The Influence of Contemporary Health and Social Care Policy on the Clinical Decision Making of Community Mental Health Nurses. A Critical Realist Exploration.

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A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the Degree of Doctor of Philosophy.

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Declaration

I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me or any other person, and is not concurrently being submitted for any other degree other than that of Degree of Doctor of Philosophy, which has been studied at the University of Greenwich, London, UK.

I also declare that the work contained in this thesis is the result of my own investigations, except where otherwise identified and acknowledged by references. I further declare that no aspects of the contents of this thesis are the outcome of any form of research misconduct.

I declare any personal, sensitive or confidential information/data has been removed or participants have been anonymised. I further declare that where any questionnaires, survey answers or other qualitative responses of participants are recorded/included in the appendices, all personal information has been removed or anonymised. Where University forms (such as those from the Research Ethics Committee) have been included in appendices, all handwritten/scanned signatures have been removed.

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Abstract: Background:

This study addresses the perceptions of Community Mental Health Nurses about factors which influence their decision making. Their role in delivering mental health care is influenced by socio-political factors which shape public policy.

Method:

The meta-theory of Critical Realism was chosen to guide the methodology. This conceptualised that social reality if complex and stratified. A policy analysis was used to identify national determinants for shaping practice. Empirical data was obtained from semi-structured interviews and captured the perceptions of Generative mechanisms were explored further using non-participant observations.

Findings:

The findings highlighted individual, team and organisational factors, experienced by the CMHN as having an impact on their decision making. The generative mechanisms identified were managing the workload, the role of the CMHN and service user self-management.

Conclusions:

This research has implications for the role of the CMHN and the organisation of CMH services. These implications include the changing role of the CMHN, structures of CMH services and organisational culture within the NHS. The recommendations for practice include reducing the administrative burden on CMHNs, leadership and staff development. Implications for research include examination of the role of CMHN in the context of a developing culture of integration and the impact this has on retention.

Commonly used abbreviations

CMHT: Community Mental Health Team

CMHN: Community Mental Health Nurse

CPA: Care Programme Approach

SW: Social Worker

MDT: Multidisciplinary team

PCT: Primary Care Trusts

NHS: National Health Service

HA: Health Authority

DH: Department of Health

DHSC: Department of Health and Social Care

WHO: World Health Organisation

MHA: Mental Health Act

STPs: Sustainability and Transformation Plans

ACOs: Accountable Care Organisations

RMN: Registered Mental Nurse

SEN: State Enrolled Nurse

NA: Nursing Associate

PBR: Payment by results

SU: Service User

ICS: Integrated Care Systems

ICB: Integrated Care Boards

CCGs: Clinical Commissioning Groups.

CQC: Care Quality Commission.

SMI: Serious Mental Illness.

GP: General Practitioner.

CR: Critical Realism.

AOT: Assertive Outreach Teams.

EIS: Early Interventions Service.

Glossary of Terms

Clustering: In mental health is a global description of a group of people with similar and social characteristics

Competition: the creation of a purchaser provider split to create competition between providers within the NHS.

Critical Realism: conceptual framework and meta theory.

Decentralisation: responsibility for planning and decision-making is delegated away from central authority to local groups.

Demi-regularity: semi-predictable pattern, structure or pathway.

Efficiency: performance in the best possible manner with minimal wastage.

Gatekeeping: controlling or limiting access to a resource.

General management: nonclinical managers, with business experience, employed in the NHS to oversee planning, implementation, and control of performance.

Integration: joint working arrangements between local health, social and non-statutory organisations to meet the needs of the local population

Marketisation: the exposure to market forces.

Parity of Esteem: the need to value mental health equally to physical health.

Productivity: measurement of input and output.

Socio-political: combination or interaction between social and political factors.

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Chapter 1. Introduction and Background

1.1 Introduction:

This introductory chapter will provide a context to the purpose of the thesis. It will provide a brief overview of English NHS policy and mental health services funding since 2012. It will explain the structures and implementation of national mental health policy as experienced by Community Mental Health Nurses (CMHNs) since 2012. This is considered in the context of their Community Mental Health Teams and operationalised structures created by their NHS mental health trust. This will be followed by an outline of the functions of generic Community Mental Health Teams and the mental health nursing workforce.

The author's professional development, experience and positionality in relation to their choice to pursue this area of study will be discussed. This will be followed by an overview the research aims and questions and the contribution of this thesis. Finally, a chapter summary and structure for the rest of the thesis will be given.

1.2 The context of this thesis

This thesis addresses the impact of contemporary health policy, since the introduction of the Health and Social Care policy in 2012, on the role of Community Mental Health Nurses (CMHN), in relation to clinical decision making. The role of the CMHN is aligned with intrinsic values of the CMHN, their sense of autonomy, intuitive knowledge and investment in the therapeutic relationship (Clarke et al 2004). Their decision-making draws upon these skills and empirical and procedural knowledge. It is also shaped by operationalised criteria, organisational priorities and the needs of the local population (Barron 2017).

The ideological and socio-political factors that drive public policy development, include ensuring the efficient use of social and economic resources (Esposito and Perez 2014). Successive government administrations have sought to ensure effective use of resources, by the introduction of marketisation, and systems which seek to demonstrate measurable outcomes, offset by costs (Roderick and Pollock 2022). These include the creation of standardised care pathways and measurable outcomes and auditable standards. These structures and outcomes are created Nationally, disseminated regionally and operationalised locally by NHS Trusts. Operationalised policies shape the function and practice of CMHTs and individual CMHNs.

Efficient use of resources therefore has an impact on team and CMHN clinical decision making. This thesis considers the potential for moral dissonance and potential conflict within the CMHN, their team or their relationship with their Trust. Alternatively, CMHNs can internalise or comply with the efficiency agenda and their decision making is influenced by standardised procedures and the need to meet outcomes. Therefore, the purpose of this thesis to examine how these drivers impact the role of the CMHN and the mechanisms which enable or constrain this.

1.3: Background.

1.3.1: The development of English NHS Policy.

English NHS policy defines a course of action reflecting decisions made by government about actions to be taken to address health concerns for the nation (White 2012). The development of successive health policy is driven by politics, ideology, evidence-based research and competing social issues (Traynor 2013).

It upholds principles of quality, safety, addressing inequalities and ensuring professionalism (Annesley 2019).

English NHS policy increasingly compels clinicians to consider productivity, cost effectiveness and allocation of finite resources (Robertson et al 2017). This has led to the creation of productivity driven outcome measures. (Alderwick et al 2016). The contemporary ideological position has sought to achieve measurable productivity, consumerism, decentralisation and a reduction in funding from taxation (Robertson et al 2017).

The policy analysis detailed in chapter five gives a historical overview of the development of NHS policy since the introduction of local commissioning and general and financial management of NHS Trusts. In Working for Patients (DH 1989) the Department of Health created the NHS internal market and introduced "self-governing" NHS hospitals and GP fundholding. This gave the responsibility for purchasing services to local commissioning bodies and the provision of services to NHS Trusts.

The NHS Plan was published in July 2000. This established commissioning arrangements the Primary Care Groups, replacing GP Fundholding arrangements, which commenced in 2000 and were fully established by 2002 (Edwards 2004). These achieved Primary Care Trusts status by 2004 which decreased the role of Health Authorities as PCTs by taking on the responsibility for local commissioning (Webster 2002). This introduced greater collaboration between the NHS and independent providers to facilitate the use of private facilities within the NHS. The role of PCTs expanded to incorporate social, community care and public health.

The White Paper Liberating the NHS (Department of Health 2010) sought to improve health outcomes: evidence-based measurement, payment by performance, increase local responsibility for commissioning. This led to the formation of a significant policy, the Health and Social Care Bill (DH 2012). This bill paved the way for the introduction of outcome measures, rationalising services, cost effectiveness and competitive tendering. The Five Year Forward View (NHSE 2014) and the NHS Long Term Plan (NHS 2019) aspired to improve quality and cost effectiveness through the development of new models which promoted integration between physical and mental health services, with greater involvement of local authorities and voluntary sector agencies. In 2017 Sustainability and Transformation Plans (STPs) were introduced (Ham et al 2017). These involved CCGs and healthcare providers forming 44 geographically based alliances with local government to plan local services.

The NHS Long Term Plan (NHS 2019) developed these plans for integration by introducing the integration of primary and secondary care, physical and mental health services involving social care, local authority and voluntary sector services. These proposals became legislation with the passing on the Health and Care Act (2022) and its aim was to move from a culture of competition to one of collaboration (DHSC 2021). Clinical Commissioning Groups were replaced by Integrated care Boards (ICBs) in 2022 which consist of medical and nursing directors, executive and non-executive board members and representative partner members from the organisations within the local partnerships. ICBs are formally accountable to NHS England for spending and performance at regional level (Wenzel et al 2023). The local integrated partnerships are known as Integrated Care Partnerships (ICPs). These were in the process of being operationalised when this thesis concluded in 2024.

1.3.2: Mental health service funding:

Linking quality to outcome measures, which determine levels of funding became a priority for the NHS mental health services (NHS England and NHS Improvement 2016). Mental health funding and staffing levels have increased 2016-17 and 2021-22. However, local mental health spending has only increased from 11.0% to 11.4% of total CCG funding spent on mental health services (National Audit Office 2023). The creation of care pathways ascribed a set menu of mental health interventions and/or specific time frames for commencing and delivering treatment.

Prior to 2016, mental health Trusts' strategic plans included measures to reduce costs with 40% of mental health providers experienced a reduction in funding between 2013 and 2015 (Gilburt 2015). NHS providers have restructured services and created standardised care pathways, to reduce costs and shifted demand from acute services and promoted recovery and self-management (Gilburt 2015).

In 2011, the Government pledged to achieve parity of esteem between physical and mental health care services. This acknowledged that mental health deserved equal recognition with physical health and that a treatment gap existed. From 2016, this pledge was supported by increased funding for mental health services (House of Commons 2023). This included a £1.25Billion investment in Child and Adolescent mental health and £1Billion investment in adult mental health. Since 2016 NHS there has been increased mental health service funding locally (NHSE website).

The Five Year Forward View (NHS 2015) delivery plan for mental health services relies on this local funding being delivered by commissioning groups to services. This is dependent upon monitoring performance based on national and local dashboards. Although this has increased, from 2016-2022, current investment is insufficient to address the historical under funding of mental health services (National Audit Office 2023). The NHS Long Term Plan (DHSC 2019) committed to increasing the funding for children and young persons' mental health services, stating that investment in these services would grow faster than both overall mental health funding and total mental health spending. The rationale for this is that early intervention will prevent the development of long-term adult mental health problems. Similarly, extra funding was assured for crisis services and home treatment to prevent hospital admission (DHSC 2019).

Between 2017/18 and 2022/23 total spending on mental health services went up by 2.7% (Gilburt and Mallorie 2024). It accounts for 8% of the total NHS budget (HM Treasury 2022). The two largest areas of expenditure were in-patient care and community mental health services (Gilburt and Mallorie 2024). Therefore, although funding has increased to frontline community mental health services, this is perhaps not in line with increased demand (National Audit Office 2023). The need to manage increasing demand with limited resources persists despite increased investment. There has been a 44% increase in the number of referrals to secondary mental health services from 2016 to 2022 (House of Commons 2023). The effects of the pandemic include economic difficulties, physical and mental health anxieties and social isolation, which has had a substantial impact on those with existing mental health problems as well as the general population (O'Shea 2020).

1.3.3: Local implementation of policy:

Regional commissioning bodies: Clinical Commissioning Groups (CCGs) and since 2022, Integrated Care Boards (ICBs) have joint responsibility for monitoring national targets and creating local targets to demonstrate value for money. These include standardised care pathways, waiting times, frequency of contact. Trusts also incorporate national guidelines for workforce development and service user involvement into their operational policies and strategic plans (Robertson and Ewbank 2020). These central directives are patterned through the hierarchy and create structures for care delivery for individual community teams. These operationalised structures need to consider local need as well as national directives. The National Collaborating Centre for Mental Health (2019) suggests that Trusts and commissioning bodies have the flexibility to develop service structures to incorporate National guidelines whist meeting the needs of their local population. The purchaser provider split has been in existence since 1990, with regional commissioning bodies purchasing the service and local NHS Trusts providing them. Since the introduction of STPs this arrangement has become increasingly collaborative with purchasers and providers deciding priorities jointly and setting local targets (Robertson and Ewbank 2020). At the conclusion of this thesis this role has been taken over by ICBs. The Health and Care Act (2022) intends to facilitate integration and collaboration of services at local level, to deliver joined up care for those with complex health issues (DHSC 2022).

1.3.4: The Development of Community Mental Health Teams.

The purpose of Community Mental Health Teams, since their inception over 30 years ago, is to provide mental health care to those with complex mental health

problems, in their homes and local communities (NHSE/NHS Improvement 2019). Their purpose is to provide an alternative to lengthy or repeated hospital admissions. Policy changes since the 1990s have resulted in service reorganisations to address perceived gaps in provision and provide solutions (Hannigan et al 2018).

The Community Care Act (CCA 1990), followed the closure of large mental hospitals and increasing provision of community-based care, consisted of supported accommodation and a range of interventions which included: treatment, therapy, vocational support and social activities (Hollingsworth 1996). The introduction of Care Programme Approach in 1991 created a clear statutory framework for the provision of coordinated care for those with SMI which included inclusion criteria, clearly defined process of assessment care planning, transfer of care and discharge (Hannigan et al 2018).

The National Service Framework (DH 1999) and NHS Plan (DH 2000) created community mental health services specific functions and skills sets for CMHSs. These included including Assertive Outreach Teams, Crisis Resolution and Home Treatment teams and Early Interventions for Psychosis teams. The purpose of creating specialist teams was to evaluate the effectiveness of specific evidence-based interventions, by creating specialist teams which followed specific care pathways (Boardman and Parsonage 2007). Generic CMHTs existed alongside these specialist teams and fulfilled the purpose of working longer term with those service users with SMI (Burns 2004). The initiative New Ways of working (DH 2007) and Creating Capable Teams Approach (DH 2007) further developed the scope for multidisciplinary working within CMHTs. This placed increased

emphasis on client centred care pathways and psychological and social interventions as well as medically led approaches.

The CMH Framework (NHSE 2019) says upholds principles of assessment, evidence-based interventions and a range of social interventions and replaces CPA with personalised support and care planning. CMH Framework (NHSE 2019) suggests that the principles of comprehensive assessment, coordinated care and review, remain central to all levels of care provision. However, the concept of a service user being “on” or “off” the CPA, creates a two-tier system and care is categorised rather than individualised (NHSE and NHS Improvement 2019).

Care coordination, a key feature of the CPA, has been central to the provision of person-centred care within mental health services, and this has persisted throughout numerous service redesigns (Hannigan et al 2018). Replacing the CPA with a meaningful interventions-based approach, is intended to replace the role of care-coordinator, traditionally a CMHN, with a key worker who can be any member of the MDT (NHSE 2022). This may have implications for the role of the CMHN, as they will no longer have the organisational and administrative responsibilities of the care coordinator role.

1.3.5: The Community Mental Health Nursing workforce:

Durcan et al (2017) cite WHO saying that in the UK there are 67.35 mental health nurses per 100,000 of the population. Numbers of mental health nurses fell between 2010-2017. Since 2017, there has been a yearly increase and an expansion in the workforce. This brings the number back to the 2010 level of 40,000 (Gilburt Mallorie 2024). Between 2016-22 the mental health workforce increased by 22%, however demand also increased with an increase in referrals to secondary mental health services increasing in the same period by 44% (House

of Commons 2023). By 2023, the number of mental health nurses had increased to 45,000 (Gilburt and Mallorie 2024).

The NHS staff satisfaction survey in 2022 demonstrates that only 30% of the mental health workforce thought that there were enough staff for them to do their job adequately (NHS Staff survey 2022). The demand for services and retention issues, mean that the mental health workforce is insufficient, which has resulted in an increase in non-qualified roles and a reliance on bank and agency staff (Gilburt and Mallorie 2024). The Mental Health Workforce Plan for England (NHSE 2017) stated that additional roles to support the existing workforce could include: support workers, wellbeing practitioners, Nursing Associates and call handlers. This could result in some of the social interventions delivered by CMHNs, in the context of holistic care, being undertaken by unqualified staff (McKeown and White 2015). The development of advanced clinical roles acknowledges that the delivery of care and client contact is a valuable motivator, whilst acknowledging the need for experienced and skilled staff to continue to deliver care to service users.

1.4: Professional development and experience informing the pursuit of this study.

The author started their nurse training in 1985 and started work as a registered nurse in 1988. They started as an adult nurse undertaking the English National Board training at a school of nursing in a teaching hospital and then then went onto train as a mental health nurse, from 1989 to 1991.

During their formative development, the author had an interest in how organisational culture and socially held views of nursing shaped nurses' identity and self-concept. This was based on having the experience of the task orientated

adult physical health care and the analytical nature of mental health nursing and being more comfortable with the latter. They embarked on a career in mental health nursing at the time the large mental institutions were being closed and had first-hand experience of working with institutionalised clients and staff who had been relocated from such settings. At this time, they read Goffman's (1968) "Asylums" and Menzies-Lyth (1988) "Containing Anxiety in Institutions". This generated an interest and understanding in the social processes of institutionalisation and a psychodynamic perspective on how individuals use mental defence mechanisms to cope with anxiety provoking situations at work. They worked in a variety of mental health settings in a clinical and managerial capacity. The two longest and most significant jobs were working for a specialist homeless mental health service and working in prison in reach. This was a specialist team delivering mental health care in prisons and staff in the team were employed by the National Health Service. The client groups in both settings have significant health and social problems. Both are marginalised and stigmatised and dwell within institutions. The author was involved in understanding the social and emotional issues that caused such clients to become socially excluded. They were also directly involved in engaging in the service boundary issues and clinical decision making to ensure these clients had rightful access to statutory health and social care provision.

The author's dissertation for their first degree was about the pathways into homelessness for people with mental health problems. The deinstitutionalisation of mental hospitals was occurring alongside the deinstitutionalisation of large local authority direct access hostels. The subculture of homelessness is an institution, in which the "inmates" are ascribed stereotypical behaviours and are marginalised and excluded from society, losing their sense of purpose and identity. Their

master's degree research project was an examination of the education and training needs of mental health nurses working within prison in reach services. It proposed that mental health nurses needed training in aspects of criminal justice process to be able to deliver effective care and access mainstream services for clients at the point of release. Both projects address the role of the CMHN working across service boundaries to obtain services for marginalised service users. They address issues of the CMHNs autonomy, intuitive and procedural knowledge and skills in working with socially excluded service users.

The author subsequently worked as a Senior Lecturer in Mental Health Nursing. This developed their interest in using theories and an understanding of research to understand the social and psychological factors which shape the role of mental health nurses. In addition, they have become, a political activist and active trade unionist, in response to the difficulties facing the N.H.S. This has added a political dimension to the social and psychological understanding of their work. They are involved in supporting and teaching pre-registration students and qualified staff. They have therefore developed a keen interest in how the politically motivated changes are altering service boundaries and service inclusion. The author has become increasingly concerned about the effects that the current political and economic changes are having on staff moral and the quality of care. The author developed an interest in how targets have become incorporated in clinical decision making, what potential conflict this causes and how nurses and teams cope. The author's political views are discussed in the section on positionality in chapter four. They are aware that these interactions not only occur between individuals and within teams, but also with their organisations. The organisations are interacting with national bodies and the style and the purpose of these

interactions at a national level may affect the interactions at a local and individual level.

1.5: Research aims and questions

Research Aims:

This research is a critical realist exploration of mental health nurses' (MHNs) perceptions of the factors which influence their clinical decisions regarding accepting and discharging service users. It aims to understand how MHNs reconcile various drivers and how this is communicated and accommodated within teams and organisations.

Research questions:

1) What do Community Mental Health Nurses (CMHNs) perceive to be the factors which influence their clinical decision making in relation to accepting or discharging service users?

2) What are CMHNs experiences of negotiating the above factors within teams**?**

3) What are CMHNs perceptions of their organisations?

4) What are CMHNs perceptions of mental health policy and how this impacts on their clinical decision making?

1.6: The contribution of this thesis

The literature review in Chapter two identifies the existing knowledge in this area and the gaps in the research. Existing research examines interaction in the context of specific mental health policy and how this is operationalised. Studies

of professional relationships within community mental health teams focusses on professional identity. The research concerning decision making is examined in the context of knowledge, skills and values. This study draws upon original sociological and psychological theories using an eclectic approach within the framework of critical realism. The methodological approach utilises Critical Realism to examine the impact of political ideology on how CMHNs experience their role, team and organisation. This will be discussed in greater detail in Chapter four. It incorporates a contemporary socio-political interpretation of current changes and how they are enacted in a dynamic professional environment.

1.7: Chapter summary.

This chapter has introduced the thesis. It has summarised the background, in relation to marketisation and efficiency within NHS policy, funding of mental health services, local implementation of targets, the functions of CMHTs and the CMHN workforce. This is followed by an overview of the researcher's professional background and motivation for undertaking the research. The research aims and questions are presented. Finally, the contribution of this thesis was presented. The thesis structure is below.

1.8: Thesis structure

The thesis is divided into eleven chapters. Chapter two details the literature review in relation to the existing work on the subject. Chapter three provides an overview of the mid-range theories which relate to the key concepts inherent in the

research. These are negotiated order, psychodynamic theories, labelling and stigma, bureaucracy and neoliberalism. Chapter four gives a detailed account of the methodology. This includes the conceptual framework of Critical Realism, the methods for data collection and analysis, sampling, ethical approval, validity, reliability, generalisability and reflexivity. Chapter five gives an introduction to the results, this includes a “thick description” of both NHS mental health Trusts and an overview of the participants’ demographic information. Chapter six presents the policy analysis. Chapters seven, eight and nine present the findings and analysis of the micro, meso and macro level empirical data. Chapter ten details the generative mechanisms and the data from the non-participant observations. Chapter eleven gives a summary of the research questions and how they were answered, the methodological contribution and implications and recommendations for practice and research.

Chapter 2: Literature Review

2.1: Introduction.

This chapter scrutinises the literature to examine the key concepts in relation to this research questions and to identify the previous work undertaken in this area and the gap which my thesis aims to address (Aveyard et al 2016). The aims of the literature review are to identify the research to date, which are of relevance to the research questions and identify any gaps in the body of knowledge.

2.2: Search Methodology

This is a supportive literature review and is intended to appraise what is already known about this area and what the gaps are (Aveyard et al 2016). The following section will give a detailed overview of the systematic approach to undertaking the review. This section will discuss the methodology used to identify the relevant research. This will include justifying the data bases used, the search terms. The inclusion/exclusion criteria and the time framework.

A basic scoping review was undertaken in April 2016. The aim of this was to gain a clearer understanding of the appropriate search terms and to start to become familiar with methodologies, findings and gaps in the research. A literature search was undertaken in January 2017. This has subsequently been repeated to capture up to date literature, in 2019 for the upgrade Viva. A scoping study review will be used, initially to test the prevalence of search terms and identify the type of research methods most commonly used to examine these issues. (Aveyard et al 2016)

An integrative review was subsequently utilised. This allows for the consideration of a broad range of literature. It consists of a comprehensive search followed by

data extraction and critical appraisal Whitmore and Knafl (2005). The aims of this approach are the thorough interpretation of primary research with an innovative synthesis. This approach enables the simultaneous definition of concepts, review of theories and analysis of methods. It was decided not to limit the literature review to studies which utilise similar methodology as this thesis. It important to consider a variety of findings and theories, as the author is particularly interested in how policy and service organisation have been accommodated by mental health nurses in Community Mental Health Teams.

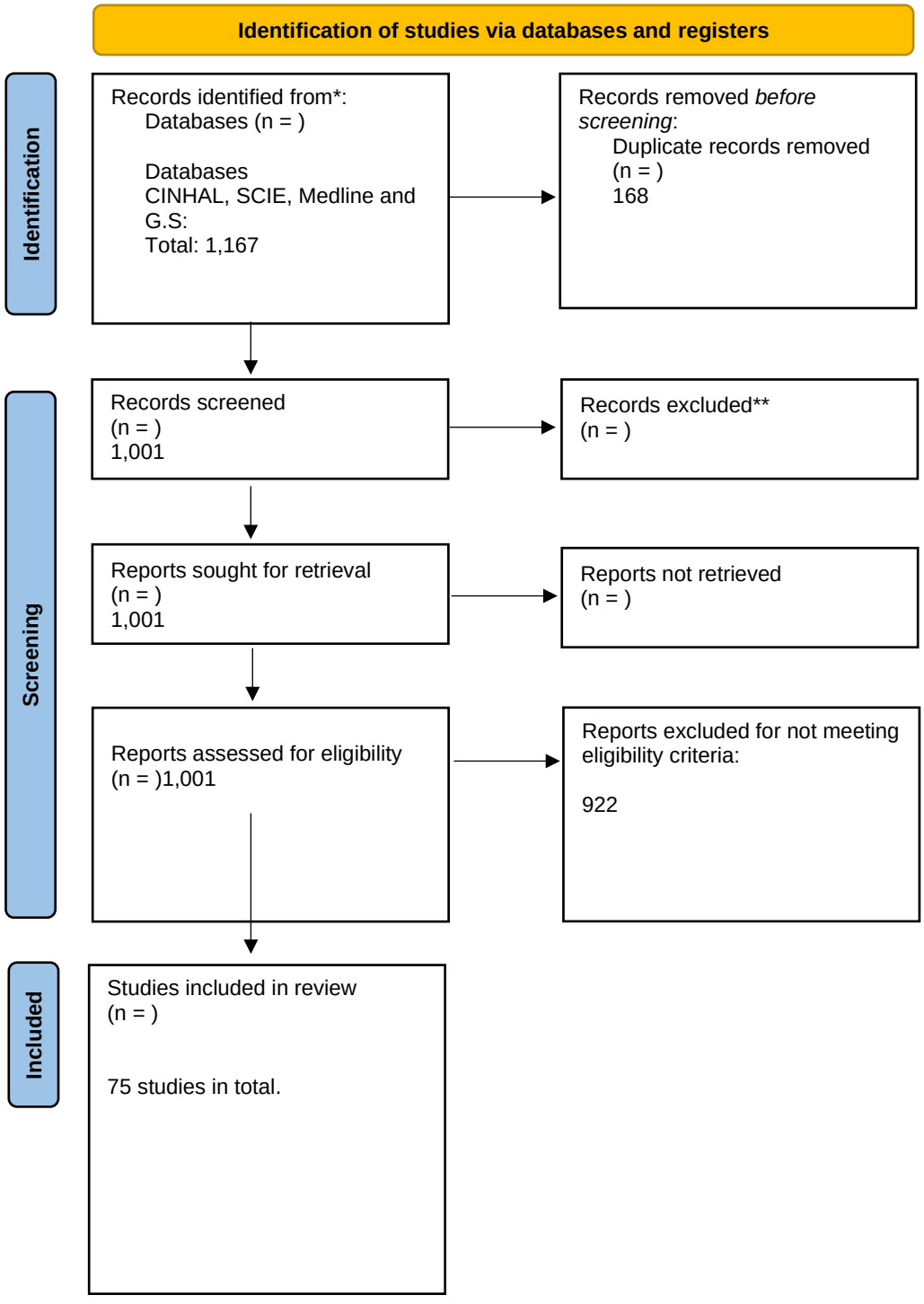
Therefore, a comprehensive literature search was undertaken (Aveyard et al 2016). The research questions consider complex multifactorial aspects of decision making at the micro, meso and macro levels and the interaction between external and internal factors. Therefore, to identify the existing knowledge in these areas whilst maintaining a clear focus on the research questions, an integrative approach was used (Aveyard et al 2016). Only UK papers were used as the literature needs to be relevant to UK policy. The time parameters: from 1990, when policy started to reflect marketisation. The time frame chosen matches the timeframe for the policy analysis in Chapter five.

The databases used were, CIHAHL, Medline and Psychology and behavioural science and SCIE. These are a valuable source of mental health literature in the UK (England and Wales only, as Scotland and Northern Ireland have devolved policies) and were available via the University access.

A further literature review was undertaken to cover the time period 2019 to 2023. The same databases, parameters, and inclusion and exclusion criteria were used. The sections below highlight the papers found. Revisiting literature following data

collection and analysis, means that my appraisal of the papers is based on my findings, retrospectively.

Prisma diagramme



2.3: Inclusion and exclusion criteria and search terms

Table 1: Inclusion and exclusion criteria

Inclusion	Exclusion
UK	Older Adults
Working Age Adult Community Mental Health	Child and Adolescent Mental Health Services
1990-2023	Learning Disability and forensic services
Primary Research	Northern Ireland and Scotland (devolved policies)

Only papers from the UK were used due to the policy context of the research. Therefore, Scotland and Northern Ireland were excluded as they have devolved health policy. Only working age adult CMHTs were considered as inclusion within these services is based on clinical decisions. Older Adult services and CAMHS were excluded as inclusion is governed by strict age parameters. Forensic services were excluded as inclusion is determined by the Ministry of Justice. Learning disabilities were not relevant to the research questions.

The literature used the search terms detailed below. These were chosen to reflect the research questions and consider alternative terms to capture all relevant papers.

Table 2. Search terms.

1.Community Mental Health Nurse		Clinical Decision Making
OR	AND	OR
Community Psychiatric Nurse		Clinical Judgement

2.Community Mental Health Team		Clinical Decision Making
OR	AND	OR
Mental Health Services		Clinical Judgement
		OR
		Teamwork

3.Community Mental Health Team		Multidisciplinary
OR	AND	OR
Mental Health Services		Multiprofessional

4.Community Mental Health Team		UK Policy
OR	AND	

Mental Health Services		

5.Mental Health Services	AND	Organisational reporting/culture

2.4: Summary of review

The literature review is structured to reflect the scope of the research questions. The examination of the factors driving clinical decision making are considered at individual, team and organisation level. At each of these levels, consideration is given to the factors which drive clinical decision making. This reflects the theory of Strauss' (1978) negotiated order in examining the interrelationships between the micro (the CMHN), the meso (the team) and the macro (the organisation). At each level the drivers of decision making are divided into intrinsic factors such as professional values and identity and knowledge and moral beliefs about the needs of the client group. Extrinsic values include political, policy, organisational culture and societal constructs. This reflects the theories used within this study. Goffman's theory on the social construct and setting of mental health care (extrinsic factors) and Mezies-Lyth's (1998) psychodynamic theory which characterise the processes nurses and teams use to deal with conflict and anxiety. The first section will consider the literature regarding factors influencing clinical decision making in mental health nurses, the second section will examine the research into these issues within CMHTs. The final section will consider the research into perceptions of organisational reporting. A table of the papers which are most relevant to the research questions are included in a table in appendix 1.

2.5 CMHNs and clinical decision making.

2.5.1: Intrinsic factors.

The following studies consider the intrinsic factors which influence CMHNs clinical decision making. The issues identified in these studies include intuition, morals and values. Knowledge and attitudes about treatment plus consideration of the clients' individuality and level of the CMHTs clinical autonomy are also considered.

These studies explore the intrinsic factors which influence CMHN clinical decision making. The findings indicate a valuable combination of empirical, evidence-based knowledge and protocols and intuitive client centred knowledge. The theoretical constructs utilised by the CMHN are an amalgamation of medical, social and psychological knowledge base. The intuitive aspects rely upon the therapeutic relationship, client advocacy and an appreciation of quality of life. Martin (1999) concludes that CMHNs cannot rely on one single approach to decision making and that a linear process does not fit easily with the multi-faceted, individualised nature of mental health work. Intuitive decision making needs to be transparent, justified and credible so that it can be replicated and taught. However, intuition alone is hard to quantify and justify and may mask a lack of empirical and procedural knowledge (Monkley-Poole 1998).

Autonomy needs to be genuine and legitimate rather than covert and idiosyncratic (Morrall 1997). A safe working environment, effective supervision and a culture which promotes openness and responsibility will promote practitioner responsibility and consistency (Martin 1999). The individual CMHNs

level of experience and the relationships within the team can have an impact on decision making. Their use of line management support was dependent on their level of experience, with less experienced clinicians referring to their managers more frequently (Donnelly et al 1996). There may be power factors such as the dominance of the medical model which may lend legitimacy to one professional group over another (Columbo et al 2003). CMHNs admitted that they sometimes superficially agreed to some decisions in meetings, when in fact they did not agree in principle (Morrall 1997). CMHNs exhibit variations in how they communicate about their work, both in terms of who they discuss it with and their use of language (Monkley-Poole 1998 and Columbo et al 2003). Crawford et al (2008) explored CMHNs views of their professional identity shaped by public perceptions and considered if this differed from their experience of their working life. The findings highlighted that identity is influenced by intrinsic motivation, to help others and by being client focussed. Other themes included not seeing themselves as a profession due to a degree of self-effacement and not having monopoly of a body of knowledge being caring and nurturing is not valued as highly as professional knowledge.

These findings illustrate that there is an existing knowledge regarding the duality of empirical and intuitive knowledge which influences CMHNs decision making. Nolan et al (2004) made a comparison of working practices and values in two mental health Trusts, one urban and one rural. The methodology utilised a questionnaire with a Likert scale and data analysis utilised descriptive statistics for the closed questions and category identification by researchers for open ended questions. The questionnaire asked about and organisational values, preferred working models and what the CMHNs would like to see improve. The findings identify a problematic interface between primary and secondary care, perception

of policies and professional development and a more sensitive delivery of policy. The conclusions suggest that CMHNs need a more clearly defined role, more time to spend with their clients and need supervision and professional development to enhance their roles. This thesis will be examining these concepts in relation to their interaction with the current ideology inherent in contemporary policy.

The theoretical and conceptual frameworks are not clearly stated in seven of the studies. It may be that these studies do not use a theoretical framework. This thesis utilises an eclectic framework which will be discussed in chapter three. Martin (1999) uses Grounded Theory. Both authors justify the use of this approach stating that understanding professional judgement and quality of life issues are uncharted territory, therefore data collection needs to be inductive. This thesis uses Critical realism as it seeks to understand subjective experience in a socio-political context and the impact of tangible policy edicts. Seven out of eight studies use multiple methods, one uses a questionnaire only. Seven studies use questionnaires, five interviews, three focus groups and one participant observation (which is used to inform questions in semi structured interviews). These are all qualitative methods and gather data regarding the participants views and clinical opinions. This thesis uses participant observation of team meetings, to inform questions for the semi-structured interviews.

2.5.2: Extrinsic factors

The previous section considered the intrinsic factors which influence CMHNs decision-making. Martin (1999) acknowledged that intrinsic factors have a reciprocal relationship with extrinsic factors. A key aspect influencing decision

making is the demographic profile and social status of the target client group. The following studies consider the influence of socio-economic demographic of the client group, policy initiatives and guidelines.

The findings of these studies illustrate that decision making regarding providing a service to clients is influenced by their material resources, the availability of treatment and the parameters set by national and local policy. Brooker et al (2005) concludes that the findings indicate that there are more referrals for people with social problems and CRHTs need to target poorer/deprived areas and utilise social interventions and those with psychosis were more likely to be admitted. Rhodes et al (2010) concluded that CMHNs are often faced with clients, who's depression occurs in the context of social problems and that the waiting list for psychological services, prevents this from being a readily available treatment. Policy changes result in the CMHN acting as a care coordinator which is a factor which detracts from their role in providing therapeutic and psychosocial interventions due to the administrative demand on the care coordinator role (Simpson et al 2005). The relationship between social factors and mental health is relevant to this thesis, given the current culture of benefit sanctions for those with long term conditions.

Simpson et al (2005) utilise participant observation and semi structured interviews to ascertain CMHNs perceptions. The other two papers utilise rating scales (Broker et al 2005) and a questionnaire (Rhodes et al 2010). These two studies highlight issues with decision making and highlight pertinent factors without including staff perceptions. None of these papers cite the use of a theoretical framework. This section considers how these relate to CMHNs. The section on CMHTs will consider how these are incorporated within the wider team setting.

2.5.3: Community Mental Health Nurses and Clinical Decision making 2019-2023 review update.

Two papers were identified and focused on specific interventions. Brimblecombe and Dobel-Over (2021): undertook a survey examining the role of nurse prescribers in mental health services. Thompson et al (2020) Green spaces and horticultural interventions. Therefore, there was nothing specifically about CMHNs and decision making in the databases originally used.

2.5.4: Intrinsic factors

The author found two papers in Google scholar, whilst looking for supplementary references. Barron et al (2017) studied CMHNs use of compassion in practice. This utilised an interpretive approach, based on data gained from semi structured interviews. The findings illuminated the complexity of compassionate practice. Participants acknowledge that being compassionate is part of their value base and intrinsic motivation. However, the struggle to articulate what it is and describe how organisational constraints, particularly administrative demands and working with challenging and resistant clients act as a barrier. This thesis considers the issues of compassion and the therapeutic relationship as intrinsic motivational factors. It also acknowledges the extrinsic constraints CMHNs experience in exercising the therapeutic aspects of their role.

2.5.5. Extrinsic factors.

Felton et al (2018) addressed therapeutic relationships, risk, and mental health practice. Semi-structured interviews regarding, making decisions about risk assessment. Also used unstructured observations to observe interactions and decision making. Two areas were used as case studies. The findings: detail themes in relation to decision making structures, moral and relational issues. It

was noted that mental health nurses in both setting maintained physical and moral distance from the service users. Their views used objectifying clinical language. This was viewed as avoidance and the data was analysed in relation to psychodynamic mental defence mechanisms as defined by Menzies Lyth. My thesis considers relational aspects of mental health nursing and how MHNs employ mental defence mechanisms when addressing risk. It considers the use of objectifying biomedical approaches to decision making.

2.6: Team Decision making

2.6.1: Intrinsic factors

The studies considered in this section address the intrinsic factors which influence team decision making. These include role identity and the boundaries and interface between professions. The team structures for managing workloads and making decisions are also examined. The findings indicate that within CMHTs there is blurring of professional boundaries. This is a departure from the clear professional demarcation inherent in hospital-based teams (Brown et al 2000). Although this is common in teams, the exact nature of the division of labour is shaped by the skill mix within the individual team and the local workforce pressures (Hannigan 2014). This thesis compares two organisations to demonstrate the phenomenon of localised patterning. The greatest variation in role identity is experienced by those who undertake the care coordination role, namely CMHNs and Social Workers. Psychiatrists and Psychologists reflected wider jurisdictions (Hannigan 2014). Within teams, local workforce pressures often result in CMHNs performing a gatekeeping role and using team structures to legitimise discharging clients and rejecting referrals (Donnison et al 2009).

Team structures such as multi professional meetings, are also useful to promote integrated working (Larkin and Callaghan 2005). Christofides et al (2012) suggest that within the business of running the team, there needs to be time and support to discuss the psychological intricacies of challenging clients. This is becoming increasingly difficult due to the dominance of bureaucracy and the audit culture within contemporary practice (Hanley et al 2017).

The studies in this section, all utilise semi structured interviews apart from one, which uses a questionnaire. Brown et al (2000) and Hannigan (2014) use similar theoretical frameworks as I have for this thesis. They cite the works of Goffman, Menzies and Strauss. They consider the importance of conflict and anxiety and social processes and the importance of interactions and language. The studies within this section do not relate specifically to identified policies. The literature on interprofessional working is largely functionalist and structural. Hanley et al (2017) examine the function of social defences in CMHTs utilising Menzies work. The approach in this thesis is also psychodynamic and studies the micro level of interactions; perceptions and containment of different views and interpretations and incorporating business language.

2.6.2: Extrinsic factors

The following studies address the influence of extrinsic factors on decision-making within teams. One of the research questions for this thesis is concerned with CMHNs perceptions of external factors, specifically policy directives. The studies discussed in this section consider the impact of policy and public perception on the clinical decision making within CMHTs. The findings of these studies indicate that practice within CMHTs is driven by policy directives. Local factors such as morbidity, interface between services and resources mediate the

impact of the macro socio-political drivers. Cooke et al (2001) suggest that if CHMTs have good multidisciplinary working relationships, then they are autonomous as a team and better able to regulate external pressures. Team focus is strongly influenced by National priorities. For example, the Care Programme Approach ensured that CMHTs prioritised the seriously mentally ill (Cornwall et al 2001).

The National Service Framework (DH 1999) and the NHS Plan (2000) created national standards for the creation and evaluation of specialist team functions (as discussed in chapter 5). Therefore, there is a large body of research regarding the effectiveness of these teams. Nelson et al (2009) these specialist teams have a clear and specific function; therefore, they have a high degree of model fidelity and role clarity. This results in a higher degree of job satisfaction and a lower degree of burnout than in staff in generic CMHTs. Crisis Resolution and Home Treatment Teams (CRHTs) were found to be effective in fulfilling their role in providing intensive support and preventing admissions to hospitals if other services collaborate and have a shared view of their purpose (Rhodes and Giles 2014).

From an organisational and resource perspective CRHTs play an important role of gatekeeping the limited number of inpatient beds (Beegum and Riordan 2016). From the perspective of Service Users, CRHTs were valued for their accessibility and availability, the consistent and good quality approach and the evidence of choice and clear communication. One aspect they were dissatisfied with was the ending of contact and being referred to another service once the crisis period had passed (Hopkins and Niemer 2007). Hannigan and Coffey (2011) undertook a theoretically informed policy analysis. This notes that the UK mental health

system policy making is a priority and that in trying to legislate for complexity and create standardised value for money structures, policy makers have imposed numerous top-down directives. These have driven the expansion of mental health services, which are increasingly community based. This paper concluded that, this has resulted in shifting professional roles and service boundaries.

Assertive Outreach Teams (AOTs) were found to be effective in maintaining contact with clients without being too intrusive (Wright et al 2011). Brugha et al (2012) state that AOTs were disbanded as they did not reduce hospital admissions, although their original purpose was to maintain contact with those who were hard to engage. However, admissions for complex clients did reduce, but it was difficult to establish which specialist team made an impact on this or if this was due to the overall reduction in the number of inpatient beds (Hamilton et al 2015). Early Intervention Services (EIS) were intended to improve outcomes for those presenting with first episode psychosis. Garety et al (2006) found that these teams made no difference to the treatment of symptoms but achieved greater levels of monitoring and social contact. Although there were clear guidelines driving the structure and function of these specialist teams, their work was shaped by the local population and the work of other agencies (Hannigan 2011) and (Freeman and Peck 2006). The interface between these teams and with the third sector agencies is affected by differing perceptions of what each team does and could lead to disagreements and challenging working relationships (Lester et al 2008). Addressing these challenges requires time and resources to create forums and communication to achieve mutual priorities (Paxton et al 2003) and (Priest el al 2008).

CHMTs have a responsibility to manage risk in relation to their clients. Positive risk taking which enables clients to progress is often undermined by a risk averse culture (Holley et al 2016). Organisational priorities regarding risk management are often influenced by the threat of adverse publicity (Stein 2002). Policy directives cite the importance of client self-management and responsibility and the importance of this is decision making (Gillard et al 2012). However, client's self-assessment of their needs may exceed available resources and so this is ultimately overridden by professionals (Carter 2003). The introduction of measurable outcomes is intended to measure and predict the cost of treatment and care, as discussed in chapter five. The use of the Health of the Nation Outcome Scores (HoNoS) was evaluated for this purpose. Rees et al (2004) stated that this was useful for monitoring improvement and stability but not outcomes of care. External measures are useful in addressing uniformity, however self- assessment tools and clinician defined categories are better at capturing the true value of mental health work (Fianger and Burns 2000) and (Ansari et al 2010). Payment by results is difficult to apply to mental health practice as outcomes are hard to measure. The creation of separate service lines leads to fragmentation with services entering into disputes about which of them should take the client (Khandaka et al 2013). However, staff stated that service lines led to a shared approach within each team with more team reviews and care coordinators being more proactive (Khandaka et al 2013).

Three of the 29 articles did not make the policy background to their study explicit Priest et al 2008), (Kinnair et al 2012) and (Stein 2002). One paper considered a range of policies: from 1989 to 1997 (Cooke et al 2001). Hannigan (2011) included New Ways of Working (DH 1996) and Values to Action (DH 1997). Fifteen of the studies cited the National Service Framework (DH 1999) and the NHS Plan (DH

2000). These policies generated the creation of teams with specialist functions with the intention of evaluating the effectiveness of their specific approaches (DH 2000), hence the large amount of research. Rees et al (2004) cited the Health of the Nation (1992) in its study of the HoNoS. Gillard et al (2012) cited the Self Care Policy DH (2006) and Holley et al (2016) cited the recovery agenda. The only studies which referred to the Health and Social Care Act (DH 2012) were Williams (2012), who acknowledged the impact of austerity measures and Khandaka et al (2013) who examines the effects of Payment by Results.

Four of the studies utilise Grounded Theory: Kinnair et al (2012), Ansari et al (2016), Holley et al (2016) and Khandaka et al (2013). These studies sought to generate theories from the data (Newby 2010). Two studies: Knight and Malnoey (2005) and Stein (2002) use phenomenology. This approach seeks to capture the lived experience of the participants (Smith et al 2009). Wright et al (2011) use Philosophical Hermeneutics and Hannigan (2011) used ethnography. Both these approaches consider the culture and context in which practice and its' associated assumptions are developed and shared by professionals. The remaining 20 studies did not cite the use of a theoretical approach. None of them utilised critical realism and eclectic theoretical frameworks.

Eight of the studies used qualitative methods. Three studies used only questionnaires a useful approach in obtaining specific demographic data about the client group (Cornwall et al 2001) or utilising an established framework such as evaluating teaching (Priest et al 2008) or assessing symptoms of burnout (Nelson et al 2009). Three studies tested the use of rating scales (Rees et al 2004) (Huxley et al 2008) (Carter 2003). Hamilton et al (2015) utilised a time series analysis of a hospital database to measure length of hospital stay One study used RCT:

randomly selected clients were allocated to two groups one received EIS interventions and one care as usual.

Cooke et al (2001) used action research and focus groups. This was useful in providing an in-depth analysis of the social and political context of the work of a CMHT and the impact on their roles, over time. Seven of the studies used interviews in obtaining subjective accounts from CMHT staff. (Knight and Maloney 2005), (Belling et al 2011), (Williams 2012), (Freeman and Peck 2006), (Kinnair et al 2012), (Stein 2002) and (Holley et al 2016). These were largely in-depth or semi structured interviews. These enabled the participants to expand on responses without constraints (Begum et al 2016). The interviewers place some parameters around the discussion to ensure all relevant matters are covered (Rhodes and Giles 2014). Interviews are the most widely used method in social sciences and the immediate and wider social context in which they take place is influential in their design and analysis (Edwards and Holland 2013). They are subject to potential bias therefore rational critique is essential in order to provide credible evidence of ideologies that shape social practice (Diefenbach 2009)

The majority of studies utilised a mixed method approach including interviews. This is a useful approach in studies where the research questions are best addressed through qualitative subjective accounts of participants and the statistical analysis of outcome variables (Gillard et al 2012). These studies obtained descriptive statistics regarding the practice context and client group, subjective accounts of staff and/or service users and then tested themes using questionnaires or focus groups. (Kinnair et al 2012) (Freeman and Peck 2006).

2.6.3: CMHT and Decision making 2019-2023 review update.

2.6.4: Intrinsic factors.

The following studies from the 2019 to 2023 period consider the intrinsic factors. Two address specific interventions practiced within the CMHT. Freeman et al (2019) considered clinical interventions for affective symptoms for service users with psychosis. This tested service users with specific assessment tools and questionnaires.

Two studies look interventions within a specialist team Early Intervention Service: Mankiewicz et al (2020) studied family interventions for psychosis, surveyed access to these services within EIS, by examining clinical records. Tuck et al (2023) Practitioners views of family work in EIS. Practitioners working in EIS were interviewed, the data was analysed using thematic analysis. This was to ascertain the focus of practitioners on considering the needs of children of the service users they are treating.

Three studies consider aspects of co-production, recovery and a psychological framework to enable CMHT staff to support service users with personality disorder. Repper and Eve (2022) undertook a study to examine embedding co production in CMHTs. This study examines the potential barriers to co production at individual, team and service level, within mental health services. It utilises a case study approach. Bowen et al (2020) looked specifically at a recovery outcome measure to ascertain the frequency of recovery orientated language used by staff. This used linguistic analysis to ascertain the aspects of recovery practice inherent in the language used by mental health professionals in patient records. Kellet et al (2020) study looked specifically at a consultancy model for clinical supervision for staff working in CMHTs. This used a two stage; mixed

methods approach which evaluated the effectiveness of this as an intervention. Overall, it was found to be effective, in helping clinicians in their work with service users who experience EUPD and changing presentations, in avoiding problematic team dynamics, including blame and splitting. These studies are concerned with specific interventions and skills utilised in CMHT practice. They address aspects of effective care and skills required to work with service users. In this study, the author is not concerned with specific interventions, however the existence of care pathways and staged interventions arise as themes.

Three studies consider the value of specific roles within the CMHT. Hannigan et al (2018) studied care coordination is imagined as a vehicle for the provision of collaborative, recovery-focused, care. (This paper was identified when searching for supplementary references and not captured in the original search.) Those who practise care coordination are concerned with the quality of their relationships with service users and the tailoring of services. However, this work also brings significant administrative demands, is subject to performance management which distorts its primary purpose, and in a context of scarce resources promotes generic professional roles. Similar conclusions about how the role of care coordinator is impacted by policies which are “designed for a service that does not exist”. Care coordinators have the power to resist but this is challenging due to the workload and that they are required to complete and prioritise documentation. The themes include engaging, attending, supporting recovery, connecting and mobilising, accommodating and adjusting. This study used the following methods: policy review, of care coordinator’s role, semi structured interviews asking questions about views of care coordination and care plan reviews. This study has some valid comparisons with mine. It considers the role of the care coordinator, a role typically undertaken by CMHNs. It draws upon

policy regarding this role and considers the duality of the therapeutic aspects and organisational demands. However, it does not use the same meta theory or Critical realism, nor the methodology of non-participant observation.

Oates et al (2020) undertook a study examining the responsibilities of leadership and decision making for nurses undertaking the Responsible Clinician (RC) role. This involved 12 semi-structured interviews and thematic analysis. The findings indicate that the aspects of leadership and responsibility enhances the RCs sense of autonomy and job satisfaction. They conclude that this is both empowering and daunting. It should not be seen as purely a means of addressing workforce shortages and retaining nurses, it also develops perceptions of responsibility and impacts team dynamics. This study considers the development of the RC role within the field of mental health nursing. This has some similarities with my consideration of the value of the ACP role in my findings, and subsequent recommendations regarding professional development of the CMHN role.

Two studies consider the role of the Social Worker in CMHTs. Abenstern (2021) studied the role of social workers in CMHT. This uses focus groups consisting of CMHT members and thematic analysis. The findings indicate that social workers enabled service users to access support, provided advocacy and supported colleagues in understanding social issues and promoting recovery. Boland et al (2021) studied the role of the social worker in CMHTs. This consisted of a literature review and survey to establish an understanding within the team and by Service users of the scope of their role. This concluded that social workers working in CMHTs are in a work culture that is predominantly health orientated. The studies considering the role of the social worker demonstrated some parallels with my study, as I am looking at the role of the CMHN, it acknowledges the

prevalence of biomedical health perspectives of CMHT work and how recovery/social interventions can be perceived as less significant.

2.6.5: Extrinsic factors

The following studies from the literature between 2019 and 2023 identify extrinsic factors, namely policy and legislation. One study addresses the use of Community Treatment orders specifically. Hayes and Stroud (2022) CTOs the influence of medical and social factors in influencing decision making around applying, renewing CTOs and recalling service users. Two studies consider the impact of COVID: Liberati et al (2021) MHW experiences during COVID. This study used semi-structured interviews with mental health staff in a variety of settings. The results indicated that due to COVID restrictions, staff faced challenges in decision making, prioritising care and managing therapeutic support. Many experienced moral injuries, due to feeling that they could not provide the support that they would like to. Bakolis et al (2021) undertook a study which looks specifically at COVID restrictions and the mortality rates of mental health service users. COVID restrictions exacerbated some of the pressures already experienced by staff working in CMHTs. The data collection for this thesis followed COVID, when CMHTs were overwhelmed with referrals and still engaging in socially distanced work patterns.

2.7: Organisational reporting/ views about organisations.

The original review included a search about organisational reporting as the original intention had been to look at Trust documentation. The author believed at the time that staff may express their view about organisational issues through

formal channels. In consultation with the supervisors, it was decided that this was not the case and decided to ask CMHNs for their views on the Trust as part of the semi structured interviews. However, this still has some relevance as reporting systems require a culture of openness and has implications for organisational culture (Martin et al 2022). All NHS Trusts and other health care providers are required to report, act on and learn from serious incidents (National Patient Safety Agency 2010). Policy reforms are usually followed by declining public trust addressed by transparency in professional regulation and constant reforms by regulatory bodies (Ehrich 2006). There were serious public concerns about patient safety following the Francis report. This led to the creation of a statutory Duty of Candour, whereby organisations and registered professionals were obliged to inform clients and/or their carers where serious harm has been caused (Kemp 2014). This led to the creation of Speak Up Guardians, who are designated people within organisations whom staff can trust to discuss any concerns which, they feel have not been taken seriously by their managers (NHS Employers 2018). This thesis will consider staff views on raising concerns with their organisation and so a consideration of existing research is addressed in this section. The search terms mainly produced studies from hospital settings. These were concerned with reviewing incident reports (Bonner and Wellman 2010), (Renwick et al 2016) and (Shaw et al 2005. Other studies looked at contextual factors and antecedents (Shepherd and Lavender 1999) and (James et al 2012).

The following studies have more direct relevance to my thesis. Vincent et al (2000) conducted a study into organisational reporting on an acute mental health ward. Although the setting is not a CMHT, this study has some relevance to this thesis as it considers staff subjective opinions utilising semi structured interviews. The framework for analysis considers contextual factors at multiple levels namely:

macro level political and economic factors, organisational structures and resources, work environment and team and individual staff and client characteristics. The conclusions highlighted that organisational changes can be a knee jerk reaction to one incident. It also commented on the importance of looking at institutional and organisation level to move beyond a simplistic blame culture. Woodthorpe et al (2013) obtained the views of 14 psychiatrists on patient safety, its application in their workplace and barriers to reporting. The findings indicate that the participants had a lack of training in patient safety. They stated that they were aware of the reporting procedure, but cited factors which were barriers to reporting. These included: being busy and the perception of a blame culture and lack of protection for Whistle-blowers. The participants also indicated that they perceived senior management to be more concerned about financial matters than patient safety and did not receive feedback about incidents and concerns that they had reported. This has relevance to this thesis it addresses staff perceptions of raising concerns within their organisations.

2.7.1 Mental Health Services and organisational culture. 2019-2023 review update.

In revisiting this search, the author substituted the term organisational culture for reporting, for the reasons discussed at the beginning of section 2.8. The following papers consider the impact of organisational culture. Bauer et al (2019) studied recovery-oriented practice takes place in certain organisational environments that importantly influence an individual's recovery. This study utilised semi-structured interviews and workshops with mental health service managers. The findings indicate that the organisational characteristics necessary to deliver recovery interventions include strong social values, shared decision-making, flat

hierarchies, and value driven leadership. Martin et al (2023) examined policy and practice in CMHTs, with a particular focus on promoting a culture of openness. This employed a mixed methods approach. The findings indicate that the key influential factors in achieving this are linked to the history of the organisation, effectiveness of administration and a culture of ongoing learning. Konteh et al (2019) studied leadership management and organisational practice. This study utilised a case study approach to demonstrate the differing characteristics between low and high performing mental health organisations between 2015-20.

Findings indicated that low performing organisations had top-down leadership, centralised decision making and a blame culture. High performing ones demonstrated collaborative leadership and open and supportive cultures. Suter et al (2020) undertook qualitative research to examine the experience of mental health nurses because of changes in shift patterns on in-patient services. Data was collected using semi-structured interviews pre and post implementation increase of shifts from eight to twelve hours. Although the setting was an inpatient mental health service, the findings highlight factors relating to unintended consequences of efficiency driven changes. These include nurses' perceptions of a decrease in the quality of care, challenges in managing their workload and a negative impact on their wellbeing. This thesis considers CMHNs view of their organisation. In examining the generative mechanisms, aspects of top-down cultures, social practices and leadership are addressed.

When looking for supplementary references in 2022, the author found a paper by Moth (2020). This looked at the impact of neoliberal mental health policy on restructuring of Community Mental Health Teams. This research also utilised a critical realist framework and similar methodology, namely, semi structured

interviews with CMHT staff and non-participant observations. The generative mechanisms identified, were consumerism, recovery, and risk. He highlighted biomedical approaches and risk, plus defence of ethical professionalism (Moth 2020). There are notable differences between this work and my thesis. Moth (2020) original fieldwork was undertaken between 2008 and 2013. This thesis is situated in a later time frame. Data collection and analysis were undertaken within a later timeframe between 2021 and 2023. Therefore, mine considers later policy issues: Health and Social Care Act (2012) had been established for seven years. It also takes into account the impact of, Five Year Forward View, NHS Long term Plan 2019 and the lead up to Health and Care Act (2022). The mechanisms identified in this thesis were: Managing the workload (use of targets, care-pathways, risk rating and standard frequency of contact), the changing role of the CMHN and service user self-management.

2.8: Summary of literature and its relevance to the research questions.

This literature review demonstrates the research undertaken regarding the role of the CMHN and the CMHT in relation to intrinsic and extrinsic factors, at the micro, meso and macro levels of the hierarchy. The rationale for time frame, was to match policy since the Community Care Act (1990) and the development of policies which deliver marketisation. This matches the time frame for the policy analysis in Chapter five. Literature from and England/Wales was utilised as it relates directly to policy governing the CMHTs included in the study, as Scotland and Northern Ireland are devolved.

This significance of the literature in relation to the research questions will now be considered. The first question is “What do Community Mental Health Nurses (CMHNs) perceive to be the factors which influence their clinical decision making in relation to accepting or discharging service users?” The existing body of knowledge emphasises the role of the CMHN in respect of intrinsic factors. These include the use of intuitive knowledge, in conjunction with procedural knowledge, in making complex clinical decisions.

Intrinsic motivation is aligned with soft skills such as compassion, valuing the therapeutic alliance, role identity and communication, are also addressed. Extrinsic factors include the availability of treatment and resources and social demographic of the client group which necessitates the delivery of social interventions to address deficits. Significant extrinsic factors also include policy directives dating back to the inception of the CPA has created processes that shape and define the role of the CMHN, in delivering and managing care processes, creates organisational and administrative demands on the role. One paper considers the impact of risk management strategies shape the role in relation to a biomedical approach.

This thesis considers the way in which this role balances therapeutic and efficiency in the current policy context one of the main motivating aspects of the choice to undertake this research. The role of the CMHN is flexible and adapts the most to fit specific service boundaries and changing work streams. The aim of this research is to capture if the intrinsic values remain or if the efficiency agenda has superseded this. The findings of this thesis highlight the process whereby the CMHN perhaps internalises the process of diagnostic inclusion and staged intervention.

The second research question is “What are CMHNs experiences of negotiating the above factors within teams?” The existing body of knowledge highlights intrinsic factors such as role identity, team dynamics and how meeting structures are shaped by care processes. Extrinsic factors, include policy directives within legislation and guidelines. These include National Service Framework (DH 1999) and NHS Plan (DH 2000). There are studies which address the CPA and policy around the Health and Social Care Act (1990). The NHS Plan research examines the effectiveness of creating specialist teams. Two studies acknowledged the impact of the Health and Social care Act (DH 2012). One acknowledges the impact on resources (Belling et al 2011) and one addresses Payment by Results and the effects of service lines and not the impact on clinical decision making. This thesis considers these in relation to contemporary policy and service delivery, namely the Health and Social Care Act (2012), the Five Year forward View for mental health (2016), the NHS Long Term Plan (2019). This thesis concludes at the inception of the Health and Care Act (2022). These directives result in the creation of specialist teams and standardised care pathways create structures and parameters within the CMHT, which guides clinical decision making. Trusts may operationalise National recommendations for care pathways differently (diagnostic or staged). They may have their own arrangements for managing non-urgent cases, waiting lists and prioritising delivery. This study considers how these variations may impact team functioning and staff experience and if team leadership and dynamics are mediating factors.

The third research question is “What are CMHNs perceptions of their organisations?” The original intention was to examine organisational reporting, as it was envisaged that if staff had difficulties with organisational challenges that

they may utilise formal reporting systems. However, the literature highlighted that this was in the event of an adverse incident, rather than a reflection of what staff thought about their organisation's priorities and culture. The literature did highlight significant aspects of perceptions of blame culture and the value of openness and compassion to promote therapeutic work. This thesis considers participants' perceptions of organisational culture and priorities and how they see this as impacting on their work.

The fourth research question is "What are CMHNs perceptions of mental health policy and how has this has impacted on their clinical decision making?" The existing literature examines the experience of CMHNs and teams and the impact this has on their work. This is considered in the team level literature as a policy background and how this impacts team structures and specific CMHN roles such as care coordination.

None explicitly ask about awareness of policy or perceptions on their Trust and organisational culture. They do not explore if CMHNs have an awareness of national issues and if they can differentiate this from the culture of their organisation. Therefore, it was decided to include this in my semi-structured interview questions. This is particularly relevant as at the time this research was undertaken the staffing crisis in mental health nursing was worsening.

The studies within this review utilised a variety of methods and conceptual frameworks. These included policy analysis mixed methods, or qualitative methods: questionnaires, semi-structured interviews, focus groups and observations. Conceptual frameworks utilised include grounded theory, ethnography and phenomenology. Two studies used Critical Realism, one was examining CMHTs from the perspective of the team psychologists and stated that

a Critical Realist approach was used in conjunction with thematic analysis (Christofedes et al 2012) however, application to the data is not clearly stated. The second study Moth (2020) used critical realism to guide the methodology and neoliberalism as part of the theoretical background. However, the timeframe is different.

2.9.: What this thesis will contribute.

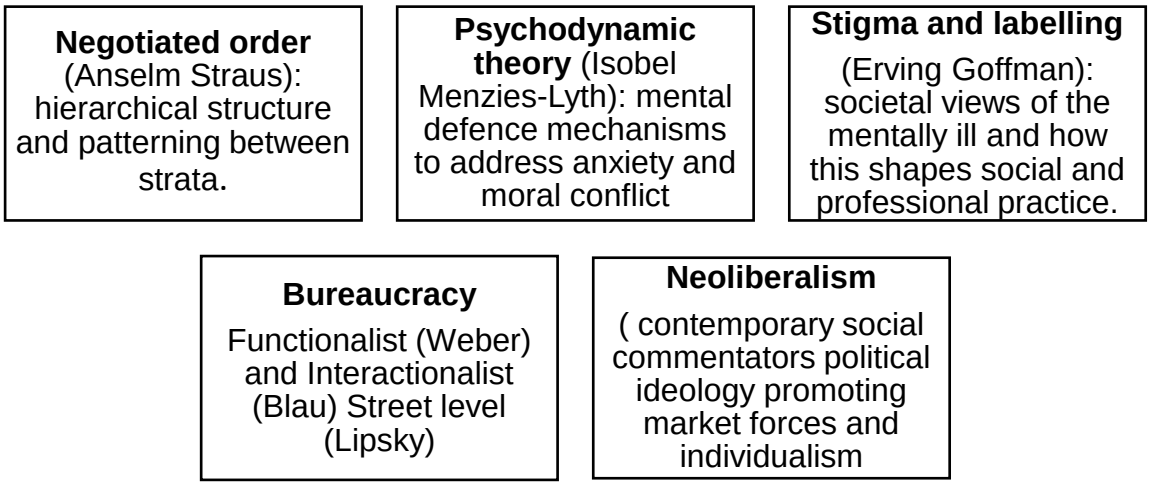
The studies considered in this review do address the impact of policy on practice utilising qualitative methodology to ascertain the views and experiences of staff. These focus on clinical outcomes, staff roles and satisfaction and the process of implementing policy. The research considered does not address the impact of contemporary policy on the process of decision making, that is the influence of efficiency on the perception of need. Another gap is the consideration of socio-political ideology operationalised within policy and how this is experienced by CMHNs within their professional and moral framework. This thesis uses Critical Realism to consider the impact of political ideology on clinical decision making. It focuses on the use of ideologically driven language and subsequent CMHNs perceptions of service functions and the needs of service users. The majority of studies considered in this review appear to be a theoretical, or the theoretical basis is not made explicit in the publication. The unique contribution of this thesis is the eclectic theoretical framework used to analyse the data. This is discussed in Chapter three.

Chapter 3 Concepts of structure, interaction and agency.

3.1: Introduction:

This chapter will provide an overview of the mid-range theories which underpin the main concepts relevant to this research. Making these explicit, contextualises the researcher's identification and analysis of stratified relationships, social structures and interaction inherent in complex, contextual settings (Kislov et al 2019). The first section will consider a theory of structure and hierarchy, that is, Anslem Straus' Negotiated Order. It illustrates the interrelationship between order/structure and negotiation/ interaction in public services such as the NHS. Psychodynamic theory is addressed, highlighting the original contribution of Isobel Menzies-Lyth, contained in her key text "Containing Anxieties in Institutions." This highlights the psychological processes and interactions that professionals use to deal with anxiety and conflict in the workplace at the individual, team and organisational level. Irvin Goffman's theories about stigma and labelling will be considered next. This underpins the social practice and process which shape widely held societal beliefs about people with mental illness. Theories which underpin political ideology and the processes that drive their implementation are then considered. Theories of bureaucracy, both Max Weber's functionalist theory and Peter Bau's interactionist concepts are discussed. The contemporary application to public service work is addressed by considering the work of Michael Lipsky "Street-level bureaucracy." Finally, the theoretical underpinning of the influence of political ideology on public service policy will be contextualised using neoliberalism. Its impact on the social practices of the recovery model and anti-stigma campaigns will be presented.

Diagramme 2: mid-range theories



3.2: Negotiated Order

This theory is used in this thesis to contextualise the relationship between the three layers in the hierarchy. The work of Anselm Strauss is a framework to demonstrate the connection between interaction and structure. The dynamic relationship between "negotiation" and "order" is rooted in Symbolic Interactionism. This theory acknowledges the distinction between agency and structure and their interaction (Nugus 2019). It connects hierarchical structure of micro, meso and macro levels and how they interrelate. The micro: the individual perspective, the meso: the team/organisation or social group identity and the macro is the social structure: policy or political ideology. (Hallett 2003). The theory of negotiated order guided understanding of these structures. It also informed the choice to use Critical Realism as a methodological framework, as its main concepts are similar.

Social order and change are inherent in all interactions and decisions and reflected in the use of language. Fisher (2013) highlights the connection between the individual's conscience and the socio-political landscape of social justice. The organisational level in between these spheres is constantly defending against both to survive and is driven by a socio-political ideology which is forcing a rapid change (Fisher 2013). The framework of negotiated order provides a useful structure for understanding individual and service level interactions in the context of national policy and ideological shift in this thesis. Strauss (1978) examines negotiations as a means of getting things done as all negotiations take place within a specific social order.

Strauss (1987) advocated that it was not possible to conceptualise clinical activities from structured pathways and policy dictates, this was only observable within the interactions and decisions of clinicians. This process of negotiation reflects the variability of clinical practice and teamwork in mental health care, whereas health policy authorities seek to systematise care and make it measurable (Degeling and Maxwell 2004). However, top-down application of national standards for measuring mental health provision is difficult to achieve due to local social and economic variables in populations (Wang 2015). The Five-Year Forward Plan for Mental Health (HM Government 2017) and the subsequent NHS Long Term Plan (DHSS 2019) seek to integrate services to work jointly to meet the complex health and social care needs of populations. The NHS long term plan for mental health, states that new developments will address health inequalities and client outcomes and experiences (Ham and Murray 2018). Negotiations will be localised, with a range of services developing in response to local need (HM Government 2017). These most recent policy initiatives are a shift towards capturing subjective experiences and staff consultation. The involvement and

intrinsic motivation of health and social care staff is fundamental to the success of these plans (Ham and Murray 2018).

Bryant and Stensaker (2011) define negotiated order as a sociological theory that explains how meaning is created through human interaction and continuous negotiation and applied the theory to the role of middle management. The focus of this work was the duality of strategic and interpersonal in delivering change. It draws upon the work of symbolic interactionism but adds to it by considering interactions at the micro, meso and macro level. Udod and Care (2012) say that nurse managers are challenged by increasingly complex issues as they balance the drive for higher productivity with resource constraints. Many feel ill prepared and unsupported in their role. Macro level negotiations incorporate governance, policies, and procedures. Negotiations therefore happen within formal boundaries set by job descriptions and service parameters. Bryant and Stensaker (2011) say that when addressing ideological issues many staff undergo a process of intrapersonal negotiation. This applies to processing internal conflicts which may arise from ethical dilemmas or moral distress. This thesis will address how this is process in examining mental health nurses' perceptions around how they negotiate these dilemmas, not only within their teams but within themselves. It will also address their awareness of drivers at an organisational and a political level, and their perception of the influence of these factors.

Organisational theories of Negotiated Order examine how institutions shape and are shaped by workers' actions (Beckhy 2011). Professional groups adapt policy edicts to fit with their interpretation of local need and professional discretion, despite the rigid mechanisms in place to ensure policy conformity (Evans 2007). Within these organisational mechanisms professionals may only partially conform

to operationalised standards and there are often varying degrees of alignment between policy and practice (Beckhy 2011). Conformity is enacted in many ways, through concerted workplace activity, which is fraught with meaning (Bryant and Stensaker 2011).

Mental health professionals are employees within their organisation but also members of an occupational group (Evans 2007). Occupational group membership can impact on organisational change, they are themselves institutions with codes, shared values, and regulatory bodies. They are also negotiated orders and in constant negotiations with other occupational groups within an organisation (Beckhy 2011). Occupational groups have their own sets of standards and codes of practice, so membership endorses values, moral imperatives, autonomy, and professional jurisdiction (Evans 2007). They interact with policy authorities to shape and advise policy. They influence how practices are embedded and applied to their professional work (Bryant and Stensaker 2011). Membership of a professional organisation such as the Royal College of Nursing (RCN), can give nurses a voice to lobby parliament regarding policy issues which affect practice (Catalo et al 2014). The RCN's (2019) recent briefing raised concerns regarding safe staffing, investment education and pay. This thesis addresses the reciprocal relationship between professional values and policy where the two may be in conflict. The subsequent negotiations take place at a national/macro level yet have an impact at organisational and team level. Therefore, the organisational dynamics and negotiations are increasingly problematic, the political and economic debate is enacted in the negotiations between services (Nugus 2019).

In summary the framework of Negotiated Order is used as a hierarchical framework to examine the interactions between the macro level policy, meso level organisational implementation and the individual team and clinician. This theory originates from the work of Strauss (1978) and is applied specifically to health service organisations. In this thesis it will be applied to the process of interaction between the levels of the hierarchy defined above and the factors which align them. The dynamics and socio-political nature of these interactions will be addressed by the following theories.

3.3: Psychodynamic theory

This theory addresses psychological process of dealing with conflict. These processes operate at individual, team and organisational level, but for the purpose of this thesis, examined through the perception of CMHNs. The original work is that of Menzies Lyth (1988): Containing Anxiety in Institutions, with specific reference to nursing. In this work, Menzies Lyth (1988) discussed the stress inherent in nursing, including making difficult decisions which affect the wellbeing of patients. She highlighted the use of mental defence mechanisms by nurses to combat their subsequent distress, conflict of overwhelming sense of responsibility. This results in the use of mental defence mechanisms: splitting and projection. Projection involves locating negative feelings in another and splitting involves placing conflicting views in separate people, teams of parts of the service (Cilliers and Terblanch 2010). Their internal conflict is manifested as an interpersonal one. The internal conflict may be one of feeling burdened by responsibility and simultaneously unable to cope with it (Menzies 1988). If nurses find they are unable to act in accordance with their professional values and obligations, they experience moral distress (Wallis 2015). If this happens

repeatedly then this leads to poor care, decreased job satisfaction, burnout and attrition. Wallis (2015) states that although this is an individual reaction, it does not happen in a vacuum and becomes the concern of the organisation. The relationship between individual's moral perception and their organisations' response will be examined in this thesis.

The psychodynamic perspective can be applied to Community Mental Health Teams. Heginbotham (1999) states that the whole nature of mental health service provision is psychodynamic. The service users' needs are complex and dynamic, therefore the clinicians' and service responses are ever changing and interacting with the intensely interpersonal nature of the clients' world (Davis 2008). The purchaser provider split (DH 1990) resulted in an organisational experience of internal fragmentation. This freely allows a blame culture to evolve in which no one takes responsibility. The process of marketisation, eroded the balance between common good and personal responsibility (Cilliers and Terblanche 2010). Therefore, those making decisions about financial measures and service reorganisations are disconnected from the consequences of clinical decisions. This thesis will consider the extent to which this conflict is experienced by the organisation, individual teams and clinicians in the current policy context.

In the contemporary healthcare setting, leaders are required to be involved in increasingly complex, competitive, technical, and interpersonal organisational systems (Cilliers and Terblanche 2010). Nurse Leaders have high levels of survival and performance anxiety. Cilliers and Terblanche (2010) state that nurse managers are often caught up in the organisational domain of strict rules and strong defences. They are defending against the anxiety of toxic atmospheres and feeling blamed and bullied. During periods of rapid change and crisis, staff

employ defence mechanisms which can involve undermining their leaders and forming maladaptive social networks, this makes managing them difficult (Loosemore and Hughes 2000). Nurse managers take on many roles and have a perception of others' expectations of them. The organisational hierarchy denies them power and so they suffer projections of deauthorisation, messiness and chaos. As a defence many managers withdraw into the concrete, task orientated aspects of their role and are not able to acknowledge their interpersonal management abilities (Fisher 2012).

The marketisation of the NHS supported a prevailing audit culture which sought to regulate and control the complex and uncertain aspects of clinical work (Stark et al 2002). Ham et al (2015) says that the Health and Social Care Act (2012) reorganisation perceived NHS providers as independent operators in a market environment, driven by political change and a large-scale ideological shift. Organisational culture develops by a process of interaction between structured external factors, namely marketisation and competition and internal relationships and local need. The development of the Sustainability and Transformation Plans potentially place greater emphasis on local need and more responsibility upon local Accountable Care Organisations (HM Government 2017). This will involve further NHS reorganisation. Reorganisation creates structures that are rationally constructed to meet the tangible aims of the organisation. These are modified by internal psychodynamic processes which are the result of internal tensions and conflicts (Czander 1993). McKenna and Dunn (2016) say that the government has decentralised the management of NHS budgets and made this the responsibility of individual Trusts. However, funding is still being reduced centrally but the responsibility for this is placed on individual organisations. This process is mirrored in the relationship between Trusts and their staff. Czander (1993)

suggests that decentralisation gives the illusion of devolving authority and autonomy. However, this process fragments the structures within an organisation and therefore fragments the power base of subordinates.

This strengthens the power of senior groups enabling them to locate the organisations failings within the subordinates' roles (Hanley et al 2017). This level of conflict can have a positive and restorative function. It can generate formative spaces which in turn lead to creativity and regulatory functions. However, it can also have negative consequences and lead to the creation of intractable, perverse spaces leading to dysfunction, crisis and collapse (Fischer 2012). Czander (1993) cites Menzies (1960) who describes the internal conflict experienced by members of staff who have an organisational culture forced upon them, which is at odds with their internalised values. They are not permitted to voice their concerns and have difficulty in introjecting the group norms. The effective development of STPs, relies upon good working relationships between organisations and public and staff engagement. There is potential for tensions between partnership organisations if respective working relationships are not clarified (Chipperfield 2017).

In summary this section has considered the relevance of the psychodynamic perspective. The original text discusses the anxiety experienced by nurses in dealing with the stress of dealing with individuals who are sick and distressed. It considers the individual and group processes for dealing with this. More contemporary literature develops these concepts in relation to ways in which the self and social world are interconnected and shaped by political change and how any resultant conflicts are manifested and addressed within organisations.

3.4: Labelling

Labelling theory forms part of Goffman's work on Institutions and has been developed as a theory by social scientists. It is useful in understanding how social practice is influenced by widely held, often stereotypical views about groups by wider society (Ritzer 2005). It is closely related to Symbolic Interactionism and Social Construction (Scheff 1974). Labels arise from definitions of how others view certain tendencies and behaviours. These are often deemed to be deviations from societal norms and are applied to mental illness, deviance and socially unacceptable behaviours. Labels such as "addict", "schizophrenic" or "criminal" define individuals and become the most significant aspect of their identity (Granello and Gibbs 2014). These labels are based on widely held values which are socially constructed (Farringdon and Murray 2013).

Rosenfeld (1997) states that labelling can have either a positive or negative outcome for the individual. The likelihood of being labelled depends on the individual's power and social distance from the agents of control (Markowitz 2014). Scheff (1974) reviewed several studies which demonstrated that social characteristics of mental health patients help determine their diagnosis therefore, those with a lower socio-economic status were more likely to be detained in hospital. Barnett et al (2019) state that those from an ethnic minority are more likely to de detained under the Mental Health Act (1983 amended 2007). Social factors, such as reduced interpersonal networks, unemployment and stress may increase stress thereby making mental health problems worse (Farringdon and Murray 2013).

Treatment seeking behaviour is dependent on self-labelling so diagnosis, can have positive outcomes, as it enables the individual's care needs to be recognised

and for treatment and support to be provided. If the individual is recognised as being “ill” then they are granted the associated “privileges” of the patient role (Angermeyer and Matschinger 2003). These “privileges” are appropriate treatment and social support, without this the individual may be socially excluded. One negative view of labelling is that it is essentially discriminatory and can affect employment. Angermeyer and Matchinger (2003) suggest that labelling can marginalise those with serious mental illness by reinforcing the belief that they are dangerous and “need help”. The concept of labelling can illustrate how power and control are exercised within society and our social institutions (Schleff 1975). It can attract limiting societal opinion which can result in discrimination and abuse. In mental health the process of labelling can set in motion a stigmatising process which can lead to limiting self and societal beliefs and prolong the labelled behaviour (Rosenfeld 1997). This concept is known as stigma.

3.5: Stigma

Goffman (1990) says that stigma is the process whereby marginalised individuals are devalued and disqualified from full social acceptance. This is one of society’s ways of controlling actions and activities. The process of stigmatising is defined by Corrigan (2004) who states that the label of mental illness can bring harm. This harm can manifest in two ways: decreased self-esteem and robbing individuals of social opportunities. Discrimination is the negative reaction to the stereotype. This involves behaviours which as avoidance and excluding groups of individuals from employment. Public stigma is where the public endorse images or values about a particular group, for example viewing the unemployed as “lazy” or the mentally ill as “dangerous”. Self-stigma is where the public view is internalised by an affected

individual (Treickler and Luckshead 2017). This leads to shame and concealment, that is individuals do not reveal their diagnosis for fear of being judged.

In the UK, the Time to Change anti stigma campaign started in 2007 and was endorsed by the Government. Social and mainstream media are portraying openness and acceptance of mental health problems to facilitate the process of "normalisation" to lessen discrimination and promote inclusion (Department of Health 2014). It operates via large scale social marketing and local events. Its' purpose was to improve public awareness, decrease discrimination in workplaces and schools and promote help seeking behaviour (Henderson et al 2013). The evaluation of this campaign demonstrated a reduction in discrimination and increase in awareness and access to support via large scale social media surveys (Time to Change 2019).

A popular anti stigma approach is saying that mental illness is like any other illness and can happen to anyone (Tyler and Slater 2018). However, mental distress often has significant psychosocial elements and this approach, although helpful to some, gives authority to medicine and fails to acknowledge societal factors (Pilgrim and Rogers 2005). Anti-stigma campaigns prioritize a symptom based, biological approach to mental illness (Walsh and Foster 2021). This fails to acknowledge varying levels of severity and the impact of social disadvantage (Ungar et al 2016). The social marketing approach used in such campaigns focusses on celebrity disclosure and success stories. Although this can be seen as promoting awareness and giving hope, the celebrity story does not match the experience of those with SMI and multiple social problems (Tyler and Slater 2018)

Public and social stigma may be influenced by social and political ideologies about the undeserving (Servaes and Oyedemi 2016). Neoliberal policies place pressure

on employees to increase performance with less resources, often resulting in chronic stress, anxiety and depression (Tyler and Slater 2018). In addition, the Government is placing an increased emphasis on those with long-term conditions such as SMI, to return to work. Unless workplaces are creating working environments to accommodate these people, they are unable to work, maintaining an underclass viewed as being responsible for their situation (Ryan 2019)

Lannin et al (2015) say that self-stigma threatens positive self-conceptions which the individual is highly motivated to protect. This in turn prevents individuals seeking treatment and support. Tucker et al (2013) studied the relationship between the self-stigma of having a mental illness and the self-stigma of seeking treatment and support. These concepts are independent of each other depending on the values the individual places on the label or as being seen as a “help seeker”. Treichler and Luckshead (2017) studied the potential benefits of individuals with serious mental illness identifying with marginalised groups as a psychosocial buffer to internalising negative stereotypes. The individual may be accepting of their diagnosis, but experience discrimination by those around them. This view is endorsed by symbolic interactionists such as Mead and Blumer. Crocker (1998) argues that self-stigma is not necessarily the result of internalised views and shame but is the consequence of the immediate social context for the stigmatised person.

Scambler (2006) examines the stigma of chronic illness and the added impact of other social structures such as class, gender, ethnicity as well as stigma and deviance. These factors are explained by Bhaskar’s (1989) critical realist philosophy that states that social structures such as class are generative and exist in the “real” domain and when triggered are enacted in the “actual” namely face

to face interactions. Social structures are tangible and enduring and have predictable effects on the social world. Fox et al (2017) also cite the influence of intersectionality, that is that people with mental illness also have a range of characteristics representing privilege and marginalisation. For example, a person with a mental illness may also be from a Black or Ethnic Minority Group. These individuals may experience greater levels of perceived dangerousness or incarceration because of these combined factors.

There has been a move from the post war positive welfare to a culture of consumerism. (Webster 2002) This new ideology supports the view of personal responsibility for health, rather than state responsibility. Promoting self-management amongst those with SMI has positive effects such as an increased sense of autonomy and a reduction in hospital admissions (Ley et al 2012). However, this informs a new sociological understanding of chronic and disabling health conditions. If these result in the person with a long-term condition being dependent on the state and therefore not able to be productive, then disease is stigmatised. Although the existence of the condition is a personal tragedy, the process of stigmatisation is a product of social structures as generative mechanisms (Elder-Vass 2012). The Welfare to Work Scheme (DWP 2015) developed and introduced a new standardised characteristic assessment on the barriers to employment for those seeking benefits. These barriers to employment, included addictions, offending, homelessness and health problems, especially mental health problems.

The Government's ideological viewpoint shape their policy approach to welfare (Williams 2009). One is that social class can be acquired, that is that any individual can improves their level of income and educational or occupational status if they

try hard enough (Goldthorpe 2012). The other is that disadvantage is a result of health and social events which the individual cannot change. The former would promote a welfare policy which encouraged individual effort and self-improvement. The latter that the state should provide support for those unable to improve their situation. Legislation has sought to marginalise and sanction the poor (Spicker 2011). In social services and social security, stigma and complex administration are used to deter people from accessing them and so ration scarce resources. There is stigma attached to using social services and social security as these are resources used by people who have social deficits. Bullock et al (2003) say that promoting a societal view of poverty being the result of individual failure, justifies restrictive welfare policies. The opposing view is that social class is ascribed and maintained through social structures which facilitate oppression and exploitation. This lends itself to progressive welfare policies which tackle the structural problems in society which cause poverty and universal health care (Spicker 2011)

The DWP (2015) state that these issues have not been systematically assessed within previous legislation. Gray (2014) discusses the implementation of the Personal Independence Payments which replace Disability Living Allowance. This was introduced in the context of fiscal austerity. The assessment process had a greater emphasis on mental health than before. Subsequent reviews highlighted problems with the impact of delays and backlogs and the collection of collateral evidence in support of a claim. In 2017 a High Court ruled that the PIP assessments of people with mental health problems were unlawful. The testing methods were deemed unsound with over 65% of claimants who had been refused payments, had their decisions overturned (Ryan 2019). These are examples of the socio-political drivers for stigmatising health conditions. The

labelling and stereotyping, social distancing and the loss of status that characterise stigma are facilitated by the differential distribution of social, economic and political power (Link and Phelan 2001).

In summary this section has considered the theoretical concepts of social constructs for labelling and inclusion in mental health services. It has examined Goffman's original text. Consideration is given to the role of mental health labels today. These may have changed to be more humanitarian and sophisticated, but still driven by socio political motives and uphold a process of social determinism. These processes are politically and ideologically driven but experienced at an organisational, team and individual level. The context of marketisation in healthcare delivery is also a significant aspect in considering the drivers in developing mental health services. The theories of bureaucracy and neoliberalism now be considered.

3.6 Socio political factors

To understand the ideological drivers which, affect organisational structure and clinical practice, the theories of bureaucracy and neoliberalism will be discussed. Bureaucracy is a complex system of coordinated human activity; to understand their dynamics, a knowledge of the patterns of social interaction within them is vital (Blau 1963). Bureaucracy is used in this thesis to define activities, structures and interactions, which drive the hemogenic political and economic ideology of neoliberalism (Springer 2012).

3.6.1: Political application; Bureaucracy

This section will consider the functionalist and interactionist constructs of bureaucracy. The functionalist perspective seeks to define the mechanisms which drive uniformity and compliance within organisations (Samier 2013). This reflects the mechanistic approach of the audit culture (Rizq 2014). The interactionist perspective seeks to examine the relationship between the political and organisational and their interaction between higher order values, emotions, and morals (Collins et al 2018). It also captures the complex interface between structure and internalised ways of working in public services (Samier 2013). Bureaucracy in this thesis seeks to identify the mechanisms which deliver political ideology to via organisational change, utilising monitoring strategies to ensure compliance. It also seeks to capture the reaction of teams and individuals to this structure and how these impact on implementation. Therefore, both the functionalist and interactionist theories of bureaucracy will be considered.

The functionalist perspective of bureaucracy emphasises the importance of structural elements in organisations. This includes management techniques and administrative functions (Samier 2013). The bureaucratic principles cited by formative theorist Weber (1864-1920) follow a legal rational paradigm (Waters and Waters 2015). Organisations have full time administrators who are arranged in a hierarchy, with well-defined roles and who follow strict rules. These measures are viewed as superior in being able to control subordinates, ensure efficiency and often involves extensive audit and paperwork (Donaldson in Crothers 2010). Research using a positivist approach to bureaucracy focusses on public policy process and strategic planning (Samier 2013). It examines functions of

specialisation, adherence to rules and policies and the decentralisation of decision-making (Donaldson in Crothers 2010).

Critics of the functional approach suggest that it too mechanistic and linear to account for the complexities inherent in public services such as health. It does not account for higher values, professional identity and moral decision making (Samier 2013). Qualitative researchers use case study approaches and are critical of bureaucracy, citing it as inflexible, stifling individuality and protecting a narrow range of interests (Donaldson in Crothers 2010). The interactionist concept of bureaucracy examines the interaction between the individual public sector worker and the structures they work within (Samier 2013). This approach acknowledges the emotional components of health work and their reciprocal relationship with rational approaches (Collins et al 2018). Blau (1963) defines the interaction between the individual and their organisation, viewing the organisational structure as dynamic. Strauss (1978) critiques Blau's (1963) perspective of this interaction as it states that the individual is subordinate to the organisation. The professional needs to have knowledge and expertise to join the organisation but if they fail to utilise these then they are judged negatively rather that the organisation.

Michael Lipsky's Street Level Bureaucracy is a contemporary theory which seeks to explain how individuals who work in public services experience the policies which direct their practice (Lipskey 1980). This theory suggests that the individual practitioners or "street bureaucrats" shape how policy is delivered. They are affected by common conditions such as: lack of resources, unrealistic expectations, large caseloads and working with policies which do not translate into clear performance measures. Lipsky (1980/2010) suggests that they use the

following coping strategies: simplification and routines, generalised assumptions and categories, referring onto other services and strategies of objectification and control. This is widely applicable to this thesis as it highlights many relevant aspects of public policy and how this impacts public sector workers. It correlates with the experiences of the participants in this study. Relevant aspects include time spent on paperwork, limited resources and the pressure not to appear to be rationing services, whilst being rewarded for reducing caseloads. The concept of bureaucracy as a structure and a process has been considered. The contemporary ideology of neoliberalism will now be addressed.

3.6.2: Neoliberalism

Over the last 30 years, neoliberalism has become a dominant paradigm in all areas of public life. It endorses the view that economic growth would be more successful if markets were allowed to run the economy (Lethbridge 2019). This approach views social order is achieved by allowing market rationality to shape all aspects of public life, which are subsequently judged purely on their monetary value (Esposito and Perez 2014). Individualism and consumer activity are considered the “norm” and those who maintain a more collective stance are viewed as irrational or even deviant (Mooney 2012). It is a term originally used to describe a political and economic ideology but is increasingly being used a theory in academic work in examining a range of social issues (Springer 2012). The rise of neoliberal politics has implications for the relationship between the Government and the state. Government involvement in running public services therefore takes place through the market through privatisation of services, decentralisation of responsibility and the promotion of individualism (McGregor 2001). Critics of neoliberalism suggest that it undermines social justice and altruism. It leads to a

productivity led management styles and the state being subordinate to the market (Peters 2001).

3.6.3: Neoliberalism and mental health

Esposito and Perez (2014) say that the in a neoliberal construct, concepts of health, self and normalcy are defined based on their commercial appeal and the ability to buy this. In this climate, a more social approach to healthcare provision is seen as undercutting efficiency and leading to undesirable traits such as laziness, lack of moral substance and a lack of self-reliance. (Mooney 2012). The emphasis on personal reliance and individuality can lead to those with SMI being viewed as personal and social failures. Those who are dependent on welfare are demonised as a moral underclass (Ramon 2008). Having a mental illness is viewed as a contained problem with the individual and ignores social, cultural and economic dimensions. Therefore, the emphasis is on treating the health problem, rather than providing social and welfare support (Esposito and Perez 2014). Social inclusion is viewed as a positive aspect of mental health recovery, this is discussed in the next section. The stress of work and social obligation can be stressful and damaging to mental health (Ramon 2008). Government backed public stigma campaigns have sought to increase the employability of those with a mental illness, but without the support necessary to cope with work, as previously discussed in the section about stigma (Esposito and Perez 2014).

3.6.4: Neoliberalism and health and social care policy

Social policy consists of three areas, namely health, welfare and education (McGregor 2001). Those with long term conditions such as SMI require both health care and welfare support. Ham et al (2017) say that since the White Paper “Equality and Excellence (2010) the Government have developed legislation and

structures to embed a provider market within the National Health Service. Jones-Devitt and Smith (2008) cite Olsen and Peters (2005) who state that neoliberal values uphold the belief about choice for individuals, organisations, and multinational corporations. Thus, healthcare is controlled by free trade principles and that state control is seen as restrictive and negative.

In the current climate, this ideology is applied to social and welfare policy as well as health care. Pollack (2010) states that in a neo liberal welfare state, social care agents are an intermediary body, which translate state power to individuals, families, groups and communities. The neoliberal agenda believes that existence of state-controlled health and social care, leads to dependence and undermines social and economic prosperity. Pollack (2010) states that neoliberal governments reduce funding to welfare measures and health services but increase criminal and immigration surveillance. Therefore, social assistance regimes are administered through surveillance and tight controls with overly punitive sanctions. Social inclusion therefore brings with it the stress of social pressures and the need to work and be independent. The societal belief is that people find their own solutions to lack of healthcare and social security, and they are blamed if they fail to do so (McGregor 2001)

The empowerment agenda becomes individualised, rendering social inequalities irrelevant. Therefore, social exclusion is viewed as a failure of the individual and not the responsibility of the state. The prevalence of these socially determined labels are reinforced by mainstream media. Hayward and Yar (2006) suggest that the mainstream media have coined pejorative phrases and stereotypes to vilify those dependent on welfare support. There have been examples of this in the mainstream media in the context of austerity and welfare reforms. Numerous

national newspapers have published articles on examples of people on welfare benefits as “undeserving” and choosing to claim benefits rather than seek employment.

We are making an historic break from a system that, despite many good intentions, failed those most in need – unwittingly fostering dependency rather than encouraging independence; maintaining people in disadvantage rather than transforming lives; spending public money without achieving outcomes or changing lives (Ian Duncan Smith Guardian newspaper 2013)

In the Budget statement (HM Treasury 2015) it was suggested that trained mental health counsellors be brought into Job Centers. There was concern expressed by professional bodies such as the British Psychological Society that refusal to accept psychological treatment may be grounds for benefit sanctions. Another criticism was that this framed being unable to find work as being a psychological disorder. Television journalism is the primary vehicle for communicating political messages using the lens of social class. Servaes and Oyedemi (2016) suggest that there is currently a structuralist framing of social inequality. This involves a neoliberal approach to social issues seeing class as a continuum of state, capital, and labour. This often portrays social mobility as achievable through choice. This view therefore does not acknowledge the existence of social class to conceal social inequalities and prevent the development of awareness. Social class can be viewed as either a protected characteristic, that is through family connections or an economic one, attained through financial acquisition (Goldthorpe 2012). Both factors are, however, interrelated as social structures enable the wealthy elite to control the distribution of wealth (Sevares and Odeyemi 2016).

The policy chapter discussed the concepts of decentralisation and marketisation of the NHS. The neoliberal approach requires the denationalisation of the National Health Service (Jones-Devitt-Smith 2008). This results in a new concept of professionalisation, namely a move away from one of professional expertise and autonomy, towards developing relationships with “consumers” and adapting to new economic structures and competition. At a policy level this introduces contractual obligation and accountability which can erode healthcare professionals’ control and clinical responsibility (Hardy (1999) cited by Jones-Devitt and Smith (2008). Professional development is measured by the organisational and economic value of an employee’s skills set, rather than their clinical credibility within their field/profession. Countering this is viewed as “old style” professionalism which is self-serving and driven by opportunism and secrecy (Jones-Devitt and Smith 2008). (The creation of Nursing Associate and apprenticeship roles will be discussed chapter six.) This has an effect of changing the culture within healthcare organisations. The results involve moving away from flatter more democratically orientated management structures to a hierarchical structure which monitors performance in a stringent way. Subsequent workload models which measure responsiveness and market led outputs. The recovery model has become the dominant philosophical approach to addressing mental distress in UK and other first world countries (Woods et al 2019).

3.6.5: The Recovery model.

The Recovery Model is a social movement which is influencing mental health service development around the world. It came from the “survivor” and “ex-patient” movement of the 1970s and 1980s (Deegan 1988). It rapidly became a widespread philosophy in mental health services throughout the 2000s (Repper

and Perkins 2003) The philosophy of recovery is that services work to empower those with Serious Mental Illness to be involved in their care and find meaningful and productive roles in society (Warner 2010). It places emphasis upon the individual working towards goals and taking responsibility for their life. The inherent concept of "social inclusion" implies that those with SMI can gain access to social and employment opportunities (Rankin 2005). The language used by mental health professionals is defining the "problems" and "symptoms" of the mentally ill imply social disability which is at odds with what society would consider normal. This can be viewed as using disease terminology which has a deficit focus (Walker 2006). The social model of disability and the service user movement support the view that social inclusion is a human right (Sayce 2001).

The Recovery model can be viewed as socially constructed (Spandler 2007). Its development has been influenced by humanitarian principles but also political and financial pressures (Walker 2006). The language used such as "social inclusion", "empowerment" place emphasis on individual responsibility and productivity, whilst disregarding the social structures which create exclusion and disadvantage (Woods et al 2019). It can therefore be viewed as a policy driver in strengthening the concept of individual determination and responsibility (Cooke and Kathari 2001). Critics have suggested that it has been more recently co-opted by mainstream health and social care policy makers to pursue a neoliberal agenda (Woods et al 2019). The recovery approach has been conceptualised and applied to mental health service user care planning using the recovery star. Dickens et al (2012) say that the recovery star is an outcome measure. It has 10 pre-determined dimensions, each with a 10-point scale which the professional and client rate. The socially orientated categories within this model are living skills, social networks, work, relationships, and responsibilities. This would indicate that adhering to

these social norms is regarded as being mentally healthy. Social inclusion strategies often target groups whose behaviour and choices are seen as problematic and imposes socially desirable goals upon them (Levitas 2005). The individual's personal and social development are subject to professionally determined outcome measures (Walker 2006).

3.7: Chapter Summary

This chapter has discussed the eclectic range of theories which will inform the data analysis in this thesis. Negotiated Order gives the overarching structure between the micro: individual and team, the meso: the organisation and the macro: socio-political ideology and policy. Psychodynamic theory relates to the individual and team psychological reaction to potential conflicts generated by policy edicts. The theories of labelling and stigma are relevant to the socially driven creation of social norms. The socio-political macro factors are analysed in relation to the functions of bureaucracy and the ideological stance of neoliberalism.

Chapter 4: Methodology

4.1: Introduction

This chapter will detail the conceptual framework and methodology used in this thesis. Firstly, it will justify and explain the use of the meta-theory of Critical Realism. This will be followed by an overview of the key components of CR. This will include ontology, epistemology, and method. The specific methodology utilised in this thesis will then be addressed. The first method addressed will be the policy analysis undertaken, the findings relating to this will be presented in Chapter five. A detailed account of sampling, selection and recruitment will be presented. The methods of semi-structured interviews and non-participant observation will be discussed. This will be followed by an account of data analysis, combining a Critical Realist Framework with reflexive thematic analysis. The issues of internal and external validity and positionality will be addressed. Finally, the process of ethical approval and considerations will be presented.

4.2: Choice of conceptual framework.

This research involves empirical evidence of CMHNs perception of how individual, team, organisational and national factors affect their clinical decision making. The author is interested in the structures and interactions at each level of the hierarchy which enact these drivers or modify them. The author was also aware that the ideology of government shapes public policy and subsequently shapes the practice of institutions such as the NHS. These social practices exist as tangible structures and may or may not be experienced by individual practitioners. This is also driven by the author's political positionality, namely the critical examination of the ideology inherent in social structures and their impact on social groups and individuals.

Therefore, a conceptual framework was chosen which endorsed the critical examination of interactions and the socio-political drivers inherent in these interactions. The author originally considered Critical Theory as a conceptual framework. This is based on the belief that social structures actively marginalise groups and making this explicit has an emancipatory function (Parlour and McCormack 2012). This framework is generally linked to theories such as Marxism and Feminism. The subsequent research usually examines concepts such as racism, sexism and homophobia. (Jones-Devitt and Smith 2008).

Critical realism seemed more appropriate for this thesis as it does not have such hard determinism. Instead, it examines the mechanisms that produce tendencies in a dynamic and multi-faceted context (Parlour and McCormack 2012). This supports the use of an eclectic and multi layered use of theories. This meta theory will be defined in terms of its ontology and epistemology in relation to this thesis. The decision to use of CR was emergent and was identified when the author was looking for a conceptual framework which would accommodate a stratified or hierarchical approach, based on the author's original interest in Strauss' negotiated order and Blau's Symbolic Interactionism.

The author's reading about Critical Realism captured their interest, but also left them feeling overwhelmed. It is a meta-theory and is intensely philosophical. Much of the reading consisted of emanant theorists in the field critiquing each other's work and engaging in lengthy debate about the use of terminology (Danermark et al 2019). As a novice researcher, it was important to clarity and direction regarding methodology and data analysis. The author engaged in a lengthy exploration of the key concepts and how this would relate to the research questions and approach. This was challenging as the author does not come from

a philosophical or social science academic background. On reflection, the author realised that one of the reasons they were so attracted to it, was that it fitted with their approach to their work as a mental health nurse. The author worked with service users with complex needs and subject to social disadvantage. They were constantly looking for meaning and explanations beyond what could be observed. The service users they worked with often experienced overwhelming distress which has its origins in their personal history and complex psychological reactions to this. They are unable to express the causes for their difficulties, making this information inaccessible, this was often exacerbated by problematic social processes such as poverty, discrimination, and exploitation. In working therapeutically with such service users, the author utilised their understanding of theories of mental illness, psychological processes, and social disadvantage to understand what may have caused their problems. Similarly, as a Community Mental Health Team Leader, they had to address issues of team dynamics and performance, plus address the impact of organisational change. The underlying causes of some of these difficulties was not always apparent so they had to use their knowledge and analytical skills to speculate about underlying causes, to find effective solutions.

Therefore, the author decided to embrace this approach as they liked the concepts of the stratified reality and that complex mechanisms produce outcomes and that these are not always possible to capture. This fitted with their belief that social practice, such as the enactment of health policies, impacts, the delivery of mental health care by shaping the subjective experience, perception, and interaction of teams and individual practitioners. These concrete social structures driven by political determinants, and that these exert control over this social practice. They do this in ways which are often hard to directly identify, that is a

chain of events, consisting of structures, choices, interpretations, and interactions. Critical realism addresses these concepts, and this will be discussed in the next section.

4.3: Critical Realism

Critical realism is both a philosophy or meta theory, originally utilised in science and social science (Danermark et al 2019). It was originally developed in the 1970s and 1980s by British philosopher Roy Bhaskar. Bhaskar's work addresses the dualism in social science research. It challenged the tenets of positivism, in that the social world cannot be reduced to what is empirically observable. He also refuted the assertion of social constructivism in suggesting that social practice entirely subjective (Bhaskar 1989). It reconciles the dualism between the positivist and interpretative approaches to research (Danermark et al 2019). It rejects the positivist stance that there is an entirely linear cause and effect relationship in social science research. Namely that we can see the social phenomenon and it will always produce the same result. At the same time, it acknowledges the existence of definite social structures. It examines, how these are shaped and patterned by groups and individuals. This differs from the interpretative stance in that it does not see the social world as existing purely through the interpretation of its people (Bunge 1993 in Danermark et al 2019). It its between objective positive approaches of deduction and subjective and interpretive position of inductive analysis (Yucel 2018).

CR does not provide one overarching set or rules, beliefs or frameworks for research nor does it ascribe to a particular methodology (Archer et al 1998). There are multiple perspectives and applications of CR. There are theorists such as Bhaskar and Archer, who discuss and develop it as a philosophy. There are other

authors who pragmatically apply its concepts to their respective areas of social and organisation research (Danermark et al 2019). This meta theory can be applied directly to methods. It invites the researcher to apply theories directly to explaining and hypothesising what is being studied (Danermark et al 2019).

In social science, the relationship between society and the individual are central. Critical realism involves looking beneath the surface of events and exploring the causal mechanisms (Danermark et al 2019). Bhaskar calls these generative mechanisms, and they are discussed later in this section. Determining what conditions and event activate them or not is the valuable contribution of Critical realism (Haigh et al 2019). Bhaskar (1989) suggests that although social structures are real, they are not fixed, they are patterned by human interpretation and activity. Subsequently they develop and change over time (Scott 2010). Social phenomena, such as structures and established practices are real. They exist whether we perceive them or not. What we know about these structures is shaped by our experiences of them and how we interpret them. Social practice is shaped by political directives and the way in which institutions are structured (Haigh et al 2019). Therefore, tangible social structures exist based on what we experience and hypothesise about the events that may have activated them. Social structures such as laws, political directives and policies are tangible, they require groups of individuals with agency for their widespread implementation (Pring 2000). The mechanisms themselves belong in different strata and these strata are hierarchically organised. These concepts will now be presented in more detail, in relation to ontology epistemology and method.

4.3.1: The Ontology of Critical realism

The basis for any research must demonstrate a congruent relationship between underlying philosophical/conceptual assumptions, the theory used and how this is tested through methodology. Ontology is the philosophical paradigm concerned with “what is”, what constitutes reality and what exists. Ontological principles establish the possibilities and limits of knowledge (Schiller 2015). It is the very nature of knowledge (Howell 2013). The purpose of ontology is to make the philosophical standpoint clear and provide common underlying language. This makes the assumptions within the domain explicit.

Critical realism asserts that reality is not limited to what we can see (Haigh et al 2019). The outcomes/events, we can observe are caused by underlying theoretical mechanisms, structures and laws, that cannot always be visible (Lawani 2021). Examples of social entities that are invisible, include marketisation, discrimination, political ideology exist. They may or may not be experienced by individuals (Haigh et al 2019). Therefore, Bhaskar distinguished between the real, actual and empirical domains of social reality.

The real domain refers to existing social structures which enable or constrain individual actions within that social group or setting. Social structures such as policies and procedures may be intangible, in that they are not physical. However, they exist and exert a powerful influence over social groups. Social settings are complex open systems, they often consist of component parts which may work against each other and are constantly changing (Haigh et al 2019). The effect of these structures is moderated by choices and interactions by groups and individuals. Their impact may be activated or blocked by such dynamic variables (Anderson 2019). For example, in this thesis: the political ideology inherent in

public policy. The choices the government makes to balance affordability and quality of care.

The actual domain is the layer of reality where individuals perform (or not) actions which may lead to outcomes. The social structure may govern individual and group perceptions and decisions. However, groups and individuals also have agency. That is, they can make choices and interact in ways which may reproduce the system directive, or they may challenge and modify them (Anderson 2019). For example, in this thesis; the choices and interactions by the Trust in structuring the CMHTs and developing local operationalised policies, the team interaction and interpretation and the individual CMHNs sense of autonomy which supports the policy directives or modifies or challenges them.

The empirical domain is concerned with the experience of individuals, that is their perception of the events enacted in the real domain. Critical realism provides the opportunity to look beneath the surface to see what causes our experiences (Anderson 2019). For example, in this thesis: CMHN's experience of their role indecision making and their perceptions of the factors which impact on this.

The research aims to identify and analyse these structures and interpretations. This process leads to increased understanding of the context which can lead to change, rather than identifying linear causal relationships (Edwards et al 2014). Increasing insight can be challenging if the individual feels powerless to challenge limitations. Perhaps change can be achieved if this insight is shared with large numbers of others who can articulate and evidence these insights. Jones and Devitt-Smith (2008) suggest that critical thinking in the context of health and social care is linked to political change. It is important for nurses to challenge social, economic, and international challenges to health care.

4.3.2: The Epistemology of Critical realism:

The nature of the relationship between knowledge and humanity is epistemology (Howell 2013). Epistemology is the philosophical paradigm which informs beliefs about the ways in which knowledge should be generated and understood (Schiller 2015).

CR is concerned with the transitive and intransitive nature of knowledge. Transitive refers to the social production of knowledge, which changes and can be questioned or modified (Danermark et al 2019). Intransitive knowledge is relatively static. This exists whether we know about it or not and are concepts that we aim to discover (Holland 2019). The examples of intransitive knowledge in natural science, include phenomena such as gravity and temperature. These would exist if there was no means of studying them. This is challenging to apply to the social world, as it consists of socially produced phenomenon. Even Bhaskar himself, changed his mind about this (Richards 2021). He concluded that this refers to phenomenon that we may never be able to access such as beliefs and interpretations that are not shared or expressed (Richards 2021). Knowledge in CR is transitive, our understanding of a phenomena can change or be modified over time (Haigh et al 2019). Theories used to create hypotheses about potential generative mechanisms are fallible and may or may not be correct. There are intransitive objects such as unobservable structures or the reason for social practices.

Bhaskar (2009) states that CR addresses the “epistemic fallacy” in research. That is reducing reality to empirical observation generating a superficial view of what is real. This fails to explore underlying structures or contextual influences (Danermark et al 2019). It has an epistemology which uses elements from both

social constructivism and realism. That is, it concerns itself with the amalgamation of actual events and the perception of these events experienced by significant groups and individuals (Edwards et al 2014). It supports the existence of contextual complexity; this leads to the epistemological approach of understanding these complex phenomena and the processes which generate them (Raynard 2014). Bhaskar (2013) stating that CR enables the identification of contextually contingent, explanatory mechanisms at multiple levels This meta theory recognises the psychosocial, socio economic and socio-cultural elements. It considers tangible events observed but analyses the participants experience and explores hidden meaning and subtexts (Bhaskar 2013).

The means of identifying the interaction between the levels of reality, as described above is the identification of generative mechanisms. These explain the contexts and events which activate the social structures which are experienced by participants. CR provides a meta-theory for framework for framing the interplay between structures and actors over time (Friedrickson and Kringelum (2021). Critical realist research is concerned with identifying generative mechanisms (Blom and Moren 2011). These are phenomenon consisting of causal powers, structures and interactions. They explain how these factors interact to cause the observable events and experiences. Generative mechanisms are an interplay between human intentions externalised by social interaction and contextual conditions within social structures (Danermark et al 2019). These are both real and tangible yet often hard to capture as they may be beyond what is observed and experienced. Social phenomenon consists of several layers of reality and causality can exist beyond what is observed. Bhaskar's theory of Critical Realism has been developed and applied to the field of social science research (Danermark et al 2019). Events in the social world are due to causal mechanisms

which include social groups, institutions, and multiple layers of psychological, social and political and economic influences (Houston 2023).

4.3.4: Critical Realism and Methodology:

This approach involves data analysis which entails an inclusive approach, multi-level description, coexisting entities, and multiple causation. Edwards et al (2014) say this approach also uses extensive methods to study social phenomenon and the contexts in which these mechanisms operate. Qualitative methods such as semi-structured interviews, are used to gain rich explanations of existing mechanisms (Bhaskar 1998). The examination of patterns over time and asking "what if" to identify hidden causal mechanisms (Dickenson 2006).

These explanations may be limited to the context in which they are studied. It may be possible to generalise these findings if the researcher can make the contextual complexities explicit and justify their generalisation (Raynard 2014). These can give rise to theoretical generalisations rather than information about populations. The findings of this thesis relate specifically to community mental health nurses but could possibly be applicable to many health care and other public service settings.

There are key aspects of critical realism research design and methodology, which are relevant here. It places the subjective experience of the research participants in a wider context. In this thesis, the language and the perceptions of the participants may show agreement. This may indicate tangible evidence of the effects of the organisational priorities and wider social structures. This is useful for this thesis, as it is concerned with real, tangible political and social changes and how these are interpreted and shaped by individual clinicians and professional groups.

Howell (2013) states that this involves the researcher examining how the participants are both affected and influenced by social and organisational change, whilst simultaneously affecting how these are implemented. The author started by undertaking a policy analysis (discussed in section 4.4 and presented in chapter six). This helped the author to identify the political ideology inherent in mental health policy throughout the thirty-year process of marketisation. This is used in an inductive way to identify the ideology which may drive the generative mechanisms, examining how policy priorities drive organisational change. The author obtained information about Trust operational policies to illustrate how the policy directives are enacted as organisational structures.

Data collection in this thesis involved semi structured interviews. These were used to obtain the experience and perception of CMHNs. Non-participant observations to find evidence of interactions and structures in the analysis of generative mechanisms (see 4.7.1 and 4.7.2.)

The subsequent analysis involved an intensive scrutiny of how generative mechanisms are known and understood. This uses CR principles of abduction and retroduction (discussed in the data analysis section). Howell (2013) describes utilising an iterative and interactive dialogue about past experiences in relation to present perspectives and future possibilities. A reflexive approach involves developing an awareness of ideological, social and political factors (Howell 2013). It may also be influenced by my socio-historical location. The author's political views regarding austerity and outcome measures may affect their interpretation of the data. This will be discussed in the section on validity, reliability, and reflexivity. Danermark et al (2019) state that it is important to link ontology to

method as the method alone does not justify the conclusions without making the ontological basis clear.

Political ideology which drives policy has an impact on organisational culture (Spenkuch et al 2023). This has an objective existence but may be hard to observe (Houston 2023). Therefore, analysis relies on theoretical hypothesis and examining tangible policy statements (Danermark et al 2019). The themes, identified in the policy analysis, chapter five, were used because they were identified in the policy analysis as being driven by ideology and having a direct impact on participants' experience. These are: managing workload, the role of CMHN and service user self-management. They represent three important factors which influence the empirical experience of the participants, namely the way in which the workload is prioritised, the development of the role of CMHN and the role of the service user.

Table 3: Ontology, concepts and method

Strata of reality	Concepts in this thesis	Methods.
Real: existing social structures which enable or constrain individual actions within that social group or setting. Social structures such as policies and procedures may be intangible, in that they are not physical. However, they exist and exert a powerful influence over social groups.	Political and socioeconomic ideology. Balancing affordability, demand, and quality care	Analysis of National policy: three themes Managing workload Role of CMHN Service user self-management
Actual: where individuals perform (or not) actions which may lead to outcomes. The social structure may govern individual and group perceptions and decisions. However, groups and individuals also have agency. That is, they can make choices and interact in ways which may reproduce the system directive, or they may challenge and modify them	Choices, modified structures at Trust and team level, such as communications with purchasers, operational policies, team structures and interactions/dynamics, boundary management. CMHN self-concept and sense of autonomy and how they choose to interact within a team	Thick description: organisational approach to operationalising national directives (structures) Non-participant observations of team meetings (choice and interaction)
Empirical: is concerned with the experience of individuals, that is their perception of the events enacted in the real domain.	CMHN experience and perceptions of what influences clinical decision making.	Semi-structured interviews

4.4: Policy analysis: Summary of papers considered

A policy analysis was undertaken to identify the political priorities leading to social structures at the macro level, with a view to analysing how they are enacted in organisations teams and individual practice. The analysis includes green papers, white papers and legislation. Green papers are consultation documents produced by the government. Their purpose is to allow those inside and outside parliament to provide feedback on proposed changes. White papers are policy documents produced by the Government, they set out proposals for future legislation. They are often published as Command Papers and can include draft versions of the Bill that is being proposed. This provides a basis for further consultation and discussion involving interested and affected groups. It allows changes to be made considering this before being formally presented to Parliament. (www.parliament.uk)

Table 4: Summary of key policies for analysis:

Year	Type of document	Title
1989	White paper	Working for Patients
1989	White paper	Caring for People: Community Care in the Next Decade and Beyond
1990	Legislation	National Health Service and Community Care Act
1991	Legislation	Care Programme Approach
1995	Guidance	Building Bridges
1996	White Paper	NHS Service with Ambition
1997	Legislation	New NHS Modern and Dependable
1998	Green paper	Our Healthier Nation
1998	White Paper	Modernising Mental Health Service
1999	White Paper/Policy Framework	National Service Framework
2000	White Paper/Policy Framework	NHS Plan
2001	Legislation	Health and Social Care Act
2001	White Paper	Shifting the Balance of Power
2007	White Paper	New Ways of working, Creating Capable Teams
2009	Green Paper	New Horizons
2011	White Paper	Equality and Excellence: Liberating the NHS
2011	Policy Framework	No Health without Mental Health
2012	Legislation	Health and Social Care Act
2014	Inquiry	Francis Report
2014	Policy Framework	Closing the Gap (Mental health) supports No Health without Mental Health
2014	Policy Framework	Care Act
2015	Guidance	A Culture of Change in NHS
2017	White Paper	Five Year Forward Plan for Mental Health
2017	Report	Mental Health Workforce Plan
2019	White Paper	NHS Long Term Plan
2019	Report	Interim People Plan
2020	Report	NHS People Plan
2022	Legislation	Health and Care Act
2023	Report	NHS Workforce Plan

4.5: Policy analysis method

The themes which guided the framework for the fieldwork observations were obtained from a policy analysis (see Chapter five). Language is a significant consideration in political and policy analysis (Fairclough 2000). This use of language becomes incorporated into professional terminology. This thesis addressed how the policy relating to finance, quality and efficiency, workforce and service users shape public and professional perspectives. The themes arose from a detailed review of the policy documents within the time frame. This involved extensive reading of numerous documents and extracting data which frequently occurred throughout the documents. (Maguire and Delahunt 2017). They reflect recurring issues throughout the documents reviewed and were coded using thematic analysis. Initial codes were ascribed to the most prevalent themes. The key issues which reflected the effects on the mental health workforce were the focus. The themes of restructuring, general management, funding, decentralisation and targets were combined to form one theme. The initial analysis was lengthy. This was subsequently summarised using historical data as a brief, historical background to the current policy and included quotes largely from contemporary policy. This process of thematic analysis is a useful staring point to determine the issues within policy which guide social practice (Herzog et al in Van der Bulck et al 2019). This is a useful method of analysing policy through identifying and analysing prevalent pattern of meaning (Van der Bulck et al 2019).

4.6: Sampling/selection and recruitment.

In order to answer the research questions, a representative sample needs to be drawn from population under investigation. (Taherdoost 2016). The population is CMHNs working within teams who work with working age adults. The teams

identified for the study were decided upon between the Trust Research and Development link and the researcher. Two NHS mental health Trusts were used (this is discussed in chapter six). Within each Trust a CMHT was identified for inclusion in the study by senior personnel identified by the Research and Development Departments. The strategy used here is convenience sampling which involves participants in an existing group to volunteer to take part in the study (Liamputtong 2010). The sample of participants were drawn from the two Community Mental Health teams chosen for the study. Community Mental Health Nurses within those services were invited to take part in the semi structured interviews. This involved active recruitment by the author and a willingness to take part on the part of the participants. Convenience sampling is criticised for being based on self-selection and therefore not representative of the population (Andrade 2021). However, as this study provides an in-depth description of the setting and is intended to represent experiences within a specific context, this was an appropriate approach to use.

The original plan was to have a sample size of 10 staff from each Trust, so 20 participants altogether. However, recruitment was challenging due to the workload of the CMHNs and the turnover, many staff were leaving, and the period of data collection was post COVID. The data obtained from the interviews was very detailed and so in consultation with the PhD supervisors it was agreed that had six participants from Trust A and five participants from Trust B, provided sufficient data.

Recruitment is a dynamic, interpersonal process involving motivating and engaging potential participants, to facilitate consent and involvement (Patel et al 2003). Teams first identified in October 2019 by Research and Development

contacts in each Trust. Initial meetings with the service managers and the author. The team in Trust A were not responsive to e mails so the area manager identified an alternative team, who had a supportive nurse manager. A pilot team recording in Trust B, in November was undertaken in 2019 to identify structures and communication patterns and to provide some initial data for the upgrade viva. The author kept in regular contact, hoping to start data collection in early 2020. The author attended team meetings and had regular e mail contact with the designated service manager contacts to obtain information regarding local policy for writing the "thick description." This contact also provided the opportunity to find out how the team were, what issues and pressures they were facing. This prolonged engagement and an understanding of workforce issues is a valuable strategy to establish rapport and trust (Archibald and Munce 2015).

However, COVID restriction meant that the Trust contacts advised not using clinicians' time for research due to prioritising adjustments to clinical work. All mental health Trusts needed to make rapid adjustments to their way of working. This included prioritising clinical workloads and adopting remote and online working practices. (NHS Providers 2020). Remote working presented huge challenges to CMHTs, including difficulties in implementing MDT care plans, increased pressure for back-to-back online meetings, clients not having access to IT (Foye et al 2020). Access was granted again in November 2020. This needed to be via online platforms rather than face to face. This necessitated making the necessary ethical and documentary adjustments. (HRA website 2021).

The author contacted service managers to ask them to identify potential participants, who were then contacted by e mail. (Bruneau et al 2020). The managers were helpful and providing contact details for CMHNs and identified

those they believed would be willing to take part. However, this form of managerial gatekeeping can be a limitation. Managers may choose those who are most likely to have an interest in research. These participants may be well versed, motivated, and articulate, but their contribution is not necessarily the most valuable (Archibald and Munce 2015).

It was several weeks before there were any responses from participants. From the conversations with managers, the author understood that the CMHNs were experiencing overwork and poor morale (Foye et al 2020). Recruiting participants was more challenging and time-consuming than anticipated. Clinicians' time is valuable, and researchers often underestimate and do not write about the strategies used to recruit participants (Hysong et al 2013). The author considered whether the participants viewed research as an additional burden and did not see any relevance to their working lives. Traditionally nursing does not have a strong research culture and nurses are not used to being asked for their opinions, or not see it as relevant to their everyday practice (Broyles et al 2011). The organisational environment and political climate can have an impact of nurses' interpretation of the purpose and impact of the research (Luck et al 2017).

When the author spoke to staff individually, they were able to explain that they were interested in the pressures that they are under and what makes their job challenging. When staff in Trust A did express an interest, arrangements were made to speak to them informally and openly acknowledge the challenges they are facing and engage in a supportive dialogue. This provided a more user-friendly approach than the formal research language in the participant information. It is difficult to articulate expectations in a participant letter and find an approach that suits all (Bruneau et al 2020). This was followed up interviews with a thank

you e mail and offer of support, in the hope that participants will encourage their colleagues to take part. This led to a snowball effect, which boosted recruitment (Luck et al 2017). In Trust B it was possible to visit the Team Base and speak to the CMHNs in person.

The pressures facing CMHN are longstanding, such as low pay, increasing workloads and staff turnover (Foye et al 2020). This has been exacerbated by a high demand on their time from increased referral rates post COVID (NHS providers 2020). In addition, many staff had left the CMHTs in both Trusts, citing stress, workload pressures and the lack of a pay rise as reasons. This had exacerbated the pressure on staff who remained, and the author was concerned about making further demands on their time. CMHNs are experiencing similar work stresses as other healthcare professions (Sheridan-Rains et al., 2020). The possible incentives and reciprocal support that could be offered participants was considered. The author spoke to one of the team managers about supporting staff to write for publication. It was acknowledged that this would be perceived as additional and unmanageable work. Common incentive strategies usually include personal contact, minimising respondent burden and sizable incentives (Hysong et al 2013).

4.7: Research methods

The methodological approach calls for stratified explanations of complex, generative mechanisms at multiple levels (Raynard 2014). Events, such as clinical decision making, are observable at an empirical level and are tangible. However, it is difficult to determine clear cut linear causal relationships due to the multi layered, co-existing and overlapping processes involved (Fletcher 2017).

4.7.1: Semi structured interviews

Data collection involved semi structured interviews with individual CMHNs. This was the source of empirical data, that is the experience and perceptions of Community Mental Health Nurses. The interview questions were developed from the research questions and the themes which emerged from examining the historical and contemporary policy documents. Vaara (2010) suggests that the development of professional discourse develops in a socio historical context. These interviews consisted of fixed questions which can be adapted or expanded upon depending on the information given by the participant (Howell 2013). In qualitative research, semi structured interviews allow the participants to discuss complex phenomena in a meaningful context. The reason for choosing semi-structured interviews is to allow flexibility. Due to the complex nature of the subject, it is important to allow the opportunity for a question to be explained or rephrased. This approach also allows for the respondents' voices to be heard and their choice of phrase, language and lived examples provides an invaluable context (Newby 2010). Semi structured interviews are useful within Critical Realism as participants' accounts of their understanding and experience of social practices are a valuable source of data regarding social and political realities (Edwards and Holland 2013)

This approach is attuned to openness, complexity, and experience (Roberts 2014). It may be subject to bias; in that the author may find some answers reflect their own assumptions and beliefs and explore these in more depth than responses they do not agree with. However, being knowledgeable about the issues under investigation and being sensitive and in tune with the respondents is also an advantage when using this approach (Newby 2010). The interview

questions aim to explore the research questions from the perspective of the participants. Supplementary questions were added which ask specifically about the issues arising from the policy analysis and the field work observations. The schedule for the interviews is included as appendix two.

4.7.2: Nonparticipant observation

Informal observations of the team meetings were undertaken as part of the process of relationship building and recruitment with the CMHTs. This enabled the author to view the meeting structure, which is outlined in operational policy. It provided insight into the roles and communication patterns within the team and gave context to my interview questions. The author had originally intended to record and transcribe the team meetings as my first data set. The initial intention was to view decision making in the team context before moving onto individual semi-structured interviews, as the author felt that this would give them insight into the contextual influences on the CMHN role. However, COVID restrictions made obtaining written consent difficult before recording the meetings as it was impossible to obtain written consent beforehand due to remote working. Therefore, it was decided to proceed with the semi-structured interviews with a view to returning to the team meetings at a later stage.

The author subsequently decided to utilise the method of non-participant observation within stage five of the data analysis to analyse the generative mechanisms. CR research often uses interviews to ascertain the interpretations of their informants and other methods to analyse contexts, resources and constraints within which the participants operate (Smith and Elger in Edwards et al 2014). It is important not to take findings at face value, always consider alternative explanations and processes. To achieve this participant accounts,

need to be triangulated with other sources such as observation (Edwards et al 2014). This gives a clear focus to the purpose of NPO in concentrating on evidence of the existence of generative mechanisms, identified within the data obtained from the analysis of the semi-structured interviews. Causal mechanisms are not always clear until some analysis has been undertaken (Edwards et al 2014). The author was concerned that the time between analysing semi structured interviews and undertaking non-participant observations was about 18 months. However, detailed analysis was necessary to work through all the stages of CR. The author considered if this would impact on the link between empirical findings and the contextual factors which caused them as Trust priorities may have changed. However, mechanisms are relatively enduring in respect of the events they cause (Mingers and Standling 2017).

In the role as non-participant observer, the author aimed to maintain a neutral stance and be as unobtrusive as possible. It was made it clear that the author was a Community Mental Health Nurse and therefore understood the clinical language and be bound by professional standards of confidentiality. The author was with the participants in their usual work setting but not be participating in the team discussions (Given 2008). Critical Realist research assumes that complete detachment is impossible. The participants were made aware of the purpose of the observations. The potential influence of the researcher's presence on the team interactions and the effect of the author's professional experience on the data collection will be discussed within the reflexivity section of the findings. A reflexive account highlights the author's history and personal interests and how this may affect their data collection and analysis (Houghton et al 2013). Following the analysis of the semi-structured interviews, the author undertook one non-participant observation in each of the three teams: the psychosis and affective

teams in Trust A and the one large generic team in Trust B. Each meeting lasted between two and three hours. In the team meetings the interactions were observed, which demonstrated hierarchical structures and generative mechanisms identified in stage four of the data analysis (Handley et al 2020). The team meetings represent the organisational structures for prioritising and categorising work. They also capture the social interaction between team members, demonstrating how structures are interpreted, circumvented, and even challenged. The clinical meetings took place as they would normally do and with the author observing. (Howell 2013). This involved using the existing meeting agenda as a template and taking field notes detailing evidence of structures to manage the workload, the role of the CMHN and reference to service user involvement. Non-participant observations provide useful data about the influence on events and interactions, within critical research and are useful in complementing data from other sources such as interviews (Handley et al 2020). The field notes consisted of a mixture of descriptions about interaction, direct quotes, and the author's reflections at the end of the observation (see appendix three). Field notes were used rather than audio recordings as they capture the author's observations of social practice. They are a fundamental resource in understanding patterns of communication, nuances and relationships (Phillipi and Landerdale 2017).

4.8: Data analysis: Reflexive Thematic Analysis within a Critical Realist Framework

This thesis is concerned with the premise that, mental health practice is driven by socio-political ideology and the psychological reactions to this within individuals

and teams. The themes identified within the policy analysis are detailed in chapter five. These reflect the current national priorities for mental healthcare in England and Wales, and their relevance to the role of the CMHN and the CMHTs within which they work. The approach used to analyse the data is a Critical Realist framework combined with Reflexive Thematic Analysis (RTA).

The author had originally considered using Critical Discourse analysis to analyse the data. The reason for this was that it is often used to explain how social change can manifest in the interaction (individual/team and or organisational interaction) around political issues (Mullett 2018). The author thought that this approach fitted the research questions as it could capture the mechanisms which generate implementation of policy within teams, and how this is enacted and shaped by professional groups (Fairclough 2013). In addition, it supports the view that that macro socio-political issues can be examined through micro analysis, that is, the ideological values within the use of words and phrases (Capdevilla and Callaghan 2008). For example, the NHS Long Term Plan (DHSS 2019) states the importance of care closer to home avoiding the need for hospital admissions and "boosting out of hospital care". This has been operationalised by trusts by monitoring admissions and delayed discharges. Therefore, the term "avoid admission" has become commonplace in both mental health policy and practice (Smith 2020). This could explore assumptions and hidden motivation within public service policy, namely making efficiency savings (Mogashoe 2014). The work of Norman Fairclough was of interest as it addresses these issues and provides critical insights into politics (Fairclough 2013). However, Fairclough is primarily concerned with the sociology of linguistics. Using this approach would require micro analysis and knowledge of the nature of language and the patterns of discourse (Braun and Clarke 2013). Moreover, CDA is often used to examine

media texts and political speeches and is difficult to transfer to individual interview data (Lawless and Chen 2019).

The author subsequently decided to use Reflexive Thematic Analysis within the CR framework. This offers theoretical flexibility, which suits the multi strata approach of CR and my eclectic theoretical approach (Terry et al 2017). Critical realist analysis may be based on predetermined assumptions about the social world, but it is a flexible deductive approach. However, a rigid approach to coding should be avoided as it may distort interpretive observations (Fletcher 2017). When considering combining this approach with reflexive thematic analysis, coding reliability and code book approaches: types of thematic analysis identified by Braun and Clarke (2013) were not used. These approaches would potentially limit the depth of engagement and flexibility of my analysis (Braun et al 2018). For example, coding reliability focuses on the degree of agreement between researchers undertaking the coding and the codebook approach utilises predetermined codes and is largely deductive. As this is a PhD study, there is only one researcher and wish to use an inductive approach to ascertain the participant's experiences in the context of the team they work in.

Braun and Clarke (2006) suggest that RTA can be used within any theoretical construct. It can be used within critical research to examine themes related to sociological contexts, ideologies, and power imbalances (Lawless and Chen 2019). This includes the national approach to resourcing mental health services, the demand on these services and the impact this has on the staff working within them. It is a popular method of data analysis in psychology and social sciences. Braun and Clarke (2014) state that RTA is used extensively in research across numerous disciplines including health research concerned with application to

policy and practice. It provides a robust approach which facilitates sophisticated analysis which can be presented in a way that is accessible to practitioners from a non-academic background. The approach to data analysis in this thesis is, therefore, a hybrid of deductive and inductive analysis, which is consistent with a Critical Realist (CR) approach. Fletcher (2017) suggests that few researchers demonstrate how critical realism informs their methodology. The steps of CR data analysis defined by Bygstadt and Munkvold (2011) are summarised in the table below.

Table 5: Combining Critical Realism and Reflexive Thematic Analysis

Critical realism and Reflexive Thematic Analysis	Application to data analysis
1. CR: Description of events: cluster of observations RTA: Familiarity data and identify items of potential interest.	Undertaking the transcription of interviews. Reading and re reading the transcripts to appreciate the context. The narrative is free from reduction and theorising to allow the researcher to appreciate the richness of the narrative.
2. CR: Identification of key components, identify demi regularities, that is semi predictable patterns related to realist assumptions. RTA: domain summaries	Examine the data for evidence of answers to the research questions and demi-regularities: examples of data which relate to the themes in the policy analysis. Develop codes: grouped for similarities and developed into themes. In NVIVO.
3. CR: Theoretical redescription: abduction RTA: Construct prototype themes	Moved themes form NVIVO into word document and annotated and analysed in relation to local and national policy and mid-range theories.
4. CR: Retroduction: identifying the interplay between objects and the micro and macro interaction RTA: Review potential themes.	Arrange themes hierarchically. Micro: CMHN Meso: Team Macro: Trust and policy
5. CR: Analysis of generative mechanisms RTA: Define and name themes.	Examine and explain, the relationship between the layers of the hierarchy Use Blom and Moren model. NPO: using templates developed from team meeting structures: observe interactions relating to decision making.
6. CR: Validation of explanatory power: identify key mechanisms, that is, those with the strongest explanatory power and the strongest evidence. RTA: Producing the report.	Analyse evidence from the NPOs and incorporate them into the Blom and Moren structure. Comment on the interrelationship between the GMs

Step one involved describing events and clustering the observations (Bygstadt and Munkvold 2011.) The author transcribed the semi-structured interviews themself as they saw this as a valuable approach to becoming familiar with the data and monitoring and adapting my interview style. They then read and reread the transcripts, shared these with the supervisors and we discussed the commonly occurring themes. Bygstadt and Munkvold (2011) suggest that the first stage of data analysis is a description of events. Braun and Clarke (2006) suggest that data analysis starts with, taking time to familiarise yourself with potential themes and items of interest.

Step two involves the initial identification of key components and involved a deductive approach, utilising the themes from the policy analysis. These are the use of outcomes and targets, the mental health workforce and the role of the mental health service user. These policy themes have been used to create the semi-structured interview questions. This process is described by Fletcher (2017) as identifying demi-regularities, based on pre-determined critical assumptions. Demi-regularities are defined as semi-predictable responses and patterns (Pinkerton 2002). The author's assumptions as the researcher regarding the impact of efficiency targets on the role of the CMHN, guided the search for demi-regularities. Large sections of text from the transcribed interviews were identified as relating to the broad categories identified in the policy analysis. These large areas of text capture everything that the participants said in response to a question based on a theme. In RTA these are called domain summaries (Braun and Clarke 2006).

Step three of the analysis involves an inductive approach, in exploring the teams' and participants' personal experience of their reactions to and interpretation of

policy directives. The demi-regularities were subdivided into codes which were participant statements about their experiences (Braun and Clarke 2006). NVIVO was used as a repository at this stage (see appendix four). The areas of text which illustrated commonalities were organised under specific codes. Some codes had large amounts of data and so became themes (for example “workload”). Other codes were smaller and combined to form themes (for example the codes: resources, functions of other services and reluctance to discharge were combined to form the themes managing service boundaries.) Critical realist data analysis involves a process of *abduction.* This involved examining and redescribing the data utilising theoretical concepts (Fletcher 2017). NVIVO was too reductionist and compartmentalised for this process. Therefore, the detailed data was then exported to a word document where review annotations were used to apply the theories highlighted in Chapter three. For example, if the participant was describing a process of being guided by diagnosis, then this could be attributed to the process of “labelling.” (Goffman 1961). The CMHN may experience having to incorporate an organisational culture which is at odds with their internalised values and the impact this has on their relationship with their manager. This could be redescribed as the psychodynamic processes of projection and splitting (Czander 1993). Excerpts from National and local policy were inserted using different coloured typeface, alongside participants’ quotes. This enabled direct comparison between empirical data and the real objects and structures which create them (See appendix five: excerpt from stage three data analysis).

Step four involves the identification of contexts and mechanisms which exist to create and maintain the shared participant experiences. This process is known in CR as retroduction (Fletcher 2017). The data themes identified in stage three, were mapped in a hierarchical structure. This included the policy and theoretical

concepts applied in stage two. In this process some themes were combined: such as productivity and objectifying language. Other themes were expanded as they had a micro and meso application, for example “morale”. Operation policy excerpts were in the meso level and National policy at the macro level. This clearly conceptualised the structures which impact on the experience of the participants and helped to identify mechanisms and structures, in matching the experiences of the participants to the team meeting structures operational policy, organisational targets and national policy. This was a lengthy and recursive process, involving extensive redescription and recontextualization of the data, moving between data, theory and policy to refine relationships and identify mechanisms (Emmel et al 2018).

Step five involved an analysis of mechanisms and outcomes (Bygstadt and Munkvold 2011). This is concerned with testing the relative explanatory power of these mechanisms (Raduescu and Vessey 2008). Generative mechanisms are structural factors and contextual conditions that produce the events observed in the empirical data (Saxena 2019). After undertaking steps one to four, the author undertook non-participant observations in the CMHTs in the identified sites. This is discussed in section 4.7.2. In reviewing the field notes, reference to structures and interactions which demonstrated evidence of managing workload, the role of the CMHN and service user self-management, were identified. These are the significant priorities identified in the policy analysis in chapter five. This employed deductive approach as it was identifying evidence of the themes previously identified in the policy analysis. However, there was an inductive element as the researcher was receptive to interactions and choices which shaped and challenged these policy-driven social practices.

There may be elements of the Generative Mechanisms which are clearly observable. For example, clear reference to care pathways and waiting times. However, other contextual factors may be harder to observe. For example: Trust communications about changing priorities updates via meetings and e mails, decisions that are made outside of meetings informally or in other forums and interface and communication with other services. It is not always possible to experience more than a subset of tendencies generated by the complex interplay of causative factors (Bhaskar 2020).

The political ideology of neoliberalism is discussed in chapter three. The purpose of political ideology can be to shape social practice, provide coherence and embed values into everyday life (Van Dijk 2006). Social practices inherent in health and social care are not value neutral as public policy is developed in a social, political and economic climate (Browne 2001). The actual domain is a subset of the real and includes events that occur due to the enactment of causal powers, structures and entities. These may or may not be observable. In this thesis, the operationalised delivery of national policy edicts and how these are patterned in organisations, constitute the actual domain. The empirical domain is a subset of the actual and consists of the human experiences of these events, this is concerned with the perceptions and lived experiences of the CMHNs interviewed. The macro level considers national political and social practice and how these impact at regional and Trust level. The meso level will consider how the Trusts operationalise these national recommendations and the impact this has on the team. The micro level considers how the operationalised structures and team level communication impacts the individual CMHN.

Stage six determined which causal mechanisms have the strongest explanatory power by reviewing the strength of the evidence which supports this (Fletcher 2017). The model for analysing generative mechanisms used by Blom and Moren (2011) was used to match the policy priorities to the data from the semi-structured interviews, non-participant observations and Trust operational policies. Policies are developed by central government and disseminated nationally. Policy implementation is complex and involves some central control and a series of national, regional, organisational and professional negotiations (Hudson et al 2018). In complex organisational systems, there can be numerous mechanisms. It may not be possible to capture them all. What is important in critical realist research is to identify those which have the most obvious and consistent influence over the phenomenon observed (Bygstad and Munkvold 2011). Generative mechanisms present the relationship between social structures and human interaction, and theorists have a variety of models to represent this (Danermark et al 2019). Bhaskar (1993) developed the transformational model showing the connection between social structures and human agency. Archer (1995) developed a model consisting of structure, interaction and structural elaboration.

The third dimension of Archer's model explains how structures impact choice and how agency shapes structure (Danermark et al 2019). Critical realist research is often concerned with complex hierarchical systems, defined by Bhaskar, as "laminated" systems (Mingers and Standing 2017). These are usually conceptualised by the researcher for a specific situation and involved the development of levels or "laminations" which capture specific concepts from the individual to the socio-cultural (Mingers and Standling 2017). The author decided to use a stratified approach utilising the micro, meso and macro layers which aligns with the presentation of the empirical data in this thesis. Blom and Moren

(2011) model was adapted as this has been utilised to address generative mechanisms in social work. The division of mechanisms into identification of power, interaction and structure demonstrate a reciprocal relationship between concepts at all layers of the strata.

Validation of these methods requires additional methods beyond the original analysis of empirical data. Validation methods can strengthen the knowledge within a context and enable analysis of how generalisable this might be (Modell 2009). Therefore, the author returned to the CMHTs in the study to undertake non-participant observations of the team meetings (see field notes appendix six). The following structure will be used to hypothesis the generative mechanisms. The evidence of explanatory power from the non-participant observations will be included to comment on the strength of the generative mechanisms. However, the operational structures and communication about decision making will be evident. The analysis of the Generative Mechanisms is presented in Chapter ten.

Table 6: Structure for generative mechanisms.

Mechanism= Powers+ Macro social interaction and structure Powers: causes, motives, considerations and choices and a collective/societal level. Interaction: at societal level between departments, organisations. Structures: National policy, monitoring
Mechanism= Powers+ Meso social interaction and structure Powers: causes, motives, considerations, and choices at a collective organisational/team level. Interaction: within the team, between the team and other services, between the team and the Trust Structures: routines, operationalised structures, accepted practice, team identity and perception of professional roles and the functions of other parts of the service.
Mechanism= Powers +Micro social interaction and structure Powers: causes, motives, considerations and choices at individual level. Interaction: oral, written Structures: role, position, and self-concept

4.9: Reliability, validity and generalisability.

Qualitative research is frequently criticised for its lack of justification of methods, its lack of transparency in data analysis and its potential for researcher bias (Noble and Smith 2015). Reliability in qualitative research refers to the consistent use of techniques to record and interpret the data (Newman 2011). This is challenging in this type of research as the processes involved in the subjective experience of participants in a dynamic social context, change and develop over time (Olmos-Vega et al 2023). In addition, the process of data collection is embedded withing the interaction and relationship between the researcher and participant. This also involves relationship building within the setting. The data this produces, are complex and contextual (Neuman 2011).

Validity refers to the extent to which the data collection and analysis measure what they are intended to measure (Leung 2015). In qualitative research, used in this thesis, it is important to demonstrate that the process has integrity (Howell 2013). This thesis uses data collection methods of semi-structured interviews and

non-participant observation. These methods are commonly used in qualitative research (Roberts 2014). These are discussed in detail in sections 4.7.1 and 4.7.2 respectively. A pilot interview was undertaken before data collection commenced. This enabled me to test the research questions and review the author's interview style and structure (Aung et al 2021). This was discussed and reviewed with the supervisors. The author also attended a few team meetings to familiarise themselves with structures and interaction, before undertaking the non-participant observations.

The structured process of data analysis is discussed in section 4.8. This presents a clear, stages process which employs abduction (theoretical redescription) and retroduction (hierarchical mapping) (Danermark et al 2019). The analytical application of policy and theory is, clearly discussed in chapters seven, eight and nine. The hierarchical mapping of themes and interrelationships between the strata is transparent (see methods diagrammes and narrative in section 4.8). The staged process for identifying the generative mechanisms is presented in chapter ten. This makes the stages of the rigorous data analysis explicit.

Critical researchers reject a neutral and objective stance, believing that this gives the researcher a detached and superior stance and fails to acknowledge the socially constructed and values-based factors involved (Mullett 2018). Therefore, transparent articulation of the researcher's standpoint and reflexivity is necessary (this will be discussed further in section 4.10 on positionality).

Generalisability refers to the extent that findings can be applied to other settings or populations (Creswell 2009). As qualitative research has contextualised constructs of reality the term transferability is often used instead (Lub 2015). This thesis will employ a "thick" description of the two sites, the nature and composition

of the team and the operationalisation of national policy at organisational level. A “thick description” is a detailed account of the research setting and context to facilitate transferability judgement, enabling the external reader to decide if it relates to other settings (Korstjens and Moser 2018). Thick descriptions give qualitative data a context rooted in structures, culture and social practice, that may otherwise be unobservable (Kostova 2017). It is most often associated with ethnography, making explicit complex cultural factors which may otherwise be hard to quantify (Freeman 2014). Thick descriptions can give context to organisational structures and how these are shaped by societal and political changes. Therefore, can be valuable in analysing the impact of social structures in critical research. It facilitates the examination of variable factors across different locations (Rankin 2011). The comparison over two sites may also support transferability (Vaseleious et al 2018). This is presented in Chapter five.

4.10: Positionality, the insider/outsider role and reflexivity.

Positionality is a key issue in nursing are often conducting studies within the field of nursing where they also practice (Borbasi et al 2005). This is common in qualitative research where the researchers are part of the social group they wish to study (Bonner and Tolhurst 2002). The researcher is required to identify themselves as an insider (those who can identify as part of the group under study) and outsiders (those who do not have identity with the group) (Flores 2018). The researcher’s insider status may form the basis for the research of informed their choice of study and involvement (Finefter-Rosenbluh 2017). This has advantages, which include gaining access, having credibility, and gaining rapport with the subjects and dealing with sensitive ethical issues (Bonner and Tolhurst 2002). If

the researcher has the same professional background as the subjects this could promote a level of trust and engagement (Dwyer and Buckle 2009). However, there are pitfalls such as overfamiliarity and the tendency to overlook routine behaviours and commonly used terms, due to making assumptions about their significance (Allen 2004).

The researcher may not be sufficiently objective and empathise with the professional perspective and lose focus of the research (Dwyer and Buckle 2009). The author is a mental health nurse and has previously worked as a CMHN for many years in a variety of settings. This enabled them to demonstrate a degree of empathy and shared understanding with the participants (Newby 2010). The author was cognisant of the difficulties facing the current workforce although they have not practiced in the field for several years, they maintain working relationships with these services. The author was therefore an insider in relation to my profession and experience but also an outsider as they have no working experience of the current policy frameworks. It is possible to occupy both positions and these can be complex, dynamic, and unpredictable (Weneger 2014). This can be influenced by the numerous and fluid identities of the researcher, the participants, and their relationship, which can include political affiliation (Flores 2018). The author's professional experience and views on policy were intertwined with the research process and aid the analysis (Olmos-Vega et al 2023). The acknowledgement of experience assumptions and views of the researcher is a concept known as reflexivity.

The author's positionality includes a critical stance against the current political ideology, which influenced my decision to undertake this research. This could have been a potential source of bias in the data collection and analysis. This was

addressed by keeping a detailed reflexive, in which they recorded their thoughts and reflections and comments on the process of data collection and analysis (Crossman 2021). This was presented to and discussed with the supervisors alongside transcripts and chapters on data analysis. This facilitated objective identification of any assumptions and areas of bias. Reflexivity is a valuable strategy for improving qualitative research (Davawsheh 2014).

4.11: Ethical approval.

The author applied for ethical approval through the NHS HRA system: Integrated Research Application System. This process of procedural ethics ensures that the study adheres to codes of formal ethical practice (Reid et al 2018). IRAS is a single online system to apply for ethical approval for all Health and Social Care research in the UK. The HRA are an arm's length body of the Department of Health. Their UK Policy Framework (NHS HRA 2018) states that they wish to support research in health and social care and make the process of applying for ethical approval straightforward. It also sets out clear principles for protecting patients, service users, staff, and the public, from harm. This includes breaches of confidentiality. It includes filters to ensure that only the information relevant to the study is gathered. It ensures that the regulatory and governance requirements are met. I then gained permission from the Research and Development leads for the two Trusts utilised in this study. Approval was granted in March 2017. As the research did not involve having contact with patients and service users, the author did not need to attend a Research Ethics Committee. Documentation regarding approval, participant information and consent are included as appendices seven, eight, nine and ten.

Research ethics endorse guidelines regarding participant confidentiality. Anonymity and confidentiality will be maintained, by coding data, so as not to store narratives with information which could identify the participant. All data was stored on a password protected laptop within password protected documents. (Haig et al 2004). ~~My~~ The author's attendance at clinical team meetings for the non-participant observations, where confidential client information will be discussed. Therefore, no information relating to the client's identity will be divulged. As a registered nurse the author's needs to respect the service users' right to confidentiality (NMC 2018)

The process of data collection involved questioning participants about their awareness of socio-political factors impacting on their work. This may have a positive and emancipatory outcome for the participants (Aluwihare-Samaranayake 2012). In understanding the impact of political factors, participants may feel empowered to challenge barriers to their work or act with greater conscious awareness by utilising the processes available to them to greater effect for the client group. Alternatively, the outcome may be to change opinion without the agency to change circumstances (Punch 1994). The author was concerned that this may have the potential to generate or increase feelings of frustration and disillusionment within the participants. This has the potential to increase any conflict between practitioners and their managers and/or their organisation. The author has a pre-existing relationship with the teams and organisations and some of the participants and they are aware that the author has been a CMHN. This means the author was comfortable in the CMHT setting and made their understanding of the work explicit to develop a trusting relationship with the participants (Borbasi et al 2005). This was an advantage in gaining access and collecting data. A potential ethical dilemma can arise in relation to what the

participants expect the author to do with the information they disclose. The participants could have expected the author to utilise this knowledge to address some of the difficulties that they may be experiencing in the workplace. However, this was not raised by the participants. Tinsdale (2008) suggests that participants involved in critical research have the right to share in the social power represented by the study. The author had to make the limitations of their influence explicit to the participants.

Prior to collecting any data, the author contacted the teams to facilitate relationship building. The author already had an established working relationship with both organisations. They have previously worked for them and visit students there in placement. They met with senior staff to discuss ways in which they could reciprocate by offering staff support with writing for publication and providing workshops. The author was aware that they were taking up staff time within their busy work schedule. They made the staff aware that they had a clinical background in community mental health work but had not practiced for 16 years and was keen to gain a contemporary perspective based on the information obtained. The advantage in having practitioner researcher duality is that the author could gauge the sensitivity of subjects and situations. The disadvantage is the potential to make assumptions of have bias (Reid et al 2018). As a registered nurse, the author would be obliged to report any issues of poor practice or any information which would compromise client or practitioner safety observing the ethical principle of non-maleficence (Reid et al 2018). If participants had used the interview to be critical of the manager or organisation or otherwise air their own grievances, then the researcher would direct them back to the interview schedule and so protect the integrity of the research.

The author was aware of my potential bias as this could affect their interpretation of the data. However, their awareness of the political agenda helped them identify the nuances of political influence at micro level clinical practice. Aluwihare-Samaranayake (2012) suggests that the critical researcher is required to take a position, plus use both an objective and subjective lens to enable exploration of individual, institutional, and cultural structural context. In this thesis the objective evidence comes from tangible policy edicts and how the organisation operationalises them. The subjective, from the lived experience of the practitioners and the observable discourse between them. As a mental health nurse, the author has developed skills of self-awareness and engaging in reflective practice.

4.12: Summary.

This chapter has presented the conceptual framework of Critical Realism and discussed its relevance to this thesis. The method of Reflexive Thematic Analysis is outlined and its use within CR is discussed and applied to this thesis. The selection and analysis of policies was considered and the emergent themes from this are linked to the use of identifying policy language within the analysis of the other data sets. The research setting and sampling is also discussed. The research methods of non-participant observation and semi-structured interviews are considered. The importance of validity, reliability and reflexivity were discussed. Finally, an account of the process of gaining NHS ethical approval and the potential risks and benefits were considered.

Chapter Five: Introduction to Findings.

5.1: Introduction.

This chapter presents an introductory context to the data presented in chapters seven, eight, nine and ten. A detailed “thick description will be provided of Trust A and B, which were used as research sites. This will include a comparison of the following: geography, demography, and purchaser arrangements, organisational level monitoring, and reporting, locality and team structures, workforce developments and service user involvement. This will be followed by an overview of the participants’ characteristics.

5.2: Setting: thick description.

To ensure validity and generalisability the contextual variables for each organisation need to be made explicit. Therefore, the two Trusts being used as research sites need to be subject to a “thick description”. This is discussed in section (4.9). The regional and organisational structures detailed in the following accounts of the two Trusts give context to the empirical data detailed in chapters seven, eight and nine. They inform the local and regional choices illustrated by the analysis of the generative mechanisms discussed in chapter ten.

Tangible political directives are examined in the context of localised organisational interpretation. As the political narrative is concerned with meeting local population needs and ensure organisational accountability, then there is scope for variation in how central directives are interpreted and operationalised. The national structure for commissioning and monitoring NHS mental health services will be outlined in chapter five. This section will present a comparison of the localised arrangements for the two NHS mental health trusts within this research. The

information was obtained by meeting with a senior representative from each trust and from copies of the relevant local policies.

Two NHS Trusts are used to compare the implementation of national policy directives and account for the generative mechanisms which pattern local variations. Two Trusts were conveniently selected due to their proximity, to the University where the author was based, accessibility, and the author's existing working relationships with them. The author was aware that many staff at all levels, including senior management, have moved between the two Trusts. The author envisaged that this could result in shared ideas and similar developments, perhaps more so than if the author had studied two Trusts which are geographically further apart. The care pathways and specialist services within both Trusts resulted in team reorganisations to meet the requirements to meet financial, service and quality outcomes. The following comparison will consider the similarities and differences between the two Trusts. It will compare the geographical and regional bodies, structural variation, and service organisation at Trust level, monitoring of productivity, efficiency and quality at team level and the workforce and service user provision.

5.2.1: Geography, demography, and purchaser arrangements.

This thick description will start with a consideration of the geography and demographics for each Trust. The policy narrative suggests that local organisations develop their services and structures to match local need, therefore allowing flexibility in service organisation and design (NHS 2015, NHS 2019). However, all Trusts are required to provide a range of data to demonstrate their compliance with a range of national standards (NHS 2019).

Table 7: Research sites: geography and demography

	Trust A	Trust B
Geography	Three London Boroughs: one inner and two outer London	County is in Southeast: urban and rural areas and seaside towns. Larger geographical area than Trust A.
Population	862,036	1.7 million
Deprivation	Inner London Borough high levels of social deprivation, inequalities, and unemployment.	The areas of highest social deprivation are parts of one of the urban areas and the seaside towns.
Morbidity	Inner London borough: mental health, outer broughs obesity and cancer.	Urban areas: mental health Rural areas: dementia
Diversity and mobility	They are the least diverse of all the London Boroughs, have an older and more static population than the inner London Borough (CCG website).	The areas of highest diversity and mobility are nearer London and the lowest are the seaside towns.

The variations within the geographical locations have implications for the work of CMHTs, in relation to their relative morbidity and associated social problems. Cities, such as London are said to have higher incidence of mental health problems (Moustaid et al 2020). This can be attributed to factors such as overcrowding, cost of living, and fragmentation of community living (Gruebner et al 2017). The seaside towns have high levels of social deprivation including rough sleeping and high mental health morbidity (HoL 2019). Rural and coastal areas present the risk of social isolation and difficulty in accessing services (Gruebner et al 2017). Trust A covers three London boroughs, two outer and one inner. The CMHTs studied are in one of the outer London Boroughs. Trust B covers a variety

of urban, rural and seaside towns. The CMHT studied is in a large town. Therefore, the population and morbidity for each team were similar.

5.2.2: Organisational level monitoring, and reporting

This section will offer a comparison between the two Trusts in relation to their commissioning structures and productivity monitoring. Consideration will also be given to their quality forums and external quality monitoring. The role of Clinical Commissioning Groups (CCGs) and the Care Quality Commission is discussed in Chapter six. These were replaced by Integrated Care Boards in 2022. This is discussed in chapter six and chapter eleven.

Table 8 Research sites organisational monitoring and reporting.

	Trust A	**Trust B**
Clinical Commissioning Group Structure	CCGs for the whole region of the city, 6 boroughs merged to form one. In 2022 Integrated Care Board: whole of the geographical part of London.	CCGs reduced from eight to 3 and now to one in 2020. In 2022: Integrated Care Board for the whole county.
Key performance indicators for CMHT productivity	2022: Referral to treatment 4 weeks 95% Risk assessment 80% Crisis plan 80% Copy of care plan 80%	4 weeks wait for assessment, the 18 week wait for treatment (both 95%), Crisis plan (95%), Risk assessment (95%), Client to have a copy of the care plan (75%).
Quality forums	Quality Assurance Committee: KPIs and CQC are discussed.	Quality Performance Review: executive and clinical leads from all care groups monitor

	Patient safety group which reports annually to the National Patient Safety group	quality measures and KPIs.
Care Quality Commission Feedback	2022: CMHTs working age adults: overall requires improvement. Good areas: staff support and leadership. Areas for improvement: recruitment problems, high workload, high levels of sickness, large caseloads, documentation of risk, improve waiting times.	2022: Overall requires improvement, Good practice: support from immediate manager and team. areas for improvement: long waiting times, recruitment difficulties, workload pressures, staff felt unsupported by senior management

Both Trusts monitor performance for their CMHTs using specific targets**.** These are based on national guidelines within the five years forward view for mental health (DHSS 2015) and the NHS Long term plan (2019). These are very similar for each Trust with a narrow margin of difference for percentage of compliance. They monitor waiting times from referral to assessment and treatment, contact and whether there is documentary evidence of the required care plans. NHS England (2019) state that these are aimed at tackling inequality by ensuring that people with SMI are accessing services and receiving support in a timely manner. The policy narrative of the past five years emphasises the importance of quality mental health services (DNSS 2017). KPIs are linked in policy to performance and productivity (NHS Improvement 2018).

In both Trusts under consideration, there are structures and forums for considering performance and quality (as there are in all NHS Trusts). This reflects a national move away from pure productivity of early marketisation of the NHS where Trusts were rewarded for cutting costs (Appleby et al 2010). Quality patient

outcomes are incorporated in organisational monitoring in developing ways of utilising resources more efficiently through staff engagement and innovation (Appleby et al 2010). When services fail to meet targets, this is not always due to their inefficiency. It can for example be due to excessive demand on that service or failure in the mechanisms of referral or coordination with other services (Moore 2018). Both Trusts are subject to regular review by the CQC. The reports available at the time of data collection were similar. Both Trusts required overall improvement for their CMHTs for working age adults. Both were found to have good staff support at team level. The areas for improvement in both Trusts were retention and recruitment problems, high workload and long waiting times for assessment and treatment. This thesis examines CMHNs perceptions of how key performance indicators (KPIs) and care pathways are incorporated within clinical decision making. It also considers how CMHNs view their organisations priorities.

5.2.3: Locality and Team structures:

The Five Year Forward View (NHS 2015) and the NHS Long Term Plan (2019) provided detailed implementation plans to guide the structure and function of secondary mental health services. The NHS Implementation Plan (NHS 2019) outlines the need for models of integrated care for people with serious mental illness. This is supported by evidence-based care pathways, developed by the National Institute for Clinical Excellence (NICE). The Community Mental Health Framework for adults and older adults (NHSE 2019) states that the function of CMHTs has its origins in the National Service Framework, and that the creation of specialist teams has led to fragmentation. The CMH Framework (NHS 2019) suggests the need for standardised frameworks which provide clear guidance and

consistency of delivery nationally. The National Collaborating Centre for Mental Health (2019) suggests that Trusts and commissioning bodies have the flexibility to develop service structures to incorporate National guidelines whist meeting the needs of their local population.

Table 9 Locality and team structures.

	Trust A	**Trust B**
Operational management	Care forums for three separate Boroughs: CHMT care forum, clinical leaders develop delivery of national standards. Performance and Quality Review Committee: report on key areas: performance indicators, quality objectives, risks and workforce developments. This was re- configured in 2021. There is one director and three associate directors. For each Borough there is one service manager. Each borough consists of two CMHTs and each has a service manager, within each CMHT, there are sub-teams: psychosis and affective and each team has a team leader.	Adult CMHT care group with one management team. weekly care group meetings between managers and senior clinicians to address performance, quality, patient safety, and serious incident management. Data is considered at the Trust contracts meeting. Directorate has a service director and deputy service director and four professional leads including a head of nursing. At team level, there is an overall service manager and team leaders for each mental CMHT.
Trust Governance structures	Executive and non-executive boards oversee committees. These include people committee (recruitment and retention), audit and risk assurance (monitors financial and corporate structures, and risk management.), quality (monitors patient safety	Executive and non-executive boards oversee committees. These include Integrated audit and risk (oversees all audits), quality (monitors quality systems), finance and performance (monitors and assures financing and resourcing, ensuring

	and experience and clinical effectiveness), business and infrastructure (financial management, IT estates and sustainability), partnerships (support the development of local partnership arrangements).	efficiency and value for money), workforce and organisational development (retention, recruitment and skill mix), mental health act (ensure compliance with the MHA),
Team structure	Primary Care Team (PCT) provide telephone and face to face assessments and short-term interventions. Psychosis Team (PT) or Affective and Personality Disorder Team (APDT).	Triage Team, telephone triage and advice or referral onto other services for assessment CMHTs work with service users with a variety of diagnoses. Based in localities and subdivisions within those localities are organised to cover defined geographical areas.
Team meetings	Red, amber and green risk categories, which are discussed at zoning meetings, three times a week. The red zone indicates the highest level of risk. The service user is in crisis, experiencing a relapse of symptoms, in hospital, requires CMHT contact 2 or 3 times a week and perhaps Crisis Resolution and Home Treatment (CRHT) involvement if this is not sufficient to manage their risk. The amber zone is for service users experiencing potential relapse, early warning signs, social stressors and reduced engagement. The green zone is for service users with none of the current risk factors detailed in	Red Board daily meetings. The purpose of this is, to deal with urgent and outstanding matters. For example, discussions about outstanding referrals, service users who had not attended appointments or injections. Service users who do not attend for appointments and may be high risk are also discussed and may be subject to “cold calls”, a police welfare check or be seen by the local Street Triage Team. The red board also considered clients being handed over from the Crisis Team service users subject to 72-hour discharge follow up and those on Community Treatment Orders who may require recall. This

	the red and amber categories.	meeting is also used to distribute the work of the CMHNs who were off sick.
Care pathways	APDT: core interventions which last 8-12 weeks, if the client has complex needs which go beyond this, they are progressed to a case management approach. Trust A's operational policy states, that for service users in the in the psychosis team, there is a "step up" function, which states that if symptoms are increasing then increased support can be given. If a service user is "stable", they can be "stepped down". The step-down criteria include, the service user not being in the red zone for six months. In the affective team: complex clients can have intensive case management which states that the service user can be on CPA and contact the team when they are in crisis.	Initial intervention programme 4 sessions: CBT by STR workers and supervised by a psychologist. Trust B has a process called "Active Review" for managing the waiting list. This process is managed by the Active Review Team which consists of a band 6 CMHN, a band 3 Support Worker and an administrator. This is for non-CPA service users who have been assessed and are waiting to be offered a service. They are provided with two to four weekly telephone contact and written information about their proposed treatment. These service users are also subject to team review every three months and have their care plans updated every six months. If their risk increases, then they can be allocated a care coordinator. Change programme, 8 sessions complex clinical interventions with CMHN. Longer term support for complex needs: CPA framework. Three care pathways: mood disorders, psychotic disorders and

		complex emotional difficulties.
Adopting Integrated Care Systems.	This started to become operationalised in 2023. The first stage: to create a new service which promotes integration between primary care and secondary mental health services.	This will be operationalised end of 2023 and early 2024.

One of the main differences between the Trusts is the operational management of their adult CMHTs. Trust A has borough based operational management whereas Trust B has Trust wide service line management. However, the move towards Integrated Care Systems requires operational management structures which are geographically based and work across service lines (RCPsych 2018). The advantage of borough-based systems is the development of working relationships with other local providers, such as the voluntary sector and local authorities and councils (Ham and Alderwick 2015). The other significant difference is the structure of the CMHTs. Both Trusts have a service which facilitates initial contact and an interface between primary care and secondary mental health services. However, their secondary services have significant structural differences.

Trust A's teams are subdivided into sub specialities, according to diagnosis (see table). Trust Bs CMHTs are generic, seeing clients with a variety of diagnoses but working within care pathways. One of the advantages of specialist teams since their inception in 2000, is that staff have specific training and skills relevant to the condition they are treating. It is also suggested that the greater degree of role clarity this gives them, results in higher job satisfaction (Hannigan 2011). A disadvantage is the potential for fragmentation and lack of continuity (NHS

England 2019). It is suggested that the integrated approach is more appropriate in dispersed rural communities with relatively low levels of serious mental illness, compared to urban and inner-city areas, as it promotes access for service users and balanced caseload size for clinicians (Joint Commissioning Panel for Mental Health 2015).

All NHS Trusts in England have governance structures. "*Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed, and the right outcomes are delivered*." (Code of Governance for NHS Provider Trusts NHSE website). Both Trusts have boards of Executive and non-executive directors. They oversee committees which address and monitor key aspects of business and quality. Each of these committees complies with an annual effectiveness review cycle, utilising data from Trust reporting structures, targets and audit (Trust A governance handbook). These are summarised in the table above.

The Long-term Plan and the development of Integrated Care Systems (ICSs) will see a more away from a division between physical and mental health and social support (NHS England 2019). The Health and Care Bill (DH 2022) is discussed within the policy analysis in Chapter six. The main change that this legislation will deliver is formalising Integrated Care Systems, which are, collaborative arrangements between physical and mental health providers, and housing and social care. CCGs are replaced by Integrated Care Boards (ICBs) as regional commissioning bodies. Integrated Care Partnerships are statutory committees with membership from NHS providers, ICBs public health, social care, voluntary sectors and housing (Grohen 2022). Delivery of these services is to be achieved via smaller, place-based partnerships. At the time of concluding this research the

implementation of these changes was in its very early stages. The only significant change at this time, for CMHTs was the development of a primary care-based service in Trust A.

5.2.4: Workforce developments:

This section will consider the workforce priorities for each Trust. This will include recruitment and retention of nurses, the development of new roles, training, and career opportunities for CMHNs and sickness and wellbeing.

Table 10: Workforce developments.

	Trust A	**Trust B**
Monitoring: retention, recruitment and sickness, implementation of national targets	Monitor the sickness and absence of staff members to see if it is related to stress. The nursing strategy, that nursing recruitment and retention will be addressed. Encouraging retired nurses to return as advisors. The KPIs for retention and recruitment are set by the Executive Team within the Trust and benchmarked against similar organisations to align to other mental health Trusts.	Job plan initiative, which sets out what is expected in every job at every grade, achieves role clarity. Nursing strategy sets targets to reduce the turnover and vacancies in its nursing staff. Promoting return to practice Monitored via payroll. Sickness national target monitored via e rostering. Data discussed at care groups to identify and address trends
Workload monitoring	Calculate safe staffing levels: staff self-report their time: clinical, associated work, caseload size and dependency. safe staffing reports are reviewed by the safe	Job plans to differentiate what they can achieve in a week for example. assessments, case management and administration provide. evidence to the commissioners regarding resources

	staffing and executive boards. Team managers perform caseload reviews: numbers and complexity.	needed Job profiles which itemise the skill set for each professional. Safe staffing is monitored and presented via the integrated quality and performance report.
New roles	Nursing Associates and band 5 CMHN roles Wellbeing practitioners and peer support workers.	Nursing Associates and band 5 CMHN roles, STR workers
Clinical career pathways for nurses	Advanced Care Practitioner roles to create development opportunities and aid retention. Developed a community mental health training strategy, in 2022, includes plan for CMHNs: role development, skills and training bands 2 to 8.	Recruiting Nurse Consultants and securing extra CPD funding to increase the skills base and retention of nursing staff

Both Trusts utilise targets to monitor staff absence through sickness and levels of recruitment and retention. Both Trusts monitor staff turnover, that is the number leaving and the number being recruited (this is a national requirement). Their recruitment strategy involves calculating the number of vacancies, based on the business plan and safe staffing levels. This is described by the Deputy Director of Human Resources as a “bottom-up approach” and decided within Care Group forums. Trust A’s recruitment and retention KPIs are set by the executive team and bench marked against other local mental health Trusts. Trust B utilise feedback from the Staff Friends and Family test for staff to identify what staff perceive as the good and bad points about working for the Trust. This is an

approach outlined in the NHS People Plan (NHS England 2020). Trust B monitor their sickness rates via the e rostering system and the financial indicator of temporary staffing spend. Through this problem areas are identified and discussed at care group meetings to identify strategies to address identified causative factors.

Both Trusts have systems for monitoring the workloads of CMHNs. However, each takes a different approach. Trust A utilises a system to calculate safe staffing for the CMHTs. (Operational Policy). This involves staff self-report their time. Trust B use a more pre-emptive approach. CMHT staff have a set of clear job plans to differentiate what they can achieve in a week for example. assessments, case management and administration (Trust policy 2020). This provides evidence to the commissioners regarding resources needed to provide the service and to demonstrate where appropriate where targets haven't been met. In addition, there are job profiles which itemise the skill set for each professional. The standardised set of interventions discussed in the previous section are also intended to ensure efficient use of resources (NHS Improvement 2017). This has implications for the role of the CMHT as they cannot engage in a variety of activities and social interventions with a client. Instead, these aspects will be delegated to a support worker. These roles have developed as the result of a national drive to increase the range of support roles in mental health services to support the work of professionals and to address the staff shortages (NHS England 2017).

Both Trusts have supported the training and employment of Nursing Associates. These roles are intended to support registered nurses as well as providing a flexible pathway into the profession (NHS 2020). Health Education England (2019) suggest that the positive benefits of the NA role in CMHTs is evident. They

are instrumental in providing follow up assessments and care and in providing carer support (HEE 2019). Community teams in both Trusts are actively employing staff to fill a variety of roles who come from non-traditional professional roles. The Affective teams in Trust A are multi-professional with keyworkers who are psychologists, social workers and Occupational Therapists. This is in response the NICE guidelines for personality disorder which cite the importance of psychological interventions (NICE 2009). Therefore, the CMHNs in this service are a much smaller group than in other CMHTs. Both Trusts have developed band five CMHN roles. These roles have traditionally been band six and above due to the autonomous nature of the work and experience required.

Both trusts have experienced the removal of Social Workers from their CMHTs. This has occurred throughout Trust B but only in one of the three boroughs in Trust A, but not the borough used for this research. Despite the policy narratives about the importance of integration of health and social care, social workers are increasingly being removed from NHS management and returning to local authorities (Lilo 2016). Whilst there is no consensus about why this is happening it is thought to be financially motivated and enable greater compliance with the Care Act (DHSC 2014) by having sufficient resources to deliver statutory responsibilities (McNicol 2016).

5.2.5: Service user involvement

Mental health services have a long history of service user involvement, and this is discussed in Chapter five. Both Trusts state a commitment to consulting service users at the level of service design and in the creation of care pathways and uphold the principles of co-production. Co-production encompasses a range of approaches whereby mental health professionals and service users work together

to democratise the power dynamic between them (Boyle and Harris 2008). This can occur at individual level with the CMHN and service user jointly planning care, and at organisational level where service users advise on strategy and policy (Dalgarno and Oates 2019). The term “co-production” although widely used may have different meanings in different contexts. It can range from being tokenistic to transformative, depending on the relationship between the organisation and its service user representatives (NEF 2013).

Table 11 Service user Involvement.

	Trust A	**Trust B**
Strategic Involvement	Involve service users in service design	Involve service users in service design
Coproduction and self-management	Adult community mental health policy makes the concept of working towards self-management explicit, plus their commitment to providing accurate information.	Adult CMHT operational policy states that services will work with clients to reduce their level of support and work towards discharge.
Monitoring satisfaction, complaints and referrals to Patient Advice and Liaison Schemes	National patient survey, Friends and family test SUs and carers ca complain directly to CQC or utilise the Patient Advice and Liaison Service (PALS) Community Mental Health Survey: Mental health team: enough time, received the help needed, other areas of life, repeat medical history	National patient survey Questionnaire: organisation of their care, the degree user and carer involvement. And quality and frequency of the contact and interventions. PALS Community Mental Health Survey: Mental health team: enough time, received the help needed, other areas of life, repeat medical history

	Scores between 4.5-6.6/10: matched national average.	Scores between 4.2-6.6/10: matched national average.
Return to work schemes	Volunteer to Work starting with up to 30 hours of unpaid volunteering within the Trust, with a day a week dedicated to job searching skills	Vocational rehabilitation service: 12-week programme of work experience within the Trust, and work skills support Peer Support workers programme

The policy chapter discusses the development of the personalisation agenda with the emphasis on the concepts of recovery and self-management. The approach of both Trusts in relation to coproduction is similar. They both indicate the importance of time limited intervention from services with self-management and discharge being the aim of interventions. The importance of self-management to reduce demand on services is a key objective for the NHS Long Term Plan (NHS England 2019). Service user satisfaction is routinely monitored in both Trusts, through a combination of the National Patient Survey and the Trusts' own internal monitoring. The patient friends and family test are national statutory requirements (NHS England website). Both Trusts have return to work schemes for service users. Trust B has a substantial Peer Support Work initiative. This involves the employment of support workers with lived experience who are employed across all services including community mental health teams, to provide coaching and emotional and practical support to service users. The NHS Mental Health Dashboard (NHS 2021) stated that the National target for those with Serious Mental Illness in contact with Individual Placement (employment) Support by 2021 is 32,000. It also states, however, that the data set is incomplete, as this information was not recorded at individual and team level. The Trusts refer service users to independent placement support (IPS) (return to work support schemes,

run by local voluntary sector services) but this is not recorded on their local databases.

This section has provided a comparison of the two Trusts where the CMHTs under study are located. The areas used for the comparison are geographical and demographic considerations and regional structures. The organisational mechanisms for each Trust are considered and following this is a comparison of the specific operational management and structures of the CMHTs used in this study. The organisational position for workforce development and the role of services users are considered. Many of these areas are broadly similar. The main difference is in the operational management and team structure of adult CMHTs.

5.3: Participants demographics

Recruitment strategies and progress are discussed in chapter four methodology: section 4.6. Detailed below in table x is the demographic information about the participants. This includes the labels which identify them in the subsequent result and discussion chapters, their gender, the time they have been qualified the time in their current role, their grade and a brief description of their role.

Table 12 participant demographic information.

Trust and team	Participant ID	Gender	Time qualified	Time in current role	Grade and role
Trust A Affective team	AA1	Female	21 years	5 years	Substantive band 6, acting band 7 interim team manager: overseeing clinical work and managing CMHNs

Trust A Affective team	AA2	Male	4 years	18 months	Band 6 Care coordination and assessments. Currently ACP trainee
Trust A Affective team	AA3	Female	9 years	3 years	Band 6 Care coordination and assessments.
Trust A Affective team	AA4	Male	26 years	1 year	Band 7 overseeing clinical work and managing CMHNs
Trust A psychosis team	AP 1	Female	16 years	2 years	Band 6 Care coordination and assessments.
Trust A psychosis team	AP2	Female	15 years	1 year (previously in the team for 2 years: left and came back)	Band 6 Care coordination and assessments.
Trust B CMHT	BM1*	Female	5 years	5 years: 1 year as a band 5 clinic nurse, 4 years as band 6 CMHN	Band 6 Care coordination and assessments. Specific responsibility for interventions within the personality disorder pathway
Trust B CMHT	BD2	Female	10 years	7 years	Recently promoted from band 6 CMHN to band 7 clinical lead for the clinics: depot, medication

					monitoring and physical health, oversees band 5s
Trust B CMHT	BD3	Male	23 years	4 years	Band 6 Care coordination and assessments. Until recently. Responsible for the active review caseload (waiting list for therapy)
Trust B CMHT	BD4	Female	6 months	6 months	Band 5 clinic nurse: runs clinics: depot injections, physical health and medication monitoring
Trust B CMHT	BD5	Female	6 years	6 months	Band 6 Care coordination and assessments.

*From a different team locality. This team was originally selected, then the locality was changed due to recruitment difficulties.

5.4: Summary

This chapter has provided an introduction to the findings and data analysis. It has presented a “thick description” of the two Trusts used in this study. This includes comparative information on geography, demography, and purchaser arrangements, organisational level monitoring, and reporting, locality and team structures, workforce developments and service user involvement. The purpose

of this “thick description” is to provide a comprehensive overview of organisational structures and developments. This contextualises the Trusts’ implementation of national policy which is utilised in the subsequent results and discussion chapters and the formulation of the generative mechanisms. This is followed by an overview of the participant demographics to give context to the empirical data presented in chapters seven, eight and nine.

Chapter 6 Policy Analysis

6.1: Introduction

To fully understand the influences on clinical decision making, it is vital to consider the policy context and socio-political climate. This is discussed in Chapter one where the rationale for the thesis is introduced. This chapter provides an analysis of key health policies and how they related to the development of mental health services and the practice of mental health professionals, including nurses. The focus of this research is the impact of recent policy changes on the decision making by CMHNs in CMHTs. It examines how the ideology within macro level political changes clinical practice through the generative mechanisms of policy and clinical language, organisational priorities and service reconfiguration. The meta theory of critical realism recognises political influence over social structures and the individuals operating within them (Hawke 2017). Therefore, this chapter will consider the wording and rationale of policy to inform the thematic analysis of the data.

The timeframe for this analysis is 1990 to the present. This time frame is chosen as the starting point of the policy analysis, as it marks the start of the business led marketisation of the NHS (Tritter et al 2010). Policy analyses are a means of assessing the activities of government and the wider multiple variables which influence policy development (Sharansky 1995). Therefore, a retrospective analysis enables a critical understanding of how policy changes in response to social and economic factors. Within this timeframe there has been a major shift in the provision of mental health care. This started with the closure of large mental hospitals and the rapid development of mental health community provision, codified in the legislative document National Health Service and Community Care

Act 1990 (Gilburt et al 2014). New treatments for mental illness and a shift to a more liberated societal view led to a re-evaluation of what constituted a mental illness (Ham and Alderwick 2015). Models of service development have continued to evolve. The National Service Framework (DH 1999) and the NHS Plan DH 2000) concentrated on the development of specialist models of service delivery. The current position focusses on recovery, social inclusion and independence and reducing stigma. This chapter will examine how policy changes have influenced the role of the CMHN in relation to workforce planning and education and the rights and responsibilities of service users. The relevant policies are detailed in the three tables below. There is one table for each of the three successive administrations.

6.2: Key reports, White Papers and Legislation 1989-2020

6.2.1: Conservative Government: 1989-1997

Table 13: Summary of policies and papers Conservative Government: 1989-1997

Reports, White Papers, Legislation	Brief description	Impact on mental health nurses
Griffiths (1983) Caring for Patients.	Introduction of general management to NHS away from consensus management	Nurses became general managers; their clinical roles were colonised by managerial priorities
Working for Patients (DH, 1989)	Improving the effectiveness of NHS management, creating measurable outcomes to ensure value for money through audit.	Nurses had to function within budgets which were managed at service level. Budgetary responsibility became an intrinsic feature of professional development and promotion.
Caring for People: Community Care (DH,1989)	Changed arrangements for the provision of care for people with long term conditions, this would be provided by social	Increased community provision, creating CMHTs and expanding the role of CMHNs

	services and not the health service.	
NHS & Community Care Act (1990)	Introduction of purchaser-provider split in NHS & local authorities	Funding changes: care of those with long term mental health problems was transferred to Local Authorities. The focus of mental health care was in residential settings.
Care Programme Approach (1990)	Statutory framework for provision of coordinated health and social care to those with SMI	CMHNs assumed role of keyworker and with those responsibilities for care coordination, risk assessment and risk management.
White Paper Building Bridges (DH, 1995)	Introduced guidelines for the arrangements for interagency work for people with serious mental illness.	CMHNs and Social Workers worked in the same teams and their roles overlapped.

6.2.2: Labour Government 1997-2010

Table 14: Summary of policies and papers Labour Government 1997-2010

Reports, White Papers, Legislation	**Brief description**	**Impact on mental health nurses**
The New NHS: Modern and Dependable (DH 1997)	Outlined inequalities targets and pledged to increase resources to deprived areas and address poverty, lack of education, unemployment, discrimination and social exclusion	CMHNs work involved increasing social care interventions.
White Paper Modernising Mental Health Services (DH 1999)	Created standards for mental health, namely: safe accessible services and value for money. This was monitored via a needs local impact assessment between health and social care plus, accurate measurement of impact	Services started to provide rapid responses, increased protection for vulnerable people, strengthened partnerships with social care. National standards for this were introduced
National Service Frameworks (DH 1999)	Targeted major areas of chronic health, including	Further developed evidence-based targets

	mental health. The narrative within these documents address the importance of preventing ill health, inequalities and set out clear quality guidelines for care.	and service frameworks for mental health, with an extensive evaluation strategy.
NHS Plan (DH 2000)	Introduction of high-quality patient and carer experience but included outcome measures and efficient use of resources. This introduced a system of Clinical Governance which codified guiding principles to ensure high quality treatment and care which is known to be effective and acceptable	This led to the development of new mental health services with specialist functions: Early Intervention Services, Crisis Resolution Home Treatment Teams, Assertive Outreach Teams and Recovery Teams. One of the main reasons for reorganising mental health teams into specialist functions was to standardise the quality and delivery of mental health care nationally
New Ways of Working and Creating Capable Teams 2007	Leadership: Proposed a move away from medical leadership and delegation towards inter-professional collaboration and shared responsibility. Team working and attitude: move from hierarchical responsibility towards capability of individual clinicians responsible for their own cases. Profession driven or user and carer focus: sharing of capabilities and blurring of professional boundaries with the focus being client and carer needs and not professional identification.	CMHNs gained greater autonomy and training. They undertook responsibilities previously taken by psychiatrists and social workers.

New Horizons (2009)	Strategies for tackling stigma (Time to Change), promote self-care and personal responsibility. Promote the Recovery model: building a meaningful and satisfying life even in the presence of ongoing mental illness. Hope and the other guiding principles should explicitly guide all practice including those preventative childhood measures.	The recovery agenda was incorporated widely within mental health practice. Introduction of the Recovery star, used principles to measure progress of mental health clients

6.2.3: Coalition Government 2010-2015

Table 15: Summary of policies and papers Coalition Government 2010-2015

Reports, White Papers, Legislation	Brief description	Impact on mental health nurses
No Health without Mental Health (2011)	It developed outcome strategies. Which they claim, empower individuals and are an alternative to the top-down traditional approach. The policy states that the government will work with private and voluntary sectors to shape policy, develop a broad service provision, ensure the delivery of outcomes and seek to hold services to account, provide quality services and choice,	Further use of targets and national monitoring to regulate the work and rate the performance of services.
Equality and Excellence: Liberating the NHS (DH 2010)	Measures to put the public first: no decision about me without me, ratings and choice and introduction of the Care Quality Commission.	Established a system of payment by results in mental health, replacing previous system of block contracts. Clustering led to further community

	Improve health outcomes: evidence-based measurement, payment by performance, increase local responsibility for commissioning. Cutting bureaucracy and increasing efficiency: targets for efficiency savings, reduce advisory bodies and management costs	mental health team restructuring to match new care pathways. The cluster generated a fixed price for the service user's care for a fixed period. Therefore, clinicians had to work within a fixed price and if the provider spends less then they make a profit.
Health and Social Care Act 2012	Reconfiguration of national structures: established CCGs, monitor moved public health from NHS to LAs, reduced advisory bodies. Devolution of financial responsibility and efficiency savings	Creation of outcome measures to improve efficiency and make savings. CMHNs have to adhere to care pathways and target monitoring.
Francis Report 2013	Greater emphasis on monitoring quality patient outcomes. Monitor retained a residual role regulating the healthcare economy their function was advisory and their measures introduced incrementally, and this was to be a secondary role to the Care Quality Commission	Recommendations led to A Culture of Change in the NHS (2015)
Closing the Gap (2014)	National outcome standards and monitoring for NHS, Social Care and Public Health. Services which demonstrate successful outcomes and recovery rates will attract the most funding.	Mental health teams had to follow waiting time and discharge protocols of be subject to financial sanctions.
Care Act (DH 2014)	L.As have responsibility to assess vulnerable people and their carers regardless of their financial means and account for the	Work to a clearer definition of after care services and requirement to provide care that meets social needs and broader scope of well-being.

	individual's well-being and carer's needs.	

6.2.4: Conservative Government 2015-2024

Table 16: Summary of policies and papers Conservative Government 2015-2024

Reports, White Papers, Legislation	Brief description	Impact on mental health nurses
A Culture Change in the NHS (DH 2015)	Reported on progress made since Francis report increased monitoring by the CQC and reduction of Monitor's power. This included greater monitoring of evidence of care and compassion	Duty of candour, requiring staff to speak out about poor practice and acknowledge failings with patients are carers.
Five Year Forward View (2016)	Made recommendations about integrated care, health promotion and self-management for those with long term conditions.	Operationalised by the Five year forward View for Mental health (2017)
Five-Year Forward View for Mental Health (2016)	Sustainability and Transformation Plans and Accountable Care Organisation. Creation of local arrangements for health, social care and third sector agencies to become integrated to meet the needs of their population.	Shift away from the NSF service configurations towards a model of pathways with standardised endpoints. increase mental health prevention, including work in schools, tackle stigma and increase employment opportunities for those with mental health problems
Mental Health Workforce Plan (2017)	Notes that mental health nurses are the "backbone" of services but that their numbers are decreasing. Suggests new roles and innovative models	CHMTs employing Peer Support Workers, Support Workers and Psychology Assistants. New focused short-term interventions as an alternative or adjunct to treatment
NHS Long Term Plan 2019	Clinical priorities, including mental health. Move towards	Nursing Associate posts, apprenticeships. In mental health the

	population, rather than activity-based payments. National workforce planning, to reduce nursing vacancies, create accessible routes into nursing, move from specialist into generalist roles and create stronger leadership. Increased spending on mental health.	creation of more non nursing roles to perform roles, previously undertaken by nurses, such as Wellbeing Practitioners. Creation of Integrated Care Systems, with health and social care agencies integrated within LA boundaries.
NHS Interim People Plan 2019	Make the NHS a positive place to work, develop compassionate leadership, address nursing shortages, more skilled and varied workforce, new workforce model.	Broader skill set for mental health nurses: physical health skills, decrease vacancies in mental health, greater collaboration with primary and social care. Tackle discrimination in the workforce.
NHS People Plan 2020	Improvement strategies to address health and Wellbeing, Flexible working, equality and diversity, Culture and leadership, new care delivery models, increased workforce and tackling retention and recruitment and deployment across systems.	Restated the priorities in the Interim People Plan.
NHS Health and Care Act 2022	Legislates the proposals set out in the 2019 Long Term Plan. Formalises Integrated care Systems: bringing together providers (NHS and others) and commissioners with Local authority to collectively plan and deliver for local population needs. Framework, with local flexibility in how these are delivered. ICBs replace CCGs	Substantial reorganisation of community health services, greater expectations regarding integrated care and joined up working with primary care.

NHS Workforce Plan 2023	Increase number of nurse training places in HE and maximise apprenticeship routes. Retain staff by improving the culture of the NHS and promoting compassionate leadership. Reform models of care to improve productivity, broader teams with flexible skills and flexibility of deployment.	Generic skills for the workforce: more physical healthcare skills for MHNs. Reorganisation of healthcare delivery will mean a more flexible workforce.

6.3: Mental Health Policy

There have been significant policy changes in the past 30 years which have impacted on funding, service structure and monitoring of mental health services. The role of the CMHN has been influenced by these changes. The NHS and Community Care Act (DH 1990) moved the funding and responsibility for housing SMI from the NHS to Local Authorities. Subsequent policy changes have sought to improve efficiency by monitoring the outcomes of mental health care and using this data to allocate funding. The New NHS: Modern and Dependable (DH 1997) emphasised quality but also related it to “efficiency “. The NHS Plan (DH 2000) pledged and delivered increased resources and quality standards in mental health. These developments led to an increased focus on skills and evidence-based practice in CMHTs. The White Paper Modernising Mental Health Services (DH 1999) pledged to increase resources and utilise research and knowledge to shape and develop the workforce.

New Ways of Working (D.H 2007) and New Horizons (D.H 2009) introduced practices which promoted service user empowerment and the autonomy of the CMHN. During the administration of the coalition government 2010-2015, No

Health without Mental Health (D.H. 2011), the Health and Social care Act (MH Government 2012) Closing the Gap (D.H. 2014) strengthened the use of national outcome measures with the emphasis on efficient use of services. The Five Year forward View (MH Taskforce 2016) and the Five year forward view for Mental Health (2017) introduced plans for self-management for those with long-term conditions and service integration to address the needs of those with physical and mental health co-morbidities. This was progressed by the NHS Long Term Plan (2019) and formalised by the Health and Care Bill (HM Gov 2022). These policies will now be discussed in relation to the themes identified within the policy analysis: managing the workload, the role of the CMHN and Service user involvement/self-management.

6.4: Managing the workload and service structures.

Policy from the National Service Framework (DH 1999) to Liberating the NHS (D.H 2011) marks a steady transition towards achieving PBR (Clarke 2011). Therefore, linking quality to outcome measures is a high priority for NHS (NHS England and NHS Improvement 2016). Gilburt (2015) suggest that that the Health and Social Care Act (DH 2012) drove a whole system transformation which was a move away from the evidence-based models of previous programmes. Mental health outcomes have often been difficult to measure, hence the use of block contracts. Therefore, mental health payment by results was based on activity instead, using a case mix approach known as clustering (Yeomans 2014). Clustering utilises a standard set of categories which identify the relative needs of the patient (Jacobs et al 2018). The cluster allocated to a service user determines the standard care pathway they are allocated to (Dye 2017).There is little evidence to suggest that clustering accommodates actual clinical, social,

cultural, and economic factors (Gilburt 2015). The cluster allocated attracted a level of funding and encourages services to deliver care within the set price range for that cluster (Yeomans 2014). There is considerable variation in need even for clients with similar diagnoses (Wang et al 2015). The measurement of care provision does not always indicate how appropriate or effective it is (Dye 2017).

At the time this analysis was undertaken in 2019 and during the data collection 2021-22, Mental Health Trusts were providers, their services are purchased by their local Clinical Commissioning Groups (CCGs). At national level the responsibility for the day-to-day budgeting, planning delivery and commissioning of all health services in England lies with NHS England, a non-departmental public body of the Department of Health and Social Care. Localised purchasing arrangements are the responsibility of the Clinical Commissioning Groups (CCGs). The number of CCGs in England has reduced since April 2020, from 220 to 135, due to mergers intended to reduce duplication and administrative costs (NHS England website). Following the publication of the NHS Long Term Plan, guidelines were established for CCGs to apply for merger. The plan was for them to become “leaner” and more strategic (NHS England and NHS Improvement 2019). CCGs set Key Performance Indicators with each Trust. These are based on national guidelines produced by NHS England; Commission for Quality and Innovation (CQUIN). This is discussed in relation to the Trusts under study in the section on setting in chapter four. In addition to monitoring performance each Trust is subject to external scrutiny of the quality of their services.

Service quality in England is monitored by the Care Quality Commission (CQC). The CQC is an independent regulator of health and social care services in

England, who ensure that services are safe, effective, compassionate and of a high quality (CQC website). Their findings are produced as public reports and a rating system. The CQC utilise hard evidence, such as incident reporting and patient records, and soft intelligence, staff satisfaction and service user feedback, to monitor performance in specified domains (CQC website). Since their inception, the CQC have developed their working relationships with providers to enable them to develop the capacity for quality improvement and the intrinsic motivation to do so (Smithson et al 2018). However, critics have suggested that the inspection process is too prescriptive and that organisations are more concerned with receiving a "good rating" than on focussing on the quality of care they provide (Burton 2017).

The Five-Year Forward View (DH 2016) proposed the development of Sustainability and Transformation plans. STPs were delivered by 44 geographical areas, consisting of a variety of local services including the NHS. These had their progress in meeting these targets monitored (NHS England 2017)

"STPs are the new strategic planning framework for local health and care economies in England and, as such, are a keyway to address the major health and wellbeing, quality and financial challenges facing local health and care systems."

NHS Confederation Briefing 2016 page 2.

The language suggested that greater consideration was being given to collaboration and to reduce fragmentation. There is an emphasis on prevention and integration driven by the Five-Year Forward View (NHS Confederation 2016). However, this is not a complete departure from productivity. The combination of

delivery from a variety of agencies was intended to break down barriers between agencies and tackle waste, duplication, and variations in care (Ham et al 2017).

“The funding pressures on each part of the system cannot be solved in isolation, so each STP must identify the totality of the health and adult social care finance and quality gap it faces”.

NHS Confederation Briefing 2016 page 5.

The aim was for the NHS to make savings of 2-3% net by increasing prevention, invest in new care models, sustain social care and see efficiency savings coming from wider services (NHS England 2014). Kotecha (2017) suggested that the growth in the use of hospital care was unlikely to fall and there are planned efficiency savings within social care. Sustainability and transformation plans were in effect, delegating resource constrained interagency working to local services (Hammond et al 2017). The Five Year Forward View Mental Health (NHS England 2017) made many recommendations. These included commissioning services which had been proven to improve mental health and how this could be applied to other populations and consider new funding mechanisms such as social finance. These recommendations were partially successful in mental health services in that service uptake improved but there were still shortfalls and long waiting lists (NHSE 2019). However, the NHS was still facing increased demand in the context of financial constraint and “place based” integrated systems of care were seen as the way forward (Ham and Alderwick 2015).

The NHS Long Term Plan (DHSS 2019) followed the Five Year Forward View and sought to progress the move from hospital care to local, joined up provision of community and preventative services.

"The NHS and our partners will be moving to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation."

NHS Long Term Plan 2019 page 10.

For mental healthcare to be effective there needed to be effective integration with social care and an acknowledgement of the impact of inequalities and societal pressures. (WHO 2014). Earlier policies had sought to address this. The Care Programme Approach (DH 1991) codified the integration of health and social care. The White Paper Building Bridges (Department of Health 1995) contained guidelines for the arrangements for interagency work for people with serious mental illness. The New NHS Modern and Dependable (DH 1997) outlined inequalities targets and pledged to increase resources to deprived areas and address poverty, lack of education, unemployment, discrimination, and social exclusion.

Social Housing continued to be paid for by housing benefit and universal credits and be topped up by a locally devolved budget, however, social care was inextricably linked to health care and faced further cuts (Timmins 2014). Public Health England commissioned a report into mental health prevention, detailing actions for local services to take to prevent mental ill health (Mental Health Foundation 2016). The government paper "Prevention is better than cure" (DHSC

2018) suggested integrated approaches between health, social care and housing to tackle causes of poor physical and mental health. The responsibility for tackling social determinants was delegated to local Accountable Care Organisations, which included mental health professionals, whereas the social and economic policies remained with central government. The NHS Long Term Plan (NHSE 2019) cited local integration as a means of tackling inequalities:

"To help tackle health inequalities, NHS England will base its five-year funding allocations to local areas on more accurate assessment of health inequalities and unmet need. As a condition of receiving Long Term Plan funding, all major national programmes and every local area across England will be required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years."

NHS Long Term Plan page 7.

The S.T.Ps created in response to the Five Year forward View, made progress towards developing partnership working between health and social care agencies across the UK (Charles 2020). The NHS Long Term Plan (NHSE 2019) will replace STPs with Integrated Care Systems (ICSs) which aim to form closer collaboration between NHS, social care, and local government. This will include a shared budget with local configuration dependent on population need (NHSE 2019).

The Health and Care Bill (HM Gov 2022) was not operational at the time the data collection was carried out for this study. It gained Royal ascent on 28th April 2022. The main change brought about by this bill, is that it legislates the proposals in the Five year Forward View (NHS 2015) and the NHS Long Term Plan (NHS 2019). It formalises and operationalises Integrated Care Systems. These are

commissioners, a range of health and social care providers (including but not exclusively the NHS) and local authorities. These local systems are required to plan for and meet the needs of their local population. CCGs are replaced by Integrated Care Boards.

This involves service reconfigurations to promote greater integrated working, between primary care, community health services and social care. This is intended to improve the experience of those with long-term conditions and co-morbidity, by providing joined up, person centred care (DHSC 2022). This Act aims to give the ICS providers responsibility regarding decisions about how care is provided (Kings Fund Website). This will involve large-scale service reorganisation and will take some time for a shared view of the needs of the local population be fully established (Groen 2021).

The Health and Care Act (DHSC 2022) aims to reduce bureaucracy, by removing the local procurement processes involved in competitive tendering. However, it gives the Secretary of State the authority to reconfigure services (DHSC 2021). This can be seen as reducing the likelihood of competitive tendering and privatisation. Alternatively, if it removes the tendering process, large block contracts could be introduced at ministerial level, without choice or transparency therefore ICP contracts could end up in private sector monopolies (Roderick and Pollock 2021). It is possible that decisions about configuration will be driven by local provider networks and not population need (Roderick and Pollock 2021). It is unclear which organisation takes the lead to resolve conflict and performance issues within ICSs. It could be argued that it is not appropriate for a non-NHS statutory body to control NHS spending and performance (Charles et al 2018).

6.5: Implications for the role of CMHN

This theme examines the policy changes regarding the mental health nursing workforce. Over the past 30 years there have been radical changes in nurse education and continuing professional development. The development of mental health services has had an impact of the practice and professional development of CMHNs. The underfunding of mental health services has led to the development of new roles. These factors have an impact on how CMHNs view their role and their level of autonomy.

There have been significant changes in Nurse Education since 1989. The level of educational attainment had increased in line with the need for an autonomous and responsible workforce. The White Paper Working for Patients (DH 1989) initiated a review of pre-registration and post qualifying nurse education. This involved universities and professional bodies. The Judge report 1985 suggested the transfer of nurse education from schools of nursing to universities (Rye 1985). An initiative named “Project 2000” in which training consisted of 3-year programme would include a year foundation followed by 2-year specialism. This gave nurses a registration and either diploma or degree level academic qualification (Ousey 2011). This was also endorsed by NHS A Service with Ambition (DH 1996) and The New NHS Modern and Dependable (DH 1997) Making a Difference (DH 1999) which stated that a well-educated workforce was necessary to enhance the quality evidence-based care. Prior to this, nurses had been trained in schools of nursing, attached to hospitals and were an employed part of the workforce and students had an anomalous status within it (Webster 2002). This marked a change from the traditional approach to training, which was the mastery of skills to one which fostered theoretical research-based practice (Elzubier and Sherman

1995). Ousey (2011) suggests that the reason for this was to redeploy training budgets. Murray (1996) highlights that this change coincided with the reduction in junior doctors' hours, creating the need for a more autonomous nursing workforce.

By 2013 the minimal qualification attainment for newly qualified nurses was a degree, the diploma level was phased out. The NMC (2010) suggested that this would create a graduate workforce who would be better equipped to provide high quality care, autonomous decision making and high-level judgements in transforming the NHS. It was also intended to be an attractive prospect for potential students and give them the same professional status as other allied professionals (NMC 2010). For this ambition to be realised, the post qualifying work environment needed to support this way of working. Graduate nurses faced high levels accountability and responsibility, following their protected status as students. This affected their confidence despite their level of knowledge, and they still required experience and a supported transition period to develop (Logina and Traynor 2018).

A parallel theme in nurse education in this period, was the creation of second level nurses. State Enrolled Nurses (SENs) were part of the nursing workforce. SENs undertook most of the same duties as first level registered nurses except for management. SEN training was stopped in 1985 and second level nurses were encouraged to covert to first level nurses by 1992.The creation of university programmes and removing SENs left a gap in the workforce which untrained staff could not fill (Glasper 2016). Health Education England (2015) undertook a consultation to review the education of Registered Nurses and Care Assistants. A new role was proposed; the Nursing Associate (NA). Like the SEN, NAs undergo a two-year training, perform many nursing duties and are on a separate

part of the NMC register (HEE 2019). The rational given for the creation of this new role was to allow flexible routes into nursing for those who do not have the qualifications for first level training. (HEE 2019). This comes only three years after the abolition of the Diploma first level nurse. This return to creating second level nurses is a response to rising nursing vacancies (Hayton 2016). Continuing professional development funding has been reduced from £190m to £84m as funding was diverted into the pre-registration budget (Lintern 2018). Other financial changes included scrapping nursing bursaries and the introduction of tuition fees for nursing students (HC 2017). These changes in nurse training left the future supply of nurses potentially depleted as applications for nursing continue to fall (Bungernorth and Fennell 2018)

Health Education England (2015) suggested an apprenticeship route in which staff are employed whilst they train:

HEE, in collaboration with employers and HEIs, should support the development of more innovative work-based learning routes. Those learning routes should be standardised to allow care assistants to move easily into the nursing profession without having to give up their employment, as they study and train for their nursing degree and Registered Nurse status.

Raising the Bar; Shape of caring: A Review of the future education of registered nurses and care assistants page 11.

The creation of second level nurses would appear to be a return to the practices pre-1985. This can be viewed as a valuable step towards bridging the gap between registered nurses and health care assistants. The aim was, to free up registered nurses for advanced clinical duties and to take a lead in decision making (DH 2017). However, critics suggested that the initiative is financially

motivated and that inevitably, NAs were used in place of registered nurses (Hayton 2016). The apprenticeship model was a return to pre 1989 practice. This involves existing staff being able to undertake degree level training, whilst being employed and included in the workforce. (HC 2018). Butterworth and Shaw (2017) suggested that it was not enough for workforce planners and employers to think of maximising the numbers who were trained to boost the workforce. There also needed to be a consideration of how these staff were effectively deployed and how their on-going development was supported. The next section will consider how the post qualifying development of mental health nurses supported them in using their clinical and leadership skills.

The introduction of general management had implications for the career pathways in mental health nursing. In the early 1990s there was an expansion in financial management within the nursing role. This was viewed as providing increased development opportunities for nurses. Alternatively, it indicated an alignment of clinicians with policy in order to exercise control over large numbers of professional groups as this responsibility lay with senior nurses (Moffatt et al 2014). Nurses took on leadership and management roles, and their level of seniority was often determined by the degree of budgetary control they held (Spinks 2006). Making a Difference (DH 1999) made recommendations for the development of Nurse Consultant roles. Their purpose was to ensure quality, specialism and advanced clinical roles plus promote clinical rather than fiscal leadership and retain expertise within the workforce. Evaluations of the role suggested that NCs tended to be given operational project management tasks to do instead, and that organisations did not support research activities due to the potential for this to expose poor practice (Dyson et al 2014). Nurse Consultants experienced a lack of clarity about what was expected of them and that it was

challenging to be a leader without also being managerial (Manley and Titchen 2012). The Health and Social Care Act (HM Gov 2012) drove widespread efficiency savings. As a result, 44,000 NHS jobs were lost. This resulted in an erosion of job security and a reduction in the scope of the workforce (Pownall 2013). These factors contributed to widespread redundancies of Nurse Consultants (Dyson et al 2014).

The Advanced Practice Position Statement (DH 2010) stated the need for advanced level nursing practice. Unlike NCs who functioned in a supervisory and advisory way and whose role developed according to local need; advanced nurse practitioners were intended to be involved in direct patient care and their role subject to national standards:

"Nurses working at an advanced level promote public health and well-being. They understand the implications of the social, economic and political context of healthcare. Their expertise, experience and professional and clinical judgement are demonstrated in the expert nature of their practice and the depth of their knowledge".

Advanced Practice Position Statement (DH 2010) page 9.

The Advanced Practice Role for nurses was developed to meet the workforce challenges of an aging population and the prevalence of chronic disease. Increased demand and constrained budgets called for the development of advanced roles (RCN 2018). The scope of practice included freedom and authority to act independently and take responsibility for their decisions. This role is still being developed and the areas where it is currently focussed is primary and emergency care (Woo et al 2017). It is available to all fields of nursing, and it is

acknowledged that mental health may need additional, mental health specific competencies (RCN 2018).

Following the closure of large mental health institutions and the creation of Community Mental Health Teams, the role of the Community Mental Health Nurse developed. This was an autonomous clinical role for nurses who were viewed as being the best placed to coordinate the care of clients (Simpson 2005). However, this was challenging as nurses lacked sufficient status, power and authority to provide direction for other professionals (Simpson 2007). Policies have driven the development of the CMHN role as an autonomous one: National Service Framework (DH 1999) and the NHS Plan (DH 2000) recommended the creation of community mental health teams with specialist functions. New Ways of Working (DH 2007) and "Creating Capable Teams" (DH 2007) recommended a move away from medical leadership and delegation towards inter-professional collaboration and shared responsibility. Teams moved from hierarchical responsibility towards capability of individual clinicians responsible for their own cases. New Ways of Working for Everyone (DH 2007) outlined the importance of having equal distribution of responsibility within Community Mental Health Teams. However, this varied from team to team depending on the capability of personnel within the team (Iqbal 2014). The Responsibility and Accountability Guidelines (DH 2010) sought to clarify areas of responsibility and acknowledges the human dimension of individual and team reactions when this was not made clear. Teams were encouraged to discuss cases and exercise leadership and consensus. (Hill-Smith 2012). This resulted in an increase in the number of mental health nurses and an emphasis on making the best use of their skills (Gilburt et al 2014)

Mental Health Nurses have a fluid identity which is expanded or eroded in accordance with the changing resources, service structures and the introduction of other professional roles (Crawford et al 2007). The identity of inpatient mental health nurses was relatively clear and often subordinate to other professionals. The identity if the CMHN is diverse and often blurred with other professional roles. This enhanced the scope of their role and increase the demands placed upon them (Crawford et al 2008). Butterworth and Shaw (2017) stated that innovations led by graduate mental health nurses made a huge difference to the quality of services provided to those who most need it. The central tenet of CMHNs identity was the client relationship and their interpersonal skills. Increasing their skills base made their role more diffuse and they constantly realign themselves with the parameters of service redesign and policy terminology (Crawford et al 2008).

The Mental Health Workforce Plan (2017) acknowledges that the mental health nursing workforce is reducing due to rapid staff turnover. It highlighted plans for new roles, such as peer support workers, support workers and Nursing Associates. Support Worker roles in CMHTs had been introduced following New Ways of Working (2007). Their purpose at this time was to provide supplementary social support to those with SMI, allowing CMHNs to focus on more specialist treatment (Proctor et al 2016). These addition roles can be viewed as replacing tasks previously undertaken by qualified nurses (McKeown and White 2015). Registered nurses may have overall accountability and have to rely on information provided by support staff in order to make decisions. This is dependent on role clarity and recognition of the limitations for the non-qualified role (Henshall et al 2018). This thesis examines the generative mechanisms which influence CMHNs clinical decision making. This was affected by ever changing professional responsibilities, service parameters and resources.

The size and capacity of the workforce is a key issue for workforce planning**.** Mental health services have been chronically underfunded (Mental Health Policy Group 2017). Butterworth and Shaw (2017) stated that the number of mental health nurses has decreased by 15% in the past six years. Bailey (2013) stated that 40% of NHS CMHTs are understaffed. Government policy since 2010 has pledged "Parity of Esteem" between physical and mental health (Bailey 2013). This needed to include parity of funding (Gilburt 2018). Historically there have been mental health nursing shortages for a variety of reasons. Nolan and Smokjis (2003) suggested that this was due to the challenges of working with those with serious mental illness and the threats of violence. In addition, nursing became increasingly bureaucratic, and government targets set high standards despite limited resources (Nolan and Smojkis 2003). McVicar (2003) stated that mental health staff have always been at risk of stress and exhaustion due to the pressure of working with people in distress. There were clearly issues with the quality of care in mental health services, the main source of these problems is funding (Gilburt 2015).

The Five-Year Forward View for Mental Health (MH Taskforce 2016) made statements about extra funding:

"The Department of Health has already supported the delivery of this plan with additional investment of £1 billion a year by 2020/21 to improve mental health services. The Government will hold NHS England to account for the effective and efficient spending of that extra funding and the delivery of the Five-Year Forward View for Mental Health." The Five-Year Forward View for Mental Health (MH Taskforce 2016) Page 2

The Five-Year Forward View for Mental Health aimed to close the estimated £30bn funding gap (CHPI 2017), whilst pledging extra funding and new roles. In the workforce plan Stepping Forward (NHS England 2017) there was a statement about “establishing 21,000 new posts and employ 19.000 new staff, 11,000 of these will be from professionally regulated staff. The additional 8,000 will be Peer Support Workers, Wellbeing Practitioners, Call Handlers, and Nursing Associates”. This was a way of addressing the staffing shortfall in mental health as the current vacancies stand at 20,000. It relied upon enough staff being recruited and retained. (Gilburt 2018). Whether or not this can be achieved is still uncertain due to the fragmented nature of workforce planning and if this will provide appropriately skilled and trained staff (Kings Fund 2018). The aims of the Five-Year Forward View for Mental Health can only be realised if there are enough suitably skilled and qualified nurses (Gilburt 2018).

The current workforce planning directs those with specialist skills towards the monitoring and delivery of evidence-based interventions, whilst employing more unqualified staff to deliver care. This is to reduce the demand on qualified staff (HEE 2017). The National Quality Board (2018) reported on safe staffing in mental health settings. This report acknowledged that staffing levels in mental health were too low to meet demand in both inpatient and community settings. This subsequently caused existing staff stress leading to increased absenteeism and retention problems. NQB (2018) recommend that local commissioners review and determine staffing levels and monitor and reduce their use of agency staff. This cites measures such as monitoring quality outcomes to ensure quality care and staff satisfaction.

The National Workforce Strategy (PHE 2018) states that its priority is to tackle the negative turnover of staff and the subsequent increasing vacancies in mental health NHS services. Trusts are required to provide data on: people leaving, total sickness, staff appraisal, completion of mandatory training. These are collated by Health Education England and NHS Improvement (NHS Improvement 2019). The staff turnover rate for mental health nursing is high nationally with 10% of posts being vacant, with London Trusts having a 25% vacancy rate (HEE 2017). NHS Employers focussed on areas where there were large numbers of staff leaving and help them develop retention and recruitment strategies (HEE 2017). One of the main reasons for the higher number of vacancies in London is the cost of living. Many nurses taking part in a recent survey said that the cost of accommodation and transport in London forced them to consider leaving the capital (Colclough 2020). The NHS Long Term Plan (NHSE 2019) made commitments to increasing mental health funding, increasing the number of nurses and investing in continuing professional development.

The Interim People Plan (NHS 2019) was intended to identify short term actions to improve the working lives in NHS staff, with a view to publishing a full people plan after the spending review. (HMFA 2019). Recommendations included developing the leadership culture and increase retention. The NHS People Plan (NHS England 2020) acknowledged the need to make the NHS a positive working environment, to retain staff. Its priorities included retaining staff through ensuring they have a voice through surveys and “speak up guardians”. It also pledges to tackle bullying and harassment, which it states is particularly problematic for BAME staff. Compassionate leadership is cited as a means of addressing this. These two people plans were short term strategies to address staffing shortfalls year on year. In 2023, the NHS published the Long-Term Workforce Plan (NHS

2023). This pledges to train more nurses, by significantly increasing the number of pre-registration training places. The RCN (2022) suggest that the NHS may struggle to accommodate these students on placement due to capacity. It also promises to improve retention of staff by offering career support, flexible working and a positive culture and leadership. It's third priority is to reform current ways of working by ensuring staff have broader skill sets and can be deployed to work where they are most needed. The NMC (2018) have made amendments to their standards to pre-registration nursing to reflect these changing expectations of the nursing workforce. This includes the acquisition of physical and mental health skills for all nurses. Mental health student nurses are taught physical health care skills such as catheterisation and venepuncture. This may reflect the NHS workforce plan (DHSC 2022) plan for "flexibility in deployment" and have "staff in roles and services where they are needed the most."

"*They (registered nurses) provide nursing care for people who have complex mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly, and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed*."

NMC proficiencies 2018 p 3.

The Royal College of Nursing (RCN 2023) criticised the NHS Workforce Plan by suggesting that it lacked detail, about how nursing numbers will be increased and how the funding will be allocated. It does not explicitly address the ongoing disputes over pay (RCN 2023) (House of Commons 2023). The RCN (2023) urged the Government to prioritise plans to address the current nursing shortages.

The report does not address safe staffing levels, that is the number of nurses needed in relation to the demand on the service (House of Commons 2023). The Kings Fund (2023) suggests that future projections of the number and skill mix of staff needed to meet growing demand, is badly needed.

The Health and Care Bill (DHSC 2022) comments on bureaucracy and its impact on staff morale. It proposes to reduce the complexity of regulation, appraisals, and mandatory training. As part of the planned reforms to improve patient safety, there are proposed changes to professional regulation. These include giving the Secretary of State for Health and Social Care to remove a profession from regulation, abolish a regulatory body or to delegate regulatory responsibilities to an alternative regulator (DHSC 2021). The creation of Integrated Care Systems requires CMHTs to work closely with a variety of other providers. RC Psych (2023) suggest that CMH services and professionals already work in this way. They provide care to service users with long term conditions in collaboration with primary care, social services, voluntary sector agencies and local authorities.

In summary, the policy directives regarding the development of the mental health nursing workforce have been considered. Educational developments have moved away from a hospital level apprenticeship scheme towards a graduate profession. Second level nursing was also phased out. This has led to a highly trained and specialist workforce. Financial constraints have led to a recent reversal in this development. Services are increasingly relying on unqualified nurses to replace qualified nurses in the delivery of “hands on” patient care in the context of budgetary constraints (Griffiths et al 2018). The development of Advanced Clinical Practice Roles, Nursing Associates and the standards for pre-registration nursing, involve mental health nurses delivering a range of physical

health interventions. This is possibly in acknowledgement of the rising incidents of comorbidity. However, it may also reduce the number of staff working with a comorbid client and allow nursing staff to be moved between physical and mental healthcare settings.

6.6: Mental Health Led Service User Involvement:

Another pertinent theme which is evident within policies is the part played by the mental health service user. This period saw the move of the mental health service user from institutional to community care. The focus became providing care in the least restrictive way possible. There have been greater expectations for and of the service user with an increasing focus on personal responsibility, recovery social inclusion and employment. This included addressing stigma and mental health prevention. The concepts of stigma and recovery in mental health are discussed within the theoretical chapter.

The Care Programme Approach (DH 1991) established the statutory provision of personalised care planning and the provision of a range of personalised, well-coordinated services (Goodwin and Lawson-Smith 2010). These initiatives were developed within NHS: A Service with Ambition (DH 1996) which stated the importance of providing flexible and accessible care to people in their own homes. Services needed to be responsive to the needs of service users and their families, with the duty to focus resources on those with greatest need (Waneless 2006). This was in the context of least restrictive setting but perhaps denotes an element of dependence. Our Health, Our Care, Our Say (DH 2006) pledged to address the inequalities and increasing access to community services and suggested a duality of state provision and social justice and individualism. This presents CMHNs with the task of making services more accessible and promoting self-

management (Kings Fund Briefing 2005). The High-Quality Care Review led by Lord Darzi (DH 2008) stated that quality measures should also include measuring patient satisfaction. Equality and Excellence: Liberating the NHS (2010) established the routine collection of data from patients, carers and families regarding their level of satisfaction with care. This mirrors the approach used within hospitality and retail and can be viewed as a consumerist approach (O'Hara 2013). The positive implications of this includes the promotion of autonomy and self-responsibility (Mold 2015). Data is obtained by the use of rated satisfaction questionnaires (Mold 2010). An overall collation of satisfaction scores for mental health trusts have their limitations as they do not account for dissatisfaction generated by social aspects and the illness itself (Priebe and Miglietta 2019)

Personalisation and self-management strategies include patient information and prevention. The NHS A Service with Ambition (DH 1996) cited the need for a well-informed public. The Government wanted the NHS to provide the public with information about services to enable the patients to make a choice about where they are treated. However, this transparency exposed underfunding (Waneless 2006). The aims included full involvement with clients who need to take responsibility for their treatment and providing seamless services where organisational boundaries are not a barrier to access. (DH 1996). The business ethos was driven by viewing the public as consumers making choices based on available information. This concept of individual autonomy justified the creation of the quasi market (Taylor 2000). This was one of the key interventions within Equality and Excellence: Liberating the NHS (DH 2011) which stated the need to provide information to support choice and accountability.

"Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available.

Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health."

Equality and Excellence: Liberating the NHS (DH 2011) page 13.

Mental health nurses often act in a way that assumes responsibility for the client and make decisions that they believe are in the best interests of the client and this needs to be balanced with an awareness of the service users' autonomy (Petro-Piri et al 2013). New Horizons (DH 2009, page 26) states that personalisation agenda of autonomy and control are important in mental health. "It reflects a more general move towards personalised public services, but has particular resonance in mental health, where autonomy and control are in themselves important factors that contribute to, and are a measure of, recovery". CHMNs must balance a sense of care and control within their practice and at times cannot give service users choice in their care (Chambers et al 2014). Mental health policy and law contains the duality of empowerment and control for example the use of Community Treatment Orders (MHA 1983 amended 2007). CTOs extended restrictive powers by mental health services over service users in the community (Banks et al 2016). These were applied to clients deemed prone to relapse and associated risks. Although this was viewed as providing care in the least restrictive setting, critics suggested this represented cost savings through deinstitutionalisation (Banks et al 2016). The personalisation agenda was a progressive departure from

paternalism and institutional care. It was in keeping with individualism and neoliberal views of personal responsibility.

The Recovery model was a social movement influencing mental health service development around the world. (Warner 2010). It promoted the concepts of building a meaningful and satisfying life even in the presence of ongoing mental illness (Barker and Bucchanon Barker 2011). This ethos was viewed positively as enabling those with mental health problems to have more of a voice and be involved in decisions about their care. Liberating the NHS: No decision about me without me (DH 2011) cited the importance of choice and individuals' responsibility for their own health. The Recovery approach requires mental CMHNs to be both professional and objective in following treatment protocols and empathic and client centred (Woods et al 2019). There is evidence to suggest that self-management strategies, such as coping skills and psychoeducation alongside standard care, improve outcomes for those with SMI (Lean et al 2019). Critics view the self-management approach as a way of diverting service users away from statutory services by encouraging the use of third sector support (Wanless 2006). The contemporary approach to self-management does not liberate the service user from the control of mental health services but instead makes them responsible for their own adherence to prescribed treatments (Howell and Voronka 2012). This approach assumes there is a common goal for recovery and that services are configured to minimise dependency (Collins 2019). This thesis will consider if this view of service users' degree of responsibility for self-management, affects the CMHNs decision making regarding service provision.

Spandler and Stickley (2011) suggested that mental health policy used this language whist endorsing socially laden expectations of those with mental health

problems. These included being productive, employed and generally socially included. These statements were supported by a societal culture which was compassionate and inclusive. Twenge et al (2010) suggest that in a market driven society inequality and poor mental health increases. CMHNs often worked with clients whose mental health problems were caused or exacerbated by social inequalities. Welfare reforms have left vulnerable groups, such as those with serious mental illness, in poverty. There is a mental health disparity in societies where there is an inequality in wealth (Elliott and Masters 2009). There are limited alternative support systems as third sector services are also experiencing funding reductions (Gilburt 2015). The recovery approach had limited impact on social and economic conditions (Elliott and Masters 2009).

The Care Act (DH 2014) was introduced for codify the personalisation agenda. It aims to put service users and carers firmly in control of their care and establish their legal entitlements. It introduced a broad definition of well-being and the importance of preventative measures to mitigate against avoidable deterioration (Barnes et al 2017). The application of these principles was intended to be individualised with client outcomes at its core and was led by service provision. The challenge for Local Authorities was that this made it difficult to monitor overall outcomes (Barnes et al 2017). It provided a statutory framework for services users' and carers' legal entitlement to care and gave Local Authorities the responsibility to decide which cases were state or self-funded (DH 2014). The decision regarding financing was the responsibility of the Local Authority, whilst the decreasing source of funding came from central government (Schwehr 2016). Hopkins and Laurie (2015) suggested that this was in keeping with the political rhetoric of individualism and personal responsibility. It can be viewed as a positive move leading to a broader view of what support systems can help (Bogg 2015).

However, it further complicated the relationship between health and social care as the latter remains means tested (Hopkins and Laurie 2015).

Integrated health and social care have been a long-standing public policy agenda (Neenan and Birrel 2018). For this to work effectively for the benefit of the service users the nature of this integration needs to be clear (Woodbridge-Dodd 2018). There needs to be time, and clear leadership to establish good working relationships for the workforce to be effective (NHS providers 2018).

The NHS Service with Ambition (DH 1996) stated the importance of preventative work. This included the introduction of a telephone advice service and the promotion of self-management. Subsequent policies also endorsed the importance of self-management (New NHS Modern and Dependable 1997, Our Health, Our Care, Our Say 2006). Advocates suggested that this this allowed for greater holistic care of a population, it followed Health of the Nation guidance that re orientates health policy more in the direction of disease prevention and healthy lifestyle. This placed an emphasis on the public taking responsibility for their own lifestyle choices (Tritter et al 2010). The Five-Year Forward View for Mental Health (DH 2017) pledged to "*tackle the burning injustices that persist in our society, including the inequalities caused by poor mental health and the continued inability of many people to get the mental health treatment they need"* (page 2.)

Kotecha (2017) suggested that the aim of the Five-Year Forward View for the NHS was to close the funding gap. This plan was based on several assumptions, including the belief that prevention reduced the burden on services. It also linked mental health outcomes to employment requiring the Health and Work Programme to commission evidence-based health orientated interventions which increased employment (DH 2017). There was evidence to suggest that

employment was beneficial for those with serious mental health problems, by increasing social inclusion and a sense of purpose (Boycott et al 2015). Social inclusion through employment provided mental health service users with a social identity, status, and social contacts (Lelliott et al 2008). However, those with serious mental illness were the disability group least likely to be in work (Schnieder et al 2007).

Previous policies had sought to increase employment of those with mental health problems. The Welfare to Work Scheme (DWP 1997) aimed to reduce the number of social security claimants of working age (Schneider et al 2007). The social exclusion unit state, that the way of tackling the exclusion of those with mental health problems was to address their level of unemployment (SEU 2004). No Health without Mental Health (2013) had targets regarding reducing the number of people experiencing stigma. It stated that the biggest barrier to employment was stigma and that individuals required support to re-enter employment. Better Access to Mental Health by 2020 (DH 2014) cited the impact of the economy of unemployment and mental health:

"A recent study estimated that mental illness costs the United Kingdom economy as much as £100 billion per year."

"44% of Employment and Support Allowance benefit claimants report a mental health and/or behavioural problem as their primary diagnosis." Better Access to Mental Health by 2020 (DH 2014) Page 1.

This policy was in the context of reducing public spending. It may be that savings are achieved by ensuring that a mental health label is no longer a guarantee of welfare. The Time to Change anti stigma campaign, launched by the Five-Year forward View for Mental Health (DH 2017). This campaign was guaranteed

funding of £12.5 million. This is a low-cost campaign when considering the effects on the wider economy of mental health and unemployment. Its introduction coincided with the recession (Evans-Lucko et al 2014). Employment can have a positive impact on and individual's mental health by providing structure and a sense of achievement (Sage 2013). However, the UKs stringent benefit system is restrictive and disempowering and contravenes the recovery orientated approach offered by CMHNs (Dwyer et al 2019). The Five Year Forward Plan (NHS England 2014) and the NHS Long Term Plan (NHS England 2019) state that those with SMI need to be supported to return to work. NHSE (2019) implemented the Individual Placement and Support Plan. This scheme has been implemented nationally and requires CMHTs to refer people with Serious Mental Illness to employment support schemes. Since 2019, Trusts have been required to provide data on the number of Service users, in contact with these schemes. In 2023 NHSE provided more detailed guidance to ICBs to monitor performance, delivery and outcomes for Service users referred to these schemes.

In summary, policy includes rights and responsibilities for service users in relation to their care and treatment. There has been a steady move towards personalisation and choice with an increasing emphasis on self-management. This can be viewed as a move away from institutionalisation and paternalism towards an approach that is enabling and inclusive. However, it can be viewed as driving an agenda of personal responsibility and productivity, to steer service users away from state provision. This duality may be reflected in the role of the CMHN, who are required to be individualised and client centred within the boundaries of service led outcomes and strict limitations on welfare.

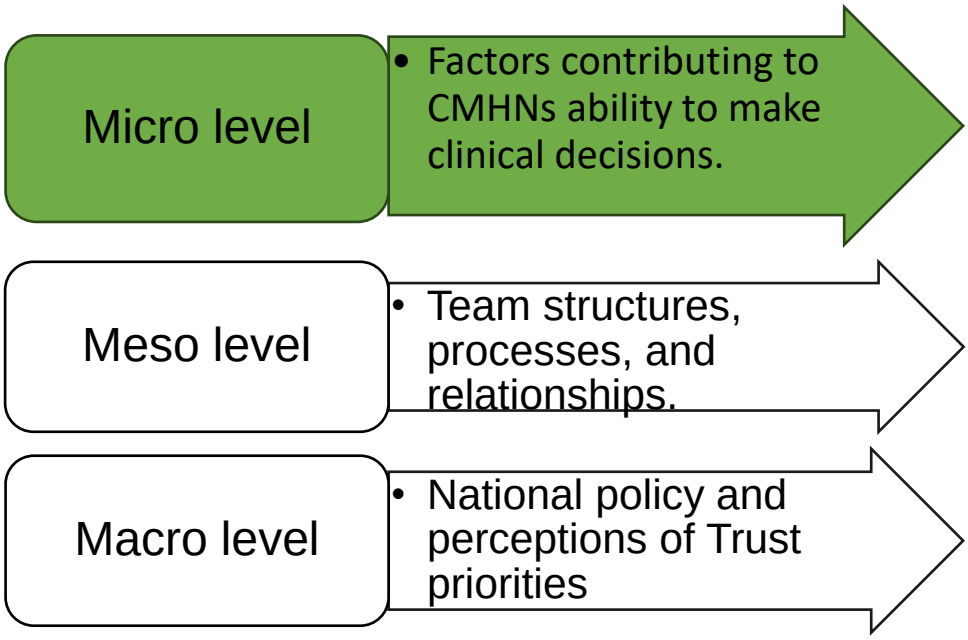
6.7: Summary

This chapter has examined policy issues in relation to the role of the CMHN. It has discussed the steady move towards payment by results and the subsequent service reconfigurations, altered funding arrangements and outcome measures. The role of the CMHN has been subject to increasing autonomy and educational attainment. However, this staff group has also experienced declining numbers due to recruitment and retention issues. Subsequent workforce planning has led to the creation of advanced practitioners, second level nurses and a range of support roles and apprenticeships. The service user rights and responsibilities promote the approach of recovery orientated personalised care. This is consistent with the rights for choice and empowerment advocated by the service user movement. It also drives the diversion of those with SMI away from dependence on services into social inclusion and economic productivity. This thesis will consider how influential these factors are in CMHNs clinical decision making.

Chapter 7: Factors contributing to CMHNs ability to make clinical decisions.

7.1 Introduction

This chapter presents an analysis of the micro-level data. That is the participants' perceptions of their role and personal contributions and the chapter addresses the themes identified through the analysis of the empirical data derived from the semi structured interviews. The first theme will address intrinsic motivation, that is the factors which give the participants job satisfaction. The second theme will consider participants' experiences of accessing training, developing skills and their perceptions of their professional development and how these impact on their clinical decision making. The third and fourth themes detail accounts of the types of knowledge used by CMHNs in making decisions. The third theme addresses intuitive knowledge, that is based on their perceptions and instincts, grounded in experience. The fourth theme considers empirical knowledge, based on intellectual evidence and procedural understanding. The fifth theme details accounts of participants' perception of their workload, that is the amount of work they are expected to undertake. This invariably has an impact of their work-life balance, which is discussed in theme six. This is further explored in addressing participants' view of their sense of autonomy (choice and control over work) and morale (enthusiasm and commitment) in themes seven and eight respectively. Theme nine considers the participants' use of diagnostic terms to discuss the service users and efficiency language to discuss their work. Finally, themes ten and eleven, address the participants' views of service users in respect of expectations of self-management and accounts of client centred care.



7.2: The value of Intrinsic motivation.

Four participants commented on their intrinsic motivation, the factors that motivate and reward them in their working day. This also includes their motives for becoming a mental health nurse and how they still hold those values, despite the challenges. This example, from a participant with over 20 years' experience captures the elements of a belief in the work, a desire to help and pride in the ability to cope.

AA4*: Absolutely, I mean anyone coming into a health care profession has to have these intrinsic values and motivation, for their career and daily work. That is a powerful motivation, and it makes you more resilient. I can speak from personal experience, I like to believe I am resilient, yes but what keeps me going is the desire to help people, who are in need. That gives me a lot of satisfaction. It is a very powerful, intrinsic energy. I wake up in the morning, get ready and go to work. If I help somebody that day to improve their lives, I am happy.*

One participant expressed ambivalence about direct clinical contact: it is the most rewarding aspects but also the hardest. The emotional labour involved in clinical

work is fundamental to intrinsic motivation but also can lead to exhaustion and burnout (Smith and Lorentzon 2005). This is especially prevalent if this aspect of the work is not supported at leadership level (Campling 2015). However, supportive, and ethical leadership can help ameliorate work stress and emotional labour (Mauno et al 2016).

BD3: *I think I would like to get away from front-line work, at this moment in time, I am not interested in being a senior. That role is way too big for me. I would like to be doing more audit work, maybe, I don't know. I do enjoy parts of my job, but I don't enjoy the bureaucracy.*

The data above, demonstrates how participants still find service user contact rewarding and motivating. Motivation is often voiced in terms of altruism, need to care, and pride in professional identity (Ballatt et al 2020). This is an example of satisfaction which arises from internal belief and self-determination. This is in contrast with the impact of external demands the approval associated with meeting targets and concerns about performance anxiety (Cilliers and Terblanch 2010). This is also evidence in how the participants talk about the value of the therapeutic relationship and providing client centred care (Onyett 2011). The codes relating to the service users' role, namely self-management, and service user centred care, will be discussed later in this chapter. Continued professional development, that is education, training, and career progression, are key factors in maintaining staff motivation (Mlambo et al 2021).

7.3: Training skills and perceptions of professional development.

The participants were asked about their plans for professional development. They also referred to the skills required for their job when discussing aspects of their

clinical role. This theme covers access to relevant training and considers if this is valued by participants and organisations in the current climate of efficiency, cost savings and under staffing. Training, skills and professional development are relevant to the CMHNs self-concept and sense of autonomy. Relevant professional education positively impacts mental health nurses' skills and knowledge and ultimately their ability to exercise judgement and accountability (Cleary et al 2011). The type of team a CMHN woks in may determine the skills they require. In Trust A, where the team is sub-divided into two diagnostic sub teams, the participants describe being skilled in working with a particular client group but deskilled in other areas.

AA1: I think if you work in a varied way, I think you can transfer skills that you have gained by working with different types of clients. It would benefit the service users for the staff to be skilled with different presentations.

In Trust B one participant described having the opportunity to develop therapeutic skills as they had expressed an interest in working with Service Users with personality disorders.

BM1*: I had an interest in this work anyway but that really sparked a fire and that is the client group I have always wanted to work with, so whenever I have seen an opportunity to work with that client group within the team, I have gone for it. I have negotiated for that to fit in.*

Two participants spoke about the training they would like to do, and one commented on limited access to training.

BD5: *I am about to start training so that I can help with some of the therapy work that goes on, in the community team, which will be interesting.*

AA1: *CPNs don't tend to go for this, maybe because they are too overwhelmed. I see examples of this all the time, because even if you did this training, you would still have the same caseload size and it is difficult to juggle the two. You might do it and end up leaving, or your hands are in so many things that it can become too much.*

The amount of data on training from participant interviews, and development is small. A culture of education and training is invaluable in addressing all the sophisticated skills, awareness and qualities needed in nursing (Malin 2017). Continuing professional development programmes which develop knowledge, promote active enquiry and facilitate skills of evaluation, are essential in developing effective clinical decision-making in nurses (Jackson and Manley 2021). The complexities of contemporary mental health care require training and education to enable CMHNs to practice competently and autonomously (Adams et al 2021). Clinical autonomy, including the responsibility for decision making and recognition in the multi-disciplinary team leads to greater job satisfaction for CMHNs (Goetz et al 2017). The ability to make clinical decisions is linked to a clear sense of professional identity. The transformational aspects of professional education are valuable in promoting this (Joynes 2017). However, current financial pressures and the logistics of releasing staff to attend training makes this a challenge for NHS Trusts (Ballatt and Campling 2011). Work pressures, fatigue and lack of perceived organisational support are seen as barriers to accessing continuing professional development (Mlambo et al 2021).

Nationally, the funding for training prioritises Improved Access to Psychological Therapies and Child and Adolescent Mental Health Services staff (Health Education England 2022). These are areas that are also priorities in the NHS

Long Term Plan (NHS 2019) which defines commitment to improve access to these services through greater investment. The participants in this study are CMHNs in generic CMHTs, supporting service users of working age with long term mental health problems. This is complex and challenging work and CMHNs need a range of skills and knowledge to make sound decisions about the care of this client group. Education and training are invaluable in supporting mental health nurses in developing intuitive and empirical knowledge and skills (Adams et al 2021).

7.4: Intuitive knowledge: The value of gut feelings and the therapeutic relationship.

The theme Intuitive knowledge refers to the CMHNs ability to "sense" that something is not right, even in the absence of obvious empirical evidence (Welsh and Lyons 2001). This theme gives examples of participants' making decisions based on their knowledge of the service user. It also captures the importance of compassion, potential to help, the value of the therapeutic relationship and a positive sense of autonomy. This is a contrast to the standardised, reductionist and diagnostic led criteria used to make decisions, which will be discussed in chapter eight. The following examples show the use of "gut feelings" and seeing the Service Users' needs in context, rather than purely in terms of diagnostic or inclusion criteria.

AA3: *There was some conflict for me there, I wondered if he was unwell enough for us to take him on or are we being used to renew his papers. I decided not to take this man on, but it was a big conflict for me because, I have issues when I see someone from my country, I tend to have a soft spot and feel bad.*

BD5 *You are not sure what is going on, but you get the feeling that there is something not right.*

BD3: *It is also the detective work, one of my skills is reading people, and reading the situation. You get a situation where you think "something isn't right here".*

Intuition enables a mental health professional to experience a situation, where concrete information has limitations (Melin-Johnasson et al 2017). The discussion to follow in chapter eight about care pathways and standardised criteria, demonstrates that a reductionist approach to decision making regarding service inclusion is a major factor in decision making. Two participants directly stated the importance of the therapeutic relationship.

AA3: *Sometimes I bring my patients in for a chat really, just to sit down with them, listen and you know, just be there. The therapeutic use of self and being available.*

BD5: *I am pretty sure that if a CMHN had a good therapeutic relationship with someone then they would have them back onto their caseload. It makes much more sense, doesn't it?*

The amount of data on intrinsic motivation and intuitive knowledge is relatively small. This may indicate that this is relatively uncommon in the participants' experiences. Intuitive knowledge is rarely acknowledged in contemporary mental health nursing practice (Witteman et al 2011). Menzies-Lyth (1988) says that nurses are exposed to emotional pressures through developing a relationship with those in their care. Organisations are structured to avoid this and so their senior colleagues do not experience this (Menzies Lyth 1988). Therefore, this is not a concept that is always appreciated by team managers. This is highlighted in the section workload and reluctance to discharge.

7.5: Empirical knowledge: Professional or procedural.

The use of CMHNs empirical knowledge will be considered alongside Intuitive knowledge as both forms are considered legitimate by nurse theorists. A combination of evidence-based guidelines and an empathic understanding of a client's needs are necessary for making crucial decisions about the needs of clients with complex mental health needs (Welsh and Lyons 2001). This section is concerned with how this is invoked at an individual practitioner level. Empirical knowledge includes the application of facts, models, theories and thematic definitions and constructs (Zanotti and Chiffi 2015). It may be intrinsically held as it is part of professional identity and practice. The researcher's assumption was that the participants would cite research, what they had been taught in university or in further study or maybe even their code of professional practice. However, the data refers largely to the use of standardised assessment schedules, these were described as they appeared in the local operational policies. Three items of data from two participants illustrate this, the emphasis is on diagnosis, with an additional "checklist" of social factors, risks and client motivation to engage:

BD2: *So, in the initial assessment we would need to start with the presenting situation, of what is going on and why they have been referred to our team. We look at the past and any past psychiatric history if they have previously been known to our team. We need to pull that together and see what has been offered. Maybe if they had disengaged, having a really good idea what this patient is all about. We need to know all about their family history, and obviously their risks as well. If they are not known to our team, we still need to know any historical risks. They ask about social circumstances, drugs, alcohol. We also need to have an idea about what their expectations are. Quite often it is about managing the*

expectations of people coming for assessment. It is about trying to understand what is going on. It might not be about our service; we can look at other services and organisations that can look at what's happening. Obviously, we also look at their medication and physical health as well.

The presence of a diagnosable mental health problem is key, followed by risk and social factors. This participant emphasised the importance of managing expectations and considering if another service might be more appropriate. A key factor considered here is evidence of past disengagement and not following past discharge advice. The Community Mental Health Framework (National collaborating centre for mental health 2019) suggests that CMHTs need to adopt practices that are inclusive and flexible and move away from rigid criteria and narrow service parameters. The NCCMH (2019) acknowledges that the ability to do this is limited by lack of resources.

Trust B operational policy states "*By reviewing their needs, this process enables us to understand and monitor if a person's situation changes to ascertain if they can be better helped by another service, or no longer requires CMHT care."* (Trust policy 2020). National and local policies emphasise the importance of self-management. This creates an expectation that Service Users will follow discharge advice. This will be explored in more detail in the code "Service User Self-Management".

The organisation encourages this approach based on the self-management approach to long-term conditions. Neoliberalism views mental illness as a failing in the individual and not the structures around them (Minta 2020). This may become internalised by the CMHNs as a method of minimising dependence on the service and controlling their workload. Healthcare staff may use the mental

defence mechanism of rationalisation to protect themselves from being overwhelmed by the service user's dependency and vulnerability at a time when they feel unable to cope. In addition, they internalise the organisational pressure to protect resources, control demand and manage their workload (Campling 2015).

7.6: Managing the workload:

This section captures participants' views on the amount of work they are required to undertake. The most shared focus is on caseload size. That is the number of service users assigned to the CMHN for ongoing care coordination. Participants describe having caseloads that are "too big" and that they are under pressure to discharge service users. Some participants view discharging service users as a solution to their workload issues, whilst others are reluctant to do so if they do not feel that the service user is ready. Participants also cited the amount of time spent on paperwork and populating audit systems and time spent in meetings as having an impact of their workload.

Four participants suggested that the number of service users they were care coordinating was too high. Trust A participants did not quote the size of caseloads but did comment on how this impacts the quality of their interventions. Bailey and West (2021) health and social care staff are experiencing excessive, chronic workload pressures.

BD3 *Initially I was given a few and told that I would be eased in slowly. Then I had 35 people on my caseload and was told that I wouldn't get more than 40. It ended up going to 45 at one point, because we just didn't have the staff. At the moment it is 42 thankfully, 43 actually because I volunteered to take somebody yesterday.*

Participants say that this has a negative impact on the quality of care they can provide and that they cannot see the clients as often as they should. Three participants in Trust A and one in Trust B.

AP2: *You can look at your cases and think that you haven't seen this person for a long time because there might be a few of them in crisis that you are concentrating on and so you kind of neglect some of them. So, when you come back you think "I haven't seen this person, or I haven't spoken to that person" Then you are not really following the plan as you are meant to see them every two weeks and not every three weeks. It all depends on the caseload really.*

BD2: *Most of the time they would need allocation, to one of the CMHNs. That is where our team are completely overloaded really, if we have got someone that the team leader has got to allocate, she has got a list, the staffing is an issue, people have got such big caseloads. That is a really difficult aspect of the job at the moment.*

This has resulted, in both Trusts for organisational directives to reduce caseload sizes. The emphasis is for managers to meet with clinicians to discuss their caseloads and decide who can be discharged. This is an example of a command-and-control approach to managing workload. It disempowers frontline staff, using a top down, organisation-wide approach to meet regulatory requirements (Ballatt et al 2020). (Eight items of data refer to reducing caseload size).

AP2: *We had a meeting recently with the locality manager, and she was thinking of starting, what you have just mentioned, she is thinking of meeting up with us to sit down with us and look through our caseloads.*

AP1: *Yes, in supervision you need to bring what you are worried about, what you are struggling with. …….. If you are struggling with your caseload, we look at who can be discharged, who is settled, how long have they been settled.*

The CQC inspected Trust A in 2021. It was noted that there was a variation in caseload size, and that the upper limit was 35. It was noted that numbers did not account for the complexity of service user needs. Trust A had developed a caseload weighting tool. However, this had not been implemented due to COVID. A CQC inspection in Trust B in 2020 highlighted the large caseload sizes for CMHNs. The action plan from the Trust was to continuously review caseloads through clinical supervision and documentation checks. In 2022 the CQC carried out another inspection and suggested that caseloads were within the expected range. They noted that although team managers were monitoring caseloads the complexity of the service users meant that staff continued to feel pressured. The current culture of healthcare is not suited to the therapeutic and emotional nature of the clinical work (Ballett and Campling 2011). Clinical supervision in mental health, is intended to address this. However, it is increasingly become a vehicle for managerialism (Ballatt et al 2020). Participants describe their reluctance to discharge service users that they are concerned about. There are six items of data which cite participants feeling under pressure to discharge.

AA2: *People have so many clients they don't want to take any more on. Then you have to discharge someone to take another client on.*

AA3*: I have had two people on my caseload for two years now. There are some people that you can't discharge, regardless of the organisational policy. I know some people say that they don't want to get themselves into trouble, but for me it is about the welfare of my patients.*

The reluctance to discharge service users may be viewed by managers as fostering dependence. The managers may be responding to organisational pressures to reduce caseload size.

AA3: *My manager called me to say hello and ask me if I am in today, but it was all about telling me to discharge patients asap. I said to him, has he gone through my caseload. Does he want to tell me who to discharge as I am the one working with the patients*?

BD2: *I don't know, I think that sometimes if you develop a relationship and you have worked with that person for a long time, I think then it becomes very comfortable. I think then the patient and the professional…there is no kind of shift, or a reason to change. It is only when someone from outside comes in, and you're like the "bad guy". You are asking "what's going on…what's your care plan about? Can this be met elsewhere?" If you don't do that then things just carry on for years and years. That's the way it will go sometimes.*

CMHTs are an example of stretched services where demand constantly exceeds supply. Frontline staff develop coping strategies to manage workload, even if these have negative consequences for the client group (Lipsky 1980/2010). Where inflow exceeds output, staff may discharge service users, often when they are not considered ready (Berlin et al 2021). However, in this instance the pressure to discharge is generated at organisational level and implemented at team level. The staff reaction to this is mixed, with some staff resisting this on the basis that the service user is not ready. Whilst others see this as a positive strategy for managing their workload. This appears to be enacted by the CHMT managers who can either be viewed as supporting staff or undermining their autonomy in managing service users on their caseloads. Nurse managers are

often caught between maintaining the organisational domain of strict rules and defending against the anxieties this causes the staff (Cilliers and Terblanche 2010).

7.7: Work life Balance: The personal cost of meeting demands.

The participants' accounts of their workload inevitably led to discussions about their work-life balance. Work life balance involves an individual having sufficient control and autonomy over where and how they work. This enables them to fulfil their responsibilities in and out of work and have a good quality of life (RCN 2022). The health and wellbeing of nurses is vital in enabling them to provide quality care and act with compassion and professionalism. Nurses and other healthcare professionals are subject to chronic and excessive work demands (West et al 2020). This can result in them being unable to meet these demands which can lead to feelings of failure and guilt. This presents a conflict between what the nurse feels they should be doing and what they are able to do due to constraints. This can lead to moral distress (Rushton et al 2017). Participants commented on working long hours and how this impacted on their wellbeing:

AA1: *Yes, I think this is because they have tried to adapt and that they are a bit burnt out. People are choosing their health and their family over the job and good luck to them. Some of us are not doing that and you can see that we are slowly but surely making ourselves ill. I worked until 12.15 am last night. I picked up an e mail from a member of staff today sent at 11pm and I replied, "Why are you still working" and they replied, "What about you?" *laughs**

BD3: *It was the frustrations of that, always having to hit targets, I was getting to the point where I was getting more and more angry and I thought "that's it, I'm done." I realised that I had to stop.*

NHS staff frequently work beyond their contracted hours to deliver a service. However, this is unsustainable in the current climate and will invariably lead to burnout and ill health (House of Commons 2021). Neoliberal policies have resulted in an underfunded NHS, unsafe staffing levels, poor recruitment, nurses are leaving, retiring or on long term sick leave. The remaining staff struggle to provide a service. The approach of demanding greater output with less resources is destroying morale (Zigmond 2021). The NHS Staff Survey (NHS Employers 2022) 43.2% of staff say that they can meet the conflicting demands of their time at work (a five-year low). The main reason for working longer hours, cited by participants is the need to complete documentation and populate audit systems. The process of documentation checks at team level and the organisational culture of overwork will be discussed in Chapter eight. There are five pieces of data relating to time spent on documentation.

AP1: *Yeah, sometimes it does, I am not going to lie. Sometimes, even before I was acting up (as temporary team manager), I would be sitting at 10pm filling it in, so that I can keep up with my work. I take my work home, which is not healthy, but to keep up, I have to do it.*

BD5: *Yes, usually I bring my laptop home, and I do a lot of my writing and reporting at home, because the whole day has just been taken up with that sort of thing. That is getting more and more.*

Participants describe how their time to see service users on their caseloads is limited due to time spent covering the duty crisis rota and by time spent in team meetings. The comments about time spent in meetings comes from participants in Trust B. Their teams are very large and so follow structures which means that all new assessments and ongoing cases must be reviewed. The team meetings

in Trust B are very long, sometimes lasting over three hours. The operational policy sets out a structure for these meetings. A significant part of these meetings is taken up with discussing service users who have been assessed to decide about whether to offer them a service. When observing the team meetings, during a preliminary visit, the author noted the pressure to “get through all the new assessments”. In Trust A the subdivisions make the teams smaller and the meetings shorter. In Trust A the RAG rating is used for meetings three times a week, with one longer MDT meeting.

BD3: *There was one yesterday. I ended up, well, I generally don’t sit for the whole 3 hours as I get so fed up with it. It starts at 11am, it finished at 2 yesterday, and we have a 45–60-minute meeting every morning as well. I spend 5 to 8 hours a week in meetings.*

BD5: *I do initial assessments once a week, that is three in one day, they are new referrals. The rest of the time, I am going round visiting my patients, giving depots and having patients come in for appointments and reviewing them, in the remaining four days. I sometimes take part in duty, which is like the triage part of the community mental health team, it’s about three and a half days which isn’t enough to feel like you have given enough support for the whole caseload.*

In the section addressing autonomy it is highlighted that managers prefer CMHNs to come to meetings with a clear decision as this saves time. Ballatt et al (2020) suggest that NHS teams tend to be large, may have conflicting objectives and approaches between disciplines, making decision-making challenging. This raises the issue of how valuable meetings are in helping staff make decisions if they are so time pressured. The need to present all new assessments at a team

meeting would appear to be an organisational requirement. Perhaps sharing this information in a formal setting, even with limited discussion, facilitates the redistribution of responsibility which protects the practitioner and team from anxiety (Menzies-Lyth 1988). Bailey and West (2021) organisations add processes rather than taking them away which adds to staff stress. Heavy workloads, leave little time for quality work and personal development can increase stress and undermine nurses' sense of autonomy (Pursio et al 2021).

7.8: Autonomy: responsibility without agency.

This section refers to the participants' accounts of their perceived freedom to make decisions and the sense that their professional judgement is valued. This is validated by their sense of their role and identification with their professional group. This may be exercised in terms of their clinical decisions and opinions about the service. Autonomy involves nurses having control over their work life and being able to act in accordance with their values (West et al 2020). Autonomy and control were a category in the NHS Staff Satisfaction survey (NH Employers 2022). According to the National results 90.4% said that they felt trusted to do their job. Whereas 53.3% said that they had a choice in how to do their job. This suggests a high degree of expectation from the organisation with limited control over how to carry out their duties. Participants describe positive experiences of being able to exercise autonomy in undertaking assessments and deciding to offer a service. (six items of data).

AA3: *Most of the time, I tend to make that decision, but when it is difficult, when you are not 100% sure, the good thing about our team and I am sure it is like that for most community mental health practices, that although we are autonomous*

practitioners, you can still take things to your team. You can then make a joint decision.

There are aspects of the work that promote autonomy, a participant in Trust B, has a specific interest in working with Service Users with personality disorder. They describe how this gives them a sense of autonomy.

BM1: *My specialist area of interest has always been to work with people with personality difficulties. So, I have been able to specialise my role a bit more. Currently, I co facilitate a twice weekly DBT (dialectical behavioural therapy) group. I do something called the "change programme" which is an 8-week extended assessment programme for those with personality difficulties and that is 1 to 1.*

Team Leaders view autonomy as the CMHNs being efficient as they present "quickly" in meetings and don't require much discussion. This supports the efficiency agenda of using less resources.

BD2*: I think some clinicians come in and they know what they are doing. They have been thorough but can narrow the assessment down. Timing is important because we do struggle when people are talking, and we have a patient's life history and we have got 20 people to discuss.*

Two participants in Trust B describe the psychiatrists as having ultimate responsibility. The role of the multidisciplinary team members will be discussed in more detail in Chapter eight.

BM1: *It tends to be a joint discussion, but I think that very often the medics will have the last word.*

This is also moderated by team meetings where standard criteria are referred to.

BD5: *I have had the odd time where I have looked at a patient after assessment and felt that they need input from the service and meets the criteria for secondary care. Then it has been discussed with the team and they don't feel that they are suitable and should be referred back to the GP.*

Two participants spoke about presenting cases to social services for care packages. They suggested that although they know the service user well and want the best package for them, due to financial constraints, they feel that their opinion is overlooked.

AP2: *To me, it is very challenging, and sometimes I find it difficult. It feels like you have to prove yourself, if you don't, then you are not going to get what you asked for.*

Two participants referred to the differences between bands five and six. Band five CMHT posts are developmental, with a view to developing into a band six. They are supported by senior staff and work with "stable" clients. In many ways, less responsibility than a ward band five who may be the most senior person on duty, caring for acutely ill clients.

BD4: (Band five) *I feel that the two roles are fairly similar, I don't think there is a huge variance in that to be honest. I do like the level of autonomy that I have. I can plan my schedules, I mean, obviously I have to be here between nine and five. However, within that I can plan my own schedule and decide what I do and when.*

AA1: (Band seven) *I think that the experience of the nurse is also necessary and in community teams you tend to take decisions by yourself at times and to do that*

you need experience. A newly qualified band 5 nurse in the community could not do that.

This illustrates different interpretations of autonomy, this may be based on their respective levels of experience, investment in work and perceptions of their roles. The band seven nurse is describing clinical autonomy, which involves accountability for decision making by nurses (Kramer et al 2006). The band five nurse is describing work autonomy, that is the ability to exercise control over the organisation of day-to-day work (Kramer et al 2006).

Two participants spoke about the process of senior team members, such as the nurse managers, and senior representatives for the other disciplines, screening referrals and holding "step down" panels. These decisions are not made by individual clinicians.

AA4: *So, basically a referral comes in, it goes into an inbox, and this is all admin work here. Admin will put that on a spreadsheet, we'll meet up, the consultant, myself (senior nurse) and the lead psychologist. We screen those referrals, and based on the screening, we will choose the pathway most appropriate for that person on that day*.

AP2: *If you have a client that you feel needs to be stepped down, you can present them to the step-down panel.*

Lipsky (1980/2010) suggests that managers in public services, often try to restrict workers' autonomy, to secure certain results. The rationale for this may be so that a standardised approach to service inclusion and reducing service input, can be applied. This is potentially a mechanistic approach which guards against the potential for CMHNs clinical judgement about service provision, where there are pressures to rationalise services. There needs to be a balance between individual

clinical responsibility and managerial measures. The individual clinician may know the service user but there may be variance within clinicians' opinions and provision will need to be moderated (Ballatt and Campling 2011). The NHS staff survey suggests that there is a positive correlation between autonomy and morale (NHS 2021). That is, the greater sense of control and involvement the staff member has over their work, the more positive and motivated they are.

7.9: Morale.

The theme Morale encapsulates data which describes participants' feelings regarding their commitment, enthusiasm, motivation, and job satisfaction. Morale is a complex phenomenon; it is difficult to define and can be described positively or negatively. Morale is a level of psychological well-being based on such factors as a sense of purpose and confidence in the future (Kessler et al 2021). It is key in NHS settings as it is linked to quality, performance retention and recruitment. Morale in the NHS is influenced by several key factors. These include staff feeling valued, supported and listened to. It can be affected by the working environment, including issues such as low staffing and changing workloads (Marsh and Proctor 2022). The National aspects of resources and pay also have a widespread impact (Findlayson 2002). The participants gave negative accounts of how work impacts on health, stress, and wellbeing (four items three participants).

AA1*: I take it all on myself to be honest. After a while it feels as if you are letting off steam, then you are moaning, and you don't want to feel like you are moaning. The previous manager that was here thought "my health or work" and they chose their health, and they requested a secondment.*

AP2: *The cases are building up and staff are getting stressed. Morale has gone down, so they have to do something about it.*

Four participants describe not feeling listened to when they raise concerns and experience a disconnect from senior management (six items, four participants)

AP2: *I am not sure if they listen to something like that as I haven't really been times when issues we have raised have been promptly responded to. I am not really sure if they do listen to our needs. I don't think they have listened to or acted quickly, to help us resolve the issue.*

BD3: *Priorities generally speaking are targets. They haven't always been targets but there has always been a lack of care, for what the staff are going through.*

The perception is that senior managers beyond the CMHT are not interested in the problems experienced by clinicians. CMHNs may be externalising the conflict they experience in trying to deliver quality care in the face of increasing demand (Hinchelwood 2010). The organisational demands placed on senior management, to maintain target monitoring requirements may mean that they feel removed from the realities of clinical practice. It may be easier for them to focus on tangible outcomes, than on the complexities of relationships with clinicians (Cilliers and Terblanch 2010). Clinical staff may not feel involved and consulted in aspects of organisational change and priorities (Ballett and Campling 2011). CMHNs manage their workloads with limited resources, often having to prioritise. This may be endorsed by managers and satisfies their drive for productivity and efficiency (Lipsky 1980/2010). Staff then experience this as a lack of concern for the client group and for their wellbeing. This leads to a culture of fearing punitive sanctions when organisational priorities are not met (Hanley et al 2017). The organisational response follows a clear-cut standard procedure, which seeks to locate the focus

on the individual and their resilience and training needs. This perhaps, does not address the underlying causes.

AA4: *There is access to activities, there is staff wellbeing, there are a lot of programmes being set up, for staff, quite often. We recently had a massage chair, delivered in our lounge.*

AP1: *Sometimes you might need time off, to recuperate. Staff can go to Care Plus for counselling themselves, to talk about what they are going through and deal with their stress. If you need Occupational Health, you can go to them for support. We look at what can be put in place for you so that you can do your work properly.*

This captures an approach to staff wellbeing which is rigid, procedural and places emphasis on moral being an individual responsibility. The emphasis within the NHS approach is that of individual resilience, with the emphasis on staff seeking support to enable them to manage the demands of the work. This reflects an individualist approach, in effect seeing the problem as the staff member rather than their work situation. This has been acknowledged by Health Education England (2018) in their report: Workforce Stress and the Supportive Organisation. This report states that a long-standing approach has been one of promoting individual resilience and absolving the organisation. This is echoed in the House of Commons Report (2021) on Workforce Burnout and Resilience in the NHS and Social Care. This report suggests that the emphasis should not be on individual staff but on systems and systematic solutions. This subsequently places responsibility onto Trusts to address issues of morale. Health Education England

(2018) suggest processes of listening to staff, gathering evidence and devising solutions. They do acknowledge the impact of national issues for the NHS, such as resource allocation, restructuring and funding. However, the emphasis is not to address these causative factors at a national level, but for each Trust to determine their effects on staff and find ways of mediating their impact. Four participants spoke about how supported they felt within their teams.

BD5: *The team is really good; it is probably the best team that I have ever worked in. I mean it's a really, really supportive team. Managers are always going round thanking people, for what they have done and for their support and that goes a long way.*

BD2: *However, I do think that the intentions are there. I think there has been a lot of effort to try and be a bit more caring, towards staff and their wellbeing. I don't know if that is just to do with COVID or if it came about a little bit before.*

The role of the CMH Team Leaders seems to play a valuable part in mediating organisational pressures and the demands placed on CMHNs in undertaking their clinical work. Healthcare middle managers are caught in a mixture of complex organisational systems which require both technical and interpersonal approaches (Cilliers and Terblanche 2010). To balance these dual demands, they occasionally need to prioritise a compassionate climate over productivity (Ballatt et al 2020).

7.10: Objectification and the terminology of productivity.

The section discusses the use of productivity driven and diagnostic language. It captures examples of participants speaking about their role in relation to addressing productivity and efficiency. It also addresses their use of objectifying,

diagnostic language when describing the service users. These are considered together because, they represent a process of objectifying service users and the approach to working with them. This represents the potential reduction of the therapeutic and individualised approach traditionally associated with mental health care, to a task orientated approach, based on diagnosis. Menzie-Lyth (1988) describes this process as depersonalisation. This is a social defence mechanism employed by nurses to protect themselves from the anxiety of having close contact with distressed individuals, and the lack of control and certainty that is engendered by a sense of responsibility for an unmanageable workload. Participants give examples of how they create and maintain systems which promote efficiency and fulfil roles in managing waiting lists, such as the clinic monitoring spreadsheet described by a participant below. Participants use of productivity and diagnostic language is incorporated into their everyday clinical discourse, possibly unconsciously and has become the norm.

AA4: *Bear in mind that it is a very pressurised service. There is a long queue, people are waiting, and there is a need to work, in a fast-paced way, but equally, safe, at the same time. That is very important.*

One participant (a band 7 Advanced clinician) openly acknowledged that a large part of their role was creating and maintaining monitoring systems.

BD2: *Going back to the clinics because that is what I am more involved with, we have now got to have spreadsheets. This is good obviously, there are so many benefits, but it is a lot of work. I mean the Clozapine spreadsheet, has about 72 patients on it. It took about 12 hours to do……. To be honest if you do, I think it will really help you when we've got the CQC coming, or audits, you can get it out*

and say this is what we are doing. Therefore, we have got a system and not chaos that we have no control over.

This participant acknowledged that this activity gave them a sense of control, as well as aiding compliance with external monitoring. In fragmented services, driven by an audit culture, clinical skills are replaced by mechanical processes and systems (Ballett et al 2015). Bureaucracy and paperwork provide an opportunity to avoid "messy" clinical work and so become a "perverse" social defence (Hanley et al 2017). This participant has been recently promoted to a band seven senior clinical role. This may give a clinician a sense of purpose, where the focus of caring is currently poorly defined and unsupported (Hanley et al 2017). This can be seen as a defence mechanism, employed by the CMHN. Perhaps the ability to create systems to monitor and promote efficiency are rewarded with promotion. In the current neoliberal climate, the efficient use of resources, driven by an audit culture is encouraged (McGregor 2001). This approach is therefore seen as organisationally desirable and is rewarded and endorsed. In a climate of fiscal management of public services, staff in these services respond to the dominant demand of functioning within a limited budget (Lipsky 1980/2010).

The following data illustrates the concept of objectification and depersonalisation, discussed earlier. In Trust B there are examples of referring to service users by their medication, or their level of perceived dependence on the service.

BD2: *For example, we had an issue last week with a Lithium patient.*

There are also objectifying terms, which seem to arise from the pressure to be productive. Participants describe the need to discharge Service Users, using terms such as "get rid of".

BD2: *I can get rid of the six standard patients quite easily and transfer them quite easily because they are stable and standard care. However, the CPA patients I need to look at them to see if they can be downgraded.*

BD3*. I am dealing with that sort of stuff quite a lot and I have got clients that I need to get rid of.*

Trust A use diagnostic language as a prevailing issue as their team is subdivided into two sub teams, based on diagnosis (six pieces of data). This team subdivision is discussed in more detail in Chapter eight.

AA1: *Sometimes when it is not very clear, the diagnosis is not very clear, or there is lots of re-diagnosing, perhaps clients have been under the psychosis team previously, perhaps being diagnosed with bipolar previously and maybe with time are re-diagnosed with personality disorder.*

AA4: *We have to work on the primary diagnosis based on the clinical coding of the ICD 10 is vital. This is the framework for accepting our patients.*

AA2: *For example, if a client has 70% of their diagnosis might be schizophrenia and 30% or 20% might be personality disorder, so obviously this person would be classified as someone with psychosis.*

This participant also acknowledges the limitations of a fixed diagnosis. However, they still describe diagnosis in terms of prioritising and in a medicalised, rather than in an individualised and phenomenological way.

AA4: *Oh, absolutely a diagnosis is a continuum, and it changes, you revise it, there is a working diagnosis and differential diagnosis.*

Giving a person a mental health diagnosis can be seen as an example of labelling. The use of diagnostic labels prevails in contemporary mental health practice. This

assumes that experience of mental illness is defined as the presence of recognised categories of symptoms. This is in keeping with a medicalised view also inherent in physical illness. It implies that symptoms are scientifically irrefutable and culture neutral (Scheff 1975). In contemporary practice, diagnosis is still used as inclusion criteria within secondary mental health services. Diagnosis can be useful in providing clarity for prognosis and treatment. However, without social and personal context this is limited (Allsopp and Kinderman 2021). A neoliberal view of mental health endorses the diagnostic view as it promotes the concept of individualism and treatment of symptoms. It does not acknowledge the impact of social inequalities and deprivation nor the government's role in addressing these (Espirito and Perez 2014). Therefore, diagnosis and the emphasis on treating symptoms and risk become the focus of interventions. This can lead to a relationship between the professional and service user being dominated by organisational function, rather than in seeing the service user as a whole individual (Scheff 1975).

Person centred and holistic care are commonly used phrases in contemporary practice. They fit with the therapeutic narrative of CMHN. However, they may have been co-opted to support the political agenda of consumerism and self-management (Blunden and Caulder 2020). Participants describe their assessments as holistic, but the emphasis for inclusion and intervention is the presence of symptoms of mental illness (two participants, two items).

AA2: *We do the generic assessment face to face to see the patient, the holistic view and look at every aspect of their health. When we talk about holistic assessment, we talk about housing, your social need, your physical structure,*

your physical health, your GP, your family background, your family, if you are married, your financial circumstances, your educational background.

Trust B tend to refer to clients in terms of their stage in the care process or their medication (where clients are supported by the "clinics"). This will be addressed in chapter eight, standardised interventions. Two participants in Trust B refer to diagnosis but say this is not the only deciding factor.

BM1: *I haven't experienced that to be honest, someone not sitting in a pathway. I think that is because, the focus is on need, as opposed to diagnosis. So, whatever pathway or intervention that is going to be helpful for this person at this time, this is where they are going.*

BD3: *I say to so many patients, "I don't know if this is important, but it gives us a direction." ……you need to treat those symptoms; what you are seeing I front of you.*

This data presents a more service user centred approach to care. The participants' view of services users' involvement in their care will be considered in the next section.

7.11: Service user self-management.

This theme captures the participants accounts of how the clients are expected to be working towards self-management (11 items from six participants). The NHS Long Term Plan (MH Taskforce 2019) makes frequent reference to the importance of those with long term conditions (LTCs) both physical and mental health, engaging in self-management. There are a growing number of people living with long term conditions, accounting for 70% of NHS expenditure (Barker et al 2018). In mental health services self-management strategies often include

providing information, psychoeducation, self-monitoring of symptoms, medication concordance strategies, psychological and social strategies (Lean et al 2019). Not all those with LTCs have the capacity of motivation to engage in these strategies (Barker et al 2018). Although the rationale for self-management may be to alleviate pressure on secondary services, to be effective, it requires staff time and a flexible approach (Kings Fund 2005). The operational policy in Trust A states "*The self-management planning process commences at the first point of contact with the service user. The aim of is to identify any continuing care needs and link the individual to the most appropriate service (e.g. voluntary sector, drug and alcohol services).*" Participants in Trust A refer to service users taking responsibility and demonstrating independence.

AP1: *So, we look at how they are functioning how they are doing in the community, have they been attending their appointments, how they are engaging with other services outside, and what they are doing well.*

AA2: *It is a shared responsibility; we have some responsibility; you have some responsibility. We are inspiring hope and empowerment, what we do in our meeting is to enable you to have hope and to gain your independence, to have insight and to manage those stressors, in case they come back in the future and not to keep you for a very long time.*

AA3: *We assessed her, took her on and it was one of our most senior psychologists gave her six sessions. During the fifth one she (clients) said this is not working for me, I want another person. ……She wasn't taking any responsibility; she wasn't bringing anything to the table.*

Woods et al (2019) suggest that the self-management and social inclusion language of the Recovery model has been co-opted by Health and Social Care policy makers to advance the neoliberal agenda. The subsequent policy aims are to reduce dependence on welfare and get service users back to work. The ability and desire to work has become an indication of good mental health (Espito and Perez 2014). The NHS Mental Health Dashboard (NHS 2022) requires trusts to monitor how many service users with serious mental illness are in contact with employment support agencies.

Another key expectation of service users is that they engage with the service provided. NHS England (2018) state that two million pounds are wasted each year on missed appointments. Mental health service users are more likely to miss scheduled appointments, than those with physical health problems (Mitchell and Selmes 2007). Filippidou et al (2014) state that the DNA rates for mental health service users are double than for any other health conditions.

The operational policy for Trust A says that service users who do not attend will be asked to contact the service within two weeks to confirm that they still wish to be seen otherwise they will not be offered further appointments. Participants in Trust B refer to the use of a “Did Not Attend” (DNA) policy, which is a procedural approach for discharging service users who do not keep appointments. In Trust B clinicians are required to undertake welfare checks and follow risk protocols for service users who do not engage and who are deemed to be dangerous and/or vulnerable (nine items of data from three participants).

BD2: *Yes, years ago we used to be able to write to clients to say to them “do you want our service?” We would say, “if you don’t get in touch with us, we will discharge you”. We could be very clear about it. Then a few years ago this*

changed, and we weren't allowed to be so direct in terms of suggesting that because we hadn't heard from someone, we were considering discharge.

BM1: *Yes, I mean for certain, if someone was offered two assessments say and they were aware of them and then don't turn up to either. They are not going to be offered another one. That is an at the door assessment of motivation in itself, I suppose.*

In applying Goffman's theory, it is unusual for a "mental patient" to be viewed as having autonomy. The neoliberal view of mental health, advocates individualism and advocates self-responsibility for mental health (Ramon 2008). Mental health service users miss appointments for a variety of reasons, including being cognitively impaired and disorganised, having social and environmental factors which make travel and time keeping difficult and negative perceptions about what the service can offer (Mitchell and Selmes 2007).

The following data illustrates the participants' accounts of how Service Users are involved in the decisions regarding their discharge. One participant suggested that discharge was often initiated by the service user themselves:

AP1: *So, the thing is, the client says stuff like (puts on a different voice) "I don't want to see you anymore, I don't want you to engage…… So, they (client) say, they want to stop, they don't need us they are doing well, they want to be discharged. We do the medical review; we try and encourage them to engage. When they are not engaging, all we can do is to discharge them back, so when they become unwell, they come back to us.*

Participants suggest that the service user is not always involved in the decision, and they are encouraged to make complaints if they are unhappy about this.

(seven items, three participants). The operational policy for Trust A states that the service user and GP are to be consulted prior to any decisions to discharge from secondary care.

AP2: *That is how we engage with their care, sometimes we talk to the client as well to find out exactly what support they need. ……. Then obviously, you have to do a discharge plan with the clients…….. some of them get so attached, or, I don't know, a sort of closeness and they don't want you to leave them in case they can't stand on their own. It becomes a bit of a challenge. Some of them might end up being unwell again. You say, "I want to discharge you" and it worries them and may stress them out.*

BD5: *They are given the opportunity to complain. The service manager is one of these people who says "if they want to complain, let them, give them all the details of how to. Quite often they will put in a formal complaint, and we just manage that, and it is investigated. It is often accepted really as if they are deemed no longer needing the service, we have so many on the waiting list, we can't keep them because they don't want to go.*

Here is an acknowledgement that the pressure to discharge is led by service demands. Three participants cite reduction in risk and symptoms reasons for discharge from the CMHT.

BM1: *Well, risk may have lowered it may be as simple as that, this person isn't a risk to themselves or others anymore. That could have been the criteria that they met in the first place, that stopped them from being supported at primary care level and that has reduced, so they can go back*.

Participants highlight the process of service users being rereferred to the CMHT after they have been discharged. They suggest that the first consideration is questioning if the service user has followed discharge advice and self-management plan, and if they have engaged with other services (five items, three participants). This approach is pragmatic and would appear to assume that Primary Care is the default option unless the service user presents a risk. This may be appropriate for service users who are managing their mental health problems. However, GPs may not be well placed to provide proactive support in detecting and managing early signs of relapse (Baird et al 2016).

AA2: *Within six months the policy charges us to review what we have done. The GP can write straight to us that our client has bounced back so then we go back on what we have done at A, B, C and D and is there support there? If there is some support, then we write back to the GP and ask them to advise the person to seek this support.*

BM1: *Well, risk may have lowered it may be as simple as that, this person isn't a risk to themselves or others anymore. That could have been the criteria that they met in the first place, that stopped them from being supported at primary care level and that has reduced, so they can go back. This isn't always the best idea as risk is likely to jump back up again if no work has happened. It could be that someone has completed an intervention and that has been helpful to them, and they no longer meet the criteria because they are functioning in a way that can be managed in a primary care setting. Non-engagement is definitely a reason that people are discharged, if the level of risk is not high and somebody is not engaging then they will be discharged. Unless they are on depot medication, then they stay with us regardless.*

Esposito and Perez (2014) suggest that in neoliberal societies, medicalisation of mental illness is preferable as it is seen as individualised and treatable. Neoliberal governments do not want to spend money on welfare systems, therefore emphasis for services is therefore that of treating symptoms and limiting spending on social and welfare support (Davies 2016). This, in turn is challenging for staff, working with complex clients. They have no way of defending themselves against the demoralising effects of feeling that they are not helping the service users make progress (Collins 2019). Practitioners distance themselves from practice issues which cause discomfort. They displace the blame onto the service user and minimise the consequences of the outcome (Hyatt 2017). However, there is acknowledgement by the Government, that mental illness is associated with social inequalities. This includes access to health, education and housing driven by social stratification, standards of living and adverse life experiences (Public Health England 2018).

In the Care Quality Commission carried out a Service User satisfaction survey in 2021. Trust B was below national average for support and wellbeing, and above average for crisis support. Trust A's were below average in reviewing care. The National commentary suggest that satisfaction for CMHTs is poor nationally. Integrated primary care networks were created to improve communication and joint working between primary care and mental health service (NHSE 2016). The NHS Long Term Plan states the importance of continuous care across primary care and secondary mental health services and timely support for those who do not meet the threshold for secondary care. These arrangements are to be fully operationalised following the implementation of the Health and Care Act (HM Gov 2022). The RCN (2022) welcome these proposals, on the understanding that funding and workforce shortfalls are addressed. Without adequate resources a,

workforce planning and clear guidelines for decision making across organisations, care will continue to be fragmented (RCN 2022).

7.12; Person-centred care.

In contrast to the above data, the code service user centred care consists of participants narratives of client stories and their circumstances. This data demonstrates that the CMHN is therapeutically engaged with the service user and views their difficulties in an individualised way (five items three participants). This involves participants utilising intuitive knowledge, discussed earlier in this chapter. The CMHNs who give these accounts were older, more experienced staff. Their clinical experience preceded the introduction of the Health and Social Care Act (2012). Therefore, they may have an approach to clinical work, which does not rely on following set criteria and pathways (Malin 2017). One of the participants, is relatively new but has a strong affiliation with working with Service Users with Emotionally Unstable Personality Disorder has a psychological approach to their work. The data in this section are positive accounts of how participants are person-centred. (three participants, three items)

AA2: *If it is a brief care coordination, but is tricky, because how long is "brief?" If we say that is brief to the client, what we are trying to say is that we expect you to work with us in a short time, although there is no definite time, until you are happy, and we are happy, and the issue has been resolved*.

BD3: *There is no space to really relax, it is about the approach. I am not grilling him, I am just posing questions, much like we are doing here. I am allowing him to talk and directing the conversation but not being overly directive.*

These participants demonstrate an awareness of the need for individualised care and circumventing service level restrictions. There is some acknowledgement that this is difficult due to time pressures, but very little evidence of moral distress. The participants giving the service user stories often acknowledge that they are not following the service structure and are putting the service user first. They give examples of resisting pressure from the team manager to discharge a service user, if they don't feel that they are ready. They state that they don't apply time frames to their interventions.

BD2*. A lot of people from ART call up, and come to duty as well, they shouldn't come to duty because they are under ART but if the ART worker is off, we can have quite a burden really, because the support workers can only do so much.*

Lispky (1980/2010) says that street level bureaucrats respond to service users who continue to push for a service despite gatekeeping processes. In these examples, the participants recognise that in the absence of preventative services the service user had no choice but to access crisis support. Long waiting lists for mental health services, lead to worsening symptoms. This is associated with greater dropout rates, or worsening symptoms necessitating a crisis response (Punton et al 2022).

BD5: *We do have a lot of the same people that end up in A and E, on a weekly basis. For various different reasons but quite often it is an overdose. I have had one patient that, we queried what she actually took, because A and E said she was sitting up in bed chatting. They were quite surprised that she could do that based on the type of medication she said she had taken. I think that may have been a perfect example of someone desperate to get into the service. For example, exaggerated the extent of what they did.*

The statement above is an example of a service user being in crisis and using emergency services. This may be a feature of EUPD, but also a reaction to feeling the need to bypass the referral route. The professional response to those with EUPD in crisis may often be that they are exaggerating or being dramatic. However, perhaps the approach to discharge is exacerbating this. The staff view may also be influenced by the policy rhetoric about service users frequently using Accident and Emergency (A and E) which has cost implications. The CQC (2016) reported on the experience of those with mental health problems using Accident and Emergency when they are in crisis. They reported that this was largely perceived as a negative experience, as service users report that it is a pressured environment, and they feel judged by the staff. They also note that service users attended A and E in crisis as they were often unable to access timely support to prevent a crisis. The NHS Long Term Plan (NHS 2019) states the need for accessible 24-hour crisis support and pledges to invest in expanding these services. In an NHS briefing in 2018 the issues of frequent attenders at accident and emergency departments were raised as a cost issue. A process called High Intensity Network was established in 2018 and piloted in several Trusts, including Trust A. This involved local arrangements between mental health providers, the police and ambulance service to divert frequent mental health service users away from accident and emergencies. It met with resistance from service user groups and professional bodies such as the Royal College of Nursing, stating that it may hinder a vulnerable person receiving support in a crisis (RCN 2021). Although Trust A was a pilot, none of the participants expressed a view on or experience of this process.

7.13: Summary.

This chapter addressed the micro level data, that is the individual factors which impact on the decision making of CMHNs. Participants cite the importance of intrinsic motivation: desire to help others, the pride they have in being able to do this work and their interest in mental health. They describe how they maintain this focus whilst still managing a large workload and demands to meet targets. The importance of skill development and training are discussed. Participants state that they develop these in relation to the type of service users they work with. The value of training is acknowledged but participants state that is hard to access training due to work pressures. Participants describe the knowledge they utilise in making clinical decisions. This includes intuitive knowledge: an innate sense of knowing, based on subtle interpersonal or situational cues. This is balanced with empirical knowledge, which includes professional and theoretical knowledge and evidence-based guidelines. There is a small amount of data on intuitive knowledge, and this is from the more experienced participants. When participants cite the use of empirical knowledge it is largely drawn from the inclusion criteria detailed in the operational policies. The intrinsic desire to deliver good care is undermined by the constant fear of not being able to (Marsh and Proctor 2022). This is exacerbated by a rigid hierarchical structure which mitigates against having control over the amount of work they do (West et al 2020).

There is a large amount of detailed data on participants' perception of their workload. The main factor is caseload size, that is the number of service users that are allocated to the CMHN. Caseload size is monitored at team and organisational level and by the CQC. The emphasis on managing this is a managerialist approach to reducing caseload size. This appears to be based on

the premise that CMHNs are not discharging service users when they should. Participants have mixed responses to this. Some describe feeling concerned that they have not got the time to fully meet the needs of everyone on their caseloads. Others say that they feel pressured into discharging service users that they still feel they should be working with. Whereas some participants view this as a positive way of reducing the demands on their time. Workload is linked to work life balance. Participants acknowledge that they feel stressed by the competing demands on their time. They are required to juggle caseloads, assessments, covering emergency duty responsibilities and completing documentation. This invariably leads to them working more than their contracted hours. This has an impact on their sense of autonomy, their freedom to exercise control over their work life. This also impacts on their morale: their sense of wellbeing and positive views about their role.

The need to manage large numbers of service users in a time efficient way, can result in CMHNs describing their work using objectifying language. That is using diagnostic labels when referring to service users, a process known as depersonalisation. There are also examples of participants gaining satisfaction from managing processes for organising work, as this gives them a sense of control. The participants describe the role of service users. The participant accounts portray expectations that service users will engage and follow the standard interventions offered. There is merit in encouraging this approach as it promotes independence and social inclusion (Lean et al 2014). However, it may be driven by the need to reduce the demand on mental health services and promote discharge at the earliest opportunity. CMHNs balance their intrinsic motivation and their therapeutic alliance with service users with a large workload. This has an impact on their morale, sense of autonomy and work life balance.

These factors are moderated at team level, and this will be addressed in chapter eight.

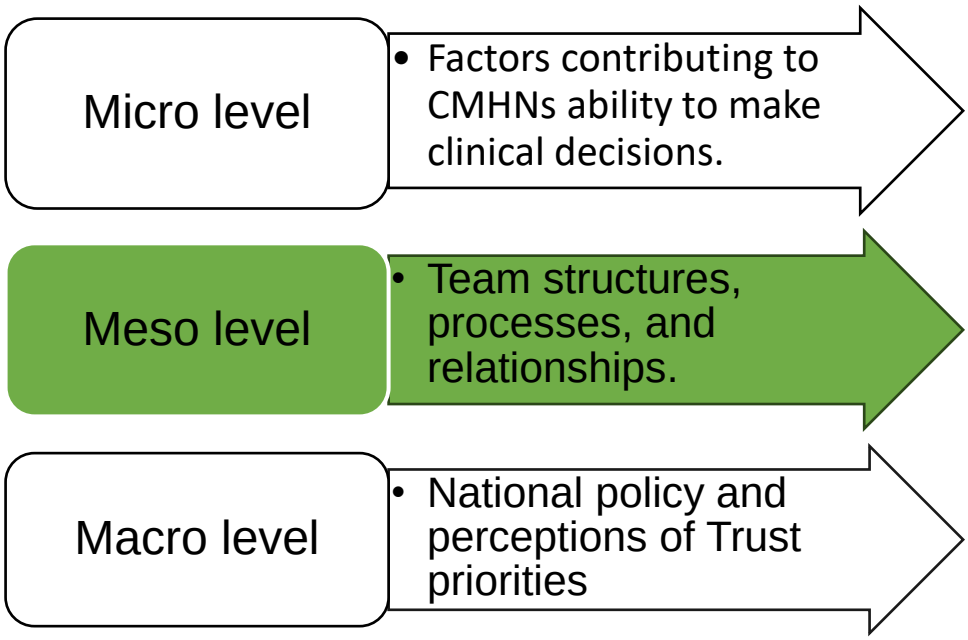
Chapter 8: Team structures, processes, and relationships.

8.1: Introduction

Chapter seven addressed the individual factors which impact CMHN decision making. Chapter eight will consider the operationalised structures and team level interactions which drive decision making at team (meso) level. The chapter addresses the themes identified through the analysis of the empirical data derived from the semi structured interviews. The following structural and relational factors were described by participants as having a major impact on their clinical decision making. The first theme will discuss the impact of care pathways and the creation of specialist sub teams. The purpose of care pathways is to incorporate national practice guidelines into a manageable process for the individual Trust and to standardise care for a particular problem or condition (Busse et al 2019). The theme on standardised time frames, risk rating and frequency of contact addresses the impact that the pressure to achieve these targets, has on CMHNs clinical decision making. These targets are detailed in NHS national dashboards or by the CCGs. They are operationalised by each Trust and monitored at team level. Risk rating is used to prioritise which service users require urgent interventions and how aften they are seen. The coalition government introduced standard waiting times for mental health services, which are outlined in the document “Achieving Better Access to Mental Health Services by 2020” (DoH 2014).

This is followed by the theme addressing waiting times and log jams. This data considers the impact of increasing demand on mental health services and the phenomenon of service users waiting for a service and in effect being “stuck” points of the care process. In 2021, the Care Quality Commission described NHS

care as being “gridlocked” (CQC 2022 website). The section managing boundaries considers data relating to, how the team deal with accepting referrals from and discharging service users to, other services. This process is procedural, utilising criteria and referral processes. It is also relational, involving interpersonal relationships and effective communication (Ballatt et al 2020). Boundary management is impacted by service pressures to manage their respective workloads and their perception of the functions of other services. This will be followed by the theme discussing the role of the CMHN, in relation to other professionals within the CMHT. This dynamic is often played out in team meetings which are a formal forum for clinical decision making. The informal forums used outside of MDT meetings are also considered. The theme on documentation checks captures participant accounts of how their documentation is subject to regular monitoring by their managers. This aspect of managerialism is a source of pressure for CMHN as it is viewed as tangible evidence of their work and is viewed as the basis for appraising their performance (Elkomy and Cookson 2018). Finally, the theme of the impact of COVID and the changes this led to for workload and service delivery will be presented.



8.2: Care pathways and specialist teams:

The two Trusts which are the settings for this study have different structures for organising the clinical workload of their adult Community Mental Health Teams. This is identified in Chapter four in the thick description of the setting. The NHS Implementation Plan states that Trusts need to develop pathways which are tailored to meet local need (NHS 2019). Public Health England (2017) suggest that this should also involve commissioners and Public Health bodies. The NHS Interim People Plan (NHS 2020) stipulate that local communities, those who use services, and their families should be consulted. NICE (2011) recommend that primary and secondary care providers need to collaborate locally to determine criteria for service inclusion and thresholds for movement between levels of care provision. The following discussion will consider how the two trusts have operationalised their care pathways and how this impacts the clinical decision making of the CMHNs.

In Trust A, the adult CMHTs are subdivided into two sub teams, based on diagnostic categories. The Psychosis teamwork with service users with a diagnosis in one of the psychosis categories (including bipolar affective disorder) who require care coordination. The Affective teamwork with service users experiencing affective disorder, depression, and trauma, who are complex and cannot be supported by primary care. There are four participants from the Affective Team and two participants from the Psychosis team. They gave accounts of how specialist teams impact their work. They cited advantages for staff but could not comment how this impacted on the service user experience (four items, two participants).

AA4: *The pros will be I guess, you are specialising more, they do overlap of course. I guess it is mainly the chance to specialise in one area. You can concentrate on what your team is designed to do.*

AA1: *There are pros and cons. Those service lines were created by the Trust years ago. One of the cons is that the staff working with affective disorder, trauma and PD and not with clients with psychosis we have kind of lost some skills. We have focussed on specific presentations. It is the same for psychosis team staff coming into the affective team, they say "I have not worked with this client group for such a long time" so they will find it difficult.*

These examples demonstrate that this structure provides clarity for the CMHN in terms of their client group, being able to specialise means developing specific skills for a defined client group. There is also an acknowledgement that staff can become deskilled in other areas. Lipsky (1980/2010) suggests that specialisation in public services is intended to ensure efficiency by optimising resources to focus on key interventions. However, this focus can result in the distortion of information to meet thresholds and a tendency to "process" care, which involves referring on and not see the care pathway through (Lipsky 1980/2010). This subdivision within one team can result in challenges for the staff in managing the boundaries between the two sub-teams.

AP2: *That is before we had the screening, it used to be like that. We would end up with someone with more of an affective disorder instead of psychosis. We used to sit down and say, "well this person isn't appropriate for the service." So, we would refer them back to the affective team.*

The focus on the most obvious diagnosis results in a defensive stance that reduces the service user to being viewed as an "inappropriate referral" (Ballatt et

al 2020). However, there are advantages to illness-specific pathways. They combine best evidence-based practice and enable Trusts to configure services to concentrate resources on greatest areas of local need (Calvan et al 2011). This is an example of how staff can deal with a sense of feeling overwhelmed by accusing their colleagues of “dumping” work on them (Ballett and Campling 2011). This not only objectifies the service user but creates tension between colleagues who need to work together to ensure a complete and seamless service for the client group. This may also involve an element of “blame displacement” whereby when a clinician cannot meet the needs of a complex service user, they locate the fault in another colleague or service (Hyatt 2017).

Another challenge involved in specialist teams is providing continuity if the service user’s presentation and primary diagnosis changes. Individuals may experience a range of mental health symptoms over the course of their life. For example, an individual may initially present with a psychotic episode and it may later transpire that they have underlying complex trauma. Conversely someone who initially demonstrates with problematic personality traits or extreme anxiety may be masking an underlying psychotic illness. The medicalised approach to diagnosing mental illness can be too reductionist and rigid. It is more helpful to see mental illness as a continuum whereby individuals can experience a range of symptoms, emotional and behavioural responses throughout their lifetime (Aho 2008). Trust As operational policy states that the purpose of care pathways is to promote a “seamless service”, by ensuring effective communication between services. Participants in Trust A describe how a service user’s care is managed when their diagnosis changes. These comments are from participants from the Affective Team, who also comment of their team not having such clear parameters as the Psychosis team.

AA4: *Recently we had one transferred from our service to the psychosis team as there was a change in the clinical picture and diagnosis and they rightly accepted the patient.*

AA1: *Uhmm *pauses* Sometimes I would say…it depends on the presentation. If they are already with us in the affective team, they tend to stay with us, as they are familiar with the team. We have clients on our caseloads with that situation and they remain with our service. We have considered transferring, but they have declined, or it was felt that the treating team should carry on with their treatment.*

The type of mental health problem determines the care pathway that the service user is allocated to (Busse et al 2019). The advantages of this approach may be clear direction for service users and role clarity for staff (Schrijvers et al 2011). A potential disadvantage is that these structures can lead to fragmentation and staff not knowing what happens in parts of the process that they are not involved in.

Trust B does not utilise separate diagnostic teams. Their operational policy defines staged care according to standardised interventions. After assessment service users may wait for intervention, if they do not require urgent care coordination, this is a process known as Active Review and is described in the code “Waiting lists and log jams.” When service users are accepted for care, they may undergo a time limited process of Initial Interventions: The aim of this intervention is to empower patient by supporting them to develop and use effective self-management techniques for self-care. This intervention is provided by Supported Time Recovery workers supervised by psychology staff so is an efficient approach to providing a clinically effective intervention (four items, two participants).

BD2: *Quite often, when they complete I.I. (initial interventions), it would need to come to the MDT, and that is where psychology would really play a part and look at what might be suitable for this person. It might be that they are offered a screening assessment.*

BM1: *I have to say that I haven't had an awful lot to do with it to be honest, as it is between psychologists and STR workers. ……. Someone goes into it and comes out the other side with a decision about whether they stay with us and what's going to happen next. They will have initial interventions and then be taken back to the MDT following that and a decision will be made again.*

There is potential disconnect between parts of the process in Trust B in the same way that there is between sub teams in Trust A. In the face of overwhelming need with limited resources to deal with the work in hand, work is reduced to tasks or rigid parts of a process, as a defensive strategy against feeling overwhelmed (Dartington 2010). There is a potential advantage for offering an initial contact in this way, in that the service user is offered an opportunity to engage, and so is not left without any support. This may also enable the team to make a fuller assessment of their needs. Trust B introduced care pathways in 2019, for Serious Mental Illness and Personality Disorder. However, this has been used to guide the staged approach to interventions and has not resulted in team reorganisation. The CMHT remains as one large team. The specialist teams in Trust A and the segmented and staged care in Trust B have developed as effective ways of managing a large and complex workload. These structures also ensure the provision of timely interventions which can be monitored. Advantages of care pathways include clarity and coordination of roles and sequencing of effective interventions (Schrijvers et al 2012). However, this can result in CMHNs

focussing on their part of the process and not the service user's journey. Care pathways can be viewed as mechanistic and reductionist, moving a service user onto another part of the service when their presentation changes, rather than managing their care holistically. Alternatively, there is scope for flexibility as the above quote would suggest, as service users progress is reviewed in the pathways and new decisions can be made.

BD2: *I think that the Trust was trying to move towards doing that. (Developing diagnostic care pathways). We do have separate pathways, and we did have a reorganisation where we were sorting out our caseloads and determine each person's pathway. At that point we had a PD pathway group, that was being run and now that is on hold as that staff member left.*

BM1: *I think one of the cons as I have said is that some parts of the team are unaware what goes on in other parts. I definitely see a positive in that, hopefully, people with a passion for a particular pathway will gravitate towards that which leads to better care for the clients. Apart from the disconnect within the team, I like that it is more specialised.*

NHS England and NHS Improvements assert that the creation of Integrated Care Systems will address the issue of fragmented care for those with long term conditions (NHSE website). The policy rhetoric refers to fragmentation between services, namely health and social care, and primary and secondary services (Charles et al 2018). Within mental health services, fragmentation is often seen between inpatient and community services (RCPsych 2019). The data above illustrates the process of fragmentation within a service. Here the productivity agenda has become internalised within the team. The pressure to do more with

less has resulted in individual practitioners focussing purely on their own workload and sphere of responsibility. Engaging with complex clients in the face of service limitations is too overwhelming (Ballatt et al 2020). The result is fragmentation either between specialist teams or between stages of the care process. One participant described the pressure to “process” referrals and decisions quickly with the emphasis of moving a service user on:

AA4**:** *Absolutely, I spoke to somebody earlier and I used the term “conveyer belt”. You know, the conveyer belt gets faster.*

In the face of increasing demand for services, practitioners and managers need frameworks and practices to prioritise resources and ensure that interventions are targeted and effective (Hupe and Buffatt 2014). Another structure which aims to ensure resources and interventions are targeted effectively is the use of standard waiting times, risk rating and frequency of contact. The term “patient flow” is used to describe the process of mapping progress through stages of a predetermined care pathway (NHS Improvement 2005). NHSE (2018) suggests that this is an effective way of ensuring better outcomes and use of resources.

8.3: Standardised timeframes, risk rating and frequency of contact.

Both Trusts have standardised structures, such as timeframes for assessment following referral and for the assessment interview, risk rating, discharge criteria and frequency of contact. This is discussed in the thick description” in Chapter four. The participants give their accounts of challenges they face in adhering to these.

The CMHTs in Trust A utilise RAG rating to categorise risk. Risk assessment and management are an integral part of mental healthcare provision and needs to be client centred, and recovery orientated (RC Psych 2016). The approach used by each Trust, is discussed in the “thick description” of the settings in Chapter four. The CMHTs have “zoning” meetings three times a week where risk management of service users is discussed. Zoning is a long-standing practice in mental health settings and provides a clear and structured framework for guiding clinical decisions about risk (Pandey et al 2022). However, CMHTs tend to concentrate their resources on reacting to high consequence risks such as violence and suicide, rather than proactive measures to prevent relapse (Higgins et al 2016). In addition, all NHS Trusts are required to report all patient safety incidents. These are recorded on the Trust local risk management systems and shared with NHSE national monitoring systems (NHSE website). In Trust A each service user is categorised by their care coordinator and discussed at meetings three times a week (six items and three participants)

AA4: *All cases are discussed in our zoning; we have three zoning meetings a week. The Monday morning zoning is much more extensive, where we discuss cases. Those that have been assessed and need a decision, then we raise it in this Monday morning zoning. Decisions are made mainly via this zoning. Other decisions are made via the clinics, through outpatients, reviews, follow up and based on risk and clinical presentation at the time, a decision will be made.*

AP1: *If it were social needs, we would put them in amber and we will put safeguarding in place if it is neglect and we would discuss that as a team. The red zone is for symptoms yes, and the amber is for social.*

Symptoms may be a risk factor but their interaction with personality and social and contextual issues need to be considered (RC Psych 2016). The zoning approach, described by this participant, does take social and psychological factors into consideration. The definition of zoning in Trust A's operational policy and the way its use is described by participants, suggests that symptoms of mental illness and high consequence risks are given priority. This is perhaps an example of a reductionist and problem focused approach to risk, which focuses on controlling symptoms and increasing surveillance. This reactive approach to short term risks is a product of defensive practice and is often at the expense of more proactive, client centred strategies (RC Psych 2016). The focus on demonstrable symptoms may give CMHNs and their colleagues a sense of control over manging emergency procedures (Hupe and Buffatt 2014).

Trust B also have team meetings to address immediate and short-term risks. They hold daily "Red Board" meetings every morning. This is discussed in "thick description" of the settings, in Chapter four (three items, three participants).

BD2: *In red board we will make the team aware of, like who is duty, which doctor is covering triage, which seniors are on that day, so that everyone is aware. We will start with immediate concerns so that everyone has the chance to discuss anyone who they are immediately concerned about, who cannot wait. Also, any concerns from duty, and anything that could be missed if we didn't look at those lists every day. Anyone who is coming back to us from Crisis or Liaison, any depots that have been missed, any CTOs that need booking or renewing, or assessing.*

The approach in both Trusts seems to involve concentrating on immediate and severe risk and constantly rearranging scarce resources on a frequent basis, to

prevent adverse incidents. Emergency procedures can be a way of prioritising the allocation of scarce resources in public services. However, there tend to be clear and strict parameters to prevent emergency processes being overwhelmed (Lipsky 1980/2010). There are standardised processes for increasing and decreasing service users' level of provision. Trust A has "step up" and "step down" processes which are discussed in the "thick description" of settings in Chapter four. The participants say that they have little time to see the less risky clients. Therefore, clinical work becomes reactive rather than preventative. Clinicians can use their judgement, but this is within agreed parameters and criteria (Hupe and Buffatt 2014). There are also standard time frames within which service users need to be seen (one participant, two items)

AP4: *With standard they don't need a lot of input, so you can see them maybe once a month or every three weeks. The CPA, like I said, they are the ones with complex needs, they go under the Care Programme Approach so, obviously you have to see them every two weeks, at least.*

The participants in Trust B described the following standard time frames: 72-hour after discharge, 28 days for assessment and 48 days for interventions. (four items, three participants)

BD3: *They need to be seen 28 days from referral, that doesn't take into account them being a DNA (did not attend). So, we fail a target if that happens, so it might be 28 days before we can book them in again. That is target led. I mean if they triage green and agree to an appointment, they didn't turn up and we cannot get hold of them on the phone that day, we will discharge them. There is an element of that. There is the bigger target of 12 weeks, which is for their second appointment, that's the 48 days. We should be seeing everyone at least every 4*

to 6 weeks. If we are not, then why not. There are targets but the 28 days is not down to us it is "did they turn up or not".

The participants in Trust B describe standard amount of time for assessment 45 minutes and how this process has been streamlined to only focus on specific clinical questions. The rationale for this is to fit in more assessments and reduce the time taken.

BM1: *There is very little you can find out in that time; you cannot really get to know a person and then they are on a list for a really long time. We follow a proforma which has changed. There used to be a section for background and family history and that's been removed. I can only imagine that that is because it takes too much time. So, we are looking at "presenting situation" what is going on right now and the impact that is having on the person, things around them, their social situation, medication, client's expectations of the service, and of family or carers, so that's helpful. Mental state examination and then a formulation of what we have got from that really.*

This could be an example of implementing standardised times for activities, such as assessment. NHS Improvement (2017) make recommendations for Trusts to "Improve their flow". This includes suggesting processes to standardise times for appointments and procedures and monitoring to ensure this is adhered to. Trust B has a "job plan" for each role within CMHTs, including CMHNs. This itemises the standard amount of time that team members are expected to spend on activities such as assessments. This may help accommodate more assessments and enable the CMHN to establish whether the individual has a mental health problem, in a time efficient way. A standardised assessment schedule would include personal and family history, to establish genetic or developmental

influences on the individual's mental health (Wand et al 2020). The assessment of the service users' functioning before the onset of their mental illness, leads to a more accurate and less superficial view of the presenting complaint (Moldawsky 2020).

A key area for CMHN clinical decision-making is discharging a service user from the service. There are no set criteria but participants from both Trusts cite the reduction of symptoms and risk, as deciding factors. Trust A's Operational policy outlines the Care coordinator's role in planning discharge from the service. They are required to ensure that service user feedback is sought and inform GP and other relevant services writing. The operational policy in Trust B states that frequent reviews are encouraged as part to the delivery of treatment interventions to ensure people only remain on team caseloads due to need. The named practitioner is expected to review their caseload in supervision at least once every three months to support good caseload management.

DB5: *The client. Usually they are quite okay, but you get the odd person, I don't know if it is because they have been in the service for a long time, and they are worried because they have used the service as a crutch, something to lean on. We have had a few people that have rung up quite angry as they have had a letter to tell them that they are being discharged*.

AP2: *That is how we engage with their care, sometimes we talk to the client as well to find out exactly what support they need. What did they come with? Have their needs been met? Err..do they agree with discharge?*

These statements would suggest that the service user is not actively involved in the discharge process. The NHS produced a document in 2019 "Universal

Personalised Care" (NHS 2019). This supplemented the NHS Long Term Plan and highlighted the importance of individuals having choices in how their care was delivered. The principles include shared decision making and promoting choice. Both Trusts have guidelines on person-centred care planning, which emphasise these principles. Providing service users with a choice about when they are discharged from the service may be problematic. They may feel that they depend on the service as indicated in the above quote. However, the service needs to ensure equitable use of resources and so discharge a service user when they have been treated and their risk has abated. Lipsky (1980/2010) states that there if often a gap between the way policy is written and performed. The pressure to discharge service users in order to have the resources to provide a service to new referrals. Access to and discharge from services is routinely monitored by the CQC. The CQC report for Trust A (2020) positively appraised the CMHTs for providing a focus on time-limited support and discharging service users back to Primary Care once they no longer required a service. However, progress through the care pathways can be hindered by waiting lists and log jams.

8.4: Waiting lists and log jams: bulges in the seamless service.

This theme encapsulates participants' accounts of the stages in the care processes where service users are "stuck." This refers to the service users waiting for allocation following assessment. It includes General Practice not taking on service users deemed ready for discharge from the CMHT due to their reluctance to monitor those on long term antipsychotic medication. Waiting lists for psychological therapies and psychiatric outpatient appointments are also considered.

AA4: *Following the screening, unfortunately, because we have a surge of referrals at the moment, they sit on a waiting list. We try to minimise this as much as possible, so they go and wait for that input. Unfortunately, the wait for psychological therapies can be quite a few months, and the same for the outpatients. Where we bypass this process is when referrals come through the inpatient services or the mental health liaison team in A and E and from the Home Treatment Team. This is where we have to prioritise, as these are deemed, riskier, needier, and we need to act on this. Unfortunately, this causes the backlog to increase.*

If service users present with a risk and/or require care coordination, then they are allocated to a CMHN caseload immediately. The operational policy for Trust A states that service users referred to the affective team will have a core assessment by a CMHN. If the service user is thought to need psychological therapies, they are reviewed by a therapist and placed on a waiting list. There is a wait for psychological therapies, and routine outpatient appointments. This can be circumvented when risk increases as the service user therefore becomes a priority. Accessing emergency services usually depends on self-referral by the service user and may result in them receiving the interventions that they cannot otherwise access due to resource constraints in routine care (Lipsky 1980/2010). The reaction of the CMHN in this example is to acknowledge the need to respond quickly to an emergency at the expense of routine work. The teams in both Trusts prioritise service users who present with significant risk and/or have serious mental illness and require care coordination and CPA level provision.

Trust B have a process called “Active Review. This is discussed in the thick description of settings, in Chapter four. Trust B had a CQC inspection in 2022

which commented on this process, noting that due to the increase in referrals post COVID service users were waiting longer than usual for a service. The Active Review process was highlighted as an area of good practice as it utilised digital and video technology to contact service users during the pandemic.

BM1: *Also, we have a high caseload of people on "active review" for those waiting for different interventions, medical review and all sorts. We have about 400 people on that caseload. So, I am taking the people who come through that who are contacting us in crisis because they haven't got an allocated intervention or worker at the moment*.

Gatekeeping ensures appropriate care, management budget restraints and is concerned with the justice of fair distribution of resources (Willems 2001). The Active Review process is an example of an extra structure to manage demand, the CMHNs role is involved with managing the waiting list. Lipsky (1980/2010) states that in bureaucratic processes practitioner level practice can function to rationalise services. Menzies-Lyth (1988) suggested that healthcare staff became emotionally detached from their clients to protect themselves from the anxiety of not meeting their needs. Similarly, organisations create systems to defend themselves against the vulnerability of not being able to provide a service by creating processes which depersonalise care (Hanley et al 2017). The creation of nursing roles to manage processes, such as waiting lists, compartmentalises clinical work. This is an example of deprofessionalisation as it removes autonomy from the professional and reduces their work to administrative tasks (Malin 2017). The waiting list for therapy prompted one participant to refer a service user to a voluntary sector service for support.

BD5: *The waiting list for therapy is a yearlong and has become even longer due to COVID. If the person is in secondary care, they cannot access therapy in MIND. That makes it harder because you cannot even refer them to another service, like MIND or Insight, so they are just sitting there waiting. We offer II, Initial Interventions, that is 8 sessions of CBT. Then the person is left without anything until they get to the top of the waiting list for therapy. That is if they meet the criteria for therapy. People are also sitting on Active Review, for a long time. If they need an allocation but there is no one to allocate them to because we have got such a shortage of nurses.*

This suggests that voluntary sector services are an alternative rather than an adjunct for statutory services. Austerity has had an impact on voluntary sector services, by increasing demand on them whilst cutting the statutory sector funding they rely on (Jones et al 2016). Trust B's operational policy states that if service users on active review do not engage with telephone, contact then they are discharged. This is only if they do not present a risk. If they do, then attempts are made to visit them. Waiting to receive services can make the Service User feel unworthy, therefore their demands and expectations are reduced (Lipsky 1980/2010). Non engagement may be an indication that the service user no longer requires support. However, it could also be a result of them having no confidence in the service and therefore withdrawing. Waiting lists can give the appearance of providing a service, whilst simultaneously being evidence of the need for more resources. They have the additional purpose of filtering out those who could be deemed not to be in genuine need or who lack motivation to pursue treatment (Lipsky 1980/2010).

There are examples of duplication of work in the care process. Participants in Trust A state that they repeat the assessments of the Primary Care team. The National guidelines: Community Mental Health Framework for adults and older adults (NHS 2019) state that service users should not have repeated assessments or fall between the gaps in mental health services. The Operational policy for Trust A states that the Primary Care team will provide a single point of access for all referrals to secondary Mental Health Services from primary care for that locality. Participants in Trust A indicate that they have to reassess service users who are referred by the primary care team (one participant three items).

AA3*: most of the time what we document is so similar to the PC assessment that you just think "what is the point"? Or someone that is known to the services, or another service and we have their notes, comprehensive documentation, their presentation, what works for them, their family history. Why do I then have to spend two hours, bothering them, again and waste my time.*

The Department of Health and Social Care (2021) states that duplication of work will be ameliorated by Integrated Care Systems. This is also a means of ensuring integrated working. Service users often have multiple complex needs which are intertwined. They may require a range of services simultaneously, each with their own priorities and targets (Ballatt et al 2020). Integrated care systems aim to improve outcomes of those with complex needs by bringing a wide range of services together (NHSE 2019). This approach focusses on integration between services. The complex nature of managing care processes described in the data above, demonstrates that there can be fragmentation within services. This appears to be due to the challenges involved in managing the flow of large numbers of service users through care pathways. Ensuring the interoperability of

IT systems, between GP surgeries and CMHTs would support the process of sharing clinical data (DoH, NHSE, NHSI and NHSD 2020). This would be a systematised way of ensuring effective information sharing between services.

8.5: Managing service boundaries.

The CMHTs receive referrals from a variety of sources. These include primary care GP practices, in patient mental health units, crisis/emergency services and other CMHTs. CMHTs need to have clear criteria which are applied consistently at entry and exit points. These service boundaries are managed by having clear, operationalised criteria and referral routes. This theme details participants' perceptions of the interface between their team and other relevant services. Participants describe the threshold between primary care and secondary mental health services. In Trust A, the Primary Care Liaison Team, is part of secondary provision but has a role in determining if a referral meets the criteria for CMHT provision (seven items three participants). Participants believe that the answer is to have mental health practitioners in Primary Care and that they were aware of plans for this.

AA2: *Ok one of the things I would say to come into our team, is not our decision. It is a primary care team decision the triage is done by them, so the primary care team make up their mind, where the client will go. After the triage, they will send a referral over to the admin of our team.*

AA1*: There are quite a lot of clients who would benefit from Primary Care or IAPT services, but because of their risk, they exceed the threshold for these services. Therefore, any risk: past or current, these services could not manage it, so it comes directly to us.*

AP2*: The GP surgeries are not willing to compromise, but I think if our mental health team are working with them, hand in hand, they might, probably, agree. I think that is what they are trying to do and get the GPs involved, in sorting out this issue.*

AP1: *It is better, it is really good. We will work more closely with GPs, and we are going to have social services, voluntary services that we need working with us, at our beck and call. Of course, it makes our life easier.*

The NHS Long Term Plan (NHS 2019) and the Community Mental Health Framework for Adults and Older Adults (NCCMH 2019) emphasise the importance of improving the interface between primary care and secondary mental health services. These include having- effective two-way communication rather than rigid referral routes. Having mental health practitioners in G.P. surgeries and rapid referral back to mental health services in the event a service user relapses (Naylor et al 2020). Trust A already have a service: Primary Care Liaison Team, which is intended to bridge the gap between primary and secondary provision. Participants' accounts would suggest that this helps with referrals to secondary care as PCL decide if service users meet secondary service criteria and which team they are allocated to.

Participants described how service users who no longer required care coordination had to stay with secondary mental health services as GPs refuse to take over their care. The reasons participants give for this include the service users having depot injections or taking Clozapine medication. This may be due to the potential for relapse in this client group and the lack of primary care resources (Naylor et al 2020). Participants state that this has an impact on their workload. Baird et al (2016) the interface between GP surgeries and CMHTs is problematic

as CMHTs are over stretched and so raise their threshold. The Community Mental Health National Framework and the creation of primary care networks suggest the placement of mental health practitioners into GP surgeries (NHSE 2019). The operational policy in Trust A, says that the primary care liaison teams need to maintain good relationships with GP surgeries in their catchment areas. This suggests that good practice involves joint meetings, clinics and joint assessments (six items of data relate to this).

AP2: *Then again you want to move them forward from where they are, you can't because of the GP surgery, if they are on depot, they get stuck with you and the GPs are saying "we cannot take them on" They stay on your caseload and they cannot move on from there. You see them once a month. They don't need your help anymore but then you have to keep hold of them because of the injections yeah. So, it is something they are looking into I have heard, they are having these conversations with the GP surgeries to resolve this issue.*

The operational policy for Trust B only covers re referring to the GP when a service user does not attend. The participants give accounts of trying to discharge service users back to their GP (five items).

BD5: *Generally, if the GP doesn't agree with it, they will just refer the person straight back. Then the whole process starts again. The someone will have to take a couple of hours, assessing that person, writing it all up, take it back to the team. The GPs are not generally involved in the discharge decision. You would know if they don't agree with it because they will refer them straight back in.*

This indicates limited consultation and liaison, just using the referral process. Baird et al (2016) describe the perception of a GP, who says that they are told by CMHTs that they can always refer the service user. However, if they do this is met

with resistance as CMHTs are under pressure to keep their caseloads down. GPs do not always have the expertise or resources to support those with serious mental illness who are referred to them by CMHTs. These service users can relapse quickly, and GPs cannot provide them with the necessary support to detect or prevent this (Naylor et al 2020). Good working relationships between primary and secondary care is desirable, as stated in Trust policy. However, these effective, mutual relationships are undermined by both services feeling overwhelmed and functioning to protect their limited resources (Cooper and Dartington 2004).

Participants shared their perceptions of the work of other mental health teams. This is either in relation to how the parameters of other services impacted on their work, or the perception that other teams had more resources and/or less work. In Trust A, participants from the affective team perceive that they accommodate service users, for whom there is no other service.

AA1*: Other teams, inclusion and exclusion criteria are a bit more structured… so anyone that doesn't fall into that criterion tends to come to the Affective team. We tend to take on those who don't fit other services.*

BD2: That is, for patients, services that have been cut over the years, staffing *of CMHTs not being a specialist service, compared to EIS (Early Intervention Service) who we share an office with.*

The Community Mental Health Framework for Adults and Older Adults (NCCMH 2019) states that there will be a greater investment in Early Interventions Services. The NHS Long Term Plan for mental health (NHS 2019) highlights the importance of early interventions to improve prognosis. This is a valid point and improves outcomes for people with psychosis. Their workload may seem more

manageable as they have a more specific focus than generic CMHTs. Also, prevention of long-term mental health problems is a priority, hence there is greater monitoring of early intervention and children and young people's services. Smaller teams, which have a clearly defined focus function well, demonstrating increased cohesiveness and job satisfaction (Ballatt and Campling 2011). Perceptions of other teams and their functions may be influenced by a belief that increased workloads are due to "inappropriate referrals" or other services "not doing their job properly." This may be an example of staff displacing their anxiety about not being able to cope with their workload onto other teams (Ballatt et al 2020). Therefore, the interpersonal, professional relationship between team members is a significant factor in making effective clinical decisions.

8.6: The role of other team members, meetings and team dynamics

This section considers participants' experiences of using team meetings to facilitate decision-making. The use of other forums such as supervision and informal discussions with colleagues is also considered. The professional identity, relationships and, communication between members of the multi-disciplinary team is discussed. Participants give examples of how helpful they find MDT meetings (six items and four participants).

AA1: *We also have a weekly MDT meeting, and this is also where clinical decisions are made. This is a multidisciplinary effort where some of the clients are looked at to make a final decision about aspects of clinical work, such as is this client going to be discharged or transferred. So, within those processes I am involved in clinical decision making.*

BD2 *Quite often it helps people who are unhappy about a decision, once you have discussed it as a team, then that is really what you fall back on.*

These examples give a positive account of the value of team meetings, indicating that decision making involves multiple perspectives and is shared. The first example indicates that the meetings have a normative function in making decisions about the care process and key stages such as discharge. The second example suggests that a team forum can reinforce a decision that an individual CMHN may be unhappy about. This example suggests that CMHNs can feel intimidated in large MDT meetings.

BD2: *I know that from experience. I know that staff sometimes feel a bit anxious about coming to the team meeting and speaking up, but I really think it offers a multi team decision. We would obviously use that meeting for clinicians to bring their assessments and talk about it and when you walk out of there you have a clear plan for what you are doing.*

Multi-disciplinary team meetings are intended to ensure effective teamwork and shared decision making. In chapter seven, in the code workload, participants in Trust B indicated that their team meetings were very long. This is due to them being a large service with no team subdivisions as in Trust A. This may result in there being limited time to discuss individual cases in detail, although it does ensure that all cases are considered. In the team meeting in Trust B, the manager documents all decisions, demonstrating a shared approach to managing risks and service user outcomes. This means that meetings reflect the normative and procedural approach to “managing” the care of large numbers of service users (Ballatt and Campling 2011). Lewin and Reeves (2011) suggest that they can be ritualistic in nature and present an outward impression of collaboration rather than a genuine engagement with it. Goffman’s theory of front stage and backstage theory can be applied to healthcare settings. Front stage settings are formal,

planned meetings where team members may be more concerned with demonstrating views and behaviours which are organisationally acceptable. Back stage settings include informal or ad-hoc discussions with colleagues, in which clinicians can discuss their concerns and views more freely and honestly (Lewin and Reeves 2011). The participants give examples of using supervision and informal discussions with seniors, doctors, and other team members (five items, three participants)

AA4: *Other decisions are made via the clinics, through outpatients, reviews, follow up and based on risk. and clinical presentation at the time, a decision will be made. A few times, I do discuss cases with my colleagues, in supervision. This is also a place where decisions are made about their progress if you can really.*

BD5: *We also have monthly supervision, so that is something I can talk to my supervisor about and ask her questions and speak to her. …….. We have case reviews with the doctors, they are about, every three months, so if we feel that the patient is needing more support or is due for discharge, we can probably discuss that with the consultant…… We have two monthly nursing forums, so we can discuss our role as well with the team, any difficulties we are having and any suggestions. We have a lot of opportunities to discuss things.*

This represents the challenging duality for CMHNs in making clinical decisions about service users. They are required to exercise individuality and compassionate care, and, at the same time, process individuals in line with structures and standardised criteria (Lipsky 1980/2010). Another aspect of the CMHN role is functioning as a care coordinator, that is having responsibility for the overall management of the service users care, whilst negotiating and brokering the involvement of other team members. CMHTs typically consist of

CMHNs, psychiatrists, psychologists, Occupational Therapists, social workers, and support and administrative staff (NHS England 2019). Professionals have role identities ascribed by their professional bodies and organisational job descriptions. The ways in which they work together are also influenced by their perceptions of each other, how they communicate, and the conscious and unconscious processes influenced by the emotive nature of the work. Psychodynamic theorists refer to these relational aspects as “team dynamics” (Ballatt et al 2020).

In Trust A, the Affective Teamwork with service users with emotionally unstable personality disorder. Participants in this team describe the psychologists and psychiatrists as being powerful members of the team. They highlight the potential conflicts between the medical model and the psychological approach when working with service users with personality disorder (seven items three participants).

AA1: A CPN also works with this client and does not know where to turn to as they feel as though their decisions are disregarded and they are trying to make their voice heard. They say, “I am also a clinician and I work with this person; I also have a valid decision that needs to me made.

AA2: *Yes, usually psychologists. The way they work is that they see things quite differently from the medics and the nurses. That is where the differences always come in……. I think it is also a case of professional egos, you know “I am the doctor” and “I am the psychologist” I think as nurses, as CPNs they tend to go lower and lower when there is a clash like this.*

These accounts suggest that clinical opinion can be polarised when working with this client-group. Service users with emotionally unstable personality disorder

(EUPD) often experience intolerable internal conflict. This influences their relational interactions, resulting in team members being in conflict over how to manage their care (Green 2018). This is a psychodynamic process known as "splitting", whereby the service user's internal conflict as "acted out" by team members (Menzies-Lyth 1988). In these accounts the "splitting" appears to be between the medical model approach and the psychological approach. The hierarchical approach and conflict of professional power, leaves the CMHN feeling powerless and carrying the organisational split between therapy and process (Haslem et al 2022). The participant in Trust B with an interest in working with service users with personality disorders, had this view:

BM1: *I think medics tend to stick with what is going on in the enduring pathway, which helps me. I will be very honest because when medics get involved with clients with personality difficulties there is not always a good outcome, they are given far too much medication, unnecessarily at times.*

Health needs are traditionally defined medically. However, psychodynamic theory remains relevant to those working with clients with complex emotional trauma as medicalisation can often be unhelpful (Haslem et al 2022). This participant contrasts with those of the participants in Trust A. Instead of feeling "caught" between the split between two powerful team members, they feel empowered to take the lead and demonstrate a degree of autonomy. The following data demonstrates participants view of the psychiatrist's role in decision making. The participants acknowledge that they have a key role in decision making but see the psychiatrists as having the greatest level of autonomy and the responsibility for making the "final" decision (four items, four participants).

AP1: *Yes, the doctors have their own decisions, but we all make decisions together. It is teamwork.*

BD3: *Then there is the whole decision-making process if you have got somebody long term, like for care coordination, it is like "what are we doing with them?" If a doctor says "no, I don't want them discharged" then they are not discharged. I can't go against the doctor; I am not going to take that risk.*

The perception of medical authority in clinical decision-making is based on how mental health problems are subject to diagnostic categories in the same way any disease is defined (Cooke et al 2019). In the contemporary setting on CMHTs it may be linked to the emphasis on diagnosis as the basis of inclusion criteria. The psychiatrist is the responsible clinician who has overall responsibility for each service user under their care (HEE 2019). Alternatively, deference to the medical model may be an evasive social defence mechanisms used by nurses, to protect themselves against the anxiety of taking responsibility (Menzies-Lyth 1988). Lypsky (1980/2010) suggests that public sector workers often use clear cut parameters such as diagnosis to forgo their discretionary rights. This relieves them of their responsibility for being unable to meet service user need in the face of service limitations. The medical model can offer "safe certainty" for a team, when faced with service users whose presentation is complex and potential for improvement in uncertain (Cooke et al 2019). Good multi-disciplinary teamwork, based on mutual respect and open communication results in a more effective, integrated approach to clinical work (Ballatt et al 2020). Both individual practitioners and teams are monitored to ensure they complete all required documentation.

8.7: Documentation checks

The participants describe how their documentation is subject to regular planned audits and spot checks. The operational policy for Trust A states that CMHTs need to collect routine outcome data which demonstrates that they have met targets and demonstrate efficiency. This is focussed on key stages of the care pathways and maps demand at the crisis, relapse prevention and health promotion functions. The aim is to demonstrate the number of service users discharged to primary care (five items, three participants)

AA2: *Every one of these calls has to be documented individually, including the time of the call, and everything that has been discussed. So' if you engage with the clients, it is client engagement, if you talk to the GP, it is consultation, if you talk to the family, it is FIP, family input psychology,*

In Trust B, the Quality Account report describes the use of CliQ checks to monitor and audit the adherence to quality standards. Participants describe the pressure to complete these in order to avoid a negative appraisal (four items, three participants).

BM1*: That is part of supervision really. One of the senior members of staff will do a CliQ check every so often, they go into various case records and note things that are out of date or need doing. That will be circulated to the people who need to complete those. If this isn't done in a timely way, it will be brought up in red board. I have noticed once or twice that people are actually named. Usually it's like "you have all received your CliQ checks…I need the response to those today". Otherwise, it is addressed in supervision, or it might be "this person is due for initial interventions, but they have got no cluster or risks, you need to get that done".*

BD3: *Close to the point where I went off sick, I had to do 180 crisis plans. That's because they suddenly changed their…it was a KPI or CQUIN must have come in, as that is what happens mostly. Then suddenly I had to do all these crisis plans. It was that and a few other bits and pieces that where I am suddenly being asked to drop everything and do loads and all in a few days. I ended up just copying and pasting the care plans into the crisis plans and it became a paper exercise.*

The organisational level pressure to fulfil these targets places emphasis on monitoring compliance through documentation. At team level, this becomes operationalised as a manager's role and is part of the supervision agenda. The neoliberal culture in the NHS is concerned with monitoring inputs/outputs (Benbow 2021). This includes the scrutiny of staff performance, ranking and league tables (Lynch 2017). Participants describe how, if they are not fulfilling these targets, then their performance and wellbeing are called into question. Accurate documentation is vital in mental health services to facilitate multi-disciplinary decision making and risk management (four items, three participants).

AP2: *With the dashboard it is just, oh, (pause). I think it is where the services get their finances from. You always have to make sure your dashboard is in green. Green means you have updates, the clients' care plans, had their CPA meetings, every six months, so there is a lot there to do. Make sure their crisis plan is up to date.*

AP1: *So, we have iFox. This guides everybody, we have items like "team performance", "team dashboard" We are supposed to be checking on this every day and the managers certainly check it….. that is all they want to see, and if your iFox is showing red, then it is seen as you not doing anything. Then we have to do supervision to highlight what we are struggling with. You talk about your*

strengths and your weakness. You identify if you need more training, if you need keep doing one to one for a while, then they (supervisor) will put you through what you need to do. If they put all these things in place and you are not improving, it becomes performance management.

This approach can create a culture of health competition and an extrinsic drive to ensure that key quality measures are achieved. This can become a culture dominated by fear of failing or making mistakes (RCN 2019). This can cause staff to just focus on monitoring and defending themselves from negative scrutiny. Staff attention is dominated by these bureaucratic processes, and they can lose sight of and connection with their professional values which can lead to disenchantment (Samier 2013). The pressure experienced by the CMHTs were exacerbated by the COVID pandemic in March 2020.

8.8: The impact of COVID.

The semi-structured interviews were conducted in 2021-22 whilst some lockdown measures were still in place. The participants had worked throughout lockdown. CMHTs continued to function throughout the COVID pandemic, many prioritised urgent referrals and assessments and consultations were moved to online platforms (Foye et al 2020). Mental health services have subsequently experienced a backlog in addressing non-urgent care (NHS 2022). Post COVID, the number of referrals to CMHTs has increased dramatically. This may be because mental health problems take longer to develop and to diagnose (UK Parliament 2021). In addition, emotional responses to trauma are often delayed until the stressful event has passed.

A Care Quality Commission inspection was carried out in Trust A in 2020. The purpose of this was with a view to seeing how CMHTs were being run through lockdown. The report found that there was good leadership, and support and home visits were maintained as necessary. Some service users reported that they lacked contact, virtual working was adopted, and group forums were cancelled. Caseload weighting tools were not introduced as planned and psychiatrists were attending less CPAs as they were deployed to the wards. In Trust B, the CQC visited in 2020 as they had received information about concerns for safety and quality of care. The only comment about COVID was that staff reported that waiting lists had decreased due to using digital platforms to contact service users waiting for a service. Despite the acknowledgement of the impact of COVID, the clinical work was judged as requiring improvement in both Trusts (four items two participants).

Trust A was rated as requiring improvement in 2020 for several reasons. These included: "*Although staff assessed the risks affecting patients they did not consistently put in place or update risk management plans to address these risks*."

"*Over a six-month period, most teams did not meet the trust target of 95% of patients to start a psychological therapy within 18 weeks of their referral".*

Trust B was also rated as requiring improvement in 2022, some of the findings included the following: "*Patients who did not require urgent care did not always receive timely treatment. Some types of treatment were not provided because there were not enough staff to learn how to provide it and then provide it. This meant some patients were left waiting for the care they needed. For example, specialist treatment for people with complex mental health needs."*

The CQC are required to report on safe staffing in relation to the number of trained staff and if they are competent and receive appropriate support and training (CQC 2022). CMHTs have experienced staff shortages for several years, this was exacerbated by the pandemic (Foye et al 2020).

AA3: *I think the fact that we are short staffed all the time, our team is too small, and it is overwhelming. The caseload size is overwhelming each and every one of us. There is no one in our team that isn't complaining. Before the pandemic we had between 5 and 10 referrals a week, now we are having up to 40.*

The staff experience the subsequent post pandemic surge of referrals overwhelming. The long-standing issues facing the workforce such as excessive workload high, sickness rates and large numbers of vacancies were exacerbated by the pandemic (West et al 2020). NHS Improvement (2019) and NHS (2022) state that there are plans to tackle the waiting lists and service shortfalls from the COVID pandemic, which includes extra funding. The NHS Long Term Plan (NHS 2019) states that there will be an extra £2.3 billion ring fenced funding by 2023/24. The development of Integrated Care Systems is also part of the LTP and is discussed in the policy analysis chapter. The plans to expand and develop the mental health workforce will be discussed in Chapter nine. The impact of these plans is yet to be realised.

8.9: Summary.

This chapter addressed the meso level data regarding factors which impact CMHN clinical decision making, at team level. This includes team structures, processes, relationships with other team members and managing boundaries between services. Care pathways are diagnostically led and focus on the treatment and management of symptoms and provide a clear trajectory and end

point (Busse et al 2019). Service inclusion and the delivery of evidence-based interventions are driven using standardised care pathways. These are operationalised at Trust level, to create structures which meet the needs of the local population. The two Trusts in this study have structures their care processes in different ways: one according to diagnosis and the other in relation to stages of the care process. This has implications for the role of the CMHN., as their role is focussed on the pathway or part of the care process that they work within. This can also be challenging if the service user has multiple diagnoses or cannot fully engage with the standardised interventions provided. One of the Trusts in this study rates service users according to their level of risk. That is focussing resources on those who currently present with the most serious and immediate risk. It is important to prioritise, but it potentially takes resources away from preventative interventions.

CMHTs have standard waiting times for service users waiting for assessment and allocation. This is intended to promote access to services encourage “patient flow” through the care process. However, parts of the service are subject to waiting lists and log jams, mainly for less risky service users waiting for psychological treatment. Waiting lists can a way of rationalising services (Lipsky 1980/2010). This can lead to service users disengaging from the service. There is also duplication of assessments carried out by sub sections of the team. However, it can be viewed as a way of directing services at those with greatest need. These structures enable CMHTs to have a clear focus and to target their resources effectively. This is also managed by managing boundaries between the CMHT and the other services that it takes referral from and makes referrals to. This involves developing effective working relationships and a shared understanding of these boundaries with other CMHTs and primary care. This is often challenging

as these services are all trying to manage large workloads with limited time to engage in discussions and shared care. Therefore, referral and re referral processes are used.

Clinical decision making takes place in regular CMHT meetings. CMHNs present the service user they are working with, and the team makes decisions about their inclusion in the service or about changes to their care. The CMHNs sense of autonomy in this process is impacted by team dynamics, the complexity of the service user's presentation and team perceptions of professional roles and responsibilities within the team. These decisions are influenced by what and how the CMHN presents at a meeting. More experienced practitioners will be succinct and already have decided, this is valued as effective by managers.

Participants describe how their documentation is subject to planned audits and spot checks by their team managers. This drives the participants experience of feeling under pressure to ensure that their documentation is completed, as discussed in chapter eight. The Department of Health and Social Care (2020) carried out a consultation entitled "Busting Bureaucracy". This acknowledges the excessive demand on front line clinical staff of documentation, and over reporting. Participants describe how this becomes a means of appraising their performance. The CMHNs role in clinical decision-making is shaped by team structures for managing patient flow and targeting resources at those in greatest need. Team meetings reinforce these processes yet provide the CMHN with the opportunity to interact and influence decisions. Chapter nine will explore the CMHNs perceptions of Trust and national priorities and how this impacts their role.

Chapter 9: Impact of National policy and workforce.

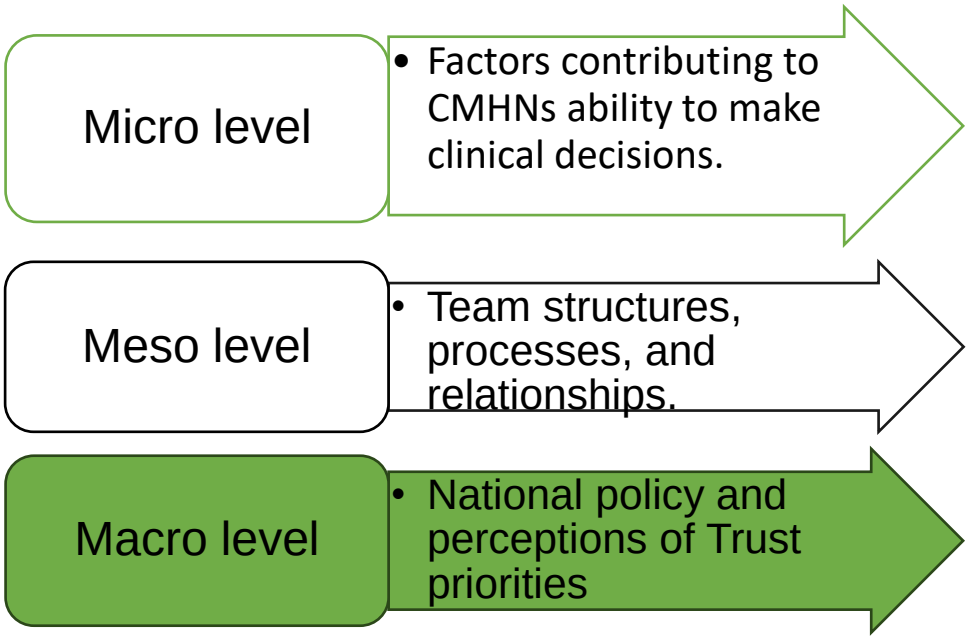
9.1: Introduction.

As suggested in Chapter eight, national policy directives shape the operationalised structures, targets and care pathways of individual NHS Trusts. CMHNs may not view themselves as cognisant of NHS mental health policy issues but may have shared experiences of their impact on the mental health nursing workforce. This chapter examines CMHNs awareness of macro level influences, that is their interpretation of national policy and how it impacts on their NHS Trust and working life. The chapter addresses the themes identified through the analysis of the empirical data derived from the semi structured interviews. The aspects of National policy which influence the operationalised structures at Trust and team level, are discussed in Chapter eight. The operationalised structures for each Trust were captured in the thick description in Chapter four.

The first theme in this chapter; awareness of national policy, considers CMHNs knowledge and opinions of current NHS National policy. Most participants said that they did not know in detail, the content of proposals and legislation. However, they could comment on practice and workforce issues that resulted from policy. The issues they raised included the impact of funding cuts on their socially vulnerable client group. Nurses have a role to play in influencing policy to advocate for those who are negatively impacted by health inequalities (MacDonnell and Buck McFadyen 2016). Their own income and quality of life are affected. The COVID pandemic has raised public awareness about the challenges nurses face and health inequalities (Morin and Baptiste 2020).

The second theme discusses CMHNs views of their Trust and their relationship with their employer. The issues raised by staff, namely feeling listened to, valued,

and supported are reflected nationally in the NHS staff survey. The third theme addresses workforce issues, this including recruitment and retention issues, the impact of continuing vacancies and high turnover. The participants recognise that this is a national problem. The fourth theme discusses the development of advanced clinical roles for CMHN. This considers the impact for the sphere of responsibility. It also addressed the potential genericism of CMHN role.



9.2: Awareness of National Policy.

The participants were asked if they had any awareness of national policy and the proposals for Integrated Care Systems. Half of the participants said that they were not fully aware of policy issues, stating that they did not have the time to read or think about this. Participants who did have a view, expressed the belief that secondary mental health services were under funded, and that the Government wanted to privatise the NHS (eight items, four participants).

BD2: *I think in terms of …I think people in our team think that often, mental health secondary services are a completely different ball game. The publicity is more around low-level stuff. Sometimes it feels like we are so far away from getting*

what we need in all senses really. That is, for patients, services that have been cut over the years, to the staffing.

BD4: *I think they are running to privatise it. I think they would happily tear it apart and screw everyone over for the sake of profit. I am trying not to be too cynical, but I do wonder what state we will be in in about 10 years. In mental health we do not have enough beds.*

Mental health nurses work with vulnerable members of the community, who experience a range of health and social problems. Fowler (2017) suggests that healthcare policies have a political dimension, reflecting the ideology of the political administration in power. Therefore, nurses have first-hand experience of how this impacts the service users. The organisation of care, determined by policy impacts on the nurse's role, their pay and how they are viewed by the public (Morin and Baptiste 2020). The participants were asked if they knew about the proposals within the green papers regarding the Health and Care Act (DoH 2022) (Two participants).

AA1: *I know it is coming and that there have been meetings about it. At the moment it doesn't really affect those of us on the front line. It will start at the top and slowly trickle down to us. I think that anything that would improve the service for service users if that is going to be the plan, then I am hopeful. I have not really had the headspace to think about it.*

AP2 (Pause*) I think that is positive, working together, bringing everything together. I think that is a positive move. So, we don't duplicate work.*

BD3*: I don't know, is the honest answer. Our Service Manager has been talking about it, I am not sure where it is going. I am happy for change if it is useful. At the moment they are talking about getting rid of CPA, enhanced and standard,*

they are talking about, all sorts of things. What does that actually mean on the ground level?

Nurses could play a valuable role in shaping policy, given their first-hand experience of what their service users need and their understanding of how services should be organised and delivered. Rafferty (2018) suggests that current policy is fragmented and financially driven and has not kept pace with demand or utilised evidence from professionals. For professional consultation to be utilised in policy development, the NHs would need to develop a more democratic structure. This would enable power and influence to be shared with clinicians or their representatives (Ferreras et al 2022). Political awareness and activism require a collective approach and activity beyond nurses' daily work. There are many factors which mitigate against nurses becoming politically aware and active. These include heavy workloads, time constraints and fear of retaliation (Boswell et al 2005). In addition, the marketisation of healthcare has meant that nursing work is focused on reductionists tasks (Carram et al 2022). This distracts them from providing holistic care and from seeing the service users' needs in a wider social context (Des Jardin 2001).

The NHS Long Term Plan (NHS 2019) pledged to increase the relative share of funding for mental health services and increase workforce. However, post COVID the demand for mental health services has increased, and the resources do not match the demand (National Audit Office 2023). Long-term underinvestment in mental health services and poor pay for nurses have resulted in significant workforce shortfalls (Adams et al 2021). Participants commented on the issue of pay and conditions and the impact this has on their morale. This participant in

Trust B, had the perception that Trust A has better recruitment as they pay London weighting.

BD5: *Yes, and it seems to be that most people that leave tend to go to Trust A. As I have never worked for Trust A, I don't know if it is about the actual Trust or the incentives like pay and that is why they go. I think if we had more nurses and doctors and we were able to give everything, well actually we do feel like that but, if we felt like the patient received everything that they needed I think people wouldn't feel so frustrated, with their workload.*

This example illustrates how staff satisfaction can be linked to being able to provide quality care. This is dependent on having enough permanent staff and stable teams. High vacancy rates and use of agency staff correlate with lower staff and service user satisfaction and higher levels of absenteeism and further retention problems (Sizmur and Raleigh 2018). Staff can experience emotional conflict when they cannot provide the quality of care they would like to (Marsh and Proctor 2022). Staff may leave the service, or employ adaptive behaviours instead, such as withdrawing psychologically, going off sick and reducing their standards and expectations (Lipsky 1980/2010). Withdrawing and becoming cynical are common psychological reactions to the feelings of helplessness that staff experience in the face of service shortfalls (Ballatt et al 2020).

9.3: CMHNs perception of their relationship with their Trust.

The participants' views on their relationship with their employing Trust is addressed (four items, four participants). In 2022, NHS England published the results of their national staff satisfaction survey. This survey sought the opinions of NHS staff about their working relationship with their employing Trust. The survey consisted of two overarching themes: engagement and morale. There

were seven elements, which included “we have a voice that counts.” Both Trusts’ scores were equal to the National average for these elements (NHS 2022). Both Trusts pledge to ensure engagement and address morale in their respective nursing strategies. However, participants report a disconnect between themselves and senior management. Trust A Nursing Strategy (2019-21) states that the Trust recognise that they will not achieve their priorities without nurses’ engagement and wellbeing being a central focus. Similarly, Trust Bs nursing strategy (2017-20) says a priority focus will be given to nurses’ engagement and wellbeing.

AA2: But, as I said, to be very honest, Trusts these days are looking at the good image, they want the CQC rating to be very good.

AA3: We go to the locality meeting to present all these issues that we are struggling with. You see top people there and they say “ooohh that’s true” and they listen. They do listen but the action is not there, to be honest.

BD2: *Their priorities, I mean it is so varied across the Trust. I do think that there is the care and compassion and everything. We do try our best to deliver. It is difficult, because quite often when you are working, you don’t really get involved with what is going on at the top.*

BD3: *Priorities generally speaking are targets. They haven’t always been targets but there has always been a lack of care, for what the staff are going through.*

There is clearly a recognition at National and Trust level, that good morale and positive staff engagement are vital in the nursing workforce. The national recommendations to address this includes guidelines for safety and organisational performance and measuring the incidence of organisational reporting (NHS Employers 2022). Other recommendations include sending

middle managers on “compassionate leadership” training (NHS Employers 2022). CMHT leaders often must manage the tensions between meeting the demands of the business processes and supporting the emotional work of delivering therapeutic care (Ballatt et al 2020). Organisations often value managers who can achieve challenging targets and deadlines regardless of the human cost of the staff. Staff who voice challenges to their aims may be ignored and devalued. This may involve not listening to staff concerns or “negative views”, lowers morale further (Ballatt et al 2020). Staff in both Trusts value the support they receive from their team managers and recognise the organisational pressures which Senior management face:

AA4: *I personally like the Trust which I why I have been here for a long time. Their priorities are to get services running to the safest level. There are problems, with recruitment and retention, but I guess that is the same everywhere.*

Care Quality Commission recommendations for Trust A (CQC 2020) included guarantee the use of the caseload weighting tool to ensure care coordinators had manageable workloads. The recommendations for Trust B (CQC 2022) included reviewing the number of staff required to provide safe and effective care. In addition to addressing issues of safe staffing there is a national and local commitment to staff wellbeing. The Health and Wellbeing Framework was introduced in 2018 (NHSE website). Its focus was to reduce staff sickness and absence in NHS, and the NHSE Wellbeing strategic overview suggests that this was achieved (NHSE and NHS Improvement 2021). A report in 2021: NHS Health and wellbeing a strategic overview, acknowledged the limitations of a reactive approach which focused purely on sickness rates. This introduced a model, which incorporated preventative work by promoting positive wellbeing and wider

organisational culture. This includes utilising independent counselling and support services, which both Trusts have addressed.

AA4: *Yes, absolutely, I mean overall it's alright. We do have a good communication system, where everyone can get access to what is happening in the Trust. There is access to activities, there is staff wellbeing, there are a lot of programmes being set up, for staff, quite often. We recently had a massage chair, delivered in our lounge. I know they are doing things like mindfulness classes for staff. We do have Care First which provides counselling support for staff. It is independent from the Trust you know. It is funded and accessible to anybody. There are a lot of good things I must say.*

BD4: *Erm, yes, I have got no real complaints. They were very supportive to me last year when I was off long-term. They paid for my training, they paid for my secondment. Obviously, everyone has gripes about specific people but as an organisation I don't have any major issues.*

Nationally, the NHS workforce experiences difficulties with morale, staff engagement and feeling that they are listened to. This is also evident in the views expressed by the participants. The participants suggest that although they experience a disconnect with senior management, they feel supported by their line managers and recognise that their employers are attempting to address morale and wellbeing.

9.4: Workforce issues.

Participants in both Trusts describe difficulties in recruiting and retaining staff within their teams. NHS England (2019) Mental Health Workforce Plan noted that the attrition rate amongst mental health nurses is higher than for other fields of nursing. There is a negative turnover, with less nurses being employed each year

and more leaving. Many vacancies are filled with bank and agency staff. The mental health nursing workforce has relied on overseas nurses and recruitment, and retention has been negatively impacted by Brexit. NHS England set out plans to monitor attrition and turnover. The development of Nursing Associates and new roles such as well-being practitioners are part of the drive to tackle these workforce issues. In Trust A, the Nursing Strategy states: “We recognise that we will not achieve our priorities without nurses’ engagement and wellbeing held central to our values. We will therefore ensure that our nursing staff have opportunities to steer our developments and are supported to maintain their own health and wellbeing as a fundamental principle of how we will develop and sustain our reputation and resilience as a profession in these coming years”. Participants in Trust A described how difficult recruitment and retention were in their teams (four items and two participants).

AP2: I don’t know why, I don’t know why, the advertisements are put out, I don’t know. They don’t turn up (for interview) they might apply but get a better job, a better deal somewhere, I just don’t know. Saying that we do have permanent staff, who have been working there for years. We had one retiring, they retired last year. It is just at the moment you don’t get people coming in as permanent staff.

AA4: *The Nursing Associates were developed to fill the gap. I am not sure how much of a gap we can fill, this is a massive problem in the NHS. Is it 40,000 nursing vacancies?*

Participants in Trust A also describe the use of agency staff and how even they don’t want to stay long (two participants four items).

AP2: *No, I don’t think a lot of people are leaving but we don’t have much permanent staff. It is agency and sometimes they just come and go. They might*

come for three months then get another job that might pay better or be closer to home so they will take that offer…… A lot of clients do complain. When you take on a case you get clients saying, "Are you here just for 3 months and then you are going to leave me?" So, there is no consistency obviously. This person comes for three months, leaves, and the client is just left. It is really a concern to them as well. A lot of clients say to me they hope I am not a temporary one.

In Trust B, the nursing strategy states: "We will ensure that a priority focus is given to nursing recruitment and retention from Bands two to eight, to ensure that the care that we provide to the people that use our services is of the highest quality, all of the time". The CQC feedback for Trust B in February 2022 noted that the Trust had difficulty recruiting registered nurses in all services. They noted that staff reported that they had large workloads. Patients reported that they had numerous changes to their community care coordinators, which had a detrimental impact (four items three participants).

BD3: *Yes, another thing I am involved in is the recruitment of band six nurses. We have just recruited three, two have started and we are waiting for the third one. We have also had a lot of people leave in the past 18 months. We have had a lot of people leave for a myriad of reasons. The official reasons are often they are moving to a different part of the country or moving to a neighbouring Trust. The climate is disaffected, we've got high caseloads, too many targets, career progression is crap.*

The most recent Care Quality Commission reports for each Trust comment on retention, recruitment, and safe staffing levels. The reports for Trust A (2020) and Trust B (2022) both address the use of bank and agency staff to cover sickness and the long-term use of locums to cover registered nurse vacant posts. Retention

and recruitment are a widespread national problem, mental health services are amongst the worst affected areas (CQC 2022). The NHS People Plan (NHSE 2020) makes recommendations for Trusts to boost recruitment and retention. These include the creation of “local recruitment hubs” to promote local and international recruitment. Measures to retain staff include changing pension rules, removing limits for contributions and the amount of time people can work after they have retired. Another recommendation is the requirement of Trusts to engage in “capacity planning.” This involves Trusts utilising monitoring tools to utilise their existing workforce and their skills more efficiently. Trust A introduced a caseload weighting tool, to ensure that care coordinators had a framework to monitor the size and complexity of their caseload with their manager (Korasz et al 2018). Issues such as organisational culture and attracting a local workforce are best addressed at local level (Beech et al 2019). Local workforce plans often underestimate the need for staff, perhaps as these are linked to funding streams which overstate the likelihood of cost reductions (Palmer and Imison 2018).

The NHS and Social Care sector have been facing the worst workforce crisis for many years. The Government are reluctant to act decisively to address this (House of Commons 2022). It is widely acknowledged that NHS staff are experiencing high levels of burnout, poor physical and mental health and taking time off sick as a result (Kessler et al 2021). Dissatisfaction with pay and working beyond contracted hours on a regular basis have been reported by nurses over the past 10 years (RCN 2020). The RCN (2021) report that 61% of nursing staff are thinking of leaving and 81% of organisations report work shortages. There is overwhelming evidence that this is a national problem. Framework 15 was a long-term strategy for the health and social care workforce, originally published in 2014. It was criticised for not providing a tangible and fully costed and funded plan

for national delivery. A reviewed version was due to be released by the Secretary of State in 2022 but has not been forthcoming (House of Commons 2022). The Mental Health Workforce Plan (NHS 2017) pledges to increase the scope of and access to mental health services, but with little commitment to how this will be achieved.

The NHS Interim People Plan (NHS 2020) acknowledges the problems with the workforce: retention and recruitment, especially in nursing and increased demand. This outlines a national plan of improving the culture of the NHS, developing fulfilling careers, flexible working arrangements and "giving staff a voice." The responsibility for delivering these plans lies with individual Trusts (House of Commons 2021). Trusts may feel the pressure to maintain their status and contain anxieties about failing or suffering adverse public scrutiny. Senior management need to balance delivering strategic plans with hearing about and containing the anxieties of staff (Ballatt et al 2020). The House of Commons (2018) recommends redressing the role of targets across the NHS to ensure that pressure to achieve these does not create a culture amongst senior managers which compromises the care of patients. The Hewitt Review (NHS 2023) has acknowledged the burden placed on staff by numerous national targets, and that clinical staff spend too much time responding to requests for duplicate data. It states that the worst affected areas are community and mental health services (NHS 2023).

9.5: Career progression: advanced clinical roles.

National workforce initiatives include the development of Advanced Clinical Practice (ACP) roles**.** These roles are for registered practitioners from a variety of professional backgrounds, including nursing. They are regarded as vital in helping

transform service delivery and maximising productivity and efficiency (NHS 2019). It is subject to national standards to ensure consistency and effective regulation. It is also intended to be an effective and attractive workforce solution (Clever Together 2019). There is a small amount of data on this. This may be because there is only one participant in Trust A who is an ACP trainee.

AA2: *Our role will be like what the Responsible Clinician is doing now, we will step up to some level of assessment and diagnosis. We will be able to help the medics and give them our impression and make a diagnosis and agree the treatment plan for a member of staff to facilitate.*

In Trust B two participants have band seven clinical roles. These are aimed at providing incentives for nurses to develop clinically. One participant is planning to develop their expertise in working with service users with personality disorder (already discussed in the code intrinsic motivation). The other states that their role is clinical, but it is managing clinics at the CMHT.

BM1: *I think what is worth noting is something that is a positive change. It used to be that if you wanted to progress within my team or any CMHT it would mean that you had to retrain, in something therapeutic or teaching or nurse prescribing. Or you would go into management. They have just developed a role for specialist community nurse, a band 7. …… It is important if that is where your passion is. You can also lose those skills if you go into management. It is what we came into nursing for*

Retaining experienced staff is paramount in building the future workforce and maintaining the safety and quality of care (Tang and Hudson, 2019). The development of advanced clinical roles may go some way to addressing this. In chapter seven, participants' accounts of the importance of the therapeutic

relationship and the value of service user contact are cited as positive aspects of intrinsic motivation. The participants gave examples of how their respective Trusts were creating advanced clinical roles for this reason. The NMC leavers survey (NMC 2022) stated that mental health nursing has high vacancy rates compared to other fields of nursing.

The development of Advanced Clinical Practice roles in mental health is intended to meet the care needs of service users with serious mental illness with comorbid physical and mental health problems. This role is central to the development of Integrated Care Systems and there is an acknowledgement of the need for generalist and advanced clinical skills (HEE 2022). Mental health nurses have expressed concern about the impact this will have on their identity as mental health nurses (Brimblecombe and Nolan 2021). The Mental Health Nurse Career and Competency Framework (HEE 2020) states the importance of mental health nurses having an identity, clearly defined roles, and career progression options. The recommendations in this report, include enhancing the therapeutic relationship and promoting the core skills of mental health nursing. This would appear to be an acknowledgement of the intrinsic aspects of the role. The report suggests that this can be achieved through education, career development and organisational support. The development of advanced clinical roles in the context of Integrated Care Systems is yet to be realised. Mental health nursing would appear to be subject to the conflicting demands of genericism (including physical health care skills) and specialism (maintaining the specific skill set of mental health nursing). Integrated care does not need to happen at practitioner level and the development of physical health skills in the workforce can be context-specific (McIntosh 2017). The CMHN may be best placed to assess the service users' physical health as they have established contact with them. In addition, the

physical health care problem may be secondary to the impact of serious mental illness and the medication used to treat this (Butler et al 2020).

9.5: Summary

This chapter addressed participants' perceptions of macro level, issues, namely their awareness of how national policy impacts their employer and subsequently their working life. Staff acknowledged that they did not have a clear understanding of this: that they didn't have time to find out and were going to wait until this "came down" from senior management. They would become aware of how this impacted on their work when the subsequent service configurations were operationalised. These are then disseminated to Trusts who generate the technical, managerial, and administrative structures to achieve policy directives (Starling 2018).

NHSE (2016) stated that there was a new vision for the NHS and a culture of local planning and integrated working. This was described as a departure from the long-history of "top-down" national initiatives (Starling 2018). Participants did comment on their subjective experience of what they saw as the impact of government policies and austerity. These included: poverty for their clients, poor pay for them and under investment in services. There is recognition at national level of the problems facing NHS staff and factors which have a significant impact on wellbeing. These factors include poor pay, high level of vacancies and working culture (House of Commons 2021). A study entitled "Beyond Demoralised" suggests that staff require a positive working culture and support from senior management (Marsh and Procter 2022). Retention and recruitment are recognised by participants as a national issue. They all have first-hand experience of the impact of the CMHTs they work in being understaffed. Participants recognised that there was an initiative at national and trust level to create

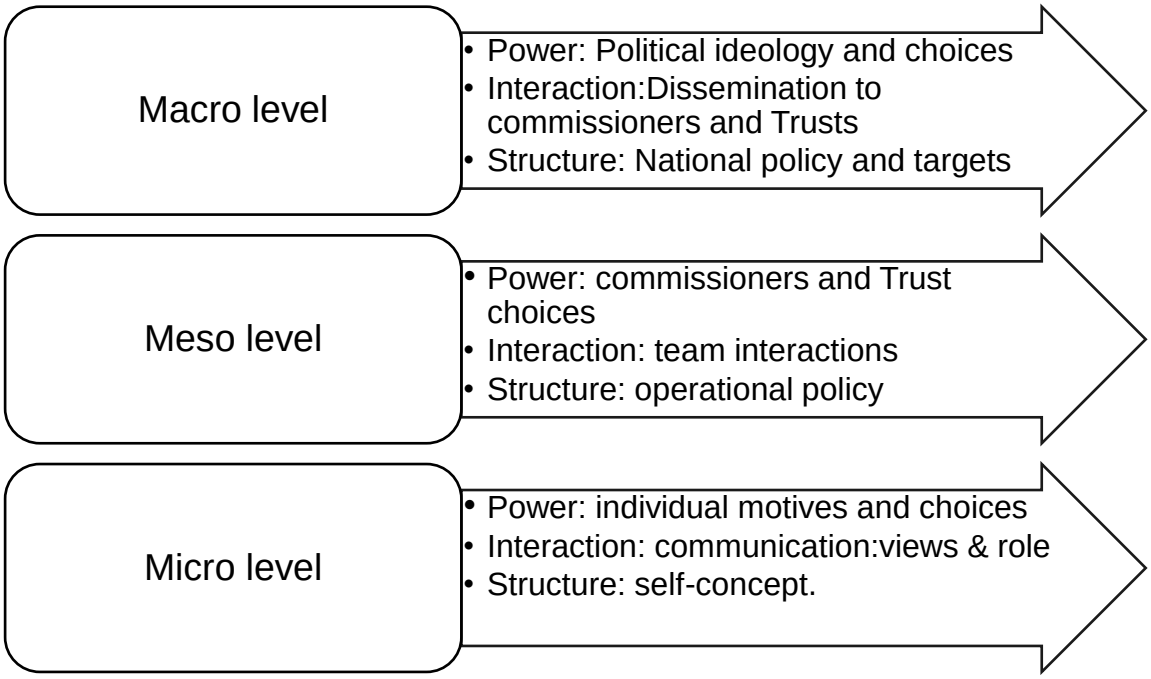
advanced clinical roles to retain and develop skilled and experienced nurses. This may also expand their scope of responsibility to assume more advanced clinical skills including physical health assessments.

Chapter 10. Generative mechanisms

10.1: Introduction.

Chapters six, seven and eight, present the empirical data from the semi-structured interviews. The analytical processes within these chapters involved the application of theory and policy to the data to hypothesis about the structures, choices and interactions which produce the empirical experience (abduction). The Data was arranged in a hierarchical structure: micro, meso and macro to demonstrate the relationship between organisational interpretation, team operationalisation and individual experience (retroduction). This chapter will present the analysis of the generative mechanisms which produce the empirical experiences of the participants. This draws upon the data in chapters six, seven and eight. In addition, data derived from non-participant observations is used to verify the generative mechanisms. The non-participant observations were carried out after the data-analysis of the semi-structured interviews, to confirm the explanatory power of generative mechanisms. Observations of team meetings were utilised as these forums capture the operationalised structures, social practice and team and individual interaction and choices, at meso-level.

This chapter will present each of the Generative mechanisms in turn. These are: managing workload, the role of the CMHN and service user self-management. Each generative mechanism will consist of an introduction, power, structure and interaction, at the macro, meso and micro levels and a concluding statement. The chapter will conclude with a summary which will comment on the relative explanatory power of the generative mechanisms and the interaction between the levels of the hierarchy, and conflation between the mechanisms.



10.2: Managing the workload.

10.2.1: Definition and justification.

Chapter five presented a policy analysis. The first section highlighted the development of policy which links the delivery of mental health care to measurable outcomes. It also acknowledges the need for efficient use of services. The increase in people experiencing complex health needs, plus rising expectations from health services, leads to increased demand on services with finite resources (Kerasidou 2019). The NHS therefore has to prioritise its services, nationally at organisational level and through decision making at practitioner level (Klein and Maybin 2012). This can be achieved in several ways. These include rationing by deterrence, that is putting obstacles in a service users' way, or rationing by deflection, involving signposting the service user to another organisation (Klein and Maybin 2012). Services need to incorporate efficient use of resources within their strategies and decision making (Knapp and Wong 2020). Gatekeeping refers to processes which control entry

into mental health services (Dawber 2014). In mental health care pathways this is often viewed as a role for primary care and CRHTs, who can decide who is referred to CMHTs (Beegum et al 2016). Operationalised policy creates structures to manage the workload, based on inclusion criteria, risk and suitability for established care pathways. These criteria are established locally between the purchaser and provider and are based on clinical guidelines, such as NICE and the Royal College of Psychiatrists.

10.2.2: Macro level mechanisms.

The concept of power**:** at the macro level, refers to political choices and priorities made by the Government. This is implemented by the development of health and social care policy. Policy implementation is driven by a combination of the perception of a social problem, by the and/or the morbidity of health problems, cost and political ideology and opportunity (Alaszewski and Brown 2012). Developing policy which, considers the Government's priorities, public opinion, and the views of relevant professional and community groups. This is discussed in the policy analysis in chapter five. The NHS Long Term Plam (2019) contains a narrative which acknowledges service pressures and unmet need. It also states the intention to drive efficiency, this has been exacerbated by COVID (Sutton 2023).

> Care pathways in the NHS Long Term Plan (NHSE 2019 page 3) "*The growing role of NHS-led provider collaboratives in delivering whole pathways of care for populations have already started to show us that short and purposeful stays, close to home linked with quality community services can deliver improved patient care".*

Services are required to monitor outcomes to demonstrate compliance with centralised plans. The NHS Long Term Plan (NHSE 2019) states that adults with serious mental illness will receive NICE approved care packages within two weeks of referral and that 390,000 will undergo physical health checks and 55,000 will have access to return to work schemes. There are also national targets about waiting times from referral to assessment and from assessment to treatment. Green paper policy documents acknowledge the need to deliver quality care to communities. This serves the purpose of creating an allegiance with professional groups and acknowledges the views of professionals and public perception NHS resources need to be used wisely and targeted to ensure positive outcomes and minimise waste (Kerasidou 2019). The measurable outcomes, have the purpose of ensuring timely access and reduce waiting times. The Mental Health clinically led review of standards (NHS 2021) state that the purpose of targets is to have measurable standards which enable organisations and commissioners to understand their systems and to improve pathway and flow issues for mental health services. This monitoring is delivered through a range of structures**.** These are nationally determined for community mental health services.

The CMH Framework suggests that existence of specialist teams is a legacy of the National Service framework and clustering (NHS 2019). CRHTs and EIS still exist in the two Trusts in this study. EIS aims to prevent long term conditions and CRHTs function to minimise hospital admissions (Begum and Riordan 2016). Dashboards are accessible digital tools which demonstrate an organisation's KPIs in relation to measurable outcomes off set against funding (NHSE 2019). NHS Dashboard 2022-23: SMI waiting for second contact and physical health check. Also, delayed discharges and 72-hour follow up after

discharge. Care pathways are diagnostically led and focus on the treatment and management of symptoms and provide a clear trajectory and end point (Busse et al 2019). NHSE (2022) aim to reduce delayed discharges by identifying a discharge date on admission to hospital, involvement with CMHT before discharge and the organisational level responsibility for discharge processes. This is outlined in Discharge challenge for mental health and community service providers. "*It will be paramount that you as leaders can account for how this money will be used and can demonstrate the value that the funding has brought to lowering the number of patients awaiting discharge and the subsequent improved flow through the system." (page 2).*

A top-down interaction involves policies being established at government level. These are then disseminated to commissioning bodies and Trusts who generate the technical, managerial, and administrative structures to achieve policy directives (Starling 2018). This approach requires clear targets and processes at Trust level, to demonstrate effectiveness and clinical outcomes. The Trusts therefore have negotiations with the commissioning body in agreeing performance targets. A senior manager in Trust A informed me that there are no sanctions applied to teams or individuals when targets are not met, but equally there are no rewards or acknowledgements when there are. The expectation of these being fulfilled is communicated by electronic systems, e mails and briefings. The Senior management team examine the reasons why targets are not met and acknowledge that it is a capacity issue. In Trust A, the number of referrals to CMHTs have increased year on year by an average of 40% since 2019. In addition to meeting this increasing clinical demand, Trusts also must collate detailed information to demonstrate to commissioners and NHSE that targets have been met. This has an impact on the workload of CMHTs which will

be discussed in the meso section. The Department of Health and Social Care (2020) carried out a consultation entitled “Busting Bureaucracy”. This acknowledges the excessive demand on front line clinical staff of documentation, and over reporting. It concludes that this makes little positive impact on quality of care and patient safety. However, the requirement to demonstrate outcomes at Trust level remains. The next section will consider how these requirements are patterned at Trust level and implemented in the CMHTs utilised in this research.

10.2.3: Meso-level mechanisms.

Power at the meso-level refers to Trust’s motives regarding operationalising structures and pathways. Their motives may be based on local need, managing finances, local competition, and improved patient outcomes. There is localised choice. This is illustrated by the fact that the two neighbouring Trusts have operationalised this differently. In Trust A diagnostic teams: reductionist view of complex diagnosis: primary diagnosis becomes the dominant narrative and psychosocial aspects are also addressed. In Trust A the separate diagnostic teams were established in 2015. The Senior Managers who provided the operational policy information to me explained why. The rationale is to make it easier for staff to focus their skills set on working with a particular client group. In Trust B CMHTs are structured according to stages of the pathway for example: assessment, initial interventions, case management, active review (waiting list) and care coordination. This is discussed in the thick description in Chapter four.

The Trusts develop structures within their operational policies which implement care pathways, patient flow and monitoring outcomes. The operational management in trust A was last configured in 2021. There is one director and three associate directors for the directorate. For each Borough there is one service manager. Each borough consists of two CMHTs and each has a service manager, within each CMHT, there are sub-teams: psychosis and affective and each team has a team leader. In Trust B, at directorate level, there is a service director, a deputy service director, two general managers, a head of nursing, social work, allied health professionals and psychology. At team level there is one service manager and team leader for each team, namely for the working age adult CMHT, the older adults CMHT and the early intervention service.

Operational policies outline inclusion criteria for each service, assessment process and standard interventions. Trust A affective team outlines the process for generic assessment, formulation diagnosis, care needs, intervention, and fast track job retentions. Interventions include psychoeducation, problem-solving, safety planning and supported self-management. After core interventions have been delivered, the service user may be considered for specialist psychological interventions. Trust A psychosis team policy states that inclusion criteria are based on the treatability of the person's illness, the plan of care is collaborative and based on evidence-based interventions. The CPA framework is used, to support recovery and discharge planning in a timely way. In Trust B: there is one large CMHT for a defined geographical area. The Care process consists of assessment and if the service user has a diagnosis of serious mental illness or is at high risk, then they are allocated for care coordination. If not, they undergo a standard set of Cognitive Behavioural

Therapy based strategies called “initial interventions”, they may go onto the affective or personality disorder pathway. These structures guide decision making and the format for team meetings. They also define care pathways and entry and exit points for managing the workload. Trust A has a RAG rating system which is used to structure team meetings. Trust B has a “red section” before their team meeting to raise any immediate risks which need to be prioritised by the team.

In chapter six, the issue of workload was addressed. This was impacted by the amount of documentation that CMHNs are expected to complete**.** Documentation checks are carried out at team level. managerialist approach to demonstrate that targets have been met and gives the impression of productivity and success (Elkomy and Cookson 2018). The pressure to complete documentation therefore becomes and overwhelming driver for practitioners (Goldsby et al 2020). Trust A: produces summaries of their performance dashboards. The stated purpose: “*These reports provide a platform through which staff can monitor and review their performance at team and service level in order to promote data quality as well as aid effective and efficient allocation of resources.”* This consists of 40 items of reporting, which are rated red if they are overdue. At the time of undertaking the NPOs, the affective team had 23 items in the red. Top of the list was “referral to psychological services.” The remaining items largely documentation: recorded and updated care plans, CPA reviews and risk assessments. The psychosis team had nine items in the red, at the top was post discharge follow up, and the remaining items referred to documentation.

Trust level structures, discussed in chapter eight develop to manage parts of the care process becoming overwhelmed. The active review waiting list in Trust B is an example of this and is a Trust-wide initiative. There are Trust and team level short term measures to manage problematic workflow issues. Trust wide caseload reduction was discussed in chapter eight. Structures temporarily shift the backlog from one part of the service to another, this may give a sense of temporary easement but does not address the underlying capacity issues.

A team level example of managing workload was observed in Trust A, Affective team *non-participant observation**:** The team manager suggested having a waiting list for allocating service users for care-coordination. The manager suggested that SUs could use the duty system (a telephone led urgent contact facility, staffed by the CMHNs in the team) as an alternative. The CMHNs were resistant to this as this also impacts their workload.*

CMHT meetings happen weekly; these are forums for all members of the multi-disciplinary team to discuss service users and make decisions. These meetings follow standard structures as discussed above. Interaction within these meetings is both verbal in the form of team discussion, there are documented outcomes to demonstrate the decisions made**.** These structures usually guide decisions based on risks which arise from symptoms. However, there are exceptions to this whereby CMHNs raise psychosocial risks, and this is accepted by the team. For example:

*Trust A psychosis team meeting non-participant observation**:** The service users in red zone, largely had psychotic symptoms and risk of*

violence/aggression, disengagement, and not taking medication. An exception to this was a CMHN and support worker escalating concerns about service users due to risk of eviction and severe self-neglect.

This demonstrates that team meetings can be a forum for individual service user issues to be considered and the team can make choices within their standard frameworks.

Trust B CMHT: non-participant observation: The CMHNs presented holistic assessments of service users clearly stating relevant historical aspects, psychosocial aspects, and service user preferences. This was acknowledged by the team manager and consultant psychiatrist. The outcome for each of these service users was initial interventions and active review waiting list. In this example the assessment was individualised, but the team level outcome was standardised. The guiding factor here was a standardised outcome to manage workload.

The standard structures for team meetings can provide clear direction as they apply consistent standards and lead to defined decisions and outcomes. However, due to the size of caseloads and the number of referrals there is a pressure to "get through everything." Therefore, it is difficult to have meaningful discussions as there is a need to be focussed and make timely decisions. Meetings are perceived by CMHNs a time consuming; they feel the need to be clear and succinct and to have decided about the service user they are working with before they get to the meetings (this is discussed in chapter eight). There

are opportunities outside of meetings to discuss issues that staff are finding problematic, for example:

Trust A, affective team meeting non-participant observation: the staff member chairing the meeting had to constantly draw lengthy and emotive discussions to a close, remining team members that there were several service users still to discuss, making the process comment "this can be taken outside the meeting."

Trust B team meeting non-participant observation: The team leader and consultant were supportive in facilitating meaningful discussions, however, after three hours, they had run out of time, with 15 cases still to discuss. The manager had to go off to another meeting and suggested that staff approach them individually with any cases that are urgent, or they will be carried over to the next meeting.

This is managing the tension that arises between the reality of meeting complex needs and policy and practice guidelines which are shaped by the need to manage limited resources and prioritise the greatest clinical need (Lipsky 1980/2010). In chapter eight the issue of boundary management between the CMHT and other services, was discussed. Communication between the two diagnostic teams in Trust A and between the CMHTs and GPs in both Trusts, is led by a formal referral process, rather than joint working. This is an example of maintaining rigid boundaries. When services face rising demands formal structures such as referral processes can be used to maintain boundaries, limit access to the team and therefore protect them from being overwhelmed. There is an interpersonal aspect of boundary management, which may limit

communication and mean that assumptions being made about other services making “inappropriate referrals” or “not doing their job properly.” This was discussed in chapter eight and there was evidence of this in the team interactions. For example:

Trust A affective team, non-participant observation of team meeting*. A CMHN expressed difficulties in joint working a risky service user with the Crisis team. They said, “The Crisis team staff said that they do not have the staff so to take it up with management.” The team manager responded in the meeting, that they meet regularly with the Crisis team manager to pre-empt any joint working difficulties*.

This was followed by a team discussion in which several team members, including the consultant said that their team went above and beyond and that this was not supported by other services. This team works with service users with EUPD and are subject to a lot of blame displacement: by the client group. This may be mirrored and in turn displaced onto other teams and services (Ballett and Campling 2020). This may also indicate a sense of powerlessness in CMHNs. They perceive a sense of having no control over their workload, perhaps more so than other members of the MDT. (This will be explored further in role of the CMHN).

In chapter eight, the theme “Documentation checks” refers to the CMHN experience of feeling pressure to complete bureaucratic elements of their work in relation to recording outcomes and populating audit systems. Participants described how this is checked by their manager and brought to their attention. This is sometimes brought up in clinical meetings, or more usually separate

business meetings. In Trust A psychosis team NPO: *The team manager suggested that they nominate the team for a Trust recognition award for their achievements in maintaining dashboard targets.*

10.2.4: Micro-level mechanisms:

Power at the micro-level refers to individual choices and motives. In chapter seven, the issues of intuitive knowledge and the importance of the relationship with the service user were discussed. This is a view shared by several participants. The CMHNs undertake assessments and present their work at team meetings for a decision to be made by the team. CHMN can make their opinions clear at the team meeting and are able to advocate for the service user.

An example of this from Trust B non-participant observation: *A CMHN presented an assessment they had undertaken. The service user was emotionally distressed and in a challenging social situation. The CMHN felt that they needed care coordination to manage their social and emotional difficulties. However, the consultant said that their mental health problem was not serious enough and advised that the GP increase their medication. The team leader suggested that the service user go on the waiting list for therapy as there were no current risk issues. The CMHN agreed*.

This is an example of how CMHNs still choose to advocate for service users based on intuition but that this can be overruled by procedural factors, following standard assessment criteria. The focus is on symptoms and risk and less on psychosocial factors. This can be challenging as the CMHN has developed a therapeutic connection with the service user and is responsible for conveying decisions made at team meetings back to them.

The micro-level structure relates to the CMHNs sense of their professional identity in relation to managing the workload. The CMHNs interviewed for this study, state they feel overwhelmed by the number of referrals and cases they care coordinate (discussed in chapter six). They care about their service users but are driven by the need to manage workload. This is enforced through team meetings and supervision, through a managerialist approach. The data from the interviews suggests that CMHNs feel that their performance is partially, appraised by their ability to complete paperwork and reduce their caseload. There may not be any sanctions for not meeting documentation targets, however, this still engenders a feeling of pressure and negative self- appraisal in the CMHNs.

Micro level interaction captures how communication is impacted by managing workload. In chapter seven, the theme “objectification and the use of productivity language” identified how CMHNs can refer to the service users in terms of their diagnosis, treatment, or stage in the care pathway. Is this indicative of “not caring” or merely a convenient “shorthand” which come from operational policies and standardised care pathways. They may become internalised by the CMHNs when discussing the service users (Hinchelwood 2010). They may become more influenced by managerialist approaches to managing workflow and this may detract from their therapeutic and intuitive knowledge of the service user (Kingston and Greenwood 2020).

10.2.5: Concluding statement about managing workload.

At the macro level, political choices (powers) which address the cost of long-term conditions and efficiency in the NHS. The language used in white and green papers and guidelines acknowledge need and uphold the principles of

timely access and quality care. There is also acknowledgement of providing value for money and managing service user progress through the system towards discharge. This results in policies, measurable outcomes and audit systems and standardised care pathways (structures). These are communicated (interaction) in a top-down, devolved way and the responsibility for delivery is delegated to regional commissioning bodies.

Trusts negotiate with commissioners (interaction) to devise targets which are relevant to their population and organisation. Trusts operationalise this to meet national and local commissioning requirements: context of localised choice and organisational history. The Trust do set their own targets with the commissioners, these need to demonstrate measurable outcomes (power). However, these are largely led by national targets, which are developed centrally. At the meso level, the Trust choses how to operationalise care pathways and ensure delivery of meeting targets (power). These are used to structure CMHTs and their meetings (structure).

CMHT meetings communicate these deliverables to their team and these structures guide decision making, language and professional roles (interaction). If targets cannot be met or workload/patient flow is not managed, this is communicated upwards from team managers to senior managers and to the commissioners as issues with capacity (interaction). At team level team leaders can make decisions about allocating work and reducing/managing workload (power). The context which activates and reinforces the workflow management systems in the constantly increasing demand. Therefore, CMHTs have no choice but to prioritise the most urgent service users but focussing on risk and symptoms. In team meetings there is an acknowledgement of individual service

user needs, but decisions must be processed in accordance with waiting times, defined care pathways, risk and diagnosis. Teams develop processes to manage parts of the system that are overwhelmed, this temporarily shifts demand from one part of the service to another. It helps prioritise and focus resources where they are most needed at any given time. However, this is a temporary easement as service users on waiting lists become urgent, those without a care coordinator use duty/emergency service and demands subsequently appear in other parts of the service. This invariably has resource implications and places further demand on the role of the CMHN.

At micro-level, the CMHN can present the needs of the service user and professional opinion (power). The team level structures socialise them into using efficiency and diagnostic language (interaction). This introduces categories and productivity language which becomes internalised by clinicians and is their objective reality. This may alter the view of their role (structure). In delivering productivity the CMHN becomes aligned with managing parts of the system which ensure effective patient flow.

10.3: The role of the CMHN

10.3.1: Definition and justification.

In chapter five policy regarding the developing role of the MHN was discussed. The thesis focusses on the impact of policy on the role of CMHN. The empirical data is derived from their direct experience and perceptions. The author worked for many years as a CMHN. They are the largest staff group in CMHT workforce, fluid identity, multi-faceted. Their identity and unique focus are not always recognised outside their professional group, but tacitly understood within it (Hurley and Lakeman 2021). In their role as care-coordinators they are required

to manage a caseload, deliver personalised care, build a trusting relationship, and help the service user navigate the health and care system (NHSE 2023). This role is impacted by the efficiency agenda and the requirement to fulfil the above. CQC (2022) stated that the shortage of mental health nurses is a widespread problem. Gaps in community provision are having a negative impact on preventative work and increases the amount of service users in crisis needing admission. Current reports comment on the prevalence of staff burnout, sickness and the large numbers of staff wanting to leave the NHS Beyond Demoralised (Marsh and Proctor 2022), and Workforce Burnout and Resilience in NHS and social care, (House of Commons 2021). These also acknowledge the importance of supporting and retaining staff to ensure the quality of care.

10.3.2: Macro-level mechanisms:

Power at macro level, refers to national political choices about the NHS workforce shortages. The Government has been criticised for not having a national strategy for workforce planning. This is detailed in House of Commons Report (2021) which noted a high level of burnout in staff. It also stated that work force plans did not assess demand and capacity but were limited by available funding. Job satisfaction for mental health nurses is the lowest it has ever been. This is linked to increased workload, subsequent sickness, and high turnover (Adams et al 2021). Subsequently mental health services have higher nursing vacancy rates than other fields of nursing (Adams et al 2021). This is discussed in Chapter five. The national staff satisfaction survey, highlights issues such as not being valued and rewarded by their organisation and experiencing high levels of burnout (NHS 2021).

Nationally the recruitment issues have been addressed by developing the Nursing Associate role. This initiative is intended to bridge the gap between unqualified support roles and registered nurses. It is a generic role and involves gaining knowledge and skills in both physical and mental healthcare (HEE website). The development of the Advanced Clinical Practitioner role is discussed in chapter five policy analysis and chapter nine macro level data. This role is across all fields of nursing and allied professions. It is intended to transform service delivery and maximise productivity and efficiency (NHS 2019). The ACP role involves skills development in physical and mental health care, similar to the NA role but with advanced assessment skills and prescribing. The physical and mental health skills set in these roles is aligned with the move towards integration and the need to meet comorbid physical and mental health problems, has resulted in increased emphasis on MHNs developing physical health care skills. This is also in recognition of the fact that those with Serious Mental Illness are likely to have a reduced life expectancy of 15 to 20 years. This is due to their increased risk of cardiovascular, respiratory, and endocrine diseases. This may be due to health inequalities, lifestyle, and medication (NHS 2019). The ACP role potentially creates career advancement for nurses whilst enabling them to maintain their identity and practice as a clinician and retain experienced staff. This is outlined in the Mental Health Nursing Career and Competence Framework (HEE 2020). The Trust A workforce plan refers to this. This National strategy would seem to be in recognition of the need to recruit and retain the mental health nursing workforce. It acknowledges the lack of information and structure available to facilitate career progression.

It states: “It *(the framework) should enable everyone to realise the contribution that mental health nurses make to the delivery of high-quality services, to the experience of individuals and to wider society.” (Page 5).*

This framework gives clear guidelines for skills, competence and academic development required at each grade. It illustrates the unique contribution mental health nurses make by presenting quotes from nurses about the factors which motivate them intrinsically. This appears to be a departure from the potential genericism of the role.

Structure at national level, refers to the actions, initiative and policies resulting from the choices and motives discussed above. National and organisational responses to issues such as staff burnout and retention and recruitment issues is to review these and produce detailed reports and recommendations. The National Workforce strategy (NHS 2018), the Interim People Plan (MHS 2019), the People Plan (NHS 2020) and the NHS Workforce Plan (2023) are discussed in chapter five policy analysis. These acknowledge the levels of absenteeism, turnover, recruitment, and retention issues. The make recommendations regarding monitoring absenteeism/turnover, address recruitment and retention and improve leadership and organisational culture. In effect this creates organisational level systems and strategies which require even more monitoring and audit. Workforce planning is directed locally and is therefore fragmented (Beech et al 2019). Contextual issues such as staff burnout or workplace bullying are extensively reported on. The plans to tackle have been directed locally, with emphasis on individual Trusts monitoring and addressing these issues.

National guidelines provide direction for dealing with burnout and wellbeing. Staff wellbeing consists of counselling services and training events. This tends to treat staff experience as symptoms of personal stress (HoC 2021). However, the wider determinants need to be addressed. Compassionate leadership in the NHS has been identified as key is creating a fulfilled and stable workforce (West 2021). To achieve the national pledges of quality care, productivity, effectiveness, innovation and patient satisfaction, NHS employers need to treat their staff with compassion, dignity, and respect (West et al 2020). Compassionate leadership, within NHS organisations are viewed as the means of achieving this. This is laudable and acknowledges burnout and low morale. However, it does not consider the wider socio-political climate, namely the efficiency agenda and how creates these negative staff reactions. It is uncertain whether pledges about inclusivity and recognising achievements and having compassionate conversations will ameliorate the effects of demand exceeding capacity and the culture of audit and performance.

Interaction at the macro-level, refers to communication at societal level. Problems with retention, recruitment and burnout are by participants as a national issue. This has been widely communicated via National reports and mainstream media. There is acknowledgement of the pressures placed on NHS services and how this undermines collaborative behaviour and autonomy. House of Commons (2021 page 9) "*The NHS Staff Survey has suggested that an unacceptably high proportion of NHS staff experience negative impacts as a result of stress in the workplace and that the proportion of staff suffering from stress is on an upward trend".*

The Government response to this is large scale publicity about the toxic culture in the NHS and the prevalence of bullying (Rimmer 2023). The emphasis is on the NHS as an organisation and on individual Trusts to establish measures to tackle this (see Trust A strategy in meso section). None of the participants reported being bullied. However, they did report low morale due to work pressure and managerialism. The therapeutic and interpersonal nature of mental health work requires CMHNs who have time to engage with services users and space to reflect on their interactions. The quality of this work is adversely affected by chronic understaffing and low morale (Baker et al 2019). Nurses, at least in part, develop their professional identity from public perception (Girvin et al 2016). Scandals regarding poor quality of care, which appear in the media, create narratives which largely discredit those who are delivering the care (Hutchison 2014). In the past year 2022-23 mental health services have been brought into disrepute by media exposes, such as the Panorama episode: Hidden Hospital about care in the Edenfield Centre in Greater Manchester and several suicides in an Essex Trust. A blame culture is fuelled by perceptions of failure and public criticism, especially around assessment and management of risk (Wand et al 2020). This reporting creates the perception that the NHS and Trusts are responsible. It perhaps disregards the wider cultural influences. This reporting seeks to create the impression that the NHS is at fault.

10.3.3: Meso-level mechanisms

Meso level power addresses the choices and pledges made by the NHS Trusts to address recruitment and wellbeing factors within their organisation. Trust philosophy and culture, reflected in their strategies and values. Nursing and Trust strategies state that they want an empowered workforce, inclusive and

compassionate leadership. Trust A overall strategy: 2021-24 states that it aims to create a culture that empowers our staff. It pledges to address workforce issues: increased focus on targeted recruitment and retention strategies and reduce use of agency staff. Trust A Nursing Strategy 2022-25's actions include wellbeing and support, career pathways, skills and competencies and workforce recruitment and retention. Trust B's strategy sets out priorities including being a great place to work and have engaged and capable staff living our values. Their aims include staff feel empowered to make improvements, supported by a capable and inclusive leadership team. In addition, they pledge to develop a sustainable workforce with reduced vacancy rates and reduced agency spends.

Meso level structure captures the material guidance for regulation, professional practice, and developments at organisational level. Role clarity provided by care pathways and job plans (see thick description). The development of senior clinical roles is an attempt to retain staff and maintain quality care. Trust A piloted their caseload weighting tool. However, it was not implemented as it was not found to be effective in clearly capturing the complexities of CMHNs caseload. Trust A have outlined their Community Mental Health Nurse training priorities in 2022. This details clear career pathways from band two to band eight. It acknowledges the need for physical health skills, but also advanced psychosocial and psychological skills. The creation of subdivided, diagnostic teams in Trust A and the staged process on Trust B has implications for the role of the CMHN. In the diagnostic teams, the CMHNs see themselves as only skilled in working with a type of service user. Their practice is driven by symptom and risk management. There is decreasing emphasis on psychosocial approaches. In Trust B, CMHN roles develop to manage part of the process (for

example the active review waiting list in Trust B). Lipsky (1980/2010) suggests that organisation of the immediate work environment is more influential over clinical decision making that professional education or identity. This is an example of fragmentation and simplification over of professional tasks.

The responsibility to make decisions about a service user being accepted into a team or being discharged lies with senior staff. This is an example of managerial control over the pace of work. These are examples of deprofessionalisation (Malin 2017). Current approaches to workforce planning have sought to address the shortage of mental health nurses by creating new roles to undertake social interventions and psychological support. This fails to acknowledge the value of registerable qualifications and acquired skill (Mailin 2017). For example:

In Trust B non-participant observation: There were two senior support workers and two trainee psychology practitioners. They presented assessments they had undertaken and made plans and decisions which were supported by the team. One said, "my client needs a risk assessment completed, and a clustering tool filled out, I cannot do that, it needs to be one of the CMHNs."

Perhaps the case management role is more about administration and communication, with less emphasis on specific clinical interventions. The creation of policies and governance arrangements which place managerial and bureaucratic standards on professional practice, limits their professional judgement and sense of autonomy (Duyvendak et al 2014).

In Trust A, psychosis team non-participant observation: a service user was discussed who was exhibiting severe self-neglect. A support worker was the only member of the team working with them. At the meeting the support worker

asked if the service user could be allocated a CMHN, the team manager questioned this, saying that they only had social problems. The support worker asserted that their self-neglect could be attributable to negative symptoms of psychosis. The manager compromised and arranged for a medical review.

This may indicate a demarcation between social deficits and clinical symptoms. This may be removing psychosocial interventions from the CMHN role. These new roles include Nursing Associate roles. In Trust A the ACP role is seen as valuable in CMHTs. Senior staff in Trust A, spoke about wanting advanced practice to focus more on specialist mental health skills, to upskill the workforce and promote autonomy. Trust As CMHN workforce priorities document (2022) would seem to address this, however, its impact is yet to be realised.

The impact of team/meso level interaction will now be addressed. At CMHT level, managers may be the key to balancing managerialism and staff autonomy and support. Managerialism is the concept that every aspect of a healthcare organisation can be managed using operationalised structures to meet goals set by policy makers which are enforced by senior managers (McCabe and Sandbrook 2018). These are communicated from senior management to CMHT managers. In the teams used in this study, these are nurses. They are responsible for ensuring that documentation checks and targets are met, and caseload size is manageable (This is discussed in chapter eight). Nurse managers play an important part in instilling trust and engendering good morale in a team of nurses. There is evidence of compassionate leadership**,** in the empirical data, staff say that they feel valued by the team leaders who constantly praise their efforts and acknowledge their difficulties.

The Team Managers like the CMHNs, must reconcile the duality of productivity and compassion. They need supportive leadership from their managers to achieve this (West 2020). Perhaps the relationship between CMHN and manager have an impact on what is communicated to senior management and this in turn may have an impact on organisational priorities (O'Rielly and Read 2011). CMHNs can experience their role as being subordinate to other professions. This is addressed in the data and discussions in chapter eight within the theme: "the role of other team members, meetings and team dynamics". Some participants commented that in the Affective team in Trust A their opinions are not as valued as those of the psychiatrist or psychologist. In Trust B, participants commented on the psychiatrist or team manager making the final decision. Alternatively, participants have said that their job satisfaction is positively influenced by support received at team level and the quality of the team relationships.

Trust A, Affective team nonparticipant observation, the following observations were made: *At the end of the team meeting there is a space for professional groups to feedback any pertinent issues. The CMHNs spoke about how overworked they are and are finding it difficult to cope with the workload and the demands om and complaints by service users. There was support and acknowledgement from the team leader, consultant, and social work colleagues. The team manager explained that they have escalated these concerns to senior management within the Trust. One CMHN said "I don't believe that they care." The CMHN group were expressing the greatest level of dissatisfaction, other team members may have greater role clarity, the CMHNs express being subject*

to multiple demands: care coordination, duty, documentation. The manager constantly expresses acknowledgement and support towards the CMHNs, plus assurances that they escalate concerns to senior personnel. This was rejected and refuted by the CMHNs.

This is perhaps because CMHNs are experiencing high demand and are short staffed and have not noticed any improvement in their workload. The team leader subsequently expressed stress and frustration at the end of the meeting. Therefore, team leaders need support but also practical solutions to the capacity issues, which cause the stress in staff which they need to address.

10.3.5: Micro mechanisms

Micro level power refers to choices and motives of the individual CMHN in defining their role. The data presented in chapter six, indicates that CMHNs are motivated by an intrinsic desire to help people with mental health problems. Participants stated that they valued developing a therapeutic relationship with service users and how this enabled them to be client centred. It is associated with the ability to utilise intuitive knowledge to make decisions in the context of the SUs story and not purely in relation to tangible evidence.

Micro level structure captures aspects of the CMHNs self-concept and role identity. This can be shaped by the challenges of reconciling the intrinsic drives with the pressures to manage workload and fulfil care management and administrative demands. CMHN with therapeutic integrity and a strong affiliation with their moral and intuitive convictions, when working in a hierarchical organisation where these values are not explicit are likely to experience moral distress, burnout, and leave (Cleary and Horsfall 2013). The intrinsic desire to

deliver good care is undermined by the constant fear of not being able to (Marsh and Proctor 2022). This is exacerbated by a rigid hierarchical structure which mitigates against having control over the amount of work they do (West et al 2020). Keeping on top of organisational demands causes anxiety. The CMHN may internalise a sense of failure when they are unable to meet these multiple demands. There may be a subsequent values mismatch between organisational values and the professional, intrinsic motivation of the CMHN (Bifarin et al 2022). This may create moral conflict or result in CMHNs internalising these demands and seeing their achievements, partly in terms of managing efficiency.

Micro level interaction refers to how CMHNs communicate which conveys their intrinsic values and role identity. This can be reflected in how they articulate their intuitive knowledge and person-centred stories, as discussed in chapter seven. This can be endorsed and supported in team meetings. Alternatively, they may advocate for the service user and feel that their opinion is not valued or are unable to articulate their intuitive knowledge. This can result in losing a sense of autonomy and impact their morale. In chapter seven, within the theme "morale" participants identified that when they speak about how stressed they are, they are concerned that they may be perceived negatively by their managers and within the team.

10.3.6: Concluding statement about the role of the CMHN:

At the macro-level, political choices about how to address chronic shortfalls in the mental health nursing workforce (power). The social reality is that the NHS is understaffed, due to pay, conditions, low morale, and burnout. The is acknowledged in national reports. The national NHS staff satisfaction survey is

distributed to the whole NHS workforce. It reports on items such as autonomy, feeling valued by employers, having a voice, and making a difference (interaction). This results in directives and workforce plans addressing recruitment, training, and creation of additional roles, to be adopted nationally (structure).

At the meso-level the Trusts adopt national strategies and incorporate these into Trust and nursing strategies (power). These address issues such as empowering staff, compassionate leadership and retention and recruitment issues. There is a clear recognition at organisational level, that there is a shortage of CMHNs. Structural aspects of CMHTs shape the role of the CMHN, this is discussed in chapters six and seven. The role concentrates on symptom and risk management and managing parts of the care process (structure). The creation of additional roles, such as specialist support workers, removes psychosocial interventions from the role of the CMHN. Team meetings manage the duality of supporting and validating staff and processing and allocating the workload (interaction).

At the micro-level, CMHNs align their identity with care and compassion and the value of advocacy and the therapeutic relationship (power). Their role identity is shaped by the need to balance their intrinsic motives with the external demands of managing the workload and administrative demands. The individual CMHN must balance bureaucracy and clinical work. The focus on administrative tasks, feed a top down, bureaucratic system. Individual practitioners are required to populate this system, but they are not in control of it (structure). They may not be aware of where this information goes, or why it is important. They are detached from the outcome and do not experience it as being of value within

their role (self-concept). The only perceived benefits to fulfilling these bureaucratic demands is a lack of negative sanctions. This may generate anxiety, pressure and takes energy and attention away from the clinical work (Interaction).

10.4: Service user self-management.

10.4.1: Definition and justification.

Chapter five considered the policy implications of the greater expectations for and of the service user with an increasing focus on personal responsibility, recovery social inclusion and employment. “The NHS will ramp up support for people to manage their own health” NHS Long Term Plan (NHS 2019 p 25). The Community Mental Health Nurses view of service users may be influenced by the self-management of long-term conditions within the NHS Long Term Plan (NHS 2019). The participant accounts portray expectations that service users will engage and follow the standard interventions offered. There is merit in encouraging this approach as it promotes independence and social inclusion (Lean et al 2019). However, it may be driven by the need to reduce the demand on mental health services and promote discharge at the earliest opportunity.

10.4.2: Macro-level mechanisms.

Macro-level power includes the political choices and societal view about people with mental illness. In Chapter five, the political ideology contained within NHS policy is discussed. This is increasingly influenced by marketisation and neoliberalism (McWade 2016). Esposito and Perez (2014) suggest that the lens of neoliberalism views mental illness purely as individual symptoms which are treated with medication. This approach disregards the impact of social factors

and psychosocial interventions. The neoliberal approach upholds the values of success and individualism and the belief that individuals should be entirely responsible for finding solutions to health and housing problems (McGregor 2001). Welfare and social housing are believed to promote dependence (Esposito and Perez 2014). The emphasis on biomedical approach to treatment, undermines the emphasis on psychosocial aspects and the impact of poverty and social in equalities. Austerity measures include a reduction in public spending which adversely affects both mental health service and welfare. This has a devastating effect on those with serious mental illness using secondary mental health services (Cummins 2018).

NHSE (2019) "*Involving people in their own health and care not only adds value to people's lives, but it also creates value for the taxpayer*." (Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England p2). The Mental Health Clinically Led Review of Standards (NHS 2021) refers to considering the needs of service users: "...in shaping standards around events which are important to patients and based on patient experience. (p. 11) and "*we are widening not restricting the lens through which we are assessing the quality of mental health services and how they are delivering what our service users want and need."* (p12).

Macro-level structure includes national strategies for promoting and monitoring self-management for mental health service users. Self-management is endorsed by the Long-Term Plan. NHSE (2019) provide frameworks for supported self-management which can be adopted by NHS Trusts.

"*Supported self-management is arguably one of the most under-utilised, evidence-based, cost-effective health interventions available to the NHS*." (NHSE website).

Self-management for those with mental health problems, involves secondary mental health services providing education and personalised support. This is to enable service users to monitor symptoms, management treatment and employ psychological coping skills (Lean et al 2019). This also includes educational and occupational support to support service users to return to work. Since 2019 Mental Health Trusts have been required to provide data on the amount of service users with serious mental illness in contact with return-to-work schemes. The target set within the NHS Long Term Plan dashboards is 55.000 per year (NHS 2019). This is discussed in chapter five.

Macro-level interaction refers to the ways in which the self-management agenda is communicated to Trusts and to services users. The narrative of Recovery, anti-stigma and co-production have driven the view that SMI is not a barrier to employment and financial and personal independence. Recovery places emphasis on the responsibility of the service user, and away from the availability of treatment (Lethbridge 2019). This is discussed in chapter three. Recovery, co production and anti-stigma campaign. These concepts were discussed in chapter three and are increasingly being used to drive the agenda of individualism. The use of frameworks such as the recovery star, place emphasis on the individual and not the contextual social and economic difficulties (Collins 2019). This is communicated to individual organisations via National policy and guidelines. The Mental Health clinically led review of standards (NHS 2021) states that to make measurable clinical standards more patients centred, there

has been service user consultation. However, consulting clinical staff and service users on service provision may increase the demand for more comprehensive services where the resources to deliver this are lacking (Alaszewski and Brown 2012).

10.4.3: Meso-level mechanisms:

Meso level power encapsulates the Trust philosophies regarding service user involvement and empowerment. This is clearly stated on their websites. Trust A emphasise the importance of co production and that they have developed strategies to support this. Service users are involved in consultation networks and contribute to service development, interviews, quality improvement strategies recruitment and training. Service users also sit on governing boards. In Trust B there is a service user engagement strategy currently being developed. Service users are involved in recruitment and board meeting presentations.

Meso level structures outline the policies and guidance at Trust level to address self-management and engagement. Trust B has a policy to address service users not attending appointments. It states that appointments need to be managed to maximise resources without compromising safety. If service users who do not present a risk, do not attend they are discharged. If there is an indication of risk, then professionals must undertake individual risk assessments and visits to ensure service user safety. Self-management is evident throughout Trust A operational policy (as illustrated by the statements in the section on power). The return-to-work scheme is run by the local MIND group. Statistics for referrals are sent straight to NHSE. Both Trusts have Patient Advice and Liaison

teams, these are designed to provide advice and support but also address complaints.

Meso-level interactions address team level communications about service users. In chapter eight, service user self-management, participants indicated that service users are not always in agreement with the team's decision to discharge them. If they are not happy with this, then they are informed that they can use the complaints system. This would perhaps indicate that this may be a decision that they are not involved with or if they are then the professionals' decision may prevail. When making decisions about key stages in care, it can feel as though the service user and professional are in opposition, with the former being concerned with personal experiences of loss and vulnerability and the latter with standard outcomes (Collins 2019).

Trust A Affective team non-participant observation. *Team manager referred to how only a small number of the most problematic service users can be discussed in the meeting due to time constraints. The issue of service user complaints was also discussed. The team manager suggested that they would hold a "complaints clinic" to meet all the service users who wanted to complain, to address their issues at team level and protect the staff. In Trust B non-participant observation, the presentation of assessments included a section on service user expectations. However, the factors utilised in decision making still focus on symptoms and risk.*

In Chapter seven, the expectations of service user self-management are discussed. This includes referring to non-engagement as grounds for discharge and re referral engendering the view of not following discharge advice. The exception to this approach is where a service user has psychosis and lacks

insight and/or presents a risk. An example of this is noted in the Trust A psychosis team non-participant observation: Many of the service users discussed were deemed to lack insight, due to the nature of their mental illness and so CCOs needed to find other ways of engaging with them. The team manager frequently recommended “unannounced visits”

10.4.4: Micro-level mechanisms.

Micro-level powers refer to the individual CMHNs powers and choices regarding how they view the service users. In the empirical data, in Chapter seven, there is evidence of CMHNs telling a person-centred story and using a service user’s situation as a reason not to discharge them. In contrast other CMHNs interviewed view service users as not engaging, not following discharge plans or lacking motivation to adopt a self-management approach. Perhaps those with more experience, uphold their sense of autonomy and can recognise and articulate their view of the service users’ holistic needs.

Micro-level structure, the role identity of the CMHN can be closely aligned with their value of the therapeutic relationship (as discussed in the previous section: role of the CMHN). Those who are person-centred tell the service user’s story, cite the use of intuitive knowledge. They contain that conflict within themselves. The CHMNs that do this indicate that this is a challenge and requires extra effort.

Micro-level interaction is concerned with the language CMHNs use to describe service user can be objectifying and based on diagnosis and risk as illustrated by the data in chapter six. This could reflect the mechanistic approach to managing the care process and the biomedical view of mental illness. There are examples of the CMHN presenting service users’ needs and preferences.

Trust B CMHT non-participant observation: A CMHN presented a service user they had assessed, who advocated for a service user who had social and emotional problems. They explained that they felt that the service user needed their support. However, their diagnosis and risk did not meet the threshold for inclusion for secondary mental health services, this was upheld by the psychiatrist and team leader. The client was put on a waiting list for therapy. The CMHN was asked to communicate this to the service user.

When their advocacy is not incorporated into team decisions this could cause them to withdraw from the therapeutic relationship. Service parameters that focus on standardised criteria and risk and not individual preferences disempower both the service and the practitioner supporting them (Kokanovic et al 2018).

10.4.5: Concluding statement about service user self-management.

At the macro-level, there are political choices about addressing the cost-implications for those with long term conditions (power). Contemporary neoliberal ideology drives the belief in individualism and self-determination. Current policy agenda is promoting self-management, focussed and time limited support from secondary services and early engagement in return-to-work schemes. This has been co-opted by the Recovery model, the anti-stigma campaign. This results in national directives which drive the self-management agenda, return to work schemes (structure). This is communicated via the recovery agenda and anti-stigma campaigns.

At the meso-level, Trusts have pledges regarding meaningful service user and carer involvement (power). The Trusts have incorporated self-management strategies and missed appointment protocols into their operational policies for

secondary mental health care. They also have organisational systems to promote service user engagement at strategic level (structures). This is communicated through teams and via CMHNs to service users in ways that promote self-management and address discharge needs at the first point of contact (interaction). The service user has avenues to provide feedback: compliments or complaints rather than being able to individually negotiate their care.

At the micro-level, the CMHN may hold the view of advocating for the service user and simultaneously fitting their care into service parameters (power). They need to follow operationalised structures about missed appointment (structures). They may advocate for the service user and present their expectations to the team (interaction). If this is rejected, then the CMHN is the one who must communicate this to the service user (interaction). This may undermine their view of being client centred and put them off trying again and distance themselves from the service users (self-concept/structure).

10.5: Summary.

This chapter has discussed the interaction between power, structure, and interaction at the macro, meso and micro levels. This has been applied to the three generative mechanisms identifies, that is: managing the workload, the role of the CMHN and service user self-management. This draws upon information from the policy analysis, the operational policy and strategies developed by the NHS Trusts used in this study and the empirical data obtained from the participants. Non-participant observations on CMHT meetings were used. These meetings bring together organisational structures which guide practice with

interactions about service users within a team setting which involves CMHNs. The data derived from these observations is used to illustrate power and interaction, within material structures.

The most powerful mechanism would appear to be managing the workload. The structures which drive this are set by central Government. This is disseminated regionally to commissioners and Trusts, who have choices and negotiations at regional level about how these can be delivered. However, they are still closely aligned with National structures. These structures are used to guide team and individual decision making. This impact on the role of the CMHN, a role that is aligned with the value of therapeutic alliance and promoting person centred care and choice and collaboration in their work with service users. The promotion of self-management and discharge at the earliest opportunity, are features of managing the cost of long-term conditions. There are exceptions where the CMHN can advocate for the service user, however, the standardised processes often override this potentially undermining the CMHNs allegiance with the therapeutic relationship. The National recruitment crisis has drawn attention to issues of low morale and retention problems in the mental health nursing workforce. This has prompted a national response to reinvesting in the value of this role. The creation of Integrated Care Systems may be the opportunity to address this. However, this is yet to be realised.

Chapter 11: Discussion, conclusions and recommendations.

11.1: Introduction.

This is the concluding chapter of the thesis. I will start by outlining my PhD journey, capturing my original interests and motives that inspired me to undertake this research. This will include how I value the role of the CMHN and the potential it has, whilst acknowledging some of the recent policy and organisational demands which make it challenging. I will then outline the value of undertaking this research, with specific reference to identifying the perceptions of CMHNs and the identification of generative mechanisms to understand what contributes to their experiences. I will then give an overview of how I answered the research questions and highlight the methodological contributions. This will be followed by overview of the contribution to existing knowledge in the field of mental health nursing. Finally, I will present the limitations and recommendations for future research and practice.

11.2: My PhD journey.

Having spent many years working as a CMHN and team leader myself, I am struck by the potential this role has. It is multi-faceted, highly skilled and utilises a broad range of interventions to work effectively and collaboratively alongside service users. In my career, I have also experienced numerous developments in policy and practice and subsequent service reorganisations. I have spent much of my nursing career, working with service users who are socially excluded, marginalised and have long-term complex health needs. I therefore view providing a full range of interventions in the context of a therapeutic relationship, as central to the role of CMHN.

My interest in politics public policy development motivated me to explore the impact that neoliberal policy reforms would have on social practices around health and social care and the subsequent implications for the role of the CMHN. In exploring the impact of policy on organisations, teams and individual CMHN practice, I have developed skills and knowledge of the interpretative and explanatory approach of Critical Realism. This is based on my belief that policy is based on political ideology, which leads to tangible structures and social practice which are directed through mechanistic deliverables.

The processes which lead to activation of social structures are hard to capture and context dependent yet their impact on organisational culture, teams and individual CMHN is profound. This thesis highlights the importance of interrogating the language of policy and the motives behind it and drawing upon theories regarding social structures and psychological reactions to explain these complex events. The potential value of organisational and political awareness in understanding the challenges faced by CMHNs. Although few of the participants had an awareness of political motives and policy priorities, it was clear that they experienced the impact of increased demand and recruitment and retention problems.

One of the key aspects of this research is the use of Critical Realism to examine CMHNs perceptions of structures and relationships which impact their decision making, in relation to their role identity, team structures and Trust priorities. Consideration of political and organisational awareness of CMHN and if this impacts their relationship with their team and Trust. I was keen to explore if CMHNs see this as linked to policy and political ideology, or if they locate the responsibility within their immediate manager or organisation. As data collection

took place between 2021 and 2023, it examined the specific impact of policy post Health and Social Care Act (2012), Five Year Forward View (2015) and NHS Long Term Plan (2019), period post COVID and the build up to Health and Care Act (2022) and the development of integrated care systems. The interaction, power, and structure at each level of the hierarchy demonstrates how policy is patterned and shaped. There are some centrally determined targets for adult CMHT, negotiation between commissioner and Trust. The structures are a way of managing the workload as secondary mental health services. Locally Trusts make choices but still need to have reporting systems to the commissioning body. Their implementation at CHMT level, includes care pathways, risk rating and outcomes to manage the workload and patient flow through the system. This is experienced by CMHNs as placing a great demand on their role. Their professional identity is eroded by managing these processes which impacts their sense of autonomy and role identity.

The identification of Generative mechanisms facilitated an exploration of structural and relational ways that policy is delivered and operationalised, and how this shapes clinical work and role identity. The key policy areas highlighted by the analysis in chapter five, are used as generative mechanisms. These are: managing the workload, the changing role of CMHN and the expectation of service user self-management. The role of the CMHN is central to this research, this is impacted by mechanistic structures used to manage their work and the therapeutic relationship with the service user. The use of Blom and Moren's (2011) framework facilitates an understanding of the interplay between power, interaction, and structure at each level of the hierarchy. This provides valuable insights into the contexts and conditions necessary for social practices to be enacted, or not. This is addressed in the methodology chapter four and in the

discussion about generative mechanisms in chapter ten. The value of this approach is addressed later in this chapter.

11.3: How the research questions have been answered.

I devised four research questions to examine the experiences of CMHNs in relation to their role in making decisions and the factors which they feel impact upon this. I took a hierarchical approach as I was particularly interested in their perception of the structural impact National policy has on their organisation (macro level), team functions (meso level) and their individual clinical work (micro level). In addition to the structural factors, I wanted to determine their psychological reactions to this, namely how they reconciled the efficiency agenda with their intrinsic motivation and how they perceived this being enacted within the teams and their relationship with their employing Trust. In this context decision making does not involve specific frameworks or processes of decision making, but rather the overall context of how CMHNs exercised their clinical judgement and the value of their intuitive knowledge in how service users are accepted for secondary care and when they are discharged. In exploring CMHNs perception the micro, macro and meso level factors, I gained an understanding of how structural policy factors became internalised and shaped their views of service users, their role and job satisfaction. The data also demonstrated their psychological reactions to the structures. They either introjected the efficiency, process led agenda or challenged it which caused a degree of conflict.

The first research question is What do Community Mental Health Nurses (CMHNs) perceive to be the factors which influence their clinical decision making

in relation to accepting or discharging service users? The presentation and analysis of themes relating to individual factors are considered in chapter seven. The themes in this chapter demonstrate CMHNs understanding of intrinsic factors which define their role. These include intrinsic motivation, training, skills and professional development, intuitive knowledge and the therapeutic relationship and the use of empirical and procedural knowledge. In addition, themes which demonstrate how dealing with service demands and organisational bureaucratic demands are addressed. These include managing the workload, addressing work life balance, perceptions of autonomy and morale. Their perceptions of the service users they work with are detailed in the themes, objectification and the use of diagnostic and productivity language, expectations of service user self-management and person-centred care.

Chapter seven conclusions highlighted that intrinsic motivation and intuitive and empirical knowledge are still valued by CMHNs and viewed as protective factors. There was a larger amount of data around experiencing a managerialist approach to addressing workload, by having to reduce caseload size, accommodate competing clinical demands and complete documentation for audit purposes. Some CMHNs either internalised the efficiency agenda by using objectifying language to describe service users and defining their role in relation to managing processes, others saw themselves as client-centred and highlighted that they felt this brought them into conflict with their managers and the team. Most participants demonstrated that in balancing workload demands and the emotive nature of clinical work had an impact on their morale, work life balance and sense of autonomy.

The second research question was: What are CMHNs experiences of negotiating the above factors within teams? The themes from the semi-structured interviews which address the CMHN perceptions of the factors within the CMHT which impact their decision making are detailed in chapter eight. These themes address operationalised structures, relationships with other services, team dynamics and interactions. The CMHT creates the working structure for the CMHN. The operational policies detail care pathways, assessment and discharge processes and team meeting agendas. These are determined at Trust level and based on national guidelines. Two neighbouring Trusts were chosen as research sites, as I was aware that they had differing operationalised structures for their CMHTs. I had the initial intention of this providing a useful comparison as it demonstrated that mental health Trusts could make choices about how to structure their community services. However, comparison was difficult as the experiences of the CMHT in each Trust was similar (this is discussed in detail in chapter eight). In both Trusts CMHNs experienced disconnection from the separate diagnostic team or stage of the care process. The themes include standardised care pathways and specialist teams, timeframes, risk rating and frequency of contact, waiting lists and logjams and team level documentation and audit requirements. Interpersonal and relational themes include managing service boundaries and the roles of other team members, team meetings and dynamics.

Chapter eight concludes that the role of the CMHN is shaped by the type of team or stage of the care pathway they are located in. This helps with skill development and role clarity. However, they experience disconnect from other parts of the team, leading to fragmentation and duplication of work. Prioritising the riskiest service users and having standard time frames for contact, results in CMHNs

perception that they cannot see all the service users on the caseloads as often as they would like to. Despite an intended ethos of shared care, most CMHNs experienced difficulties in referring service users back to G.Ps. Instead of this being addressed through negotiations rigid processes of referrals and complaints are utilised. Team meetings are concerned with managing the workload and provide limited space for detailed and supportive discussions around service users. The CMHN relationship with the team manager (usually a nurse) is a mediating and supportive factor.

The third and fourth research questions are considered together. The participants were asked in the semi-structured interviews about their views of their employing organisation and their perception of the impact of national policy on their clinical work. This produced less data that the questions about their role and team and they identified this as outside of or detached from their daily work. I initially anticipated that the participants may be able to distinguish between what was national and what was their Trust. The reality is that what is originated from National policy directives and what is implemented by their Trust is conflated. The third research question was: What are CMHNs perceptions of their organisations? This question considered whether there was perceived congruence between clinicians and senior management. The participants expressed mixed views of the Trust; some blame senior management who appear to embody some of the factors causing their stress. There was some acknowledgement that Senior staff are aware of the issues, but either are unconcerned or powerless to make the necessary changes. There were also comments about the Trust being concerned about staff and service users. The fourth research question was What are CMHNs perceptions of mental health policy and how has this impacted on their clinical

decision making? The participants all stated that they were unaware of the mental health priorities embedded in the Health and Social Care Act (DHSC 2012), or how this has been developed by the Five Year Forward View (NHS 2015), or NHS Long Term Plan (NHS 2019). They stated that they do not have time to read national policies, and that this is something that the Trust senior personnel address and that it is filtered down to them. This data did reveal that participants had first-hand experience of retention and recruitment problems in their place of work and recognised this as a national issue. I was interested in whether this level of awareness is empowering and helps CMHNs externalise and reconcile the efficiency driven ethos with their therapeutic approach.

11.4: The methodological contribution.

The methodology is discussed in chapter four. The use of Critical Realism and its relevance to this study and is linked to the research methods used. As I considered the tangible social structure of National Policy, I started by identifying the aspects of NHS policy which were relevant to the function of CMHTs and the role of CMHNs. I undertook a policy analysis, to find evidence of the tangible policy priorities, which create structures to guide practice and efficiency. In the policy analysis I traced the development of mental health policy to the commencement of marketisation and the introduction of the Community Care Act (1990). Therefore, I considered policies from 1990 to the present. I wanted to demonstrate how policy had developed continuously over 30 years to the policy priorities we have today. Understanding the reasons for policy priorities, needs to be in the context of socio-political, economic, and ideological factors. Retrospective examination for these can link these factors and provide insights into whether they achieved their intended outcomes and any factors which

enable/hinder this. An understanding of how past policies impacted on structure and practice helps as understand the current relationships. The development of NHS policies to address efficiency and priorities for delivery develop over time, successive policies are developments of previous ones, even if the Government changes. I highlighted three main themes, which were of relevance to this study: efficiency/managing demand, the changing role of the CMHN and expectations of service user self-management. These are linked to operationalised local policy in the thick description, which serve to organise and direct practice at Trust level and subsequently influence the empirical experience of the participants.

The value of Generative mechanisms is in linking power, interactions and structures at each level of the hierarchy. This helps explain the contexts which may give rise to the lived experience of the CMHN. Targets and clinical guidelines provide structure for NHS mental health Trusts to organise care processes and to demonstrate outcomes to their local commissioning body. The framework chosen for representing the generative mechanisms in this thesis, is stratified and hierarchical. This fits with the research questions and the subsequent presentation of the data.

The structure chosen to represent Generative mechanisms (adapted from Blom and Moren 2011), power indicates choices and motives, structure the bureaucratic processes and social practice that develop and interaction how structures impact on organisations, groups, and individuals, and how they respond to challenge these structures. This is presented in chapter ten. Identifying generative mechanisms, was valuable in informing my understanding of the contextual factors which give rise to the lived experience of the CMHN.

It is not always possible to be aware of the factors which lead to challenges in the workplace. CHMNs experience challenges in their daily work but may not be aware of the choices and structures at organisational and national level which have created these. In busy work environments where there may be little time to explore and reflect on Trust issues, CMHNs may experience the impact of these on their daily work, but not be aware of the origins. Increasing the CMHN awareness of these factors, understand what causes these negative experiences and stop them internalising a sense of failure or the efficiency agenda at the expense of being therapeutically responsive.

Critical research is intended to be emancipatory and empowering: understand processes which cause low morale, lack of autonomy and job satisfaction. However, increasing their awareness may also be detrimental, as CMHNs may be aware of the factors which cause them difficulty in their daily work, but feel powerless to challenge or influence them. There are structures at local and national level which ask for staff feedback but may not address the underlying structural causes of low morale. At team and organisational level, recognising the experience of staff is a valuable indication of problematic structures and practice. Staff feedback could be used to address unintended consequences of structures used to organise work. The experience of the CMHN may also be an indication of how the service user is affected. Where these processes are challenging capture, the use of critical realist analysis has been invaluable. The use of abduction involves examining empirical data using policy and social and psychological mid-range theories. This enabled me to hypothesis the possible mechanisms to explain the CMHNs experience. The use of retroduction, that is and examining

inter relationships between layers of the hierarchy, enabled me to identify how these mechanisms are patterned from National policy, through commissioner, Trusts teams and the practice of individual CMHNs.

11.5: Implications for Practice

11.5.1: The role of the Community Mental Health Nurse:

The findings presented in Chapters seven, eight and nine demonstrate the factors which influence CMHNs decision making and broader aspects of their work. This captured their perceptions of their own role and development, team structures, meetings and boundary management with other services. It also included their perception of their Trust's priorities and their understanding of the impact of national policy. The demand for secondary mental health services has continued to increase post-COVID, in Trust A referrals have increased 40% per year since 2020.

The CMHNs interviewed for this study expressed intrinsic motivation, namely the desire to help vulnerable service users and make a difference to their quality of life. They acknowledged that this is a rewarding aspect of the role but also involves a degree of emotional labour which makes it challenging. This is part of the CMHNs self-concept, with many participants describing their service users' stories and being in the position to fully understand their needs and advocate for them.

An important part of intrinsic motivation is skills development and education and training. Participants cited examples of how being able to focus on specific skills

sets helps their motivation. This is particularly relevant when they have a choice about the client group they work with and experience their skills and opinions being valued within the team. This sense of empowerment is also enhanced when they can undertake training and development of their choosing. Several participants stated how they valued the therapeutic relationship**.** In community mental health practice, the therapeutic relationship the CMHN has with the Service user viewed as key in delivering interventions and maximise positive treatment outcomes (Farrelly et al 2014).

In the context of the Care Programme Approach, the care co-ordinator's role was undertaken by CMHN or Social Worker. The CPA has been in existence since 1990s. A central tenet of this process is for the CMHN to work closely with the Service User to promote empowerment, choice, and collaboration through developing and significant therapeutic alliance. Contemporary definitions of the care coordinator's role, state that, collaborative and therapeutic relationships are still considered invaluable to supporting service user recovery (Hannigan et al 2018). However, the fragmentation of the role, due to care pathways to manage the workload, mean that the CMHN is engaged with parts of the care process, rather than with the service users' entire journey through to recovery. The drive towards service user self-management and discharge at the point acute symptoms and immediate risk have abated, has resulted in engagement which is time limited and focussed. A more contemporary view of the care coordinator's role is reflected on the NHSE website.

"Care co-ordinators help to co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at

the right time. They can support people to become more active in their own health and care and are skilled in assessing people's changing needs. Care co-ordinators are effective in bringing together multidisciplinary teams to support people's complex health and care needs." NHSE.

The above, definition suggests that the role of CMHN is focussed on assessment and supporting service users in accessing services and manage their conditions themselves. This would suggest that perhaps the role is more that of broker or case manager.

The CMHNs role is patterned by their Trust's operationalised structures to manage workload**.** CMHNs working within diagnostic sub-divisions or focussing on parts of the staged care pathway, have potentially resulted in their role becoming fragmented. Therefore, practice develops to manage this workload, prioritise service users with the greatest need and facilitate discharges and referrals to other services. CMHNs adapt to fulfil this function and the focus of their role is managing demand. Clinical priorities are based on symptoms and risk. Therefore, pressure to discharge and refer, reduce caseload size become extrinsic drivers. Extrinsic motivation refers to factors which are linked to the managerial approach to managing workload, ensuring outcomes and efficient use of resources (Kingston and Greenwood 2020).

The emphasis of diagnosis as a basis for inclusion. Some participants gave detailed personalised accounts of their service users stories when describing their work. Others referred to them in a more objectifying way, in terms of their diagnosis, treatment or stage of the care pathway. Individual practice and

language can be driven by the parameters of the service: productivity and diagnostic language becomes internalised. Self-management and client centred care is driven by Government agenda of the cost to the NHS of managing LTCs. Self-management can be seen as aligned to recovery and be empowering and normalising. However, the process encourages further objectification and if the service user relapses, the perception that they have not followed discharge advice. In this sense recovery can be viewed as the largely as the service users responsibility. CMHNs with a strong affiliation with the concept of the therapeutic relationship, experience a conflict with their team and manager in respect of pressure to discharge.

It is recognised that nurses experience the managerialist approaches to monitoring and audit as being counterproductive to the therapeutic approach they feel their service users need (Kingston and Greenwood 2020). The top-down approach to monitoring targets means that CMHNs spend large amounts of time populating documentation and audit systems. This is an extrinsic pressure; they are not aware of how this information is used or any intrinsic connection to its value. They receive notification when they have not fulfilled these requirements. There are no punitive sanctions if targets are not met, but there are no rewards either. CMHNs can internalise this sense of not keeping up with the targets and documentation, or not being able to control the amount of work within the service. This has implications for the CMHNs sense of autonomy and their morale**.** The above processes may lead to fragmentation of the role and undermine a sense of control. The pressure to manage the emotive aspects of client work in a client centred way which and process the large number of cases and new referrals leads to conflict, within the CMHN: in reconciling their perceived needs of the service

users with the large workload and the need to fulfil documentation and audit demands. Many state that trying to manage these dual demands has an impact on their work-life balance. It is recognised that managing this duality can lead to internal moral conflict within the CMHN. This can lead to burnout and contribute to sickness and high staff turnover. Pressure to reduce caseload size. In some cases, CMHNs take on managing and developing processes as they find this rewarding as this may give them a sense of control.

The above factors could be viewed as contributing to a process of deprofessionalisation of the CMHN role. With the focus on risk and symptoms, CMHNs are led by diagnosis and thresholds of risk. This may reduce the psychosocial aspects of their role. The creation of other roles, such as NAs of Health and Wellbeing or STR workers, potentially erodes the more fulfilling aspects of the CMHN role. Fragmentation caused by care pathways and managing processes, plus the managerial control over allocation of work and decisions about inclusion and discharge may contributes to fragmentation of the therapeutic process, reducing the CMHN role to a series of tasks. If key functions within the role of the CMHN do not align with their intrinsic motivation this will lead to low morale and impact on retention and recruitment issues.

11.5.2: The Community Mental Health Team:

Many of the structural issues which cause challenges for the CMHN are driven by operational structures at team level. These are created to manage the workload and meet organisational demands for monitoring targets and outcomes. There are clear operational guidelines for each CMHT, which direct inclusion criteria,

referral processes, team purpose, job plans and clinical pathways. Trusts can decide how they operationalise their CMHTs, based on national guidelines. These are discussed in detail in chapter eight.

CMHTs are organised into structured workstreams: which are decided at Trust level. Two neighbouring Trusts have operationalised these differently. One has used diagnostic subdivisions to create two separate teams. The other has one large team, with staged interventions. This is discussed in the thick description and in chapter eight. These provide clear operational structures, provide equity and consistency across the Trust which can help focus skills and make workload manageable.

The diagnostic subdivisions can present problems where there is changing presentations and co-morbidity. The staged approach can result in waiting lists and clients being “stuck.” However, where demand exceeds resources, this may be unavoidable. Risk rating is used to direct resources towards those clients with the highest level of immediate risk. This directs resources towards reactive, rather than proactive risk management. Participants expressed the view that they feel they do not see the less risky service users as often as they would like to. Processes to manage shortfalls: usually managed by the CMHN, for example, the active review team, or clinics with specific functions. This is possibly a negative impact of work designs which are centralised and detract from individual teams and choices. Increasing demand for secondary mental health services necessitate boundary management between services. There is extensive data on managing the interface between primary care and secondary mental health services is challenging. This is discussed in chapter eight. The need for each

service to manage its workload effectively, can lead to rigid boundary management and undermines the ethos of shared care. The Trusts are acutely aware of this and are keen to create structures to facilitate a smoother transition for service users to be discharged to primary care. This is a development that may be progressed as a priority in the implementation of ICS.

The data suggests that team meetings function to process decisions, reinforce structures and manage workload**.** These are forums for socialising staff into the chosen working practices. Identity is shaped by the social function of the profession. Socialisation takes place within the institution and its social function (Bifarin 2016). This is impacted by political, social and economic circumstances. Due to the size of the workload, it is a challenge to ensure that everything is covered within the timeframe. There is therefore limited time for in-depth discussions about individual service users.

Decisions about accepting referrals for assessment, increasing or reducing levels of care are made by groups of seniors and the opinion of the CMHN may be devalued. Key mediating factors, highlighted by participants are supportive team managers and positive team dynamics. Most participants said that a protective factor was the support they received from their immediate manager within the team. These managers were aware of the pressures and tried to contain the anxieties of the CMHNs and meet the organisations demands for fulfilling audit requirements as well as managing increasing demands for the service.

11.5.3: The Trust in the context of National directives:

Participants had limited knowledge of National Policy and how this shaped their daily practice**.** National and local policy make laudable statements about person-centred care, shared care and seamless service provision. However, the resultant practice can be experienced by participants as mechanistic, fragmented and reinforces boundaries between services and parts of a service. Its implementation is experienced by participants as top down throughout layers of the hierarchy. The participants cannot distinguish between organisational and national policy differences, seeing national and local policy the same and then national responses make the problem a local responsibility. Some participants describe experiencing a disconnect with senior management, seeing the difficulties as coming from the Trust. The dualism of productivity and the challenges experienced by frontline staff can be seen to create a split in organisations between senior management and clinical staff. Trusts are required to monitor targets which are negotiated at regional level. They are also required to address quality issues raised by the Care Quality Commission. Participants expressed the belief that the Trusts priority was addressing targets and action plans, rather than the experience of the staff delivering care.

National reports on staff shortages and morale recognise the level of burnout in staff and cite the importance of inclusive cultures and compassionate leadership (West 2021). The importance of compassionate leadership has been raised by NHS England, Professor Michael West of the Kings Fund, and the CQC review services to ensure that they are “well led.” These include suggestions of leadership behaviours which support compassion and inclusion, staff

development and ensure high quality care (West 2021). The introduction of the ICSs is also viewed as an opportunity to deliver this promise (NHS 2021). The reconfiguration that this will entail will inevitably increase the demands on managers and team leaders. The service managers and team leaders are already recognised by participants, as providing invaluable emotional support to CMHNs. They need to be treated compassionately too, as they also must manage the large demand for services as well as support staff. The intrinsic value of mental health nursing practice needs to be recognised. This could have implications for a supportive and restorative approach to clinical supervision, individual and group, and meaningful staff consultation, developing relationships between front line staff and senior managers (This will be discussed in the recommendations section). Staff wellbeing is recognised as important in supporting retention strategies. NHS Trusts have comprehensive strategies which include free and confidential support for their staff (HoC 2021). The balance between demand and resources and the increasingly mechanistic approach to work and the bureaucratic nature of delivery is the cause of wellbeing issues. Therefore, wellbeing support needs to consider the structures and situational factors which impact on wellbeing. This is necessary to have an impact on retention and recruitment.

I discussed my findings with the Director of Nursing and the head of the Community Mental Health Directorate, in Trust A. They both expressed concern about the retention and recruitment issues affecting CMHNs. They are becoming increasingly aware that the band six role involves a large amount of administration and statutory responsibility. They also suggest that the introduction of new roles, such as wellbeing workers removes some of the more rewarding, therapeutic aspects of the CMHN role. They are keen to look at ways of aligning the role with

intrinsic motivation, providing role clarity and a sense of professional development. They are also concerned that the ACP role is too generic and would like to see a programme which developed more advanced therapeutic skills, specific to mental health nursing. Trust A have outlined training priorities for CMHNs, based on the Mental Health Nursing Career Competency Framework (HEE 2020). This framework states the intention to acknowledge in the unique contribution of mental health nursing and invest in training and career progression. This may have a positive impact on recruitment and retention. As it recognises the importance of factors promoting intrinsic motivation, job satisfaction and autonomy.

The scale of burnout and staff satisfaction is also clearly stated in the NHS staff satisfaction survey. This has resulted in the Government producing report on the toxic culture in the NHS and focussing on bullying and discrimination. Reports such as: Staff Burnout and Resilience in NHS (House of Commons 2021) and Beyond Demoralised (Marsh and Proctor 2022) make detailed and accurate observations about the scale of poor morale and the impact this is having on the workforce. These are discussed in relation to the data in chapters six, seven and eight. The recommendations state the need for individual Trusts to create safe and inclusive cultures which enable staff to speak out. It is also suggested that senior staff listen to and act on staff feedback and address bullying and discrimination.

Both the Trusts in this study have produced reports in the last year which have addressed this. The NHS workforce plan focuses on training more staff to address vacancy rates. However, this devolves all the responsibility to NHS Trusts, to

address their organisational culture. What it fails to do is to look at the broader social and economic factors which have created these issues in the workplace. Public services have been governed by the productivity agenda, policies which are driven by making savings, promoting individualism, and creating fragmented and mechanistic approaches to care. However, addressing these broad ranging societal influences and established practices is clearly beyond the scope of this thesis. The NHS state that development of ICS, would be an opportunity to develop more effective leadership strategies. However, this involves another large-scale top-down reorganisation, which may place services under greater pressure. This potentially represents a cultural shift, from the ethos of competition inherent in the Health and Social Care Act (HM Gov 2012) to one of collaboration. How this is operationalised over time is yet to be realised. Perhaps genuinely giving staff a voice and enabling them to contribute to policy development and national consultation on shaping healthcare would help.

11.6: Limitations

The third and fourth research questions were concerned with CMHN perception of their Trusts priorities and their understanding of national policy. The focus was specifically on participant's' perceptions of these factors as I wanted to see if they knew the origins of the structures which shape their practice. The identification of macro level influences on generative mechanisms, sought to identify Trust level choices which led to operationalised structures for CMHTs. The macro level data and the choices and structures at the commissioner/Trust level, may have been better understood by an examination of organisational culture, detailed interaction between Trust and commissioners. The analysis of these macro-level influences

would have been greatly enhanced by interviews with representatives of the commissioning bodies, Trust executives and service managers. Non-participant observations of Executive Board and/or its sub-committees and service level meetings and commissioning processes would provide insights into the hierarchical processes which impact on the CMHNs experience. This is addressed in section 11.8, recommendations for future research.

Another potential limitation is the lack of data from service users. I assumed that if CMHNs experienced workload pressures, fragmentation and a disconnect from their roles, then this would impact on the quality of care they were able to provide to the service user. Although this may be the case, service users may experience benefits from the introduction of standardised care pathways or waiting times. Alternatively, they may experience their care as fragmented if they are moved between teams and care pathways. It would be useful to understand how service users feel they are involved in decision making and their views of access to services and self-management.

Identifying Generative Mechanisms was challenging. By their very nature, they are hard to observe. The real and tangible structures exist regardless of our ability to know or experience them. The identification of them was based on my empirical data, interrogation of policy and application of mid-range social and psychological theories, to explain participant experiences. I used nonparticipant observations to verify meso level structures and interactions which may enact policy directives and constrain them. These observations provided a rich source of data. However, I was aware that they were snapshots in time and that so much communication occurred in other meetings, forums, and briefings. Therefore, I was left with the feeling that I could have gone on indefinitely but had to reach a point when I could

draw some realistic conclusions. I have learnt that the challenge of Critical Realist research is to find practical and feasible ways of researching complex, conflated, and stratified social issues in a transparent practical way.

My data collection was impacted by the COVID pandemic. I was due to start the semi-structured interviews in early 2020, when lockdown measures were put into place. CMHTs continued to provide services and moved to online provision where possible. The Trusts informed me that due to pressures on their staff at this time, I could not have access to them for my research until further notice. Therefore, I had to delay my data collection for over a year. When I resumed, I needed to undertake the interviews online due to partial social distancing still being in place. Post-COVID, CMHTs were inundated with referrals which made engagement with the research sites and recruitment of participants challenging. Recruitment for the semi-structured interviews was slow and I was very aware of how busy staff were.

11.7: Recommendations for future research:

My research focussed on the perceptions of CMHNs on the individual, team and organisational influences on their work. This is consistent with my work experience of being a CMHN and team leader. The organisational perspectives and choices were only addressed in relation to local policies and using these to analyse my data. In undertaking this work, I have developed positive relationships with senior management who are interested in my results and what implications this may have for strategic developments regarding the CMHN role. Therefore, I may undertake post-doctoral work in exploring aspects of organisational culture and Trust level change management. It would be useful to explore this in relation

to moving towards working in ICSs**.** How this impacts boundary management, shared care and implications for leadership. The change in focus from competition embedded in Health and Social Care Act 2012, to the proposed ethos of collaboration seemingly inherent in Health and Care Act 2022.

The above requires consideration of organisational cultures and how they can work effectively together. The support provided by leaders at band seven and eight staff in CMHTs is invaluable in providing staff support**.** Compassionate leadership is considered a vital component within organisations in ensuring staff wellbeing and motivation, throughout the NHS (West et al 2020). This is discussed in chapter nine. This thesis has demonstrated that policy which seeks to deliver efficiency can create an audit culture, which may promote an organisational culture of managerialism. This in turn can lead to low morale in staff and teams. The pressure to provide this support to staff and manage the workload for the team, can place pressure on team leaders and they too can be at risk of burnout. NHS England cite compassionate leadership as a key feature in the success of Integrated Care Systems.

"*We commit to supporting compassionate, inclusive leadership and doing what we can to create the conditions for it, including addressing issues that stand in the way such as bureaucracy and misaligned policy*." (NHSE Our Shared Ambition for compassionate and inclusive leadership." Page 1).

Therefore, research which identifies key issues within national and local policy and the bureaucratic structures which operate to deliver this, is required.

NHSE has published a position statement regarding phasing out the CPA (NHSE 2022). This states that the Care Programme Approach which has provided

structure for care in secondary mental health services for 30 years, has been superseded by the Community Mental Health Framework. It suggests that new models of care will provide a shift from generic care coordination to meaningful interventions. This has implications for the role of the CMHN, which would require further research to determine the part they may play in delivering meaningful interventions. NHS England have developed guidelines to increase the scope of meaningful psychological interventions for service users in contact with secondary mental health services, with serious and complex mental health problems (NHSE 2024). This guidance suggests that NHS England is committed to upskilling and training the workforce, including mental health nurses. It has been suggested that the effectiveness of such interventions is linked to the development of a therapeutic alliance (Coffey et al 2019). It is pertinent to note that Hartley et al (2020) state that the value of the therapeutic relationship, which is a key skill of mental health nurses, is under researched. This may also have an impact on enhanced career development that harnesses a mental health nurses' identity and increases their scope for advanced psychosocial interventions. An examination of factors which enhance the intrinsic motivation and core values of mental health nursing and how these can be incorporated into career pathways and continued professional development.

11.8: Recommendations for practice:

In chapters seven and eight there is extensive data relating to the CMHN perception of their large workload. It is recognised that NHS staff spend an inordinate amount of time on documentation and administration. This has been addressed by a government report "Busting Bureaucracy" (DHSS 2020) which

acknowledges the need to reduce the administrative burden of clinical staff to free up their time to deliver care. One of the suggestions in this report is to reduce the use of top-down performance metrics, such as dashboards. This may be a challenge to achieve whilst implementing another major reorganisation, namely the reconfiguration involved in developing ICSs. On the other hand, this may be an opportunity to have administrative staff working across service boundaries which may result developing systems to share information and record multi-agency interventions and outcomes.

In the previous section, research to evaluate the role of the CMHN was suggested. Perhaps national groups such as the RCN mental health forum and the Mental Health Nurse Academics could possibly work together to reinvest in the unique focus of the CMHN. As CMHNs hold onto the belief of holism and undertake the role of care coordinator, they risk the erosion of their role identity and their subsequent intrinsic motivation (Warrender et al 2023). Trusts could evaluate this role to have a closer alignment with specialist mental health therapeutic skills and their valuable contribution to developing trusting therapeutic relationships with clients. If care is to be truly person centred, the CMHN is ideally placed to view that person in a holistic way. CMHN empowerment could be seen as linked to service user empowerment.

Much has been written about compassionate leadership in the NHS. Compassion is a central value of staff working in care settings. Therefore, organisations need to mirror this in being sensitive to the needs of its staff, to promote a sense of commitment, engagement, and satisfaction (West 2021). In the context of delivering efficiency measures and dealing with increasing demands with limited

resources, it is hardly surprising that a command-and-control approach has been dominant. Band seven and eight managers of community services could be freed up from managerialist practices to focus on the therapeutic integrity of CMHN practice and provide restorative supervision group and individual which focuses on the service user from a holistic perspective.

In addition**,** career pathways and Continuing Professional Development: which enhance the therapeutic identity of CMHN, may be beneficial. The ACP role in mental health had a strong focus on physical health care and prescribing. Education which promoted advanced therapeutic skills would reflect the unique skills and intrinsic motivation of mental health nursing. The Mental Health Nursing Competence and Career Framework (HEE 2020) sets out a clear skill set including assessment and formulation of mental health conditions and a range of therapeutic/psychological interventions. Its purpose is to ensure quality care and provide a career framework and job satisfaction. The delivery of these competencies through educational frameworks is endorsed by the Advanced Practice in Mental Health Curriculum and Capabilities Framework (HEE 2022).

It is important at National and organisational level, to recognise and reward aspects of practice which reflect the intrinsic motivation inherent in the CMHN professional identity. Acknowledgement of skill and experience involved in therapeutic engagement and the value of intuitive practice, is enhanced by staff awards and service level compliments which recognise these values. Educational programmes and professional bodies could also promote political awareness and an understanding of the factors which drive policy development. RCN (2024) have developed a Nursing Activism Academy with the intention of strengthening training and awareness of activism within nursing.

Trusts could continue to develop clinical forums which value the holism of the client story. Trust A has reflective practice forums. It may be possible to reconsider the purpose of large team meetings which cover all aspects of the care process. Do these enhance decision making or are they ritualistic in nature? It may represent safe practice to ensure that everything is discussed with key staff members present. However, given the large volume of work and the time taken, perhaps clinical meetings which are smaller and promote case discussions with the role of the CMHN as central would help.

Staff wellbeing may be enhanced by creating an organisational culture which allows CMHNs to challenge unhelpful practice and acknowledge their psychological reactions to be evidence of contextual constraints rather than an individual problem they need to manage. Wellbeing strategies are currently concerned with addressing emotional issues within individual staff once factors such as stress and burnout have become established problems. This has the effect of framing these problems as a deficit within the practitioner, perhaps a legacy of sickness monitoring being linked to performance. This approach does not address the underlying causes of stress. Meaningful staff consultation may also be a valuable organisational strategy. Agenda for Change outlines key responsibilities for each pay band including nursing. Band eight nurses typically provide service level leadership and development, band seven nurses provide advanced clinical leadership and autonomy (HEE 2020). Band eight service managers and band seven CMHT leaders can be seen as linking clinical practice and the strategic demands of the organisation. Ideally, they could (and do) pass staff concerns upwards as well as strategic measures downwards. However, they

are frequently hindered by conflicting demands and pressing issues of workload management and allocation (Gatenby et al 2015). Clinical staff expressed the view that they feel disconnected from senior management. Forums for staff to share their views with senior management seem a viable solution. These need to be realistic in managing staff expectations, without coming across as tokenistic. Perhaps CEOs and/or directors could have staff facing addresses and explain the purpose of organisational changes and take questions.

11.9 The unique contribution to knowledge in the field of mental health nursing.

In this section, I will present the unique contribution, this research makes to knowledge in the field of mental health nursing. There is an existing body of knowledge based on research into the role of CMHN and the functions of CMHTs. This is discussed in chapter two and summarised in appendix one. The existing body of knowledge highlights aspects of the role of the CMHN: role definitions, job satisfaction, the duality of the administrative aspects of care coordination and the interpersonal approach to therapeutic care. There are research studies which also consider the culture and practices of CMHTs, considering changing policy directives, structures and work practices.

The unique contributions of this research will now be summarised. This study considers the impact of policy on the perceptions of CMHNs on their decision making. This is in the context of the timeframe post Health and Social Care Act 2012/ Five Year Forward View (2015) and during the delivery of the NHS Long Term Plan (2019) and prior to the inception of the Health and Care Act (2022) and the creation of Integrated Care Systems.

It uses Critical Realism as a conceptual framework, to guide analysis and the exploration of generative mechanisms. There is a gap in evidence to show the exact contribution Critical Realism can make in nursing practice, although much is written about its potential to do so (Williams et al 2016). In this research it has proven to be an ideal philosophical standpoint for examining the relationship between political ideology, the development of public policy and the structures, interactions and causal powers which translate this into organisational practice and the lived experience of the CMHN.

The data analysis uses a combination of Reflexive Thematic Analysis and Critical Realism (RTA) to identify initial codes and themes within the empirical data. The use of abduction: using a unique combination of mid-range theories to interpret concepts: hierarchy, bureaucracy, psychological reactions, social practice and political ideology. This combines the perceptions of participants with the operationalised structures they work with, to explain and contextualise factors which cause their experiences. This thesis uses the CR analytical process called retroduction, which examines a stratified understanding of social practice, to explain contexts which link national policy to individual experiences. These causative factors are defined as generative mechanisms, which are challenging to identify as key influential factors are often intangible yet have a powerful impact. An adapted social work framework is used to present the Generative mechanisms.

The findings highlight the importance of the subjective experience of CMHNs being a valuable indication of potentially problematic structures and practices. The resultant impact on morale and self-concept can lead to retention problems and burnout. This is valuable knowledge in the current context of a new NHS policy:

Health and Care Act (2022) which seeks to achieve integration and minimise fragmentation and duplication of work. This research concludes at a time when there is national commitments to investing in the role of the mental health nurse, reducing administrative burdens on front line staff and promoting political awareness amongst nurses.

11.10: Summary

This concluding chapter has summarised the learning I have gained through undertaking this PhD. I reflect on my original motivation in terms of my professional experience and values, my interests in political ideology and the complexities of social practice. It has addressed the value of examining CMHNs perceptions of the stratified factors which impact on their practice. The contextual factors which impact on their perceptions have been analysed by identifying generative mechanisms. The ways the four research questions were answered was summarised, by presenting an overview of the empirical data. The implications of the data were considered. The implications for the role of the CMHN included the value of intrinsic motivation and the therapeutic relationship with the service user. The impact of structures to manage workload and managerialism may in turn have an impact on their sense of autonomy, control, role identity and how they view the service user. The implications for the CMHT, include the creation of structured workstreams, to manage workload and the boundary management between services. These are reinforced by team meeting structures and often mediated by supportive leadership and positive team dynamics. At the political and organisational level, it seems that the political approach to devolving responsibility to Trusts mean that staff experience their

difficulties as being located within their employer's control. Limitations and recommendations for future research and practice are addressed. These include considering the impact of organisational factors such as compassionate leadership, restorative supervision, meaningful clinical forums and staff consultation. However, the macro-level factors which exist at Government level are difficult to impact, perhaps acknowledging their impact rather than internalising them may be helpful.

This exploration has been enhanced by my development as a Critical Realist researcher. This has provided me with a valuable framework and guiding philosophy to enable me to gain deeper insights into policy, use practical methods to obtain meaningful data and analyse this using a variety of mid-range theories. In undertaking this work, I hope I have made a valuable contribution to the body of knowledge of mental health nursing. That it can contribute to increasing awareness of some of the factors which make the job of CMHN so challenging in the current context. The process of identifying generative mechanisms is invaluable in demonstrating how large-scale socio-political determinants and social practice impact on mental health care. It may be beyond professional and academic scope to change these social practices. However, gaining insight into these factors and the protective and mediating actions undertaken by organisations, teams and individuals may go some way to shaping their implementation and influence how services utilise the unique and valuable role of the CMHN.

Reference List

A

Abendstern M, Hughes J, Wilberforce M, Davies K, Pitts R, Saqba B, Robinson C and Challis D (2021) Perceptions of the social worker role in adult community mental health teams in England. *Qualitative Social Work.* Vol. 20(3) 773–791

Adams R, Ryan T and Wood T (2021) Understanding the factors that affect retention within the mental health nursing workforce: a systematic review and thematic synthesis. International Journal of Mental Health Nursing 30, 1476–1497

Aho K (2008) Medicalizing Mental Health: A Phenomenological Alternative. *The Journal of Medical Humanities.* DOI 10.1007/s10912-008-9065-1

Alaszewski A and Brown P (2012) *Making health policy a critical introduction.* Cambridge Policy Press.

Alderwick h, Dunn P, McKenna H, Walsh N and Ham C (2016) *Sustainability and Transformation Plans in the NHS; How they are being developed in practice.* Kings Fund

Allen D (2004) Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry* 11(1): 14–24

Allsop K and Kinderman P (2021) The use of diagnoses in mental health service eligibility and exclusion criteria. Journal of Mental Health, 30:1, 97-103, DOI: 10.1080/09638237.2019.167787

Aluwihare-Samaranayake D (2012) Ethics in Qualitative Research: A View of the Participants' and Researchers' World from a Critical Standpoint. *International Journal of Qualitative Research.* 11 (2) pp 64-81.

Anderson B (2019) *Developing Organisational and Managerial Wisdom.* KPU Press books.

Andrade C. (2021) The Inconvenient Truth About Convenience and Purposive Samples. *Indian Journal of Psychological Medicine* Volume 43 Issue 1 pp 86-88.

Angermeyer MC, Matschinger H. (2003) The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. Acta Psychiatr Scand:108:304–309

Ansari W, Lyubovnikova J, Middleton H, Dawson J, Naylor P, and West M (2016) Development and psychometric evaluation of a new team effectiveness scale for all types of community adult mental health teams: a mixed-methods approach. *Health and Social Care in the Community* 24(3), 309–320

Appleby J, Ham C, Imison C and Jennings M (2010) *Improving NHS Productivity: More with the same not more of the same.* The Kings Fund.

Archer M, Bhaskar R, Collier A, Lawson T and Norrie A (1998*) Critical Realism: Essential Readings.* Centre for Critical Realism.

Archibald M and Munce S (2015) Challenges and Strategies in the Recruitment of Participants for Qualitative Research*. University of Alberta Health Sciences Journal*. July 2015, Volume 11 , Issue 1, pp 34-37.

Aung, K.T., Razak, R.A., & Nazry, N.N.M. (2021). Establishing Validity and Reliability of Semi-Structured Interview Questionnaire in Developing Risk Communication Module: A Pilot Study. Edunesia: *Jurnal Ilmiah Pendidikan*, 2 (3): 600-606.

Aveyard H, Payne S and Preston N (2016) *A Postgraduate's Guide to doing a Literature Review in Health and Social Care.* McGraw Hill.

B

Bailey D and Liyange L (2012) The Role of the Mental Health Social Worker: Political Pawns in the Reconfiguration of Adult Health and Social Care. *British Journal of Social Work* 42, 1113–1131

Bailey S (2013) *Whole-person care: from rhetoric to reality Achieving parity between mental and physical health*. RC Psych

Bailey S and West M (2021) *Naming the issue, chronic, excessive workload in the NHS.* Kings Fund.

Baird B, Charles A, Honeyman M, Maguire D and Das P (2016) *Understanding pressures in general practice.* Kings Fund.

Bakolis I, Stewart R, Baldwin P, Beenstock J, Bibby P, Broadbent M, Cardina R, Chen S, Chinnasamy K, Cipriani A, Douglas S, Horner P, Jackson C, John A, Joyce D, Lee S, Lewis J, McIntosh A, Nixon N, OsbourneD, Phiri P, Rathod S, Smith T, Sokal R, Waller R and Landau S (2021) Changes in daily mental health service use and mortality at the commencement and lifting of COVID-19 'lockdown' policy in 10 UK sites: a regression discontinuity in time design. *BMJ Open*
. 11:e049721. doi:10.1136/bmjopen-2021-049721

Ballat J. and Campling P (2011) *Intelligent Kindness reforming the culture of healthcare*. RC Psych.

Ballatt J, Campling P and Maloney C (2020) I*ntelligent Kindness: Rehabilitating the Welfare State. 2nd edition.* RC Psych/Cambridge University Press.

Baker J, Canvin K and Berzins K (2019) The relationship between workforce characteristics and perception of quality of care in mental health: A qualitative study*. International Journal of Nursing Studies* 100 103412

Banks L, Stroud J and Doughty K (2016) Community treatment orders: exploring the paradox of personalisation under compulsion*. Health and Social Care in the Community* 24(6), e181–e190

Barker P and Buchanon-Barker P (2011) Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing.* 5 pp 337-344

Barker I, Steventon A, Williamson R, (2018) Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records *British Medical Journal of Quality and Safety* 27:989–999

Barnes M C, Gunnell D, Davies R, Hawton K, Kapur N, Potokar J, Donovan J L (2017) Understanding vulnerability to self-harm in times of economic hardship and austerity: a qualitative study. *BMJ Open* No 6

Barnett P, Mackay E, Matthews H, Gate R, Greenwood H, Ariyo K, Bui K, Halvorsrud K, Pilling S and Smith S (2019) Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet.* Vol 6, Issue 4 pp: 305-317.

Barron R, Deery R and Sloan G (2017) Community mental health nurses' and compassion: an interpretative approach. *Journal of Psychiatric and Mental Health Nursing*, 24, 211–220.

Bauer A, Evans-Lacko and Knapp M (2019) Valuing recovery-oriented practice at the interface between mental health services and communities: The role of organisational characteristics and environments. *International Journal of Social Psychiatry*. Vol. 65(2) 136–143.

Bechky B (2011) Making Organizational Theory Work: Institutions, Occupations, and Negotiated Orders. *Organisation Science*. Vol. 22, No. 5, pp. 1157–1167.

Beech J, Bottery S, Charleswork A, Evans H, Gershlick B, Hemmings N, Imison C, Kahton P, McKenna H, Murray R and Palmer B (2019) *Closing the Gap. Key areas for action on the health and care workforce.* The Health Foundation, The Kings Fund, Nuffield Trust.

Begum R and Riordan S (2016) Nurses experiences of working in Crisis Resolution Home Treatment Teams with its additional gatekeeping responsibilities. *Journal of Psychiatric and Mental Health Nursing,* 23, 45–53.

Belling R, Whittock M, McLaren S, Burns T, Catty J, Rees-Jones I, Rose D, Wykes J (2011) Achieving Continuity of Care: Facilitators and Barriers in Community Mental Health Teams. *Implementation Science* 6:23

Benbow D. (2021) An Adornian ideology critique of neoliberal reforms to the English NHS, *Journal of Political Ideologies*, 26:1, 59-80.

Berlin J, Szucs S, Hojer S and Lijegren A (2021) How do street-level bureaucrats manage high workloads? Collegial mechanisms at the organisational level—experiences from public healthcare organisations. *European Management Review*.19:299–312.

Bhaskar R (1989) *Reclaiming Reality: A critical introduction to Contemporary Philosophy.* Routledge.

Bhaskar R (2009) *Scientific Realism and Human Emancipation.* Routledge.

Bhaskar R (2013) *From Science to Emancipation: Alienation and Actuality of Enlightenment.* Routledge.

Bhaskar R (2020) Critical realism and the ontology of persons, *Journal of Critical Realism,* 19:2, 113-120.

Bifarin O (2016) Professional socialisation: The art in mental health nursing practice. *British Journal of Mental Health Nursing.* Vol 5. No 5. pp 228-231.

Bifarin O, Felton A and Prince Z (2022) Defensive practices in mental health nursing: Professionalism and poignant tensions. *International Journal of Mental Health Nursing* 31, 743–751

Blau P (1963) *The Dynamics of Bureaucracy: A study in interpersonal relations in two government agencies.* University of Chicago Press.

Blom B and Morén S (2011) Analysis of Generative Mechanisms*, Journal of Critical Realism*, 10:1, 60-79, DOI: 10.1558/jcr.v10i1.60

Blunden N and Calder G (2020) Co-production and person-centred care in neoliberal conditions. *European Journal for Person Centred Healthcare.*8(1) pp 75-85.

Blumer H (1998) *Symbolic Interactionism.* University of California Press

British Medical Association (2015) *Models for paying providers.* Health policy and economic research unit.

British Medical Association (2024) Mental health pressures in England. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis

Bogg D (2015) The Bigger Picture. *Mental Health Today.* Jan Feb 16 p16

Boland J, Abendstein M, Wilberforce m, Pitts R, Hughes J and Challis D (2019) Mental health social work in multidisciplinary community teams: An analysis of a national service user survey. *Journal of Social Work* 0(0) 1–23

Bonner, A., and Tolhurst, G. (2002). Insider/outsider perspectives of participant observation. Nurse Researcher, 9(4), 7-19.

Bonner G and Wellman N (2010) Post Incident Review of Aggression and Violence in Mental Health Settings *Journal of Psychosocial Nursing*. Vol. 48, no. 7.

Borbasi S., Jackson D. and Wilkes L. (2005) Fieldwork in nursing research: positionality, practicalities and predicaments *Journal of Advanced Nursing* 51(5), 493–501

Boswell C, Cannon S, and Miller J (2005) Nurses' Political Involvement: Responsibility Versus Privilege. Journal of Professional Nursing, Vol 21, No 1 (January–February), 2005: pp 5–8.

Bowen A, Maguire T and Newman-Taylor K (2020) Do recovery outcome measures improve clinical practice? A linguistic analysis of the impact of the Hope, Agency and Opportunity measure in community mental health teams. *Perspectives in Public Health* Vol 140 No 2

Boycott N, Akhtar A and Schneider J (2015) ‘‘Work is good for me’’: views of mental health service users seeking work during the UK recession, a qualitative analysis. Journal of Mental Health Nursing 24 (2) pp 93-97.

Boyle, B, Harris, M (2009) The Challenge of Co-production: How Equal Partnerships and the Public Are Crucial to Improve Public Services. London: New Economic Foundation.

Braun, V. & Clarke, V. (2013) *Successful qualitative research*: A practical guide for beginners. London: Sage.

Braun V and Clarke V (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health.* Vol 11. Issue 4. Pp 589-597.

Braun V, Clarke V, Heyfield N and Terry G (2018) in Liamputtong P *Handbook of Research Methods in Health Social Sciences*. Springer

Brimblecombe N and Nolan F (2021) A qualitative study of perceptions of senior health service staff
as to factors influencing the development of Advanced Clinical Practice roles in mental health services. *Journal of Psychiatric and Mental Health Nursing*. 28:829–837.

Brimblecombe N and Dobel-Over D (2021) The development of nurse prescribing in mental health services from five national surveys 2004-2019. *Journal of Nursing Management* 30 pp 1018-1026.

Brown B, Crawfoed P and Darongkama J (2000) Blackwell Science, Ltd Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community* 8(6), 425–435

Broyles L, Rodriguez K, Price P, Bayliss N and Sevick M (2011) Overcoming Barriers to the Recruitment of Nurses as Participants in Health Care Research. Qualitative Health Research 21(12) 1705–1718.

Bruneau J, Moralejo D, Donovan C, and Parsons K (2020) Recruitment of Healthcare Providers into Research Studies. *Canadian Journal of Nursing Research* 0(0) 1–7

Bryant M and Stensaker I (2011) The Competing Roles of Middle Management: Negotiated Order In the Context of Change. *Journal of Change Management* Vol. 11, No. 3, 353–373ingar

Brooker C, Ricketts T, Bennet S, Lemme F (2005) Admission decisions following contact with an emergency mental health assessment and intervention

service. *Journal of Clinical Nursing* 16, pp Journal of Clinical Nursing 16, 1313–1322

Brown B, Crawford P and Darongkamas J (2000) Blackwell Science, Ltd Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community* 8(6), 425–435

Browne E (2001) The influence of liberal political ideology on nursing science. *Nursing Inquiry* 8 (2): 118–129.

Brugha T. S, Taub N, Smith J, Morgan Z, Hill T, Meltzer H, Wright C, Burns T, Priebe S, Evans J and Fryers T (2012) Predicting outcome of assertive outreach across England. *Social Psychiatry and Psychiatric Epidemiology* 47:313–322

Buchan J, Charlesworth A, Gershlick B and Seecomb I (2019) *A Critical Moment in NHS Staffing trends: retention and attrition.* The Health Foundation.

Bullock, H. E, Williams, W. R., & Limbert, W. M. (2008). Predicting support for policies: The impact of attributions and beliefs about inequality. *Journal of Poverty, 7, 35–56.*

Bungernorth L and Fennell E (2018) *Left to chance: the health and care nursing workforce supply in England. Policy Report.* Royal College of Nursing.

Burton J (2017) *What's Wrong with CQC? A proposal to reform the regulation of social care A Discussion Paper from the Centre of Welfare Reform* Centre for Welfare Reform.

Busse R, Klazinga N, Panteli D and Quelin W (2019) *Improving healthcare quality in Europe Characteristics, effectiveness and implementation of different strategies.* OECD.

Butler, J., de Cassan, S., Turner, P. *et al.* (2020). Attitudes to physical healthcare in severe mental illness; a patient and mental health clinician qualitative interview study. *BMC Fam Pract* **21**, 243 https://doi.org/10.1186/s12875-020-01316-5

Butterworth T and Shaw T (2017) *Playing our Part: The work of graduate and registered mental health nurses: An independent review by the Foundation of Nursing Studies.* Foundation of Nursing Studies.

Bygstadt B and Munkvold B (2011) In Search of Mechanisms. Conduction and Critical Realist Data Analysis. Conference: Proceedings of the International Conference on Information Systems, ICIS 2011, Shanghai, China, December 4-7, 2011. : https://www.researchgate.net/publication/221600158

C

Calvan O, Dash P, Drouin J, Fountaine T and Riahi F (2011) Using care pathways to improve health systems. *Health International* Number 11 pp 6-17.

Cameron, D. and Landsley A (2007) *NHS Autonomy and Accountability*. 1st ed. London: Conservatives.

Campling P (2015) Reforming the culture of healthcare: the case for intelligent kindness*. British Journal of Psychiatry Bulletin* 39, 1-5.

Capdevilla R and Callaghan J (2008) 'It's not Racist. It's Common Sense'. A Critical Analysis of Political Discourse Around Asylum and Immigration in the UK. *Journal of Community and Applied Social Psychology, 18: 1–16.*

Caram C, Peter F, Romos F and Brito M (2022) The process of moral distress development: A virtue ethics perspective. *Nursing Ethics* Vol. 29(2) .402–412.

Carpenter J, Barnes D, Dickinson C and Wooff D (2006) Outcomes of interprofessional education for Community Mental Health Services in England: The longitudinal evaluation of a postgraduate programme. *Journal of Interprofessional Care, 20(2): 145–161*

Carter M (2003) The relationship of a self-reported assessment of need in mental illness to insight*. Journal of Mental Health* 12, 1, 81–89

Catallo C, Spalding K, and Haghiri-Vijeh R (2014) Nursing Professional Organizations: What Are They Doing to Engage Nurses in Health Policy? *SAGE Open* October-December 1 –9

Chambers M, Gallagher A, Borschmann R, Gillard S, Turner K and Karstaris X (2014) The experiences of mental health service users: issues of dignity in care. *BMC Medical Ethics. 15:50* http://www.biomedicalcentral.com/1472-6939/15/50

Charles A, Wenzel L, Kershaw M, Ham C and Walsh N (2018) *A year of Integrated Care Systems, reviewing the journey so far.* The Kings Fund.

Charles A (2020*) Integrated care systems explained: making sense of systems, places and neighbourhoods.* Kings Fund.

Chipperfield C (2017) *Leadership for a Purpose.* NHS

Chow W and Priebe S (2013) Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry 13:169*

Christofides S, Johnstone C and Musa M (2011) Chipping in': Clinical psychologists' descriptions
of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice (2012), 85, 424–435*

Cilliers L and Terblanch L (2010) The systems psychodynamic leadership coaching experiences of nursing managers. *Journal of Interdisciplinary Health Services.* Vol. 15 No. 1 Page 1 of 9

Clarke M (2011) Mental health care clusters and payment by results: considerations for social inclusion and recovery. *Mental Health and Social Inclusion.* 15 (2). pp. 71-77.

Cleary M, Horsfall, O'Hara-Aarons M, Jackson D and Hunt G (2011). The views of mental health nurses on continuing professional development. *Journal of Clinical Nursing*, 20, 3561–3566 3561 doi: 10.1111/j.1365-2702.2011.03745.x.

Clever Together (2019) *Developing Advanced Practice in clinical care: analysis of physical and online workshops.* *https://www.hee.nhs.uk/sites/default/files/documents/19-05-29%20Report_Developing%20advanced%20practice%20in%20clinical%20care_CleverTogether_%20FINAL.pdf*

Coffey M (1997) Supervised discharge: concerns about the new powers for nurses. *British Journal of Nursing*, Vol 6, No 4 pp 214-215

Coffey M, Hannigan B, Barlow S, Cartwright M, Cohen R, Faulkner A, Jones A and Simpson A (2019) Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: A cross national comparative mixed methods study. BMC Psychiatry Vol 19. Issue 1. Article no 115.

Colcough T (2020) *Living in the Red: the cost-of-living crisis for London's nursing workforce.* Royal College of Nursing.

Collins B (2019) *Outcomes for mental health services What really matters?* Kings Fund Publications.

Collins P, Garot R and Garot T (2018) Bureaucracy and Emotions - Perspectives across Disciplines *Administory Zeitschriftfur Verwaltungsgeschichte* BAND 3, pp 5–20

Columbo A, Bendelow G, Fulford B and Williams S (2003) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine* 55 (7) 1557-70

Cooke B and Kathari U (2001) *Participation: The new tyranny?* St Martin's Press

Cooke G, Gerrish K and Clarke C (2001) Decision-making in teams: issues arising from two UK evaluations. *Journal of Interprofessional Care*, VOL. 15, NO. 2

Cooke A, Smith D and Boothe A (2012) Beyond PICO; The SPIDAR Tool for qualitative evidence synthesis. *Qualitative Health Research* 22.10 1435-43.

Cooke A, Smythe W and Anscombe P (2019) Conflict, compromise and collusion: dilemmas for psychosocially oriented practitioners in the mental health system, *Psychosis,* 11:3, 199-211, DOI: 10.1080/17522439.2019.1582687

Cooper A and Dartington T (2004) The vanishing organisation. *In Working below the surface* (edsHuffington C, Armstrong D and Halton W et al) pp127-150 Karnac.

Cornwall P, Gorman B, Carlisle J and Pope M (2001) Ten years in the life of a community mental health team: The impact of the care programme approach in the UK. *Journal of Mental Health* 10, 4, 441–447

Corrigan P (2004) How Stigma Interferes with Mental Health Care. *American Psychological Association* Vol. 59, No. 7, 614–625.

Care Quality Commission (2022) *Gridlocked Health and Care System leading to deterioration in peoples' access to and experience of care.* Available at https://www.cqc.org.uk/press-release/gridlocked-health-and-care-system-leading-deterioration-peoples-access-and-experience (accessed 2023)

Crawford P, Brown B and Majomi P (2008) Professional identity in community mental health nursing: A thematic analysis*. International Journal of Nursing Studies* 45 1055–1063

Creswell, J. (2009*). Research design: Qualitative, quantitative, and mixed methods approaches.* (3rd ed.). Thousand Oaks, CA: Sage.

Crisp N (2001) *Shifting the Balance of Power within National Health Service: Securing Delivery.* Department of Health

Crocker J (1998) Social Stigma and Self-Esteem: Situational Construction of Self-Worth. *Journal of Experimental Social Psychology* 35, 89–107.

Crossman J (2021) *Handbook of Qualitative Research Methodoligies in Workplace Contexts.* Edward Elgar.

Cummins I (2018) The Impact of Austerity on Mental Health Service Provision: A UK Perspective*. International Journal of Environmental Research in Public Health*.1;15(6):1145. doi: 10.3390/ijerph15061145. PMID: 29865157; PMCID: PMC6025145.

Czander, W. M. (1993). *The psychodynamics of work and organizations: Theory and application.* Guilford Press.

D

Dalgarno M and Oates J (2019) The crucible of co-production: Case study interviews with Recovery College practitioner trainers. *Health Education Journal* Vol. 78(8) 977–987

Danermark, B., Ekström, M., Jakobsen, L., and Karlsson, J. (2019*). Explaining Society: Critical Realism in the Social Sciences,* Routledge, London.

Dartington T (2010) *Managing Vulnerability. The underlying dynamics of systems of Care.* Karnac.

Davis H (2008) Psychodynamics and empowerment in community mental health. *Journal of Social Work Practice Psychotherapeutic Approaches in Health, Welfare and the Community* Volume 10, Issue 2 pp 157-162.

Davies W (2016) The New Neoliberalism. *New Left Review 101.* Sept Oct 2016. pp 121-134.

Davawsheh W (2014) Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. International Journal of Therapy and Rehabilitation. Vol 21 No 12 pp 560-570.

Dawber C (2014) Gatekeeper Versus Concierge: Reworking the Complexities of Acute Mental Health Care Through Metaphor*. Social Alternatives* Vol. 33 No 3, pp: 53-59.

Deegan, P. (1988) Recovery: The Lived Experience of Rehabilitation. *Psychosocial Rehabilitation Journal 11(4):11–19.*

Degeling P and Maxwell S (2004) The negotiated order of healthcare. *Journal of health Service Research Policy.* Vol 9 No 2 pp 119-121.

Delgano M and Oates J (2019) The crucible of co-production: Case study interviews with Recovery College practitioner trainers. *Health Education Journal* Vol. 78(8) 977–987

Department of Health (1989) *Working with Patients*. HMSO

Department of Health (1989*) Caring for People: Community Care in the Next Decade and beyond.* HMSO

Department of Health (1990), *Care Programme Approach* HMSO

Department of Health (1994) Working in partnership. HMSO

Department of Health (1996) Health of the Nation; Building Bridges; Interagency Working HMSO

Department of Health (1996) NHS Service with Ambition

Department of Health (1997) Developing Partnerships in Mental Health HMSO

Department of Health (1997.) *The New NHS: Modern and Dependable (Command Paper)*. (s.n.).

Department of Health (1998) Our Healthier Nation. DH Publications

Department of Health (1998) Modernising Our Mental Health Services. DH Publications

Department of Health (1999) National Service Framework. DH Publications

Department of Health (2006) *From values to action: The Chief Nursing Officer's review of mental health nursing.* DH Publications

Department of Health (2000) The NHS Plan DH Publications

Department of Health (2001) Health and Social Care Act DH Publications

Department of Health (2001) Shifting the Balance of Power. DH Publications.

Department of Health (2002) Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform (Command Paper). Stationery Office Books.

Department of Health (2007) New Ways of working, Creating Capable Teams. DH Publications

Department of Health. (2008) High quality care for all: NHS Next Stage Review Final Report. Cm 7432. London: The Stationery Office,

Department of Health (2009) New Horizons DH Publications

Department of Health (2010). *Equity and Excellence: Liberating the NHS* DH Publications

Department of Health (2010) Preceptorship framework for newly qualified nurses, midwives and allied health professionals. London. Department of Health.

Department of Health (2011). *No Health without Mental Health* DH Publications

Department of Health (2012) *The Health and Social Care Act* DH Publications

Department of Health (2012) *Liberating the NHS: Do decision about me without me.* DoH

Department of Health (2014) *Closing the Gap*. DH Publications

Department of Health (2014) *The Care Act*. DH Publications.

Department of Health (2014) *Hard Truths: The Journey to Putting Patients First*. DH Publications.

Department of Health (2014) *Achieving Better Access to Mental Health Services by 2020.* DH Publications.

Department of Health and Social Care (2017) *Stepping forward to 2020/21: The mental health workforce plan for England*

Department of Health and Social Care (2020) *Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England.* DH Publications.

Department of Health and Social Care (2021) Integration and Innovation: working together to improve health and social care for all. Department of Health and Social Care.

Des Jardin, K (2001). Political Involvement in Nursing—Politics, Ethics, and Strategic Action. AORN journal. 74. 614-8, 621. 10.1016/S0001-2092(06)61760-2.

Dickens A, Weleminski J, Onifade Y and Sugarman P (2012) Recovery Star: validating user recovery. *The Psychiatrist*, 36, 45 -50

Dickenson H (2006) The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future. Health and Social Care in the Community 14 (5), pp 375–383

Diefenbach T (2009) Are case studies more than sophisticated storytelling? Methodological problems of qualitative empirical research mainly based on semi-structured interviews. *Quality and Quantity* 43:875–894

Donaldson L in Crothers C (2010) *Historical Developments and theoretical approaches in sociology.* Eoloss

Donnelly P (1996) Decision-making in a community mental health team. *Mental Health Nursing.* Volume 16 number 2. Pp 12-15

Donnison J, Thompson A and Turpin G (2009) A qualitative exploration of communication within the community mental health team. International Journal of Mental Health Nursing 18, 310–317

Dormin F, Butcher H and Taut R (2016) *Catalyst or distraction? The evolution of devolution in the English NHS.* The Health Foundation.

Dowling B and Glendinning c (2003) *The New Primary Care. Modern, dependable and successful?* Open University Press

Durcan G, Stubbs J, Appleton S and Bell A (2017) *The Future of the Mental Health Workforce.* Centre for Mental health/ NHS Confederation.

Duyvendak J, Knijn T and Kremer M (2014) *Policy, people and the new professional: De-professionalisation and Re-professionalisation in care and welfare.* Amsterdam University Press.

Dwyer S and Buckle J (2009) The Space Between: On Being an Insider-Outsider in Qualitative Research.
International Journal of Qualitative Methods 8(1) pp 54-64

Dwyer P, Scullion L, Jones K, McNeill J and Stewart A (2019) Work, welfare, and wellbeing: The impacts of welfare conditionality on people with mental health impairments in the UK. Social Policy Administration 54 pp 311–326.

Dye S (2017) Can mental health clusters be replaced by patient typing? *British Journal of Healthcare Management* Vol 23 No 5 pp 229-237

Dyson S, Traynor M, Liu L, Korukcu O and Mehta N (2014) *Scoping the Role of the Nurse Consultant.* A report commissioned by HENCEL and produced on behalf of Middlesex University, School of Health and Education. University of Middlesex.

E

Edwards, N., (2004) *Working together strengthening relationships between primary care trusts and acute trusts*. 1st ed. London: NHS Confederation.

Edwards R and Holland J (2013) *What is qualitative interviewing?* Bloomsbury Publishing plc.

Edwards D, O'Mahoney J and Vincent S (2014*) Studying Organizations Using Critical Realism: A Practical Guide.* Oxford Scholarship Online.

Ehrich K (2006) Telling cultures: 'cultural' issues for staff reporting concerns about colleagues in the UK National Health Service. *Sociology of Health and Illness* Vol. 28 No. 7 pp. 903–926.

Elder-Vass D (2012) Top-down causation and social structures. *Interface Focus.* 2, 82–90

Elkomy S and Cookson G (2018) Performance Management Strategy: Waiting Time in the English National Health Services. *Public Organization Review* (2020) 20:95–112

Elliott, L and Masters, H (2009) Mental health inequalities and mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 16, 762–771

Elzubier M and Sherman M (1995) Nursing skills and practice*. British Journal of Nursing,* Vol 4, No 1 pp 1087-1092

Emmel N, Greenhalgh J, Manzano A and Haigh N (2018) *Doing Realist Research.* Sage Publications.

Esposito L and Perez F (2014) Neoliberalism and the Commodification of Mental Health*. Humanity and Society* Vol. 38(4) 414-442

Evans T (2007) Confidentiality in Mental Health Services A Negotiated Order? *Qualitative Social Work* Vol. 6(2): 213–229

Evans-Lacko S, Corker E, Williams P, Henderson C and Thornicroft G (2014) Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: an analysis of survey data. *Lancet Psychiatry.* (2):121-8. doi: 10.1016/S2215-0366

F

Fairclough N (2000) *New Labour. New Language?* Routledge.

Fairclough N (2013) Critical discourse analysis and critical policy studies, *Critical Policy Studies,* 7:2, pp. 177-197.

Fairclough N and Fairclough I (2018) A procedural approach to ethical critique in CDA, Critical Discourse Studies, 15:2, 169-185, DOI: 10.1080/17405904.2018.1427121

Farringdon D and Murray J (2013) Labelling Theory: Empirical Tests (Advances in Criminological Theory) Transaction Publishers

Felton A, Repper J and Avis M (2018) Therapeutic relationships, risk, and mental health Practice. International Journal of Mental Health Nursing (2018) 27, 1137–1148.

Ferras I, Battilana J and Meda D (2022) *Democratize Work: The case for Organising the Economy.* University of Chicago Press.

Fianger M and Burns T (2000) A Delphi Approach to Describing Service Models of Community Mental Health Practice. *Psychiatric Services.* Vol 51. No 5. pp 656-658.

Finefter-Rosenbluh I (2017) Incorporating Perspective Taking in Reflexivity: A Method to Enhance Insider Qualitative Research Processes. *International Journal of Qualitative Methods*. Volume 16: 1–11.

Filippidou M, Lingwood S and Mirza I (2014) Reducing non-attendance rates in a community mental health team. *British Medical Journal Quality Improvement Reports* u202228.w1114 doi: 10.1136/bmjquality. u202228.w1114

Findlayson B (2002) *Counting the smiles. Morale and motivation in the NHS*. Kings Fund

Fisher B (2013) The Dangers of Marketisation. *Health Service Journal.* https://www.hsj.co.uk/comment/the-dangers-of-marketisation-/5053782.article

Fletcher J (2017) Applying critical realism in qualitative research: methodology meets method. International Journal of Social Research Methods Vol 20. Issue 2 181-194

Fowler M (2017) Unladylike Commotion': Early feminism and nursing's role in gender/trans dialogue. *Nursing Inquiry.* ; 24: e12179; DOI: 10.1111/nin.12179
Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2017, September 21). Conceptualizing and Measuring Mental Illness Stigma: The Mental Illness Stigma Framework and Critical Review of Measures. *Stigma and Health. Advance online publication. http://dx.doi.org/10.1037/sah0000104*

Foye U, Dalton-Locke C, Harju-Seppänen J, Lane R, Beames L, San Juan N.V. , Johnson S and Simpson A (2020) How has COVID-19 affected mental health nurses and the delivery of mental health nursing care in the UK? Results of a mixed-methods study. *Journal of Psychiatric and Mental Health Nursing.28:126–137.*

Francis R (2013*) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* HMSO.

Frederiksen D and Kringelum L (2021) Five potentials of critical realism in management and organization studies*, Journal of Critical Realism*, 20:1, 18-38, DOI:10.1080/14767430.2020.1846153

Freeman T and Peck E (2006) Evaluating partnerships: a case study of integrated specialist mental health services. Health and Social Care in the Community 14 (5), 408–417

Freeman D, Taylor K, Molodynski A and Waite F (2019) Treatable clinical intervention targets for patients with schizophrenia. *Schizophrenia Research.* 211 pp 44-50.

Freeman M (2014) The Hermeneutical Aesthetics of Thick Description. *Qualitative Inquiry*. Vol. 20(6) 827–833. Qualitative Inquiry

G

Garety P, Craig T, Dunn G, Fornells-Ambrojo M, Colbert S, Rahaman N, Reed J and Power P (2006) Specialised care for early psychosis: symptoms, social functioning and patient satisfaction Randomised controlled trial. *British Journal of Psychiatry* 188, 37-4 5

Gilburt H (2015) *Making change possible: A ;352:i658doi:10.1136/bmj.i658 Transformation Fund for the NHS* The Health Foundation and The King's Fund

Gilburt H, Edwards N and Murray R (2014) *Transforming mental health A plan of action for London* Kings Fund.

Gilburt H and Mallorie S (2024) Mental health 360: workforce. Kings Fund website: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce

Gillard S, Adams K, Edwards C, Lucock M, Miller M, Simons L, Turner K and White R (2012) Informing the development of services supporting self-care for severe, long term mental health conditions: a mixed method study of community based mental health initiatives in England. *BMC Health Services Research* 12:189

Glasper A (2016) Can a nursing associate role fill the void left by enrolled nurse training*? British Journal of Nursing* Vol 25, No 3 pp 178-179

Gleave R and Peck (2009) Images of contracting for the mental health service. *Journal of Mental Health Vol 1 No. 3 pp 217-227*

Goddard M and Mannion R (2006) Decentralising the NHS; Rhetoric, reality and paradox. *Journal of Health Organisation and Management.* Vol 20. Issue 1. Pp 67-73

Goetz K, Klein-Budde K, Bramesfield A and Stegbauer C (2017) Working atmosphere, job satisfaction and individual characteristics of community mental health professionals in integrated care. *Health Social Care Community*.26:176–181.

Goffman E (1990) *The Presentation of Self in Everyday Life.* Penguin

Gobel F and Chassy D (2007) Towards an alternative to Benner's theory of expert intuition in nursing: a discussion paper. *International Journal of Nursing Studies.* 45(1):129-39

Goddard M. and Manion R (2006) Decentralising the NHS: rhetoric, reality and paradox. *Journal of Health Organization and Management.* Vol. 20 Issue: 1, pp.67-73.

Goffman E (1961) *Asylums: Essays of the social situation of mental patients and other inmates.* Penguin

Goffman, E. (1990). Stigma. Harmondsworth, Middlesex: Penguin Books.

Gough, B., and A. Madill. 2012. "Subjectivity in Psychological Research: From Problem to Prospect." *Psychological Methods* 17 (3): 374–384

Goldthorpe J (2012) *Sociology as a Population Science*. Cambridge University Press.

Goodwin N and Lawson-Smith S (2010) Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-

term conditions management. International Journal of Integrated Care Volume 10, pp: 1-10

Granello B and Gibbs T (2014) The Power of Language and Labels: “The Mentally Ill” Versus “People with Mental Illnesses” *Journal of Counselling and Development* Volume 94 pp 31-40

Gray P (2014) *An Independent Review of the Personal Independence Payment Assessment.* HMSO.

Green H (2018) Team splitting and the ‘borderline personality’: a relational reframe. *Psychoanalytic Psychotherapy*. Vol. 32, No. 3, 249–266,

Griffiths P, Maroutti A, Recio-Saucedo A, Redfern O, Ball J, Briigs J, Dall’Ora C, Schmidt P and Smith G (2018) Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. British Medical Journal Qual Saf 0:1–9.

Groen B. (2022) Will 2022 be the year that ‘integrates’ health and social care in England? *British Journal of Healthcare Management.* https://doi.org/10.12968/bjhc.2021.0161

Gruebner O, Rapp MA, Adli M, Kluge U, Galea S, Heinz A. (2017) Cities and Mental Health. *Deutsches Arzteblatt International*. 114(8):121-127. doi: 10.3238/arztebl.2017.0121. PMID: 28302261; PMCID: PMC5374256.

H

Haigh F, Kemp L, Bazekey P and Haigh N (2019) Developing a critical realist informed framework to explain how the human rights and social determinants of health relationship works. *BMC Public Health.* **19**, 1571 (2019). https://doi.org/10.1186/s12889-019-7760-7.

Hallett T (2003) Symbolic Power and Organizational Culture *Sociological Theory*, Vol. 21, No. 2 pp. 128-149

Hamilton I, Lloyd C, Bland JM and Savage Grange J.A. (2015) The impact of assertive outreach teams on hospital admissions for psychosis: a time series analysis. *Journal of Psychiatric and Mental Health Nursing,* 22, 484–490

Ham C and Alderwick H (2015) Place-based systems of care A way forward for the NHS in England. Kings Fund.

Ham C (2016) Government and national bodies take charge of decision making as NHS crisis grows. *British Medical Journal. ;352: i658doi:10.1136/bmj.i658*

Ham C, Alderwick H, Dunn P, McKenna H, (2017) *Delivering Sustainability and Transformation Plans; from ambitious proposals to credible plans* Kings Fund

Ham C, Murray R (2018). ‘The NHS 10-year plan: how should the extra funding be spent?’ The King’s Fund website. Available at: www.kingsfund.org.uk/publications/nhs-10-year-plan

Hamblin R and Ganesh J (2007) *Measure for measure Using outcome measures to raise standards in the NHS.* Policy Exchange.

Hammond, J.; Lorne, C.; Coleman, A.; Allen, P.; Mays, N.; Dam, R.; Mason, T.; Checkland, K. (2017) The spatial politics of place and health policy: Exploring Sustainability and Transformation Plans in the English NHS. *Social science and medicine* (1982). ISSN 0277-9536 DOI: https://doi.org/10.1016/j.socscimed.2017.08.007

Hannigan B (2011) Giving a fig about roles: policy, context and work in community mental health care. *Journal of Psychiatric and Mental Health Nursing.* 18, 1–8

Hannigan B and Coffey M (2011) Where the wicked problems are: The case of mental health. *Health Policy* 101 pp 220-227.

Hannigan B (2014) 'There's a lot of tasks that can be done by any': Findings from an ethnographic study into work and organisation in UK community crisis resolution and home treatment services. Health 2014, Vol. 18(4) 406 –421

Hannigan B, Simpson A, Coffey M, Barlow S and Jones A (2018) Care Coordination as Imagined; Care Coordination as Done: Findings from a Cross-national Mental Health Systems Study. *International Journal of Integrated Care,* 18(3): 12, 1–14.

Handley, M., Bunn, F., Lynch, J., & Goodman, C. (2020). Using non-participant observation to uncover mechanisms: Insights from a realist evaluation. *Evaluation*, *26*(3), 380-393. https://doi.org/10.1177/1356389019869036

Hanley B, Scott H and Priest H (2017) The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): a psychodynamic perspective. *Psychoanalytic Psychotherapy*. Vol 31 Issue 2 pp 176-194.

Hartley S, Raphael J, Lovell K and Berry K (2020) Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies. 102. 103490.*

Haslam MB, Ellis S, Plumridge M. (2022) 'It's not you; it's us!': the relevance of mental health team psychodynamics to the care of individuals with complex emotional needs. *British Journal of Mental Health Nursing*. https://doi.org/10.12968/bjmh.2021.0033

Hawke G (2017) *The Order of natural Necessity: Roy Bhaskar. A kind of introduction to Critical Realism.* Amazon.

Hayes P and Stroud J (2022) Practitioner Perspectives About Managing Community Treatment Orders (CTOs) in England and the Importance of Social Influences. *Community Mental Health Journal* 58:pp 1584–1591.

Hayton J (2016) Perspectives: The Nurse Associate: an asset to supplement the NHS workforce or a cheaper substitute for the registered nurse. Journal of Research in Nursing. Vol 21 (5-6) pp 483-486

Hayward K and Yar M (2006) The 'chav' phenomenon: Consumption, media and the construction of a new underclass. *Crime and Media Culture* 2 (1) pp 9-29.

Healthcare Financial Management Association (2019) Briefing Summary of the Interim NHS People Plan. HMFA.

Health and Social Care Act (2012), chapter.7. Available at: https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 2023)

Health and Care Act (2022), chapter 31. Available at: https://www.legislation.gov.uk/ukpga/2022/31/pdfs/ukpga_20220031_en.pdf (accessed 2023)

Health Education England (2017) *Stepping forward to 2020/21: The mental health workforce plan for England.* HEE.

Health Education England (2019) New Roles in Mental Health Nursing Associate Task & Finish Group Supporting the mental health workstream.

Health Education England (2020) *Mental Health Nursing Competence and Career Framework.* HEE

Health Education England (2022) The Department of Health and Social Care mandate to Health Education England: April 2022 to March 2023. https://www.gov.uk/government/publications/health-education-england-mandate-2022-to-2023/the-department-of-health-and-social-care-mandate-to-health-education-england-april-2022-to-march-2023

Health Education England (2022) *Advanced Practice in Mental Health Curriculum and Capabilities Framework*. HEE

Health of the Nation (1995) *Building Bridges: A Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People.* Dep of Health.

Heginbotham C (1999) The Psychodynamics of Mental Health Care. *Journal of Mental Health* 8 (3) pp253-260. *Social Psychiarty and Psychiatric Epidemiology* 49 pp 1599-1608.

Henderson R, Corker E, Hamilton S, Williams P, Pinfold V and Rose D (2014) Viewpoint survey of mental health service users' experiences of discrimination in England 2008–2012.

Henshall, C., Doherty, A., Green, H. et al (2018) The role of the assistant practitioner in the clinical setting: a focus group study. *BMC Health Services Res*earch **18,** 695 https://doi.org/10.1186/s12913-018-3506-y

Higgins A, Doyle L, Downes C, Morrissey J, Costello P, Brennan M and Nash M (2016) There is more to risk and safety planning than dramatic risks: Mental

health nurses' risk assessment and safety-management practice. *International Journal of Mental Health Nursing* 25, 159–170

Hill-Smith A (2012) Staff relationships in multi-disciplinary teams. *Mental Health Practice.* Vol 15 No 8 pp 14-19.

Hinchelwood R (2010) Organizational schism: Looking after a psychiatric service. *Psychoanalytic Psychotherapy,* Vol. 24, No. 3, 202–212

HM Government (2017) *The Government's response to the Five Year Forward View* DH Publications.

Holland D (2019) Enlightened common sense II: clarifying and developing the concepts of intransitivity and domains of reality, *Journal of Critical Realism*, 18:2, 189-210, DOI: 10.1080/14767430.2019.1600122.

Holley J, Chambers M and Gillard S (2016) The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation. *Journal of Mental Health* 25(4): 315–322

Hopkins N and Laurie E (2015) Social Citizenship, Housing Wealth and the Cost of Social Care: Is the Care Act 2014 'Fair'? *Modern Law Review* 78(1) 112-139

Hopkins C and Niemiec S (2007) Mental health crisis at home: service user perspectives on what helps and what hinders. *Journal of Psychiatric and Mental Health Nursing* 14, 310–318

House of Lords (2019) *The Future of Seaside Towns*. House of Lords.

House of Commons and Health and Social Care Committee (2021) *Workforce burnout and resilience in the NHS and social care.* House of Commons.

Houston S (2023) Dialectical critical realism, transformative change and social work. *Critical and Radical Social Work.* vol 11 no 1 pp: 27–41.

Howell K and Voronka K (2012) Introduction: The Politics of Resilience and Recovery in Mental Health Care. Studies in Social Justice Volume 6, Issue 1, 1-7,

Howell K (2013) *The Philosophy of Methodology*. Sage

Houghton C, Casey D, Shaw D, Murphy K (2013) Rigour in qualitative case-study research. *Nurse researcher*. 20, 4, 12-17.

Hupe P and Buffatt B (2014) A public service gap: Capturing contexts in a comparative approach of street-level bureaucracy. *Public Management Review*, Vol. 16, No. 4, 548–569,

Hurley J and Lakeman R (2021) Making the case for clinical mental health nurses to break their silence on the healing they create: A critical discussion. *International Journal of Mental Health Nursing* 30, 574–582

Hutchison (2014) The construction and legitimation of workplace bullying in the public sector: insight into power dynamics and organisational failures in health and social care. *Nursing Inquiry* 22(1): 13–26

Huxley P, Evans S, Munroe M and Cestari L (2008) Integrating health and social care in community mental health teams in the UK: a study of assessments and eligibility criteria in England. *Health and Social Care in the Community* 16 (5), 476–482

Hyatt J (2017) Recognizing Moral Disengagement and Its Impact on Patient Safety. *Journal of Nursing Regulation.* Volume 7/Issue 4 pp: 15-21.

Hysong S, Smitham KB, Knox M, Johnson K E, SoRelle R and Haidel P (2013) Recruiting clinical personnel as research participants: a framework for assessing feasibility*. Implementation Science 2013, 8:125*
http://www.implementationscience.com/content/8/1/125

I

Iqbal N (2014) Decision making, responsibility and accountability in community mental health teams. *Mental Health Practice.* Vol 17. No 7 pp 26-28.

J

Jackson C and Manley K (2021) Contemporary Challenges of Nursing CPD: Time to change the model to meet citizens' needs. *Nursing Open;*9:880–891.

Jacobs R, Chalkey M, Aragon MJ, Bohnke J, Clarke M and Moran V (2018) Funding approaches for mental health services: Is there still a role for clustering? *British Journal of Psychiatric Advances* Vol 24. Issue 6 pp 412-421

James K, Stewart D, Wright S and Bowers L (2012) Self-harm in adult in-patient psychiatric care. A national study of incident reports in the UK. *International Journal of Nursing Studies.* Vol 49. Issue 8 pp 1212-1219

The Joint Commissioning Panel for Mental Health (2015) *Guidance for commissioning public mental health services. Practical mental health commissioning*. Joint Commissioning Panel for Mental Health. https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/rehab-social---joint-commissioning-panel---guidance-for-commissioners-of-rehabilitation-services-for-people-with-complex-mental-health-needs---2016.pdf?sfvrsn=82cbb5e4_6#:~:text=The%20Joint%20Commissioning%20Panel%20for,for%20mental%20health%20and%20learning last accessed 18/12/23

Jones-Devitt S and Smith L (2008) *Critical Thinking in Health and Social Care* Routledge.

Jones G, Meegan R, Kennett P and Croft J (2016) The uneven impact of austerity on the voluntary and community sector: A tale of two cities. *Urban Studies* Vol. 53(10) 2064–2080.

Joynes V (2017) Defining and understanding the relationship between professional identity and interprofessional responsibility: implications for educating health and social care students. *Health Soc Care Community.*26:176–181.

K

Kemp S (2014) A statutory duty of candour: The pros and cons of imposing the duty on individuals*. Clinical Risk*, Vol. 20(1–2) 24–28.

Kellet S, Ghay j, Ackroyd K, Freshwater K, Finch J, Hartley J and Simmons-Buckley M (2020) Delivering cognitive analytic consultancy to community mental health teams: Initial practice-based evidence from a multi-site evaluation. *Psychology and Psychotherapy: Theory, Research and Practice* 93, 429–455.

Kelly S and McKenna H (2004) Risks to mental health patients discharged into the community. Health, Risk and Society, Vol. 6, No. 4, pp 377-385.

Keohane N (2018) *The NHS, innovation and productivity*. Social Market Foundation.

Kerasidou and Kingon (2019) Austerity measures and the transforming role of A and E professionals in a weakening welfare system. https://doi.org/10.1371/journal.pone.0212314.

Kerr I, Dent-Brown K and Parry G (2007) Psychotherapy and mental health teams. *International Review of Psychiatry*, 19(1): 63–80

Kessler, I., Manthorpe, J., Samsi, K., Steils, N., and Woolham, J. (2021) *Rapid review on understanding morale in the NHS workforce, London*: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-056

Khandaka G, Gandamaneni P, Cherukurin S, Cairns P and Ray M (2013) Evaluating care pathways for community psychiatry in England: a qualitative study*. Journal of Evaluation in Clinical Practice* 19 298–303298.

Kings Fund (2005) Working *Paper. Managing Long Term Conditions*. Kings Fund.

Kings Fund (2011) *Briefing Health and Social Care Bill.* Kings Fund

Kings Fund (2015) *Making change possible: A Transformation Fund for the NHS* The Health Foundation and The King’s Fund.

Kings Fund (2018) The health care workforce in England: make or break? https://www.kingsfund.org.uk/insight-and-analysis/reports/health-care-workforce-england

Kings Fund (2023) The NHS Long Term Workforce Plan explained. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/nhs-long-term-workforce-plan-explained

Kingston M and Greenwood S (2020) Therapeutic relationships: Making space to practice in chaotic institutional environments. *Journal of Psychiatric and Mental Health Nursing.* 27:689–698.

Kinnair D, Anderson E and Thorpe L (2012) Development of interprofessional education in mental health practice: Adapting the Leicester Model. Journal of Interprofessional Care 26: 189–197.

Kislov R, Pope C, Martin G and Wilson P (2019) Harnessing the power of theorising in implementation science. *Implementation Science. 14:103*

https://doi.org/10.1186/s13012-019-0957-4

Klein R (2013) The Twenty-Year War over England's National Health Service: A Report from the Battlefield*. Journal of Health Politics, Policy and Law*, Vol. 38, No. 4 pp 849-869.

Klein R and Maybin J (2012) *Thinking about Rationing.* The Kings Fund.

Knapp M and Wong G (2020) Economics and mental health: the current scenario. *World Psychiatry* 2020; 19:3–14

Knight M and Maloney M (2005) Anonymity or visibility? An investigation of stigma and Community Mental Health Team (CMHT) services using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health* 14(5): 499–512.

Konteh F, Mannion R and Jacobs R (2019) Changing leadership, management and culture in mental health trusts. *Mental Health Review Journal. https://doi.org/10.1108/MHRJ-03-2022-0018*

Korasz K, Miller M, Steadman P et al (2018) Measuring complexity and quantity of community caseloads. *Mental Health Practice*. doi: 10.7748/mhp.2018.e1278

Korstjens I and Moser A (2018) Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing, *European Journal of General Practice*, 24:1, 120-124.

Kostova I. (2017) Thick description. In: Turner BS, Kyung-Sup C, Epstein CF, Kivisto P, Ryan M, Outhwaite W, eds. *The Wiley Blackwell Encyclopedia of Social Theory*. New Jersey, NY: Wiley-Blackwell;

Kotecha V (2017) The Five-Year Forward View: do the numbers add up? The Centre for Health and the Public Interest (CHPI)

Kramer M, Maguire P, Schmalenberg CE. (2006) Excellence through evidence: the what, when, and where of clinical autonomy. Journal of Nursing Administration 36: pp: 479–91.

L

Lannin G, Vogel D, Brennan R, Abraham W and Heath P (2015) Does Self-Stigma Reduce the Probability of Seeking Mental Health Information? *Journal of Counselling Psychology* © 2015 American Psychological Association 2016, Vol. 63, No. 3, 351–358

Larkin C and Callaghan P (2005) Professionals' perceptions of interprofessional working in community mental health teams. *Journal of Interprofessional Care*, A 19(4): 338–346.

Lawless B and Chen Y (2019) Developing a Method of Critical Thematic Analysis for Qualitative Communication Inquiry. *Howard Journal of Communications.* Vol 30. No 1 pp92-106

Lean M, Fornells-Ambrojo M, Milton A, Lloyd-Evans B, Harrison-Stewart B, Yesufu-Udechuku, A Kendall T and Johnson S (2019) Self-management interventions for people with severe mental illness: systematic review and meta-analysis. *The British Journal of Psychiatry* 214, 260–268. doi: 10.1192/bjp.2019.54

Lelliott, P, Tulloch, S, Boardman, J, Harvey, S, Henderson, M, Knapp, M. (2008) Mental Health and Work. Royal College of Psychiatrists.

Lester H, Birchwood M, Tait L, Shah S, England E and Smith J (2008) Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. Health and Social Care in the Community 16, (5), 493–500

Lethbridge J (2019*) Democratic Professionalism in public services*. Policy Press

Leung L (2015) Validity, reliability, and generalizability in qualitative research. Journal of Family Medicine and Primary Care Volume 4: Issue 3 pp 324-328

Levitas, R. (2005) *The Inclusive Society? Social Exclusion and New Labour* (2nd edn). Macmillan Press

Lewin S and Reeves S (2011) Enacting 'team' and 'teamwork': Using Goffman's theory of impression management to illuminate interprofessional practice on hospital wards. *Social Science and Medicine.* 72. pp 1595-1602

Lewis R (2005) *Governing Foundation Trusts: A New Era for Public Accountability.* Kings Fund

Ley B, Salize H, Dressing H, Rusch N, Schonenberger T, Buhlman M, Bleiker M, Lenger S, Korinth L and Rossler W (2012) Preventing compulsory admission to psychiatric inpatient care through psychoeducation and crisis focused

monitoring. *BMC Psychiatry* 12:136 http://www.biomedcentral.com/1471-244X/12/136

Liamputtong P (2010) *Qualitative Research Methods.* Oxford.

Liberati E, Richards N, Willars J, Scott D, Boydell N, Parker J, Pinfold V, Martin G, Dixon-Woods M and Jones P (2021) A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic. *BMC Psychiatry. 21: 250*

Lilo E (2016) *Mental Health Integration Past, Present and Future A Report of National Survey into Mental Health Integration in England.* NHS

Link B and Phelan J (2001) Conceptualizing Stigma. *Annual Review of Sociology,* Vol. 27 (2001), pp. 363-385

Lintern S (2018) Thousands of NHS staff use speak up guardians*. Health Service Journal. https://www.hsj.co.uk/policy-and-regulation/thousands-of-nhs-staff-use-speak-up-guardians/7023444.article Last accessed 2/9/19*

Lipsky, M. ([1980] 2010). *Street-level bureaucracy: Dilemmas of the individual in public services* (30th anniversary expanded ed.). Russell Sage Foundation Loader K (2014) Resolving the psychiatric bed crisis: a critical analysis of policy. British Journal of Nursing, Vol 23, No 3 pp 150-155.

Logina A and Tranor M (2018) The relationship between effective transition models and the optimal management of patient care. *British Journal of Nursing* Vol 28, No 3 pp 168-171.

Loosemore M and Hughes W (2000) Confronting Social Defence Mechanisms: Avoiding Disorganisation During Crises. *Journal of Contingencies and Crisis Management.* Volume 9 Number 2 pp 73-87

Lub V (2015) Validity in Qualitative Evaluation: Linking Purposes, Paradigms, and Perspectives. *International Journal of Qualitative Methods* 2015: 1–8

Luck L, Chok N and Wilkes L (2017) Nurses as participants in research: an evaluation of recruitment techniques. *Nurse Researcher*. 25, 2, 44-48. doi: 10.7748/nr. 2017.e1546.

Lynch K (2017) New managerialism in education: the organisational form of neoliberalism. In Abraham-Hamanoiel A, Freedman D, Khiabany G, Nash K and Petely J. Liberalism in Neoliberal times : Dimensions, contradictions, Limits. Goldsmiths Press

M

Maguire M and Delahunt B (2017) Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars. *All Ireland Journal of Teaching and Learning in Higher Education.* Volume 8, Number 3 pp 3351-3365

Malin N (2017) Developing an analytical framework for understanding the emergence of de-professionalisation in health, social care and education

sectors. *Social Work & Social Sciences Review* 2022 pp.66-162. DOI: 10.1921/swssr.v19i1.1082

Manley K and Titchen A (2012) Becoming a Nurse Consultant: Towards greater effectiveness through a programme of support. RCN Learning Development Institute

Mankiewicz P, Reid J, Hughes E and Attard A (2020) Management of demographic equality of access to family intervention for psychosis in specialist community mental healthcare teams. *British Journal of Healthcare Management.* https://doi.org/10.12968/bjhc.2020.0136.

Marsh C and Procter L (2022) *Beyond demoralised. Listening and responding to NHS frontline staff is everyone's business.* NHS Improvement Academy.

Martin P (1999) Influences on Clinical Judgement in Mental Health Nursing NT Research Vol 4 No 4 p 273-281.

Martin G, Chew S, McCarthy I, Dawson J and Dixon-Wood J (2022) Encouraging openness in health care: Policy and practice implications of a mixed-methods study in the English National Health Service. *Journal of Health Services Research & Policy*. Vol. 28(1) 14–24.

Mauno S., Ruokolainen M., Kinnunen U. and De Bloom J. (2016) Emotional labour and work engagement among nurses: examining perceived compassion, leadership and work ethic as stress buffers. *Journal of Advanced Nursing* 72(5), 1169–1181

McCabe T and Sandbrook A (2018) A discourse analysis of managerialism and trust amongst nursing professionals. *Irish Journal of Management* DOI: 10.2478/ijm-2018-0009.

MacDonnell J and Buck McFadyen E (2016) How Activism Features in the Career Lives of Four Generations of Canadian Nurses. *Policy, Politics, and Nursing Practice*. 2016, Vol. 17(4) 218–230

McGregor S (2001) Neoliberalism and health care. *International Journal of Consumer Studies*, 25, 2, pp82–89

McNicoll A (2016) Withdrawing social workers from NHS will 'boost Care Act compliance', claims council https://www.communitycare.co.uk/2016/01/08/withdrawing-social-workers-nhs-will-boost-care-act-compliance-claims-council/

McKenna H and D (2016) *What Planning Guidance means for the NHS.* Kings Fund

McKeown, M and White (2015) The future of mental health nursing: are we barking up the wrong tree? Journal of Psychiatric and Mental Health Nursing 22 (9) pp 724-730 *and Mental Health Nursing*, 22 (9). pp. 724-730

McVicar A (2003) Workplace stress in nursing: a literature review. *Journal of Advanced Nursing*, 44(6), 633–642

Melin-Johansson C, Palmqvist R and Ronnenberg L (2017) Clinical intuition in the nursing process and decision-making— A mixed-studies review. *Journal of Clinical Nursing*. 26:3936–3949

Mental Health Task Force (2016) *The Five Year Forward View for Mental Health.* NHS England

Menzies-Lyth I (1988) Containing Anxieties in Institutions: Selected Essays Vol 1. Free Association Books

Mingers, J and Standing, C (2017) Why things happen – Developing the critical realist view of causal mechanisms*. Information and Organization*, 27 (3). pp. 171-189. ISSN 1471-7727. (doi:10.1016/j.infoandorg.2017.07.001) (KAR id:62468)

Minta K (2020) Neoliberalism and the Commodification of Mental Illness in Surveillance Society. *Critical Student Reflections on Contemporary Society and Social Futures.* Leeds Becket University Vol 8.

Mitchell A. and Selmes T (2007) Why don't patients attend their appointments? Maintaining engagement with psychiatric services? *Advances in Psychiatric Treatment* vol. 13, 423–434 doi: 10.1192/apt.bp.106.003202

Mlambo M, Silen C and McGrath C (2021) Lifelong learning and nurses' continuing professional development, a meta synthesis of the literature. *BMC Nursing* 20:62 https://doi.org/10.1186/s12912-021-0057

Moffatt F, Martin D and Timmons S (2014) Constructing notions of healthcare productivity: the call for a new professionalism? *Sociology of Health and Illness* Vol. 36 No. 5 ISSN 0141-9889, pp. 686–702

Moldawsky R (2020) Is the Psychiatric History Losing Its Relevance? *The Permanente Journal* https://doi.org/10.7812/TPP/19.186

Monkley-Poole S (1998) Calculating risk in community mental health nursing: the decision analysis approach. *Mental Health Care* 2 (2) pp 56-59.

Mooney G (2012) Neoliberalism is bad for our health. *International Journal of Health Services,* Volume 42, Number 3, Pages 383–401,

Moore A (2018) The forgotten foundations: in core mental health services, no one can hear you scream*. BJPsych Bulletin* 42, 225–228, doi:10.1192/bjb.2018.79

Morrall P (1997) Professionalism and community psychiatric nursing: a case study of four mental health teams. *Journal of Advanced Nursing*, 25, 1133–1137

Morin K and Baptiste D (2020) Nurses as heroes, warriors and political activists*. Journal of Clinical Nursing*. 2733–2733.

Moth R (2020) The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change.* Vol. 24(2) 133–153

Moore A. (2018) The forgotten foundations: in core mental health services, no one can hear you scream. *British Journal of Psychiatry Bulletin* 42, 225–228.

Moustaid, E., Kornevs, M., Lindencrona, F. *et al.* A System of Systems of Mental Health in Cities, Digging Deep into the Origins of Complexity. *Adm Policy Ment Health* **47**, 961–971 https://doi.org/10.1007/s10488-020-01035-0

Mukuria C, Brazier J, Barkham M, Connell J, Hardy G, Hutten R, Saxon D, Dent-Brown K and Parry G (2013) Cost-effectiveness of an Improving Access to Psychological Therapies service. The British Journal of Psychiatry 202, 220–227

Mullett D (2018) A General Critical Discourse Analysis Framework for Educational Research. *Journal of Advanced Academics* Vol. 29(2) 116 –142

Murdoch C and Kendall T (2016) *Implementing the five-year forward view for mental health.* NHS England

Murray C (1996) ENB report on Project 2000: is there cause to celebrate? *British Journal of Nursing,* 5(13), p. 776

N

National Quality Board (2018) *Safe, sustainable and productive staffing. An improvement resource for mental health.* NHS England.

National Audit Office (2019) *The Adult Social Care Workforce in England*. NAO Publications.

National Audit Office (2023) *Progress in improving mental health services in England.* NAO Publications.

National Collaborating Centre for Mental Health (2019) *The Community Mental Health Framework for Adults and Older Adults: support, care and treatment.*

National Institute for Clinical Excellence (2011) *Common mental health problems: identification and pathways to care.* https://www.nice.org.uk/guidance/cg123 last accessed 2/12/22

Naylor C, Bell A, Baird B, Heller A and Gilburt H (2020) *Mental health and primary care networks Understanding the opportunities.* Kings Fund.

Nelson T, Johnson S and Bebbington P (2009) Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health. *Sociology Psychiatry Psychiatric Epidemiology* 44:541–549

Neuman W (2013) *Social Research Methods. Qualitative and Quantitative Approaches*. Pearson

Newby P (2010) *Research Methods for Education* Longman

New Economics Foundation (2013) *Co-production in mental health A literature review.* Creative commons.

NHS Confederation Briefing (2016) *Understanding sustainability and transformation plans.* NNS Confederation Issue 291.

NHS Employers (2022) NHS Staff Survey: analysis of results. Available at https://www.nhsemployers.org/articles/nhs-staff-survey-2022-analysis-results (accessed 2023)

NHS England (2014) *Five Year Forward View*. NHS England.

NHS England (2016) *General Practice Forward View.* NHS England.

NHS England (2019) Board Paper: PB.24.05.2018/05 https://www.england.nhs.uk/

NHS England (2019) *The NHS Long Term Plan*. NHS England.

NHS England (2019) *The NHS's recommendations to Government and Parliament for an NHS Bill*. NHS England and NHS Improvement.

NHS England (2019) *Interim People Plan*. NHSE and NHS Improvement.

NHS England (2020) *We are the NHS: People Plan 2020/21 - action for us all*. NHS England.

NHS England (2022) *Mental Health Dashboard.* Available at: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/ (accessed 2023)

NHS England (2022) *Discharge Challenge for Mental Health and Community Services providers.* NHSE website: https://www.england.nhs.uk/long-read/discharge-challenge-for-mental-health-and-community-services-providers/ last accessed 15/12/23.

NHS England (2023) *The Long-Term Workforce Plan.* NHSE

NHS England and NHS Improvement (2016) *NHS Operational Planning and Contracting Guidance 2017-19*. NHSE

NHS Improvement (2017) *Use of Resources: assessment framework*. NHS Improvement.

NHS Improvement (2019) *Technical guidance: workforce planning 2019/20*NHS Improvement

NHS (2018) Kent and Medway: *Our case for change*. NHS England.

NHS England and NHS Improvement and the National Collaborating Central for Mental Health (2019) *The Community Mental Health Framework for adults and older adults.* NHSE

NHS Providers (2020) *The impact of COVID-19 on Mental Health Trusts in the NHS.* NHS Providers.

NICE (2009) *Borderline Personality Disorder: recognition and Management.* Available at: https://www.nice.org.uk/guidance/cg78/chapter/1-guidance (accessed 2023)

NICE (2011) Common Mental Health Problems: identification and pathways to care. Available at: https://www.nice.org.uk/guidance/cg123 (accessed 2023)

Noble H and Smith J (2015) Issues of validity and reliability in qualitative research. *Evidence Based Nursing volume* 18 number 2 pp 34-35

Nolan P., Haque M. S., Bourke P. & Dyke R. (2004) A comparison of the work and values of community mental health nurses in two mental health NHS Trusts *Journal of Psychiatric and Mental Health Nursing* 11, 525–533

Nolan P and Smokjis M (2003) The mental health of nurses in the UK. *Advances in Psychiatric Treatment* Vol. 9, 374–379

NHS Confederation (2013) *Challenging bureaucracy*. NHS Confederation.

NHS Future Forum (2011) *Choice and Competition: Delivering Real Choice.* NHS Future Forum

Nugus P (2019) Re-structuring the negotiated order of the hospital. *Sociology of Health & Illness* Vol. 41 No. 2, pp. 378–394

Nursing and Midwifery Council (2010) *Standards for pre-registration nursing education*. NMC.

Nursing and Midwifery Council (2018) *Future Nurse: Standards of proficiency for registered nurses*. NMC. https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/ (accessed 2023)

Nursing and Midwifery Council (2022) *Leavers' survey: Why do people leave the NMC register? https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/leavers-survey-2022.pdf (accessed 2023).*

O

Oates J, Burrell C, Ebrahim S, Taylor J, Veitch P and Brandon T (2020) Responsibility as professional leadership and decision making: Interviews with non-medical Responsible Clinicians. *International Journal of Law and Psychiatry.* 71 https://doi.org/10.1016/j.ijlp.2020.101575

O'Hara G (2013) The Complexities of 'Consumerism': Choice, Collectivism and Participation within Britain's National Health Service, c.1961–c.1979. *Social History of Medicine*, Volume 26, Issue 2, May 2013, Pages 288–304

Olmos-Vega F, Stalmeijer R, Varpio L and Kahlke R (2023) A practical guide to reflexivity in qualitative research: AMEE Guide No. 149, Medical Teacher, 45:3, 241-251, DOI: 10.1080/0142159X.2022.2057287Onyett S (2011) Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health,* 20(2): 198–209.

Onyett S (2011) Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health.* 20 (2) pp 198-209.

O'Rielly D and Read R (2011) The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization. *Organization Studies* 32(8) 1079–1101

O'Shea N (2020) COVID-19 and the Nation's Mental Health. https://www.centreformentalhealth.org.uk/publications/COVID-19-and-nations-mental-health-october-2020/

Ousey K (2011) The changing face of student nurse education and training programmes. *Wounds UK,* Vol 7, No 1 pp 70-76

P

Palmer W and Imison C (2018) *Lesson 3: Don't treat the workforce as an afterthought*, Nuffield Trust comment. https://www.nuffieldtrust.org.uk/news-item/lesson-3-don-t-treat-the-workforce-as-an-afterthought

Palys, T (2008). Purposive sampling. In L. M. Given (Ed.) *The Sage Encyclopaedia of Qualitative Research Methods.* (Vol.2). Sage: Los Angeles, pp. 697-8.

Pandey S, Smith A, Gall E, Bhatanagar A and Chausalet T (2022) A Conceptual Framework to Predict Mental Health Patients' Zoning Classification. *Informatics and Technology in Clinical Care and Public Health.* doi:10.3233/SHTI210924

Parlour R and McCormack B. (2012) Blending critical realist and emancipatory practice development methodologies: making critical realism work in nursing research *Nursing Inquiry* 19: pp 308–321

Parsons T (1951) *The Social System* Routledge

Patel M, De Zoysa N, Barker D and David A (2005) Antipsychotic depot medication and attitudes of community psychiatric nurses. *Journal of Psychiatric and Mental Health Nursing,* 12, 237–244

Patel MX, Doku V and Tennakoon L (2003) Challenges in recruitment of research participants. Advances in Psychiatric Treatment (2003), vol. 9, 229–238

Pater J (1981) *The making of the NHS.* Kings Fund

Paxton R, Chaplin L, Selman M, Liddon A, Cramb G and Dodyson G (2003) Early intervention in psychosis: A pilot study of methods to help existing staff adapt. *Journal of Mental Health* 12, 6, 627–636

Peckham S, Exworthy M, Powell M, Greener I. (2005) Decentralisation as an organisational model for health care in England. *Report for the NHS Service Delivery and Organisation R&D Programme.* London

Peters M (2001) *Poststructuralism, Marxism and Neoliberalism: Between theory and politics.* Rowman and Littlefield.

Phillipi J and Landerdale J (2017) A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research* 2018, Vol. 28(3) 381 –388

Pilgrim D and Rogers A (2005) Psychiatrists as social engineers: A study of an anti-stigma campaign. *Social Science and Medicine.* 61 pp: 2546-2556.

Pollack S (2010) Labelling Clients 'Risky': Social Work and the Neo-liberal Welfare State. *British Journal of Social Work* 40, 1263–1278

Powers M and Fadden R (2006) *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford University Press.

Pownall H (2013) Neoliberalism, austerity and the Health and Social Care Act 2012: the coalition government's programme for the NHS and its implications for the public sector workforce. *Industrial Law Journal*, Vol. 42, No. 4 pp 422-433

Priest H, Roberts P, Dent H, Blincoe C, Lawton D and Armstrong C (2008) Interprofessional education and working in mental health: in search of the evidence base. *Journal of Nursing Management*, 16, 474–485

Pring R (2000) *The Philosophy of Educational Research.* Continuum.

Procter S, Harrison D, Pearson P, Dickinson C, Lombardo C (2016) New Ways of Working in UK mental health services: developing distributed responsibility in community mental health teams? *Journal of Mental Health*, 25(2): 126–130

Public Health England (2017) *Psychosocial pathways and health outcomes: Informing action on health inequalities.* Public Health England and UCL Institute of Health Equity

Public Health England (2018) *Public mental health leadership and workforce development framework Executive summary: Confidence, competence, commitment.* PHE

Punch, M. (1994) Politics and Ethics in Qualitative Research. In: Denzin, N.K. and Lincoln, Y.S., Eds., Handbook of Qualitative Research, Sage Publications, Thousand Oaks, CA, 83-95.

Punton G, Dodd A and McNeill A (2022) You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *Plos one. https://doi.org/10.1371/journal.pone.0265542*

Purcell, T., (2005) *National Health Service and Community Care ACT 1990 (Chapter 19)*. Stationery Office Books (TSO).

Pursio K, Kankkunen P and Sanner-Stiehr E (2021) Professional autonomy in nursing: An integrative review. *Journal of Nursing Management*. 29:1565–1577.

Q

Quilter-Pinner H (2016) *Devo-health. What and why?* Institute for Public Policy Research

R

Raduescu, C. and Vessey, I. (2008). *Causality in Critical Realist Research: An Analysis of Three Explanatory Frameworks.* International Association for Critical Realism Annual Conference 2008, London, UK, 11-13 July 2008. London: Kings College.

Rafferty A.M (2018) Nurses as change agents for a better future in health care: the politics of drift and dilution*. Health Economics, Policy and Law* 13, 475–491

Rankin J (2005) *Mental Health in the Mainstream: Mental health and social inclusion*. Institute for Public Policy Research.

Rankin K (2011) Assemblage and the politics of thick description. *City.* Vol 15. No 5 pp 563-569

Ramon S (2008) Neoliberalism and its implications for mental health in the UK. *International Journal of Law and Psychiatry.* 31. Pp 116-125.

Rapp CA, Goscha RJ (2004) The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal*, 27(4), 319-333.

Raynard R (2014) A Critical Realist Perspective on Decisions Involving Risk and Uncertainty. *Polish Psychological Bulletin*, vol 45(1), 3-11

Rees A, Richards A and Shapiro P (2004) Utility of the HoNOS in measuring change in a Community Mental Health Care population. *Journal of Mental Health* 13(3): 295–304

Reid A, Brown J, Smith J, Cope A and Jamieson S (2018) Ethical Dilemmas and Reflexivity in Qualitative Research. *Perspectives in Medical Education.* 7 pp 69-75

Renwick L, Lavelle M, Brennan G, Stewart D, James K, Richardson M, Williams H, Price O and Bowers L (2016) Physical injury and workplace assault in UK mental health trusts: An analysis of formal reports. *International Journal of Mental Health Nursing* 25, 355 –366

Repper, J and Perkins R (2003) *Social Inclusion and Recovery: A Model For Mental Health Practice.* First Edition. Edinburgh and New York: Bailliere Tindall.

Repper J, and Eve J. (2022) Embedding coproduction in organisational culture and practice: a case study. *Leadership in the Health Service*. Jul 26; ahead-of-print(ahead-of-print). doi: 10.1108/LHS-04-2022-0039. PMID: 35877449.

Rhodes L, Genders R, Owen R, O'Hanlon K and Brown J (2010) Investigating barriers to implementation of the NICE Guidelines for Depression: a staff survey with Community Mental Health Teams. *Journal of Psychiatric and Mental Health Nursing,* 17, 147–151

Rhodes R and Giles S (2014) 'Risky Business'': a critical analysis of the role of crisis resolution and home treatment teams. Journal of Mental Health, 23(3): pp 130–134.

Richards H (2021) On the intransitive objects of the social (or human) sciences. *Journal of Critical Realism.* DOI: 10.1080/14767430.2018.1426805.

Rimmer A (2023) NHS culture change is difficult, not impossible—but essential, says health ombudsman. *BMJ 383* doi: https://doi.org/10.1136/bmj.p2742

Ritzer G (2005) *Encyclopaedia of Social Theory*. Sage.

Rivett G (1998) *From Cradle to Grave: fifty years of the N.H.S.* Kings Fund.

Rizq R (2014) Perversion, neoliberalism and therapy: The audit culture in mental health services. *Psychoanalysis, Culture and society.* 19 209-2018.

Roberts J (2014) Critical Realism, Dialectics, and Qualitative Research Methods. *Journal for the Theory of Social Behaviour.* Vol 44 Issue 1 pp 1-23.

Robertson R, Wenzel L, Thompson J and Charles A (2017) *Understanding NHS financial pressures How are they affecting patient care?* Kings Fund.

Robertson R and Ewbank L (2020) *Thinking differently about commissioning Learning from new approaches to local planning.* The Kings Fund.

Roderick P and Pollock A (2021) A new bill to reform the NHS in England: the wrong proposals at the wrong time. *British Medical Journal.* A new bill to reform the NHS in England: the wrong proposals at the wrong time - The BMJ

Roderick P and Pollock A (2022) Dismantling the National Health Service in

England. *International Journal of Health Services*. Vol. 52(4) 470–479.

Rosenfeld S (1997) Labelling Mental Illness: The Effects of Received Services and Perceived Stigma on Life Satisfaction. American Sociological Review, Vol. 62, No. 4 pp. 660-672

Royal College of Nursing. (2019). Nursing staff stretched to breaking point over workloads, report reveals. Royal College of Nursing. [online]. Available from: URL: https://www.rcn.org.uk/news-and-events/pressreleases/
staff-survey

Royal College of Nursing. (2020a). *RCN Submission to the Pay Review Body 2020-21*. Royal College of Nursing. RCN Submission to the Pay Review Body 2020-21| Royal College of Nursing Royal College of

Royal College of Nursing. (2020b). *Speaking up: How UK nursing staff expect to be valued [Policy and Position Statements]*. Royal College of Nursing. Speaking up| Royal College of Nursing (rcn.org.uk) 21. Royal College of Nursing. (2021). Staff Side Evidence To The Pay Review Body. Royal College of Nursing. Evidence submitted to the NHS Pay Review Body | Publications | Royal College of Nursing (rcn.org.uk)

Royal College of Nursing (2021) *RCN position on the national roll out of Serenity Integrated Mentoring (SIM) and other similar models in England*. RCN position on the national rollout of Serenity Integrated Mentoring (SIM) and other similar models in England | Royal College of Nursing last accessed 2/12/22.

Royal College of Nursing (2022) *Working Flexibly to support a health work-life balance. https://www.rcn.org.uk/Professional-Development/publications/working-flexibly-to-support-a-healthy-work-life-balance-uk-pub-010-031 (accessed 2023)*

Royal College of Nursing (2024) Activism Academy. https://www.rcn.org.uk/Get-Involved/Activism-academy

Royal College of Psychiatrists (2016) *Rethinking risk to others in mental health services*. CP201 RC Psych.

Royal College of Psychiatrists (2019) *Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities.* RCPsych.

Rushton C, Schoonover-Shoffner K, and Kennedy M, (2017) A Collaborative State of the Science Initiative: Transforming Moral Distress into Moral Resilience in Nursing. Advanced Journal of Nursing Vol. 117, No. 2

Ryan P (2019) *Crippled: Austerity and the demonisation of disabled people.* Verso

Rye D (1985) The Education of Nurses: A new dispensation. The report on the RCN Commission on nursing education. *Journal of Advanced Nursing.* 10 505-506.

S

Sage, D. (2013). Activation, health and well-being: Neglected dimensions? *International Journal of Sociology and Social Policy,* 33, pp: 4–20.

Salhani D and Coulter I (2009) The politics of Interprofessional working and the struggle for professional autonomy in nursing. *Social Science and Medicine.* 68 pp1211-1288.

Saltman, R. and Figueras, J. (1997), European Health Care Reform, WHO Regional Office for Europe, Copenhagen.

Samier E (2013) Bureaucratic Theory: Myths, Theories, Models, Critiques in The Handbook of Educational Theories (Irby B, Broun G and Lara-Alecio R) pp . 901–907 Information Age Publishing, Inc.

Sayce L (2001) Social inclusion and mental health. *Psychiatric Bulletin 25(4):121-123.*

Sayer, A. 2004. "Why critical realism?", in S. Fleetwood and S. Ackroyd, eds., Critical Realist Applications in Organisation and Management Studies. London: Routledge, pp. 6-20.

Scambler G (2006) Sociology, social structure and health-related stigma. *Psychology, Health and Medicine,* 11(3): 288–295.

Sharpe et al (2017)

Scheff T.J (1974) The Labelling Theory of Mental *Illness American Sociological Review*, Vol. 39, No. 3 pp. 444-452.

Schiller C (2015) Critical realism in nursing: an emerging approach. *Nursing Philosophy*, 17, pp. 88–102

Schrijivers G, Van Hoorn A and Huiskes N (2012) The care pathway: concepts and theories: an introduction. *International Journal of Integrated Working*. 2012 Jan-Dec; 12(Special Edition Integrated Care Pathways): e192.

Schneider J, Secker J, Grove B, Floyd M, Slade J, Boyce M and Johnson R (2007) The SESAMI evaluation of employment support in the UK: Background and baseline data. *Journal of Mental Health*, 16(3): 375–387.

Scott D (2010) *Education, Epistemology and Critical Realism*. Routledge.

Sevares J and Odeyemi T (2016) *Social Inequalities, Media, and Communication: Theory and Roots.* Lexington Books

Sheridan Rains, L., Johnson, S., Barnett, P., Steare, T., Needle, J. J., Carr, S., Lever Taylor, B., Bentivegna, F., Edbrooke-Childs, J., Scott, H. R., Rees, J., Shah, P., Lomani, J. O., Chipp, B., Barber, N., Dedat, Z., Oram, S., Morant, N., & Simpson, A. (2020). Early impacts of the COVID-19 pandemic on mental health care and on people with mental health conditions: framework synthesis of international experiences and responses. *Social Psychiatry and Psychiatric Epidemiology*, 56(1), 13–24. https://doi.org/10.1007/s00127-020-01924-7

Sharansky I (1995) Policy analysis in historical perspective", *Journal of Management History*, Vol. 1 Issue: 1, pp.47-58

Shaw R, Drever F, Hughes H, Osborn S and Williams S (2005) Adverse events and near miss reporting in the NHS. Quality and Safety in Healthcare. 14(4) pp 279-83.

Shepherd M and Lavender T (1999) Putting Aggression into Context. An investigation into contextual factors influencing the rate of aggressive incidents in a psychiatric hospital. *Journal of Mental Health. 8,2, PP159-170.*

Simpson A (2005) Community psychiatric nurses and the care co-ordinator role: squeezed to provide 'limited nursing'. *Journal of Advanced Nursing* 52(6), 689–699

Simpson A (2007) The impact of team processes on psychiatric case management. *Journal of Advanced Nursing* 60(4), 409–418

Simpson N, Hamilton S, McSherry R and McIntosh R (2019) Measuring and Assessing Healthcare Organisational Culture in the England's National Health Service: A Snapshot of Current Tools and Tool Use. *Healthcare* doi:10.3390/healthcare7040127

Simpsom C (1998) Contracting in mental health. *British Journal of Psychiatry* Vol 172 Issue 1 pp 4-6

Sizmur S and Raleigh V (2018*) The risks to care quality and staff wellbeing of an NHS system under pressure.* The Kings Fund.

Smith J, Flowers P and Larkin M (2009) *Interpretive Phenomenological Analysis. Theory, Method and Research.* Sage

Smith P and Lorentzon M (2005) Is emotional labour ethical? *Nursing Ethics.* 12(6) pp638-42.

Smithson R, Richardson E, Roberts J, Walsh K, Wenzel L, Robertson R, Boyde A, Allen T and Proudlove N (2018) *Impact of the Care Quality Commission on provider performance Room for improvement?* The Kings Fund.

Social Exclusion Unit (2004). Mental Health and Social Exclusion. Social Exclusion Unit Report, London: Office of the Deputy Prime Minister. http://www.soci-alexclusionunit.gov.uk

Spandler H (2007) From Social Exclusion to Inclusion? A Critique of the Inclusion Imperative in Mental Health *Medical Sociology online* Volume 2, Issue 2 (Nov 2007) 3-16

Spandler H and Stickley C (2011) No hope without compassion: the importance of compassion in recovery-focused mental health services. *Journal of Mental Health,* 20(6): 555–566.

Spenkuch J, Teso E and Xu G (2023) Ideology and performance in Public Organisations. Econmetrica Vol 91, No 4 pp: 1171-1203.

Spicker P., (2011). Stigma and social welfare. Available from OpenAIR@RGU. [online]. Available from: http://openair.rgu.ac.uk

Spinks M (2006) Reflecting on success. *Nursing Management* Vol 13 No 4 pp 14-15

Springer s (2012) Neoliberalism as discourse: between Foucauldian political economy and Marxian poststructuralism. Critical Discourse Studies Vol. 9, No. 2, 133–147

Standing M (2017) *Clinical Judgement and Decision Making in Nursing* 3rd Ed SAGE

Stark S., Stronach I. and Warne T. (2002) Teamwork in mental health: rhetoric and reality. *Journal of Psychiatric and Mental Health Nursing* 9, 411–418

Starling A (2018) Implementing new models of care: Lessons from the new care models programme in England. *International Journal of Care Coordination* Vol. 21(1–2) 50–54.

Stein W.M (2002) The use of discharge risk assessment tools in general psychiatric services in the UK. *Journal of Psychiatric and Mental Health Nursing* 9, 713–724

Steve Tee, Judith Lathlean, Lesley Herbert, Tina Coldham, Bella East & Tammy-Jo Johnson (2007) User participation in mental health nurse decision-making: a co-operative enquiry. Journal of *Advanced* Nursing 60(2), 135–145

Strauss A (1978) *Negotiations: Varieties, Contexts, Processes and Social Order.* Jossey-Bass Publishers

Strauss A (1987*) Qualitative Analysis for Social Scientists* Cambridge University Press

Suter J, Kowalski T, Anaya-Montes M, Chalkley M, Jacobs R and Rodriguez_Santana I (2020) The impact of moving to a 12h shift pattern on employee wellbeing: A qualitative study in an acute mental health setting. *International Journal of Nursing Studies. 112.* *https://doi.org/10.1016/j.ijnurstu.2020.103699*

T

Taherdoost H (2016) Sampling Methods in Research Methodology; How to Choose a Sampling Technique for Research. International Journal of Academic Research in Management Vol. 5, No. 2, Page: 18-27.

Tang J and Hudson P (2019) Evidence Based Practice Guideline: Nurse Retention for Nurse Managers. *Journal of Gerontological Nursing*. Nov 1;45(11):11-19. doi: 10.3928/00989134-20191011-03. PMID: 31651984.

Taylor I (2000) New Labour and the enabling state. *Health and Social Care in the Community* 8(6), 372–379

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig, & W. Stainton Rogers (Eds.), The SAGE Handbook of Qualitative Research in Psychology (17-37). (2nd). London: SAGE Publications

.

Time to Change (2019) *Our Impact 2019-21.* DHSC

Tisdale, K. (2008). Being vulnerable and being ethical with/in research. In K.B. De Marrais, & S.D. Lapan*, Foundations for research: Method of inquiry in education and the social sciences (inquiry and pedagogy across diverse contexts series).* London: Lawrence Erlbaum Associates.

Timmins N (2012) *Never Again: The Story of the Health and Social Care Act: A Study in coalition government and policy making.* Kings Fund

Timmins N (2014) The challenges of the Five-Year Forward View. *British Journal of Healthcare Management* Vol 20 No 11 p544

Timmins N (2016) *The chief executive's tale Views from the front line of the NHS.* Kings Fund.

Traynor M. (2013) *Nursing in context: policy, politics, profession.* Palgrave Macmillan.

Treichler, E. B. H., and Lucksted, A. A. (2017). The Role of Sense of Belonging in SelfStigma Among People with Serious Mental Illnesses. *Psychiatric Rehabilitation Journal. Advance online publication. http://dx.doi.org/10.1037/prj0000281*

Tritter J, Koivusalo M, Ollilia E and Dorfman P (2010) *Globalisation, markets and Healthcare Policy.* Routledge.

Tuck et al (2023) What about the children? Adult mental health practitioners' experiences and views of family-focused practice in Early Intervention Services. *Psychology and Psychotherapy Theory Research and Practice.*;96:697–715.

Tucker J, Hammer J, Vogel G, Bitmen R, Wade N and Maier E (2013) Disentangling Self-Stigma: Are Mental Illness and Help-Seeking Self-Stigmas Different? *Journal of Counseling Psychology © 2013 American Psychological Association 2013,* Vol. 60, No. 4, 520–531

Twenge J, Campbell S, Hoffman B and Lance C (2010) Generational Differences in Work Values: Leisure and Extrinsic Values Increasing, Social and Intrinsic Values Decreasing. *Journal of Management* Vol. 36 No. 5, 1117-1142

Tyler I and Slater T (2018) Rethinking the sociology of stigma. *The Sociological Review Monographs* Vol 66(4) pp: 721 –743

U

Udod S and Care W (2012) 'Walking a tight rope': an investigation of nurse managers' work stressors and coping experiences. *Journal of Research in Nursing. DOI: 10.1177/1744987111434189.*

UK Parliament (2021) Mental health impacts of the COVID-19 pandemic on adults. *Post Note.* Number 648. Udod S and Care W (2012)

Ungar T, Knaak S and Setzo C (2016) Theoretical and Practical Considerations for Combating Mental Illness Stigma in Health Care. *Community Mental Health Journal* 52:262–271

Urry J (1988) Disorganised Capitalism. *Marxism Today.* P 30-32

V.

Vaara E (2010) *Strategy as Practice Research* Cambridge University Press.

Van den Bulck, H., Puppis, M., Donders, K. & Van Audenhove, L. (Eds.) (2019, in press). The Palgrave Handbook of Methods for Media Policy Research. Basingstoke: Palgrave Macmillan.

Van Dijk (2006) Critical Discourse Analysis Chapter 18 in *The Handbook of Discourse Analysis*, Second Edition. Edited by Deborah Tannen, Heidi E. Hamilton, and Deborah Schiffrin. John Wiley & Sons, Inc. by John Wiley & Sons, Inc

Vasileious K, Barnett J, Thorpe S and Young T (2018) Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *Medical Research Methodology* 18:148

Vincent C, Stanhope N and Taylor-Adams S (2000) Developing a systematic method of analysing serious incidents in mental health. *Journal of Mental Health.* 9, 1 pp 89-103

W

Walker M.T (2006) The Social Construction of Mental Illness and its Implications for the Recovery Model. *International Journal of Psychosocial Rehabilitation.* 10 (1) pp 71-87.

Wallis L (2015) Moral Distress in Nursing Coping with this rising concern in health care delivery systems. *AJN* Vol. 115, No. 3 pp 19-20.

Walsh F, Cleary A and Dowling M (2017) Maximising Psychiatric Nurses contribution to interdisciplinary nursing. *British Journal of Community Nursing.* Vol 17. No 6 pp270-275

Walsh D and Foster J (2021) A call to action: A critical review of Mental Health Related Anti-stigma campaigns. *Frontiers in Public Health.* Vol 8. doi: 10.3389/fpubh.2020.569539

Wand T, Buchanan-Hagen S, Derrick K and Harris M (2020) Are current mental health assessment formats consistent with contemporary thinking and practice*? International Journal of Mental Health Nursing* 29, 171–176

Waneless D (2006) *Securing Good Care for Older People Taking a long-term view.* Kings Fund.

Wang R, Shaw I and Middleton H (2015) Delaying the implementation of Payment by Results in mental health: the application of standardisation. Mental Health Review Journal, Vol. 20 No. 3, pp. 156-165.

Warner R (2018) Does the scientific evidence support the recovery model? *The Psychiatrist* 34,3–5, doi: 10.1192/pb.bp.109.025643

Warrender D, Connell C, Jones E, Monteux S, Colwell L, Laker C and Cromar-Hayes M (2023) Mental health deserves better: Resisting the dilution of specialist pre-registration mental health nurse education in the United Kingdom. *International Journal of Mental Health Nursing.* Vol 33, No 1 pp 202-212.

Waters T and Waters D (2015) *Weber's Rationalism and Modern Society: New Translations on Politics, Bureaucracy and Social Stratification.* Palgrave MacMillan.

Webster C (2002) *The National Health Service: A Political History* Oxford University Press

Welsh I. and Lyons C (2001) Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: an empirical contribution to the debate. Journal of Psychiatric and Mental Health Nursing, 8, 299–305

Wenzel L, Robertson R and Wickens C (2023) What is commissioning and how is it changing? Kings Fund website: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-commissioning-and-how-it-changing

West M, Bailey S and Williams E (2020) *The courage of compassion Supporting nurses and midwives to deliver high-quality care.* Kings Fund.

West M (2021) *Compassionate Leadership: sustaining wisdom, humanity and presence in Health and Social Care.* The Swirling leaf press.

White KM, Dudley-Brown S (eds) (2012) *Translation of evidence for health policy.* Springer Publishing

Whitmore R and Knafl K (2005) The integrative review: updated methodology. *Journal of Advanced Nursing* 52(5), 546– 553

Willems D (2001) Balancing rationalities: gatekeeping in health care. *Journal of Medical Ethics* 27:25–29

Williams W.R. (2009) Struggling with Poverty: Implications for Theory and Policy of Increasing Research on Social Class-Based Stigma. *Analyses of Social Issues and Public Policy, Vol. 9, No. 1, 2009, pp. 37--56*

Williams P (2012) Integration of health and social care: a case of learning and knowledge management. *Health and Social Care in the Community* 20(5), 550–560

Willig C and Stainton Rogers W (2017) *The Sage Handbook of Qualitative Research in Psychology.* Sage.

Witteman C, Spaanjaars N and Aarts A (2011) Clinical intuition in mental health care: A discussion and focus groups*, Counselling Psychology Quarterly*, 25:1, 19-29

Wodak R and Meyer M (2016) *Methods of Critical Discourse Studies.* Sage

World Health Organisation (2014) *Social Determinants of Mental Health*. WHO

Woo B, Lee J and Tam W (2017) The impact of the advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: a systematic review. *Human Resource Health. 15.63 DOI 10.1186/s12960-017-0237-9*

Woods A, Hart A and Spandler H (2019) The Recovery Narrative: Politics and Possibilities of a Genre. *Cultural and Medical Psychiatry. https://doi.org/10.1007/s11013-019-09623-y*

Woodthorpe N, Bakhsh C and Paton C (2013) Quality and patient safety in mental health. *British Journal of Healthcare Management* Vol 19 No 8

Wright n, Callaghan P and Bartlett P (2011) Mental health service users' and practitioners' experiences of engagement in assertive outreach: a qualitative study. *Journal of Psychiatric and Mental Health Nursing,18, 822–832*

Y

Yucel R (2018) Scientists' Ontological and Epistemological Views about Science from the Perspective of Critical Realism. Science and Education 27:407–433. https://doi.org/10.1007/s11191-018-9983-x

Yeomans D (2014) Clustering in mental health payment by results: a critical summary for the clinician. *Advances in psychiatric treatment*. Vol. 20, 227–234

Z

Zanotti R and Chiffi D (2015) A normative analysis of nursing knowledge. *Nursing Inquiry* 23(1): 4–11

Zigmond D (2021) How and why have we so hazardously misconceived our NHS staff? British Journal of General Practice 2021; 71 (702): 26-27

Appendix one. Table of studies most relevant to the research questions and findings.

Study	Objective	Methodology	Results	Conclusion
Columbo A, Bendelow G, Fulford B and Williams S (2003) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine* 55 (7) 1557-70	Examine the influence of implicit models of mental disorder on shared decision making within community-based mental health teams.	Interviews, 2 stage, with psychiatrists, CPNs, ASWs, SUs and carers. Ascertain what models of mental disorder they use to make decisions. Analysed using theoretical and empirical work to determine use of models. Kapa index analysis	CMHNs used medical, psychotherapeutic and social models.	Models influence shared decision making They contribute to our understanding of the relationships between professional groups (including informal carers),
Crawford P, Brown B and Majomi P (2008) Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies* 45 1055–1063	The study aimed to explore how community mental health nurses (CMHNs) UK perceived their working lives. In terms of professional status in terms of public image compared with	Semi-structured interviews. Thematic analysis	Themes: Client focus, Not being a profession, Growing out of the role Wanting recognition	Self-concept is linked to needing recognition and the need to legitimatise the role and the work.

	their understanding of their working lives.			
Nolan P., Haque M. S., Bourke P. & Dyke R. (2004) A comparison of the work and values of community mental health nurses in two mental health NHS Trusts *Journal of Psychiatric and Mental Health Nursing* 11, 525–533	To compare the work and values of CMHNs working in two mental health NHS Trusts.	Comparison between CMHNs working in 2 teams. Questionnaire: Likert scale	Collaborative working Bureaucracy Autonomy Role definition. Interface with primary care.	Proposed developments: Clear definition of the role of CMHN, to enhance job satisfaction and collaborative working. Develop a theoretical basis for the professions Reduce administrative burdens and release time to care. Enhanced development opportunities, supervision and supportive management.
Simpson A (2005) Community psychiatric nurses and the care co-ordinator role: squeezed to provide 'limited nursing'.	Examine factors which facilitate or hinder the role of the CMHN in their role as care coordinator	Multiple case study of 7 sectorised CMHTs Participant observation, semi structured interviews and document review.	Care coordination duties and responsibilities and large workloads detract from caring aspects of this role.	Role of care coordinator negatively impacts on the CMHN capacity to undertake skilled, therapeutic interventions.

Journal of Advanced Nursing 52(6), 689–699			CMHNs unable to provide PSI.	
Brown B, Crawford P and Darongkama J (2000) Blackwell Science, Ltd Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community* 8(6), 425–435	Highlight the boundaries that exist between different roles in CMHTs	Study of staff in CMHT following a structural change. Fieldwork/interviews Grounded theory and thematic analysis	Role boundaries and perception of work. Subjective and intuitive ways of relating.	Boundaries are perceived to be eroding: can be a threat or an opportunity Provides flexibility and yet role clarity Awareness of boundaries facilitates effective collaboration and generic working within a flattened hierarchy.
Hannigan B, Simpson A, Coffey M, Barlow S and Jones A (2018) Care Coordination as Imagined; Care Coordination as Done: Findings from a Cross-	To contrast the policy guidelines for care coordination with the reality of how the work is experienced by those undertaking the role	Critical review of policy Semi-structured interviews with 28 care coordinators, employed in four Trusts: 2 in	Themes identified: Engaging, attending and supporting recovery. Connecting and mobilising.	Care coordinators make choices in organisational contexts. CC still value the therapeutic relationship they have with service users.

national Mental Health Systems Study. *International Journal of Integrated Care,* 2018; 18(3): 12, 1–14.		England and 2 in Wales.	Accommodating and adjusting.	They have a commitment to recovery and high-quality therapeutic work Balance this with managing risk and large caseloads CPA creates a large administrative workload for care coordinators.
Donnison J, Thompson A and Turpin G (2009) A qualitative exploration of communication within the community mental health team. International Journal of Mental Health Nursing (2009) 18, 310–317	To explore the conceptual models employed by CMHT staff and how clinicians communicate with each other.	Semi structured interviews Interpretative phenomenological data analysis	4 themes: Complex and competing demands Managing complex demands Identity within the team Approaches to clinical work	Challenges in managing long-term clients and making room for acute work. Anxieties about gatekeeping and accountability. High number of referrals. Valued supervision, joint working and team work.
Larkin C and Callaghan P (2005) Professionals' perceptions of interprofessional working in community mental health teams. *Journal of*	Examine if the presence of core structures influences the perception of interprofessional working in CMHTs.	Cross sectional questionnaires to staff in integrated CMHTs Likert scale SPSS analysis	Operational policy and CPA has little influence over perceptions of professional working.	Respondents valued: case discussion, referral meeting, staff support group, joint risk policy and clear set of goals and values, clinical supervision and support groups.

Interprofessional Care, A 19(4): 338–346.				
Hanley B, Scott H and Priest H (2017) The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): a psychodynamic perspective. *Psychoanalytic Psychotherapy*. Vol 31 Issue 2 pp 176-194	The aim of this study was to explore the effects of organisational change upon staff working in a Community Mental Health Team (CMHT).	Grounded theory methodology Analysis drew upon psychodynamic theory (Incl. Ballett and Campling 2014). Eight semi structured interviews	Core category: Corrosion of good work 5 key categories: Cultural change, caring clinicians and uncaring managers, confusion about professional roles, disconnecting and isolating, staff departing and risk for clients.	Cultural change within CMHTs Participants described bureaucracy and depersonalisation. Organisational defences include how conflict is displaced onto bureaucratic structures. Administrative tasks enable staff to avoid clinical contact. Splitting between clinical staff and management with clinical staff maintaining the “good caring” identity.

Hannigan B and Coffey M (2011) Where the wicked problems are: The case of mental health. *Health Policy* 101 pp 220-227	To provide a retrospective account of mental health policy and these solve (or not) challenging issues in mental health services.	Theoretically informed policy analysis.	MH system is a policy making priority in the UK.	Policy makers need to recognise the complexities faced by mental health services.
Hannigan B and Allen D. (2011) Giving a fig about roles: policy, context and work in community mental health care. *Journal of Psychiatric and Mental Health Nursing.* 18, 1–8	To examine the perception of staff in CMHN about changes to their role in light of policy changes (namely New Ways of Working 2007)	2 CMHTs Local policy documents were obtained Interviews and team meeting observations. Semi structured interviews with practitioners and service users.	Themes: Roles and jurisdictions: CMHN biomedical treatment interventions Roles in the local workplace: varied according to local operationalised policy cites patterning and Stauss. Organisational culture and history, and relationships with other services,	Staff are required to manage clinical work and autonomy with administrative/organisational demands. Draws upon Strauss and Lipsky. Greater flexibility and a broader skills set in CMHNs. Blurring of professional boundaries.
Freeman T and Peck E (2006) Evaluating partnerships: a case study of integrated specialist mental health services. Health and Social Care in the	Examines the outcomes of partnership working, using a UK case study.	Qualitative and quantitative data, semi structured interviews and focus groups with staff Sus and carers.	Themes: Pressures for fragmentation and integration Interface difficulties between services.	Highlighted the difficulties in evaluating the impact of complex service interventions.

Community 14 (5), 408–417		Questionnaires: staff satisfaction	Specialist teams do not reduce the burden on generic CMHTs. Benefits and difficulties: reconfiguration of generic CMHTs and concerns for recruitment and retention.	National policy is patterned by local demographics and organisational history. Team level analysis captures the interplay of these factors.
Ansari W, Lyubovnikova J, Middleton H, Dawson J, Naylor P, and West M (2016) Development and psychometric evaluation of a new team effectiveness scale for all types of community adult mental health teams: a mixed-methods approach. *Health and Social Care in the Community* 24(3), 309–320	To establish characteristics of multiprofessional team working in adult CMHTs	Stage 1: Productivity Enhancement scale with stakeholders Stage 2: survey with staff from 135 CMHTs from 11 Trusts.	Dimensions of effective CMHTs: Improved SU wellbeing Creative problem solving Continuity Interagency working Professional relationships and respect Engagement with carers Therapeutic relationships with Sus.	Lack of measures of CMHT effectiveness. Important facilitative factors include trust and respect between professional groups, therapeutic relationships with Sus. SU centred decision making, Measurement of effectiveness is most effective if it involves team self-assessment.

Belling R, Whittock M, McLaren S, Burns T, Catty J, Rees-Jones I, Rose D, Wykes J (2011) Achieving Continuity of Care: Facilitators and Barriers in Community Mental Health Teams. *Implementation Science* 6:23	Examine the factors which hinder policy directives re continuity of care.	In depth semi structured interviews 113 health and social care professionals. In 8 CMHTs, and inpatient wards, GPs and voluntary sector organisations.	Facilitating factors: team decision making, and teamwork and support. Relational, personal and longitudinal were facilitated by workforce stability. Barriers: inadequate staffing, high caseloads and administrative demands	There are challenges to harnessing the benefits of integrated CMHT working. This can be maximised by utilising: IT and administration, role development and education, supportive leadership, staff retention, development of skills to meet the complex demands of Sus.
Moth R (2020) The business end': Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change.* Vol. 24(2) 133–153		Examines the neoliberal policy reforms on professional practice within CMHTs and concepts of mental distress. Methods: fieldwork: non-participant observation and semi-structured interviews: with practitioners and	Themes: Reconfiguring the context of mental health provision *Outsourcing and competition.* *Downbanding and deskilling.*	Neoliberal policies result in practice which is disease focussed and risk averse, leading to deskilling the workforce,

		service users. 2 teams within one Trust. Continuous data analysis layered form of thematic analysis drawing upon Layder's notion of adaptive theory (used CR in his thesis on the same topic). Time frame 2008-13.	Strenuous welfarism and labour process restructuring in CMHT. *Transformation of the tacit knowledge of MH practitioners into codified forms subject to audit and control* *Flexible intensification of worker effect* *Imposition of administrative burdens that reduce time for care and support of SUs* *Loss of breathing space and porous time* Responsibilization in the CMHT: policy discourses of consumerism recovery and risk Practitioner responses: biomedical residualism	

			and ethical professionalism *The retreat into biomedical residualism: checking sleep, moods and meds.* *Defence of ethical professionalism.*	

Appendix 2: Semi-structured interview schedule.

Experience and perception of role

1. Demographic data: date of qualifying, experience, grade, type of team you are in, length of time in this team.
2. Can you outline your understanding of your role and responsibilities within the team?
3. *Supplementary questions*
4. *Have these changed overtime? When and how? What is your understanding of the reasons for this?*

Factors driving clinical decision making.

1. Tell me about how you are involved in contributing to making decisions about client's care. Perhaps explain the process of being allocated a client to assess, performing the assessment, deciding on their care and inclusion within the service.
2. *Supplementary questions:*
3. *Who do you consult: manager/supervisor other team members?*
4. *Explain the use of set assessment schedules and tools: criteria for the service, structures, care pathways (from the Trust community mental health policy and National guidelines?*
5. *Explain what informs your understanding of client needs and the knowledge and processes you use to identify these? Eg: training, professional values, client's perceptions.*
6. *Are there examples when the assessment schedules and service criteria have been useful in supporting a clinical decision? Perhaps give examples.*
7. *Are there examples where the client does not meet the threshold for ongoing support, but you have felt they have a legitimate need? Are there examples where you have had to discharge clients due to time limits, targets/outcomes but you have felt that the client needs further support. Describe how you felt about this and how you dealt with it.*

Team discussions

1. What is your experience of discussing clients you have assessed or are working with in team meetings? Explain how the meetings are structured and what the agenda is.
2. *Supplementary questions: Do the team utilise the same processes and information as you do? Do they introduce other considerations and alternative suggestions? Give examples.*
3. *Are service parameters, care pathways, targets and time limits discussed in team meetings?*
4. *How are divergent opinions/factors in decision making processed? Use examples*

Organisational position.

1. What do you know about national policy and guidelines (and plans like the “NHS Long Term Plan?) regarding the work of Community Mental Health? EG: KPIs, CCQIUNs, clustering.
2. *Supplementary questions: How do you contribute to meeting these targets within the team?*
3. *If you had any concerns about your workload, resources aspects of care and provision. How would you escalate this?*
4. *How do you see the team and your role developing?*

Appendix 3: Non-participant observation templates.

The templates were used to make field notes based on observations of the following factors.

Managing workload:

1) Operational policy structure is used to structure meetings. Slight variation between Affective and psychosis team in Trust A. General commentary on running order, which part takes the longest. Who chairs? Who has the final decision?
2) Are targets and audit requirements discussed? Other workload issues: number of referrals and caseload sizes?
3) Are care pathways, inclusion criteria and outcomes mentioned when making decisions? What are the key deciding factors: diagnosis and risk? Are psychosocial aspects included? Are some referrals considered "inappropriate"? If so, why?

Role of the CMHN:

1) How the CMHN presents the client: assessments and clients for review. Is their opinion supported or challenged? What is the basis of this?
2) What part does the CMHT manager play? Is there evidence of mediation and compassionate leadership?
3) Is there reference to short staffing, sickness and recruitment?

Service user self-management:

1) Note the language used to describe the service user.
2) Discourse about self-management and re referral or lack of engagement.
3) Evidence of advocacy?

Trust A. Affective team

Red Zone
.
Amber Zone
Green zone
Cases for discussion
Professional group updates: therapies, OT, Nursing and Social Work
IRAS/MALRAP
A
Incidents and learning from complaints

Business items

Trust A: Psychosis team:

Red Zone
Amber zone
.
Green zone clients for discussion.
Perinatal Red zone
Inpatient Red Zone
See red zone.
Community Treatment Order Expiry and rights
Allocation list for the multi-disciplinary team and multiagency mapping
Children Safeguarding
Business issues AOB:

Trust B.

Red Board
New assessments
Initial interventions
Active review caseload
Ongoing cases

Appendix Four NVIVO codebook

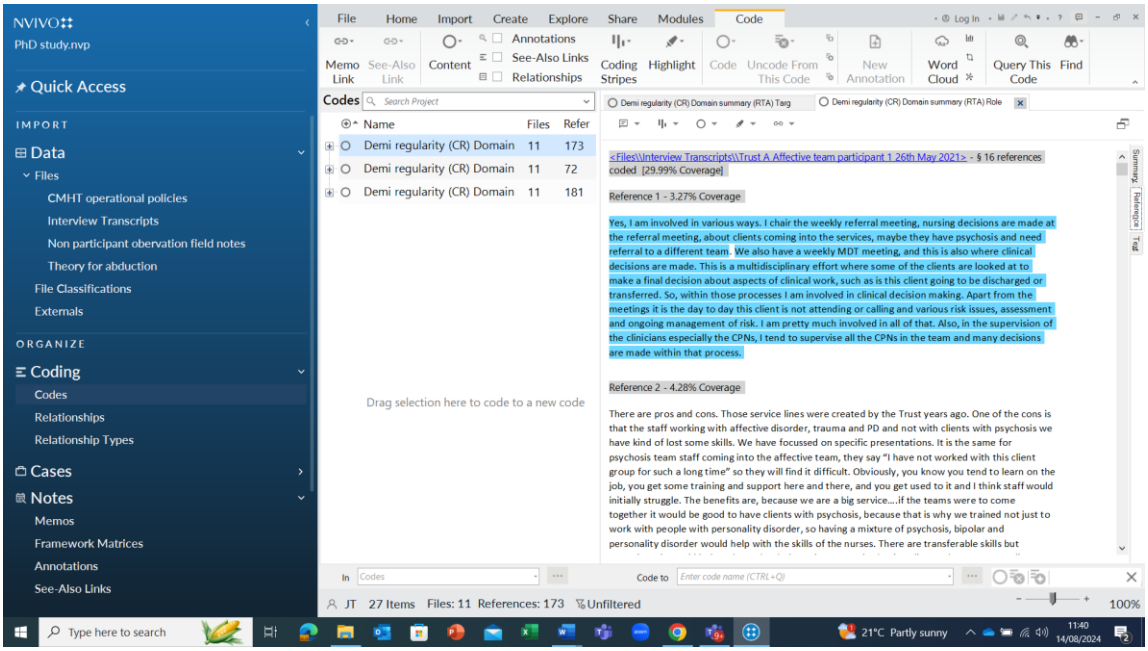
PhD study

Codes

Name	Description
Demi regularity (CR) Domain summary (RTA) Role of CMHN	All large sections of data which refer to this domain
Advanced clinical roles	
Autonomy	Participants' accounts of their level of autonomy and factors which enhance this or undermine it
Deprofessionalisation	Tasks are allocated to specific roles, which are to manage and maintain part of a pathway or system
Empirical knowledge and process	Evidence based processes and schedules
Intrinsic motivation	This captures participants' reference to what intrinsic motivation and personal satisfaction drives their practice.
Intuitive knowledge	Participants' use of intuitive/moral/ethical knowledge in making clinical decisions.
Morale	This captures the participants' accounts of their confidence, enthusiasm and sense of pride and belonging in relation to their role and clinical work. Includes staff health and wellbeing and how supported they feel by the organisation.
Nursing Associates and pathways into nursing	

Name	Description
Recruitment and retention	Reference to issues relating to staff turnover, vacancies, recruitment issues
Reluctance to discharge	Views about why CMHNs say they don't want to discharge clients and how this is opposed.
Role of other team members and dynamics	Includes accounts of how CMHNs work with other members of the multi professional team in making decisions. It also captures how CMHN may refer to the roles and responsibilities of other team members and aspects of conflict and collaboration within the team
Skills and training and development	Participants accounts of how clinical skills impact on clinical decision making. This theme covers access to relevant training and how participants see their role developing and their aspirations
Workload	Participants reference to their workload. This commonly includes caseload size, paperwork, monitoring targets and self-reporting on their activities.
Demi regularity (CR) Domain summary (RTA) Service user role in decisions	
Carers	Only 2 items, not enough for a code.
Service user centred	Captures the factors which relate to considering the SUs needs, underlying causative factors and associated needs Does this link to the code intrinsic motivation and intuitive knowledge?.
Service User responsibility	How much decisions are based on the policy context of client self-management and DNA appointments. Use of self-help agencies. This links with the code productivity and objectifying language?? Client driven discharge
Demi regularity (CR) Domain summary (RTA) Targets, care pathways, inclusion and exclusion criteria	All large sections of data which refer to this domain

Name	Description
Diagnosis or need	This captures if the participants referring to the client diagnosis or needs or both when making decisions. The diagnosis may be the main driver in decision making, or, participants may also refer to associated needs and/or risk. Risk categories are covered in "direct reference to targets and care pathways"
Documentation checks	
Functions of other services	Participants' perceptions of thresholds, criteria of other services regarding accepting or providing referrals.
Productivity Language and objectifying labels	Participants do not overtly refer to targets, pathways or criteria but the language they use demonstrates that a productivity mindset has been introjected. Referring to clients by their pathway or treatment.
Resources	Participants refer to resource issues impacting on their clinical decision making, such as housing and social care. This does not refer to staffing levels as this is considered under "retention and recruitment"
Standard care pathways and specialist teams	Use of diagnosis or risk to determine provision.
Time frames, frequency of contact and risk rating	Includes reference to admission and discharge criteria, RAG rating, clustering and waiting and treatment times
Waiting lists and log jams	Participants' reference to waiting lists of clients for assessment, to start interventions or a build up of those who cannot be discharged or referred on


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IMPORT
Data
Files
CMHT operational policies
Interview Transcripts
Non participant obervation field notes
Theory for abduction
File Classifications
Externals
ORGANIZE
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Codes
Relationships
Relationship Types
Cases
Notes
Memos
Framework Matrices
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Demi regularity (CR) Domain summary (RTA) Role
<Files\\Interview Transcripts\\Trust A Affective team participant 1 26th May 2021> - § 16 references coded [29.99% Coverage]
Reference 1 - 3.27% Coverage
Yes, I am involved in various ways. I chair the weekly referral meeting, nursing decisions are made at the referral meeting, about clients coming into the services, maybe they have psychosis and need referral to a different team. We also have a weekly MDT meeting, and this is also where clinical decisions are made. This is a multidisciplinary effort where some of the clients are looked at to make a final decision about aspects of clinical work, such as is this client going to be discharged or transferred. So, within those processes I am involved in clinical decision making. Apart from the meetings it is the day to day this client is not attending or calling and various risk issues, assessment and ongoing management of risk. I am pretty much involved in all of that. Also, in the supervision of the clinicians especially the CPNs, I tend to supervise all the CPNs in the team and many decisions are made within that process.
Reference 2 - 4.28% Coverage
There are pros and cons. Those service lines were created by the Trust years ago. One of the cons is that the staff working with affective disorder, trauma and PD and not with clients with psychosis we have kind of lost some skills. We have focussed on specific presentations. It is the same for psychosis team staff coming into the affective team, they say "I have not worked with this client group for such a long time" so they will find it difficult. Obviously, you know you tend to learn on the job, you get some training and support here and there, and you get used to it and I think staff would initially struggle. The benefits are, because we are a big service....if the teams were to come together it would be good to have clients with psychosis, because that is why we trained not just to work with people with personality disorder, so having a mixture of psychosis, bipolar and personality disorder would help with the skills of the nurses. There are transferable skills but
In Codes
Code to Enter code name (CTRL+Q)
JT 27 Items Files: 11 References: 173 Unfiltered
100%
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21°C Partly sunny
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Appendix 5: Excerpt of transcript demonstrating abduction.

I have organised the data under the themes, grouped based on codes identified. I have then arranged the information to follow a structured discussion. Relevant policy information is inserted. National policy is in red and local policy is in blue. Theory is as comments on the right hand side.

Demi regularity (CR) Domain summary (RTA) Targets, care pathways, inclusion and exclusion criteria

In the code *standard care pathways, and specialist teams:* I am trying to identify some patterns in how the operationalised aspects of impact on CMHNs perceptions. The structures for managing the workload are set out in the Trusts' operational policy. These structures are used as a framework for the meetings, and they are reflected in the language used by the participants in discussing their work. In Trust A there are 2 separate teams for diagnostic categories, in Trust B there is a staged process of standard interventions and then categorisation within that. In Trust A, the CMHNs see SUs in terms of their diagnosis, as this is key in deciding which team they are allocated to. In Trust B this is less apparent, instead S.Us are allocated for care coordination or put for II and then on a waiting list. In Trust B there are standardised interventions and processes. Local policies are based on National directives which are driven by efficiency.

Commented [JT1]: Link to theories of medicalisation and social construction of mental illness. Goffman in the Conrad and Barker paper. Diagnosis focusses on individual response and not social factors and inequalities. Policy responses are determined by how a problem is defined and framed in the first place. Therefore, diagnostic factors focus on the observable presence or absence of symptoms, and this is a priority in CDM and how services are organised.
Medical and professional knowledge is also socially constructed.

NHS Mental Health Implementation Plan 2019-20 2023-24 We heard from stakeholders that a continued focus on high quality care in the community is the right thing to do for patients, and this plan also includes an important emphasis on ensuring that inpatient care, when required, is world class. The growing role of NHS-led provider collaboratives in delivering whole pathways of care for populations have already started to show us that short and purposeful stays, close to home linked with quality community services can deliver improved patient care. There are no specific directives for adult CMHTs in terms of how care is delivered, in the same way as there is for EIS and IAPT. Specialist care teams were first developed from the NHS National Service Framework (1999) and delivered via the NHS Plan (2000). The rationale given that this helped evaluated evidence-based interventions. However, it was also driven by the development of Payment by Results and establishing specific outcomes and end points of care. (Reference needed). The two Trusts in this study have developed their care pathways differently. The Five Year Forward Plan and NHS LTP give direction for CAMHs, IAPT and crisis services but not for adult CMHTs. The current policy directives (NHS Plan 2019-20, 2023-34) emphasise local autonomy and development.

NHS Mental Health Implementation Plan 2019-20 2023-24: states that local systems will have the flexibility to tailor local pathways and staffing mix to meet local needs. There will be increased opportunities for the Voluntary, Community and Social Enterprise Sector. It states that this is in keeping with multi agency working and local pathway design. It also suggests that the development of new models to improve effective delivery, will allow providers to make savings which they can invest in service improvements.

Commented [JT1]: This points towards devolved responsibility for care provision and workforce design. This is moving towards ICS where more NHS mental health work will be provided by cheaper 3rd sector services or private providers. If care pathways are determined locally, is their development still shaped by the information that Trusts are required to report on in terms of outcome measures.

The staff in Trust A work in two separate teams. The Affective team, work with SUs with anxiety, depression, and complex trauma. The Psychosis team, work with SUs with major psychoses including Bipolar Affective disorder. I interviewed six staff in total across both teams with staff volunteering to be interviewed. I interviewed 4 CMHNs from the Affective team and 2 CMHNs from the Psychosis team. They commented on the advantages and disadvantages of having separate diagnostic teams.

Trust A Operational Policy:

Affective team: provides focused, therapeutic interventions to adults residing within the respective Boroughs who require care and treatment for anxiety, depression, affective disorders, personality disorders and trauma.

Psychosis team: provides care and treatment for service users who are diagnosed with schizophrenia or bi-polar disorder.

Rationale: The care pathways aim to offer a seamless service to assist individuals and their carers in resolving crisis, promoting recovery and reducing the risk of further relapse. In achieving these aims, the service recognises the importance of effective communication with primary care, acute services, community services, third and voluntary sector and other agencies that will be working with the individuals. The new service structure creates a series of locality-based teams that will work together seamlessly to enable service users to move along and across treatment pathways whilst maintaining the highest quality of care for the service user and their families; Overall the service users capacity to enable themselves to manage their needs better is essential within this overlapping care systems within primary care, the voluntary sector and other partner organisations. Our aim is, as far as possible, to reduce the need for inpatient care and maximise the use of community-based services

Trust A Affective team: *The pros will be I guess, you are specialising more, they do overlap of course. I guess it is mainly the chance to specialise in one area. You can concentrate on what your team is designed to do. The disadvantage of that is you get challenging cases with personality disorder, which can go hand in hand with drugs and alcohol. Therefore, our team is constantly dealing with those challenges. I am not saying that the psychosis team doesn't have challenges because they do. The client group we have that is personality disorder combined with drugs and alcohol, makes our work very difficult and challenging. Having said that there are members of staff who, believe it or not, love working with that client group.*

Commented [JT1]: Value judgement.

Trust A Affective team participant 1: *There are pros and cons. Those service lines were created by the Trust years ago. One of the cons is that the staff working with affective disorder, trauma and PD and not with clients with psychosis we have kind of lost some skills. We have focussed on specific presentations. It is the same for psychosis team staff coming into the affective team, they say "I have not worked with this client group for such a long time" so they will find it difficult. Obviously, you know you tend to learn on the job, you get some training and support here and there, and you get used to it and I think staff would initially struggle. The benefits are because we are a big service*

There is an emphasis on staff preference and skills. Some staff suggest that separation is preferable as they can focus on a specific disorder. Other staff say this can be deskilling and they would like a variety. Few of the participants, even when asked could comment on advantages and disadvantages for the SUs. One of them did but their response was linked to staff skills, rather than being client centred.

Commented [JT2]: Social construction and medicalisation: see Conrad and Barker (2010). The social construction of diagnosis. Working with clients with PD is often viewed as a negative experience by CMHNs. Conrad and Barker (2010) suggest that diagnosis is socially constructed and often driven by viewing certain behaviours as not acceptable or desirable. PD clients are stigmatised within mental health services, as they are viewed and prejudged in terms of stereo typical views of their actions.
There is diagnostic overlap between EUPD and BAD. SUs who were previously viewed as having bipolar are now diagnosed with EUPD. In Trust A, this may mean a transfer between teams. In Trust B, to a different set of interventions.

AA1: *I think if you work in a varied way, I think you can transfer skills that you have gained by working with different types of clients. It would benefit the service users for the staff to be skilled with different presentations. Although I said we don't take on clients with bipolar we do have one or two clients on our caseloads with emergence of bipolar, because it isn't always about diagnosis, presentation is important. You can't just say "I don't know what to do with you" Clients with personality disorder can have psychotic episodes so you can't say "I don't know what to do".*

....if the teams were to come together it would be good to have clients with psychosis, because that is why we trained not just to work with people with personality disorder, so having a mixture of psychosis, bipolar and personality disorder would help with the skills of the nurses. There are transferable skills but sometimes it would help to have that balance in a way. Also having clients who are personality disordered and always self-harming and with a risk history staff can experience burn out. Having that mixture would help the clinician in a way.

Commented [JT3]: Value judgement.

This approach requires staff to focus on diagnosis. This is described as key in the SU receiving the appropriate care.

Commented [JT4]: Link to labelling theory.

Commented [JT5R4]: Move to the code "Diagnosis or need?"

Appendix 6 NPO Field notes.

Trust A Affective team:

Red Zone
Starts with red zone. Existing client checked on. CMHN is care coordinator. Client is at risk of self-harm and risk to her child. Ref to CRHTT, agreed to take the SU on. CMHN stayed late to refer to social services. The CMHN has communicated with the SUs husband the SU was placed in a crisis house. CMHN said there was no support from the HTT managers. Limited response from HTT, CMHN reported difficulties in collaborating with HTT staff. Manager and consultant in the Affective team were supportive and acknowledged this. The referral pathway was cited and lack of staff in HTT team was cited as a difficulty. The consultant noted that the affective team support other services but that this is not reciprocated. CMHN perceived that the HTT team did not take their concerns seriously as the staff said she would have to take it up with management as there are no staff. The team manager explained that he has regular contact with HTT and discusses these issues and will pursue this. There was limited time so the chair tried to call this discussion to a close. The manager was very supportive and acknowledged the difficulties. They acknowledged that the CMHN went above and beyond. *When another CMHN said that they had utilised the HTT for a client, the manager asked if they had similar problems, they did not. The manager said that if staff want to utilise HTT then to let him know and he will discuss in advance with the HTT manager.*
No other community clients.
In patients: one update from a SW. The care coordinator is not attending ward rounds, raised as an issue.
Another in patient: rehab. She is awaiting accommodation.
CMHN: in patient awaiting accommodation. Refused what was offered as a perpetrator lives in the identified project. Waiting for a housing review: delayed, advice given by one of the team SW to escalate this. OT assessment also suggested.
One in private sector SW will do social circumstances report. Advice about placement support given by SWs, nearest relative issue also discussed.
Another SU : in the private sector. Needs to be allocated a CC, to attend ward rounds in the hospital.
Another SU care transferred to EIS, due to emerging psychosis.
SU: on section 3, CMHN is liaising with the SUs Mum. The client is out of area in private hospital. CMHNs supported and acknowledged by the consultant, SW advised CC for sect 117 requirements. CMHN (same one that raised 1st problem) people who are in hospital are not allocated CC and there is no contact person, acknowledged by consultant and TL.
SU: another who does not have CC. Also under WRAP. Discussion between CMHN and SW about safeguarding. Consultant suggested that this could be discussed with the ward. He has psychosis and is therefore not suitable for the affective team, the inpatient service will refer to the psychosis team and they will take over his care. Affective team will support until discharge.
Team manager explained that he has a number of SUs to allocate for care coordinators but there is a shortfall. He explained that this is a capacity issue that he has raised with senior management.
SU discharged and followed up by HTT and will be allocated in due course.
SW raised that another Trust service was asking them to refer to MASH, this was felt to be inappropriate.

Commented [JT1]: Interaction, boundary management and blame displacement. Meso level interaction, managing workload.

Commented [JT2]: Managing workload, waiting list team level structure.

Amber Zone
SU risk of self-harm, wants a change of CC. Has a history of doing so. To be discussed by complex care team. Discussion between team manager and consultant. TL does not feel they can be managed safely, but the consultant says they can. The consultant said that this is down to the client not engaging. Team manager suggested a professionals meeting for this client as they are manipulative. Out of meeting decisions. SU with medication change. CMHN fedback and the consultant acknowledged this. The CMHN took the lead and had a clear plan which the consultant agreed to. SU presented by OT, due an assessment, requested that a nurse does a blood test for the client. SU needs allocation for CC. Shortages of CC due to staff leaving. CMHNs said they cannot take on any more SUs. An enquiry officer was suggested to determine threshold for section 42. SU update over weekend. Arrested after smashing the wing mirror on the bus. Seen by CJLT in custody and not ill so discharged, will press charges. SW asked for them to be referred to homeless panel. Drug use is an issue: raised by consultant. CMHN agreed that pressing charges is a deterrent. Ref to risk panel, will involve all services and prevent splitting. Team manager said they had a risk meeting last week, including HTT and liaison: capacity and making unwise decisions. SW asked if care assessment has been done.- Manager suggested use of duty, the CMHNs refused saying that she misuses this facility. SU alcohol use has stopped moved from red to amber, manager is following him up until he can be allocated. SU, under HTT self-harmed face in team base. HTT taken them on but not taken up contact with them. Manager checked if there were any issues with HTT, CMHN said there wasn't. Consultant asked the CMHN to let HTT continue until the end of the week. CMHN central to decision making and had considered a full range of options. CMHN compliment from the SU. SW raised a client about financial management for a client. Has OPA with RMO. 7 day follow-up SU: needs CC so asked CMNH in the meeting. SU CC is a SW. Sect 42 self-neglect. OA and needs OPA.

Commented [JT1]: Clear and assertive CMHN, decision respected.

Commented [JT2]: Meso level interaction about workload management.

Commented [JT3]: Structures, other meetings which take place outside the MDT. These are CMHT wide and have specific functions.

Commented [JT4]: Duty system is used as providing SU with contact in the absence of being allocated a CC. The CMHN's resist that as they say it still has a large impact on their workload. WORKLOAD MANAGEMENT STRUCTURES.

Appendix 7: Ethical Approval,

Ethical Approval HRA.

Ms Julia Telfer
Senior Lecturer Mental Health Nursing
University of Greenwich, Southwood Site, Avery Hill Campus,
Avery Hill Road,
Eltham
London
SE9 2UG

Email: hra.approval@nhs.net

25 September 2017

Dear Ms Telfer

Letter of HRA Approval

Study title:	**Factors influencing mental health nurses', clinical decisions: a qualitative exploration of reconciling therapeutic care with service criteria.**
IRAS project ID:	**214132**
Sponsor	**University of Greenwich**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their

participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

s critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **214132**. Please quote this on all correspondence.

HEALTH SERVICES RESEARCH STUDIES RESTRICTED TO RECRUITING NHS STAFF

After HRA Approval – guidance for sponsors and investigators

This document sets out important guidance for sponsors and investigators on the conduct and management of health services research with HRA Approval that is outside of the remit of the NHS Research Ethics Service (see GAfREC for further information on this remit). Please read the guidance carefully. A failure to follow the guidance could lead to the Health Research Authority (HRA) reviewing the Approval status of the research.

1. Further communications with the HRA

1.1 Further communications during the research with the HRA are generally the responsibility of the sponsor.

However, the sponsor may delegate responsibility to the chief investigator (CI) or another representative.

2. Commencement of the research

2.1 It is assumed that the research will commence within 12 months of the date of HRA

Approval.

2.2 The research should not commence at any non-NHS organisation until the local principal investigator (PI) or research collaborator has obtained management permission or approval from the organisation with responsibility for the research participants at the site.

2.3 The research should not commence at any NHS organisation in England until the site confirms their capacity and capability to undertake their role in the research (except when advised otherwise by HRA). Details of how capacity and capability should be confirmed are provided in the HRA Approval letter.

2.4 The research should not commence at any NHS organisation in Northern Ireland, Scotland or Wales until the processes specific to each nation have been undertaken and the relevant management permissions have been issued.

2.5 Should the research not commence within 12 months of HRA Approval, the sponsor should send a written explanation for the delay to the HRA via e-mail to hra.approval@nhs.net. A further written explanation should be sent after 24 months if the research has still not commenced.

2.6 If the research does not commence within 24 months, the HRA may review the Approval status.

3. Registration

3.1 For health services research, registration is strongly recommended for reasons of transparency but it is not currently a condition of HRA Approval.

4. Duration of HRA Approval

4.1 Once issued, HRA Approval generally applies for the duration of the research. The conclusion of the research is defined as the final date or event specified in the protocol, not the completion of data analysis or publication of the results. If it is proposed to extend the duration of the study beyond that specified in the application form, the HRA should be notified.

5. Working with participating NHS organisations in England

5.1 Unless specifically advised by the HRA, CIs and sponsors should provide all necessary documentation and work in partnership with participating NHS organisations in England to assess, arrange and confirm that participating organisations have the capacity and capability to undertake the research. The study documents should be sent to both the local study team and the research management function of the participating organisation (e.g. the R&D office), and the Local Clinical Research Network (LCRN) where applicable. In certain cases, participating organisations will not be expected to confirm capacity and

capability to
participate and / or receive study documents. Such instances will be clearly indicated and explained in Appendix B of the HRA Approval letter.

5.2 Where some or all participating NHS organisations in England are not expected to provide formal confirmation of capacity and capability (see HRA Approval letter for full details), the HRA encourages the organisations to confirm by email to the CI and sponsor that the research may proceed in advance of the no-objection deadline.

5.3 Where formal confirmation of capacity and capability is expected, sponsors should arrange with participating NHS organisations in England to have an agreement in place which outlines the roles and responsibilities of each party. This agreement should be proportionate to the study type and study activities undertaken locally and may take the form of agreeing the content of a Statement of Activities (where this approach is agreed by the HRA). Wherever model agreements are applicable, it is encouraged that unmodified templates are used. The fully executed agreement or Statement of Activities will be taken as confirmation that the organisation is ready to participate in the research. Confirmation of the type of agreement to be used in a study (or for different types of site in a study) is provided in the HRA Approval letter.

5.4 There is no expectation for CIs, sponsors or principal investigators to complete or submit site level forms to participating NHS organisations in England. If asked to do so, the CI or sponsor should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent system.

6. Amendments

6.1 If it is proposed to make an amendment to the research, the CI should email a notice of amendment to the HRA.

6.2 A substantial amendment is any amendment to the terms of the application for HRA Approval, or to the protocol or other supporting documentation approved by the HRA that is likely to affect to a significant degree:

(a) the safety or physical or mental integrity of the study participants, or:
(b) the scientific value of the study, or:
(c) the conduct or management of the study.

6.3 A Notice of Substantial Amendment should be generated by accessing the original application form on the Integrated Research Application System (IRAS). The Notice of Substantial Amendment should be electronically authorised by the CI and the sponsor of the study before the amendment is submitted to the HRA by email to hra.amendments@nhs.net.

6.4 Amendments that are not substantial amendments ("non-substantial amendments") should also be submitted for review by the HRA. These should be submitted to hra.amendments@nhs.net using either the form provided on the HRA website or detailing the non-substantial amendment in the body of the email.

6.5 The HRA will categorise both substantial and non-substantial amendments in line with UK wide policy on the handling of amendments. Following categorisation an assessment will be undertaken to confirm that the amendment meets the HRA criteria and standards and a confirmation letter will be issued. The amendment should not be implemented at NHS organisations in England until the HRA have issued a confirmation of continuing HRA Approval letter.

7 Conclusion or early termination of the research

7.1 The sponsor should notify the HRA in writing that the research has ended within 90 days of its conclusion. The conclusion of the research is defined as the final date or event specified in the protocol, not the completion of data analysis or publication of the results.

7.2 If the research is terminated early, the sponsor should notify the HRA within 15 days of the date of termination. An explanation of the reasons for early termination should be given.

7.3 Reports of conclusion or early termination should be submitted in the form prescribed by the HRA.

8 Review of HRA Approval

8.1 The HRA may review the Approval status at any time in the light of any relevant information it receives.

8.2 The sponsor may at any time request that the HRA reviews the Approval status, or seek advice from the HRA on any issue relating to the research.

Appendix 8: Participant Information.

Julia Telfer,
Senior Lecturer and PhD Student,
Department of Family Care and Mental Health,
Southwood Site,
Avery Hill Campus,
University of Greenwich,
Avery Hill Road,
Eltham,
LONDON.
SE9 2UG.
tj72@gre.ac.uk
4th March 2022

Dear Team,

Study Title: Factors influencing mental health nurses' clinical decisions: a qualitative exploration of reconciling therapeutic care with service outcomes.

I am undertaking a PhD research study (as above) My main sources of data collection will be observing clinical team meetings and interviewing mental health nurses about clinical decision making. This will involve audio recording the interviews. I will observe the Team meetings and take field notes which record evidence of the use of or reference to structures and processes identified from the semi structures interviews and Trust operational policies.

I will not take note of specific client demographic, personal or clinical information. I am only concerned with decision making processes. I will not share any information and the notes I make will not identify the team or any individuals. I am a registered mental health nurse and so bound by the NMC Code of Practice regarding professional conduct and confidentiality.

Invitation and summary:

Mental health nurses play a crucial role in making decisions about the provision of comprehensive health and social care to clients with mental health problems. Assessment and decision making is fundamentally concerned with a detailed and holistic understanding of the clients' history and current needs.
Recent policy increasingly requires clinicians to consider "productivity"," cost effectiveness" and allocation of finite resources. The subsequent decision regarding service provision is also influenced by the service criteria for inclusion and discharge. This study seeks to explore how nurses achieve this balance and how this is accommodated within teams and organisations.

Changes due to COVID restrictions

Due to the need to reduce contact and maintain social distancing. Data will be collected via the online platform used by the Trust for the team meetings and Microsoft Teams for the interviews. Semi structured interviews will be recorded using an encrypted audio recording device and software (not the online platform's recording facility).

What's involved

The researcher is an experienced mental health nurse and academic, currently undertaking a PhD. They have a keen interest in the skills mental health nurses use to accommodate a variety of individual, team, organisational and political factors in their everyday practice. Numerous studies have addressed mental health nurses' decision making, but none in the context of the Health and Social Care Policy (2012) paved the way for the introduction of outcome measures, rationalising services, cost effectiveness and competitive tendering. This has led to the creation of productivity driven outcome measures, upon which the financial security of the service and organisation, is reliant. The care provided is also expected to be of a good quality and meet clients' needs.

What are the possible benefits of taking part?

This study will be contributing to the body of nursing knowledge and highlighting the valuable skills and judgement utilised by mental health professionals.

What are the possible disadvantages and risks?

It is expected that the risk/disadvantages to the participants involved in taking part should be no greater than might be expected in their everyday life. The team meeting would be expected to be business as usual, with me as the researcher adopting a non-participant observer role. I will not be present at any meeting or part of a meeting where a client or carer is being interviewed.

Confidentiality:

All the information you share will be kept confidential. The quotes from the interview will be published in an anonymous fashion, without identifying the participant or team. Each participant will be allocated a code when their interview is recorded and transcribed. This will only be known to the researcher.

Complaints:

You will not be required to share information that you are not comfortable with. If any distress is caused, then the researcher will advise you to seek support from the Trust counselling services. If you are unhappy or feel compromised in any way, by the interview or any way the process has been carried out, you are welcome to contact the

researcher's academic supervisor. Their contact details are: Sally Glen S.Glen@gre.ac.uk

Escalation:

The researcher will maintain confidentiality. However, if any participant shares information pertaining to risk, poor practice or unprofessional behaviour, then they will need to escalate such matters to senior personnel within the Trust. This will be done with the full knowledge and involvement of the participant.

Further supporting information.

You will be invited to give consent, should you wish to participate. This will be demonstrated by signing a form provided. However, this is not binding, and you can withdraw your consent at any time. The information you provide will be anonymised. Comments may be included in the write up, but your name and place of work will not. The researcher will spend some time, prior to the interviews, observing interactions and information sharing forums in your clinical area, to familiarise themselves with the working practices of the team.

Yours faithfully,

Julia Telfer.
Senior Lecturer/PhD student.

Appendix 9: Consent form semi-structured interviews.

Consent to participate in the study entitled: Factors influencing mental health nurses', clinical decisions: a qualitative exploration of reconciling therapeutic care with service outcomes:
Semi structured interviews.

I.....(please insert your full name) am willing to participate in this project. I understand that my contributions in the semi structured interview will be audio taped and that I can withdraw my consent at any time.
I understand that the information I provide may appear in the finished project but that neither I nor my organisation will be identified.

Name.....

Contact details.....

Signature.....

Date.....

Appendix 10: Consent forms Nonparticipant information.

Consent to participate in the study entitled: Factors influencing mental health nurses', clinical decisions: a qualitative exploration of reconciling therapeutic care with service outcomes: 1/11/20
Team meeting Field notes.

I.....(please insert your full name) am willing to participate in this project. I understand that my contributions in the team meetings will be subject to note taking by the and that I can withdraw my consent at any time.
I understand that the information I provide may appear in the finished project but that neither I nor my organisation will be identified.

Name.....

Contact details.....

Signature.....