed to pursue an initiative, being given advice or support. They can also be the individual's personal drive, positive attitude, tenacity and creativeness and good problem solving skills

2. Factors that improve or enhance the driving forces. Eg the things that added to the driving or helping forces which are positive things by improving/enhancing/ amplifying/ heightening/ intensifying or increasing them. Things that develop further an already existing good practice or idea so it makes it even better than before. These can include actions of the person or their attitude to something or an increase in knowledge. It could also be if the person sought support or supervision for them to improve how they do things.

2. Restraining Forces. These negative factors that hold back, interfere with, hinder, block, restrain, and constrain events or goals being achieved or changes being made. These can be a lack of the areas identified in the driving forces being available or being withdrawn. These can also include not having training, lack of time, not being allowed to pursue an initiative, not having advice or support. They can also be the individual's lack of personal drive, negative attitude or lack of tenacity and creativeness to solve problems.

4. Factors that decrease restraining forces eg the things that the person has done or have just happened that have decreased or diminished the strength of the negative restraining factors. They may be planned or by chance or coincidence but have had a beneficial effect

on reducing or inhibiting the powerfulness of the hindering forces. These can include being creative about resolving a block or issue that is interfering with progress or an ingenious way around an immovable problem to weaken its impact. These factors can be personal characteristics of the person or what they actually do to resolve issues.

KEY

- . **Driving forces – bold**
- . *What improved the driving forces – italic*
- . Restraining forces – underlined
- . **WHAT REDUCED THE RESTRAINING FORCES – CAPITALS**

Stage 1

A transcript

FOCUS GROUP 01.07.08

Hello everyone, thanks for coming. I'm glad to see so many of you today. Who would like to start with some feedback about progress with the WBSP?

WSBP In-patient 20: I will begin, when was it we did the training, about six weeks ago wasn't it?

That's about right.

WSBP In-patient 20: Six weeks ago. We've been implementing the well being assessments on the ward, we've started the groups more than anything else just initially like the well-being group and healthy eating and things like that.

WSBP In-patient 21: Obviously we give them a lot of information but if she keeps it we can't sort of follow it, *I mean although she's the designated well being nurse she's also asking other people and seeing if they were interested and they wanted to do something, but I don't know if they are prepared to do it. It's hard work.*

WSBP In-patient 20: It's very hard work!

WSBP In-patient 21: *This is why UNCLEAR 03:51 if we just do activities and just keep giving them information somebody will think "oh yes, I need to..." and then we could work at it round that way rather than approaching them just well-being.*

WSBP Lead Nurse: Yes. Just generally, have you all got access to the map that Karen put together, a list? You've all got that have you?

Yes.

WSBP Lead Nurse: So that you know where people are.

WSBP In-patient 20: How do you get access to a code word or a password?

WSBP Lead Nurse: Good question. You've not got yours yet?

WSBP Community 22: No

WSBP Lead Nurse: How long ago did you do the training?

WSBP Community 22: It must have been about March or April.

WSBP Lead Nurse: RIGHT. IF ANYBODY, BECAUSE I THINK THERE'S A COUPLE OF YOU AT THE MOMENT HERE, CAN YOU EMAIL ME WITH YOUR NAMES AND WHEN YOU DID THE TRAINING AND I'LL GET ON TO LILLY BECAUSE THEY GET THE PASSWORDS.

WSBP Lead Nurse: YES, TRY THAT BUT IF YOU DON'T HAVE ANY LUCK GET BACK TO ME AND I'LL SORT IT OUT MY END.

WSBP Community 22: There IS A HELPLINE THERE ISN'T THERE?

THERE'S A HELPLINE THERE SORT OF HELP OUT WELL-BEING SUPPORT.ORG .UK IF YOU HAVE ANY QUESTIONS REGARDING ACCESSING THE WELL-BEING SUPPORT AUDIT TOOL.

WSBP Community 22: IT'S REALLY GOOD, IT'S REALLY, REALLY YOU KNOW, IT'S VERY HELPFUL

Researcher : I suppose we could put those details in the minutes couldn't we and then you could keep....

WSBP Community 22: Yes that's a good idea.

WSBP Lead Nurse: Yes, in case you get stuck.

WSBP Community 22: That ticket you have....

WSBP Community 23: I've got a little card.

WSBP Lead Nurse: Yes, that's got the number, same number.

WSBP Community 22: I'm covering the Assertive Outreach team and I'm doing the programme well-being programme. OBVIOUSLY IT'S NOT GOT OFF THE GROUND QUITE AS YET BUT THERE'S A LITTLE, I DO ANXIETY, RELAXATION MANAGEMENT WITH SOME CLIENTS, BUT I'M ALSO INTRODUCING THE WELL-BEING HEALTHY EATING, YOU KNOW, CAFFEINE, ALL THIS SO, BUT THEY'RE NOT WITH US VERY LONG. Some of them are just a few days and some of them they are on leave from the ward, and then they're off again so not everyone's really engaged, but there's a few of them that are, so that's all I've really done at the moment. It's very slow.

WSBP Lead Nurse: *But I think that's important isn't it, you know, different people ready to engage with it at different stages of their recovery, you know, so some people will engage with it on the ward, some people when they get back home maybe, you know.*

WSBP Community 22: *At least the start's there isn't it, you know, and leaflets have been given out, but it's helpful coming to these groups because then you pick up ideas, what people have been saying, and you take it back and implement your own programme, so I find it really helpful coming.*

WSBP Lead Nurse: **I think that's where the Audit Tool's actually quite helpful for when patients on leave are having different services we can all tap in to the Audit Tool at some stage and pick up where the last person left off.**

WSBP Community 22: *That's right, yes. So now I heard someone say about care plans, I think I should do a shared care plan and put it in their notes. I only designed it yesterday so it will work, because it will be like a, it's a tighter regime then isn't it.*

WSBP Community 21: ***It's a good idea, I'll start to do that now. At least it's going somewhere.***

Researcher : *I think you just keep chipping away at it, you know.*

WSBP Lead Nurse: *And it's fine to be run the way it works with your team.*

WSBP Community 22: *That's a learning process as well, you know, I mean I think that you learn what you need to know when you do the training but then the real learning starts like within the training and adapt it to, and I think that's why, you know, the training doesn't sort of, it's not too directed about 'you need to do it like this or like that' because I think it's different, so it's gradually building up a programme.*

WSBP Lead Nurse: Yes. Good. Thanks for that.

WSBP Community 21: We've got kind of the age old problem of time and levels of staffing and things like that, SO WHAT WE'VE INTRODUCED IS JUST DOING WELL-BEING CHECKS WHEN PEOPLE COME FOR DEPOT CLINICS, SO I GO AROUND

TARGETING THE PEOPLE THAT ARE ON INJECTIONS. IT'S AT LEAST A START, AND WE'VE KIND OF CREATED OUR OWN LITTLE SHEET WITH ALL THOSE LINE OBSERVATIONS THAT WE NEED TO TAKE because we've only got 20 minutes to kind of squeeze an injection and all the checks in at the same time, but IT SEEMS TO BE WORKING QUITE WELL AND THE IDEA IS WITH MORE STAFF WE CAN THEN TRY AND REACH OTHER PEOPLE WITH THAT, BUT WE'VE ALSO GOT A WELL-BEING GROUP STARTING AT THE END OF THE MONTH SO WE'RE KEEPING OUR FINGERS CROSSED FOR THAT. AND EVEN NOW JUST HAVING A LEAFLET STAND IN THE WAITING AREA, WHICH WE NEVER HAD BEFORE, WHICH IS GOOD, YOU SEE PEOPLE COMING UP FOR THEIR APPOINTMENTS WITH LEAFLETS IN THEIR HANDS SO PEOPLE ARE LOOKING AT THAT. IT'S A SMALL START BUT IT'S BETTER THAN NOTHING.

Researcher : It starts small doesn't it?

WSBP Community 22: Yes, and again it's, unfortunately we've not put any of the information on to the Audit Tool so it's just there on our paper form and on ebax really but...

WSBP Lead Nurse: Ok. And is that about time again?

WSBP Community 22: Yes.

WSBP Lead Nurse: Is that something that you see could change? You know, is that about staffing levels, vacancies?

WSBP Community 22: Yes, a lot of posts are frozen at the moment so we've got two on maternity, we're two social workers down, we have no OT at the moment, and we're a small team anyway so...

WSBP Lead Nurse: YES, YOU'RE NOT A HUGE TEAM ARE YOU? SO YOU'RE DOING WELL TO DO WHAT YOU'RE DOING REALLY, YES, AND I THINK IN SOME WAYS JUST GETTING THOSE BASELINE CHECKS IS SORT OF LIKE THE, IF YOU CAN'T DO ANYTHING ELSE, THAT'S THE IMPORTANT THING TO DO ISN'T IT, AND YOU'RE TARGETING THE CLIENTS AND THOSE THAT ARE AT RISK ASWELL.

WSBP Community 22: WE HAVE PICKED UP A FEW PEOPLE, SO IT'S GOOD.

WSBP Lead Nurse: Excellent.

WSBP In-pt 23: We've turned a corner today.

WSBP Lead Nurse: Did you?

WSBP In-pt 23: **We're supernumerary today. We've actually merged our own little clinic on the ward** and although we're supernumerary, we're supernumerary on the day that we've got the link meeting so the time constraint is still there in as much as we couldn't really do much until after sort of med, but we did the exercise group in the garden, which was good, we've got sit down exercises and standing exercises and then we're able to, well I did the standing exercises, someone stands and everyone else sits! But then we were able to use the other consultation rooms and we did a consultation this morning with a follow-up appointment and input stuff on the Audit Tool, although we couldn't get the follow-up on the Audit Tool because of the timing, but it's....

WSBP In-pt 24: BUT THEY CAN ASK I THINK IF THAT SUPERNUMERY DAY CAN ACTUALLY BE ON A DAY OTHER THAN ON A MEETING DAY BECAUSE IT JUST LIMITS YOU TO TWO HOURS REALLY AND IT'S NOT ENOUGH TIME.

WSBP Lead Nurse: What ward are you on?

WSBP In-pt 23: AW ward.

WSBP Lead Nurse: AW ward, so you've got the travelling time as well haven't you?

WSBP In-pt 23: Yes. We have got 11.30, but it's, it will work. It would work.

WSBP Lead Nurse: Has anybody else got that as an issue?

WSBP In-pt 22: Well it will be an issue when I've started on it. It's trying to fit everything in isn't it.

WSBP Lead Nurse: Yes. Because sometimes it's about sort of thinking about how you use the time, you know, and if it's, because if you're supernumerary for a day does it, well I suppose it does have to be on the same day to cover the shift doesn't it? Do they get somebody to replace you? If I remember rightly yes. Makes it more complicated doesn't it? Whereas if you've got protected time you can sort of space it over a number of days, you know, and that could be more effective but if you've actually got somebody replacing you for a shift that sort of hits you a bit more doesn't it? Ok. Yes I mean just negotiate that wad for time.

WSBP In-pt 22: BUT AGAIN I KNOW THAT WE TRIED A FEW MONTHS AGO. YOU STARTED IT I THINK DIDN'T YOU J? YOU KNOW WE DO THE PHYSICAL HEALTH CHECKS, WHICH IS REALLY SOMETHING WE SHOULD DO ANYWAY, AND I'VE GOT TO SAY THIS BECAUSE I BET YOU'LL GET CROSS ABOUT ME BUT EVERY SINGLE WEEK FOR EVERY SINGLE PATIENT WE HAVE WEIGHT, BLOOD PRESSURE, BMI AND THEN AT LEAST WE CAN KEEP A CHECK ON IT AND SEE IF THERE'S ANY CHANGES.

WBSP Lead Nurse: But it is very fundamental isn't it, and I know it's something we've talked about...

WBSP In-pt 22: I'm sorry but if you're seeing someone then it should be done anyway.

Researcher : Yes. It's interesting isn't it that it's sort of been, because I think in your area it's been linked with the WBSP and with new ways of working hasn't it? Interesting. I don't know. It is new ways of working but in somebody it's old ways of working as well. It's important to link it to something that's current isn't it.

WBSP In-pt 22: I THINK THAT THE PROGRAMME HAS RAISED THE PROFILE OF PHYSICAL HEALTH CARE WITHOUT A DOUBT.

All: Yes.

WBSP In-pt 23: And I think certainly with the issues with weight and what have you for people with serious mental illnesses because I think historically people with longer term mental illness we haven't done a lot about it anyway to their general health, and I'll be honest with you, we haven't, and I think that needed to be highlighted with the possibility.

Researcher: *And it's changing a little bit at a time isn't it?*

WBSP In-pt 22: *Yes, because I think people felt oh poor things "they like their food" and, you know, that's not necessarily the best thing.*

WBSP In-pt 23: *'What else have they got?' sort of attitude, yes.*

All: Yes.

WBSP In-pt 22: *And of course the newer drugs have more of an effect on weight don't they than the older drugs so in a way that's what's caused us to look at it but...*

WBSP Lead Nurse: Ok, so you've said you were doing groups, I didn't catch the groups you said you were doing.

WBSP In-pt 22: *Standing group. It's an exercise group. We've got a standing exercise group and sitting, because sometimes we've got quite older patients and they can't lift their legs behind their ears! So we'll do sit down exercises; An exercise clinic.*

WBSP Lead Nurse: Ok, well let us know how it goes with the time. It will be interesting to see. I mean I think you're right, *there is something about the mentality of embedding it in every day practice as well and that there's sort of an innate tension isn't there between on the one hand wanting to do that and on the other hand having the protected time which sorts of makes it something different, but it's about maybe using that time to think about how you*

can change that thinking as well as actually delivering the service to the clients. Ok. We've got some really good work going on. We're still to feed back. WBSP In-pt 24: ?

WBSP In-pt 24: : **Well we've got exercise groups going on and it's sort of like every Thursday and then one night a week it's either games or something in the garden. We have a breakfast group so people come down to breakfast which isn't that successful, well it's successful in that it gets people up but not the people it's actually aimed for, because we've got some very difficult diabetics on our wing at the moment who are not complying at all and they're the ones that are giving us the problem.**

WBSP Lead Nurse: Right. What sort of problems are you having?

WBSP In-pt 24 : Well one's been a diabetic since she was a child and she's not 37 but she doesn't accept that she's a diabetic so she refuses her insulin some days, and other days she'll eat and eat and eat and it doesn't matter how much we sit down and talk to her and explain everything she's adamant that there's nothing wrong. I'm a diabetic and I know my body and her favourite saying is "well it's Saturday and I can do what I like on a Saturday because it doesn't affect me on a Saturday".

Researcher: Is that wrapped up with delusional thinking or is it more about her cognitive functioning do you think?

WBSP In-pt 24 : I think it's cognitive more than...

WBSP Lead Nurse: Right, yes.

WBSP In-pt 24 : It's really hard isn't it? And the other diabetic just does what she likes. I mean I've had well-being, healthy lives groups with her and everything and she takes it all on board but then just merrily goes on and does what she wants.

WBSP In-pt 22 : Passive non-compliance that's called isn't it.

WBSP In-pt 24 : BUT WE'VE GOT THE RESOURCE ROOM AND WE'VE GOT ALL THE INFORMATION OUT AND EVERYTHING THERE SO.

WBSP Lead Nurse So there's a few groups that are going.

Yes.

WBSP In-pt 24 : **We have a discussion group every Tuesday and we're trying to make every other Tuesday something around well-being, now they're realising, so one Tuesday they choose the subject and the next week we sort of choose it and that way it's good.**

WBSP Lead Nurse Yes.

WBSP In-pt 24 : With somebody who's like that, I mean again you're sort of going back to like people who don't want to give up smoking isn't it? You can't force it, you know, I THINK IT'S JUST ONE OF THOSE THINGS YOU HAVE TO CHIP AWAY OVER TIME.

WBSP Lead Nurse Yes.

WBSP In-pt 24 : But I mean the diabetic that has been a diabetic, she's quite worrying really because before she was admitted she had the ambulance people break down her door 20 times when she was in a coma, so, in less than a year, and she's quite dangerous but you just can't...

WBSP Lead Nurse What did she say about that?

WBSP In-pt 24 : "Well I know what I'm doing. I understand my diabetes." And then she said "Well I really don't know why it's gone like that".

WBSP Lead Nurse Yes so it's cognitive isn't it, you know, something she's not making a connection with.

WBSP In-pt 24 : She can't understand that if you don't take your insulin and you eat it's going to go high and if you take your insulin and don't eat you're going to go high, she can't seem to relate the two, but I mean she's on insulin 4 times a day but you're lucky if you get her to take it twice. And I guess really if you think about yourself, if you bleed like yourself then you wouldn't want to inject yourself 4 times a day would you?

WBSP Lead Nurse No.

WBSP Lead Nurse: You absolutely wouldn't would you, no. That's a difficult one. It would be interesting to do like a little case study solution because I'm sure there's a solution in there somewhere it's just finding it, and that takes time.

WBSP In-pt 24 : Yes, and I did spend quite a bit of time with her trying to work out...

WBSP Lead Nurse Yes.

WBSP In-pt 24 : But she doesn't like the idea of being a diabetic and having injections

WBSP Lead Nurse: No. Has the psychologist made any suggestions? Because I worked with a guy around substance misuse a few years ago and he had some cognitive difficulties and one of the things I found quite useful was the psychology reports that had been done on him. He'd had lots of assessments done and it was around his sort of, he'd had an IQ test and various other tests and there was all sorts of suggestions as to the sort of things that might help him to learn, because he had sort of reached a point, his diagnosis was schizophrenia

but because of the cognitive that had occurred it brought him to the borderline range of intelligence and he'd got specific difficulties and there were really sort of useful prompters and visual aids were really critical to helping him to learn, because sometimes you know we all try and explain things verbally but if somebody is more damaged in that way there are other areas of helping them to sort of remember things. It's often helpful, but yes that might be a way to just sort of think about it. It just sort of highlights doesn't it, you know, how sort of well-intentioned we are, whatever we do in our work there's always going to be somebody who's needs are a bit more complex than that aren't there, and particularly your clients, you know, some of them are quite damaged aren't they.

WBSP In-pt 24 Yes.

Researcher: And especially because she's had so many comas she might have quite a frank learning disability.

WBSP Lead Nurse: She might do yes. That's true.

WBSP In-pt 24 It changes the complexion of things altogether doesn't it?

WBSP Lead Nurse: Yes, and of course altering blood levels affects your cognitive functions as well so she's probably got several factors impacting on how she's able to take things on board or not.

WBSP In-pt 24 Yes.

Lilly rep: Does she let you take her blood test ok?

WBSP In-pt 24 : We take it.

Lilly rep: She lets you take it?

WBSP In-pt 24 : Yes. Well, sometimes, sometimes she doesn't and she won't let you at all and she's adamant, it doesn't matter how you approach it.

WBSP Lead Nurse: Which is remembering what Pat was saying, I was thinking if it did show up that there was some sort of frank learning disability it might be worth speaking to somebody from the learning disabilities service because I think, I'm trying to think who's, I think DW has done the well-being training. She manages the AIS, but I think she's done the training but if she hasn't I'm sure there's a couple on there that have done it so they must have similar problems and it might be worth, has she come to any of these meetings do you know? Has anybody been aware of her coming? Anybody from AIS coming here?

No.

WBSP Lead Nurse: *Right. Well I'll go back and have a look at the map because I'm sure there's a couple of them that have done the training, and we'll see if we can get them along. They are often useful people to have around. I know Debbie quite well so I'll email her and see what she says.*

We were saying that, obviously not getting too despondent, we were at a conference weren't we a couple of weeks ago and there was a chap there who was an endocrinologist who was quite human wasn't he?

All: He was.

Researcher: *You could understand what he was talking about, and he was saying that you know you might have overweight, you know, a problem with obesity, a problem with diabetes, a problem with maybe high blood pressure and something else, and he said even if you can just sort of solve one of the problems the rest kind of diminish respectively quite quickly, so even if you weren't kind of getting on top of the diabetes which I know is key, if you do those other things even reducing those ones it can manager. I think the message was if you can reduce the weight or the blood pressure or whatever, the others will get respectively quite a lot less of an issue.*

WBSP In-pt 24 *Because they interact with each other.*

Researcher: *Yes, and sort of trigger each other off.*

WBSP Lead Nurse: *Yes, and I think the message they were saying very much was small changes, big effect, in sort of the long haul. So that's why it's important, you know, those of you that are saying "oh we're not doing much, we're only doing this" you know, even if what you're doing feels quite small it's going to be important.*

WBSP In-pt 24 *Well when we started the swimming group we had one client that went an now I think there's only one client that doesn't go, because even if they go swimming, half of them go off and walk round Mote Park while the other half are swimming so at least they're getting exercise.*

WBSP Lead Nurse: *And it's a social even as well isn't it.*

WBSP In-pt 24 *It is isn't it?*

WBSP Lead Nurse: *A reason to get up, get out, something to look forward to, something different from the daily structure. Yes, it ticks so many boxes doesn't it, sort of activities. Again good work, good work, but you know, the client group is getter better but you know we're going to see more difficulties but you know but as the researcher very rightly highlighted just to see the small changes one of the areas can have a big impact, so yes keep up the good work. No, I will talk to DW and see if we can get her on the learning disabilities*

because it might useful just to get one to talk about how they work with their clients as well generally, tell us what they do, because they have these sorts of issues don't they with people who sort of can't understand or take things on board as easily as perhaps other people might be able to. Ok.

WBSP In-pt 25 Last.....

WBSP Lead Nurse: But not least!

WBSP In-pt 25 : I started by, when we were at the meeting we do their blood pressure and weight and so on, and we've been doing that regularly, but our patients don't stay with us for very long. We only keep them while they are acutely ill, so we do tend to discharge them after a while, BUT LATELY WHAT I HAVE DONE IS I HAVE BEEN TALKING TO THEM ABOUT THEIR DIET, KEEP IT SIMPLE, because when they come to the ward they just have their food, eating anything, and their visitors would come in with all sorts, chocolates and biscuits and everything and they are left in their bedroom and it's melting in this weather but they will still eat it. We have got a patient there who has got maybe 12 snickers in her bag and she will have the whole lot at night.

Researcher: She binges.

WBSP In-pt 25 YES, SO WE'VE BEEN TRYING TO KEEP THE FOOD AWAY FROM HER REALLY BECAUSE I HAVE BEEN TALKING TO THE HUSBAND ABOUT BRINGING FOOD IN, AND ALSO LAST WEEK I STARTED TO SET UP A DAY ON A TUESDAY TO HAVE 4 OR 5 PEOPLE I WOULD HAVE A CHAT WITH THEM AND TALK TO THEM ABOUT THEIR DIET AND THEIR WEIGHT AND EXERCISE. WE'VE BEEN TAKING THEM TO THE PARK, ONE A WEEK, AND THEN WE'VE BEEN TAKING THEM STRAWBERRY PICKING AS WELL AND WE'VE BEEN MAKING JAMS FOR THE OT. WHAT I WOULD LIKE, I DO PRESCRIBING AS WELL, YOU SEE I'M TIED TO MEMORY CLINIC, SO WHAT I WAS GOING TO ASK YOU LEAD NURSE AM I, IS IT ALRIGHT IF I GIVE THEM LEAFLETS WHEN THEY COME TO SEE ME?

WBSP Lead Nurse: Yes.

WBSP In-pt 25 : Where I work with older adults who have cognitive and organic problems and it's not just inpatients it's out patients too. I wasn't sure so I didn't do it last week and I've got a clinic Friday so when they come to me I could talk to them about that and give them out. I've got loads and loads of leaflets.

WBSP Lead Nurse: Yes, I mean if that's part of your role then I would say go ahead. It's just information isn't it?

WBSP In-pt 25 Yes it is. So my main worry is that when I finished the training here I was sort of “oh I’m going to do this, I’m going to do that at work” and I took everything on board and I went to work and I saw my, this is all confidential isn’t it?

WBSP Lead Nurse: Yes it is, absolutely

WBSP In-pt 25 : So I went in to work and I told my manager what I wanted to do but I didn’t have any response from that. She didn’t say “it’s a good thing. It’s a bad thing” she just said that I can’t be running two clinics because I run the other clinic and I can’t be running two clinics, so I went to the clinical services manager and I said “I’ve done this now, I can’t let it stay I’ve got to take it further” and he said to me “you can’t be doing all this”, you know, but I want to do all this and he said to me “start small” and that’s what I want, I’m small and make it big, but I don’t think I’m having the support I would like really. I feel like I am working on my own.

WBSP Lead Nurse: Why did your manager send you if they weren’t going to support you?

WBSP In-pt 25 : My manager sent me because she didn’t know herself what it was all about. So she sent me to find out what this is all about. She did say one thing that what I’ve learnt we do anyway but we don’t do all of it, we do the blood pressure and temperature when they come in but we never used to speak to them about their diet, we just let them eat whatever they fancy, BUT NOW I HAVE PUT A STOP TO THAT NOW AND SAY “NO, THIS IS WHAT WE EAT, THIS IS WHAT WE HAVE TO DO”, AND IT’S SO DIFFICULT WHEN YOU DON’T GET THE SUPPORT.

WBSP In-pt 22: I THINK SOMETIMES WE NEED TO HELP OUR MANAGERS TO UNDERSTAND WHAT IT IS THAT WE’RE TRYING TO DO BECAUSE THEY, RIGHTLY OR WRONGLY, BEING MANAGERS THEY DON’T HAVE ACCESS TO THE CLINICAL TRAINING OR THEY DON’T HAVE TIME TO DO THE PEOPLE TRAINING THAT WE DO AND THEY RELY ON US TO SORT OF INFORM THEM. I DO.

WBSP Led Nurse: Yes you do obviously. Yes some people do and some people don’t. I think it does vary but I think you’re the exception rather than the rule but it’s....

Researcher: Because it’s managing the change isn’t it, what we did about before, you know, a lot of people who have started off have got that bit of a bump before they got into the group properly, so I think a lot of people will feel, not obviously, but feel a bit threatened by the change and they see it as a potential criticism of what’s going on at the moment, and it’s kind of inevitable but I don’t know whether you can actually change that but realising that it’s just a stage of the process and that will move along once they get more accustomed to it, but it’s potentially quite threatening.

WBSP Lead Nurse: AND I THINK TO PRESENT THE WELL-BEING TO THEM AS POSITIVE IN ADDITION TO WHAT WE'RE DOING AT THE MOMENT RATHER THAN 'WE DON'T DO THIS AND WE DON'T DO THAT' SAY "WELL WE COULD DO THIS AS WELL AS WHAT WE'RE DOING". UNCLEAR 33:38.

WBSP Lead Nurse: **BECAUSE I THINK THE FACT THAT SOME OF THE THINGS THAT ARE HAPPENING ALREADY IS GOOD AND I THINK IT'S SORT OF AS YOU WERE SAYING IT'S MORE ABOUT SAYING "WELL THAT'S GREAT, WE'RE DOING THAT ALREADY AND THEREFORE WE'VE GOT A HEAD START ACTUALLY, AND THAT'S GOING TO HELP US BUILD ON IT". IT'S ABOUT THE WAY YOU TALK ABOUT IT SOMETIMES I THINK, BUT AGAIN WHAT THE RESEARCHER WAS SAYING IT TAKES TIME AND SOME PEOPLE, PEOPLE ARE PEOPLE WHETHER THEY'RE MANAGERS OR WHATEVER THEY ARE, SOME PEOPLE ADAPT MORE QUICKLY TO SOME CHANGES THAN OTHERS AND I THINK OTHER PEOPLE TAKE LONGER TO PROCESS IT ALL.**

WBSP In-pt 25 : **BUT THAT'S WHY IT'S IMPORTANT FOR ME TO COME HERE TO GET THAT SUPPORT.**

WBSP Lead nurse: Yes.

WBSP In-pt 25 Even though I came in at 9 o' clock this morning UNCLEAR 34:32

WBSP Lead Nurse: You were so desperate for the support!

WBSP In-pt 25: So I came here at 9 o' clock this morning and now it's 12 o' clock, but I saw a few people so it's alright. So we've done 3 hours working.

WBSP In-pt 25 : **BUT THERE ARE 2 OTHERS WHO HAVE DONE THIS PROGRAMME ON MY WARD SO WHEN SHE COMES BACK OFF HOLIDAY WE WILL BE WORKING TOGETHER AND I REALLY WOULD LIKE TO GET THIS STARTED AND GET SOMETHING OUT OF IT.**

WBSP Lead Nurse: Yes. I mean one of the things that really struck me about when RG the speaker at the recent conference, one of the arguments that he made was about risk assessments and about when we do risk assessments we think about suicide, we think about harm to yourself, harm to others, you know, potential self neglect and what harm might come from that, we don't necessarily automatically think of physical well-being, but physical problems particularly from cardiovascular disease are the biggest killer of our hearts related to their medication. More of them will die of cardiovascular disease than will die from suicide.

WBSP In-pt 25: By a long way.

WBSP In-pt 25 **I won't give up.**

WBSP Lead Nurse: That's depressed everybody now hasn't it me saying about the years hasn't it? Yes, but I mean most people don't fall into that category, it's quite rare but just, I WBSP Lead Nurse: BY A LONG, LONG WAY, YOU KNOW, AND IT'S ABOUT GETTING PEOPLE TO UNDERSTAND THAT YES WE'RE A MENTAL HEALTH ORGANISATION BUT BECAUSE OF THE TREATMENTS WE GIVE PEOPLE AND BECAUSE OF THE ILLNESSES THAT THEY HAVE THEY ARE AT FAR HIGHER RISK OF PHYSICAL DISEASES THAN PERHAPS OTHER PEOPLE MIGHT BE SO THAT IS PART OF THE MENTAL HEALTH ISSUE. IT'S SOMETHING THAT WE NEED TO BE TAKING ON BOARD, BUT IT WILL TAKE TIME TO GRADUALLY GET THAT SHIFTING THINKING TO GET THAT MESSAGE ACROSS. THESE THINGS DON'T, I ALWAYS REMEMBER SOMEBODY COMING AND DOING A TALK ON CHANGE WHEN I WAS A CPN AND SAYING YOU'LL GET, YOU KNOW, YOU GET YOUR INNOVATORS, YOU GET YOUR EARLY ADAPTORS, YOU TAKE BITS OF IDEAS AND YOU TAKE THEM BACK AND RUN WITH THEM, AND THERE'S SORT OF ALL THESE RANGE OF PEOPLE THAT TAKE THEM, THERE'S VARIED TIMES, AND THE LAGGARDS TAKE 5 YEARS, SO YOU KNOW, PEOPLE TAKE A VERY DIFFERENT AMOUNT OF TIME TO ADAPT TO CHANGE SO IT'S JUST ABOUT BEING AWARE OF THAT REALLY AND JUST SORT OF PLUGGING AWAY AT IT I THINK.

think it's like with the clients, you know, ***SOMETIMES WHAT YOU NEED TO LOOK FOR IS INSTEAD OF INSTANT CHANGE YOU NEED TO LOOK FOR SMALL CHANGES OVER TIME WHICH AMOUNT TO A BIG CHANGE.***

All: Yes.

Researcher: I THINK IF YOU CAN LATCH IT ONTO SOMETHING THAT'S EXISTING AND NOT THREATENING, SO SAY SOMETHING LIKE THE CPA WHICH REQUIRE US TO LOOK AT PHYSICAL HEALTH AS WELL AS MENTAL HEALTH AND SOCIAL ISSUES, YOU CAN SAY WELL, YOU KNOW, IT'S NOTHING REALLY THAT FABULOUS, IT'S WHAT WE SHOULD BE DOING AND SHOULD HAVE BEEN DOING FOR THE LAST 25 YEARS SO IT'S ONLY KIND OF UPPING THE ANTE ON THAT ELEMENT OF WHAT'S CUSTOM AND PRACTICE, AND THEY COULD SAY OH WELL MAYBE IT'S NOT SO BAD AFTER ALL, AND ESPECIALLY IF YOU'RE IN ACUTE ADMISSIONS YOU CAN DO THAT WHEN YOU'RE DOING THE CPA DISCHARGE PLAN AND ALL THAT KIND OF, OR IF YOU'RE DOING THE CPA REVIEWS YOU COULD, SOME PEOPLE IN THESE MEETINGS HAVE BEEN TUCKING IT IN THERE NOT WANTING TO BE TOO SECRETIVE ABOUT IT OR NEEDING TO BE SECRETIVE ABOUT IT BUT JUST SORT OF TUCKING IT IN SO THAT PEOPLE WILL JUST THINK 'OH THAT'S PART OF WHAT WE DO. NO BIG DEAL'.

WBSP Lead Nurse: ***AND YOU KNOW, IF YOU WERE DOING IT, OF YOU WERE MODELLING IT THEN PEOPLE WILL SEE THE BENEFITS. NOTHING, IN MY EXPERIENCE IT'S BETTER WITH JUST GETTING ON AND DOING IT SO THAT PEOPLE CAN SEE WHAT IT IS THAT YOU'RE TALKING ABOUT, YOU KNOW, AND IT SORT OF SPEAKS FOR ITSELF THEN.***

All: Yes.

WBSP Lead Nurse: Ok. That's everybody fed back. Is there anything else we need to talk about?

Researcher: Can I just ask a quick couple of questions?

All: Yes.

Researcher: I was just wondering what kind of things help you make your work in this line of work successful? What are the things that help you make it a reality or implement it?

WBSP In-pt 22: *The backing of the team. That's what I think first and foremost really, and your managers.*

WBSP In-pt 23: *Manager and the team and your consultant really as well, because I as the manager I actually spoke to our consultant because our clients don't stay in our work very long because we sort of do crisis and they're under the crisis team then, and he's quite happy to back me up to do, like I was saying to WBSP Lead Nurse because we've been doing this creative capability team with the new ways of working and he's been part of it because we've been piloting, so he's quite on board as to what we're doing so the back up of the consultant does help really, and the manager and the team like you said earlier so we've actually really got a good team so we've started quite nicely.*

WBSP In-pt 20: *I think it's really recognition and what you want and all of that, especially from the managers, and others of course.*

Researcher: Recognition that it's kind of valuable?

WBSP In-pt 20: *Valuable. Things like relaxation and anxiety management, and now it's accepted, at first when I first started it was just "oh do your thing with them" but they now realised it was more than that and there's paperwork and evaluation forms and it was like "oh, so this is a programme then? Oh yes!" and it goes on, so it's a bit like slowly developing.*

Researcher: Evolution. Revolution.

WBSP In-pt 21: *I think it's getting more people on the training as well because I've only been with ES ward for six months and I'd come from somewhere that does a lot of physical*

well-being checks and gone to ES ward and there was nothing at all, but there's someone else who's now been on the training who has come back and enthusiastic about "oh yes let's do this and let's do that" and I'm like "at least I'm not on my own then", I've got someone else and there's two people on the training next week as well so it's getting people on board more and to be enthusiastic. I think the training does make you think about things and you do go back to your workplace and think "oh well actually yes we need to be doing this", and I did a lot of work with my own patients but I'm asserted outreach so I have the time to be able to do that and I'll go out and I'll take the BP machine on home visits and things like that and it's only, I think other people see me doing that and they are like "oh, we can do that as well" rather than it has to be done in a clinic. It doesn't have to be done in a clinic.

WBSP Community 24: *Yes so it's the custom and practice and the way it's presented. Some of the things that we had on the well-being training, statistics etc, we use some of that information to present the well-being programme to the staff with handouts so that everybody is aware and to sort of show it in a positive light which helped.*

WBSP Lead Nurse: *Because that's quite scary information isn't it when you see it.*

WBSP Community 24: *Yes and you realise the importance of the well-being programme then rather than "oh we've got additional work to do, we've got to do the weights regularly" but to have shoed the importance meant that you're going to want to do that anyway. I think that did help. Definitely. Because some of it's quite scary, at this same conference you know the information about how soon somebody with schizophrenia might die compared with other people has been sort of banded around about sort of 10 years hasn't it, quite a while, but the recent stuff is saying more like 15-20 years younger, which is horrible.*

WBSP In-pt 21: *It's like a quarter of the life span isn't it?*

Researcher: *Yes, and I think that might have been a bit conservative as well.*

Researcher: What do you think gets in your way of implementing it? What kind of hinders you?

WBSP Community 24: Time.

Researcher: *So is it the time to do the checks or time to input the information, or time to sort of prepare yourselves?*

WBSP In-pt 21: We found it's been the time for us to get together and actually prepare the way and organise ourselves and know what we're going to do. We're still not really there. I mean this is the first time we've actually been worked together since we did the training I think and the conference, and that I think is what I have found aggravating.

WBSP In-pt 22: BECAUSE WHEN IT'S YOUR WARD OR YOU'RE ON A WARD OF YOUR OWN YOU DO FEEL ON YOUR OWN, AND SO IT'S BEEN MORE DIFFICULT, BUT NOW WE'VE GOT SUPERNUMERY AS WELL THAT'S MADE A HUGE DIFFERENCE I THINK, WE'VE GOT THE WHOLE ROOM SET UP FOR CLINIC, WE HAVE LEAFLETS, AND WE DO ALL THE WEIGHTS FOR THE WHOLE WARD WE DO ALL THE WEIGHTS AND BP'S ETC THE SAME TIME AS THE MEDICATION AND THEN WE DO THE EXERCISE GROUP TOGETHER AND DOING CONSULTATIONS.

WBSP in-pt 21: We're doing the exercises and things separately because we've never actually got together to plan anything. We still haven't planned a lot have we?

WBSP Community 24: No, I'm booking a tasting....

WBSP In-pt 22: Yes, and a few odd things that we might be able to do realistically.

WBSP In-pt 26 : This morning I was doing some work and they roped me in to do a report for a health tribunal, I mean....

WBSP In-pt 22: Yes, you're never supernumery.

WBSP In-pt 26: Yes, so that's a couple of issues I have, so I'm trying to give it to somebody else.

Researcher: How do you get around that sort of, because I've heard this from other people in the same sort of role as you, so how do you get around that or how do other people get around that?

WBSP In-pt 26: WELL WE'RE SPECIALIST, LIKE I WAS SAYING TO WBSP LEAD NURSE, GETTING PROTECTED TIME AFTER WE'VE DONE THIS PILOT THING, LAST WEEK I SORT OF SAID TO ONE OF OUR NURSES SO SHE SHUT HERSELF AWAY IN THE SECRETARY'S OFFICE BECAUSE AGAIN IN THE MAIN OFFICE YOU'VE GOT COMPUTERS BUT THERE'S SO MUCH HAPPENING LIKE YOU'VE GOT ADMISSIONS COMING IN, YOU'VE GOT DISCHARGES, THERE'S SO MANY THINGS HAPPENING IN THE ACUTE WARD SO SHE IF SHE SHUTS HERSELF THEN SHE FINDS THAT VERY USEFUL. IF SHE SHUTS HERSELF IN THE SECRETARY'S OFFICE SHE MANAGES TO DO QUITE A LOT WITHOUT DISTURBANCE, AND WE MADE SURE WE DIDN'T CALL HER. SO I THINK AT THE END OF THE DAY YOU NEED TO BE A BIT MORE PROACTIVE AND A BIT MORE SORT OF BOUNDERING AND DON'T COME OUT BECAUSE YOU'VE GOT ENOUGH STAFF ON THE WARD TO DEAL WITH A DISTURBANCE OR ANYTHING SO WE DON'T NEED HER. THAT'S HOW WE'VE STARTED WORKING.

Researcher: But it makes a difference because you're the manager, on other units, you know...

Researcher: So was your time supernumerary?

WBSP In-pt 26: Yes.

Researcher: So how are you going to get around that then, what are you going to do?

WBSP In-pt 26: WELL WE'LL MAKE CERTAIN BOUNDARIES AND REMINDING THEM THAT I'M NOT HERE TO DO THAT.

BECAUSE IT'S SOMETHING LIKE THESE LADIES WERE SAYING ABOUT VALUING WHAT YOU'RE DOING AS WELL, YOU KNOW, THAT'S NOT AS IMPORTANT AS WHAT I WANT YOU TO DO SO DO WHAT I WANT YOU TO DO FIRST THEN IT'S NOT QUITE, SO SOMEHOW THE VALUE THEN NEEDS TO GO UP DOESN'T IT IN THEIR VIEW. Did that used to happen to you, because you were in an acute admissions ward weren't you?

Researcher: So that's been about what, six months?

WBSP In-pt 26: About five months, but we found the Audit Tools the thing we're not having time for. We've only just now got a computer in another room so we can input now, but before we only had the one computer so I had to do it as and when I found the time. Yes, it's involving the team aswell, then you're not constrained to doing everything yourself.

WBSP Lead Nurse: WELL IF EVER ANYBODY WANTS TO COME HERE IF YOU RING UP YOU CAN USUALLY USE A COMPUTER HERE AS WELL IF YOU NEED TO GET OFF YOUR UNIT AND THERE ISN'T ANYWHERE FOR YOU TO GO.

Researcher: Yes, sometimes they're like little libraries. Is there one in A Block medical libraries and things like that.

WBSP In-pt 22: Yes there are varied resources.

Researcher: What about in the rehab, what has helped you, and what gets in the way?

WBSP In-pt 22: What gets in the way is people's attitude. It's not seen as that important.

Researcher: So how have you got around that?

WBSP In-pt 22: BY SETTING UP DIFFERENT ROOMS AND THAT, AND BY PEOPLE SEEING THAT OH THEY'RE ACTUALLY ENJOYING THE GROUPS AND THEY'RE ACTUALLY DOING MORE NOW THAN THEY USED TO, BUT WE HAD ONE CLIENT THAT NEVER EVER GOT UP BEFORE ONE O' CLOCK AND NOW HE'S UP

BY HALF PAST NINE EVERY DAY AND IT'S JUST THROUGH WORKING ON THEM.

Researcher: So THE STAFF HAVE SEEN THE RESULTS OF IT?

WBSP In-pt 22: YES, A SLOW COMING ROUND, BUT THEY STILL CAN'T SEE THE REAL IMPORTANT LIKE IF THERE'S SOMETHING GOING ON THE UNIT YOU SHOULD BE DOING THAT BEFORE YOU DO YOUR WELL-BEING, BUT IT'S NOT THE MANAGER BECAUSE HE'S VERY GOOD. NO, HE'S VERY SUPPORTIVE.

WBSP Community 26: I've found the GP's to be a little difficult as well. I've written letters about people's blood pressures and, you know, something needs to be done, these are the results of the last 4 readings, and yet nothing seems to be happening.

WBSP Lead Nurse: THERE'S A CASE AT THE STEERING GROUP FOR THE WELL-BEING PROJECT ARE CURRENTLY DEVELOPING A PROTOCOL FOR HOW THE PRIMARY CARE AND THE MENTAL HEALTH SERVICES INTER-RELATE SO IF YOU DO PICK SOMETHING UP HOW YOU CAN REFER, AND IF, YOU KNOW, BASED ON WHERE THE PATIENT WANTS TO GO AS WELL, YOU KNOW, WHERE THEY STAY, AND BECAUSE THERE ARE GP RESPONSIBILITIES AND THEY DO GET PAID FOR THOSE BUT I DON'T KNOW HOW YOU'RE GOING TO GET AROUND IT. HAVE YOU GOT ANY IDEAS?

WBSP Community 26: Well, just keep pestering them! You know, we were picking up on these things but then nothing's been done about it, but it's pretty high blood pressure and it's consistently high, it's not just a one off reading. I even put the evidence there in black and white for them and yet still nothing's happened.

Researcher: IF YOU WENT BACK THROUGH THE, YOU'VE PROBABLY DONE THIS ANYWAY BUT, GO BACK THROUGH THE MDT AND THEN GET THE CONSULTANT TO WRITE TO THEM, BECAUSE SOMETIMES YOU HAVE TO BE MORE, IT SHOULDN'T BE THAT WAY, BUT SOMETIMES THEY LISTEN DON'T THEY IF IT'S DOCTOR TO DOCTOR, AND INTEGRATE IT INTO THE CPA, YOU KNOW, PART OF THE DOCTOR'S ROLE IS THE...

Yes, UNCLEAR 51:41

Researcher: But we are working on that but it is a very tricky one.

WBSP In-pt 22: It is. I'm just wondering, do you think the blood pressure, have you got a sense of, you may not have, why the blood pressure's high? Is it to do with weight gain or...

WBSP Community 26: Yes, they have gained quite a lot of weight gain. I asked for all her bloods to be taken, cholesterol, fasting, the full works because I was quite concerned that

maybe she was getting a bit diabetic, and she was having memory lapses and sometimes came across as quite slurry and quite lethargic one minute and then quite active the next, which again I have kind of requested them and it's the patient that's come back and said everything's fine. There's very poor communication between GP and psychiatrist I feel, which again is an issue with the blood department, and the results, and the relationship really.

WBSP Lead Nurse: AND THAT'S SOMETHING THAT I HAD A DISCUSSION WITH LM ABOUT, AND AGAIN IT WAS TALKED ABOUT AT THE WELL-BEING CLINIC THAT THEY HAVE TRIED TO MAKE SURE THAT THERE WERE STAFF WITHIN OUR TRUST THAT CAN ACCESS BLOOD RESULTS ELECTRONICALLY BECAUSE IT HAPPENS, GP'S CAN, IT HAPPENS IN GP'S SURGERIES, THEY HAVE AUTOMATIC ACCESS AND I THINK WE'VE BEEN TOLD THAT WE'RE GOING TO HAVE ABOUT 20 PEOPLE WITHIN OUR ORGANISATION WHO WILL BE GIVEN ACCESS, BUT IT'S BEING NEGOTIATED AT THE MOMENT.

Researcher: Sorry, can you not request that the results be sent to the GP and you?

WBSP Community 26: We do, but it's quite difficult when you phone up requesting results, there's just barriers there all the time.

Researcher: WOULD THE GP MIND IF YOU SORT OF KNOCKED ON HIS DOOR AND SAID 'CAN I TALK ABOUT THOSE RESULTS?'

WBSP Community 26: THAT'S PROBABLY WHAT WE'RE GOING TO HAVE TO DO I THINK, TO MAKE AN APPOINTMENT FOR MYSELF TO GO ALONG WITH THE CLIENT.

Researcher: Yes, because it does sound like there could be some diabetic problems there, couldn't there.

WBSP Community 26: Yes, and I'm quite concerned about it.

Researcher: Yes, she's quite at risk then isn't she? Like if it was a suicide, like the Led Nurse was saying if it was a suicide risk then it would be a different ballgame altogether, but because the risk is 5 years or 10 years down the road it's not being....

WBSP Community 26: She's 19 stone and just only about 5' so her BMI is....

Researcher: Yes. My goodness. Yes a very high risk isn't it. How old is she?

WBSP Community 26: Early 50s.

Researcher: Is she taking an A typical anti-psychotic drug?

WBSP Community 26: Yes.

Researcher: BUT TECHNICALLY SPEAKING; THE REASON I ASKED ABOUT THE WEIGHT AND THE BLOOD PRESSURE WAS TECHNICALLY SPEAKING, WELL LEGALLY SPEAKING, THE PERSON THAT PRESCRIBES THE DRUG THAT CAUSES THE SIDE EFFECT IS RESPONSIBLE FOR THE SIDE EFFECT. SO IF IT'S YOUR DOCTOR OR YOUR CONSULTANT THAT'S DOING THE PRESCRIBING, LEGALLY IF SOMETHING HAPPENED TO HER THEY WOULD BE HELD RESPONSIBLE SO IT'S WORTH PERHAPS JUST GETTING THEM INVOLVED IN ACTUALLY TRYING TO GET IT SORTED OUT AS WELL.

Researcher: Because we had quite a long discussion about this, and I'm not going to go on and on about it but they were saying that if it was say a person who had a cardiac problem and didn't have any mental illness or some sort of other health problem and the GP referred then to the cardiologist or the endocrinologist or whoever it was then the GP will assume that that team would sort that out and then it would only really come back to them when it's been sorted out, and I think that's the GP's kind of view and expectation of that sort of thing isn't it?

Yes.

Researcher: That they're not the experts in that field and that's why they've referred them, so it could be a case that they're sitting on it and they're thinking that something's being done at our end, and they don't necessarily understand the increased risk that our patients are at either, where as we assume that as GP's they would, but they don't, they don't always understand that. Yes, so put your suit on and go and knock on the GP's door!

Yes, it's just quite concerning that nobody seems to be doing anything.

Researcher: IT IS CONCERNING, IT IS, AND IT SHOWS HOW IMPORTANT IT IS THAT YOU'RE DOING THESE CHECKS, YOU KNOW THAT YOU'RE HIGHLIGHTING IT AND THAT YOU'RE ON IT NOW, YOU KNOW, WHICH IS GOOD BECAUSE IF YOU HADN'T HAVE DONE THAT NOBODY WOULD BE WOULD THEY. DID THAT ANSWER YOUR QUESTION?

Yes, thank you very much.

Researcher: Did anybody else have anything else they wanted to talk about or bring up; any questions or comments or anything?

WBSP Lead Nurse: All you want to get away and get your lunch now because we didn't provide one! Oh well thanks for coming. I'll put a few brief minutes together just to cover what we've talked about really.

KEY:

DRIVING FORCES – BOLD

WHAT IMPROVED THE DRIVING FORCES – ITALIC

RESTRAINING FORCES – UNDERLINED

WHAT REDUCED THE RESTRAINING FORCES - CAPS

Stage 2 Experimental test
(8 paragraphs plain text – find the category)

WBSP 13 – In-pt : And for the patients as well.....I mean the carers think....what the carers say to me I just feel so unsafe on the ward, and we are just managing safety a lot of the time depending on what patients you've got, so I mean just the changing from one thing to another and trying to get your head focused very quickly, its really quite stressful.

So it is happening but its just its exhausting because you've got all this pressure and your head just wants to explode at some point, but I will keep doing it, but I don't know how Vanessa's going to find it because whether she'll still get that protected day or whether it will be seen as, you know, you just do it as you can

WBSP 12 – In-pt : And I went in and he's not eating and like we're really really worried about him, but I managed to find out that he'll eat cheese sandwiches, and that in itself is like a really big thing to find out, isn't it?

WBSP Lead Nurse: But I think that's important isn't it, you know, different people ready to engage with it at different stages of their recovery, you know, so some people will engage with it on the ward, some people when they get back home maybe, you know.

WBSP 7 COMMUNITY: MOST OF OUR VISITS ARE ALONE UNLESS SOMEBODY IS FLAGGED UP AS BEING POTENTIALLY A RISK, RATHER THAN RELAPSING OR DON'T KNOW, THEN WE WOULD DO THE JOINT VISITS, BUT NO USUALLY IT'S ALONE. BUT I'LL KEEP THE ONES THAT I KNOW ARE GOING TO BE EASY TO START OFF WITH AND GRADUALLY WORK MY WAY IN.

LOOKING AT THIS I WOULD SAY THAT ITS ORIGINALLY FROM A MENTAL HEALTH TRUST PERSPECTIVE BECAUSE THIS IS WHERE A LOT OF THE WORK'S BEING DONE AND IT'S ABOUT WHAT DO SECONDARY CARE DO OR NOT AS THE CASE MAY BE, XXX DUPLICATING EFFORT IN A SECONDARY CARE SETTING, WHAT REFERENCE ARE THE THINGS THAT ARE BEING DONE IN THE PRIMARY CARE

IT'S BEEN QUITE...I'VE ENJOYED DOING IT, IT MAKES A CHANGE. THEY'VE QUITE ENJOYED IT; THEY'VE QUITE ENJOYED THE ATTENTION AS WELL, THE ONES THAT I'VE PICKED. OTHERS MAY NOT BE QUITE SO EASY, SO...

WBSP Lead Nurse: I think that's where the Audit Tool's actually quite helpful for when patients on leave are having different services we can all tap in to the Audit Tool at some stage and pick up where the last person left off.

Stage 2 Experimental test (8 paragraphs fonted text – see key for details)

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Stage 3 – blind examination of data

Focus Group 1 14-5-08

Researcher: Yes, they do it like you said too, you know, like to a UNCLEAR 05:02 patient. A lot of our students have quite serious physical health problems themselves, they don't have to pretend. They have huge BMI's and diabetes and all that sort of thing so, but it's really a drop in the ocean and I don't know if it's really enough, you know, so I'm toying with that for next year. We've got so much to give them in such a short space of time.

WBSP Lead Nurse: WELL IF THEY'RE NOT USED TO WORKING WITH PEOPLE, THOSE SKILLS DEVELOP OVER YEARS DON'T THEY? YOU DON'T JUST SUDDENLY BECOME AN INCREDIBLE COUNSELLOR, YOU KNOW, IT'S YEARS OF ACTUALLY JUST LEARNING HOW TO LISTEN AND TO UNDERSTAND WHAT PEOPLE ARE SAYING TO MAKE SURE YOU'VE HEARD CORRECTLY, YOU KNOW, AND HELP THEM FIND A SOLUTION RATHER THAN US JUS 'THIS IS THE PROBLEM, THIS IS WHAT YOU SHOULD DO ABOUT IT', AND THAT TAKES YEARS DOESN'T IT SO EVEN IF YOU'VE GONE AWAY AND SORT OF GOT CERTAIN QUALIFICATIONS AND CERTAIN PSYCHOSOCIAL INTERVENTIONS TO ACTUALLY THEN USE IT YOU STILL DON'T PERFECT IT UNTIL YOU'VE BEEN USING IT FOR YEARS FOR IT TO THEN SIT COMFORTABLY WITHOUT YOU SOUNDING PATRONISING.

WBSP In-patient 19: **No, no, she's a Buddhist, so they wear the orange and the red, shaved head, yes I guess that's why I was a bit surprised because I've never seen that before, but she does meditation and it's wonderful.**

WBSP Lead - that's what I've been doing since the awareness stopped in December is actually saying to teams "ok well look none of you came to the awareness session, are you aware of the well-being? Are you aware of the physical health policy? Can I come to your team?" and some people are moaning that they haven't been involved or invited to stuff and yet we sent out invites constantly...

Focus Group 2 – 08-04-08

WBSP 16 – Community : Yes. For the last two, probably three months, we've been banned from using any of the rooms for anybody. Yes. Unfortunately there was an incident and, I think it was always dreadful, but this incident was just the icing on the cake. So we have got some facilities over Gravesend Hospital.

WBP Lead Nurse: YES DO YOU KNOW G ? IF YOU RING HER SHE'S THE ONE, SHE'S GOT LOTS OF THINGS IN HER STORE AND WHEN I RANG HER RECENTLY FOR BLOOD PRESSURE MACHINES AND SCALES AND THINGS BECAUSE SHE'S GOT EXCESS STUFF IN STORE AND SHE CAN.....

WBSP 17 - In-pt: **And then they'll have the CD of sort of feel good sing along music, because sometimes you've got young ones who only like hip hop or whatever, and a lot of the older ones, so I've come middle-of-the-road existing system is sing along to feel good music with a like standing up exercises on one side, sitting down exercises on the other side, so I try to alternate one hour's we'll do sit down type of exercises with the feet and legs, the next day we'll do it standing up,**

Researcher: *And do you remember the one used for substance misuse with the Cycle of Change? With the pre-contemplated, contemplated, and all that, you can sometimes see the staff and the patients in terms of these sort of dangers, and they were using this although it was the clinical model to explain what was going on in their ward about what the responses were and where people work and how xxxx so that was a really good idea, I've never tried that before. But that was only the other day so...*

Focus Group 3 – 20-03-08

WBSP 7 Community: And because it was such a long while ago that I did my training I can't navigate my way around the inputting well and I keep getting a bit stuck in various places,

SO I WAS WONDERING IF I COULD POSSIBLY TAG ONTO THE NEXT LOT OF TRAINING, IF I COULD JUST COME FOR THE TRAINING AROUND THE INPUTTING. IF SOMEONE COULD TELL ME WHEN THE NEXT LOT OF TRAINING IS, IF IT WOULD BE POSSIBLE FOR ME JUST....BECAUSE I DON'T WANT SOMEONE TO COME OUT TO ME JUST FOR THAT, I CAN SORT OF COME....

WBSP 8 Community: **We've got a room that's been dedicated for the well-being service now and it's all nicely transformed, it's stable, we've got leaflets and everything, handouts for all the people to come in for the consultations. We do have a dedicated day and it's operated by two members of the staff now, that's A.P who done the nutrition and that's her.....she really enjoys that, and V as well we've got, she's a nurse.**

WBSP 10 In-patient: *I don't know, my manager's very receptive to things and realising it's part of a policy that is driven by the Trust and we are, you know, we have got contracts and we're trained to make it work so it follows for logical process, so it's something that that's what we need to do, and it is still about raising that awareness, you know, people are.....*

Focus Group 4 – 01-07-08

WSBP Community 22: **There IS A HELPLINE THERE ISN'T THERE? THERE'S A HELPLINE THERE SORT OF HELP OUT WELL-BEING SUPPORT.ORG .UK IF YOU**

HAVE ANY QUESTIONS REGARDING ACCESSING THE WELL-BEING SUPPORT AUDIT TOOL.

Some of them are just a few days and some of them they are on leave from the ward, and then they're off again so not everyone's really engaged, but there's a few of them that are, so that's all I've really done at the moment. It's very slow.

WSBP Community 22: *At least the start's there isn't it, you know, and leaflets have been given out, but it's helpful coming to these groups because then you pick up ideas, what people have been saying, and you take it back and implement your own programme, so I find it really helpful coming.*

but we did the exercise group in the garden, which was good, we've got sit down exercises and standing exercises and then we're able to, well I did the standing exercises, someone stands and everyone else sits! But then we were able to use the other consultation rooms and we did a consultation this morning with a follow-up appointment and input stuff on the Audit Tool,

Focus Group 5 02-04-08

WBSP 12 – In-pt : The time before last I was stood there in the toilet holding this woman up with blood pouring all over her and two pints of blood all over the floor, and ok ill go to A&E with her because I'm a spare. And it's that sort of thing I don't know how you get over that. Now I'm sort of also carer lead nurse for that ward and I'm sort of being pulled more to that role because there isn't anyone else doing that....

WBSP 12 – In-pt : *It's like this morning I saw this chap there and oh he's so poorly and just so thin as well and yes I did a quick consultation and the doctor wanted to see him she wanted to do his bloods, so I sort of went in with him....C*

Lead Nurse: I WAS WONDERING ABOUT YOURS....YOU KNOW...IF IT....I MEAN I'M NOT SURE WHAT THE LOGISTICS ARE BUT IF YOU HAVE THE EQUIVALENT OF A DAY RATHER THAN A DAY A WEEK, AND WE WOULD POSSIBLY CONVERT IT DOWN TO TWO HOURS A DAY....

WBSP 12 – In-pt : Yes the nurse checks the blood pressure, the height, weight and the height and weight at initial assessment. The team think this is the best way to do it and the patients seems to like it, even if they are unwell, it seem to settle them in and reassure them. It seems to be working very well.

Managers Group 1 – 28-04-08 TEST PAPER

Person 3: Yes. I think they had a very poor response, although that's because they actually sent them out in the mail didn't they, and one of the things that I was saying to Rachel, or they were given to the service users to post back or whatever, but it might be worth sort of getting them to complete it actually when they're being seen because otherwise....

Person 1: Yes, but that's going to be going over into our website, the staff zone, so we can't....because I took a lot of information off when it went over to the web but once we get the staff zone that only staff can get into then yes we will, but also it's about getting out of there while you do it as well, not everybody accesses the web, believe it or not, or uses it so yes that was something that we looked at and we did.

Person 13: OK, WELL WHAT YOU'VE GOT, YOU'VE GOT THE GRAPHS FOR EACH QUESTIONS AND YOU'VE GOT COMMENTS FOR THE OPEN-ENDED QUESTIONS AS WELL THAT HAVE COME ROUND. I MEAN INTERESTINGLY IF YOU LOOK AT QUESTION THREE WHICH IS AROUND THE DIRECTORATES WE'VE HAD THE HIGHEST RESPONSE FROM THE WEST DIRECTORATE OUT OF THE TRUST, AND NOT A GREAT RESPONSE FROM MEDWAY OR EASTERN COASTAL SO IT MIGHT BE IF WE DECIDE TO SORT OF CARRY ON WITH THIS QUESTIONNAIRE THAT WE SORT OF TACKLE THOSE AREAS MAYBE.

Person 3: I THINK GOING BACK THEN ABOUT THE SERVICE IMPROVEMENT GROUP THAT MIGHT BE THE VEHICLE OF ACTUALLY GETTING SOME MORE OF THIS DISSEMINATED AND MAYBE THAT MIGHT BE THE RIGHT ROUTE BECAUSE THINKING ABOUT IT LOGICALLY PEOPLE SITTING ON THAT SERVICE AGREEMENT GROUP WILL BE ACROSS PRIMARY AND SECONDARY CARE, SO THAT MIGHT BE A GOOD ONE

Steering Group 2 – 30-06-08

Person 1: And just coming down to the Audit Tool, I looked on Friday and we've got 709 registered now, which is really good, but I still keep saying we could double that because people are still keeping paper copies but I think, you know, I've just been talking to Matt earlier on that it's something that we need to look at about the, and maybe the training for the Audit Tool itself because I know we do it on the third day as part of the training but maybe that isn't quite enough, maybe we're missing something about skilling people up to use this Audit Tool.

Person 2: They shouldn't do no. Really and truthfully they should come back in 2 weeks, I mean that's only my experience of it. Really and truthfully as soon as I've got them because I take them out to training from my perspective I send them off to Rachel Clayton where they're then sent off to the IT department where they're processed. Really and truthfully I've no idea why it takes so long.

Person 1: BUT I DO THINK THAT WE NEED TO PROACTIVELY ADDRESS THE ISSUES AROUND THE AUDIT TOOL AND MAYBE THAT IS SOMETHING THAT WE DO MAKE IT A 4 DAY TRAINING, I MEAN IF WE CAN GET A TURNAROUND FOR 2 WEEKS THEN WE CAN SAY COME BACK IN 4 WEEKS TIME AND WE GO THROUGH THE AUDIT TOOL AGAIN, AND MAYBE THAT'S SOMETHING THAT WE CAN LOOK AT.

Person 4: I just thought that I would give you a bit of verbal feedback about some of the analysis, more from the focus groups not from these groups at the moment, and I've just sort of narrowed it down to 2 or 3 things from each side, sort of positives and negatives, because it may sort of help us today to have that information. Essentially the 3 positives that seem to be coming out is that most of the nurses feel quite sort of enabled and re-skilled and quite sort of facilitated having done the training and quite enlivened by that, they enjoy the feeling that they have mastered this skill and they like that.

Steering Group 3 – Oct 08

Person 13: No, that's fine. Ok, and then I've got professional qualification. Nurses were in the top respondents to this questionnaire and that's probably not surprising because they're probably more aware of it than some other professionals are. And 'other' included support workers or counsellors, or health care workers, and we've got some admin people that still haven't replied.

Person 5: Because actually that's more than I would have expected. Even the 'don't knows'. They might be saying that they don't know about particular conditions that are listed there and they're not sure whether the answer would be 'more' or 'less', but it's the 'no responses' to that, you know, that they're not actually saying one thing or the other against all of those conditions, so it would be useful to understand which group of people that is.

PERSON 13: BUT QUITE A LOT OF THE NEW MACHINES CAN DO BOTH BUT THEY DON'T HAVE....BECAUSE THE STUDENTS I HAD THE OTHER DAY THAT WERE SAYING "OH I KNOW HOW TO USE THIS MACHINE" AND I SAID "WELL DO YOU KNOW THAT IT DOES CHOLESTEROL AS WELL?" BUT THEY DIDN'T KNOW THAT, THEY'D ONLY EVER USED IT FOR SUGAR LEVEL.

Person 13: Which is because the smoking cessation the students do a health promotional project in their training and smoking cessation is always a favourite....this is mental health students.....and I have become aware that they're not taking into account the medication that people are on when they do this sort of thing, but now they are aware so they have to write that into the factors about how careful they have to be

Steering Group 4

They get paid per physical health check for an SMI client. There's about 42 points they can actually claim for so, and some of them will do things like for patients on lithium for

example, for patients that have bi-polar when maybe on lithium should make sure their bloods are done and that they've had a mental health check within fifteen months. They'd have to have been invited in for physical health checks. There's lots of xxxxx but because they're actually being paid for it there's actually not an awful lot do to get money for.

WELL THAT'S WHAT I WAS SAYING GIVEN THE DIRECTION OF TRAVEL NOW IT MIGHT BE WORTH GETTING SOMEONE LIKE PERSON 7 OR DAVID IN THEIR DISCUSSIONS INTO THAT KIND OF FORUM TO TAKE IT FORWARD, SO IT'S NOT JUST COMING FROM KIM'S PERSPECTIVE BUT IT'S ACTUALLY COMING FROM THE CARE PT PERSPECTIVE AS WELL BECAUSE I THINK THAT WILL ADD WEIGHT

She could pave the way but they're also....the SHA now really asked to have more hands-off. The PCT's now are commissioning organisations so ultimately they would be back into "who do you go to with PCT?" Now in each PCT's there's somebody who handles all the mental health....in Eastern coastal Kent's case it's just Amanda Harrison, but it would also be worth, because....

And also because the standards are there but there wasn't a framework, some organisations have gone further and said "ok the Quaf does the basic but what we're going to do is set the standards against that as well".

Steering Group 5

But one of the areas identified, where we kind of struggle with, is the interface with primary care. And I'm sure you've heard in the past "well why is secondary care doing this kind of work?" and you know "it's for primary care" and the Quaf.

PERSON 7 IS GOING TO FACILITATE THIS FOR US AND TAKE US THROUGH A PROCESS, SO WE COULD END UP AT THE END OF TODAY WITH A REALLY SUCCINCT ACTION PLAN THAT SAYS "RIGHT, THIS IS WHAT WE'VE GOT TO DO, THIS IS WHAT WE'VE GOT TO ACHIEVE"

If we don't know where we're going then we don't know what we're going to do. So I'll show you my process map, if you've seen this before, very simple, and for the record it's absolutely simple and I've learnt that simple works.

Person 1: Well I think that we should work through today because this is our starting block isn't it, and if we haven't got this right and clear in our minds then how can we go into primary care and say "this is what we're doing" and if we can't answer the questions ...

Steering Group 1 – 28-04-08 ANSWERS

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...

Appendix 2

Reflective practice guidance handbook

Handbook for Reflection

Patricia Ryan-Allen

Ed.D Thesis

INTRODUCTION

Thank you for agreeing to participate in my study which is investigation your reflections' on the issues that are helping and hindering you implementing the Choosing Health policy and the Well-being Support programme (WBSP). As I have explained the groups will be reflective in nature and I realise that you may be familiar with reflection through educational or supervisory experiences. However, I have put some ideas regarding Reflection in this handout to refresh your memory and provide an idea of what reflection is.

There are two reasons I chose *reflection* as a means to gather your views. The first is because it is hopefully a familiar approach to you and the second it is also a very useful process to capture experiential knowledge that emerges from nursing practice. This handout shows a few different models, structures and frameworks that can facilitate the reflective process which all essentially follow a similar process. However, as I understand that Gibbs model (1988) is a commonly used in nursing so I tended to focus on it as the main model of choice and have outlined it in detail for your information.

Before we explore these frameworks some important distinctions are needed to be made about different types of reflection. Schon, described reflection in two main ways: reflection *in* action and reflection *on* action. Reflection *on* action is looking back after the event whilst reflection *in* action is happening during the event. In our meetings you will be generally reflecting *on action* however, in doing so you may be drawing on experiences when you were reflecting *in action*.

Reflection in action

“To think about what one is doing whilst one is doing it; it is typically stimulated by surprise, by something which puzzled the practitioner concerned” (Greenwood 1993:45).

Reflection in action allows the practitioner to redesign what he/ she is doing whilst he/she is doing it. This is commonly associated with experienced practitioners. However, it is much neglected.

Reflection on action

“The retrospective contemplation of practice undertaken in order to uncover the knowledge used in practical situations, by analysing and interpreting the information recalled” (Fitzgerald, 1994:67)

We can see here that reflection *on* action involves turning information into knowledge, by conducting a cognitive post mortem.

For the purposes of this study you do not have to be too concerned about these distinctions but for your own development I thought you would like to know the difference. Please don't let these worry you or interfere with your accounts in our groups.

Gibbs Framework for Reflection (Linked with the core skills of reflection)

Stage 1: Description of the event

Describe in detail the event you are reflecting on.

Include e.g. where were you; who else was there; why were you there; what were you doing; what were other people doing; what was the context of the event; what happened; what was your part in this; what parts did the other people play; what was the result.

Stage 2: Feelings and Thoughts (Self awareness)

At this stage, try to recall and explore those things that were going on inside your head. Include:

- How you were feeling when the event started?
- What you were thinking about at the time?
- How did it make you feel?
- How did other people make you feel?
- How did you feel about the outcome of the event?
- What do you think about it now?

Stage 3: Evaluation

Try to evaluate or make a judgement about what has happened. Consider what was good about the experience and what was bad about the experience or what did or didn't go so well

Stage 4: Analysis

Break the event down into its component parts so they can be explored separately. You may need to ask more detailed questions about the answers to the last stage. Include:

- What went well?
- What did you do well?
- What did others do well?
- What went wrong or did not turn out how it should have done?
- In what way did you or others contribute to this?

Stage 5: Conclusion (Synthesis)

This differs from the evaluation stage in that now you have explored the issue from different angles and have a lot of information to base your judgement. It is here that you are likely to develop insight into you own and other people's behaviour in terms of how they contributed to the outcome of the event. Remember the purpose of reflection is to learn from an experience. Without detailed analysis and honest exploration that occurs during all the previous stages, it is unlikely that all aspects of the event will be taken into account and therefore valuable opportunities for learning can be missed. During this stage you should ask yourself what you could have done differently.

Stage 6: Action Plan

During this stage you should think yourself forward into encountering the event again and to plan what you would do – would you act differently or would you be likely to do the same?

Here the cycle is tentatively completed and suggests that should the event occur again it will be the focus of another reflective cycle

Gibbs model incorporates all the core skills of reflection. Arguably it is focused on reflection on action, but with practice it could be used to focus on reflection *in* and *before* action.

Bortons` (1970) Framework Guiding Reflective Activities

This is another simple reflective model is Gibbs does not suit your preferred way of reflecting. It is also simple and easy to use.

| What? | So What? | Now what? |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| This is the <i>description</i> and <i>self awareness</i> level and all questions start with the word what | This is the level of <i>analysis</i> and evaluation when we look deeper at what was behind the experience. | This is the level of <i>synthesis</i> . Here we build on the previous levels these questions to enable us to consider alternative courses of action and choose what we are going to do next. |
| Examples What happened? What did I do? What did other do? What was I trying to achieve? What was good or bad about the experiences | Examples So what is the importance of this? So what more do I need to know about this? So what have I learnt about this | Examples Now what could I do? Now what do I need to do? Now what might I do? Now what might be the consequences of this action? |

References

Boyd, E. and Fales, A. (1983) 'Reflective Learning: the key to learning from experience.' *Journal of Humanistic Psychology*, 23(2), 99-117.

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Fitzgerald, M. (1994) 'Theories of Reflection for learning' In *Reflective Practice in nursing* eds. Palmer, A. and Burns, S. eds. Blackwell Scientific: Oxford.

Greenwood, J. (1993) 'Reflective practice a critique of the work of Argyris & Schon.' *Journal of Advanced Nursing*, 19, 1183-1187.

Schon, D.A. (1983) *The Reflective Practitioner* Basic Books: New York.

Appendix 3

National Research Ethics Service

(NRES) approval letter



National Research Ethics Service

West Kent Research Ethics Committee

South East Coast Strategic Health Authority
Preston Hall
Aylesford
Kent
ME20 7NJ

Telephone: 01622 713067
Facsimile: 01622 713158

Mrs Patricia Allen
Senior Lecturer

8 October 2007

Dear Mrs Allen

Full title of study: Implementation and Evaluation of the Physical Health & Wellbeing Programme for people with Severe Mental Illness (SMI): An Action Research study
REC reference number: 07/H1101/83

Thank you for your letter of 30 September 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternate Vice Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|-------------|---------|----------------|
| Application | | 28 August 2007 |

*This Research Ethics Committee is an advisory committee to South East Coast Strategic Health Authority
The National Research Ethics Service (NRES) represent the NRES Directorate within the National Patient
Safety Agency and Research Ethics Committees in England*

Appendix 4

Participants invitation letter



Date

Dear Colleague

I am writing to invite you to consider being a participant in a research study I will be conducting in the Trust from September 2007.

The study is called:-

**THE IMPLEMENTATION AND EVALUATION OF THE PHYSICAL
WELLBEING PROGRAMME FOR PEOPLE WITH SEVERE MENTAL
ILLNESS: AN ACTION RESEARCH STUDY**

The rationale for the study is that according to the Dept of Health (2006) people with diagnoses of schizophrenia and bipolar disorder are almost twice as likely to die from coronary heart disease, four times more likely to die from respiratory disease and are also significantly more at risk in regard to diabetes, infections and greater levels of obesity. Because of this the Wellbeing initiative has been introduced to support the physical health and wellbeing care needs of serious mentally ill.

The Kent & Medway Health and Social Care Partnership Trust initiated the Wellbeing programme in 2007 where training, support and protected time are given to prepare the mental health practitioners who are involved in Wellbeing activities.

The purpose of the study is to follow how the Physical Health and Wellbeing programme is put into operation in your Trust. This study will find out what the mental health practitioners think about the Physical Health and Wellbeing programme and how the Trust goes about implementing it. The research will form part of my doctorate study and will take 2 years to complete

I would very much appreciate your participation in the project and will contact you soon with more information about what being involved will mean to you personally.

Yours Sincerely

Patricia Allen
(Senior Lecturer - University of Greenwich).

Appendix 6

Research Consent Form and Participants

Information Leaflet

PARTICIPANT INFORMATION

AND

CONSENT FORM

PARTICIPANT INFORMATION SHEET

Study title: The integration of physical health policy recommendations for people with severe mental illnesses

Study aims: This study aims to investigate the reasons why health policy such as the Choosing Health (2006) policy, which is concerned with improving the physical health and well-being of people who have a severe or serious mental disorder or illness, are successful or unsuccessful in being properly integrated into clinical mental health nursing practice.

I would like to invite you to take part in my research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. I would suggest this should take about 5 minutes. Talk to others about the study if you wish before you decide to participate. The following questions and answers will help you understand the purpose of the study and your role within it.

Ask me if there is anything that is not clear.

What is the purpose of the study?

The purpose of the study is to investigate what helping and hindering factors are involved in the implementation of new health policy in to clinical mental health nursing practice. At the moment the physical health state of our service users with serious and severe mental disorders experience very poor physical health and can die up to 25 years earlier compare to a member of the general population. I hope to discover why or why not the Choosing Health policy is successfully implemented in order to reduce these risks to our service users, draw conclusions from the findings and make recommendations concerning the issues concerned. As a nurse myself I am also keen to add to the body of nursing knowledge and contribute the mental health nursing perspective more broadly.

Why have I been invited?

You have been invited because you are directly related to the implementation and integration of the Well-Being Support Programme either as a clinical practitioner or as a clinical manager. You have specific and detailed professional knowledge about the areas I wish to investigate and by sharing

your experiences, can offer insights into why and how professionals integrate policy led changes in clinical practice.

Do I have to take part?

It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Your decision to join the study is entirely your choice. If you choose not to partake there will be no repercussions or recriminations in terms of your current role or job in this NHS Trust.

What will happen to me if I take part?

How long the participant will be involved in the research: you will be involved in the study for a period of six months when you will be invited to voluntarily join a group to reflect on and discuss your experiences of implementing the physical health policy and the Well-Being Support Programme (WBSP) with other practitioners/managers. This will be for one hour on a monthly basis in a range of sites across the Trust.

Will I be recorded or videotaped?

There will be no video-taped recordings however the discussion in the groups will be audio-taped and transcribed in full by me in the strictest confidence.

What will I have to do?

All you have to do is attend as many of the groups as possible. I will send you the pre-arranged dates, times and venues for the next six months if you agree to participate. If you do not agree now but change your mind later it will still be possible for you to join in the groups. Just let me know and I will send you the details.

What are the possible benefits of taking part?

I cannot promise the study will help you but the opportunity to reflect on your practice could help you with developing your practice and 'trouble-shooting' and issues you have regarding the responsibilities related to implementing the physical health agenda. You will also be party to an ongoing piece of nursing research which may benefit you directly in terms of having that experience, and indirectly by benefiting the profession with the overall outcomes of the study.

What happens when the research study stops?

When the research stops I would recommend continuing with the networks developed through the study for on-going support.

What will happen to the results of the research study?

The results of the study will be published in a number of different ways in a range of journals; however no names, dates or places of work or any other identifiable information about the participants will be published.

Will my taking part in this study be kept confidential?

The data that is collected from the groups' discussions will be kept for the duration of the study in a confidential way in a password protected home PC. Use of small pieces of data such as short quotes from your discussion will be presented in the study in an anonymised way in terms of whom you are and where you work. When the study is completed the data will be destroyed and at no stage will be used for any purpose other than that of this study.

What if there is a problem?

You should inform patients how complaints will be handled and what redress may be available. This must be applicable, as appropriate, to NHS and private settings for the research.

Complaints

If you have any concerns or complaints about any aspect of the study you can contact me directly on 02083319490 and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the Trusts Acting Head of Nursing, Donna Eldridge on 01227 238765. If you remain dissatisfied you can contact the Chair of the Trusts Research and Development Committee, Lona Lockerbie or the NHS Complaints Procedure (www.nhs.org.uk)

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a National Research Ethics Service, to protect your interests. This study has been reviewed and given favourable opinion by the West Kent Research Ethics Committee; the Trust Development Committee and the University of Greenwich Research Ethics Committee and Research degrees Committee. .

Further information and contact details

For general and specific advice about your role in this study please contact me on 02083319490 or email ap17@gre.ac.uk .For advice as to whether you should participate in the study or who you should approach if unhappy with the study please contact Donna Eldridge donna.eldride@kmpt.hs.uk or Lona Lockerbie lona.lockerbie@kmpt.nhs.uk at the Trust

The Consent Form

The attached consent form should be signed if you are willing and happy to participate in this study and will provide consent for everything described in the text of the information sheet.

CONSENT FORM

Title of Project: **The integration of physical health policy recommendations for people with severe mental illnesses**

Name of Researcher: **Patricia Allen RMN, MSc., DipN., PGCEA**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated September 2007 V2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any repercussions or my rights being affected.

3. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix 7

Participants quotes and references

**Professional change and knowledge translation in mental
health nursing: case study of the integration of a health policy
into practice**

Focus groups quotes (1-95)

Steering groups quotes (96-244)

Ed.D. 2009

Patricia Ryan-Allen

FOCUS GROUPS QUOTES (1-95)

DRIVING FACTORS THEMES (NURSES GROUPS)

Flexible attitudes

1. A WBSP in FG 5 exemplified flexible attitudes to care by saying “in the community all that gets chucked out the window, which I love, and say this is your home, if you want to sit there in your dressing gown and talk to me, if you want to sit out in the garden, if you don’t want to open the front door but you want to talk to me out of the window, that’s fine, that’s ok”.
2. In terms of flexibility of resources in FG3 WBSP 15 – community : “but I think, I mean that to me with the environment you work in, if you can manage to get base line obs done and record them and then raise any issues and concerns you sort them out before xxxx discharging them....”
3. Flexibility of attitudes was shown in FG6 by WBSP lead nurse: but I think that’s important isn’t it, you know, different people ready to engage with it at different stages of their recovery, you know, so some people will engage with it on the ward, some people when they get back home maybe, you know.

Value to service users of the WBSP .

4. WBSP community 9: so I think we need to be aware of how by not putting advocating our clients physical needs we are putting with the fact that mental health needs or people with severe mental illness regardless have different needs to everybody else, I think I feel quite strongly
5. WBSP lead nurse: I think there are definite advantages in getting them (the service users) away from an institution
6. Researcher: when you’re talking about empowering the patient through health promotion that’s all got behind it hasn’t it, the staff have got to feel the same haven’t they and the skills and all

Support for well-being support practitioners

7. WBSP in-patient 19: so I suppose i’m lucky that i’ve got that support and people that they can see how good it is.
 8. Lead nurse WBSP : right. So that’s a very good example isn’t it of why the link meetings are so important and it just envisions people doesn’t it
- 1.
 2. **Policy**
 9. WBSP 12 in-patient: what we said, what we were going to do was incorporate it with our

admission policy so that's there so everybody's got to do it, . . . And on our handover sheet we've got, we've incorporated physical obs. So that person is, so we allocate the named nurse for that day

10. Come to the wards and i'm really aware and tell them about the well-being and I said "please

Manager's support for the well-being initiative

11. WBSP in-patient 19: yes, you see i'm so lucky that i've got the modern matron recognises the importance of it all and cd as well, my ward manager

12. Lead nurse WBSP : but I think if you simply say to your manager, your ward manager, "you've given me this job and I want to do it really well can you suggest to me, can you help me now with how to make it work so that when you're not on duty it still happens"

Feel good factor for WBSP 's'

13. WBSP in-patient 19: yes but that's the other thing we have a lot of, I have a lot of students come" and they're really keen, you know, a girl the other day she was like "oh xxx when are you on next because i'll make sure i'm on duty when you're there, can I spend the day with you?", I said "yes absolutely

14. WBSP in-patient 19: I love to 9 to 5 and I love what i'm doing as well because just a different approach

3.

4.

Enthusiasm

15. WBSP in-patient 21: obviously we give them a lot of information but if she keeps it we can't sort of follow it, I mean although she's the designated well being nurse she's also asking other people and seeing if they were interested and they wanted to do something,

Training

16. WBSP lead nurse: I think the only other stuff is 150 now trained, training's full, that's another thing X's going to have to do is book future training because you need to book well ahead, certainly booking the PDC's not a problem but down in the east in the whole year I could only book it in September.

Team support

17. WBSP in-patient 19: yes, but i'm confident because I know the team i'm working with they are, I mean I have to say they are a fantastic team and i'm confident that they will continue to do that

Personal attributes

18. WBSP 6 - in-pt: I'll keep going. I think they think I'm just quite quiet but actually I'm

quiet but I keep going, I keep going and I will get there.

Dedicated resources

19. WBSP 8 community: we've got a room that's been dedicated for the well-being service now and it's all nicely transformed, it's stable, we've got leaflets and everything, handouts for all the people to come in for the consultations. We do have a dedicated day and it's operated by two members of the staff now,

WHAT INCREASED DRIVING FACTORS THEMES (NURSES GROUPS)

Being supported

20 - WBSP 11 in-patient: and actually I've been doing her bloods every day so we've got a nice mixture of kids so, you know, so we done the presentation and b our manager's on board with it and she's quite pleased,

21 Lead nurse: because they do that at M town and they've only just told me that they all meet up on a regular basis as a group to do what I've just said, you know, that they inspire each other they keep, you know, "have you tried this? Have you tried that?"

22 WBSP 16 – community : yes thank you very much for the advice and the support.

Flexibility

23 WBSP lead nurse: and that's the whole point of the well-being training is that we're meeting nice guidelines. But if it works in your team best that it's done in your caseload that you offer a well-being service to clients in a one-to-one

24 WBSP 13 – in-pt : sometimes it's better to be flexible because on the Thursday when I run well-being sometimes there isn't anybody that's well enough to engage but there might be someone who's really crying out on a Sunday night when the ward is more settled

5.

Resourcefulness

25 WBSP lead nurse: and she is quite good really, she'll send you a procurement form and then she'll say to you where you'll get it from or if she's got it in her side then she'll send it over to

26 WBSP 16 – community : and that's exactly what we need really because it almost saves you the worry about the financial situation

Creativity

27 WBSP 17 - in-pt: well i'm trying to include other people in it and when we did the presentation we sort of talked about all the staff being involved and if they've got ideas let us know what they are

28 WBSP 15 - I have tried my hardest, i've done a lot, and i've put a whole well-being pack together, we don't do lots of different exercises, they actually use an exercise sheet that I got from

the internet

Being realistic

29 WBS 16 – community : and that would be really realistic. Well I think that's a much more realistic way of us doing it, and I don't see why people should have to go to d town, why they should go anywhere really.

6.

30 WBS lead nurse: something you said to me months and months ago now about that you need to bring about change when people are on a high, it's no good going in when people or staff or a team are really at a low place, because to bring about something quite dynamic it needs a lot of effort

Recognition

31 WBS lead nurse: and whatever you do achieve, acknowledge it, don't just think oh well that's only a bit of what the bigger picture is, actually that's a huge step and maybe point that out to the rest of the team and sort of let the team feel that it's the achievement for the whole team that you're not just taking the glory yourself because you're doing all the hard work but actually this is a team, you know

Service users care

32 WBS 8 community: we started off working a referral process and there are referrals but equally if the referrals aren't coming through it's just a question of going through the cpa enhanced register and a few people are referred to the service, to the team, the idea was that within the health policy once they're on that we should offer a well-being clinic appointment just to make sure that's covered.

33 WBS 8 community: no, I would say most of them, they are ok I think. Yes. Once I think they hear what the issue is and perhaps make an appointment time, and I just, i'm always advocating our clients go to the GP themselves and do that.

7.

Determination

34 WBS 17 - in-pt: yes, and they think "oh she's eager, she's new, she's fresh, she's eager, she'll wear herself out"....

35 WBS lead nurse: so they're persisting with their manager. I've been over twice and I've talked to those groups to say "how about this? How about that?", so you've just not let it go and its taken time to change the practice, but you don't have to be absolutely 100% successful at a certain date, it's a journey you know it's a process and about not giving up...

8.

9. Enthusiasm

36 WBS lead nurse: your team, your ward manager should acknowledge your keenness, your enthusiasm, and say the staff need get behind you and maintain that because you're leading up on this you know.

10.

11. Job satisfaction

37 WBS 10 in-patient: and I think it's something about staff recognising the value that they can offer to their clients isn't it?

Team effort

38 WBS 11 in-patient: yes, and then the other people they see the care plan, they've got to sign it, the others have got to sign it so it's all above board, you know, they've got to agree to the plans really.

Confidence

39 Researcher: and they're not going to do any harm, because a lot of people are quite reticent when they think they might do more harm than good, you know like talking to patients when you're a student, you might upset them or make an error,

12.

Negotiation (various)

40 WBS lead nurse: I think you need to sit with your manager's and say we totally agree with you a well-being clinic is brilliant but actually how are we going to do this

RESTRAINING FACTORS (NURSES GROUPS)

Lack of resources

41 WBSP 16 – community : yes. For the last two, probably three months, we've been banned from using any of the rooms for anybody. Yes. Unfortunately there was an incident and, I think it was always dreadful, but this incident was just the icing on the cake. So we have got some facilities over g hospital.

42 Also they said, 'the dinner's are dreadful, there's like one banana, one orange, and that's the fruit that comes' and so it's a valid point which i'm going to take it back to management that we should be ordering more fruit and veg, fruit for dessert rather than the stodgy, I don't know, jam roly-poly and custard, and kind of do it on a daily basis, but again I get patients that are not interested because they are so mentally unwell.

43 WBSP lead nurse: but your managers they do have a budget to provide you with equipment that you need to deliver the care, so if they're saying there's no money we're in a new financial year so they should provide you with a height chart, they should provide you with scales, they should provide you with your blood pressure, the one.

Lack of team support

44 WBSP 17 - in-pt: so that nurse for the patient should actually take the responsibility really, do you not think so? Because our manager comes on us like a ton of bricks, she says "why wasn't this patient's physical obs done?"

45 WBSP in-pt 21 - I can get it going from there but it's difficult to get it carried on when i'm not there so that's my struggle at the minute's

46 WBSP 17 - in-pt: oh WBSP lead nurse, i'm finding it a real struggle. I'll start on the negative stuff and end on a positive note. But what i'm finding is that, actually don't get me wrong the staff are lovely, they all work with me but the attitude that is portrayed is "oh bless isn't she eager" sort of attitude or the other one is "oh it's another project that will fall by the wayside" and so I find it really hard to get the support of the team.

Skills

47 Researcher: absolutely, because you'll get individuals as well that are naturally good at it and then you get someone that's got all the qualifications under the sun but they are patronising and it's very difficult sometimes to get that balance isn't it.

48 WBSP 16 – community : on anything they're saving though is WBSP people that are training here as well because I think where we've been using the electronic ones and, you know, I think people are a bit nervous about using those as well

49 WBSP lead nurse: yes, we need to do the pressure for a lot of the majority of staff who don't get it if you do it. But you just think in the well-being clinic we have a trust policy that anyone, it's not just the drug company saying it, it's the trust as well that we have a policy where

we need to be doing people's blood pressure, pulse, and weight at every visit not just their bloods, and the amount of well-being clinics where they

13.

14.

50 WBSP lead nurse: and the same as the physical health policy, the xxx is there and if we have a client coming through the service coming into a health care, whether it's mental or not, it's a health care service and if they're coming in with severe headaches because they've got hypertension but nobody takes their blood pressure all the time they come through the service because we just think they're schizophrenic, they're responding to voices and it's all part of what's going on in their head, which is often, often it's missed out and they're discharged and then they have a severe stroke, and we could have picked that up, prevented it. Focus group 4 - 8.4.08 ref 3

Expectations

51 WBSP 16 – community : well I think the pressure is a little bit on k because she was the first one that was trained. Our senior nurse keeps on going up to her and saying “we've got to be seen to be doing a well-being clinic” but the practicalities of doing that is just, you know, and I don't think that people should be so stressed out to the eyeballs, staff, because we're going to end up having a stroke..

52 WBSP 12 – in-pt : but I do feel quite pulled in all different directions and i...you know.... It's really difficult to fit it in.

53 WBSP 13 – in-pt : and I think that's a common complaint of many of the staff there isn't it? They are pulled in different directions.

54 WBSP 12 – in-pt : yes. I think the WBSP is that its a case in itself, its so busy, we get people there for three days and then they're gone and there's so much to do I don't know if we'll ever achieve it

15. Confidence

55 WBSP 16 – community : I don't know whether it's confidence, whether people don't do it because of confidence or time. I think

56 WBSP 16 – community : it's almost based on reservations xxxx they do don't they, and I feel like I haven't done any training on anything like that for a really long time and I would like to feel more confident in it.

57 And so if you're a professional, and it's up to that nurse who's taking on the responsibility of running a well-being clinic, she's a professional within her own right, she should find out before she says yes that she can do all those things and that she's confident and competent to actually run that well-being clinic as it should be run.

16.

Workload

58 WBSP lead nurse: my clinic yesterday was two home visits, that's all I could fit in because of my workload, my well-being clinic for this week was two home visits yesterday afternoon

59 WBSP 15 – community : it's a lot. It's improving. It's very frantic isn't it? I was horrified, I went to meet A at the computer desk and the change since I....course I last worked on the ward probably about thirteen years ago and I was absolutely horrified, it's hideous, and how anybody works there I do not know.....I tell you....

17.

18.

60 WBSP lead nurse: absolutely chaotic, which, yes. And they did have two people trained up from that unit from that particular ward but one person had to be transferred because she was pregnant and another person emigrated and they just say that the staffing situation they just haven't been able to release anyone to do the training, and of course everybody does have to do mandatory training before this, you know, before well-being so what some managers say is no you can't go in the well-being until you've actually gone to every single mandatory training which....

Stigma - outside MH services

61 Researcher: and that's because we've had some discussions in the WBSP steering group about the primary care interface. But under primary care I would say the other hospitals....i think, and that's where i'm thinking when I heard when we were speaking earlier about we can't get a place in a general hospital, i'm thinking we shouldn't be included with that stigma about, and that way forward, that's really my argument is that "hold on a moment".

62 WBSP lead nurse: I think they just imagine people with mental illness as down-and-outs who are likely to suddenly, you know that they've have also got alcohol problems, drug problems, they're going to be very smelly, you know, that they just see that don't they, they don't see that one in three of us is affected by mental illness at some stage in our life and that it's very likely that they work alongside colleagues who have mental illness and they didn't even know, so it's very narrow minded and it's quite shocking still in this day and age.

Awareness of WBSP

63 WBSP 10 in-patient: i'm also quite concerned of people who come in from residential care into depots clinic's what their healthcare checks are, that's something i'm....can we have them in for, you know, refer them to a well-being clinic day just...and it's about practice or we're just giving them an injection and we're not checking their physical health.

64 WBSP lead nurse: 450, when it used to be 0 to 700, now they're saying anything over 450 but when I had someone that was 3800 or something and I phoned all the nurse advisors in inventive and said "what's your local", you know.....upper range?

Different views

65 One of our nurse practitioners has said that someone above her has said that we should be seen to be having a clinic. But it seems a bit useless really if we can't actually do anything and get there and do it, it's much better surely to be doing things on a one-to-one....

66 WBSP 17 - in-pt: well I suggested that it should be done for everybody, it's everybody rather than leaving someone to faint and fall on the floor they take their bp, because we've got a picture of what their bp's doing. Sometimes you can see that something's going wrong. Because where I trained as a different class where it was done on a daily basis

Service user's reluctance

67 WBSP 8 community: the problem that I think they're having is that although they're offering appointments and the clients aren't attending, although they're leaving that information about it and clients are saying yes , then they're offered appointments and not actually coming so that's an area to look at.

68 WBSP 8 community: but they don't value themselves do they?

WHAT DECREASED RESTRAINING FACTORS (NURSES GROUPS)

Having support

69 W BSP 16 – community : this is why these sort of link groups are so supportive really because I think sometimes it does feel like you're banging your head against a brick wall and we've got so much of this movement issue that everybody doesn't want to talk about anything else or do anything else...yes...and you can't...Focus_group_6_-_1.07.08_categorised>

70 W BSP lead nurse: yes, try that but if you don't have any luck get back to me and I'll sort it out my end.

71 W BSP community 22: there is a helpline there isn't there?

72 There's a helpline there sort of help out well-being support.org .uk if you have any questions regarding accessing the well-being support audit tool.

73 W BSP community 22: it's really good, it's really, really, you know, it's very helpful

74 W BSP lead nurse: with you so that you're nurturing them to do it when you're not on duty, but I think if your manager has asked you to do all of this and then is not actually backing you up on it you need to go back and say "I really do need your support" and that's not confrontative, and that's saying "I really want to do what you've asked me to do but I need your support here.

Organisational skills

75 W BSP 16 – community : it may be that we could organise transport to take people up to town to then get them to go to the well-being clinic and then get them involved in the well-being clinic, that's what I was thinking is something we might be able to do,

76 W BSP lead nurse: well if your manager's asking you to sort of give a lead on it, I mean I would suggest that every Sunday you write in red in your diary that the weights and the BP's need to be done and that you actually get like M's just said someone like a buddy, someone alongside you who that when you're not there they can be making sure, so that each time you do anything see if you can have a colleague who's not trained....focus_group_2_-_20_3_08_coded[2]>

77 W BSP 6 - in-pt: and we have been promised a day a month so, it hasn't happened yet though, it has been run, whoever did this bit flapped that so at least then I'll know that I'll have that day to catch up all the paperwork and stuff.

78 W BSP 11 in-patient: we haven't actually started inputting anything. A was part time but she's now doing regular shifts four days a week so we are planning, I have my work sort of more from the weekend so she works on a Saturday so we are planning to get this tool up and running....

Resources

79 At the moment it would be d town and I think we need to make the service local so we need to start looking at local facilities somewhere where we could actually have a room for the day really. Yes, we do have an access to g hospital but it has cpa's most afternoons and they have limited availability there as well and i'm not sure how we're going to do it. If I was honest, I think unless we deal with our own patients individually on a one-to-one level, just us do our own patients initially, because I understand that we should be seen to be having a clinic at the moment. One of our nurse practitioners has said that someone above her has said that we should be seen to be having a clinic. But it seems a bit useless really if we can't actually do anything and get there and do it, it's much better surely to be doing things on a one-to-one....

80 Wbp lead nurse: at least you're staying and your managers can document that to say that due to the circumstances, due to the lack of facilities, like resources, the only way we can actually offer this at the moment is on a one-to-one basis.

Creativeness

81 I'm not sure how we're going to do it unless we do it on a one-to-one basis with the clients really. I don't know. I mean, d was saying maybe we could catch these people when they come to the depot clinic and things like that, because rather than trying to...you could actually... But it's just you have to have a parallel clinic running with the depot clinic. We haven't got...there isn't the room, there's only one..

82 WBSP lead nurse: if she's seeing three people on her visit and she does well-being that is her clinic. So don't get it into...don't have it into you head that a clinic needs to be that you have got a room, that you set up a clinic, everybody comes to you at that clinic..

19.

Persistence

83 WBSP 17 - in-pt: and I wonder if she's thinking that I should do it I try to get it in every handover; you know, remember to talk to our patients about physical health stuff as well and remember to point out the well-being posters that will maybe come to me or s. So i'm bringing it up and i'm sort of getting "yes j, well-being"....

84 WBSP 8 community: you've just got to be a bit thick skinned really, you know, or deaf, you know, how can we get proper care or look after the family, so yes, but....

85 WBSP 8 community: that, but I think from my point of view just asking people who are thinking more physical health for clients and perhaps persevering more with GP's to get things looked at rather than just accepting it's the side effect of a mental health medication and, or something else.

WBSP

86 WBSP lead nurse: and so then we do the quiz and the awareness session as well because that really is, again it's something they're all doing, it's interactive and it keeps them alert.

Problem solving

87 WBSP lead nurse: the only issue there is to do their BMI you need your height thing....just get a tape measure, an extra long tape measure that some stores do, and your scales which can be heavy but each visit that you go on you need to take the scales.

88 WBSP lead nurse: so, and so I say to them “please don’t email me and ask me for some information on hypothyroidism, you know, why should I spend my time getting it off the internet and then emailing it to you? You do it yourself”.

Flexibility

89 WBSP 13 – in-pt : but I will continue and try and fit some well-being bits in at the weekend as and when it arises, there’s no input, because the weekends are quieter you’ve got no admissions and discharges.

20.

90 WBSP 12 – in-pt: no. And it was quite interesting the other day, this lady that I took to A&E I actually did a well-being assessment while we were there because we were there ages

Professionalism

91 WBSP – in-pt 18: but I suppose if you’ve got the legitimate reason for saying “oh what was so-and-so’s blood pressure on Monday because I’ve been off” and if it’s not in the notes then it’s kind of a professional issue whether it’s been written up so you can get it from such a different angle

92 WBSP 17 - in-pt: if you start to pin it down to a particular individual patients and nurses and that gets sort of verified through the MDT like in a case conference, and say “this is one of the things we want to do” that puts a legitimate stamp on it, you know, that the MDT have proved this so it’s not just a sort of an exercise for them, it’s so-and-so needs to have such-and-such so it makes it much more concrete.

Patient care

93 WBSP 12 – in-pt : it’s like this morning I saw this chap there and oh he's so poorly and just so thin as well and yes I did a quick consultation and the doctor wanted to see him she wanted to do his bloods, so I sort of went in with him....c

94 WBSP 11 in-patient: but being it gradually when kids are gaining weight and reaching their BMI but they can’t, they’ll be gradually sort of weaning them back off that mars bars, chocolate biscuits and full cream, we can get them off that and then they go on to healthy food

Acknowledgement

95 But she’s aware because I’ve encouraged her to write up her approach to the well-being and the prison in-reach and actually then ad would help her write an article, or you guys can from Lilly, but that would be a brilliant piece of she could have an article published before she leaves prison in-reach.

21.

Managers' groups Quotes (96-267)

DRIVING FACTORS (STEERING GROUPS)

Training

96 There are still a lot of people out there really wanting to do the training. So we're booked through to September and then obviously it will be over to person 9 to plan future dates for further training, but there's certainly not a shortage in people being interested.

97 Person 13: I think it's more training dates, although there was a mixture, I think some people were saying that they would like to actually go on the training and have mental health training so therefore would like to go on it, and some people did say that they require further training, so it was a bit of a mix but I think most people were saying that they were new to it and wanted to actually receive the training.

22. 98 I just wanted to say that the BSc on this level 3 course is going ahead next semester despite OM leaving us to pastures new, so yes, she was the course co-ordinator but we're confident that it will still run unclear

Policy drivers

98 Person 3: I guess we'll see the policy in the physical health policy's reflected very much with what's in the well-being audit tool.

99 Person 2: because that's the thing, showing cholesterol is the thing if we can demonstrate that we're reducing the risks of cardiovascular events, you need to have that for it because that's one of the things, there's a formula from the world health organisation to calculate your risk factors. So if we were to collect, it we were collecting that then we could actually demonstrate that we are making a difference of so many years of people's lives.

Knowledge and skills

100 Person 13: and this one was about which skills are important, and you've got verbal communication and non-verbal communication, non-judgemental attitude and respect, and dignity, and as you can see most people agreed that in order to do all of those things there were hardly any no's and I think a couple of people said 'don't know' and there are a few no responses but most of it is people said yes to that so that is good.

23.

101 - Person 1: because we've opened the trend to healthcare workers now, haven't we, provided that they work alongside somebody that's qualified, so maybe if you did this in twelve months time or whatever, because we've only just started that, you might start seeing the difference.

102 - Person 5: yes, because if you look at how people work with clients, the people who are seeing more frequently are qualified staff.

Attitudes

103 Person 4: so this bit about collaboration and asking the person clients what they want, they like that and that seems to be part of the health promotion and it seems to be encouraging the nurses to talk more to the person clients about positive things and not just necessarily talking about the negative things about their mental health problems, they're talking about how they can get better and the clients seem to respond more to it.

Flexible

104 Person 9: we ask them at the training that they fill them in at the first appointment, but I think the way that the actual unclear 06:56 service is delivered is it's very flexible to meet the needs of how the patient is that day so I think that sometimes they will do a bit one day and try and capture them another day depending on how they are, so it just takes time. I mean that's one reason.

Formal procedures

105 Person 1: no? I think there's a pink book on my filing cabinet person 3 if you want to get one. It's an assessment tool that was developed by r g from the institute of psychiatry and m j who is my double over in surrey borders and it basically looks at physical health assessment

Service users

106 But maybe if it was written from a person patients perspective....

24. Absolutely, then I think that might be betterThe absolute clarity to both sides, so it seems

107 Person 3: especially seeing as one of the unclear 06:20 people in the form, you know, the unclear 06:23 are looking for service user feedback this would certainly help the trust in terms of evidence in the sort of responses back from service users.

Support

108 Person 6: yes certainly in the network meetings and link meetings people are finding that sometimes because the service have said that's the way it is and then they've been given that one day the service is adapted to meet the needs of the individual by creating them and holding onto that day, and some managers are very good at doing that and of course with the change of managers sometimes that's lost but I think it's just naturally evolves depending on the service make up.

Leadership

109 Person 3: and also it depends on where they work because I think as DE said with AB, I think she's actually doing it to a wider audience and she gets to go unclear 17:40 so she's more or less being paraded as a specialist in that field so I think in the community teams where that may not be possible unless you have that approach then you would expect others to be involved as well.

Communication

110 Person 4: so that's the kind of key that i'm using. There was one bit here that i...ok, this was just to remind us and me because I have to do it now and again but what the aims of my study was anyway and that it was to focus and to look at and explore the implementation and evaluation of the well-being so the detail of these well-being programmes wasn't as such a great interest to me to begin with anyway, it was how as a trust you manage this implementation, so it could have been well-being, it could have been clinical supervision, it could have been cpa, but for this purpose it was. So we examined the knowledge and skills base which person 13 and I have done so we know that, and investigate strategic and operational change which is what you talk about in your steering groups as well, but also then look at the stakeholders perception, as stakeholders I mean of well-being nurses and so on unclear 1:28:48 clients but maybe that will be the next one. So that's kind of all coming on.

Empowerment

111 Person 4: ... essentially the 3 positives that seem to be coming out is that most of the nurses feel quite sort of enabled and re-skilled and quite sort of facilitated having done the training and quite enlivened by that, they enjoy the feeling that they have mastered this skill and they like that.

Access to resources

Person 1: yes. A g, she does sometimes where there's old stock on the ward or whatever she'll take it back and then give it to us so she's always a good person to tap

WHAT INCREASED DRIVERS (STEERING GROUPS)

Physical health assessment process

112 Person 2: yes if we do a baseline and six months down the line, or twelve months down the line, because it would probably take at least twelve months to make a difference.

113 Feedback from the SHIP conference, well we had two held last month, they actually were received exceedingly well and they introduced the ship assessment so it really compliments all the well-being that we've been doing. People liked the idea of the sexuality part and then the fact that you can do teeth as well,

114 Person 12: I think historically as well what person 13 reflects is the fact that blood glucose has been talked about or associated with SMI for many years whereas the links with cholesterol's probably become more prominent in the last 5 year

115 Person 5: no. But I think it's probably more a reflection that say in my directorate in the west I've got 2 or 3 teams where they have well established well-being programmes, clients are encouraged to think about their physical health coming along to that opportunity to have that reviewed.

116 Person 5: there is and I think its understanding what that's going to look like. To me we should be in the business of promoting anybody's mental health and physical well-being because the two are inter-related. You can't take physical health away from mental health, you have to actually look at the whole picture the whole person and we should be in an educative programme in encouraging people to look after themselves, to take care of their physical health needs, and their mental health needs. And that actually that's the emphasis and that's what we're good at doing, you know, the business about making sure that people get the necessary screening and tests done, that doesn't have to be done by us at all as an organisation but if we raise awareness with the clients that we work with that they should be asking those questions and supporting them to ask the questions if they're a bit hesitant about doing that, then that's the business we should be in and that those are the KPI's that could actually worked up around that sort of educational facility role around the...

117 Person 1: well it's in there in a sense. Obviously all our risks certainly come through CPA and it's in there around self neglect but it's not really physical health.

118 Along with it and people don't necessarily tie in physical implications of people not looking after themselves. The overt ones they probably pick up but some of the others that they perhaps don't drill down far enough in to it.

119 That will be picked up because somewhere in that somebody will write diabetes but there's no real home for it so we do need some sort of trigger box that actually picks that up particularly depending on what type of diabetes somebody has. You know if they're insulin dependent then that's likely to get picked up

120 I know that some GP's in some areas have been rubbing their hands together and saying "oh secondary care are doing our quafs and we're getting the money" and you know we're not doing the quafs but we need to make sure that our person clients do get that, so yes they can come into secondary services and we can do all these bits, but it's about how we signpost them back, that's the bit....

121 Person 1: they more or less support the nurses don't they, rather than do anything. But even for the social workers, there are nurses in the team aswell and what we've been trying to do is have at least one well-being trained in each team, so what they would actually do is maybe refer to that nurse, and some of them have got nurse led clinics, and we've got all sorts going on, so social care would actually refer in but they would have to be aware of....

Training or instruction

122 Person 3: well there are 138 professionals trained up and like you said earlier we've got social workers and our first two social workers are trained up and ot's and nurses mainly and we're now doing the training to qualify down unqualified people so the training needs to be pitched at a level that suits everyone

123 Person 11: just to help me how many total staff would you want to be trained and what percentage have already been trained?

124 Person 3: well we've got 4200 members of staff in the trust!

125 Person 1: we've got just under 4000 and we've got just over 1000, I think it's 1200 that are within the nursing profession, 900 of those are qualified nurses. I don't know where they all are, do you know person 10?! And the reason I know this is because i'm on the hr committee for the trust so I get all the details

126 Person 9: if that works and we all send in train-the trainers in addition, obviously you've got the three lead nurses that are doing it in their own counties, but if it works for them to have the involvement of some senior practitioners for example to deliver some of the training and that might be something to think about in the future then maybe that's a way of actually increasing the cascade.

127 Person 1: yes, definitely, because otherwise it does limit people.

128 Person 3: we've certainly got people trained up that are very very effective in their workplaces and they're being asked to go to other areas and start implementing it where they haven't really staff as yet to deliver so there's a huge interest and the skills are out there

129 Person 3: just while R's doing that, one of the things from a primary trust perspective, one of the things that we are looking at person 11 is to see whether we can actually do unclear 37:36 kind of training with the practice nurses. I would sort of go further forward in terms of where we are with that unclear 37:46 and it would be looking at unclear 37:49 for them so it if does I will be

able to let you know because one of the things about doing training with practice nurses has been getting them out of quite a family affair unclear.

130 Person 6: i'm just thinking if we do the pre-registration nursing and it's only now I think it's really getting properly into the pre-reg programme University, and we've just finished mapping the mc core areas which will include it, so yes (131)

131 Person 6: even with Y University's, post registration, I mean that's run once now hasn't it, I mean it needs to run a couple more times to get that sustainability and think 'yes, we've now got that pathway right from the beginning when you train right through to when you registered (132).

Change

132 Person 7: so it depends what your project aim was. What the change aim was. If the change was to get the trust to buy-in to, as an organisation, well-being support as a central cornerstone of practice....

133 Person 13: one thing that I want to sort of propose to the group really is because we need to have an action plan following this project for implementation for all the improvements and changes we want to make

134 Person 13: we also had an idea that we might kind of have top down but a bottom up as well, so some practitioner players, stake holders there probably like the people we were talking about today just so that if there's an action planning group that it holds water as far as the practicalities are concerned. But we thought that you would probably know, like maybe I and a.

135 Person 13: Remember a little while ago when I was asking you where you thought we were in the sort of linear sort of process and it was kind of somewhere between halfway and three quarters of the way through the first phase wasn't it, and I think this might sort of mark it off as the end of a phase because all the people/trusts all over the place are talking about too much change, change, change and it never kind of stops, but I think some of the time what happens is that the end of a bit doesn't get noted properly and flagged up.

136 Person 13: it's just that you know when we were talking about it the other day it's that you've got this little....this is a bit of a cheesy analogy.....you've got a little something that's trying to grow on its own but you have to kind of put it in to something that's very fertile and active to make it flourish, and if you just leave it there on its own it will just sort of fizzle out, so if the cpa or a risk assessment policy

137
yes. And I think it's because this is ice-breaking that's why it's hard, isn't it?
Embedding to practice

138 But one of the things that we've always said person 3 right from the very beginning is that we want this embedded in practice so that we're not sat here still in years to come talking about

how we get people to address physical needs, it should just be happening. So does that answer your question?

139 Person 4: yes, and I think the last thing is that they do feel as though this has brought on a whole new level of inter-personal engagement with service users that they haven't had before, do you find that in the link which is kind of, s did this, that they're finding that because this is part of a level playing field and that they're joining in the activities it's all become the hierarchy's gone down and that they're sort of getting stuck in together and learning together and they've engaged more sort of effectively in some of these activities than they have with a kind of deliberate type of engagement process which is quite unusual I suppose

140 Person 7: yes, I see it probably a different way, I mean I agree entirely with people but i'm not on the graph. I would see it in sort of a prince 2 model what you've got. Stages. So we've completed the stage of kicking it off and the training's provided and there's a lot of support. We ended that last year. And there was another stage about implementation and developing in-house programmes, and that's ended, but there was another one implementing and I think the experience that you've got, so I think the steering group monitored all those different levels so it's not been one change, there's been a number of changes and if i'm right commonly that's the problem with change models is that you've got layers of change at the same time, so I could say I feel as if I've ended but AD, you're saying you're just beginning with..

26.

141 Person 8: and we've also embarked on these huge pieces of work about re-designing the services in both west, east, and midway, and what we're very clear as part of that re-design work is that well-being, recovery, all of those issues have to be embedded within the day-to-day workings of everybody that comes in contact with the service, so that is a piece of work that is going to continue and needs to continue and evolve. We're in the early stages of that really across the board.

142 Person 12: on a positive though talking about the data collections now the one thing you have got here is a good bank already of data that has been collected where we need to get smarter as an organisation as to say 'well actually we know for a fact we've got some person clients names on the audit tool without any information attached to it but we know that it exists', and I know Darzi is one of the themes on the agenda today but again with that coming through because the mental health trust will have to have a response to Darzi the same as the pct's do so it's about increasing the importance of all of this in terms of physical health because again it's very much in the mainstream now.

143 Person 2: I mean actually, you know, looking at it from a nurses perspective it would actually create fluidity of care and it would actually create much more people if you like other than just those that are keen actually feeling part of the normal recording procedure to get it on the system and that way you can get more SMI results coming through.

144 I recently met with a lady called PS, you know P, and she's very verbal in the patient public forums, not just in this trust but nationally as well, and she had a son that died last year, but he was very ill, overweight, and she was saying that our client group just don't get the physical health, and she made that very real for me from what we were doing she made it real through experience and personal experience and also from

what they were saying nationally, but she was even saying “well ok we know that this needs to happen in primary care but can you go into the acute trusts as well and talk about physical health and mental health” she said because there’s a xxxx as well to get into primary care, you know, that’s leaving the acute side out of it, but you know, it’s real, it’s out there, but I don’t know, I mean i’m not giving up and I think we should keep chipping away and go through the avenue’s like you say with david and person 7, but it’s a slog and it’s not going to .

145 I mean I recognise where you’re coming from. The CPA it’s extremely important and maybe the backbone of this, but I think let’s get this right, let’s get it out there, and then we start merging it into cpa. Because at the moment we’ve got people in the trust specifically trained around delivering this. CPA covers every clinician who may not be involved in this, and I know the argument could be well they should be, and yes that’s fine, but we haven’t got to that stage yet so I thinks that’s why it’s.... To me... A later stage.

Research

146 Person 1: right, shall we move on as time’s running out, but to person 13 and person 4 thank you very much for that. The audit data, i’ve just brought you the summary just so that you can have a look. We’ve got 819 on the programme to date. Now with this data i’m working with professor rg, professor th, and myself and we’re putting a paper together on the data itself. With cleansing the data we’ve got a statistician looking at it because it’s to clean it from just to get those SMI person clients and also you’ve got people that have just got their names up there at the moment and nothing else. We’re going to get that published in....is it Acta?

147 Person 13: yes, I think it would be really useful because I’ve had a few back, as I say bits and pieces from places that I think are really keen, but basically it never really took off and I think it just maybe needs a bit of revising. But yes that’s my next project to do from this group! But I wanted to get the staff one done and finished.

148 Person 5: it would give a natural follow up wouldn’t it about having established it and then re-looking at what has influenced its progression, attitudes, because you know...

Communication with staff

149 Person 1: yes, but that’s going to be going over into our website, the staff zone, so we can’t....because I took a lot of information off when it went over to the web but once we get the staff zone that only staff can get into then yes we will, but also it’s about getting out of there while you do it as well, not everybody accesses the web, believe it or not, or uses it so yes that was something that we looked at and we did.

150 Person 2: unclear 48:56 but I was thinking while you were speaking there as far as awareness is concerned with everything changing, i’m just offering here, if you wanted to maybe twice in the next six months maybe or something just go out and speak to perhaps one of the community teams or just let them know exactly what the unclear 49:12 is and exactly whatever it is that you’re trying to implement and I could actually facilitate that within my role. I’d be happy to do that.

151 Person 13: and the simpleness of it will make it easy to follow and work from it.

152 Person 5: and from the communities perspective something like this laminated would be excellent particularly for all practitioners, you know, to have it.

153 Person 1: well if we can get it agreed by primary care then that's exactly what we will do, we will laminate it and just flood the whole of the trust and possibly flood the GP's surgeries with it.

154 Person 13: and service users.

Policy

155 Person 5: I think that part of the problem is that there are global emails come out that say that new policies now on the intranet are now being signed on or whatever and staff are actually encouraged to go on and to actually look at that. What the managers will do, particularly for the community teams, is they will pull off a hard copy of the policies which have a direct reference to work that individuals are doing and will make sure that it's discussed in their teams meetings of new policies that have come out on the intranet

156 Person 12: when I last met with L though I was pretty sure that she told me that there was going to be a KPI around physical health within the trust.

157 Person 1: well maybe it's something that, you know, if we are going down the route of KPI'S for physical health that the board has to sign up to setup costs in each team.

158 Person 1: the other thing is just to let you know that I have the responsibility for the course standards for public health, so ultimately it will come down to me!

159 Person 5: well that's good for us!

160 Person 1: it's good for you, yes. And just on digressing a little bit I had to go in front of the healthcare commission in July and one of the one's that they were looking at was the public health, and obviously I just talked all about the well-being and in the end they were kind of going "we've done really well in public health", but it's all well-being stuff so that's where it will come down to. Karen will rightly only just say to me...

161 Person 1: lord Darzi was commissioned to do a whole review of the National Health Service, basically. There was lots of different work streams and, I mean there was a mental health work stream, and there was a staying healthy, and I was actually on the staying healthy one for the south east coast and there's been lots and lots of gatherings of all these eminent people and basically the whole Darzi review's come out now with all the recommendations around taking it forward. Very strong emphasis on leaderships, and the staying healthy

Implementation success

162 Person 9: but given where we started from this is absolutely amazing I have to say and it is such a pleasure to come and sit and hear that people have the desire to have skills there because there are still so many areas of the country where that isn't the case, so to have people now passionate about the importance of physical health I think is really encouraging and even though you work it out to be .5% or whatever it is right now you can almost say per year this is what we will strive for working on what we're doing right now and that will still be better than what we've currently got.

163 Person 11: no I think it's a great achievement and i'm not trying to knock it.

164 Person 5: I would agree. I think it's more of a job because we know that, I mean I know that just within the west I've got it well developed in some areas and fledgling in the others and it's trying to get cross pollination at the moment trying to give encouragement to those that are just starting out in pursuing it and keeping that momentum going, so it feels in the middle really to me.

Empowerment

165 Person 4: we've got, obviously you've done an article already looking at how the service, but soon it will be 2 years since you actually embarked on the start of the journey if you like, and I think it might be worth actually revisiting and actually perhaps write another article or whatever but to look at the impact because I think the impact it's actually had within the organisation and the service users could actually be very empowering, and certainly to get some service user feedback and to add that in to the publication I think would be really powerful because that's the evidence if service users say "yes this has really helped me" and certainly it's great to actually hear that staff are actually getting more out of their engagement with service users, bearing in mind this is a group that's probably been in the service for quite a long time so they're finding out new bits about their service users. That's got to be positive

166 Person 3: from a steering groups perspective, towards the end in a way because you can steer it to a point and then you have to stand back and let it go and sort of monitor what's going on, and I think just the fact that we don't meet every month like we used to, so we're gradually pulling away because it has gained momentum. The whole idea was to set up so it gains its own momentum, and I think that's there. I say towards the end but on the one hand it's almost like the beginning which is primary care because there's still a big journey. We started at the specialist end so we're sort of pulling back but we still need to tackle the primary care end and if we can get this agreed with primary care then that's halfway there from that perspective, and then there's a whole lot of raft work that needs to be done within the primary care setting. But that's my view, I don't know.

167 Person 5: no. But I think it's probably more a reflection that say in my directorate in the west I've got 2 or 3 teams where they have well established well-being programmes, clients are encouraged to think about their physical health coming along to that opportunity to have that reviewed.

168 Person 5: there is and I think its understanding what that's going to look like. To me we should be in the business of promoting anybody's mental health and physical well-being because the two are inter-related. You can't take physical health away from mental health, you have to

actually look at the whole picture the whole person and we should be in an educative programme in encouraging people to look after themselves, to take care of their physical health needs, and their mental health needs. And that actually that's the emphasis and that's what we're good at doing, you know, the business about making sure that people get the necessary screening and tests done, that doesn't have to be done by us at all as an organisation but if we raise awareness with the clients that we work with that they should be asking those questions and supporting them to ask the questions if they're a bit hesitant about doing that, then that's the business we should be in and that those are the KPI'S that could actually worked up around that sort of educational facility role around the....

Skills

169 Person 2: also as well not just taking the blood pressure it's recognising when someone is hypertensive.

170 Person 12: I think historically as well what person 13 reflects is the fact that blood glucose has been talked about or associated with SMI for many years whereas the links with cholesterol's probably become more prominent in the last 5 years I would say, much more so compared to what it used to be, therefore in some ways that's no surprise. In 5 years time you would expect that to be unclear 21:57 update that these are the areas that we need to make sure that we cover off given the feedback, so it will lend itself very nicely to actually developing.

Attitudes and knowledge

171 Person 1: it's really about the staff's attitudes and knowledge around physical health and implementing well-being etc because I think that the thinking was is that if you don't tackle that you can ask as many service users as you want but if they're not getting the service it means nothing, so it was about getting the staff to tell us what they know and, because that's about right isn't it?

Enthusiasm

172 The other positive thing is that they're being incredibly creative about how they implement this, in all the different areas they've all got different stories and they're fantastic and the ingenuity is just outstanding. They're not going to be stopped in doing it.

Inter-professional issues

173 So it goes back to what we were saying initially, if I remember correctly, which is basically roles and responsibilities, so if somebody in social xxxx secondary care services what they wanted to state to receive, but when they go back out to primary care, because the reason why this was started is because what we don't know as an organisation we want to get service users back out to primary care sooner rather than later, is to ensure that the good work that you've done in secondary care doesn't then get unpicked if you like (174)

Acknowledgement

174 Person 1: just to let you know I have entered it again in to the nursing times award, but as you know we didn't get through last year although I became a judge! So I kind of thought that they won't ask me to judge it again this year so I've put it in, but they were inundated with

people's entries around physical health and mental health so they're actually such a huge, but I put in some of our unclear 21:46 that, you know, that makes it shows that there's a difference being made, so you know they might feel sorry for me again and ask me to judge! You never know! That's a good experience.

27.

Feedback from SU

175 Person 3: especially seeing as one of the unclear 06:20 people in the form, you know, the unclear 06:23 are looking for service user feedback this would certainly help the trust in terms of evidence in the sort of responses back from service users.

176 If it's that.... If there is a client and client service users mention there that we're assisting them to access a service, they would benefit, it is primary care benefits, it's that we're improving outcomes of this minority of their caseload.

178 Person 10: could I just ask the question....the care team, if you have primary care workers, that it's an assumption that its secondary carei don't know... Do you have primary care? You don't have primary care workers?

Resources

177 Person 4: so, for instance, you might do a bit and somebody else would be doing other bits and so on, so it's not kind of a tidy thing necessarily. This particular lady was well-being and there was an incident on the ward and she had to take someone to A&E so while she was sitting there in the waiting room she did the assessment and did it as a one-to-one because you can't often afford get that on the ward so she kind of took the opportunity which was quite ingenious. So they also say about the flexibilities which helped as well. And instead of having a protected day as seven hours they might have an hour here and an hour there. Another thing that is not on this lot because this was just from one script, one session, there was some nurses who were thinking about well-being clinic as a sort of bricks and mortar sort of arrangement rather than a virtual arrangement, so when they talked to the others in the group they realised that they have a clinic which may be these ten people that they may not all be in the same room together, they may do them at home

RESTRAINTS (STEERING GROUPS)

Putting into practice

178 Person 4: well arguably, I mean the embedment's and getting it consolidated so there's no slippages is what people say is the hard bit, you know, because the initiative is the kind of exciting bit.

179 Person 6: could I just make one point? I think this is absolutely brilliant by the way but if it's going to the service users should we not explain what primary and secondary care is?

180 Person 3: yes, because otherwise you could start a riot of because if that process is then not followed service users could get very upset. And it's going to take time to make sure that this is happening across the board in the same way that the list of medical services has taken time, so I think that if the relevant bits of information could be included in the leaflet as appropriate, but this is perhaps just for healthcare professionals across primary and secondary care.

181 Person 5: and I think, I was actually in the EMT this morning, and I think that there are going to have to be some high level discussions with the SHA, the pct, around well-being because of the contracts that have been drawn up for us and the fact that these things will have to be replaced from April of next year as to actually are we going to be expected to deliver this because if we are delivery means there will be targets attached to it, we fail to deliver, we lose revenue, or is this something that needs to have some means of joint ownership and in which case how do we then collect the data that enables us to be able to demonstrate that we're doing our bit and the pct's are doing their bit, so there are some concerns within the organisation as to how we can actually deliver on a well-being physical health programme and making sure that people do get their physical health checks, and at the moment they're concentrating on the in-person client units, well the majority of people we support never go anywhere near an in-person client unit and we know that we have huge numbers of people fairly long-standing clients within the service that haven't had a physical health check for years and years and years and are very unlikely to accept anything that a GP offers them. So how do we ensure that those people actually get what they're entitled to have

182 Person 5: and I think you've only got to look nationally at the normal men and women's screening that goes on within GP practices at the high number of people that just don't bother to turn up. Look at the cervical screening. How many don't bother to turn up to have those tests done? And it would be interesting to see how many of those are people with severe mental illness because I would think that there's probably quite a lot but there's also a lot of people that can't be bothered and don't think that it's actually something that's going to happen to them so they don't do it, they'll be fine so they're ok they don't need to go.

183 Person 5: I think what they're also looking at is particularly for people who are admitted to hospital...i think that there is a high percentage of people that when they are clerked in do not get any form of physical examination at all. And that is one of the things that has been picked up out of a number of incidents that have taken place and then when you look back you see that actually they didn't have a physical examination and that is why there is going to be a huge emphasis on the clerking in of clients when they're admitted to hospital that everybody has to have a physical check. I mean I remember back in the days when I started in nursing, you know, the first thing that actually when you came into hospital was that you had a physical examination

and that you got asked all the questions that you needed to. And the routine blood tests that we were doing always included VR which actually it needs to re-include now as the evidence of syphilis has increased across the population.

184 Person 5: no, there's no trigger for physical health so actually if you included physical health, I mean, one of the other things is if you have a diabetic who when they become depressed is prone to stop eating and drinking that will have major implications on their physical well-being.

185 Because I think GP's are wanting to be paid for what and it's as though we're blaming them and they're immediately getting prickly, but it's not that we're saying that you're not doing it it's actually our client's, for whatever reason, are not engaging with you. The fact is that you're not very flexible with your service and you're not very sensitive to some of the issues around mental ill health. The fact is that the client's missing that important link and coming to us, so it's not that we're pointing the finger and saying it's because you're not doing it, it's that we're dealing with the type of client's that they'll always be a huge percentage of them that won't engage in primary care but will feel safe with us.

186 But it's not about ... I mean the thing is we don't do the QOF we don't do that and we don't venture anywhere near that. I think for the trust and, you know, I agree with you that clinicians do feel quite bewitched by this kind of process because it's bringing back their nursing skills really. So we're not asking ... We're not saying that primary care does the lot because it didn't work and that's where we've had a lot of our clients not having physical health or the research shows that,

And so if we're talking about social inclusion then we should be, and that's what we aim to do not just because we like them to be paying for those tests and not us in secondary care so, you know, and we have that in our heads all the time but actually we're meant to be the recovery model moving them back out to access, but realistically a lot of them have never really truly accessed it anyway, so is it realistic for us? But that has to be our ultimate goal.

187 Maybe rather than present...i don't know whether this would work, but rather than presenting this to GP's with a new system, we tinker with the cpa policy and process as it stands at the moment slicing this into it enriching the assessment, the physical health assessment xxx the cpa as it stands at the moment, building that up, making people aware of that change and that the emphasis is much stronger.

188 The problem is we can't tinker with the CPA process because that isn't just our trust, it's not a policy just for our trust, that's KCC as well and they've just undergone a review and it took about a year just to get it back where it is now, so to say "well we'll pop this in it" that's not going to happen until their next review, but what we can do is what you said earlier on pat about latching it on to CPA, so it won't be that we can get it in to CPA but we can get it in to....

Responsibility

189 Person 3: because you kind of need to get buy-in from all the GP's and to get run by the GP's first of all it needs to be kind of agreed by the pct probably, some of its groups, and then for the stuff i'm doing you kind of get it agreed by your own internal pct groups and take it out to

practices via the training development via kind of sending out information practice manager's group sort of, you know, so it's just difficult if it just sort of goes out...

190 Person 5: I can't understand why the pct's aren't more concerned if they're paying GP's for doing something that they're not actually necessarily doing, why the pct's aren't doing anything with it.

Person 3: well I think pct's, to be honest that's not my area of responsibility, but it's obviously that those monitor as best they can what's going on and if it is basically fraudulent then that's obviously an issue but yes it's....

Person 13: well I think this is your point that was being made by peter isn't it, your colleague, when we were looking at the primary care interface, wasn't it, about do we really want to have it or should it be in primary care, and if it's with us whether we get paid for it and are we then responsible? So it's very complicated isn't it?

Person 1: I think some people get confused though around the QOF and actually delivering the QOF to delivering basic physical health care. And I think within a mental health trust we should be doing the basic physical health care and looking at activities etc but the monies lie and the KPI'S lie around the QOF and I think that's what people get touchy about.

And I suppose really, it all comes back down to that political agenda. Why is secondary care doing it? Why primary care doesn't do it, and that's the rounds that we are getting stuck in. When I was on the Darzi review for staying healthy, it was a virtual group, and when I put in and said about this work that we're doing the amount of GP's, public health director's etc , that came back saying "well why is secondary care doing it?" And i'm like "well basically the research shows you don't do it", and it was like this, and I said well "there's no use arguing. This is what we're actually doing". And it was interesting because when the final report came out there was no mention of it and I copied the world and his wife into my email including xxxx, and you name it they're all in there, and I was saying that I was surprised that I didn't see anything in there, and it was like "oh, oh our mistake" and they put it in but it was like if I hadn't have been that pushy then they don't take it high on their agenda, and especially public health because they put diabetes, teenage pregnancies and everything else high on their agenda. But again in my email when I was having my rant I was saying "well you're talking about social inclusion. You're socially excluding" but it's just that rapport all the time but what's interesting, and I've noticed it's been advertised in the HSJ client bit, is that there's conferences coming up around primary and secondary care interface,

Lack of knowledge and skills WBSF

181 Person 13: that would explain it. And the next questions are around the unclear 15:04, the first one is 'have they ever undertaken a physical health assessment?' and it's quite sort of even between the yes's and no's really to that questions, although there's slightly more no's to that. And then if they said yes they were asked 'have they recorded or documented the discussions within the caseloads' and some people had but some people had partially documented it, and again there's a kind of a no response, I think quite a lot of people didn't answer the question. This is what the question was pointing at not the documentation as much as the collaboration with the client, and that might have been a bit different. And then this one was around 'can they take blood

pressure and calculating the body mass index as well?' most people know how to do that but there were still a percentage of no's there.

182 Person 12: no, unless they've been trained as part of their well-being they wouldn't necessarily have had it.

183 Person 13: and the next one 'knows the significance of raised lipid levels and the effects of smoking on some medication which used'.

184 Person 1: so again it's quite high on the no's.

185 Person 12: out of interest are these covered off in the current training?

186 Person 5: and I think where some of the well-being clinics are run, for people who are running them, I think the biggest issue is around the increasing number of clients on cholesterol and the huge impact that stopping smoking has on the level of cholesterol in somebody's system, and a lot of staff are actually not aware of the impact of clients from stopping smoking.

187 Person 13: it could be dangerous. They want it so that they're doing the person a favour, and fortunately they are probably, but.....

188 Person 5: they might be in the long term but in the short term they've got to look at....

189 Person 1: the cholesterol again doesn't surprise me because they don't actually have the facilities to take cholesterols on the wards, they don't have the machines, so it doesn't surprise me that they wouldn't know how to do that, but blood glucose, again, the machines are freely available but cholesterol isn't though.

190 Person 12: well there is a question, and for me there is a question about 'how are trust policies rolled out to staff?' because, and I know we go on the intranet, but when you talk to people about policies you know exist, or guidelines you know exist within the organisation, the attitudes of a few of the staff don't know of that existence.

Availability of resources

191 Person 1: so it's like 'we can't get on it now' and I said that we'll see what we can do. And again we've got to appreciate that at the moment that a, m, and n have other remits to their job so it can't be all. In saying that i'm meeting with c f, I think it's this week, and we are going to look to see how we can raise some money to get a substantive k post

192 Person 13: and then we asked if they were....so the next few questions is just for the people that are trained, have they experienced any challenges when implementing/embedding programme and most people said yes and 10 people said no. Again there were people that didn't respond, and although this is what they actually listed were the barriers to implementation, and they were the kind of main things that came out. A lot of people said time which is just the same all the way through.

193 Person 5: and certainly with the issue around equipment, that is a really big issue for my community teams, and I mean I can only speak for the west but the equipment in order to have all the necessary stuff there is not cheap, it's expensive, we don't have any available money within our budgets in order to actually buy the equipment that we needs and so therefore we've actually had to rob Peter to pay Paul to actually...

194 Person 5: no, what we've done is we've looked at a number of pieces of equipment held within the team, so it might be held centrally that people then book out when they're taking it out and what have you. Portable scales. Good portable scales and what have you, so we don't have a budget for it, the miscellaneous budgets that most of the teams had have gradually got smaller and smaller and smaller and smaller, you know, we're just about to go round into the next budget setting and we've got another 3% savings to find so you know that we're going to cut and pair down our budgets as much as possible but we don't actually have any budget line around clinical equipment that might be needed

Poor response to survey

195 Person 13: yes, ok. Well I've got the results with me today of the staff questionnaire that we circulated. Unfortunately we didn't have a very good response rate; we only had 67 questionnaires returned from the whole trust which is quite poor really considering the amount of staff. So I've brought it along anyway so that everybody can have a look at the initial results but it might be worth us trying to tackle it in a different way and getting and generating more responses so I wanted to sort of throw that out to the groups that we're unclear 37:16 really. Well I'll hand these out. We might not have one for everyone.

196 Person 13: it went out on admin emails. Yes, I mean I sort of umm'd and ahh'd as to how to get it out there really and whether to go down to the manager route but I thought that maybe by doing it via an admin email you'd capture so many people in one sort of hit really but whether that's been successful I just think that shows a poor response rate.

Clarity

197 Person 3: because you kind of need to get buy-in from all the GP's and to get run by the GP's first of all it needs to be kind of agreed by the pct probably, some of its groups, and then for the stuff i'm doing you kind of get it agreed by your own internal pct groups and take it out to practices via the training development via kind of sending out information practice manager's group sort of, you know, so it's just difficult if it just sort of goes out...

198 Because I think GP's are wanting to be paid for what and it's as though we're blaming them and they're immediately getting prickly, but it's not that we're saying that you're not doing it it's actually our client's, for whatever reason, are not engaging with you. The fact is that you're not very flexible with your service and you're not very sensitive to some of the issues around mental ill health. The fact is that the client's missing that important link and coming to us, so it's not that we're pointing the finger and saying it's because you're not doing it, it's that we're dealing with the type of client's that they'll always be a huge percentage of them that won't engage in primary care but will feel safe with us.

Resistance to change

199 As far as the percentage it's a very low percentage that we've actually got trained at the moment. I would like to sit here and say that we would like 100% of our staff that are delivering clinical services trained, that is what we will go for. I think that's a bit unrealistic because not everybody wants to be trained in this

200 I think GP's... I think they're responding....they're very defensive, they're responding as we'd expect them to

Communication channels

201 Person 3: or whether it goes back, because obviously there are clinical leadership, what do they call them, where all the pbc leads with the peck, there are where each of the three organisations have meetings where a lot of the things are discussed which are strategic but also impact on the rest of primary care and it almost feels as if there's a need to go to one of those because it's a clinical issue....

202 I think it's more accurate isn't it? Something like that. By calling this a shared care protocol, is that one of the blocks do you think? Or if we said a primary and secondary care interface of physical health... I know it's a play with words but we're saying it's the interface between....

Change in roles

203 I don't know whether some of you are aware but i've had to take on a lot more responsibilities within my role due to p h now being the interim operational director so some of my workload has had to give and the well-being is one that now has to give because initially, I'd say for the first year we were getting it up and running but i'm sure you'll all agree is that it really is getting out there now, it's embedded and we're running away so my involvement doesn't have to be as strong as it used to be and I've had to hand quite a few bits over to the lead nurses and this is one that person 9 is actually picking up for us.

204 Yes, I suppose my only concern is around hearing those comments "great, secondary care are doing our QOF", and I think that if we're not careful and by saying, you know, these are the benefits for primary care they could turn around and say "yes but we want you to do this, and we want you to do that, you can do this as well" but it might leave ourselves opened....yes.

Lack of consistency

205 Person 12: and the one that follows that, the lack consistency in the trust. Because the one thing that I thought we had got over all other organisations is consistency.

206 Person 13: I think it's not implemented uniformly, and I think that's a good thing because it's such a big trust and the areas are so different, but I don't know what they're talking about in the actual consistency element.

207 Person 5: no. But I think it's probably more a reflection that say in my directorate in the west I've got 2 or 3 teams where they have well established well-being programmes, clients are encouraged to think about their physical health coming along to that opportunity to have that

reviewed. I've got other teams where they're struggling to get that message across to other team members that this is something that they need to do. Staff have done the training, they haven't yet got them well established so therefore it looks as though this inconsistency is across the directorate as to what is happening and I think that the fact that at the moment you could be being supported by a team in one area and actually not have that available to you within that team, you'd have to rely on the primary care service actually delivering that for you. And if you were 10 miles down the road and actually being supported by another team you would be encouraged to get involved in the programme, so I think it is something to do with the levels of the sort of progress that we're making within each teams that gives that level of...

Training and education

208 If the GP's in primary care are saying they need to be trained, that they need to have extra money, do they really know what we we're asking for?

Lack of support

209 Pro with work but when it actually comes to doing something from a primary care perspective, I think....i would say something different in terms of....because they've only got a limited amount of resource, what they felt they could do, and that for me was.....it did get me slightly concerned about "so you're going to focus more on the common mental health problems but actually we're both agreed that we need more support".

Lack of creativity-vision

210 One of the things that is holding them up though is that they are reporting, and I've spoken to donna about his already, that they're sometimes not having all the basic equipment that they need like unclear 14:48 and weight scales and stuff, and we have thought that some practitioners that maybe who work in the community would like to have one of their own so that they keep it with them but that's probably not going to be possible, but they're saying I think that there's not one in the team so they need to have some of the specialist stuff. What's going along with that is that the idea is that this well-being clinic as defined in the nice kind of documents means that you have to have a room with people and stuff and they're not thinking about the virtual clinic or a clinic activity rather than bricks and mortar establishment where that happens, but I think that change is kind of moving on in their minds a little bit more, it's going to be broken down a bit, and some of them are feeling that now that's getting embedded or the expectation is that other members of the team who are here that the loss of protected day, which was their sort of holy grail, is slipping away from them and they're not seeing it as a day that's integrated throughout a week rather than a day on its own

REDUCED RESTRAINTS & FREQUENCY OF REFERENCES

Exploiting existing systems

Person 3: I think going back then about the service improvement group that might be the vehicle of actually getting some more of this disseminated and maybe that might be the right route because thinking about it logically people sitting on that service agreement group will be across primary and secondary care, so that might be a good one

Person 6: the thing I wanted to raise was a physical well-being policy. I think this is something that we missed out on when we set up the training and I think that's probably because maybe the physical well-being policy came out after we started rolling the training out

I think if you, I mean, if you latched it on to something that was an existing system I don't think it would be quite so threatening, and I think if you, i'm pretty sure that you could probably latch that into a CPA if a CPA process was slightly tweaked, because we're currently doing CPA's as often as necessary isn't it, around mental health and seriously mental health issues and if it was this the physical health was linked into the CPA process and it just got linked in, we've agreed the CPA forms and there's an expected and a division of labour with the CPA about who does what and where it gets done and that sort of thing, it might not be quite so obvious, but it's linking, but it's still achieving the same aim.

Education & training

Person 1: so you could say it's a 4 day training, they do 3 days and then they come back in 4 weeks time and do another day. Do it that way

Communication

All we're asking for really is that communication, aren't we? That they know what we're doing and we know what they're doing and that we actually share so that the patient/client isn't having the same done in both primary or secondary.

Person 1: well we did a well-being one at the very beginning, and it might be that I put some of this in that leaflet and send that out to everybody that's been trained and a cross and say "please can you print these off and make sure that your service users have them". I mean you can still put the GP and mental health service so that makes it very clear for everybody.

But there are quite a few people there that have said no as well so I think that's perhaps something that we need to look at in terms of how we communicate the message to them more.

GP's role

Person 8: but I think the challenge for us now is that we are looking at step to wardens of care as part of the design and we're all very focused on the fact that that primary care end we need to get it right and we need to be sure that we don't go in to competition with our practice based commissioners around quaf payments and all of that, but the important thing is that we don't lose sight of the service user in all of this who we know at the moment there are still a large number that will not access the normal well-being checks that they should be getting from their GP's for a variety of reasons and we need to understand that more to enable it to happen and develop better in primary care, because if it was working in primary care none of this would need to happen in the

first place.

Creativity

Person 13: it comes up a lot in the focus groups doesn't it, support groups with people and the histories and CPN's have sort of bought a set of scales in T's store and kept them in the back of their car, you know, and they kind of have all these genius ways around things

Person 13: I think what they seem to do is like most of the health professionals and nurses they will be quite creative with what they can do and they will use clients own stuff,

Increasing awareness

Person 3: question 8 actually is quite interesting from a lot of skills and attitude because it's talking about, it was the one that actually asked compared to the general population people with severe mental illness are less likely or more likely or equally likely to develop the following, and they list some of the risk factors, and what's interesting is that some people think a lot of the risk factors are still the same, so from a training perspective across the organisation. Again it's a scope for sort of increasing the awareness. This is fascinating

Leadership

Now I will still be involved as far as it comes to the steering group and then in the strategic direction that we're taking this, but for the day to day grounding of well-being that is now over to person 9. Person 9 is dual qualified, she's our GN as well as our RM so she has a handle on physical health needs but person 9 will also need supporting with this because you're playing catch-up a little bit aren't you

So the lead nurses will still be working with person 3 in some of the training but the lead nurses will now be taking over the link meetings and getting it out there, and I suppose the advantage of that is because they already work within the directorate's and they have those in-roads already in the senior nurses for contacts it's going to be high on your agenda, so they are things that are going to change but hopefully not too much but I will still be involved within this steering group and chairing it

Motivation

No. I've done it with one or two and I've spent the whole day taking someone to a pre-op assessment and then the whole day's sitting in a hospital with them so they didn't do a runner to have a biopsy taken, and it was a huge commitment and a huge time out of my caseload that my manager said "you know this biopsy has to be taken, you don't help assist with that"

Developments

I was talking to m j about the ship assessment tool because one of the things that will put people off is that it's got schizophrenia on there and if you look at the assessment you could do that with anybody with a mental health need and regardless of age etc and I think people will look at it and say it's not for me because I work with older adults, I don't know, dementia or something, and I was talking to m j and he said that they might even call it a hip and take the s for schizophrenia

because they are aware, and I said I don't care what you call it but you need to take that schizophrenia element out.

Providing resources

Person 1: right, basically you just open this up and....it's the cd now, it auto runs!....you've got all the documentation that we use within the trust and we've also put some key documents, such as choosing health went on there, 'doesn't it make you sick' went on there, and a few others so, we'll hand these out, we haven't disseminated these widely yet because we are actually going to be looking at where they go to because not every individual will need one of these but every team will need one,

211 We have run awareness sessions around the Trust for the first year so once a month A and I would go to a different place across the Trust and run a session and repeat it twice more so that people could come to a morning session, a lunchtime or an afternoon and we raise the awareness about the physical health policy, the well-being service and what it was all about and we get them to do a quiz which was quite fun and it got them all interactive, so that was raising awareness and it covered a large area and a large amount of staff, and now we just do awareness sessions when they're wanted because then their staff attend sessions if they actually want them to come rather than us saying they're coming, so that's still ongoing and the people are requesting an awareness session

212 This[question in the survey] is under the knowledge and awareness section, so here we asked these questions specifically about 'are they aware of the physical health policy in the Trust?' and also the well-being support programme, and this is kind of quite split really in that 147 people said 'yes' and 132 have said 'no'. I guess it doesn't really surprise me because I think people aren't always aware of them (policies)

213 I agree with you, they'll [staff] only go to it [the policy] if they need it or if they think they'll need it

214 And that's more of an issue. If they think they need to look at it they'll go and look at it, ... there are some instances where people don't go to the policy that would have given them the guidance that they're actually looking for because they haven't recognised that they needed to do that

215 What I've been doing since the awareness [roll-out programme] stopped in December is actually saying to teams "ok well look, none of you came to the awareness session, are you aware of the 'well-being': are you aware of the 'physical health' policy? Can I come to your team?" Some people are moaning that they haven't been involved or invited to stuff [such as the Physical Health policy launch] and yet we sent out invites constantly

216 And so if you're a professional, and it's up to that nurse who's taking on the responsibility of running a WB [well-being] clinic, she's a professional within her own right, she should find out before she says yes that she can do all those things and that she's confident and competent to actually run that well-being clinic as it should be run

217 The thing I wanted to raise was a physical well-being policy. I think this is something that we missed out on when we set up the training and I think that's probably because maybe the physical well-being policy came out after we started rolling the training out, and the issue is that in the physical well-being policy there is a form that needs to be completed and should be filed in patients notes, and the information on the form is very similar to what the well-being people would be collecting anyway, and of course in terms of the training we've been focusing and encouraging people to collect information so it can go onto the database and we missed the point that really they should be completing that form in the physical well-being policy

218 Could you not, I'm just thinking about people are going to start complaining about having to fill in the two things, if you've got the form that should be completed as part of the physical health policy, they've got a print out for what's on the Audit Tool, can you not just staple the two together so that you actually have got the outputs?

219 When I talked to D about it when we finally realised this by talking with JS the pharmacist, the information is there it just needs to be put on a piece of paper and followed in order, and they're not that dissimilar. I think there are just 1 or 2 areas that are missing, for example, it's about blood tests, the actual physical policy checklist says about blood tests, we're not just being awkward, and of course the well-being person may not necessarily do that at the first consultation, they may do it at the second, we need to get them to start thinking of doing it the first consultation. So you're right, it's bundling it together so we do not have to duplicate it

220 We've got an opportunity to start tweaking the form that's in the policy to fit in, so that people aren't duplicating, and I think that's what you were wanting

221 How does the HIP or the SHIP [physical health assessment tools] fit into that? Is that the third piece of information?

222 That's the third one. It partly overlaps but partly other information which would be relevant and useful to bring in, but at the moment we're not going to be doing anything with the SHIP in relation to the training, they're still distinct aren't they, I guess we'll see the policy in the physical health policy's reflected very much with what's in the well-being Audit Tool

223 So you're right, it's bundling it together so we do not have to duplicate it. And we've got an opportunity to start tweaking the form that's in the policy to fit in so that people aren't duplicating, and I think that's what you were wanting. The problem is obviously because this has happened it's very difficult to audit the policy. It's possible but it's not as easy as we'd like it to be because the information is scattered

224 Is there a procedure kind of thing in the physical health policy?

225 No. No, we've never had....

226 So you do need a sort of clinical procedure really.

227 Yes, and maybe that's something that we can do.

228 Its not just taking the blood pressure, it's also recognising when someone is hypertensive

229 I think historically that blood glucose has been talked about or associated with SMI for many years whereas the links with cholesterol's probably become more prominent in the last 5 years

230 we've got just under 4000 (staff in the Trust) and we've got just over 1000, I think it's 1200 that are within the nursing profession, 900 of those are qualified nurses and the reason I know this is because I'm on the HR committee for the Trust so I get all the details

231 Just to help me, how many total staff would you want to be trained and what percentage have already been trained?

232 well there are 150 professionals trained up and like you said earlier we've got social workers and our first two social workers are trained up and OT's and nurses mainly and we're now doing the training to qualify down unqualified people so the training needs to be pitched at a level that suits everyone. If that works and we all send in train-the trainers in addition, obviously you've got the three lead nurses that are doing it in their own boroughs, but if it works for them to have the involvement of some senior practitioners for example to deliver some of the training and that might be something to think about in the future then maybe that's a way of actually increasing the cascade

233 We've certainly got people trained up that are very effective in their workplaces and they're being asked to go to other areas and start implementing it where they haven't really staff as yet to deliver so there's a huge interest and the skills are out there

234 One of the things from a primary trust perspective that we are looking is to see whether we can actually do the WBSP kind of training with the practice nurses

235 I'm finding it a real struggle. I'll start on the negative stuff and end on a positive note. But what I'm finding is that, actually don't get me wrong the staff are lovely, they all work with me but the attitude that is portrayed is "oh bless, isn't she eager" sort of attitude or the other one is "oh it's another project that will fall by the wayside" and so I find it really hard to get the support of the team. Now I know you came to the last one and my manager came and "oh we must start weighing everybody. J, can you sort that out" which I did. The charts that we've got for temperature, blood pressure etc are stuck in weight charts integrated on the back so we do that, turn over, do the weight. I said to ask that when everyone's having their meds on the weekly basis I'd have it set up, BP machines, scales etc so they're there and they're not having to go back and forth, but we are....I'm not there every Sunday because like the Sunday wasn't a weekly time it hasn't been done since, and so I'm struggling to get everyone else to keep doing

236 In the community all that gets chucked out the window, which I love, and say this is your home, if you want to sit there in your dressing gown and talk to me, if you want to sit out in the

garden, if you don't want to open the front door but you want to talk to me out of the window, that's fine, that's ok

237 I think one lady [WBSP nurse] at D town runs it all by herself which I can't think is very good for her at all. Well it will be alright until something happens, like everything, and then it will be well because no-one else wants the responsibility of it. That's what it is! But I think the responsibility is there through the policy, regardless.....for everybody yes