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# An exploration of the factors influencing the local implementation of the Care Programme Approach in the provision of mental health services for clients with learning disabilities

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# An exploration of the factors influencing the local implementation of the Care Programme Approach in the provision of mental health services for clients with learning disabilities.

Michael A. Kelly

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# Abstract

## Background

The Care Programme Approach (CPA) was introduced in 1990 by the Department of Health as an approach to provide care to people with mental health problems in secondary mental health services. It aimed to improve partnership working across health and social services. However CPA faced problems from early on in its introduction to front-line services. These issues were not confronted and the policy frequently struggled at the implementation stage.

Although never clearly indicated, clients with learning disabilities and concurrent mental health problems were meant to have their care provided through CPA. (For the purpose of this study the term 'dual diagnosis' is used to refer to this client group). However as they were under the care of social services they were managed through care management models instead. More recently policy statements have made it clear that these clients should have their care provided through CPA. Meanwhile, CPA has become established practice in mental health care and care management has become the standard model of care in learning disability services. Service providers are now expected to work in partnership to integrate these entrenched modes of care delivery into a single approach, namely CPA.

## Study aim

This study aimed to explore the factors shaping the local implementation of the adoption of the Care Programme Approach for clients with a dual diagnosis from a meso-level perspective.

## Methods

The study was carried out using a case-study approach in a Mental Health NHS Foundation Trust which was working across five separate localities to implement CPA. A total of 26 semi-structured interviews were carried out with key stakeholders and members of local Steering Groups responsible for CPA

implementation across the five localities. Documentary analysis of relevant Trust documents and Steering Group minutes was also undertaken. All participants in the study completed the Partnership Assessment Tool (Hardy et al, 2003). The data were analysed using a Framework Approach (Ritchie & Spencer, 1994).

**Main findings**

The study identified a range of meso-level contextual challenges around health and social services working together in partnership which impacted on CPA implementation. These included problems with: accessing finances and resources, having competing priorities, poor information sharing and technology systems, organisational complexity, governance and accountability, staff turnover. There were also issues more specifically related to features of CPA policy (shared strategies and policies, shared vision, understanding and commitment, the commitment of key people, care and case management cultures, education and training, administrative support, CPA for particular client groups).

**Discussion**

The discussion suggests that many of the problems encountered with the implementation of CPA in the 1990s continue for its introduction for dual diagnosis clients in the present day. These issues reflect generic challenges of partnership working between health and social care at the strategic organisational level and more particular issues to do with the policy itself. The broader implications for the implementation of similar policies that require partnership working across services for this client group are discussed.

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# Chapter 1: Introduction

## 1.1. Introduction

The Care Programme Approach (CPA) is the approach through which clients with complex needs are intended to receive mental health and social care from mental health services in the UK. This study looks at the factors influencing the implementation of CPA for clients with a learning disability and concurrent mental health condition. For the purpose of the study the term *dual diagnosis* is used to describe this client group.

This chapter outlines the motivation for carrying out the research. Referring to some of the key literature it summarises the justification for the study's aims and objectives and the methods used. It then outlines the contents of the subsequent chapters.

## 1.2. Motivation for Research

This study emerged as a result of my experience working as a mental health practitioner in a community mental health team between 2005 and 2009. All clients who received ongoing care from the team had their care provided through CPA and, as a minimum, would have yearly face-to-face meetings with the professionals involved in their care and any carers or family members they may have had.

However my experience showed that although most of our clients were entitled to have their care provided through CPA, people with a dual diagnosis were often assessed by the team and discharged to the care of learning disability social services. They were frequently classified as ineligible for mental health services as their problems were deemed to be caused primarily by challenging behaviours or communication problems resulting from their learning disability. These clients were not placed on CPA. On exceptional occasions, if the client displayed clear and indisputable psychotic symptoms, the team took them on. Care would then be provided through CPA and yearly multi-disciplinary meetings would be held to plan and review their care and develop a care plan.

Dual diagnosis clients' problems were often complex and the implementation of the CPA care plan required mental health and learning disability social services to work together to ensure that all their needs were met. I had two such clients on my caseload. One of these, "Ahmed" (see box 1.1), posed particular problems for services due to the complexity of his needs. This resulted in sub-standard, and at times inadequate, care and support.

Ahmed* was a twenty-eight year old man of Pakistani origin. He lived at home with his mother, sister and wife.

Ahmed had an IQ of 68 and was known to the local learning disability social service team. He had an allocated social work case manager and was seen by the learning disability consultant psychiatrist when occasion required it. He had been referred to the local mental health team where I was working at the time. The team refused to assess him stating that his issues were primarily related to challenging behaviours rather than any underlying mental health problem.

However, in 2008 he was admitted to the local mental health unit following a psychotic episode in which he believed that the electrical appliances in his house were communicating with him. He also attempted to attack his wife with a kitchen knife but was prevented from causing harm by the physical intervention of his sister. He was prescribed Respiridone, an anti-psychotic medication, by the ward and was discharged into my care for ongoing follow-up and support.

A CPA meeting was held with his care manager, his learning disability consultant psychiatrist, the learning disability team manager and me. A plan of action was agreed. However some months later it became apparent that the learning disability team had not completed some of their allocated tasks i.e. a carer's assessment, a referral to day services or a psychology assessment.

A second CPA meeting was held and these issues were raised. It was agreed that Ahmed's care manager would follow-up the issues identified. However 4 months later this had not been done.

Over the 10 months that I worked with Ahmed he was never seen by a specialist learning disability day service, his family did not receive a carer's assessment and he was seen only once by a learning disability psychologist, who discharged him from the psychology service after it was deemed that he was too psychotic to engage in treatment, even though at the time his mental state had stabilised considerably and there were no psychotic symptoms evident.

I discussed these issues with the learning disability consultant psychiatrist. I was informed that learning disability services, although in the process of implementing CPA within their team, primarily worked within a brokerage care management model in which the allocated care manager was seen as a purchaser of services rather than a professional who would see clients face-to-face and undertake direct care delivery. Consequently the process of referring on to externally purchased services to complete the agreed tasks took longer than the care provided by mental health services, who had direct face-to-face contact and provided care through CPA.

Mental health services continue to work with Ahmed.

*The name Ahmed is a pseudonym, and some personal details have been changed, to protect the client's identity as per guidance issued by the Nursing & Midwifery Council (NMC) (2008).

**Box 1.1: Case example of the discontinuities in the care provided to a client with a dual diagnosis**

This and other similar experiences showed that although dual diagnosis clients were intended to have support from both mental health and learning disability services through CPA, the practicalities of such inter-organisational care provision were difficult. Learning disability services were at the time beginning to implement CPA for clients with mental health problems but they continued to work within a predominantly care management framework. This meant that there were two separate services, working within two separate approaches for the same clients.

Within my community team's catchment area, cases such as that of Ahmed were common and both mental health and social services were aware that this client group was falling between the two agencies.

This situation prompted me to wonder why health and social services, whose purpose was to provide care and support for this client group, found it difficult to coordinate that care and why social services, in particular, found it difficult to implement CPA and work with clients through this approach. I was aware that when CPA was first introduced into mental health services in the 1990s there had been resistance to its implementation by front-line staff. Now that CPA was to be implemented within the Trust and its partner organisations in a second phase for clients with a dual diagnosis I wanted to explore what factors were influencing the implementation process, to see what lessons had been learned from the first round of implementation in the 1990s and whether there were any similarities or differences the second time round.

### 1.3. Preliminary Exploration of the Literature on the Implementation of CPA

To clarify the focus for my study and gain a better understanding of CPA and the factors influencing its implementation I undertook a preliminary exploration of relevant literature.

The Care Programme Approach was introduced in 1991 by the Department of Health (DH)(DH, 1990a) as a framework for providing care to people with mental health problems who were being treated by secondary mental health services. It required health and social services to work in partnership to implement systematic arrangements for the assessment of clients needs and provide appropriate support services based on those needs.

In one of the first empirical studies looking at the factors affecting the implementation of CPA in clinical areas, North and Ritchie (1993) highlighted a number of key issues which appeared to have facilitated or hindered this process. For example the Department of Health allowed for a large degree of local flexibility and interpretation of how CPA policy was to be implemented for each local health authority. Although this was meant to promote more localised care, North and Ritchie (1993) found that each health and local authority had employed different implementation strategies with each working in isolation from each other. This led to the duplication of work which had already been done elsewhere. Although variable implementation was acknowledged by the then Labour Government as a factor affecting CPA  (DH, 1999a) it was not addressed sufficiently and it continued to remain a problem sixteen years after its original introduction (DH, 2006).

The variable implementation nationally led to delays in introducing CPA in to services, and inconsistent application across different localities (Simpson et al, 2003a). In many areas this lack of consistency across localities was also to be found within individual teams, with some clients having their care provided through CPA whilst others did not (e.g. Gilleard 1995; Royal College of Psychiatrists, 1996a).

Other factors identified as impacting negatively on CPA implementation included: lack of coterminous boundaries between health and social services; insufficient commitment from senior management; absence of a lead person allocated to oversee the implementation process; lack of enthusiasm for CPA on the part of some of the professionals involved; and lack of training for staff on CPA processes (North and Ritchie, 1993; DH, 1999a; DH, 1999b; DH, 2006). However these issues were not addressed sufficiently (Jones et al, 2004) and CPA struggled at the front-line where practitioners were expected to implement CPA in their day-to-day practice and work jointly across health and social services (Hall & Higgins, 2006).

The process of joint-working across health and social services itself also proved difficult. Part of the reason for this was the introduction of care management processes in social services following *The Griffiths' Report* (Griffiths, 1988). This care management model, although similar in some respects to CPA, had some fundamental differences e.g. in the role of professionals, their responsibility for providing direct face-to-face care, and the philosophical underpinning of the different models of care (Schneider, 1993).

Attempts were made to address these issues by the Department of Health in its *Building Bridges Report* (DH, 1995a) which offered guidance on inter-agency working. The Department later pushed for the integration of CPA and care management models (DH, 1995b) but acknowledged that there were factors which would potentially impact on the ability of services to work in partnership to achieve this. These issues included;

- Different political and work cultures
- Different accountability structures and systems
- Different ways of considering patient need
- Different statutory responsibilities, and
- The different professional backgrounds of those people charged with making it work (DH, 1995b).

However, although these issues were identified they were never addressed in local services and, the expected 'integration' never fully happened in clinical areas (Cambridge et al, 2005). Part of the problem Dowling et al (2004) suggest was that in the drive to develop and implement CPA policy there was a focus on partnership working, despite a lack of sound evidence on its effectiveness and outcomes. Alongside this there was little evidence to suggest that, even when a health and social service partnership was successful at achieving its stated outcomes, what worked well in that particular area could be replicated elsewhere (Sullivan & Skelcher, 2002). The failure to recognise and address these points had previously led Burns and Liebowitz (1997) to describe “sterile, wearing partnerships” (p427) which failed to acknowledge real differences across health and social services. This they argued would compromise the ability of CPA to be effective in the longer term.

### 1.4. Mental Health Services and CPA Implementation for People with a Learning Disability

The provision of health care for people with a learning disability followed a different route to clients in mainstream services. Through the National Health Service and Community Care Act 1990 (DH, 1990b) people with learning disabilities became the responsibility of local authorities and thus came under social service care management models. In 2001 the government released its *Valuing People Report* (DH, 2001a), which stated that people with both a learning disability and a mental illness should have access to mainstream mental health services. The underlying idea was to encourage the integration of this group into society rather than having separate services. For people with a dual diagnosis this meant that the mental health component of their diagnosis should be provided through mental health services and thus through CPA.

However in 2008 *Valuing People Now* (DH, 2008a) acknowledged that mental health and social services had failed to deliver on this agenda. With greater legislative pressure from the Disability Discrimination Act 2005 and Human Rights Act 1998, *Valuing People Now* again felt the need to reiterate to services that this client group should be allowed access to mainstream mental health care. In order to achieve this target by 2011 the Care Quality Commission was given the power, under the Health and Social Care Act 2008, to assess whether health and social service departments were performing to government targets.

Presently however health and social services remain largely separate entities, not only in terms of physical separation, but they also have different care provision models, referral routes and philosophies. People with learning disabilities remain principally clients of mental health services or users of social services. With pressure on services to meet the *Valuing People Now* targets by this year (2011) there is great pressure to ensure that CPA is implemented for this client group.

However, many issues at the local level affected the implementation of CPA for mental health clients in the 1990s. Although it has taken many years for CPA to become standard practice within mental health services this was achieved through partnership working across health and social services. The integration of care management and CPA models of care aided this process through the creation of a single care pathway for clients in mental health services. Currently a similar integrated care pathway does not exist for clients with a learning disability and mental health problem.

This presents a similar picture to the 1990s when CPA was first introduced for mental health clients who received care through care management and CPA concurrently. However one fundamental difference is that at the time of its introduction into services CPA was a new system of working across both health and social services. It since has become established practice in mental health care, whereas a contrasting care management model introduced at the same time as CPA, has become the standard model of care in learning disability services. As both these models of care have become entrenched in their respective organisations this may pose an additional challenge for services expected to work in partnership to provide mental health care to dual diagnosis clients through CPA.

It is apparent from what has been presented here that the original implementation of CPA required health and social service organisations to change the way in which they provided care to their clients at the front-line, challenging their organisational processes and structures. Expecting health and social services to work in partnership to achieve this was in itself an organisational change. Although some 20 years later mental health services may have embedded CPA into their practice this is not the case for learning disability services and therefore many of the front-line and organisational challenges faced previously by mental health services may, if lessons have not been learned since the previous round of implementation, arise again.

## 1.5. Study Aims and Methods

### 1.5.1. Aim of the Study

This study aimed to explore the factors shaping the local implementation of the adoption of the Care Programme Approach (CPA) for clients with a dual diagnosis from a meso-level perspective.

The objectives of the study were to:

1. Describe and compare local approaches to the introduction of CPA for dual diagnosis clients in selected localities.
2. Identify the various factors (including organisational, contextual and partnership related factors) that appear to have influenced the implementation process in the different localities.
3. Explore how key factors identified as important by participants appeared to help, hinder or otherwise affect the implementation of CPA for this client group.
4. Investigate whether, and how, these issues were acknowledged and dealt with by those involved in the implementation process.

It is anticipated that the findings will generate learning about policy implementation at a local level which may be of use to services dealing with related policy issues in the future. The findings will also contribute to an understanding of policy implementation for dual diagnosis clients from the perspective of people charged with determining policy or preparing for its implementation from a strategic viewpoint.

It is also anticipated that the study will provide a picture on the state of CPA implementation for this client group and will enable comparisons to be made with the original implementation of CPA in the 1990s, to determine whether lessons have been learned from the implementation process in the intervening years.

### 1.5.2. Methods

The study was carried out using a case-study approach (Yin, 2009) in a Mental Health NHS Foundation Trust (referred to in this study as the 'Trust'). The Trust was working with five separate Primary Care Trusts (PCTs), local authorities and their respective social service departments in an effort to implement CPA for people with a dual diagnosis. To achieve this each locality had a separate and especially formed mental health and learning disability Steering Group. These groups comprised of managers and professionals from both the Trust and local learning disability social services.

The study was carried out in two phases. Phase 1 sought interviews with key people in the Trust and the chairpersons of each locality's Steering Group. Documents, such as Steering Group minutes and local and Trust CPA implementation policies, were also sought for analysis. The interviews and documentary analysis used in Phase 1 of the study were used to identify potential participants for Phase 2.

Phase 2 of the study sought interviews with those who contributed regularly to each locality's Steering Group. These interviewees comprised of managers and senior professionals from mental health and social services. Some localities also had professional client and carer representatives.

All participants in the study were asked to complete a Partnership Assessment Tool (Hardy et al, 2003). All data collected were analysed using a Framework Approach (North and Ritchie, 1993).

## 1.6. Organisation of the Thesis

The thesis is organised as follows:

- Chapter 2 provides background information on the needs of clients with a dual diagnosis. It describes the characteristics intrinsic to that diagnosis and illustrates how services have continued to provide a poor level service to this particular client group.

- Chapter 3 provides an historical account of CPA, outlining its development from 1990 and the factors that have influenced its implementation into clinical areas. It reviews the evidence supporting CPA as a care strategy and identifies gaps in that evidence. It then considers the application of CPA to clients who have a dual diagnosis.
- Chapter 4 describes how CPA challenged organisational processes and describes the governments' continued push for partnership working across health and social care services. It reviews the relevant research undertaken in this area and identifies gaps in the literature. The relevant research and the identified gaps are then used to set up the meso-level analytical lens used in this study.
- Chapter 5 describes the processes that were undertaken to achieve the aim and objectives of this study. It describes the decisions taken on study design and illustrates how the research site was chosen. The process of entry into the field, the sampling and process of participant recruitment, data collection, and the approach taken on data analysis, are also discussed. Ethical considerations and procedures are also outlined.
- Chapter 6 provides basic background information about the Trust and each of the five localities in the study. It summarises the progress achieved in each locality with implementing CPA for dual diagnosis clients at the time of data collection and information about the wider political, geographical and organisational contexts in which the Trust and each of its partner organisations were operating is then presented. The impact of this broader context on the implementation of CPA from an organisational perspective is also discussed.
- Chapter 7 identifies factors that appear to have had a direct impact on the implementation of CPA in each of the localities. It highlights common factors affecting implementation and identifies notable differences between the localities.
- Chapter 8 brings together the findings from the current study and discusses these in relation to the literature reviewed in earlier chapters. The fact that

the implementation of CPA for dual diagnosis clients presents with a similar picture to that of its original implementation in the 1990s is discussed and the similarities and differences between the implementation processes in the intervening years is explored. The findings are then discussed in relation to the literature on organisations and partnerships, whilst the impact that the *Greenlight Framework* (DH, 2004) had on CPA implementation is also explored. The chapter concludes with a discussion on why CPA implementation for dual diagnosis clients who presented with high risk or required an in-patient admission was more likely, but was less likely for those who presented with fewer risk issues.

## Chapter 2: The Mental Health Needs of Dual Diagnosis Clients

### 2.1. Introduction

This chapter starts by defining the term learning disability and explains the issues faced by professionals and services in diagnosing clients and identifying and treating underlying mental health issues. It provides an historical account of mental health services for dual diagnosis clients over the past 25 years and highlights the factors from clinical to national level that have impacted on service provision. It pays particular attention to the relationship between health and social service departments, which were tasked by the Department of Health with jointly managing the care of this client group.

### 2.2. Characteristics Intrinsic to the Condition

The term learning disability refers to a pervasive developmental disorder characterised by abnormalities in social functioning, communication and behaviour (Clark and Griffiths, 2007). According to the Department of Health, a diagnosis of learning disability includes the presence of:

- “a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.”

(DH, 2001a, p14).

This definition is broad and encompasses a wide range of disabilities. Diagnosis is made therefore on an Intelligence Quotient (IQ) of <70. However this alone should not be used to make a diagnosis but must be viewed concurrently with two or more limitations in the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, leisure and work (Luckasson et al, 2002). These limitations need to have become manifest before the individual turns 18 years of age.

It is generally accepted that 25-30 people per 1000 of the general population have a mild learning disability with 3-4 people per 1000 on the severe end of the spectrum (DH, 2001a; Gates, 2007). However these figures are expected to rise as prevalence rates of learning disabilities seem likely to increase at a rate of 1% per annum between 1999 and 2014 due to:

- The increased life expectancy of clients, especially those diagnosed with Down's Syndrome;
- an increase in the number of children and young people with learning disabilities surviving into adulthood;
- an increase in the number of children with a diagnosis of autistic spectrum disorders (some of whom have learning disabilities); and
- an increase in the prevalence of learning disabilities amongst particular ethnic groups of South Asian origin (DH, 2001a).

For clients with a learning disability and an additional mental health problem the term 'dual diagnosis' was introduced by Frank Menaloscino (Reiss, 1994) due to difficulties in identifying a primary diagnosis and so that services could be offered on a needs rather than diagnosis basis. The use of this term acknowledges that mental health and learning disability problems are often co-existent. However, as this chapter illustrates, services find it difficult to provide the care required by this client group not only as a result of dual diagnostic issues but also because a complex mix of services is often required to support their needs (Hudson and Chan, 2002).

The term 'learning disability' itself may also be misleading. Although it generally requires a diagnosis of sub-average levels of intellectual functioning, onset in childhood and impairment to adaptive functioning, it is generally acknowledged to cover a group of heterogeneous conditions rather than a single disorder (Bouras and Holt, 2001). This heterogeneity may help explain the difficulties experienced in attempting to provide exact data on the prevalence of concurrent mental health and learning difficulties.

Reported prevalence rates of mental health issues in people with learning disabilities range from 7% to 97% (Borthwick-Duffy, 1994; Hudson and Chan, 2002; Cooper et al, 2007). The enormous variation in estimates between studies reflects problems with the definition and identification of learning disabilities and mental illness in these groups, with their presentations frequently masking symptoms. Borthwick-Duffy (1994) and Cooper et al (2007) noted that these wide discrepancies might also be explained by the methodological limitations of studies in the field. The quality of research in the area has long been criticised for using biased samples, inconsistent diagnostic criteria and ambiguous classifications as well as failing to distinguish between incidence, point and period prevalence rates (Reid, 1994).

Uncertainty about prevalence notwithstanding, it is generally accepted that people with learning disabilities are three to four times more likely than the general population to experience an emotional, behavioural or psychiatric disorder (Debs et al, 2001). These in many cases continue to go undiagnosed and lead to inappropriate service provision or increased admissions into institutional environments (Patel et al, 1993; Emerson, 2001). Undetected mental illness can also have an impact on social functioning, quality of life and the ability to integrate into local communities (Reiss, 1994).

Problems in detecting mental illness in this group have also been compounded by current psychiatric assessment tools that require a level of communication and language skills that these clients often do not have. Professionals are thus frequently left to make a diagnosis based on reports from care-givers rather than from the clients themselves (Vitello and Behar, 1992; Chan et al, 2004). An inability to communicate can mean that aggressive behaviour, linked to underlying environmental (e.g. inappropriate accommodation), physical or psychological conditions (Moss et al, 2000) become wrongly attributed to mental illness (Bouras and Holt, 2001). It has also been suggested that clinicians are reluctant to diagnose a psychiatric disorder, instead attributing the client's mental state or behaviour to the fact that they have a learning disability. This may be done out of fear of stigma, an inability to obtain accurate information from the client or a lack of understanding and training amongst professionals (WHO, 2001).

## 2.3. The Circumstances of Service Provision for Dual Diagnosis Clients

Care for this group was initially provided largely in long stay institutions run by the NHS. During the 1980s, responsibility for residential and social care was increasingly transferred to local authorities, leaving health services to focus primarily on clients' health needs. The shift of responsibility to community social services and thus to a predominantly social model of care brought advantages in terms of integration into mainstream society and a move away from people with learning disabilities being classed as 'unwell' to a greater acceptance of them as individuals with rights and needs (O'Hara, 2000). Community learning disability teams were set up within social services and tasked with providing direct service delivery, identifying service deficiencies and developing or commissioning new services where gaps were present. These teams also created individual plans of care for dual diagnosis clients which became integral to care management systems in social services.

Although learning disability services managed to develop effective systems to enable people with learning disabilities to settle in the community, these successes were not equally matched with effective and efficient services for those clients who also had mental health problems (Bouras et al, 1995). With the closure of the long stay institutions, it was anticipated that mainstream mental health services would step in where required, but they were slow to provide appropriate care (Maloney, 1993)(see table 2.1) and disagreements ensued around whether health or social services were more suitable to care for this client group.

| |
|---|
| • Ideological debates around normalisation, integration, medical model, least restrictive alternatives<br>• Changing trends in institutionalisation and community care<br>• Conflicts about models of service delivery – mainstream versus specialist models<br>• A lack of interest by, and training for, psychiatrists<br>• Issues around diagnosis of mental illness versus behavioural problems<br>• The complexity of treatment of this group<br>• A lack of epidemiological data on prevalence of psychiatric disorder amongst client group hindering service planning. |

**Table 2.1: Reasons for the slow development of mental health services for dual diagnosis clients (adapted from Maloney, 1993)**

## 2.4. NORMALISATION & COMMUNITY TREATMENT

This section outlines the current models of mental health care provision for dual diagnosis clients. It shows how coordination of care between mental health and social services remains challenging, despite repeated attempts by policymakers to address these problems through the creation of more unified processes and structures.

### 2.4.1. Mental Health Services

The closure of the institutions and the drive for community care for this client group was part of a ‘normalisation’ or ‘social valorisation’ process (Wolfensberger, 1969, 1991). The aim was to enable people with learning disabilities to experience patterns and conditions of everyday life as close as possible to those of mainstream society. In keeping with this, the proposal was that these clients should be treated in mainstream mental health services. Although the concept of normalisation appeared to have become embedded within legislative frameworks, there continued to be a lack of consideration or understanding of the implications of normalisation for those with a dual diagnosis (Holt et al, 2000). For example, in Holt et al’s (2000) study on the provision of services to learning disability clients across five European countries, it was noted that in the UK there were gaps in mainstream service provision with a lack of consistency in the service models used in different areas. There was also a lack of access to specialist in-patient services, with some based in residential settings and others in the community. Part of the underlying issue, Holt et al suggested, was that Government policy and legislation tended to separate clients' disability needs from their mental health issues. The result of this was a general failure to recognise and address their needs, which consequently led to inappropriate service provision (Holt et al, 2000).

The lack of integrated modelling at a national level appears to have filtered down into local services which are more directly influenced by local, and often more pressing, service demands such as access to resources, staffing and by structural environments e.g. access to in-patient facilities. This led to a wide disparity in service provision nationally with an uneven implementation of policy, and in some areas clients were found to have no access to specialist community provisions (Moss et al, 2000; O'Hara, 2000). The problems were perceived to have been compounded by a more general failure to negotiate service provision at a local level (Bouras et al, 1995). The splitting of care across two organisations was seen as evidence of the government's failure to recognise the complex interaction between health and social care needs (Bouras et al, 1994). The lack of integration was manifest in continuing discussions about whether clients with a dual diagnosis should receive mainstream or more specialist mental health services. National policy in the area appeared unclear. The Department of Health for example stated that specialist services were required to support these clients (DH, 1989a) but later suggested that mainstream services ought to be used as a first resort, with access to specialised services only if necessary (DH, 1992a). The *Mansell Report* (DH, 1993) then recommended the creation of specialist mental health teams based in multi-disciplinary learning disability services which would liaise and work with mainstream services.

In practice this led to the creation of multidisciplinary learning disability community teams based within social services and attempting to manage a wide variety of physical and mental health issues. The care provided by this means was found to be fragmented and there was often a poor understanding of mental health issues

(Hassiotis et al, 2000). It has been suggested that mainstream mental health services may reduce the discrimination and stigma associated with mental illness for this client group (Chaplin, 2004). However, mainstream services also find it difficult to manage the complex health and social issues that clients experience, since they often lack the understanding, training, skills and expertise needed to provide appropriate care. To improve the situation in mainstream services it has been suggested that attention needs to be given to the training of all staff who provide care to dual diagnosis clients and to improve linkage between psychiatric and learning disability services, supported by specialist services for dual diagnosis clients with access to sufficient funding and resources (Lennox and Chaplin, 1996; Bouras and Jacobson, 2002).

### 2.4.2. The Division between Health and Social Services

Currently the provision of mental health and learning disability services is frequently through separate agencies which are often not co-located and which employ staff from different professional backgrounds. Having separate services means that each is unaware of the philosophy of care and service models of the other, with each responding to its own pressures and priorities (Mohr et al, 2002). In areas where health and social services attempt to coordinate more efficiently and effectively the results have often been inadequate, with clients requiring assistance from both but often finding it difficult to receive comprehensive support from either due to different service models and approaches to client care (Patterson et al, 1995; Chaplin, 2004).

Even in areas where specialist services do exist it is apparent that clients continue to experience issues with the interface between specialist and mainstream services due to disputes around role and function (Chaplin, 2004). The problems are compounded by a lack of clear local operational policies and service agreements, definitions of service entitlements, restricted budgets and rivalries amongst professional groups (Singh et al, 1994; O'Hara, 2000; Bouras and Holt, 2001).

With health and social services thus divided, Doody (2001) argued that clients are allowed to fall between "the two proverbial stools of general adult psychiatry and learning disability psychiatry" (p301). Although models of partnership between the two services have emerged, no single model predominates due to the different management, budgetary and operational arrangements between them and the different organisational structures and variable models of care management within social services themselves. Inequities between authorities and gaps in implementation in community policy are apparent as there is no single framework though which health and social services can integrate their care strategies at a local level (Cambridge, 1999). A key aspect of this was the joint commissioning of services, which required both health and social services to have common aims and objectives and shared strategies to achieve them. However, apart from the legal aspects of joint working (e.g. lead commissioning and pooled budgets) the joint commissioning of services turned out to be logistically and organisationally extremely difficult. In part this has been blamed on confusing national policy and a lack of coterminosity between health and social service boundaries (Cambridge, 1999). The Social Service Inspectorate (SSI) (SSI, 1998) also held local services responsible for lacking strategic and coordinating leads and highlighted that there was too much diffusion of responsibilities across services.

## 2.5. National Policy

Although national policy recognises the vulnerability of people with a dual diagnosis and advocates that they have the same rights of access to mental health services as other groups, policy guidance in this area has been broad, open to interpretation and lacking a conceptualisation of how services ought to be (Perry et al, 1998). The lack of a clear, central direction has meant that identified priorities are frequently not supported by protected funding streams. As a consequence, once mental health and learning disability policy has been decided, implementation has lagged behind its adoption (Bouras and Jacobson, 2002).

Although greater administrative procedures and increased resources may make a positive difference to policy outcomes, services need a more comprehensive and rational approach to policy making. Marcos et al (1986) suggested this would involve considerable human and financial resources and an understanding of client need from a ‘bottom-up’ perspective. They argue that in many situations policy makers leave basic service structures unchanged, opting for change through an incremental approach which entails minor changes or modifications to existing policies, limited analysis of alternatives, limited resources and little research-based evidence to back up decisions made (Marcos et al, 1986).

### 2.6. Conclusion

This chapter has shown that people with a learning disability are susceptible to mental health problems. However compared to the general population there are greater difficulties in both diagnosing and treating these problems effectively and ongoing arguments about which service model is the most appropriate in the provision of care. Meanwhile dual diagnosis clients continue to fall down the divide between health and social care.

One strategy employed in the 1990s to reduce the likelihood of people with mental problems encountering such issues was the Care Programme Approach (CPA). In more recent years, as people with a dual diagnosis have come into contact with mainstream services and as specialist mental health services and generic learning disability services employ more mental health staff, the use of CPA as a strategy for improving the mental health needs of clients with a dual diagnosis has become more common. Although government policy supports the use of CPA for this client group it has offered little financial support to assist its implementation.

The next chapter outlines the earlier introduction of CPA for people with a mental illness in the 1990s and explores the factors found to affect its implementation. The more recent implementation of CPA for dual diagnosis clients is then examined.

## Chapter 3: The Care Programme Approach

### 3.1. Introduction

The introduction of the Care Programme Approach (CPA) in mental health services is outlined in this chapter. The factors influencing its implementation are discussed, paying particular attention to those areas which proved problematic. The chapter then examines the implementation of CPA for dual diagnosis clients and explores the limited literature in this area.

### 3.2. The History of CPA

In 1986, the Audit Commission identified that the provision of community care for people with a mental illness was inadequate (Audit Commission, 1986). This was supported two years later when the *Spokes Inquiry* (1988), conducted following the killing of a social worker by her client, paved the way for the introduction of registers of mentally ill clients living in the community. With public pressure on the Department of Health to respond, “demands to improve quality of care for institutionalised victims of the system” shifted “to demands for safety for the public as potential victims” (Muijen, 1997, p21). In response to the inquiry, the *Griffiths Report* (1988) recommended the introduction of care packages for clients, with the allocation of caseworkers who would work across services in the provision of care. These recommendations were further supported by the White Paper *Caring for People* (DH, 1989b) which directed psychiatrists not to discharge clients from in-patient settings without an appropriate care plan agreed with social services, and by a circular in 1990 which introduced CPA into mental health services (DH, 1990a).

The purpose of CPA (see table 3.1) was to ensure that clients known to mental health services received appropriate health and social care. Health authorities and social service departments were required to have systematic arrangements in place to provide psychiatric, health and social care for clients in the community and to ensure that arrangements were made for the ongoing provision and review of that care. The detail of these arrangements was not specified centrally, but was expected to be agreed at local level.

- Systematic assessment of health and social care needs bearing in mind immediate and longer term needs;
- Development of a care plan, agreed with relevant professional staff, the client, carers and recorded in writing;
- Allocation of a keyworker whose role is to:
    - keep in close contact with the client;
    - monitor that the agreed programme of care is delivered;
    - take immediate action if it is not.
- Regular review of client's progress of health and social care needs.

**Table 3.1: Essential elements of the Care Programme Approach (DH, 1990a)**

Working in an inter-professional manner, and involving clients and carers in care planning, keyworkers (later known as care coordinators) were to be appointed as a single point of contact for clients to enable them to access both health and social services. Multi-disciplinary teams were expected to contribute to the care planning process and make their own arrangements to implement care plans and to monitor and maintain contact with clients.

The application of CPA for clients discharged from in-patient settings was regarded as particularly important, with emphasis placed on the need for thorough risk assessment "to ensure the support of mentally ill people… thereby minimising the possibilities of their losing contact with services and maximising the effect of any therapeutic intervention" (DH, 1994, p3, para 9). To deliver this agenda an inter-agency approach across health and social services was required "to prevent people falling through the net" (p5, para 14), with each agency expected to understand its role and those of partner agencies. The *Building Bridges* Report (DH, 1995a) provided examples of how this approach would enable services to successfully implement CPA. It recommended a three-tiered system in which service provision would vary according to the level of need and complexity of issues experienced by the client. With CPA described as a "specialist variant of care management for people with mental health problems" (DH, 1995a, p56, para 3.2.8) there was an expectation that it could be fully integrated with social service care management systems.

By 1999 the Department of Health (DH, 1999c) indicated that social services and health authorities had indeed begun to work more closely together, with joint strategies and greater service flexibility being developed or already in place. There was a better understanding of CPA in front-line services and many areas had developed integrated teams for referral, assessment, and the planning and review of care packages. The best examples of integration between CPA and care management were found "where the budget holding responsibilities of care management had been incorporated into the CPA coordinator role" (DH, 1999c, para 1.41).

### 3.2.1. CPA and the National Service Framework

To improve consistency in policy implementation and build on these perceived successes, the Department of Health published the *National Service Framework for Mental Health* (NSF) (DH, 1999a) which set out national standards and service models for mental health services. This ten-year plan required that specific arrangements should be in place for the integration of CPA and care management and local health and social services were expected to translate the national standards of the NSF into local delivery plans.

Having aligned CPA with the NSF, the Department of Health also set out to modernise CPA (DH, 1999d) following feedback from reviews and inspections which indicated that it was, in practice, neither an efficient nor effective system. Professionals and managers in front-line services complained that the implementation of CPA was inconsistent and that its introduction led to increased bureaucracy. The modernisation plan sought to achieve the following; better integration of CPA and care management; consistency in the implementation of CPA nationally; more streamlined processes to reduce the burden of bureaucracy; and a proper focus on the needs of clients (see table 3.2).

| 1. | The integration of CPA and care management |
|---|---|
|  | Keyworkers were expected to take a lead across organisations, working together to meet client needs, with the integration of CPA and care management central in providing a seamless service. This integrated system where “CPA is care management” (DH, 1999d, p9) would involve single referral points, unified health and social care assessments, co-ordination of roles and responsibilities and access to both health and social service support and resources through a single access point following a joint assessment. |
| 2. | Consistency in the implementation of CPA nationally |
|  | National standards were outlined in the NSF and all services, irrespective of locality, were expected to meet these. Mental health care was to be provided through two new levels of CPA: standard and enhanced. It was expected that if clients were placed on enhanced CPA due to the complexity of their needs, services would work more efficiently to meet their needs through an allocated keyworker. |
| 3. | Streamlined processes to reduce the burden of bureaucracy |
|  | The process of improving services through streamlining involved a more integrated approach to front-line practice and procedures. This included, for example, combined case notes and shared records with a single referral system for health and social care. Service audits were expected to review the quality of CPA delivered and not simply the quantity of people placed on it. |
| 4. | A proper focus on the needs of clients |
|  | The role of the keyworker was outlined. They were expected to have the ability to work across agencies, their managers were to assist them in combining care coordination and care management roles through appropriate training, education and competences. |

**Table 3.2: Modernising the Care Programme Approach (DH, 1999d)**

To oversee this process, lead officers with sufficient authority at local level to ensure the agenda was met were to be appointed. Keyworkers (by this stage known as care coordinators) with appropriate training and competencies were seen as central to delivery at front-line level.

However, seven years after these recommendations were published, the Department of Health acknowledged that the process of integrating care and case management, and reducing the associated bureaucracy and inconsistencies, had not worked as well as anticipated (DH, 2006). In response, it reiterated that partnership working needed to improve. It proposed removing the two-tiered system of standard and enhanced CPA so that services could focus on those with the most complex needs. Key groups of clients who had not previously been placed on enhanced CPA were identified as needing this level of service, however clients with a dual diagnosis were not mentioned.

From October 2008, CPA became the approach through which all mental health needs were to be assessed, and care planned, received and coordinated for mental health clients with complex needs (DH, 2008b). CPA was identified as an *approach*, rather than just a *system*, since the process of providing care was perceived to be as important as the actual tasks carried out. The intention of the so called 'new CPA' was to enable services to focus on those with the highest level of need and those requiring a multi-agency approach to their care (including those with a learning disability).

As the NSF neared the end of its ten-year lifespan a new consultation, *New Horizons*, was launched (DH, 2009) to build upon what the Government felt were its successes and create more personalised services "by building a cross-government multi-agency alliance" (p2). A key theme of the consultation was again the continued need to achieve joint working, commissioning and collaboration between local agencies, the success of which would "depend on coordinated action across government departments at national level, and effective working at local level between commissioners and providers, including primary care and the statutory, private and tertiary sectors" (p98).

The *New Horizons* consultation was yet another attempt to get services to work closer in partnership to deliver the CPA agenda. However, despite the repeated reports and reviews, services and professionals continued to struggle to achieve this.

With the aim of trying to understand why the effective delivery of CPA proved so intractable, the next section explores the research and other literature on CPA implementation in the 1990s.

### 3.3. Factors Influencing the Implementation of CPA in the 1990s

A computerised search of the key mental health databases (Embase, PsycINFO) and more generalist databases (CINAHL, Medline, Cochrane, Social Policy and Practice) was undertaken. Searches were made using a combination of key words including: CPA, care programming and case management. Approximately 350 articles were retrieved and reviewed, of which 29 were deemed relevant. There were 14 empirical studies. The literature located generally focused on the implementation of CPA from the perspective of its actual practical application in front-line teams (e.g. Matthews, 1995; Burns and Liebowitz, 1997) and tended to be small-scale and/or specific to a single mental health team (e.g. Horder, 1998). The vast bulk of papers located were reviews, discussion pieces, editorials, surveys and audits (e.g. Gilleard, 1995; Simpson et al, 2003a, 2003b, Warner, 2005). There was one Cochrane review (Marshall et al, 2001), which aimed to determine the effects of case management as an approach to caring for severely mentally ill people in the community.

A sub-analysis of the literature search, exploring the factors influencing the use of CPA in front-line areas, showed a similar pattern of discussion pieces, editorials and surveys. In general these studies and audits discuss CPA from the perspective of its integration with care management processes (e.g. Hughes et al, 2001), describe clients’ experiences of their care provided through CPA (e.g. Webb et al, 2000), or do both of these at the same time (e.g. Carpenter et al, 2004). Case note surveys were common (e.g. Wallace and Ball, 1998; Philpot et al, 2001) and there was only one randomized controlled trial (Tyrer et al, 1995). A summary of the key literature identified and used for this study, including methodologies and key findings, is presented in Appendix 1.

The literature highlighted a number of key themes: problems with partnership working and variable implementation, concerns about the effectiveness of CPA in front-line areas, the role of professionals in CPA, challenges associated with increased bureaucracy and the underlying philosophy of CPA. Each of these is discussed in turn.

### 3.3.1. Partnership Working and Variable Implementation

In the first study undertaken to evaluate progress on the implementation of CPA, North and Ritchie (1993) examined how CPA was being implemented and operated in four health authorities and identified factors that appeared to have influenced this process. Their study was undertaken in two phases. In phase one interviews were conducted with those involved in determining CPA policy and preparing for its implementation at a local level. In phase two staff involved with CPA at an operational level were interviewed, alongside ex-clients, carers and members of the voluntary sector.

Of the four health authorities studied, two had coterminous boundaries with local social services, the others had catchment areas covering more than one local authority, and thereby several social service departments were involved. In the four health authorities there were three different strategies employed for planning the development and implementation of CPA policy (see table 3.3). This indicated a lack of consistency between the Government’s attempts to improve national uniformity in local service provision and what was actually happening at the local level. CPA had not been fully implemented in any of the study areas.

| |
|---|
| 1. Joint health and social services planning from inception;<br>2. Policies drafted by the health authority and then sent to the local authority. Once agreed joint local groups were set up to facilitate implementation;<br>3. Social service departments took a lead without health authority input. |

**Table 3.3: Contrasting local strategies for CPA development & implementation (from North and Ritchie, 1993)**

Although there was inconsistency in the strategies employed, participants were unanimous in the view that effective implementation on CPA depended on sustained leadership from a single individual. Such an individual might be delegated, appointed or specifically employed to help develop, implement and monitor CPA and could be from either the health or local authority. In the areas where no specific lead had been appointed, local managers complained of the extra burden they felt to be associated with implementing the policy.

In all four areas studied by North and Ritchie, Steering Groups with both health and social service representatives had been set up to address issues raised by CPA and its implementation. However, group composition varied from area to area and all the groups encountered difficulty in convening, due to the time commitment involved, slow progress in operationalising CPA and regular changes in membership. The presence of senior health authority staff was seen as adding weight to the importance of CPA policy and enabling decisions requiring senior approval to be made more efficiently. Their absence had the opposite effect and appeared to hinder CPA implementation in the localities where they were not present.

Table 3.4 provides a summary of the key factors affecting progress on the implementation of CPA in the 1990s, as reported by North and Ritchie (1993).

| | |
|---|---|
| 1 | The need for lead development |
| | • Each health authority was working in isolation which led to the duplication of effort.<br>• There was a lack of good practice guidance through the issuing of e.g. case studies showing best practice. |
| 2 | The need for further guidance from the Department of Health |
| | • Information from the Department of Health did not always filter down to local staff.<br>• There was a need for more information from the local health authority on CPA. |
| 3 | Overlap between initiatives |
| | • CPA, care management and Section 117 aftercare arrangements of the Mental Health Act (1983) were perceived to have roughly similar aims which caused confusion with their implementation at a management level. |
| 4 | Misunderstanding of the complexity of CPA |
| | • Many staff for example felt the need to attend CPA meetings when in fact the client's level of need did not require it. |
| 5 | Offering in-patient care where there were insufficient resources to meet clients' minimum needs in the community |
| | • Such cases were not documented and there were no widely available definition of 'minimum need'. |
| 6 | Further impetus for implementation |
| | • Once the initial wave of implementation was over some aspects of the implementation process (these not identified by North and Ritchie) remained outstanding e.g. establishing and clarifying the role of the keyworker, establishing procedures for prompting and holding review meetings. |

| | |
|---|---|
| 7 | The relationship between the health authority and social services departments |
| • | • Most progress was made in areas where strong mechanisms between services for joint planning and development of local services already existed. These arrangements needed to be at both the management and operational levels and accompanied by an equal level of commitment to the provision of community mental health services.<br>• Joint working at an operational level was seen to be most effective where there were coterminous boundaries between health and social services. This was because there was only a single social service department from which commitment was required.<br>• In the health authorities that had not progressed with CPA there was a low level of involvement in joint planning from the Health Authority at a senior level, both in relation to CPA and other initiatives where joint-working was required. When this occurred the social service department expressed frustration at having to take a lead on CPA. |
| 8 | The need for a sustained lead |
| • | • There was a unanimous view amongst the study participants that there was a need for a 'driving force' to make CPA implementation effective. Lead people, with sufficient authority, were needed to provide direction to ensure that CPA would work at an operational level and to maintain the momentum of the CPA initiative. This could be achieved by nominating a lead officer with the responsibility of regularly reviewing progress. Progress in implementing CPA was greatest in areas where a lead officer was appointed. The converse was true in areas where there was no lead officer. |
| 9 | The role of key professionals |
| • | • There were different levels of commitment from professional staff, with psychiatrists perceived as having the lowest levels.<br>• There was a lack of interest or 'ownership' of CPA which affected the pace of CPA implementation.<br>• Key professionals in senior positions were important. Their role could be used to demonstrate the importance of CPA, encourage its |

| | |
|---|---|
| | adaption and any associated procedures to more junior colleagues. |
| 10 | Induction and training |
| • | • At an operational level clinical staff were critical of how CPA was introduced and the training that they received. They felt there had been insufficient training, consultation or information available prior to the introduction of CPA, with little information particularly on its introduction or purpose. Once implemented, CPA procedures and the associated paperwork used to document them were continually changing. |
| 11 | Review and progress |
| • | • There was a need to review and continually monitor the introduction of CPA. Without this, implementation was likely to be patchy or non-existent. Progress needed to happen at both the managerial and operational levels.<br>• To maintain the implementation process ongoing access to resources was required. |

**Table 3.4: The key factors affecting progress on the implementation of CPA in the 1990s (North and Ritchie, 1993).**

North and Ritchie's findings were supported by the Social Service Inspectorate (SSI)(DH, 1995c), which evaluated the contribution made by five social service departments (from across England) to CPA in the discharge of clients from in-patient units to community services. Collecting data from local policies, case files, care plans and interviews the SSI findings indicated:

- A wide variety in the quality and detail of community care plans, policies and strategies
- Little evidence of other agencies (e.g. housing, voluntary sectors) being involved in the development of policies and strategies
- Despite CPA having an implementation date of April 1991, only one of the five areas reviewed had a formalised and detailed inter-agency agreement on the introduction and implementation of CPA across health and social services
- Need for a strong lead to drive through the implementation process
- CPA, as an approach to mental health care, was not universally known about or understood by staff, clients or other voluntary organisations
- Good joint-working was sporadic
- Only two areas had appointed CPA keyworkers, while other areas experienced confusion about the role, its responsibilities and the knowledge and skills required,
- Limited client and carer involvement
- Poor documentation and recording of care plans.

The SSI review advocated the introduction of formal inter-agency arrangements to develop and implement policies and strategies to introduce and review CPA across services.

A further study undertaken by Schneider (1993) investigated how CPA was being implemented across three contrasting health districts through interviews with 60 professionals involved in CPA and its implementation. Schneider identified a number of strengths and weaknesses to CPA (see table 3.5) and found inconsistencies in its application across and within districts.

| Strengths |
|---|
| • Monitoring role of keyworker enabled early identification and treatment of relapses;<br>• Identification of keyworker and clarification of role with improved team working and shared responsibility for client care;<br>• Reduces duplication and improves utilization of resources with more rigorous recording systems;<br>• Greater client and carer involvement and thus increased satisfaction with services;<br>• Enables staff to carry out more roles and interventions. It teaches staff about each other's roles and resources available to support clients locally. |
| Weaknesses |
| • A lack of resources to implement CPA and to meet the identified needs of patients. More staff required to meet these demands;<br>• Some clients not allowed access to care under CPA;<br>• Keyworkers saw role as similar to, and potentially leading to, budget holding care manager type roles as seen in social services;<br>• CPA seen as bureaucratic (and imposed from top-down), taking away from face-to-face contact time with client;<br>• CPA put pressure on system leading staff to have rigid interpretations of their role and tasks. |

**Table 3.5: Strengths and weaknesses of CPA (Schneider, 1993)**

The inconsistency in CPA implementation, particularly at a front-line level was also noted by Gilleard (1995) who examined all the case notes of one community mental health team's clients who had been discharged from in-patient settings. Of those clients, 46% had no care programme and considerably fewer had a documented care plan, named keyworker and planned review date. While a review of the same team in 1993 did show significant improvement, this increasing trend did not happen consistently throughout the country. This was shown in 1996 when a report into homicides and suicides committed by clients with mental health problems found that, of those clients known to services who had committed a homicide, only 16% had an active care plan, 48% had a care plan which had not been implemented and fewer than 50% had a nominated keyworker (Royal College of Psychiatrists, 1996b). The same report reviewing suicides found that just 33% of out-patients had a care plan that was operational and just under half of all clients who had committed suicide had a nominated keyworker. This again illustrated that CPA was being only partially implemented across services and supported a previous House of Commons Health Committee (1994) review which found that in many inner-city acute units CPA was barely evident.

This variable implementation continued into the late 1990s, with Bindman et al (1999) finding that CPA continued to be implemented variably in practice settings with different trusts implementing different levels of tier systems. They reported that among the 180 trusts they studied there was little consensus as to which clients should be placed on the top tier of CPA.

### 3.3.2. The Effectiveness of CPA in Front-Line Areas

It is clear that the introduction of CPA into mental health services was problematic, with variable implementation and a lack of commitment from both organisations and professionals. One reason for this may have been to do with doubts among front-line staff about the value of CPA. In the only randomized control trial that investigated the effectiveness of CPA and in particular the impact of having an allocated keyworker, Tyrer et al (1995) randomized 400 clients from an inner-city area into two groups. One group received close supervision by a named keyworker (as required through CPA) and the other received standard health and social service care. The findings indicated that the clients who were closely monitored were, as suggested in CPA guidelines, more likely to remain in contact with psychiatric services. However they also had significantly higher admission rates and, when admitted, spent 68% longer in hospital than non-supervised clients. The researchers concluded that as responsibility for the clients' welfare fell solely on a single named keyworker they were more likely to admit unwell clients more quickly than those where responsibility was shared more equally within the multi-disciplinary team. The increase in admissions was in part also due to the time it took a keyworker to organise reviews of people relapsing with the rest of the team. By the time such reviews were organised the client had sometimes become so unwell that admission was the only option.

This view was further supported by a Cochrane review which found that, with case management (including CPA) clients diagnosed with schizophrenia were more likely to remain in contact with services but also twice as likely to be admitted to hospital compared to those not under case management (Marshall et al, 2001). Although the findings of Cornwall et al (2001) in their study evaluating the changes in the operation of a single community mental health team contradicted these rates of increased admission, they did find that there was a significant increase in the use of home treatment services by clients under CPA.

The variety in these findings indicates the challenge of measuring the success of CPA. Part of this may be due to the way in which CPA policy was interpreted and implemented by local services. Although two-thirds of local authorities were aware of CPA there appeared to be great variance in how they interpreted it (Schneider, 1993). Even where CPA was in use, the tiered system was being applied to individual client's diagnoses rather than their actual levels of need. Health and local authorities complained of confusion around their role in the purchasing and provision of mental health services (Schneider, 1993), the outcome of which may have led to the variability in the use and application of CPA policy, registers, and eligibility criteria at front-line level (Wallace and Ball, 1998; Philpot et al, 2001).

Although the Department of Health acknowledged that there was wide variation in how CPA policy was being interpreted (DH, 1999c; DH, 1999d) it felt that implementation was being hindered by inconsistent commitment from health care professionals who were charged with its implementation, something which was later raised by the Commission for Health Improvement (CHI) (CHI, 2003). It is useful therefore to look at the literature on role of professionals in CPA to determine whether this was the case and if so, why.

### 3.3.3. The Role of Professionals in CPA

Within social services, care managers were employed as brokers of services across statutory and independent sectors. As such, and to reduce the possibility of conflicts of interest, they were expected to have no direct involvement in service delivery or managerial responsibility for services arranged.

The lack of direct involvement in service delivery distinguished care managers from CPA keyworkers who did have a direct service-providing role. Although this separation of functions was later removed (DH, 1995a), the ease with which the merger could occur was over-estimated. Social service staff were reluctant to take on the keyworker role as they feared it would involve over-monitoring and review of clients by services (DH, 1999c). This reluctance led to inconsistencies across the country in the delegation of keyworkers from care management backgrounds, with some areas appointing named workers to particular clients, whilst others remained with traditional care management systems of team allocation (DH, 1995c).

In a review of all NHS trusts in England between 1997-8 which assessed the involvement of professionals in CPA, it became clear that it was not just social workers who were not engaging with CPA processes (Schneider et al, 1999). General practitioners, junior doctors and even consultant psychiatrists were often not included in clinical discussions around CPA, a finding supported by Kessler and Dopson (1998) in their discussion of the tensions between centralization and decentralization in CPA policy implementation. In practice, those most likely to be involved in CPA at a clinical level were mental health nurses, particularly in in-patient units. Under CPA they appeared to have become *de facto* keyworkers since within in-patient settings mental health nurses represented the largest group of health professionals (Wolfe et al, 1997). In community settings it was also nurses who had taken on the keyworking role, although there appeared to be tensions between that role and their wider therapeutic remit (Simpson, 2005).

Up until 2004 questions continued to be raised about which profession was the most suitable to keywork clients (Mace, 2004) and there appeared to be a continued lack of engagement by most professionals in the CPA process.

### 3.3.4. Increased Bureaucracy

The level of perceived duplication led many professionals to see CPA, not as a therapeutic framework or approach as the government insisted, but rather as a bureaucratic process (Easton & Oyebode, 1996). This view was compounded by the increased amount of documentation which needed to be completed under CPA (Gilleard, 1995; Mace, 2004, Simpson, 2005).

As Aslan (2002, p14) noted, much of this process involved “pre-determined questions requiring little more than ‘yes’ or ‘no’ answers,” a process he saw as “light years” away from including and respecting the individual and not reflective of the actual clinical contact that staff had with clients. With the increasing administrative demands being placed on clinicians by CPA, direct patient contact was low, with Wolfe et al (1997) estimating contacts between clients and professionals to be one per client per month. The increase in bureaucracy was not helped by a lack of resources in front-line teams where, for example, information systems proved inadequate to support CPA or were lacking altogether (Gilleard, 1995).

The Government’s response was again to blame local implementation procedures for making CPA a ‘tick-box’ exercise (DH, 2006). Little acknowledgement was given to the complexities of implementing a policy which challenged the traditional roles, models, and systems within which front-line professionals worked.

The next section explores the underlying philosophy of CPA and how that may have challenged these services and professionals thus impacting on its own implementation process.

### 3.3.5. The Underlying Philosophy of CPA

Although the Department of Health acknowledged that the introduction and implementation of CPA had been problematic it still argued that in principle it remained sound (DH, 2008b). However other commentators questioned this assumption. In part the argument rests not on CPA itself, but on its underpinning philosophy. CPA derived from 'case management' models but the basic principles of CPA aligned very closely with the principles of other forms of care provision and in particular 'care management', which was used in social services.

There are a number of approaches to the case management model, with variation in the size of caseloads and the level of direct therapeutic input. Marshall (1996) argued that with the appropriate guidance and supporting funding framework CPA might have evolved into what is called 'assertive case management', as its original target client group was those with severe mental illness who were to be appointed an allocated keyworker with responsibility for undertaking a level of direct client contact. However "in practice, the Care Programme Approach has meant 'standard case management' for all, through a combination of lack of funding, mushrooming paperwork, and its extension to all psychiatric patients" (Marshall, 1996, p524) thereby making it much more difficult to define either a focused client group or a particular underlying model. Although they are similar in some respects, the numerous models of case management (clinical, intensive, assertive and rehabilitation-orientated) are different approaches to mental health care with CPA, which Simpson et al (2003b) argued, not appearing to have derived from any particular one.

Care management on the other hand was also seen as a remake of case management models, but there was little clinical evidence presented to show that either it, or CPA, were effective in client care. Attempts by the Department of Health to combine the two through integration proved problematic, as some professionals saw CPA as clearly a case management system (Downing and Hatfield, 1999), whilst others felt that it was more aligned to care management (Schneider, 1993). This lack of direct linking to a particular model meant that from its inception CPA was viewed as a "hybrid" (Burns and Liebowitz, 1997, p428), but more importantly it appeared to lack a specific philosophical underpinning through which the role of keyworkers and services could be defined. According to Schneider (1993), proposals to integrate CPA and care management paperwork confused the status of both, playing down their differences and attempting to emphasize their common features so that health and social care service staff were comfortable with both.

### 3.3.6. Summary of CPA Implementation in Mainstream Mental Health Services

Although CPA was meant to clarify "the complex issues surrounding the coordination of care for the severely mentally ill and to promote inter-professional communication and effective targeting of resources by community mental health teams" (Burns and Liebowitz, 1997, p426), from the outset it was ambiguous with uncertainty about whether it was an administrative process or a therapeutic strategy. CPA, care and case management, although similar in some respects, were three different approaches to mental health care, but the government failed to differentiate them, leading CPA to become viewed as a "flawed policy" (Simpson et al 2003a, p489).

Allowing local flexibility in interpreting CPA policy was meant to help local services be more responsive to local need. However having what was seen as an overall 'framework definition' whilst recommending locally agreed operational definitions caused confusion and disagreement which then led to inconsistencies in its application nationally (Simpson et al 2003a). Even in the localities where CPA was implemented, the evidence showed that it appeared to lack any clear advantages in relation to improving clients' mental state, social functioning or quality of life and thus, as an intervention, was of questionable value to mental health services (Marshall et al, 1996). However as Kessler and Dopson (1998) point out, the Department of Health's decision to continue with CPA, despite mounting clinical evidence against it, may have been to do with the fact that audits of CPA were focused more on processes rather than outcomes, which led to an unbalanced and distorted view of the benefit of CPA in practice.

The wide disparity in its implementation was defended by Kingdon and Amanullah (2005) who argued that in the absence of any viable alternatives to the provision of mental health care, professionals were beginning to see CPA as a clinical intervention, something which they claim was the original intention of the Department of Health. However by 2006, 16 years after its original introduction, inconsistencies still remained in the policy's implementation and even the Department of Health admitted that there was variability in the quality and standards seen across different localities (DH, 2006).

More vocal opponents of CPA argued that for mental health services it was no longer being advocated but enforced (Easton & Oyebode, 1996) because "case management, a practice with little justification, has displayed an astounding ability to flourish in the age of evidence based medicine. There is a simple explanation for case management's immunity to scientific analysis; in Britain it is no longer just an intervention, but a government policy" (Marshall, 1996, p524).

It is with this history, and into this contentious environment, that CPA was also to be applied to clients with a dual diagnosis.

### 3.4. CPA Implementation for Clients with a Dual Diagnosis

When first introduced it was expected that CPA would be applied to all adults of working age known to mental health services. By implication this included people with learning disabilities who were known to these services, but there was no explicit mention of this client group until a Department of Health Circular in 1994 (DH, 1994) made mention that CPA was to apply to these clients when discharged from in-patients services. However in 1999 the Mental Health National Service Frameworks (DH, 1999a) made no specific mention of clients with a learning disability. In the same year, the Department of Health published its CPA modernisation document (DH, 1999b). There were two stated reasons for this publication; to reaffirm CPA as *the* framework for care coordination and resource allocation in mental health, and to set out important changes to make it more effective and efficient system. It reiterated the need for services to get “people to the right place for the right intervention at the right time” (p4). This was seen as particularly important for those with multiple and complex needs, and people with learning disabilities were cited as an example of one such group. This was followed up in 2001 when *Valuing People* (DH, 2001a), the government White Paper on developing services for learning disability clients, stated that CPA and the NSF should in fact also apply to those with a dual diagnosis. This clarification came nine years after the original introduction of CPA into services.

It was expected that mental health teams would allow clients access to their services with support from specialist learning disability services. As the NSF sought to integrate CPA and care management procedures, it was expected that this would lead to a seamless service for dual diagnosis clients. The intention was that there would be clear protocols for collaboration between mental health and learning disability services and local care coordinators were expected to have expertise in both fields (Royal College of Psychiatrists, 2003) (see table 3.6).

*Valuing People* stated that dual diagnosis clients should benefit from the *National Service Framework* and that:

- People with learning disabilities should be enabled to access general psychiatric services wherever possible. This will require mainstream mental health services to become more responsive and specialist learning disability services to provide facilitation and support;
- The NSF for Mental Health applies to all adults of working age. A person with a learning disability who has a mental illness should therefore expect to be able to access services and be treated in the same way as anyone else. The NSF for Mental Health seeks to integrate CPA with care management. This will lead to a seamless service for people with learning disabilities who have mental health needs.

To achieve these goals the government will ensure that:

- Strategies for improving access to services, which enhance and promote mental well-being, will include people with learning disabilities and mental health problems;
- Clear protocols are in place for collaboration between specialist learning disability services and specialist mental health services;
- For dual diagnosis clients, the health action plan will equate with the care plan. Care coordinators should have expertise in both mental health and learning disabilities. There will be close collaboration between psychiatrists in the relevant specialities;
- If admission to an assessment and treatment facility is unavoidable, specialist staff will help the patient understand and cooperate with treatment.

**Table 3.6: Summary of *Valuing People* (taken in part and adapted from the Royal College of Psychiatrists (2003))**

In order to help mental health and learning disability services implement the NSF for dual diagnosis clients, the Department of Health and the National Institute for Mental Health in England published *Green Light for Mental Health* (DH, 2004). (This is also known, and referred to later in this thesis, as the *Greenlight Toolkit* or GLTK). This provided a framework and a self-audit toolkit for services to determine where they were at in relation to an overall picture of how things ought to be. It was anticipated that this would enable trusts to establish which services were working well for clients and where improvements were needed (Care Quality Commission, 2010). Table 3.7 highlights the key requirements of the toolkit.

| | |
|---|---|
| 1 | Local partnerships with primary care service |
| 2 | Local partnerships with people with learning difficulties |
| 3 | Local partnerships with carers of people with learning disabilities |
| 4 | Agreed criteria and boundaries between services |
| 5 | Transition Protocols |
| 6 | Police and criminal justice services |
| 7 | CPA - Sharing information and accessing Care Pans |
| 8 | CPA - Person-centred and whole life |
| 9 | Culturally specific services |
| 10 | Workforce Planning |
| 11 | Representative Workforce |
| 12 | Mental Health Promotion |

**Table 3.7: The twelve key requirements of the *Greenlight Toolkit* (DH, 2004)**

Points were to be awarded to trusts for achieving 'amber' or 'green' status on each of the indicators and for having a plan in place for the full implementation of a requirement where it had not achieved a 'green' status. The scores were to be monitored by the Care Quality Commission which was also assessing the quality of, and equity of access to, services for learning disabled clients following the publication of *Healthcare for All* (DH, 2008c) and *Death by Indifference* (Mencap, 2007) reports, which had highlighted deficits in NHS care for this client group.

### 3.4.1. Literature Review on CPA Implementation for Clients with a Dual Diagnosis

A search for information about progress on implementing CPA for dual diagnosis clients was carried out using the same databases and search terms as described earlier, but with the addition of 'learning disability' and 'intellectual disability'. The search revealed just four research studies, three of which were audits (Bhaumik et al, 2005; Brooks et al, 2005; Ali et al, 2006) and one a discussion of a national survey undertaken by Patton and reported in Roy (2000)(see table 3.8). Like the literature on the implementation of CPA in mental health settings the studies primarily focused on risk assessment and management issues i.e. whether clients had received a care plan and whether there were updated risk assessment and risk management plans in place (as expected of CPA). There were also numerous commentary and editorial pieces that were not based on empirical evidence. There was no literature exploring the implementation of CPA for this client group from the perspective of people charged with determining CPA policy or preparing for its implementation from a strategic viewpoint.  Nonetheless the commentaries and editorials are discussed here as they illustrate the inconsistency in the application of CPA for this client group and the importance, or lack thereof, that professionals working in the field appear to have placed on its implementation at a local level.

| Author(s) | Study Details | Key Findings |
|---|---|---|
| Ali, A. Hall, I. Taylor, C. Attard, S. Hassiotis, A. (2006) | A retrospective audit of CPA carried out between 2002 and 2005 to evaluate implementation of CPA in two inner-London learning disability services.<br>Clients notes were reviewed and an audit questionnaire completed by front-line practitioners. | In 2002 only 35% clients on enhanced CPA in area A and 33% in area B.<br>Over the three years the audit showed a gradual improvement in the numbers of clients placed on CPA across both services.<br>Weaknesses shown in completing or updating risk assessment and the availability of an updated care plan every 6 months. |
| Bhaumik, S. Nadkarni, S. S. Biswas, A.B. & Watson, J.M. (2005) | A small retrospective audit to evaluate the effectiveness of CPA in adults with learning disabilities by auditing in-patient records over a 6 month period.<br>Questionnaires sent to professionals of clients admitted to specialist in-patient unit and a separate questionnaire to their carers.<br>15 clients in total – 100% response rate from staff with 14 questionnaires (out of 15) returned from carers.<br>CPA only in place on unit for 6 months. | 87% (n=13) clients received CPA screening on admission.<br>80% (n=12) received CPA screening pre-discharge.<br>60% (n=9) had CPA planning meeting before discharge.<br>27% (n=4) had a risk assessment pre-discharge.<br>All professionals involved with 12 clients were aware of CPA screening proforma whilst the staff for the other 3 were unaware of it. |

| | | |
|---|---|---|
| Brooks, D. Spiller, M.J. & Bouras, N. (2005) | An audit in the South Thames region to evaluate practice in the delivery of CPA, the assessment and management of risk and other key policies in learning disability community services. To also identify areas where CPA and risk assessment/management standards were not being met and make recommendations for service development.<br>Fifteen trusts (19 separate services) took part, including Primary Care Trusts and mental health and learning disability trusts.<br>Used a structured interview tool - 19 professionals interviewed (1 from each service area); 8 consultant psychiatrists and 11 managers. | Levels of CPA implementation:<br>32% (n=6) had complete formal implementation<br>32% (n=6) had incomplete formal implementation<br>36% (n=7) had no formal implementation.<br>Complete formal implementation occurred in specialist mental health learning disability teams within mental health and learning disability trusts.<br>PCTs and community learning disability teams were less likely to implement CPA.<br>Minimal protocols for CPA implementation or joint working between learning disability services and mental health services. |

|  |  |  |
|---|---|---|
| Roy, A. (2000) | Reported a national survey of learning disability services undertaken by Patton. | A national survey of learning disability services.<br>80 responses to a questionnaire regarding the use of CPA in learning disability services found that only 29 provided CPA.<br>Of this, 24 had a risk assessment, 15 provided CPA for people with a dual diagnosis<br>36 not providing CPA – as commissioners and local managers had not asked them to. CPA seen as not relevant to this client group – i.e. it was for mainstream services and this client group did not have mental health issues. |

**Table 3.8: The key empirical literature on the implementation of CPA for learning disability clients**

In a study by Patton (reported in Roy, 2000) 80 responses to a questionnaire in a national survey of learning disability services were received regarding the use of CPA in learning disability services. Of those 80 only 29 services were providing CPA and 36 did not provide CPA at all. The reasons for this, as explained by the participants, were that they had not been asked to use CPA by their managers or commissioning bodies and that many deemed CPA to be irrelevant for clients with a learning disability. (Unfortunately the description of the study is limited to what is mentioned here. A number of attempts to contact Patton to locate further details were unsuccessful and therefore the study cannot be critiqued or discussed further).

In the first of the aforementioned audits, Bhaumik et al (2005) attempted to evaluate the effectiveness of CPA (including risk assessment and management) for adults with a learning disability in a specialist treatment unit. They found that, of the 15 notes audited, 87% documented that the client had a CPA screening on admission. However only 60% of the same clients had a pre-discharge CPA meeting. Bhaumik et al (2005) surmised that these findings indicated deficiencies in CPA screening, particularly around risk issues, which meant that care arrangements were potentially inadequate once clients were discharged.

In the second audit, Ali et al (2006) carried out another small retrospective review of clients' notes evaluating the implementation of enhanced CPA. In the two learning disability services audited, the percentage of clients placed on enhanced CPA was 35% and 33% respectively. Although the study showed gradual improvements over four years (achieving 10 out of 13 care standards set by the team between 2002 and 2005) the authors indicated that there continued to be weaknesses in areas around updating risk assessments and the regular review of (CPA) care plans.

In the largest of the three audits Brooks et al (2005) reviewed practice in the delivery of CPA, assessment and management of risk, and other key policy targets in community learning disability teams in an attempt to identify areas where CPA and risk assessment/management standards of implementation were not being met. Despite it being the largest in terms of the studies found (19 services from 15 different trusts) there was only one participant per service interviewed and therefore the findings may be prone to participant bias. Of the services included in the audit, Primary Care Trusts and community learning disability services were less likely to implement CPA compared to mental health trusts, combined mental health and learning disability trusts and mental health learning disability teams. The key findings from the audit are presented in table 3.9.

Services which were less likely to implement CPA were also less likely to:

- Implement risk assessment and management plans
- Have good information sharing systems
- Have access to a wide variety of in-patient services for their client group
- Have comprehensive multi-professional training (including risk training)
- Have comprehensive discharge and transfer mechanisms
- Integrate CPA, risk assessment and management
- Undertake a needs assessment of clients
- Follow up clients within 7 days post-discharge
- Have joint working protocols across services
- Adapt CPA policy for specific client groups
- Have protocols in place to ensure 24hr access to mental health support
- Admission facilities low and variable especially for clients who offended or had challenging behaviours.

Services which implemented CPA were more likely to:

- Have appropriate care planning standards
- Engage clients in care planning process
- Have appropriate discharge and transfer policies
- Have integration between health and social services in the assessment and delivery of care through CPA, care management and Section 117 aftercare arrangements.

However these services still lacked:

- A unified assessment and eligibility criteria
- Unified assessment and treatment procedures
- Coordination of responsibility
- Common risk assessment and management procedures
- Have common information systems.

**Table 3.9: Key findings from Brooks et al (2005)**

From these findings two key issues emerge. Firstly a lack of implementation of CPA procedures appears to impact on wider joint-working practice, procedures and policies with the most vulnerable and complex clients (offenders and those with challenging behaviour) being particularly affected by a lack of admission facilities. Secondly, even services which were more likely to implement CPA had problems with coordinating and combining assessment procedures. More fundamentally, however, they also appeared to have different eligibility criteria and coordinated their respective responsibilities separately. This had the potential to lead to uncoordinated service provision resulting in clients with the most complex needs not receiving the service they needed. These shortcomings even in areas where CPA was in use led Brooks et al to observe that "the implementation of CPA in learning disability services has been shown to be limited" (Brooks et al, 2005, p5).

The serious potential impact of this limited and inconsistent coordination of services in the implementation of CPA was noted by Roy (2000) when he declared that "people with mild LD may find themselves falling between the two stools of learning disability and general adult services..." (p384). He argued that their complex mental health needs should be managed jointly between services and in order for CPA to be successfully used "it is vital that there is joint working between health and social agencies in both the learning disability and generic mental health services…" (p385). However Simons and Russell (2003) in their study of partnership working between mental health and learning disability services found that there were often disputes between agencies around roles and responsibilities, access to long-term placements, patients being transferred from mental health to learning disability services (and not other way around), complex clients not 'fitting' into any particular services and ongoing boundary disputes across organisations.

Part of the underlying issue, as Hemmings (2008) points out, is that there is a general lack of research in the area and in particular into the effectiveness of community services. This lack of research "together with the inexcusable failure of many community intellectual disability services in the UK to implement the recognised national care standard of the Care Programme Approach (which) can be considered important forms of disempowerment" (Hemmings, 2008, p461). Brooks et al (2005) therefore called on services to ensure that there are appropriate local service delivery models for this service user group. However a key barrier to this provision has been a failure to address inter-organisational barriers between services which has led to dual diagnosis clients being under-served, experiencing unnecessary hospital admissions and delays in community placements (Moss et al, 2000).

### 3.5. Conclusion

This chapter has shown that the Department of Health has continued to reinforce CPA as the approach through which all clients known to secondary mental health services should receive care, despite mounting evidence questioning its effectiveness.

At a front-line level it has been shown that the policy's introduction into services was particularly problematic, with inconsistencies across localities and questions raised about its clinical effectiveness, the lack of supporting mechanisms for its implementation and the increased bureaucratic processes experienced by front-line professionals. All these issues were underpinned by the fact that the underlying philosophy of CPA was unclear, with the consequence that services repeatedly failed to implement CPA at the front-line. Unfortunately it was those clients with the most complex needs and, in particular, those requiring a multi-agency approach to care who appear to have been particularly affected by these issues. Clients with a learning disability are one such group and it has been shown that research exploring the implementation of CPA for this client group is severely limited.

The inability of professionals to work together through CPA processes may have been indicative of more strategic issues. However the literature on CPA implementation for mental health clients has been shown to focus primarily on the front-line level, despite the fact that some of the key issues identified in this chapter indicate that problems of implementation may actually originate at the strategic or meso-level (e.g. service integration, access to financial resources). There is no literature exploring the implementation of CPA for dual diagnosis clients from the perspective of people charged with determining CPA policy or preparing for its implementation from this strategic viewpoint. More information, focusing on the effects of strategic-level issues on policy implementation, is therefore required. The aim of the study reported in this thesis was to contribute to knowledge in this field by exploring the factors shaping the local implementation of the adoption of the Care Programme Approach (CPA) for clients with a dual diagnosis from this meso-level perspective. It was also anticipated that the study would provide a picture on the state of implementation for this client group and would enable comparisons to be made with the original implementation of CPA in the 1990s, to determine whether lessons have been learned from the implementation process in the intervening years.

The next chapter explores the literature on more generic issues of organisational change and partnership working, which was reviewed here in order to identify potential facilitators and obstacles acting at the meso-level of policy implementation that might help inform the design and analysis of this study.

## Chapter 4: Organisational Change and Partnership Working

### 4.1. Introduction

Chapter 3 has shown that the first implementation phase of CPA required professionals and their respective organizations to work differently to accept a way of working which was not the same as they had done before. The changes in working practices and organisational structures were further complicated by the fact that they were to occur across a number of organisations which would have to work in partnership with each other.

This chapter therefore first looks at some of the key literature on organisational change and then considers the national policy on partnership working. It considers the relevance of this key literature to the implementation of CPA. The research evidence on partnership working is synthesised and insights are drawn to inform the planned investigation of implementation for clients with a dual diagnosis.

### 4.2. Organisational Change

The seminal literature on organisational change comes generally from the mid-1970s through to the 1990s. Although more recent theorists in the field have built upon the original works from that time, much of the contemporary theory of change writing draws heavily on the original literature. Historically the audience for this work was in the business field. However, since the late 1990s there has been a shift within health care to understand how key learning from this field could be applied to the NHS.

In 2001, Iles and Sutherland's comprehensive summary of the literature on organisational change made much of this literature accessible for health care audiences (Iles and Sutherland, 2001). Their review typologised the changes that organisations (both private and public) may undergo over time (see table 4.1).

| |
|---|
| Emergent or Planned |
| • Emergent change unfolds in a spontaneous and unplanned way and may be the result of factors which are internal or external to the organisation although it is more common for this particular type of change to originate from outside the control or influence of people working within the organisation itself.<br>• Planned change, as identified by Nadler and Tushman (1989), is generally initiated by leaders or managers within the organisation but can be traced back to factors external to the organisation e.g. a change in legislation. |
| Episodic or Continuous |
| • Episodic change groups together change that is infrequent, discontinuous, and intentional, and occurs during periods of divergence when organisations move away from, what are described as, equilibrium conditions. This type of change may be the result of perceived environmental demands or events or may also occur due to internal organisational changes.<br>• On the other hand continuous change tends to be ongoing, evolving and cumulative with the emergence of a new pattern of organising. This type of change generally takes the form of small continuous adjustments occurring simultaneously across individual organisational units or departments but have the potential to accumulate and create substantial change (Weick and Quinn, 1999). |
| Developmental, Transitional or Transformational |
| • Developmental change may be planned or emergent and often focuses on improving skills or processes within an organisation.<br>• Transitional change seeks to achieve a known desired state that is different to the existing one and, in this circumstance change is generally episodic and planned.<br>• Transformational change is generally viewed as radical and requires a shift in the assumptions made by the organisation and its members. With such change the organisation may differ significantly in terms of structure, process, culture and strategy (Iles and Sutherland, 2001). |

**Table 4.1: Types of organisational change (Iles and Sutherland, 2001)**

The types of change identified in table 4.1 are not mutually exclusive, and Iles and Sutherland (2001) suggest that there are areas of overlap across and between them. This becomes apparent when one considers their relevance for the original implementation of CPA as described in the literature presented in Chapter 3. The characteristics of that change process can be classed primarily as planned, episodic and transformational.

- 'Planned', because the implementation of CPA in the 1990s was a deliberate policy shift in response to growing pressure from the public and media which raised increasing concerns about the care and follow-up of mental health clients.

- 'Episodic', because the implementation was a one-off policy which was intentional and required more than minor adjustments across services, particularly in relation to ensuring that services were working in partnership and had integrated processes for the provision of health and social care.

- 'Transformational', because CPA challenged traditional roles and assumptions made by NHS, social service organisations and the professionals working within them. Organisations were expected to work in partnership with each other and consider a more holistic perspective on client care incorporating both health and social needs.

Although change may be typologised in this way, theories of change do not necessarily employ the same categories, with much focus in the literature on the challenges that can come from numerous angles, irrespective of the change type. With the view that change processes are made up of three-intermeshing systems; the individual, the organisation itself, and the environment in which it exists (March, 1981; Maddock and Morgan, 1998; Buchanan et al, 2005), one might expect challenges to CPA implementation to come from each of these areas.

Senge et al (1999) identified three key challenges to change which could be useful in illuminating the CPA implementation process (see table 4.2).

| |
|---|
| • Initiating challenges<br>• Sustaining<br>• Systemwide design and rethinking |

**Table 4.2: Challenges to change (Senge et al, 1999)**

From this perspective it appears that the challenges faced when implementing a change strategy can commence at the initial introductory stages and continue through to the final phases of change which require more visible outcomes throughout the organisation. In the case of an initiative such as CPA, challenges may therefore be anticipated at the commencement of the implementation strategy at an organisational level and be present when it is to be put into action in local front-line teams.

A key challenge to change initiatives as highlighted by Markus (1983) (a specialist in organisational issues particularly around the introduction of e.g. new information systems) is that initiators of change programmes often fail to consider the impact that change may have on all levels of the organisation (a view supported by others, albeit using different terminology e.g. Robbins et al, 2010). Markus (1983) suggested that resistance was therefore likely from four key areas (see table 4.3).

| |
|---|
| • People focussed resistance may be present due to the attitudes, values and perceptions of individual staff within the organisation.<br>• System focussed resistance may be due to new systems being complex or not user friendly. This may be particularly an issue if the initiative is introduced without the appropriate education and training of staff.<br>• Organisational focussed resistance may be seen when new systems do not integrate with the current organisational structure, culture or technology.<br>• Finally politics focussed resistance comes from the organisational power structure and resistance to change may be present from particular individuals or groups who may lose power as a result of the proposed change. |

**Table 4.3: Resistance to change (Markus, 1983)**

The barriers to CPA implementation, identified by North and Ritchie (1993) in the 1990's (see table 3.2), fit with this model. Resistance, or barriers, to CPA were found to crosscut all levels of the organisations involved and ranged from a lack of proper training in CPA for the professionals involved, to a lack of integration at an organisational level between health and social services. From North and Ritchie's study it is clear that resistance to CPA did not come from a single area for example from either the people or the organisations implementing it, but from across all four key areas, or levels, as outlined by Markus (1983). This highlights the complexity of attempting to implement changes, such as CPA in health and social care settings and the importance of considering the impact that they may have on the organisations and localities in which it is to be implemented. Such issues are likely to be relevant again during the implementation process for dual diagnosis clients.

However it may be that organisations, having previously implemented CPA, undertook a process of learning in which the current round of implementation is informed by that undertaken previously in the 1990s. This 'double loop learning' (Argyris and Schon, 1978) requires organisations to have learned from their previous experience and to have adapted their processes and structures to deal with the change and any future similar pressures. Senge (1990) identifies some characteristics of ‘learning organisations’ (see table 4.4).

- Existence of a common and shared vision in which personal self-interest and departmental interests are sublimated so everyone works together.
- Old ways of thinking and old routines of work are discarded.
- Stakeholders think of all organisational processes, activities and functions as part of a system of connected interrelationships.
- There are open lines of communication across horizontal and vertical boundaries.

**Table 4.4: Characteristics of ‘learning organisations’ (Senge, 1990)**

There is no evidence from the CPA literature that anything similar to such a ‘double learning loop’ process was employed when CPA was originally introduced into mental health services, primarily because it was a new system at that time. However, as CPA has become embedded in mental health practice and learning organisation processes have become more mainstream, it may be something that has been used to assist the current implementation process for clients with a dual diagnosis.

As change processes occur within organisations which are based within an environmental context there is a need to have an understanding of the wider setting (Nadler and Tushman, 1989: Weick and Quinn, 1999). The next section therefore outlines the Government’s expectation of how health and social services would work in partnership as policy in the area developed from 1997 to the present. It explores how partnership working was itself a new system of operating for these organisations which was a major change in its own right (Carnall, 2003). The literature on the factors which appear to help (or hinder) partnership working is explored, some of which are similar to the characteristics of Senge’s (1990) learning organisations as previously outlined in table 4.3.

## 4.3. Partnership Working between Health and Social Services

In 1997 the then Labour Government sought to redirect the NHS away from the internal market system of the previous Conservative Government. It saw this as having created unnecessary bureaucratic processes which diverted services away from clients. Although the government did not seek to restructure organisations or their boundaries it intended to bring down what it described as “the Berlin Wall” between health and social services to enable clients who “do not fit into neat service categories” to be placed at the centre of service provision (DH, 1998a: para 6.5). This new ‘Third Way’ (Giddens, 1998) was “based on partnership and driven by performance” (DH, 1997a: para 2.2) and sought to be an altogether more collaborative healthcare system which would offer a “new model for a new century,” (DH, 1997a: para2.3).

Through a system of integrated care between health and social services, organisational boundaries which prevented patients from accessing services were to be removed (DH, 1998b), a process very much in keeping with the drive for the integration of services so that CPA could be implemented more effectively (DH, 1995a**)**. The *Partnership in Action* (DH, 1998b) report emphasized that joint working across organisational boundaries was needed at three levels: in the strategic planning, commissioning and provision of services. To achieve this a new Health Act was created in 1999 (DH, 1999e) in which joint working would be made more practicably possible through the pooling of budgets, lead commissioning and the integration of service provision (see table 4.5).

| |
|---|
| Pool Budgets |
| Health and social services were to be able to combine their resources into a single budget which either service could access to commission and/or provide services. It was anticipated that this would enable staff to have easier access to funds in order to provide integrated care packages. |
| Lead Commissioning |
| This was to enable either the health or social service authority to transfer funds and delegate functions to the other so that they could take a lead in commissioning health and social care for their clients. In order to make best use of resources there would be times when service provision and/or commissioning would be best done through a single authority, especially in mental health or learning disability services. The proposal enabled one authority to delegate functions and funding to the other who would take responsibility for the commissioning of services for both health and social care. |
| Integrate Provision |
| This gave power to an NHS, Primary Care Trust (PCT) or local authority to provide health or social care services beyond those which they were then able to provide. It would allow clients to access health and social services from a single provider. It was recognised that the intention of integrating provision was not for one authority to become a significant supplier of services normally under the remit of the other but to allow authorities to provide a range of services which would enhance the clients experience of the care being provided. |

**Table 4.5: The Health Act 1999 flexibilities (DH, 1999e)**

The flexibilities were not mandatory but would enable services to cease functioning as separate and discrete agencies and, in taking on what the government called a ‘whole systems approach’ (DH, 2000), to provide a holistic perspective on the range of different interests and components of complex organisations, helping them to identify the benefits of partnership working. It was anticipated that this would in turn help services to think more widely about clients’ needs, especially those whose needs cut across traditional organisational boundaries.

The Department of Health acknowledged that although there were many examples of partnerships working well, there were no consistent areas of success and no single model of partnership working which could be used as a blueprint for other areas (DH, 1997b). It identified that the creation or development of a seamless service which would work across geographical and organisational boundaries needed to be based on decisions about “care and treatment based on evidence and knowledge of what is successful” (DH, 1997b: 3, para 1.3). Six changes to health and social policy were thus proposed. Two of these; making national standards a local responsibility, and the breakdown of organisational barriers between the NHS and local authorities were central. Although this was a national policy it was anticipated that services would work together in the planning and provision of services to improve care at a local level.

To drive quality and to ensure national consistencies with this approach the *Mental Health National Service Framework* (NSF)(1999a) was later published. Standards four and five of the NSF recognised that the planning, delivery and regular review of comprehensive packages of care were a multi-agency endeavour, therefore requiring local health and social service agencies to translate the national service standards and models into local delivery plans. Services were to effectively manage organisational interfaces and boundaries in the commissioning and provision of better and more integrated services, not only between health and social services but also across primary health care, housing and other agencies such as the independent sector. Any potential organisational barriers were to be removed where they prevented the improvement of services to clients.

The Audit Commission found that many existing partnerships had failed in their objectives to create seamless services for clients (DH, 1998c). The Commission acknowledged that the government’s focus on strengthening partnership working faced many problems including issues to do with capacity problems, organisational change, the lack of alignment of performance management mechanisms between partners and a lack of coterminosity between local authority and Primary Care Trust boundaries. It was this lack of coterminosity, along with the poor coordination of services, which the Department of Health felt impacted on those with the most complex health and social problems. It identified that clients with mental health and/or learning disability issues were particularly affected due to organisational boundaries and a lack of clarity over responsibility for service provision (DH, 1998b).

The *Still Building Bridges Report* (DH, 1999c) published the following year highlighted some of these areas where partnership working had not worked well over the previous four-year period. However these achievements were not widespread and clients with a learning disability in particular continued to experience poor quality care. The White Paper *Valuing People* (DH, 2001a) acknowledged that this was due to major problems with poorly coordinated services and still few examples of partnership working between health and social services. The low priority given to partnership working by these organisations meant that clients were passed between services with little or no agreement or clarity on responsibility for service provision, on service values or objectives, or around joint-financial arrangements despite the Health Act flexibilities (DH, 2001b). NHS services in particular were identified as having failed to previously consider these clients healthcare needs and so clear protocols were expected to be in place locally to enable improved access to services and for greater collaboration and partnership working between learning disability and mental health services. Learning Disability Partnership Boards were given the responsibility to agree plans for using the Health Act flexibilities in ensuring the implementation of this strategy.

By 2004 the *Wanless Report* (Wanless, 2004) found that there was some evidence of partnership working across services but again this tended to be ad hoc and was frequently linked to particular funding streams which were not sustainable in the longer term. This was compounded by mental health services which the Department of Health admitted were not always organised to identify and meet the needs of some vulnerable and high risk groups (DH, 2006).

In 2008 the *Health Action Planning Report* (DH, 2008d) sought to be a fresh stimulus for local authorities and their partner organisations to review the planning and provision of learning disability services and reiterated that services needed to work in partnership through a ‘whole-systems approach’. It identified that a number of mechanisms would be of use to help this process; improved information sharing between agencies, local shared provider agreements and an integrated care pathway approach. The Department expected that services would be "working with partners and collaborating with clinicians" (DH, 2008d, p9) with each level of the respective partner organisations assigned particular responsibilities to support partnership working. There was also a responsibility to engage with partners from other key stakeholder agencies to ensure that services reflected the priorities set out in the government's strategy for learning disability policy, *Valuing People Now* (DH, 2008a).

However just a year later the *Michael's Report* (Michaels, 2008), a cross government strategy for people with learning disability, found that partnership working and communication between agencies, across services and across the boundaries of NHS, primary, secondary and tertiary services, continued to be poor and particularly so for clients with a learning disability, despite the fact that healthcare services for clients with chronic conditions were to be coordinated across agencies and based on power sharing with the clients themselves (Barr and Ross, 2007). The issue of poor inter-agency coordination was compounded by the fact that there were still problems for this client group in accessing mainstream services (DH, 2008a). The Department announced that it would explore how to increase the statutory requirement on public bodies to work with Learning Disability Partnership Boards and review the NSF to consider how they could be best extended to better integrate the mental health care of people with a learning disability into mainstream services.

### 4.4. Partnership Working and the Implementation of the Care Programme Approach

From this description it is evident that the government recognised that there were continued issues with partnership working across services and, despite attempts to resolve these, there was little success. In 1995 a report by the Social Services Inspectorate (DH, 1995a) identified that there were little or no partnership working arrangements agreed between health and local authorities in local implementation processes. The inspection advised that CPA and care management should be coordinated more effectively across services, a process which required further partnership working and the integration of services at some levels. However it wasn’t until 1997 that the drive and policies needed to achieve such partnerships were instigated by government, some six years after CPA was expected to be implemented in mental health services.

By the time of the *Still Building Bridges Report* (DH, 1999c) services had begun to develop, or already had developed, joint health and social service strategies with some use being made of the Health Act flexibilities. The majority of social service departments had also developed integrated teams for mental health service provision, or had begun the planning of such. It recognised that partnerships were most successful in areas where:

- Careful planning had taken place with a named person whose responsibility it was to oversee this process
- There were coterminous boundaries
- A single lead person was recruited to take responsibility for a single geographical area
- There was commitment from senior managers
- There were complementary management arrangements across organisations
- There was agreement on service provision, and where
- There was shared monitoring and evaluation of the partnership process.

These findings were very similar to those of North and Ritchie (1993) in their study of factors affecting the early implementation of CPA as a whole (see table 3.4). This had shown that most progress at implementing CPA policy occurred in areas where there were strong mechanisms in place for partnership working which were themselves supported by the commitment of all partners involved.

However these mechanisms were not nationally widespread and in an effort to address some of the issues identified by services and practitioners alike the Department of Health’s *Modernising CPA* agenda (DH, 1999b) placed a reliance on local health and social services to make use of the Health Act flexibilities to achieve integration, consistency and to streamline service provision to implement CPA. To achieve this services were expected to follow the guidance set out in *Partnership in Action* (DH, 1998b) to:

1. Have shared objectives and a shared sense of responsibility to deliver care across boundaries
2. Provide training, education and support for staff to enable them to develop appropriate competencies
3. Have appropriate systems so that information may be shared across services at both a strategic and operational level through for example compatible information technology systems.

However, even with a new *NHS Plan* (DH, 2000b), and despite the government’s continued attempts to dismantle the “old fashioned demarcations between staff and barriers between services” (p10) the audit of CPA delivery by Brooks et al (2005) identified that there continued to be issues with services working together for dual diagnosis clients. Professor Louis Appleby (the then National Director for Mental Health) in a review of CPA (DH, 2006) therefore reiterated that when more than one service provided support for clients it was the client themselves who were to be the focal point of services, a critical component in the effective implementation of CPA policy which was, the report reiterated, a multi-agency endeavour. No single service or agency was expected to be central in such a system and so the role of CPA and care coordination was therefore to facilitate access to the full range of services available to clients. The subsequent *Refocusing CPA Report* (DH, 2008b) saw this as an example of CPA being part of a ‘whole-systems approach’ which required local protocols for joint working between the different planning systems and provider agencies.

This section has illustrated that the government at this time placed a heavy emphasis on partnership working between health and social care organisations. To support this process it introduced both legislative and policy changes so that organisations could find it easier to work together to meet the needs of the most complex client groups. Despite these efforts, inspections and audits carried out by the Department of Health found continued problems with the effective implementation of partnerships.

The original implementation of CPA also experienced issues with partnership working. For the purpose of my study it is important therefore to bear these issues in mind when reviewing CPA implementation for dual diagnosis clients. In order to gain a better understanding of the key factors facilitating or preventing mental health and social services from working in partnership, and to determine whether they may have a bearing on CPA implementation, the next section considers the evidence base on ‘partnership working’ and what is known about the factors that affect its implementation.

### 4.5. Factors Affecting Partnership Working: The Research Evidence

This section presents the literature on the key factors found to affect partnership working across health and social care organisations following a computerized literature search (see table 4.5). The key mental health databases (Embase and PsychINFO) were searched alongside the more generalist databases (CINAHL, Medline, Cochrane, Social Policy and Practice). The primary keywords used were: ‘partnership working’, ‘joint-working’ and ‘collaboration’ in various combinations to locate articles relevant to partnership working across health and social care organisations within the United Kingdom. Empirical research from outside the United Kingdom was excluded due to differing health care systems. A number of articles were included which focused on the collaboration of partners from an interactional or personnel level. This was because the literature on partnership working indicated that an understanding of partnership working from those charged with collaborating was important. In total 376 articles were located and reviewed, of which 33 were deemed relevant for this study. A full list of those used for this study is located in Appendix 2.

Much of the literature on partnership working dates from the mid-1990s to mid-2000s as this was when the Labour Government promoted it across health and social services. There is a vast literature covering many different aspects of partnership working including empirical research, opinion pieces from personal experience and systematic literature reviews. It covers relationships between services including primary care (e.g. Holtom, 2001), a variety of topics including e.g. health promotion (e.g. Pavis et al, 2003), partnership from the perspective of service integration (e.g. Hardy et al, 1999; Glenndinning, 2002), or from the perspective of collaborative processes at an interpersonal level (e.g. San-Martin Rodriguez et al, 2005). For the purpose of this study I have drawn on some of this literature but have primarily focused on those studies which were empirical. I have also drawn on reviews which were, for the most part, undertaken in a systematic manner. This was so that a more rounded and synthesised picture of the factors that could potentially affect partnership working could be drawn.

The empirical literature appears to support much of what the government strategies and policies stated were necessary for effective partnership working. Table 4.6 therefore presents the key factors found in these combined government and research literatures. Separated under three broad headings: contextual factors, developmental factors and personnel factors, they draw on the work of Wistow and Hardy (1991), Holtom (2001) and Cameron and Lart (2003). It also draws on the work by Hardy et al (2003) in their development of the Partnership Assessment Tool (PAT) which is discussed further in Chapter 5. It is important to note that many of the factors identified in the table are similar to those factors which were discussed earlier in the chapter as potential challenges to change in organisations (table 4.3). There are also similarities to the factors identified as characteristics of 'learning organisations' (table 4.4).

| Contextual factors |
|---|
| • The coterminosity of geographical boundaries<br>• History of joint working<br>• Governance & accountability arrangements<br>• The availability of finances & resources<br>• Information technology & information sharing<br>• User focus & involvement |
| Developmental factors |
| • Clear joint goals, aims & objectives<br>• Shared vision, understanding & commitment<br>• Shared strategies & policies |
| Personnel factors |
| • The commitment of staff & key people<br>• Roles, power & authority<br>• Staff networking<br>• Staff turnover<br>• Cultural differences<br>• Staff education & training<br>• Reward |

**Table 4.6: The key factors impacting on the effectiveness of partnership working (Wistow and Hardy, 1991; Holtom, 2001; Hardy et al, 2003; Cameron and Lart, 2003)**

Contextual factors provide the background setting in which the partnership operates and may be systemic or organisational in nature. The partnership may be able to influence some of these whilst others it may not. Developmental factors are those which enable the partnership to create a joint-vision of what it intends to achieve and translate that into practical policies and strategies. Personnel factors are those which are related to staff involvement in the partnership process and who are charged with taking the agreed policies and strategies forward. As with the contextual factors some of these, and in particular cultural differences, may be influenced by factors external to the partnership group.

### 4.5.1. Contextual Factors

#### 4.5.1.1. The Coterminosity of Geographical Boundaries

The coterminosity of geographical boundaries has been found in some studies to aid the partnership process (e.g. Hardy et al, 1999; Callaghan et al, 2000; Hamer and Smithies, 2002; Rummery and Coleman, 2003) as a lack thereof can mean that within a single geographical area there is the potential for a number of accountability arrangements across the partner organisations (Rummery and Coleman, 2003). Without coterminous boundaries Hamer and Smithies (2002) found that organisations found it more difficult to create pooled resources and made it more difficult for partnering organisations to balance strategic expectations with the work they did at a local level.

#### 4.5.1.2. History of Joint Working

However even if organisations did not share the same geographical boundaries Callaghan et al (2000) and Cameron et al (2007) both found that a previous history of positive joint-working had the potential to help organisations develop an awareness of what each could offer to the partnership agenda and enable a realistic view on what each could potentially achieve from the partnership itself. However they advised that it was necessary to view this within the context of a series of other inter-organisational interactions, both past and present, and they suggest that use must be made of the experience of individuals who have previously helped develop shared priorities across organisations (Callaghan et al, 2000; Cameron et al, 2007). This view of prior learning from past partnerships was also supported by Evans and Killoran (2000) who found that organisations needed to have applied lessons learned and experience gained to contemporary partnership arrangements. This, they advised, was so that newly created partnerships were continually responsive, in a creative and flexible way, to changing environmental, organisational and political agendas.

#### 4.5.1.3. Governance & Accountability Arrangements

One of the first steps to achieving such flexibility was an agreement between partners on the governance and accountability arrangements of the partnership. However, as Hardy et al (1999) point out, health and social services "operate within a framework of central-local relationships which are constitutionally separate" (p89). The NHS is funded through national taxation and is therefore accountable to the Department of Health. Local Authorities are funded, not only through national taxation, but also from local council taxes. This makes them accountable to the local electorate, which Rummery (1999) points out may have an impact on the autonomy of the organisational representative, individual professional practitioners and the organisation itself in terms of how and what decisions it can make.

At the partnership level, Rummery and Coleman (2003) found that NHS staff frequently did not comprehend these differing accountability arrangements which led them to become impatient with social service partners, feeling that they were too slow to respond to change, when in fact they were merely being accountable to the chain of command and accountability arrangements within their own organisation or were simply finding it difficult to balance internal organisational priorities with those of their NHS partners.

Individual accountability was also a particular issue for the participants of Marks' (2007) study on 25 local Strategic Partnerships in the North East of England. The study found that each partner (including the voluntary sector) was not only accountable to its own organisation for decisions made but also to the partner organisations with which it was working. Each organisation had its own decision-making processes and accountability arrangements with confidentiality making it difficult for partners to know what was allowed to be discussed or shared within the partnership. These arrangements were particularly cumbersome for voluntary sector organisations involved, which had to balance the accountability of being community representatives with a strategic role in which they shared the responsibility to meet local and national targets within the partnership. This has the potential to be problematic to partnership working as Milbourne et al (2003) point out that the voluntary sector are under no obligation to adhere to the same performance indicators or centrally prescribed targets as health and social services.

A number of authors therefore advocate having clear, transparent and straightforward governance and accountability arrangements across all partners (e.g. Higgins et al, 1994; Villeneau et al, 2001; Evans and Killoran, 2000; Cameron et al, 2007). A key step towards joint governance and accountability arrangements was the ability of health and social care organisations to make use of the Health Act flexibilities which enabled them to share finances and resources through, for example, pooling budgets (Amery, 2000).

#### 4.5.1.4. The Availability of Finances & Resources

The introduction of pooled budgets, along with the creation of joint appointments, funding of partnership posts and the creation of joint-funding streams have all been shown by Hamer and Smithies (2002) to help with partnership working. However they advised that the Health Act flexibilities needed to be interpreted creatively to make the most out of the freedoms and flexibilities it offered. Although the clarification of resource availability at the outset of the partnership has been shown to potentially assist with understanding the levels of each other's contributions (Higgins et al, 1994) a willingness to commit resources was found, by Glendinning et al (2002), to be difficult to achieve.

Glendinning et al (2002) stated that such financial commitment was viewed by the participants in their study as the most tangible sign of dedication to a partnership. However their study also showed that this was not easy to achieve, with problems around the process for determining the size of each other's financial contributions, the differences between NHS and local government financial management systems, and a general acknowledgement of poor administrative support to fully operate a pooled budget. They also found that if these hurdles were overcome at the partnership level there were wider financial issues at an organisational level to be contended with. These included; different financial planning and audit arrangement times for each organisation; different financial availability; pressures on overall health and social service resources and the commitment of short term funds not being sufficient for long term partnership commitments (Glendinning et al, 2002).

#### 4.5.1.5. Information Technology & Information Sharing

A particular problem for partnerships appears to be reluctance or inability to share information across organisations on the grounds that such sharing could breach client confidentiality. Both Secker and Hill (2001) and Glendinning et al (2002) found that partnerships frequently failed to address or manage these issues effectively, something which Hancock et al (1997) and Villeneau et al (2001) have shown may be alleviated through a joint commitment to information sharing. Villeneau et al (2001) advised that such joint commitment needed to be supported by the wide dissemination of jointly agreed confidentiality and information sharing protocols. However the creation of such formal procedures was not, in itself sufficient to overcome information sharing barriers. Secker and Hill (2001) found that informal networks, which developed within partnerships, also had an important role in easing the process of information sharing between specific partners. However as Glendinning et al's (2002) study noted, even if partners wished to work together, the supporting frameworks (information sharing systems and technologies) were frequently found to be incompatible or non-existent thus adding further technical barriers to attempts at partnership working.

#### 4.5.1.6. User Focus & Involvement

Meeting the needs of clients may involve expertise, knowledge or resources beyond the remit of health and social services and as such the voluntary sector has a key role to play in supplementing, and providing, mental health services for hard to engage clients (Tait and Shah, 2007). With increasing Government pressure to include the voluntary sector there has been concern that the involvement of user groups in partnership processes was merely what Milewa et al (2002: p798) called "ceremonial forms of consultation" rather than true partnership working. The voluntary sector was often found to be involved at the beginning of joint projects but over time became less engaged and less informed about the partnership's progress (e.g. Hancock et al, 1997; Villeneau et al, 2001; Deardon-Philips and Fountain, 2005). These studies indicated that these stakeholders were not given feedback on the implementation of strategies in the partnership following initial consultation phases.

Milbourne et al (2003) suggest that part of this may be explained by voluntary sector partners being regarded as subordinate by the statutory sector, which applies pressure on its partners to conform to its practices and demands. This has also been suggested by Armistead and Pettigrew (2004) who reaffirmed the existence of these power differentials and found that the voluntary sector were often seen as lobbyists rather than as equal partners as a result of differing cultural and accountability arrangements of the sector.

Both Cameron et al (2007) and Marks (2007) found that at a practical level statutory partners were not sharing information with their voluntary sector partners, and this reinforced their perceived inequality and exclusion. Many of these issues they found (as did Milbourne et al, 2003) to be related to the history of the sectors' involvement with the organisations previously i.e. if there was no history of partnership working with the voluntary sector then it was unlikely to occur in the development of new partnerships. As Marks (2007) put it "hierarchical relationships remain, along with determined strategic objectives, partnerships may be framed by previous partnerships set up for different purposes and decision-making structures are not geared to the very different needs of the VCS (Voluntary and Community Sector)" (p145-146).

Tait and Shah (2007) argue that there is a responsibility on both the statutory and voluntary sectors to raise awareness of what the voluntary sector can provide to partnership working. This they suggest may be helped by having greater transparency and more open channels of communication within the partnership itself, a responsibility, according to Gillies (1998) and Milewa et al (2002), of local statutory sector managers involved in the partnership process.

### 4.5.2. Developmental Factors

#### 4.5.2.1. Clear Joint Goals, Aims & Objectives

A good relationship between the partner organisations and project stakeholders, with joint ownership of jointly agreed aims and objectives, has been found to assist the partnership process (Higgins et al, 1994; Rummery and Coleman, 2003; Cameron et al, 2007; Andrews and Entwistle, 2010). According to Evans and Killoran (2000) agreed aims and objectives could be achieved when partners take ownership of the practical steps required, focusing on the assessment of local need and identifying each partner's contribution to the partnership process. However as Higgins et al (1994) and Rummery and Coleman (2003) point out, the aims and objectives need to be clear, achievable, jointly owned and sufficiently robust to withstand changes in personnel or partnering organisations.

Amery (2000) suggest that a partnership's longer term success could be facilitated by articulating and agreeing key aims and objectives at an early stage and the means to achieve them whilst also identifying potential outcomes and milestones. Cameron et al (2007) found that joint working was most effective when professionals not only understood the aims and objectives of what they were doing but also appreciated the fundamental roles of others in the partnership. This requires a shared understanding that they would not be able to meet their clients' needs sufficiently, or achieve their own organisational aims and objectives, by working separately.

#### 4.5.2.2. Shared Vision, Understanding & Commitment

The Department of Health (1999a) observed that the creation of joint goals across partner organisations is a complex process requiring a common vision, strategy and an equal commitment from all partners. To achieve such a unified vision each partner needs to have an awareness of the different priorities, structures, processes and cultures which may constrain their progress (Evans and Killoran, 2000; Rummery and Coleman, 2003).

Although the organisations involved may show a high level of commitment, this may not translate into practical actions as illustrated by Cameron et al (2007) who found that groups expected to work in partnership did not meet regularly and did not have a shared understanding of their clients' needs. This was despite the fact that Armistead and Pettigrew (2004) showed that successful partnerships were driven by the needs of their clients and consisted of people who had a level of personal commitment to the partnership goals and who, in turn, had the support of their respective organisations.

#### 4.5.2.3. Shared Strategies & Policies

Hancock et al (1997) illustrated that joint working was most effective where there were clear joint strategies and policies which were supported by underpinning processes to review their development, implementation and review. However these processes themselves needed to be underpinned, as Hamer and Smithies (2002) suggest, with agreed agendas which took priority in determining resource allocation and were balanced with what was expected of the organisations from a local and national level.

Although Villeneau et al (2001) and Hancock et al (1997) both indicated that there could be some disagreement as to what constituted a policy or strategy, some localities in their studies developed strategies without consultation with other partners. This may be understandable when considering some of the factors found by Hamer and Smithies (2002) associated with attempting to develop joint strategies and policies. These included some of the issues already discussed in this section including governance and accountability arrangements, information sharing processes, the sharing of finances and resources, as well as avoiding short term solutions to achieving targets, agreeing local indicators and targets which aligned with those at a national level, involving local communities in target setting and using shared priorities to help rationalise resources.

The creation of legal frameworks and strategies to support the partnership in developing shared policies has been shown by Glendinning et al (2002) to be very important in enabling partnerships to work together. However these were not stand alone strategies and needed to be underpinned by joint acceptance of, and commitment to deal with, unmet need and gaps in service provision locally.

### 4.5.3. Personnel Factors

#### 4.5.3.1. The Commitment of Staff & Key People

Of course the structures to create partnership arrangements would be insufficient without the individuals to take it forward. In partnerships where a senior manager had been appointed it was found that there was greater direction, progress and commitment to the partnership goals, with the greatest progress in achieving these goals made when services worked together to appoint a single person to take a lead (DH, 1999c). The Department of Health (2009) expected these cross-sector local leaders to develop and deliver local strategies which engaged all stakeholders.

In general the literature suggests that leadership is required to support partners and get them to work within an agreed framework to create a consensus on what the partnership aimed to achieve. To accomplish this, these individuals need to have a high profile across each of the partner organisations, be regularly involved in the work of the partnership, have appropriate leadership skills and be supported by the appropriate authority to make decisions on behalf of each organisation.

Although Hancock et al (1997) found that having key people who were known and trusted helped to transcend any possible suspicion from partner organisations, they also needed to have the ability to make key decisions which, within the partnership, required transferred powers from all partners. However as Higgins et al (1994) found, this type of power transference was not easy to achieve, due to differing accountability arrangements across organisations and some professional staff who resisted being supervised by an individual from a profession or organisation different from their own. This was supported by Armistead and Pettigrew (2004) who found that individual partners often came to the partnership table with their own organisational and hierarchical roles.

To overcome these issues, Rummery and Coleman (2003) suggested that leadership within the partnership needed to be a joint activity in which no single organisation or partner was allowed to take a lead. However the literature in general was more supportive of leaders, irrespective of their organisational background, having strong senior management support to enable them to commit to the partnership goals (Stewart et al, 2003). This organisational commitment and the direct involvement of chief officers was found by Hancock et al (1997) to enable managers to have the delegated authority to plan, commission and develop services. However achieving such support from higher up in the organization was not always easy to achieve, as indicated by the findings of Villeneau et al (2001). They found that there was often a lack of understanding of mental health issues by non-executive trust directors, health authority members and local authority councillors. This meant that they had a poor conceptual understanding of mental illness and therefore the implications of policy and issues within such partnerships were sometimes not fully appreciated.

At a front-line level project champions, who reinforced the work of the designated leader, were found by Evans and Killoran (2000) to have a positive impact on supporting the partnership project amongst operational staff. In terms of personal traits, Villeneau et al (2001) found that these individuals needed to have the ability to see things from the perspective of all partners, have tenacity, consistency, continuity, and flexibility, the ability to deal with practicalities, an understanding of the strategic framework, share responsibility locally, and have a level of seniority in their respective organisation.

#### 4.5.3.2. Roles, Power & Authority

Although the commitment of staff and key people has been shown to be important for partnership working, the literature also suggests that collaboration should be based on the sharing of power and identity and non-hierarchical, with power based on knowledge and expertise rather than on an individual’s or organisation’s role or function (e.g. Henneman et al, 1995: Carnwell and Carson, 2005). As Carnwell and Carson (2005) pointed out, this could be difficult to achieve particularly when previous contact with other agencies, especially across voluntary and statutory sectors, may have led to stereotyping in which each agency expects the other to behave in a way which is not conducive to partnership working.

This can manifest itself within partnerships at an individual level. Partners have been found to assume profession specific roles that impact on the ability of the team to jointly agree aims and objectives and lead to role boundary conflicts between professions and organisations (Secker and Hill, 2001; Hall, 2005). In part this may also be explained by a lack of understanding of each other's roles and inadequate resourcing within the partnership (Secker and Hill, 2001). At an individual level, partners needed time to balance their own role within their organisation whilst taking on a strategic function in the partnership. Time was also needed to adjust to the expectations of the partnership and for others to be aware of these new responsibilities (Rummery and Coleman, 2003). This involved individual partners having a clear understanding and acceptance of their own, and other peoples' roles within their respective organisations, and within the partnership. This itself requires a level of communication, respect, sharing and trust for each other and each other's responsibilities (Henneman et al, 1995; Pavis et al, 2003; Hall, 2005). Hall (2005) found that this could be supported by open communication and leadership skills which recognised the challenges in group dynamics and managed the different professional groups and cultures within the partnership.

Johnson et al (2003) also found that the organisations represented in the partnership needed to have the authority to make decisions on behalf of the organisation as the delegated power of an organisation's representative was viewed as important in decision-making processes (also supported by Amery, 2000; Callaghan et al, 2000). This required the organisations and their senior management to have a level of trust in their representatives (Amery, 2000) and to enable them to work outside the limitations set by their own organisation, its priorities and traditional values (Rummery and Coleman, 2003). Reward systems which recognised group rather than individual achievement and encouraged the use of skills in a co-operative rather than competitive manner were also found by Pavis et al (2003) to help address this issue.

#### 4.5.3.3. Staff Networking

Although formal collaborative processes within partnerships are important, Secker and Hill (2001) and Armistead and Pettigrew (2004) both found that there was also a need to recognise informal networks between partners, as it was these individuals who were the most able to achieve specific partnership goals more quickly. These informal networks could be achieved with the support of senior management encouraging a culture of informal communication between all hierarchical levels (Villeneau et al, 2001). However Pavis et al (2003) found that in some instances partners used formal partnership groups to network and develop interpersonal relationships amongst themselves. Although this networking was positive in the sense that it was used to exchange information about their respective organisations, policies and remits, some partners felt that networking opportunities alone were sufficient justification for the existence of the partnership (Pavis et al, 2003).

#### 4.5.3.4. Staff Turnover

A key threat identified in the literature to the work of a partnership is staff turnover (e.g. Johnson et al, 2003; Pavis et al, 2003; Cameron et al, 2007). Fundamentally, partnerships are based upon the relationships between individuals within the partnership itself. This means that partnership working can be a fragile process as service reconfiguration, or personnel leaving their posts, impacts directly on that relationship (e.g. Cameron et al, 2007). Interestingly Pavis et al (2003) found that staff contracts were often shorter than the time the group was expected to work together and they suggested that staff often left as a result of frustration when the partnership was unable to achieve what it set out to do in that time. Johnson et al (2003) reinforced this point by indicating that staff leaving was itself a contributing factor to partnerships not achieving their goals which, according to Higgins et al (1994), left the remaining partners finding it difficult to manage change as a result of that departure. In general, there is agreement that staff turnover within partnerships results in a lack of continuity in the group and its work, a loss of knowledge related to the specific project and changes in the internal group dynamics.

#### 4.5.3.5. Cultural Differences

According to Carnwell and Carson (2005), mental health policy has placed great emphasis on partnerships between health and social services with joint agreements, community development and teamwork seen as a way to break down what they believe to be professional barriers. It is widely accepted that professions go through a socialisation process in which their occupation is developed, a process involving the creation of boundaries defining what it is the profession does or does not do. Their education instills a common culture which includes the beliefs, values, attitudes, customs and behaviours expected of them by colleagues and reinforced by society's perception of them (Hall, 2005).

The creation of this occupational identity and culture has been shown to be a challenge for partnership working. This has been found to be particularly pertinent when interprofessional and cultural differences arise from different staff working within health and social care models across health and social services (Peck et al, 2001; Secker and Hill, 2001; Johnson et al, 2003). In Peck et al's (2001) study, different professionals had different perspectives on what culture meant, with some seeing it as the relationship between the medical and social models of disabilities while others viewed it as the different history and language of health and social services. To break down the barriers between these cultures it was felt that a shared culture needed to be developed through the formation of a unified vision and the creation of common values and language within the partnership. Team managers within Peck et al's (2001) study felt it was their role to bridge the cultures of health, social services and professional bodies whilst staff felt that a shared culture needed to be developed at a local level between individuals rather than across professions.

The concept, and creation, of a shared identity has also been supported by Carnwell and Carson's (2005) findings, although they warn that the creation of a shared identity may lead to the erosion of traditional and current professional identities which in turn may lead to professionals behaving defensively, resulting in further tensions. The creation of this identity is not straightforward. As Higgins et al (1994) point out, because of these identities, partners find it difficult to develop a shared single framework from which to operate. Their findings indicate that within each organisation there are a number of cultures, each with further sub-cultures, with issues around professionalism leading to some partners not seeing themselves as equal within the partnership. These differences between the partners have been noted to surface early on in the development of the partnership with professionals having a general preoccupation with clinical issues, slowing reform and acting as an early barrier to the partnership (Rummery and Coleman, 2003).

Potential solutions to this issue have been offered by a number of other studies (e.g. Amery, 2000; Peck et al, 2001; Stewart et al, 2003). They include:

- A need to understand each other's organisational and professional cultures at the strategic planning level and at operational level. This required commitment at all levels of the organisation which was shown by giving sufficient time and resources to enable the partners to develop a productive relationship (Amery, 2000).
- Trusting staff and giving them appropriate levels of responsibility and autonomy, thus increasing their willingness to take risks and overcome professional or organisational tribalism (Stewart et al, 2003).
- The creation of a positive team culture by enabling people to work more closely together rather than relying on formal sets of procedures (Stewart et al, 2003).
- Identifying that services needed to work with professions and their meanings and understanding of professional culture. But as Peck et al (2001) advised this should be done with an awareness that these understandings

may extend beyond the boundaries of the organisation and thus be outside of its’ control.

#### 4.5.3.6. Staff Education & Training

Partnership working however is not always most effective within current organisational systems and structures and as such new ways of working might be required to create a clear, shared purpose. Armistead and Pettigrew (2004) suggest that this may involve the development of trust, understanding and respect from all partners and, as such, joint training may be required to meet this end. This joint training has been found to enable staff to be aware of, and appreciate, the roles and responsibilities of each other (Johnson et al, 2003; Stewart et al, 2003). It has also been shown to enable them develop a shared understanding and sustain their commitment and enthusiasm for the partnership (Higgins et al, 1994; Cameron et al, 2007).

The investment in joint training was found by Rummery and Coleman (2003) to allow partners time to develop trust, share values, develop relationships and enabled them time-out to work together to achieve the partnerships’ aims and objectives. The interpretation of joint training however did not need to be literal, with joint secondments or shadowing attachments providing alternative learning opportunities, processes which Amery (2000) found to have a positive effect on partners’ understanding of each other’s roles and organisations.

#### 4.5.3.7. Reward

The public acknowledgement of achievements was also an important factor in motivating developments within the partnership (Hancock et al, 1997), with those who worked across organisational boundaries needing to be acknowledged and rewarded (Armistead and Pettigrew, 2004). Partnership required the involvement and commitment of all and both Amery (2000) and Stewart et al (2003) found that in order to support and sustain this, individuals needed support from senior management and to be rewarded for their innovation in working across organisational boundaries. However Pavis et al (2003) and

Carnwell and Carson (2005) both advise that to enable partnerships to work co-operatively rather than competitively reward systems should recognise group rather than individual achievement.

## 4.6. Conclusion

This chapter has outlined some key theories of change, the policy trajectory of the previous Labour Government's imperative for health and social services to work in partnership to deliver client-centred care across numerous organisations, and some of the evidence on key factors that influence the success of such a strategy. It has also shown that the factors identified in the literature on successful partnership working appear to align with the factors associated with the successful implementation of CPA policy. However this did not happen when CPA was first introduced despite the government recognising that partnership working was key to its successful implementation

The factors identified are numerous and complex and this may be a key reason why effective partnership working across health and social services has been found to be consistently challenging to the organisations involved. It is important therefore to be aware that these issues may still exist and as such the potential that they may impact on the implementation of CPA for dual diagnosis clients needs to be considered.

This chapter has also identified that many of the factors essential for effective partnership working are similar to the characteristics associated with 'learning organisations,' whilst factors potentially impeding partnerships show some similarity to resistors to change initiatives. Table 4.7 synthesizes these insights into a list of likely challenges to, and factors affecting, the implementation of CPA for dual diagnosis clients in the current context. It also includes the key factors found to affect the implementation of CPA from the 1990s, as identified in Chapter 3 (table 3.10). In the next chapter these are used to inform the research design of the current study.

As outlined in Chapter 3 the aim of this study is to explore the factors shaping the local implementation of the adoption of the Care Programme Approach (CPA) for clients with a dual diagnosis from a meso-level perspective. Bringing the literature and insights gained over the last two chapters together, it is worth considering whether CPA, as an organisational change, and whether partnership working between mental health and social services have any bearing on the current round of CPA implementation. These insights suggest that the following research questions are relevant to the current study:

- What are the local approaches to the introduction of CPA for dual diagnosis clients?
- What factors (including any organisational, contextual and partnership related factors) appear to have helped, hindered, or otherwise, the implementation of CPA?
- Were these factors identified and acknowledged by those involved in the implementation process?

Chapter 5 presents these as a series of study objectives, and outlines the research method and process undertaken to meet these.

| Key factors affecting CPA implementation | Key factors impacting on effectiveness of partnership working | Resistors to change | Characteristics of 'learning organisations' |
|---|---|---|---|
| | Coterminosity of boundaries | Organisational | |
| Good relationship between health and social services<br>Limited partnership working with other agencies | History of joint working | | Open lines of communication across horizontal and vertical boundaries |
| Service integration | Governance and accountability arrangements | Organisational | Stakeholders think of all organisational processes, activities and functions as part of a system of interconnected relationships |
| Lack of resources | Availability of finances and resources | Organisational | |
| Integration of information sharing and systems | Information technology and information sharing | Systems | Open lines of communication across horizontal and vertical boundaries |
| | User focus and involvement | | Open lines of communication across horizontal and vertical boundaries<br>Existence of a common shared vision |
| | Clear joint goals, aims and objectives | Organisational | Existence of a common shared vision |
| | Shared vision, understanding and commitment | System | Existence of a common shared vision |
| Development of joint working protocols | Shared strategies and policies | Organisational | Stakeholders think of all organisational processes, activities and functions as part of a system of interconnected relationships |

|  |  |  |  |
|---|---|---|---|
| Need for lead development<br>Need for a sustained lead<br>Client and carer involvement | The commitment of staff and key people | People | Existence of a common shared vision<br>Stakeholders think of all organisational processes, activities and functions as part of a system of interconnected relationships |
| Role of key professionals | Roles, power and authority | Political | Old ways of thinking and old routines are discarded |
|  | Staff networking | People | Open lines of communication across horizontal and vertical boundaries |
|  | Staff turnover | People |  |
|  | Cultural differences | Cultural<br>Political | Old ways of thinking and old routines are discarded |
| Induction and training of staff | Staff education and training | People<br>System |  |
|  | Reward |  |  |
| The need for further guidance from the Department of Health |  |  | Open lines of communication across horizontal and vertical boundaries |
| Overlap between initiatives |  | Organisational | Stakeholders think of all organisational processes, activities and functions as part of a system of interconnected relationships |
| Misunderstanding of complexity of CPA |  | System |  |
| Offering in-patient care where insufficient resources |  | System |  |
| Further impetus for implementation |  |  |  |

|  |  |  |  |
|---|---|---|---|
| Need to review and monitor progress |  |  |  |
| Increased bureaucratic processes |  | System<br>Organisational | Old ways of thinking and old routines are discarded |

**Table 4.7: Potential challenges to, and factors affecting, CPA implementation for dual diagnosis clients**

## Chapter 5: Methods

### 5.1. Introduction

This chapter describes the processes that were undertaken to achieve the aim and objectives of this study. It describes the decisions taken on study design. Further sections illustrate how the research site was chosen, the process of entry into the field, discuss the sampling and process of participant recruitment, data collection, and the approach to data analysis. Ethical considerations and procedures are also outlined.

This study aimed to explore the factors shaping the local implementation of the adoption of the Care Programme Approach (CPA) for clients with a dual diagnosis from a meso-level perspective. The objectives of the study were therefore to:

1. Describe and compare local approaches to the introduction of CPA for dual diagnosis clients in selected localities.
2. Identify the various factors (including organisational, contextual and partnership related factors) that appear to have influenced the implementation process in the different localities.
3. Explore how key factors identified as important by participants appeared to help, hinder or otherwise affect the implementation of CPA for this client group.
4. Investigate whether, and how, these issues were acknowledged and dealt with by those involved in the implementation process.

### 5.2. Study Design

The study was conducted in a Mental Health NHS Foundation Trust in England which was implementing a joint mental health and learning disability CPA policy in five different localities within its catchment area. For the purpose of this study the localities are referred to as Localities A, B, C, D and E.

The study used a ‘case study’ approach (Yin, 2009), analysing and comparing the process and experience of CPA policy implementation within each of the localities.

A single-case study design was chosen in which there were multiple units of analysis. This is known as an embedded case study design (Eisenhardt, 1989; Yin, 2009). The Trust was the single-case and each of the five localities were classified as the embedded units of analysis. The Trust was therefore disaggregated for the purpose of analysis and could be described as an instrumental case i.e. chosen to answer specific questions about factors influencing CPA implementation. In such cases it is the underlying issue it exemplifies (i.e. CPA policy implementation) rather than the case itself which is important (Bergen and While, 2000). This is so that inferences beyond the single-case may be made. Therefore it is the phenomena of CPA implementation, and not the case itself, which has driven the study (Ellis, 2004).

The study aimed to be explanatory in nature, presenting data bearing on cause-effect relationships and exploring how events shaped the policy implementation process (Yin, 2003). A priori constructs, which were drawn from the research literature presented in the previous chapters, enabled the creation of a framework for analysis and for the comparison of the constructs from the wider literature with those of the Trust.

The use of multiple data collection techniques added stronger validation of constructs and hypotheses (Eisenhardt, 1989). In line with the aim of the study the qualities of the chosen methods determined the ability of the findings to have a representative value to the wider field. Providing a detailed description of the Trust enables others to perceive how representative of the wider society this particular case is (Hamel et al, 1993).

The defining features of a case study are the multiplicity of perspectives which are context specific (Lewis, 2010). Case study design can therefore create a very detailed in-depth understanding where no single perspective is able to provide a full account of the research issue, and where this understanding needs to be "holistic, comprehensive and contextualised" (Lewis, 2010, p52). This is in keeping with Yin's (1981) original view that the distinguishing characteristic of a case study as a research strategy is that it attempts to examine a contemporary phenomenon within its real-life context particularly when the boundaries between context and phenomenon are not clearly defined i.e. the CPA policy implementation strategy may not easily be separated from the Trust and the organisational and other factors which influence it.

In keeping with the particular features of the single-case study method, as outlined by Lewis (2010), the Trust was chosen as the single case or ‘bounded system’ (Stake, 2000), the study is detailed, the issue of CPA policy implementation is studied within the context of the Trust, and a number of data collection methods were used which converged to support triangulation (also recommended by Yin, 2009). The qualitative methods, i.e. the interviews and documentary analysis, chosen for this study aligned with those of case studies more generally in which the aim is to address the “practical and policy questions that impinge on the lives of professionals, particularly where those questions are concerned with how or why events take a particular course” (Keen & Packwood, 1997, p66).

The responsibility for developing and implementing the CPA policy in front-line areas had been delegated by the Trust to those working in specially formed mental health and learning disability Steering Groups in each locality. These also had the responsibility of working with various partners to work through the *Greenlight Toolkit* (DH, 2004). Membership of the Steering Groups was expected to include various health and social service representatives (e.g. chairperson, lead clinicians, administration and local, middle and senior management representatives) as well as professional representatives from external voluntary agencies (e.g. client and carer agencies). Each group was also expected to have two joint chairpersons, one from health services and one from social services. Chairpersons had been asked to take positions on the Steering Groups by more senior managers in their respective organisations. Other members had then been invited to attend by these chairpersons or had requested to attend of their own volition. Voluntary organisation representatives, where present, were invited to participate by the chairpersons of each Steering Group.

The study was organised in two phases. Phase 1 included interviews with key people (including senior managers and Steering Group chairpersons) within the Trust, social services and other organisations involved with the implementation of CPA, as well as the collection of relevant documents for analysis e.g. the Trust CPA implementation policy. It was anticipated that Phase 1 interviews would provide a senior management perspective on the factors influencing the implementation of CPA within the Trust as a whole, whilst interviews with each Steering Group chairperson would provide local perspectives on the same topic. Documentary analysis of Trust-wide policies and local Steering Group minutes was intended to supplement this information by providing an account of factors and issues raised within meetings and how each of these were addressed. Insights from Phase 1 of the study were then used to frame the questions and guide the selection of participants for Phase 2.

It was anticipated that Phase 2 of the study would generate a more local perspective on each of the four objectives. The participants in this phase were staff who had more direct responsibility for local services which were expected to implement CPA and thus would provide a more local viewpoint on factors promoting, hindering, or otherwise affecting the implementation of the CPA policy. It was also anticipated that Phase 2 would enable a comparison of the perspectives of respondents across both phases to identify concordance or differences of perspectives between staff at different levels of the organisation, as well as enabling comparison across organisations in different localities.

### 5.3. Study Site

The Trust chosen for the study was a Mental Health NHS Foundation Trust which covered both a large inner-city and suburban population. Like many mental health trusts in the country it was in the process of working on the development and implementation of CPA for dual diagnosis clients.

Before selecting this Trust, phone calls were made to Service and Operations Directors of a number of different mental health trusts with the aim of finding out where each was at with regard to CPA implementation for dual diagnosis clients and ascertaining whether they would be willing to participate in the study. The Trust selected was chosen following discussions with the Learning Disability Divisional Manager who stated that CPA implementation was being undertaken in the Trust in five different localities, each of which were aligned to different local authorities. Each of these localities were at different stages of CPA development and implementation and were working relatively independently of each other. One of the localities had a particular history of being innovative in mental health policy implementation and had commenced CPA implementation for dual diagnosis clients before many other Trusts had even begun contemplating its development.

It was anticipated that an analysis of current work being undertaken to develop and implement CPA across all these localities would provide an insight into the different factors influencing the CPA policy throughout the stages of its development and implementation.

### 5.4. Entry to the Field

Preliminary discussions about the study and the research process were held with the Trust's Director of Learning Disability Services and the Learning Disabilities Divisional Manager (who was also the Deputy Director for Learning Disabilities and who during the course of the study became the Director). They both agreed in principle for the project to be carried out and gave permission for me to invite potential participants from the five local Steering Groups to interview. The discussions with the Learning Disability Divisional Manager also provided insight into how the Trust intended to organise the policy implementation process and where each locality was at in relation to this process. She also furnished the names and contact details of the relevant chairpersons for each locality and sent an introductory email to each of them informing them about the study.

An honorary contract was negotiated with the Trust for the period of the study.

### 5.5. Data Sources

Data were collected through semi-structured interviews, documentary analysis and the administration of the Partnership Assessment Tool (Hardy et al, 2003). Data collection took place between January and July 2009.

#### 5.5.1. Sampling and Recruitment

The purpose of sampling in qualitative research is “not to establish a random or representative sample drawn from a population but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied’ (Mays & Pope, 1995, p12). A purposive approach to sampling was therefore taken (Miles and Huberman, 1994) whereby respondents were selected on grounds of relevance to the questions driving the research. Potential respondents were identified on the basis of their work roles and their known engagement with the process of CPA implementation either centrally within the Trust or at the local level. Potential respondents were expected to include Trust senior management, Steering Group chairpersons, lead clinicians, CPA leads and representatives from the voluntary sector. The Learning Disability Divisional Manager identified the names and roles of potential respondents for Phase 1. Respondents for Phase 2 of the study were identified through the documentary analysis undertaken in Phase 1 and at interview with the Steering Group chairpersons.

#### 5.5.2. Phase 1

The purpose of Phase 1 was to develop an initial understanding of:

- Existing arrangements (pre-CPA) regarding mental health services for people with learning disability in each of the five localities within the Trust;
- the structure, process and progress of CPA policy implementation; and
- key informants’ perspectives on the effectiveness of partnership working across health and social services.

#### 5.5.2.1. Key Informant Interviews

To achieve these aims and get an overview of the CPA implementation process from a Trust-level perspective, interviews were sought with four key individuals concerned with the implementation of CPA for people with a learning disability (the Director of Learning Disability Services, the Trust Lead for CPA, the Trust Deputy Director of Operations and the Learning Disability Divisional Manager). Three of these board-level senior managers participated. The Trust Director for Learning Disability Services declined to be interviewed, insisting that the Learning Disability Divisional Manager was the most appropriate person to speak with. The Trust Director later resigned from his post during the study period and the Divisional Manager (who had already been interviewed) took on this role.

A fourth person was identified as a key informant as the study got underway. This was the Project Lead for CPA implementation and the *Greenlight Toolkit* for Locality B and they were also interviewed as part of Phase 1. From Phase 1 it was noted that Localities C, D and E had Primary Care Trust representatives on their local Steering Groups (the other localities did not have such representation). However none of these representatives responded to requests inviting them to participate in the study and no senior manager at board level from any of the local authorities could be specifically identified as having responsibility for CPA for this client group in any of the five localities.

As part of Phase 1 it was anticipated that interviews would be held with the chairpersons of each of the five locality Steering Groups to obtain an overview of where each locality was at in the implementation process and to ascertain their views on any issues that might be facilitating or hindering this process. In practice only two of the Steering Groups (Localities A and E) had joint- chairpersons, the others (B, C and D) each had a single chairperson. In total 11, people were interviewed for Phase 1 including all seven chairpersons and joint-chairpersons.

There were two interviewees in this phase who presented with unique circumstances:

- Locality B had a specially appointed project lead to oversee the CPA implementation process. She was interviewed in Phase 1 as a key informant. No other locality had an appointed project lead at the time of data collection.

- Locality E had a lead social worker who acted as joint-chairperson of the local Steering Group. Although she worked with social services she was primarily a health service employee and was classed as such for the purpose of data collection.

The interviews with key informants in Phase 1 of the study focused on generating an inter- and intra-organizational perspective on CPA policy implementation from a senior-level viewpoint. Interviews with local Steering Group chairpersons were intended to consolidate this information to ascertain whether there was a match between senior management ambitions and perspectives and those of the local chairpersons (See Appendices 3 and 4 respectively for the topic guide and interview schedule for Phase 1).

At interview, the Trust key informants and Steering Group chairpersons were also asked to complete a Partnership Assessment Tool (see section 5.5.4.). This was later extended, with amendment to the ethical approval, to also be completed by those who were interviewed in Phase 2 of the study.

#### 5.5.2.2. Documentary Analysis

A range of documents were anticipated to be useful for Phase 1. These included:

- Trust level policy documents e.g. the Trust-wide CPA policy
- Minutes of CPA Steering Groups for the previous 18 months for each of the five localities

- Guidance on policy development and implementation, Trust strategy for learning disability clients with mental health problems and care pathways.

The plan was to use these documents to obtain information about overall strategy and progress with the implementation of CPA over the previous 18 months, about who had been involved in the implementation process and how it was handled in each locality. In practice, obtaining such documentary evidence proved difficult, particularly at locality level. The Steering Groups in Localities A, C, D and E were unable to provide complete minutes for the previous 18 months despite repeated requests to different people including Chairpersons, Steering Group administrators and general members. Locality B provided the only two sets of minutes that they had, reflecting that their Steering Group had only met twice. At Trust level the CPA Manager provided documents including, amongst others, the Trusts overall CPA policy and strategy.

Documents from each locality were classified under four headings: Local CPA Implementation Strategy Documents, Local Steering Group Minutes, *Greenlight* Assessment Documents, and Others (see table 5.1).

| | | | | |
|---|---|---|---|---|
| Trust Level Documents | | | | |
| Trust-wide CPA policy<br>Trust-wide *Greenlight* Toolkit status document<br>Trust-wide CPA Steering Group minutes (only 1 annual meeting held) | | | | |
| Local Level Documents | | | | |
| Locality | Local CPA Policy Implementation Strategy | Local Steering Group Minutes | *Greenlight* Assessment | Others |
| A | No | Yes -incomplete | Yes | Project Manager Report. |
| B | Yes | Yes -incomplete | Yes | Learning Disability CPA Policy. |
| C | No | No | Yes | Joint Protocol on Services for Dual Diagnosis Clients.<br>Joint Review of Commissioning for Services. |
| D | No | Yes -incomplete | Yes | Service Interface Protocol. |
| E | Yes | Yes -incomplete | Yes | Care Pathways Protocol.<br>Refocusing CPA Project Plan. |

**Table 5.1: Documents collected and analysed (total = 48)**

### 5.5.3. Phase 2

The purpose of Phase 2 was to develop a further understanding of:

- The factors identified in phase 1 of the study
- The factors influencing the CPA policy process from the perspective of those charged with its implementation.

#### 5.5.3.1 Interviews with Steering Group Members

Interviews were sought with all members of the five Steering Groups in each locality. The intention was for the researcher to attend a Steering Group meeting in each locality to introduce and explain the purpose of the study. Information about the study and letters inviting potential respondents would be given out to those present at each meeting (see Appendix 5). For those not present invitations would be distributed via the chairperson. In practice this approach proved impractical in four of the five localities because no clear pattern of Steering Group meetings had been established and members and chairs proved more elusive than anticipated. In Locality A only four people turned up to the Steering Group meeting. One of those was a student and another was the new chairperson who had just been appointed to her role and was unaware that she had also been appointed as chair of the meetings. In Locality B there had only been two Steering Group meetings and subsequent meetings had been placed on hold as the chairperson had taken leave and had just returned to work. In Locality C the staff recently appointed to lead on the CPA implementation process did not know about any previous or planned Steering Group meetings. In Locality D no one attended the meeting the researcher went to. In Locality E the researcher attended a Steering Group meeting in which the study was presented. The meeting was attended by the two joint-chairpersons, two psychiatrists, a psychologist and a carer representative.

In the localities where the researcher did not attend a Steering Group meeting, the names and contact details of all Steering Groups members were obtained by asking the chairperson and examining previous minutes from meetings, where these were available. Each person was then phoned or e-mailed, offering them the opportunity to participate in the study. Those who agreed to participate were then sent a participant information sheet (see Appendix 5) and a consent form (see Appendix 6), together with the researcher’s contact details. On receipt of each completed consent form each person was again contacted to arrange a date, time and venue for interview.

Those who responded were, in the main, managers or professional leads of local mental health or learning disability services who had an interest in CPA implementation for this client group, or were charged with implementing CPA policy in their respective teams. Other respondents included representatives from local client and carer organisations. In this phase of the study there were also three learning disability consultant psychiatrists (in Localities C, D and E) who were officially Trust employees but were actually working within social service departments and as such were 'boundary spanners'. A fourth consultant located in social services in Locality B was in the process of having her employment contract transferred to the Trust but was to remain working in social services. For the purpose of this project the psychiatrists have been classed as working in social services as this is where they were primarily located.

Phase 2 interview questions attempted to gain insights into the perspective of those people, at locality management level, who were charged with actual implementation of CPA in front-line services. Although generally similar to those of Phase 1, the questions in Phase 2 focused more specifically on the respondents' locality to determine whether there were issues which had not been identified by those at a more senior level. (See Appendices 8 and 9 respectively for the topic guide and interview schedule for Phase 2).

In total 15 respondents were interviewed in Phase 2. A number of people declined to be interviewed, others did not respond to invitations to participate, two had left their posts and had no onward contact details and one, despite repeated assertions that they would participate never responded to requests to arrange a specific time. The exact number of potential respondents was difficult to identify as the data from documentary analysis indicated that attendance at Steering Group meetings was extremely variable. People in the circulation list frequently did not attend meetings or when approached by the researcher stated that although they continued to receive meeting minutes they were no longer actively involved in ongoing Steering Group work.

In total twenty-six interviews were conducted across both Phase 1 and 2 of the study. They lasted approximately 30-45 minutes each and took place at a time and location convenient to the participant. With the participants' permission all interviews were audio-recorded and transcribed. Those who were interviewed were also asked to complete a Partnership Assessment Tool. Transcripts and all other data were collected, stored and disposed of in accordance with King's College London regulations and the Data Protection Act 1998. The researcher was the only person who had access to person identifiable information and each transcript was identified by an anonymised code. No person or site identifiable information was included in the writing up or dissemination of the findings.

From the identified 51 potential respondents at locality level 23 interviews were conducted. At Trust level four potential respondents were identified. Three participated in the study. The overall potential participation for both Phase 1 and 2 was 55 with 26 agreeing to participate. The overall response rate (for both Phase 1 and Phase 2) was therefore 47%.

Table 5.2 shows the overall response rate. In general the response rate across the localities was consistent.

| | Number of people interviewed | Potential number of interviewees | Response rate (%) |
|---|---|---|---|
| A | 5 | 12 | 42 |
| B | 5 | 14 | 36 |
| C | 4 | 4 | 100 |
| D | 4 | 9 | 44 |
| E | 5 | 12 | 42 |
| Trust level | 3 | 4 | 75 |
| Total | 26 | 55 | 47 |

**Table 5.2: Response rate (total =26)**

Respondents in Phase 1 were primarily NHS employees whilst those in Phase 2 were primarily from social services. This reflects that more senior staff involved in the implementation process tended to be from health services whilst local Steering

Groups consisted primarily of social service employees. Table 5.3 identifies the respondents by locality and the service in which they worked.

| | Total Number (n=26) | Phase 1 | | Phase 2 | | |
|---|---|---|---|---|---|---|
| | | Health | S/serv | Health | S/serv | Vol. |
| Senior Mngt | 03 | 03 | 00 | n/a | n/a | n/a |
| Locality A | 05 | 02 | 01 | 00 | 01 | 01 |
| Locality B | 05 | 00 | 01 | 00 | 03 | 01 |
| Locality C | 04 | 01 | 00 | 01 | 02 | 00 |
| Locality D | 04 | 01 | 00 | 02 | 01 | 00 |
| Locality E | 05 | 01 | 01 | 00 | 02 | 01 |
| Total | 26 | 08 | 03 | 03 | 09 | 03 |

**Table 5.3: Respondents by locality and service in which they worked**

Key: Health = NHS services; S/serv = social services; Vol = voluntary agency

Table 5.4 identifies the different role types of respondents who participated in the study. They reflect a wide variety of senior staff involved in the development and implementation of CPA policy at a Trust and local level. They are not identified by locality to protect their confidentiality.

- Deputy Director of Trust Operations
- CPA Compliance Manager
- Learning Disability Divisional Manager/Deputy Director for Learning Disabilities
- Health Service Director
- Learning Disability Service Manager
- Health Service Manager
- CPA Project Lead
- CPA Manager
- Professor of Learning Disability Psychiatry
- Learning Disability Consultant Psychiatrist
- Learning Disability Psychiatrist (non-consultant)
- Mental Health Service Psychiatrist
- Learning Disability Senior Practitioner
- Mental Health Lead Nurse
- Mental Health Lead Social Worker
- Learning Disability Lead Nurse
- Professional Social Work Lead
- Learning Disability Psychologist
- Carer Representative*
- User Representative*

**Table 5.4: Respondents by role-type**

*Key: The user and carer representatives were paid employees from voluntary organisations and were not direct users of services, or their carers.

### 5.5.4. The Partnership Assessment Tool

The Partnership Assessment Tool (PAT) (Hardy et al, 2000) was originally designed by the Nuffield Institute of Health in Leeds as a developmental tool to enable partners to create a vision of how they would like their partnership to be. However it may also be used as an audit tool to enable participants in ready formed partnerships to review how effective their partnership processes are, or as a diagnostic tool to enable a partnership systematically identify areas of consensus or conflict within it (Hardy et al, 2003). The PAT enables individual partners to assess the overall success and progress of their partnership against six key partnership principles which, based on empirical research, express common factors promoting or hindering, successful partnership working (Hudson et al, 2002). Although it may be used prospectively to explore views and aspirations in new or emerging partnerships, it may also be used to ascertain views retrospectively to assess the effectiveness of existing partnerships (Hardy et al, 2003). Although it does not provide a comprehensive framework it does emphasise the importance of context to partnership working and places an emphasis on the level of analysis at an organisational or strategic level (Asthana et al, 2002).

The six partnership principles, each with six sub-headings, are founded on factors which are known to be critical to successful partnership working (see table 5.5, with the full version available in Appendix 10). The principles within the tool are generic thus enabling its use across a variety of contexts, not only across organisations but within them as well (Hardy et al, 2003). When used internally it allows for the assessment of partnership working at different organisational levels with people in different layers of the organisation or partnership able to contribute.

| | |
|---|---|
| Principle 1 | Recognise and accept the need for partnership |
| Principle 2 | Develop clarity and realism of purpose |
| Principle 3 | Ensure commitment and ownership |
| Principle 4 | Develop and maintain trust |
| Principle 5 | Create robust and clear partnership working arrangements |
| Principle 6 | Monitor, measure and learn |

**Table 5.5: The six principles of the Partnership Assessment Tool (Hardy et al, 2003)**

The PAT has been used in a number of studies assessing the effectiveness of partnership working in health care e.g. it was used by Hudson et al (2002) as part of a national evaluation of notifications for the use of Section 31 Partnership Flexibilities of the Health Act (1999). In Rummery & Coleman's (2003) three-year longitudinal study on the development of partnership working between Primary Care Groups (and Primary Care Trusts) with social service departments in England the PAT was used alongside semi-structured interviews to supplement data collected. It has also been used by Asthana et al (2002) to develop a conceptual framework for the evaluation of partnerships within Health Action Zones whilst Halliday et al (2004) used the PAT in a similar fashion. Halliday et al (2004) showed that the PAT had potential to identify a number of strengths and weaknesses at a principle or thematic level as well as at the level of the composite elements and illustrated that the tool not only provided "detailed insights into partnership working on a geographically and initiative-specific scale but also a foundation for comparisons with generic findings on partnership" (p300).

In order to generate a picture of the state of partnership working in each locality and gain some sense of the consensus and disparity amongst respondents within each, a revised version of the PAT (Hardy et al, 2003) was used in this study as an additional data collection tool to help meet Objectives 1, 2 and 3. This version of the PAT is an adaptation of the original and focuses on the strategic level within partnerships. It was not used as a stand-alone tool for data collection and as advised by Hudson et al (2002) (and Hardy et al, 2003 and Halliday et al, 2004) was used alongside the other data collection methods. It was also used to encourage interviewees to consider how the different organisations were working in partnership to implement CPA. It was used with participants in both Phase 1 and Phase 2 of the study.

A licence was obtained from the Office of Public Sector Information for the use of the PAT in this study.

### 5.6. Data analysis

Data were analysed using the 'Framework Approach' (Ritchie & Spencer, 1994)(see table 5.6), which was developed specifically for applied or policy relevant qualitative research in which the objectives of the research are set in advance (Pope et al, 2000). Starting from the pre-set aims and objectives it reflects the original accounts and observations of the research respondents. The use of interviews to generate new data is a central component of the Framework Approach, and were used in this study as the primary data collection method.

| | |
|---|---|
| Stage 1 | Familiarization |
| Stage 2 | Identifying a thematic framework |
| Stage 3 | Indexing |
| Stage 4 | Charting |
| Stage 5 | Mapping and interpretation |

**Table 5.6: The 'Framework Approach' (Ritchie and Spencer, 1994)**

A thematic framework is used to classify and organize data according to key themes, concepts and categories, each with related sub-categories. This framework was derived from the empirical literature as synthesised in table 4.7 in Chapter 4. Through a process of familiarization with the data these themes evolve and are refined with each theme then charted against individual respondents. Data are then synthesized into the appropriate section of the thematic framework (Ritchie et al, 2003). This form of data collection has been described as being more structured, and the analytical process more explicit, than other qualitative analysis (Pope et al, 2000).

Data from the interviews and documentary analysis were used to build a profile of each of the five localities participating in the study. Each locality's profile was then used to compare and contrast it with each of the other participating localities. This provided an overall perspective on the factors influencing the implementation of CPA in the Trust as a whole, as well as identifying areas of overlap or contrast between each locality.

## 5.7. Ensuring Rigour

Rigour was considered prior to data collection and throughout the study period. The interpretative procedures and the use of Framework Analysis were developed from the empirical literature and decided upon before the data analysis commenced, as advised by Yin (2009). This helped to ensure that any personal views which arose as a result of previous interest in the subject of CPA implementation or from personal views on data collected could be managed objectively.

Choosing a non-probabilistic sample allowed for the deliberate inclusion of different types of respondents, whilst also enabling the selection of particular key informants who had access to important sources of knowledge, relevant to the study. The first interview was conducted with the chairperson from Locality D and was viewed as a pilot interview. Minor amendments to the wording of the interview schedule were conducted following this interview to ensure that it was relevant and appropriate to the study. For example, respondents were subsequently asked whether completing the PAT had raised any issues for them which they specifically felt was relevant to the CPA implementation process in their locality. Subsequent interviews and the consistency of respondents' responses indicated that the questions were indeed relevant to the study topic. This was further supported through triangulation in which data were also collected from other sources e.g. Steering Group minutes, and which following analysis reaffirmed the interpretation of data through the interview process (Yin, 2009).

All interviews conducted were audio-recorded and transcribed so that they could be made available for subsequent analysis and scrutiny, if required. Transcriptions were undertaken immediately after interviews were conducted so that they could be analysed. Due to the short time frame of the study it was not possible to return transcripts or analysed themes to respondents for validation. However the interpretation of data from interviews conducted was discussed with subsequent interviewees within and across localities. This is known as member checking or validation (Miles and Huberman, 1994).

Alongside the transcription interviews a detailed audit trail of all other data collected and analysed was kept to facilitate 'confirmability' (Lincoln and Guba, 2005). These data included the actual audio recordings, documents collected and the Partnership Assessment Tools administered. The use of direct quotes, with accompanying commentary and interpretation in the subsequent findings chapters has also helped to minimise research bias by creating transparency in the data collection process.

The validity of the Partnership Assessment Tool has been shown from its grounding in the empirical research on partnership working. It has also been used for a number of empirical studies in the subject area, as discussed in Section 5.5.4.

As outlined by Bergen and While, 2000) this was a single-case study in which the Trust was viewed as an instrumental case. It was therefore the topic of CPA implementation rather then the actual Trust itself which was important. This enables the generalisation of findings and makes comparison with other similar trusts, undertaking similar processes, possible. This is further facilitated through description of the study's context in Chapter 6 which shows how the study contributes to and fits in with empirical work in the field.

### 5.8. Reflexivity

My professional background in the field meant that one of the key issues while undertaking the study was to understand how my own presence in the localities, the interactions with interviewees and my personal viewpoints on the topic of CPA, might influence the research process and subsequent findings, and to develop strategies to recognise and manage this (Gobo, 2011).

I had to acknowledge that, because of my own personal experience with CPA in mental health services I had come to the study with the view that the implementation of CPA was a positive process. That experience had also led me to believe that many professionals struggled with re-aligning traditional professional roles and values with what was required of them through care coordination. I therefore came to the study with the belief that one of my primary findings would be in some way related to this tension, with professional power issues also arising as a result. However working on the organisational change and partnership literature shifted my perception on this topic and made me more aware of the wider issues potentially impacting on CPA implementation. The data collection process also ensured that the views of respondents and the analysis of documents, rather than my own personal beliefs, were the sole foundation on which the findings of the study were based.

Consideration also needed to be given to the possibility that my presence in the localities inquiring about CPA implementation, could in some way potentially influence respondents' views on CPA and the implementation process. It was important, therefore, that interviews were handled with this awareness and that efforts were focused on the respondents' beliefs, and their own work and engagement with the implementation process so that their viewpoints were not misrepresented.

Key strategies to deal with ensuring that my own personal beliefs did not influence the findings, and to reflect on how my presence in the localities may potentially influence respondents, was through the use of fieldnotes and through discussion with my study supervisors. These were used to document observations on my experiences and thoughts on the interviews conducted. These strategies were also used to document issues raised and problems experienced whilst the fieldnotes provided context to each individual interview undertaken. They were also used to reflect on the research process and consider my own engagement with the field. They enabled the identification of potentially subjective experiences in the data collection process, so that these could be isolated to ensure that they did not bias the subsequent analysis and writing-up processes.

### 5.9. Ethical Issues

Ethical approval for the project was obtained from the local Research Ethics Committee and Research and Development Consortium (see Appendices 11 and 12 respectively). As some potential respondents were social services employees, ethical approval was also sought from, and granted by, the Association of Directors of Adult Social Services (ADASS)(see Appendix 13). An amendment to the original ethical approval forms was later approved so that the Partnership Assessment Tool (Hardy et al, 2003) could be administered by the researcher to those participating in Phase 2 of the study.

A key concern for single case study research is the issue of confidentiality and the potential to identify respondents even when attempts have been made to anonymise the data. This is particularly important in the writing-up and dissemination of findings as a balance has to be struck between giving contextualising information and removing detail about particular informants in order to maintain their confidentiality. In the subsequent findings chapters many details, which would enable identification of the Trust, the localities and respondents, have been omitted to prevent their identification.

Respondents were given information leaflets prior to participating in the study which detailed how information would be used and how their details would be protected. They also had the opportunity to withdraw at any stage of the research process.

### 5.10. Conclusion

This chapter described the aims and objectives of this study and outlined the processes that were undertaken to achieve them. It described the decisions that were taken on the study design and illustrated how the research site was chosen. The process of entry into the field, the sampling and process of participant recruitment, data collection, and the approach to data analysis were also discussed. Ethical considerations and procedures were also outlined.

Chapter 6 presents some demographic information about the Trust and each of the localities in the study. Based on the findings it provides a contextual picture of where each locality was at with the implementation of CPA at the time of data collection.

The key findings from the administration of the Partnership Assessment Tool are also presented.

## Chapter 6: Setting the Context

### 6.1. Introduction

This chapter starts by providing some basic background information about the Trust and each of the localities. It also summarises the progress achieved in each locality with implementing CPA for dual diagnosis clients at the time of data collection. Information about the wider political, geographical and organisational contexts in which the Trust and each of its partner organisations were operating is then presented. The impact of this broader context on the implementation of CPA from an organisational perspective is discussed, whilst factors impacting at a more local level are explored in Chapter 7.

The key findings from the administration of the Partnership Assessment Tool are also presented. The complete PAT findings are contained in Appendix 14.

Throughout the findings chapters, reference is made to interview data sources from which information was obtained e.g. A4: 275 refers to line 275 of the interview transcript of respondent 4 in Locality A; B3: 120 refers to line 120 of the interview transcript of respondent 3 in Locality B; T1: 380 refers to line 380 of the interview transcript of respondent 1 who was based at a senior management level in the Trust.

Direct quotes from respondents have been placed in italics.

### 6.2. Demographic Information on the Trust

The Trust was formed in 2002 following the merger of a mental health trust, a healthcare trust and a separate substance misuse service. It became a NHS Foundation Trust in 2007. By 2009 it was one of the largest specialist NHS mental health trusts in England with 3600 employees across 84 separate sites providing a range of mental health and social care services to 46,000 people across nine separate localities and working with over 100 separate statutory and voluntary organisations. It also provided prison mental health services for three separate inner-city prisons. Table 6.1 lists the type of services provided by the Trust in each of the five localities participating in this study. Of the nine localities in the Trust, five were in the process of implementing CPA for dual diagnosis clients at the time of data collection. The other four localities did not have learning disability services and were therefore not implementing CPA for dual diagnosis clients. They have not been included in the study.

Mental health services for Localities B and C joined the Trust in 2006 and this was followed in 2007 by the takeover of a specialist in-patient learning disability hospital in Locality A. The Trust had also taken over the employment and management of the medical teams within learning disability services in Localities D and E and was in the process of doing the same in Localities B and C.

| Localities | Adult mental health | Older adult mental health | Child & adolescent mental health | Substance misuse services | Learning disability services | Eating disorders | Prisons |
|---|---|---|---|---|---|---|---|
| A | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | |
| B | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | |
| C | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | |
| D | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | |
| E | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | |
| Other localities & PCTs | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |

**Table 6.1: Range of mental health and specialist services provided by the Trust (Trust website, 2010)***

*The website details for the Trust have not been included in the reference list in order to maintain confidentiality.

In 2009/10 24,318 people accessed secondary mental health services provided by the Trust (Mental Health Minimum Data Set (MHMDS), 2010). In the same period the Trust's income stood at £245.1m, of which £200.7m came from Primary Care Trusts (PCT) purchasing clinical specialties. General adult services accounted for 62% of its income, followed by 15% for older adults and 11% of substance misuse and offender care. Learning disability services income accounted for only 2% of its overall budget (see figure 6.1).

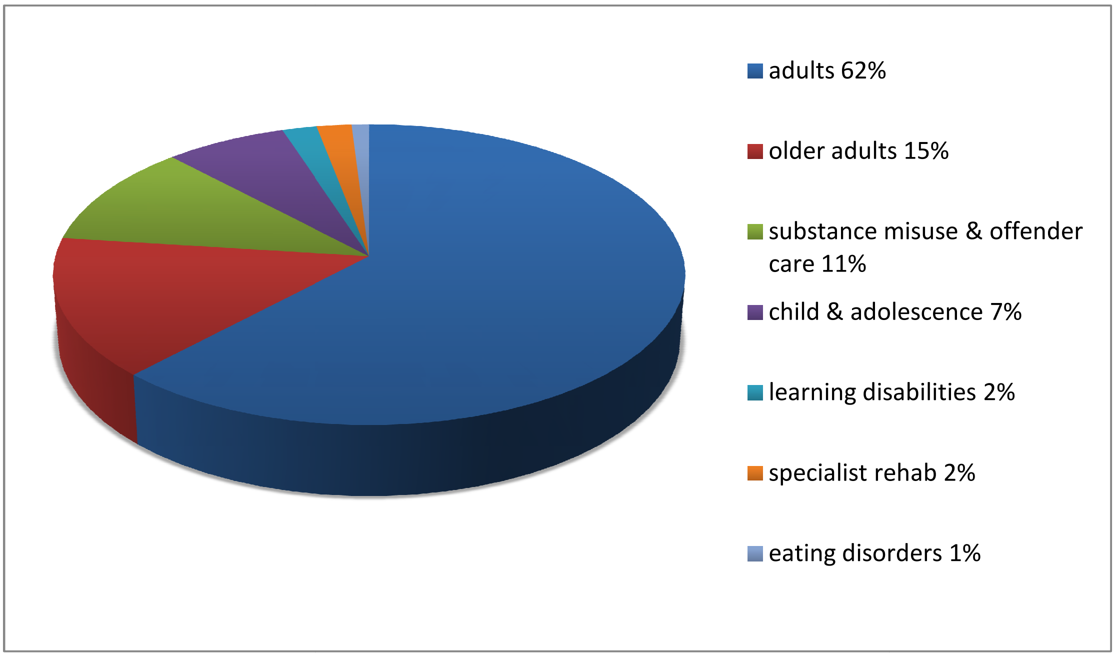

**Figure 6.1: Trust sources of income in 2009 (Trust website, 2010)**

## 6.3. Demographic Information on the Localities

This section provides a brief overview of the demographics of the localities. The data were primarily obtained from local authority websites and the Office for National Statistics (ONS) 2001 Census.

The five localities included in the study were all boroughs within a large UK city. Three of the localities (A, B, C) were outer-city boroughs whilst D and E were inner-city. They varied in size from approximately 1,213 to 11,570 hectares. Localities A, D and E had the highest population densities and Locality C the lowest, with half its area being classed as parkland, woodland or waterways.

Household numbers across the localities ranged between 79,146 and 199,991 with Locality A having one of the largest household sizes in the country. A quarter of its population lived in overcrowded conditions. The percentage of households rented from local councils or housing associations was generally consistent across Localities A, D and E (around 25%) whilst Localities B and C had the largest number of households owned outright or with a loan or mortgage.

| Locality | A | B | C | D | E |
|---|---|---|---|---|---|
| Locality Size (hectares) | 4325 | 5044 | 11570 | 1213 | 2204 |
| Resident Population | 263464 | 206814 | 243006 | 158919 | 181286 |
| Population Density (persons per hectare) | 60.9 | 40.98 | 21 | 131.02 | 84.41 |
| Mean Age of Population | 35.4 | 37.8 | 36.9 | 37.68 | 37.3 |
| Number of Households | 199991 | 79112 | 96643 | 79146 | 91172 |
| Average Household Size (people) | 2.61 | 2.59 | 2.43 | 1.96 | 1.98 |

**Table 6.2: Locality key statistics (ONS, 2001)**

All of the localities, except Locality E (which had climbed 33 places), had slipped down the national ranking of deprivation scores since 2004. Some parts of Localities C and D were amongst the most deprived areas in the UK whilst other parts of Locality D and E were amongst the most affluent.

### 6.4. The State of CPA Implementation in each Locality.

This section describes the progress made by each of the localities in implementing CPA for dual diagnosis clients.

The Trust had a general CPA policy which had been reviewed in 2009 by the CPA Compliance Manager. This included a section on the provision of CPA for dual diagnosis clients. All localities were expected to review their own local CPA policies and generate a separate operational policy specific to their services and client needs.

Each locality had a specialist mental health learning disability service based within general learning disability services. The provision of these services was the joint responsibility of each locality's PCT and local authority. In Locality B learning disability services were managed directly by the PCT without any input from the local authority.

There was an expectation from the Trust and PCTs that dual diagnosis clients known to specialist mental health learning disability teams were placed on CPA. However this was only happening in Localities C and E. Locality B was beginning the process of placing some clients on CPA whilst Localities A and D were not. All clients, from all localities, were placed on CPA if admitted to Trust in-patient mental health services. However once discharged back to mental health learning disability services, clients were only followed up through CPA in Localities B, C and E. Clients discharged back to general learning disability services were not followed up through CPA in any of the localities. The total number of clients (including those with a learning disability) on CPA within the Trust was 3228 in 2009/10 (MHMDS, 2010).

However according to the same source when broken down by PCT in each of the localities that figure comes to 3532 (see table 6.3). The difference of 304 people may be accounted for by the PCTs placing clients who were their responsibility into the care of other mental health trusts or services outside of the remit the Trust involved in this study.

| Locality | A | B | C | D | E | Total |
|---|---|---|---|---|---|---|
| Total | 851 | 822 | 570 | 546 | 743 | 3532 |

**Table 6.3: Number of people on CPA by PCT in each locality in 2009/10 (MHMDS, 2010)**

There were no figures available on the number of clients on CPA who had a dual diagnosis.

Table 6.4 summarises progress with CPA implementation by each locality in terms of the available markers of organisational commitment and related bureaucratic processes. These markers have been used here because they were the only substantive indicators available by which progress might be judged.

| Indicators | Localities | | | | |
|---|---|---|---|---|---|
| | A | B | C | D | E |
| Steering Group meetings | Yes | Yes | No | No | Yes |
| Operational policy | No | No | No | No | Yes |
| Key responsible person | Yes | No | No | Yes* | Yes* |
| Access to finances/budget | No | No | No | No | Yes |
| Trust employed mental health staff in learning disability services | No | No** | No** | Yes | Yes |

**Table 6.4: Key indicators for CPA implementation in each locality**

* (Leads had previously been in post in these localities but were not employed at the time of data collection).

** (At the time of data collection the Trust was in the process of taking over the employment contracts of the psychiatrists and psychologists in the learning disability teams within these localities).

The following sections outlines the state of CPA implementation in each of the localities and incorporates data collected through the administration of the PAT, respondent interviews and documentary analysis.

### 6.4.1. The State of CPA Implementation in Locality A

Locality A had a CPA Steering Group which met six weekly. The team manager from learning disability services and the in-patient service manager for the locality jointly chaired it. However the in-patient service manager had stopped attending the meetings due to a lack of financial support from the PCT. Respondents generally felt that partnership working between health and social services was working well in the locality but some aspects of the partnership were identified as suboptimal. For example, it was suggested that professionals in some departments were working in "*silos*" (respondent A4) which meant that they were aligning themselves to historical professional roles and therefore were not able to work well as equal partners

The locality also had a separate *Greenlight Toolkit* (GLTK) meeting and it was the chair of this meeting who actually took the lead for implementing CPA for dual diagnosis clients. She had been seconded for six months from learning disability mental health services and was about to move on to take a similar position to undertake the GLTK audit and oversee CPA implementation in Locality B.

The locality had an operational policy for CPA. This had been implemented and was being used in regular practice within the in-patient learning disability unit which had been built in the locality. This unit, which was owned and operated by the Trust, was open to clients from across the country and was set to receive a multi-million pound investment to expand its size.

However mental health learning disability community services in the locality showed a different picture. They were operated by the PCT and Trust CPA policies had not been adapted or even taken on by the learning disability community team.

### 6.4.2. The State of CPA Implementation in Locality B

In Locality B a CPA Steering Group had only recently started meeting but was already encountering problems of commitment and attendance from learning disability and mental health services. Although there was a chairperson who had been identified by the Trust, learning disability services had not supplied a co-chairperson. Preliminary discussions were happening to get a representative. Except in one learning disability community team, the locality did not have CPA for learning disability clients and there were no locality-wide operational policies on CPA for this client group.

Generally respondents felt that there was limited partnership working between health and social services and that the aims and objectives of the local Steering Group were not clearly defined, or that all necessary partners were engaged fully. Part of the issue was that learning disability services were managed separately by the PCT and so neither the Trust nor the local authority had any control or authority over this area. However the local mental health learning disability community team had begun to implement CPA for a few clients. This was in part due to the efforts of the local learning disability psychiatrist based within the team. Having previously worked in mental health services she was an advocate of CPA and keen to implement it within her team. There had been a couple of Serious Untoward Incidents in which social workers working with clients through CPA had not taken full account of their clients needs and a number of social workers had been formally disciplined for failing to support their clients properly. This had made the rest of the team aware of the need to implement CPA in a comprehensive manner.

The learning disability psychiatrist had a close relationship with the GLTK/CPA lead from Locality A and was anticipating working closely with her once her secondment started.

Unlike the other localities dual diagnosis clients in Locality B who needed in-patient mental health services were admitted to a hospital outside of the Trust. Unlike the other localities, this meant that there was no opportunity for the Trust to place these clients on CPA when admitted to hospital.

### 6.4.3. The State of CPA Implementation in Locality C

In Locality C most respondents indicated that the partnership between mental health and social services was working well. However, there were still many barriers to CPA implementation and there was no motivation for staff in learning disability services, in particular, to implement CPA for their clients.

In practice this was reflected by a lack of a CPA Steering Group and no identified CPA implementation lead. Although CPA had been used for dual diagnosis clients in the locality since its original implementation in the 1990s, this was primarily due to the work of the local Professor of Learning Disability Psychiatry who worked closely with community learning disability services (the Professor, like the psychiatrist in Locality B, was also in the process of becoming a Trust employee). These services were however separate to general learning disability services and had a close relationship with the Trust. Outside of this particular mental health learning disability team, dual diagnosis clients were not placed on CPA.

### 6.4.4. The State of CPA Implementation in Locality D

In Locality D respondents acknowledged that further work needed to be done to develop and maintain trust in the partnership between health and social services. There were no clear goals for CPA implementation and there was a view that there was no mental health service back-up for learning disability clients.

In the locality the implementation of CPA was being discussed as part of the GLTK Steering Group agenda. There was no separate CPA Steering Group. Originally the locality had a Trust employed CPA implementation lead who had been seconded from a similar post working on CPA implementation in Locality E. However he left post after a year and was replaced by a second lead who was employed by learning disability services.

The appointment of the new lead coincided with the commencement of the locality’s work on the GLTK and this took priority over CPA implementation. There was also a lack of support from senior managers within learning disability services to implement CPA. This was because they had invested considerable resources on the *Personalisation Agenda* (DH, 2007), which they felt was similar to CPA in terms of its holistic approach to client care.

The lead, and his predecessor, had left their posts prior to data collection. Attempts to locate them for interview for this study were unsuccessful.

The locality had no operational policy for CPA, no identified lead and no CPA for dual diagnosis clients. The local learning disability consultant psychiatrist was the only mental health professional based in learning disability services. It was her responsibility to implement CPA in these services but she did not feel that she had the support of learning disability services.

However a new forensic learning disability hostel had just opened in the locality. Clients from outside of the Trust were expected to be transferred here and there was concern within the locality about support available should local learning disability or mental health services be required to intervene, particularly for emergencies. Care pathways were therefore being reviewed and the need to have CPA implemented was high on the agenda of Trust services.

### 6.4.5. The State of CPA Implementation in Locality E

Locality E was the most advanced with the implementation of CPA. Unlike the other localities the PAT results indicated that all partners at a strategic level were consistent in their views that partnership working between mental health and learning disability services was good. However they were aware that at the front-line there "*continues to be a strong divide between our services*" (PAT response from respondent E4). It was felt that this issue had not been addressed by senior management and it was also reported that there was a constant problem with staff turnover across the various teams (respondent E5).

The locality had benefited from the work of the original CPA implementation lead who had created operational policies and developed care pathways for dual diagnosis clients. The locality also had very close relationships with both the Trust and its local PCT. Because of its longstanding presence within the Trust (it was one of the original localities which come together to form the Trust) and its proximity to Trust Headquarters, regular meetings with key people were relatively easy to arrange.

The local PCT commissioner had previously worked within the learning disability service and this historical relationship made requests for funding from the PCT easier, since she continued to have an informal relationship with the team and was aware of their work, achievements and needs.

However a number of Serious Untoward Incidents (SUIs) had recently occurred in which dual diagnosis clients had been refused access to mainstream services at a time of crisis. Subsequent inquiries had concluded that Trust services had failed these clients and this had enabled the locality to get the attention of key managers to ensure that incidents of this sort did not re-occur. The locality had also acquired a new post for a community psychiatric nurse, who would sit alongside the Trust employed consultant psychiatrist and psychologist within learning disability services. It was anticipated that this role would improve relations across learning disability and Trust mental health services. The post was funded by the PCT, which was also in the process of reviewing a proposal to fund a learning disability advocacy worker for the locality.

These new roles were part of a wider review and restructuring of learning disability services by the PCT. As part of this review the learning disability service manager and consultant psychiatrist had worked closely with the Trust to discuss the establishment of a specialist sub-team within learning disability services. This team would focus on clients with a dual diagnosis and/or challenging behaviours. All clients admitted to this team would be automatically placed on CPA and all staff working within the team would be expected to work as care co-ordinators.

This section has illustrated that the implementation of CPA was variable across the five localities in the study, and that there were a range of strategies used by each in attempting to develop and implement CPA within their respective front-line teams. Even in those which had managed to implement CPA, it was only being used in a number of practice areas within the locality, rather than across all front-line teams. Overall it was apparent that there was limited progress within the Trust as a whole with the implementation of CPA for dual diagnosis clients.

## 6.5. Contextual Factors Affecting CPA Implementation

This section discusses six key contextual factors which were found to be impacting significantly on the Trust and its partner organisations at the meso-level (see table 6.5) and were felt by respondents across all localities, to be impacting on the CPA implementation process.

| |
|---|
| The lack of finances and resources; |
| Competing priorities; |
| Incompatible Information Sharing & Information Technology Systems; |
| Organisational complexity; |
| Lack of governance and accountability arrangements; |
| High staff turnover. |

**Table 6.5: The six contextual factors affecting CPA implementation in the Trust**

These factors were affecting all areas of the Trust's operation, including but not limited to, CPA implementation. In the next sections of this chapter, consideration is given to how these factors impacted on CPA implementation across the Trust generally, whilst their impact at a locality level is discussed in Chapter 7.

### 6.5.1. The Lack of Finances & Resources

"*It always comes down to resources and it's…used as kind of justification for why they don't want to support people*" (E4: 275).

At the time of this study the UK was struggling through an economic recession with widespread cutbacks of funding to bodies like the NHS and social services. With such tight financial parameters NHS trusts, local authorities, PCTs, social services and other public bodies all needed to prioritise their expenditure. The Trust and many of the local authorities had overspent in the previous financial year and were working to cut back on costs. This meant that when localities asked for funding to implement CPA they were unlikely to receive it (T1: 380). In those localities where CPA had already begun to be implemented, an ongoing lack of resources meant it was hard to maintain the momentum for wider implementation across all front-line teams.

The financial situation also had a direct impact on the relationships that localities had with commissioners from their local PCT. As one respondent observed, since commissioners had no access to funds to support CPA they did not see any reason to attend local Steering Groups (A1: 121, 136). This lack of engagement meant that the work of Steering Groups was perceived by some respondents to be a waste of time. Given the lack of commitment and money to back up CPA, and awareness of more pressing priorities elsewhere, the view was that they simply could not achieve what they had set out to do (A1: 241).

While the recession may have added to the problem, even before it began social service departments mental health budgets for clients with a learning disability had accounted for only around 1% of their overall finances but was nevertheless supposed to cover all staff employment and service provision (E1: 427). This illustrates not only the limited priority given to this area in social services at that time but also the impact that reductions in these budgets could have on CPA implementation. With a unilateral withdrawal of funding for posts in learning disability teams (T3: 43) and the increasing financial pressures their attention was drawn away from strategic initiatives like CPA so that resources could be focused on more urgent "*fire fighting*" (T3: 181).

Although Trust management recognised that joint-funding with social services had previously enabled the employment of project workers to implement CPA in Locality E (resulting in the development of CPA policies, procedures and protocols), the current economic climate meant that the localities were not in a strong position to argue for funding for further such posts (T1: 64, 380). As one respondent observed, with such huge pressures to save money, client need was no longer the central concern. Instead, the cost of any care or services provided became a primary focus (B3: 127, 284). For example, clients could not be referred on to other services particularly where there were fees involved and decisions about care were now being made on cost rather than clinical need (B2: 129, 239).

Even in the localities where there was some momentum with CPA implementation (Localities C, D & E), the financial situation meant that front-line team boundaries were very tightly drawn, which made it difficult to work in the kind of integrated way across health and social services that CPA required. With such tight service boundaries there was a real possibility and concern that clients would fall between services. The lack of finances was particularly visible at the front-line level where there was no funding to provide any training to social service staff on CPA, to pay for care coordinators or administrative support, develop local operational policies or appoint jointly-funded community psychiatric nurses (CPN) in learning disability services. Such roles had been expected to play a key part in driving through CPA implementation, with leading by example as part of their job remit (D2: 25, 223; D4: 267; T1: 316).

With the localities finding themselves continuously "*overstretched*" (E3: 98), some health and social care staff had begun to look at alternative ways to get funding so they could provide the basic care clients needed. CPA meetings in front-line areas were beginning to be used by professionals to highlight gaps in care for individual clients. It was anticipated that this would provide care coordinators with the power to argue for finances to provide care from the PCTs (A2: 529). However this practice was not widespread across all the localities. As one respondent observed, the preoccupation with chasing finances for the care of current clients was rendering them unable to think strategically about CPA implementation (A4: 303).

The bottom line was that the overall lack of resources hampered the Trust's ability to work in a systematic way with social services across the board. The resources were simply not available to introduce any new strategies such as CPA into learning disability services and even if it was introduced it was unclear how the Trust and social services would make individual clients CPA care plans work particularly if additional resources were required (D4: 260).

#### 6.5.2. Competing Priorities

The implementation of CPA across all mental health services was a mandatory requirement for the Trust but not for its partner organisations such as the PCTs and local authorities (T1: 122; T3: 29), which managed learning disability services. This lack of a mandate gave those organisations less reason to invest any financial support, staff assistance, or representatives to attend Steering Group meetings in the localities.

To try and increase their engagement, the Trust held contract review meetings with its partner organisations. The aim was to put CPA implementation for dual diagnosis clients high on contractual agendas for service provision and to emphasise to the other organisations that the requirement for CPA originated from the Department of Health, not simply from the Trust. Two primary reports; *Healthcare for All* (DH, 2008c) and the *Six Lives Report* (Parliamentary and Health Service Ombudsman, 2009) which had highlighted the risks of unmet needs in this client group were being used by the Trust CPA Compliance Manager and Director of Operations in these meetings to show how the unmet needs of this client group could impact on learning disability and mental health services, particularly if clients were allowed to fall through the net and not receive the care they needed (T3: 131, 406). However these negotiations were in their infancy at the time of data collection. Since the contract monitoring meetings occurred only once a year they were unlikely to impose sufficient pressure to generate or maintain ongoing momentum or investment (T1: 122, 369).

The lack of investment was also reflected at locality level. In Locality D, for example, one respondent reported that many policies, such as CPA, were not prioritized unless there were targets attached or financial implications for failing to implement them (D3: 131). For example learning disability services were focused on the implementation of the *Deprivation of Liberties* regulations (DH, 2007a), *Mental Capacity Act* legislation (DH, 2005) and in particular the *Personalisation Agenda* (DH, 2007b)(C3: 518). As PCTs and local authorities had no specific targets from the Department of Health to implement CPA it was viewed as a health care policy and therefore a Trust issue (C2: 435). At the same time the Trust was working on implementing the *Health of the Nation Outcome Scores* (HoNoS)(DH, 1992b) in front-line services. There was a risk of being fined if targets set within this policy were not achieved. In contrast, there were no such formal sanctions associated with failure to implement CPA in learning disability services and therefore policies such as HoNoS took precedence: "*there are other developments which attract lots of attention publicly, like HoNoS, and a lot of the changes around CPA are intangible. They're about attitudes and ways of working, whereas things like introducing HoNoS scales are quite high priority, quite concrete and compulsory. And we will lose real money if we don't do them properly*" (T2: 422).

The impact of these competing priorities also filtered down to front-line mental health professionals who, although they were aware of and sought to promote CPA, also had their own competing priorities which had "*more significant consequences*" (A1: 159; A2: 423). These other agendas became a central focus for front-line teams even though in many cases these priorities were not viewed by staff in the localities as necessarily needs-led or client-focused (C1: 411; C2: 623). The result of these competing agendas at the front-line was that CPA was "*not on their radar as much*" (C3: 518).

One key national strategy being worked on by the Trust was the *Greenlight Toolkit* (GLTK), mentioned in Chapter 3 (section 3.4), a self-audit toolkit which measured how well local mental health services were achieving in providing services for people with learning disabilities as compared with national recommendations. Nationally, trusts were given points for the full implementation (or 'green-lighting') of key requirements within the toolkit. The power of the GLTK point system was apparent, as it was able to ensure that key people attended GLTK meetings and placed pressure on the Trust to work closely with learning disability services: "*it's a compulsion because they are a Foundation Trust, they get inspected on care quality provision, so they have to – they get inspected that (sic) provisions are in place for people with a learning disability, so that helps a lot*" (E3: 34). This pressure gave learning disability services the "*ears*" of key people in the Trust (E1: 100), something which CPA did not have the ability to do by itself (E2: 47). In fact without the targets within the toolkit, Trust staff acknowledged that they might not have paid much attention to dual diagnosis clients at all (E1: 45, 77, 113; E3: 48).

Although it was seen to highlight areas where CPA policy needed further development and to have the potential to supply leverage for change and help with the monitoring of contracts with partners (T3: 197, 203, 220), the individual targets within the toolkit had become a primary focus for the Trust and even the local Steering Groups. This took attention away from CPA implementation and there was scepticism about whether the Trust's focus on the audit requirements was actually of any use: "*it was only an audit tool, nothing actually improved for patients. We spend months and months and months designing a service user survey, satisfaction survey on in-patient services, and we only ever got…two people who'd fill it in*" (T1: 236).

The pressure of multiple, and often competing, priorities was present at all levels of the respective organizations. Those involved in the local Steering Groups continued to have clinical caseloads and/or large workloads and CPA implementation was merely a single aspect in a wider role competing for their attention and time: "*I think probably because people are under a lot of pressure in terms of workload…I've* *been able to sort of snatch time here and there...but the actual protocol documents need to be done, finalised in a couple of weeks time. And finding the time to do that is, you know, it's quite difficult for me*" (E2: 175); "*My caseload is big as well, so you try to be involved as much as you can, but there's only so much you can do in one week…so although you would want to spend more time developing things, it's simply not possible because you have to run a service as well*" (E3: 430).

### 6.5.3. Incompatible Information Sharing & Information Technology Systems

One direct consequence of the lack of finances and competing priorities for services was the inability of the Trust and its partner organisations to prioritise or address problems with incompatible information technology (IT) and information sharing processes. This incompatibility of systems was yet another priority which undermined CPA implementation (T2: 330). It meant that services had no overall picture of the numbers of clients with a dual diagnosis or of their needs within each locality (T1: 101, 467). It also meant that there was no simple or effective way for health and social services to communicate with one another at front-line level. Although a new IT system was being developed by the Trust to work across health and mental health social services it was unclear whether this would be available for use by learning disability social services across all localities (T2, 402).

Part of the problem was that learning disability social services information systems did not recognise CPA and were not compatible with how CPA was structured. For example, their IT systems only recognised that social workers would hold cases for 28 days, in keeping with social service care management models: "*That's the way the…system works with social services. If a referral comes, you do it, you get the care plan out, do your research kind of thing, get the care plan out, and within 28 days it must go through your management for authorisation…and unless they're a complex person, they don't have social workers, they don't tend to have long cases now*" (A2: 139). Cases under CPA could be held for much longer than 28 days.

In fact, social service IT systems did not recognise the needs of dual diagnosis clients at all: "*they don't even recognise that somebody might be detained under a Section 2 or 3…social services are very much geared in terms of adult social care, not mental health, not learning disabilities…so it just does not recognise, you know, the needs of people who have dual diagnosis in terms of learning disability and mental health*" (A5: 230). This meant that clients could only be assessed for service eligibility based on social rather than mental health need. This created difficulties for learning disability staff attempting to care coordinate through CPA and often led to the duplication and inputting of information across different IT systems; something which it was reported that staff were not prepared to do (A4: 208). Front-line professionals found this challenging and regularly faced difficulties in accessing client information held by partner organisations. This was a particular problem for the Trust employed learning disability psychiatrists and psychologists who could not access Trust IT systems because their offices were physically based in learning disability services.

Underlying these incompatible systems was a general lack of understanding across all the organisations about what information was acceptable to share and in what context (D3: 189). Due to a fear of litigation resulting from potential breaches of client confidentiality, all partners felt that it was important that they gave approval on what information was to be shared, and how, with partner organisations: "*it's about people protecting their own backs from possible litigation…so there's just that constant kind of barrier being put in place*" (D3: 194). Although general protocols for sharing information were in place the practical application of these was complex due to the size of the Trust and the number of partners and services it worked with.

### 6.5.4. Organisational Complexity

There was no evidence in this study to suggest that a lack of coterminous boundaries affected the implementation of CPA. This was because the boundaries of each of the localities were coterminous with those of the Trust. However the number of partners the Trust worked with had increased dramatically as it doubled in size over the previous five years. It had become directly responsible for the mental health services of the five separate localities included in the present study and was in the process of taking over learning disability services from a sixth. It also had responsibility for numerous other services in three other localities. Each of these localities had its own local authority, PCT, learning disability and mental health social service departments with which to work and communicate. This created many challenges for the Trust; with so many local teams and disparate groups across localities it was difficult to prioritise particular policies, since each service and team were working with their own local agendas and issues. Even if a general consensus was reached on a particular policy, the actual number of organisations and services involved would make implementing it consistently across all areas extremely challenging: "*it's that there are so many disparate groups, who, you know…provide some kind of service, and it's how do you bring all of those people together*?" (D3: 85). These difficulties were a particular problem for the Trust CPA Compliance Manager, whose workload had expanded to cover these new geographical areas (T1: 353; T2: 114). He spent considerable time and effort trying to implement CPA consistently across all Trust managed mental health services in the localities. He was working on a CPA project plan which included the implementation of CPA within learning disability services. However there were so many people and services with which to liaise and consult with that the plans lacked consistency, were resource intensive and the Trust was struggling to have a single joint strategy for policy implementation across all of the different organisations (T1: 400).

This complexity was particularly troublesome for the voluntary sector organisations, which continuously had to meet with numerous separate partners. Different localities had engaged with voluntary organisations to varying degrees. Against a backdrop of their own financial cutbacks, these organisations struggled to provide staff representation at the numerous Steering Groups and often had separate meetings across and within localities which they felt should have been held jointly (B5: 285).

### 6.5.5. Lack of Governance and Accountability Arrangements

One key problem associated with the large number of partners was that there was a lack of governance and accountability arrangements between the Trust and its partner organisations. Although the Trust could make its policies mandatory and expect local areas to have appropriate reporting mechanisms on progress, it could only do this with its own services. It did not have any authority or formal control over learning disability teams (T3: 52) who were managed by the local PCTs and local authorities.

The fact that the Trust and learning disability services were separate, autonomous entities was also problematic at the front-line level in that the various configurations of professionals and their teams often had no responsibility to, or authority over, one another resulting in the further enforcement of team and service boundaries (B3: 29, 87, 99). The Trust had focused on trying to bring both the mental health learning disability specialist teams and general learning disability services together, but as it did not manage these services it had no authority over either of them (B1: 300, 373). The problems were compounded by the internal organisation of these teams each with its own systems, processes and accountability arrangements and professionals who, in turn, had their own cultures, rates of pay and service line management (B5: 332). This complexity meant the Trust had no authority to implement its policies at any level of its partner organisations and having these different organisations managing different local teams, simply reinforced the status quo. Attempts to implement appropriate care provision and CPA "*hasn't pulled together*" (B1: 373).

Paradoxically, the presence of a specialist mental health learning disability team in the localities often further hampered the Trust's ability to enforce accountability or governance arrangements, as clients seen within these teams had little or no contact with mainstream services provided by the Trust (C1: 165, 185). This meant that there were no opportunities to implement CPA for these clients or introduce governance arrangements when for example a client might be admitted to a Trust in-patient service.

To get round these issues, the Trust had offered to employ learning disability psychiatrists and psychologists within individual learning disability teams or to completely take over the running of learning disability services from social services (T1: 400; T3: 380). This was done in the recognition that without greater control over the individual teams, the Trust could not effectively promote CPA or any other mental health care agenda (T3: 273). However, in learning disability teams which included Trust employed staff, the non-Trust employed staff and services still had no obligation to report back to the Trust. This placed the Trust employed staff in a difficult situation: "*a lot of community teams are social services led and there's often a poor understanding of clinical governance, so it puts Trust employees in quite a tricky situation*" (E3: 575). This situation created a tension between the Trust staff, who were obliged to implement CPA, and those employed by learning disability services who were not.

### 6.5.6. High Staff Turnover

To address this tension the Trust had begun negotiations with PCTs and local authorities on the possibility of employing further mental health staff in learning disability services. This was welcomed by these organisations as they were experiencing high levels of staff turnover in learning disability services. This resulted in a lack of permanent staff, a loss of commitment to ongoing initiatives and temporary leadership across the different hierarchical levels within the organisations. Temporary or new staff employed into vacant positions were often reluctant to "*stick their neck out*" to ensure that dual diagnosis clients received the services they needed and so the idea of having mental health employed staff was seen as being a positive move (B3: 116, 275, 298).

All organisations were affected by staff turnover at both strategic and front-line levels. This had a direct impact on services and CPA implementation. Frequently, much time was spent on developing relationships with various partners and getting them to commit to and be supportive of policies and strategies, and then the individuals concerned themselves moved on (T1: 345, 414). A clear example of this was that “*there isn’t one borough who has the same commissioner as was there last year*” (T1: 397). Staff who remained in post were constantly and repetitively having to deal with new people, trying to explain the importance of policy and get them on board with the agenda. Staff turnover also meant that information was not handed on and a loss of collective organisational memory: “*we’re not aware of the history of where things were and where we’re going to“* (E4: 232).

## 6.6. Conclusion

This chapter has presented some key demographic information about the populations and neighbourhoods covered by the Trust and the five localities involved in this study. From the data presented it is apparent that although the localities had some similarities, they each present unique challenges in terms of service provision to the Trust e.g. variable population densities, groups, poverty indices, etc.

Alongside these demographic differences the meso-level analytic lens used in this study to explore the factors influencing CPA implementation enabled the identification of six key contextual factors impacting on the Trust and its partner organisations at a meso-level. These factors were impacting on all areas of the Trust’s operations including, but not limited to, the CPA implementation process. The complexity of these issues meant that there needed to be a more strategic and determined approach to the implementation process. However this was hampered by the lack of resources and the complexity associated with the fact that there were so many different organisational priorities, structures and internal issues such as incompatible information sharing and technology systems; issues which the relatively new Learning Disability Directorate within the Trust had yet to get to grips with.

The impact of these contextual issues filtered down to locality-level where each of the localities was struggling to implement CPA and where they were also experiencing further difficulties specific to implementation at that level. These issues are discussed further in the next chapter.

# Chapter 7: Factors Affecting CPA Implementation at Locality Level

## 7.1. Introduction

This chapter identifies factors that appear to have had a direct impact on the implementation of CPA in each of the localities. It highlights common factors affecting implementation with particular localities used as exemplars. Notable differences between localities are also identified. The contextual findings presented in Chapter 6 also had a significant bearing on many of these issues. Their influence will be outlined where relevant.

The use of the Framework Approach (Ritchie and Spencer, 1994) supported the process of identifying the key issues affecting CPA implementation at locality level by enabling the organisation of data according to key recurrent themes identified through the analysis of documents and interview transcripts. Table 7.1 presents these key factors affecting CPA implementation at locality level.

- The Absence of a Shared Vision, Understanding and Commitment;
- The Absence of Shared Strategies and Policies;
- The Commitment of Staff and Key People:
    - Senior Management,
    - Project Leads,
    - Mental Health Staff in Learning Disability Services,
    - Learning Disability Consultant Psychiatrists,
    - Clients, Carers and the Voluntary Sector,
- Traditional Professional Roles and Cultures
- Education and Training;
- Administrative Support;
- CPA for Particular Client Groups:
    - Dual Diagnosis Clients in In-Patient Settings,
    - High Risk Clients.

**Table 7.1: Key factors affecting CPA implementation at locality level**

## 7.2. The Absence of a Shared Vision, Understanding and Commitment

The development of a shared understanding of and commitment to CPA, by those involved in the implementation of CPA at locality level, was perceived by senior managers within the Trust as crucial to its effective implementation. There was acknowledgement that there was a level of organisational commitment from social services and ongoing meetings tried to engage that further (T1: 90; T3: 177). The commitment of the Trust to the process was seen as strong in some localities but not others, whilst the commitment of commissioners, other key stakeholders and senior managers in some local areas was questioned by respondents: "*that's where the issue is, and that comes from how you get commissioners and senior managers to buy into the idea, because they themselves have to, of course, understand CPA and sort of see it as, 'Yes we need to be delivering on this.' And that's lacking*" (A4: 272). Local authorities in particular were reported as not seeing a need for CPA and thus did not set up supporting systems for those front-line staff who wished to take the policy forward (T3: 32). This overall lack of a joint vision and approach between the Trust and local authorities was reflected in each of the localities.

CPA implementation was seen to be contradictorily pushed, as either a Trust or learning disability social service initiative, but not both. In general it was reported that there was an overall lack of commitment and ownership from learning disability managers in social services at locality level (A3: 281; D2: 141). This led to a lack of cohesiveness in some localities with each organisation having its own agenda or making "*their own unilateral decisions*" (A5: 196) without negotiation with the other partner organisations. The result being that "*it didn't feel as a whole…and even though we were together, for me it didn't feel as if we were together*" (C3: 35).

Attempts had been made through the creation of interface meetings to create better partnership working between mental health and learning disability services. However, although these meetings and the local Steering Group meetings were happening in some areas they were mainly attended by staff from either mental health or learning disability services rather than having equal representation from both. This was clearly illustrated in Locality B, where the Trust and PCT each had their own separate CPA implementation Steering Groups; the Trust's group did not have learning disability representation and the PCT group did not have Trust representation (B1: 85; B4: 382). Initial attempts had been made to develop an interface meeting across services to draw up a common strategy but questions were already being asked by respondents about how that could be achieved given the perceived lack of commitment to CPA implementation by local Steering Group attendees. Only two people had turned up to the second meeting and only one to the third, which the chair herself had forgotten about (B5: 34).

The lack of commitment within the Steering Group was reported by the local CPA manager as filtering down to front-line mental health services, where she reported that staff did not engage with, or commit to, CPA implementation for dual diagnosis clients and where there was a perception that "*it's nothing to do with us…that's not our service here, we deal with adults, you know, we don't deal with learning disabilities…it's at Trust headquarters level, there should have been more coordination, you know to get everybody from every service attending…*" (B2: 298). Instead she identified that staff in front-line teams reinforced strong service and professional boundaries to prevent them working through CPA processes. These boundaries meant that even if the Steering Group was able to come to a joint agreement in principle it would face hurdles in its translation to practice (B3: 279).

The main fear to come from this disjointed approach was that as these organisations failed to agree on how to provide appropriate support through CPA, clients were slipping through the net between health and social services (B1: 58). The issue was compounded by the size of the organisations involved. With so many organisations, services, groups and individuals there were difficulties in reaching a general consensus (D3: 89, 155). At a front-line level this meant that although the learning disability consultant psychiatrists may have had access to a CPA policy from the Trust there was no commitment from learning disability services management to take ownership of it so that it could be operationalised (D2: 340). Without this commitment it was not possible to implement CPA at a front-line level.

In areas where learning disability services did take ownership of the policy (e.g. Locality E), they had been left to their own devices in the implementation process by the Trust. This led to CPA being seen by the local authority as a separate and specialist process of the psychiatrists within the learning disability teams (E4: 146) resulting in those interviewed feeling that they lacked ongoing support. To drive the CPA agenda forward, unsuccessful attempts had been made by the locality's psychologist to forge a unified relationship across all organisations involved in the implementation process by "*trying to…hoping to forge more kind of links at a more qualitative level, developing relationships with professionals in the different mental health teams, and we've kind of offered that out quite a lot, but there hasn't been any take up of it*" (E4: 25).

### 7.3. The Absence of Shared Strategies and Policies

"*(There is) no protocol, they don't have a process, they don't have a policy*" (A2: 13).

Within the Trust an organisational wide policy on CPA placed an expectation on all services and teams to implement CPA at the front-line level (T3: 298). However, as discussed in Chapter 6, the lack of governance or accountability arrangements and the level of organisational complexity meant that at a local level there was no single joint strategy across the different organisations, few completed local operational policies or guidance on how teams ought to work together, take on care coordination, allocate champions or train staff on CPA (D2: 170).

A disparity between policy on paper and its operationalisation in front-line services was observed in many of the localities. To aid the process of implementation at a local level, the Trust offered its own CPA policy and supporting documentation to local Steering Groups so that they could be altered to meet local need. Mental health services had completed local draft operational policies from these in some localities and had offered them to their respective learning disability teams so they could review and adapt it for their clients (A2: 106). However it was observed that the teams which attempted to take on these policies or local systems of working had no local frameworks into which learning disability services could translate and operationalise them: "*when it comes to the practical aspect of actually working around that, it becomes problematic*" (A4: 184, 337).

One strategy employed to address this was the creation of more local subgroups within front-line services which aimed to show how services could work in partnership with the Trust and use its policies to benefit their practice whilst taking ownership of CPA (A2: 102, 448). In Locality A these forums had enabled the creation of a local draft CPA policy in which both mental health and learning disability staff had taken joint-ownership: "*you can take the (Trust's) policy, look at it, take the parts that you like out of it, and then make it unique to your service for the pathway, so a person on CPA would get this, this and this, that fits into your service…so they started thinking more positively about it. So they've got drafts now, of a system, of how they could support someone on CPA*" (A2: 103, 274).

Locality E appeared to have made the greatest progress in developing joint strategies and protocols. The local Steering Group which had more learning disability than mental health staff had succeeded in focusing on the needs of the clients and set about ensuring ongoing support and delegation of work within the group (E1: 505). This Steering Group constantly flagged up impediments to CPA implementation e.g. staff training (E1: 230) and was viewed by one of its co-chairpersons as taking a problem-solving approach to issues as they arose (E1: 50). In this situation the Trust CPA policy was used by the Steering Group in a positive way to add weight to the ability of the locality to continue with its plan to implement CPA for all its dual diagnosis clients: "*I think now if it's in the policies, people will see how they should access it (CPA)…you could refer to the policy and say; 'Actually it's part of your service remit'…"* (E3: 492). The policy was seen by Steering Group members to create more of a push to implement CPA and provide more of a structure in which that could be achieved (E4: 185). This process had been helped by the creation of the Learning Disability Directorate within the Trust which was viewed by the Steering Group as adding weight and credibility to their work, and in particular in negotiations with PCT commissioners (E1: 514).

However the general impression across the localities was that without a joint strategy or policy "*it doesn't all quite link up at the moment*" (C2: 548) and local Steering Groups were left trying to reconcile differences of ethos between mental health and learning disability services, often with little understanding of either by each (B4: 11). As succinctly put by one interviewee: "*one's from Mars and one's from Venus*" (B5: 265).

### 7.4. The Commitment of Staff and Key People

Although there were questions at a locality level about the organisational commitment to CPA by interview participants, it was hoped at Trust level that the commitment of individual staff based in each area would enable a nurturing of local partnerships which would in turn drive CPA implementation across the localities (T3: 139). However Trust level respondents felt that staff commitment at a local level faced a number of hurdles; more junior doctors were perceived to be less committed to CPA and therefore did not try to implement it in practice (T1: 330), front-line staff viewed CPA as adding on to their administrative and bureaucratic workload (T2: 144) and staff turnover meant constantly spending time to get new staff to commit to CPA and thereby distracting from the implementation of the actual policy (T3: 166). Overall staff commitment was measured by respondents through attendance at local Steering Group meetings, drawing up draft policies, circulating information on CPA and by taking overall ownership of the process (A3: 302). However there did not appear to be any incentives for staff to do this work and it was suggested by one respondent that there was an over-reliance on the dedication of key people to keep this process moving (A3: 232).

Trust management interviewees viewed lack of commitment from front-line staff as a primary reason why attempts to implement CPA were "*floundering*" (T3: 140) in some localities, whereas front-line staff suggested the opposite. They felt there was a lack of support and commitment from senior Trust managers and this was, according to them, a primary block in their localities. In fact the study findings indicate that there appeared to be a lack of commitment from staff at all levels of the respective organisations involved. Commissioners from the PCTs were particularly identified by a number of respondents as lacking commitment to the process, illustrated by their non-attendance at Steering Group meetings (A4: 300), not being on board with agreed targets (A1: 89) or not buying into, or in some cases understanding, the concept of CPA (A4: 272). It was speculated by a couple of respondents that this was due to their fear of needing to commit financial resources to the process (A4: 280).

The lack of engagement of the PCT commissioners appeared to have a direct impact on local Steering Groups, particularly in Locality A where one of the chairpersons had disengaged from the process, since without the finances or resources to back it up, working on the CPA implementation process did not seem the best use of their time (A1: 197). The impact of this was that Steering Group members in the locality viewed CPA for dual diagnosis clients as a non-priority and this feedback had a negative effect on their own commitment and perception of the need to implement it (A3: 185).

In general, those who were involved in local Steering Groups across the localities understood that there was a need for CPA. However it was difficult to keep the implementation process moving. With other competing priorities and demands diverting their attention and taking precedence they felt that there was a lack of a collective commitment and an over-reliance on key individuals to drive the agenda forward and keep any level of momentum (A3: 298; A5: 71).

Locality E presents an example of the benefits of commitment from a core group of people. The particular commitment of the Trust lead consultant psychiatrist and lead social worker meant that they were both in turn able to get the commitment of their senior colleagues to engage in the process (E1: 159, 447). Both these staff were in senior positions within the Trust and showed a personal drive to take CPA forward (E1: 152). However, even with the commitment of such key senior people, the localities overall frequently lacked commitment from front-line services across both learning disability and mental health. This resulted in the slow take-up of strategies and policies and meant that in some front-line teams local CPA policy was being implemented whilst in others it lagged behind (E4: 18, 36).

There were a number of groups and individuals who were identified by respondents as needing to be, or actually being, committed to the CPA implementation process. These key people were identified as health and social services senior managers, CPA project leads, mental health staff based in learning disability services, learning disability consultant psychiatrists, clients, carers and the voluntary sector. These are discussed in turn.

### 7.4.1. Senior Management

Senior management support for CPA implementation appeared to be offered at two levels; from the Trust Board of Directors and from senior management in the localities. At board level the Director of Operations pushed the CPA agenda through meetings with the five localities PCTs and local authorities emphasising that its implementation was necessary to meet the needs of dual diagnosis clients (T1: 390; T3: 154, 361).

The Trust had also formed a Learning Disability Directorate which consisted of a Director and a Deputy Director (who also acted as the Learning Disability Divisional Manager). However, this Directorate was relatively new and had not yet established relationships with local learning disability services, so its ability to influence CPA implementation was limited (A4: 356). Instead, there appeared to be a reliance on the goodwill of local managers and professionals to act as leaders and set an example in front-line services (A2: 252).

However, in Locality A for example, local managers were in relatively junior positions and with a perceived lack of role-modelling from more senior Trust management they had limited power or influence over CPA implementation (A1: 110, 255; A3: 12). Invitations to more senior management had been sent in attempts to add gravitas to local Steering Groups. However it was reported that these invitations had been declined, for reasons unknown (A4: 209).

In Locality D the issue of senior support was addressed through the appointment of a ‘Modernisation Manager,’ part of whose remit was to lead on improving partnership working across and between services (D3: 213). This had come about because it was recognised that the previous CPA project lead’s role in the locality had had limited impact due to a lack of commitment from learning disability services (D2: 139). It was unclear whether this new Modernisation Manager post would be joint-funded, something which respondents identified as being important to its success – since it would indicate commitment and support from senior managers across both organisations (D4: 214).

Despite a lack of commitment to the previous work of the CPA project lead in Locality D there was a common view amongst respondents that such roles were important and were required for the successful implementation of CPA, particularly at a front-line level.

### 7.4.2. Project Leads

One group of people expected to commit to CPA implementation were appointed project leads, who were viewed as key to bringing different groups together to lay the foundations on which ongoing work around CPA could be developed. Their role was described by the lead nurse in Locality D as “*quite positive from our perspective because it means there is a single person there who is coordinating and managing and bringing disparate people together*” (D3: 213). Project leads had previously been appointed in Localities D and E whilst the project lead for Locality A was in the process of moving her job to Locality B as part of a planned process of implementation in that locality. However the primary focus of these lead roles was working on the GLTK audit. The role of leading on CPA implementation was either a subsidiary element within that (as in Locality A) or due to the weight of work involved with the GLTK, had been sidelined altogether (as in Locality D).

The posts were funded solely by the Trust and were developed to engage and network with the local authorities, social services and PCTs to show a need for CPA, educate them about the CPA process, show a need for a multi-agency endeavor and to make sure that they did not feel that CPA was forced upon them by the Trust (A2: 69). Through networking, project leads developed relationships in front-line services and had used these relationships to identify key people in local teams who were not resistant to CPA (A2: 324).

In Locality A for example, the project lead worked with the locality's lead social worker and supported her in championing CPA in social service teams (A2: 112). This resulted in one group of social workers setting up a CPA sub-forum to look at how best to implement CPA in their own front-line team. The role of the project lead in this area and her achievements were recognised by other interviewees both from within and outside the locality. They saw her ongoing work and commitment as key to enabling the introduction of CPA in the locality (A3: 92) and using her connections to develop relationships with key people so she could drive the CPA agenda at both a senior and more local front-line level (A1: 114; A3: 90; B1: 204). This dedication was seen as having enabled some movement on CPA training in the locality (A3: 73; A5: 118).

Interviewees in Locality E also recognised the importance of the groundwork laid by their original project lead. He was the only CPA lead across the localities to not have had any involvement in the GLTK as he had left post prior to the Trust's involvement with the toolkit. His departure to work as project lead in Locality D however meant that there was a perceived lack of ongoing leadership, leaving individual staff to lead by example in front-line areas where possible (E2: 385; E3: 175). After he left post a link worker between mental health and learning disability services was appointed, who focused on developing joint protocols and clinical interface policies and pathways for clients, which indirectly helped with the CPA agenda (D1: 59). However there were questions about whether this had any impact on CPA implementation at all, since he he lacked senior learning disability service management support and although his remit was to push CPA, without this support he ended up working on other learning disability priorities and in particular the GLTK (D2: 126, 139).

In Localities B and C where there was no appointed lead there was also a lack of key champions at a senior level to take CPA forward (B1: 98, 298). Instead a number of interviewees saw their own role as championing CPA within their own sphere of responsibility. For example, the learning disability consultant psychiatrists used their positions to review policies and provide basic CPA training to front-line staff or used wider networks to influence social workers to care coordinate and lead on CPA for their own clients (B4: 60, 313). However these achievements were not widespread throughout the localities and tended to be local to the service in which the consultant worked in.

With no specifically appointed leads, work on CPA was done by “*default rather than design*” (C2: 164; C3: 555). This meant that work was ad hoc and no single individual had any overview or responsibility for CPA implementation. Those who had been delegated aspects of this work were generally not clear about what they were expected to do, including the mental health Service Manager in Locality C: “*I suppose what’s going through my mind at the moment is, you know, what’s the local strategies or strategy, where does it sit…it’s that for me, it doesn’t all quite link up at the moment*” (C3: 556).

It was noted by participants however that the Trust had appointed specific project leads for the GLTK, something which had not been done for CPA (D2: 340). For example Locality D had a project manager from a senior position who, by virtue of that position, was able to get commitment from the PCT and senior Trust and learning disability service managers. However commitment from key people in the same locality for CPA was not felt by participants to be present and was evidenced by a lack of key senior staff at Steering Group meetings.

### 7.4.3. Mental Health Staff in Learning Disability Services

As mentioned in Chapter 6, staff turnover in learning disability and mental health services was a problem for the Trust and its partner organisations. One key strategy employed by the Trust to implement CPA in learning disability services was to register its interest in taking responsibility for learning disability teams that were at the time run by social services or the PCT in each locality (T1: 407). In terms of mental health care, the Trust was in discussion with the various local authorities of each locality about taking over the management of learning disability psychiatrists and psychologists where this had not already occurred (T3: 417). This was part of a two-pronged process to implement CPA; mental health staff with CPA knowledge and experience would lead by example in these teams and would then use their positions to push the CPA agenda (T3: 270, 367).

In the localities where the Trust had taken over psychiatrists' contracts (Localities B, D and E), CPA was actually being implemented in some front-line teams, or at least appeared to be higher on the local agenda. In these localities there were also discussions about employing more staff under Trust contracts in learning disability services. Locality E was the most advanced in this process, having already appointed a Trust employed learning disability consultant psychiatrist and a staff grade psychiatrist and having just received joint funding (between the Trust and social services) for a community psychiatric nurse within learning disability services. Learning disability services were working closely with the Trust to help recruit into this post as part of a programme of continuing relationship development between both organisations (E1: 636). It was anticipated that like the psychiatrist and psychologist in the team the nurse would use their role to implement CPA for their caseload of clients, thereby showing to others in the team that CPA was no extra burden and had benefits for both clients and staff alike.

### 7.4.4. Learning Disability Consultant Psychiatrists

Of those staff employed by the Trust in learning disability services the role of the consultant psychiatrist was seen as crucial in leading on the implementation of CPA (T3: 366). At Trust level the Deputy Director of Learning Disabilities was working alongside the Medical Director to look at ways of encouraging all consultants to work with their local authorities to embrace CPA in each of the localities. She identified that the consultants were "*leaders, and implement CPA in their teams and we will support them, that we will take joint-responsibility with the consultants…so I've been doing some work with (the medical director) around how do we get the consultants talking more and co-operating a bit more*" (T1: 186). This had already started through one-to-one meetings, attending consultant meetings and raising CPA as a clinical governance issue (T1: 29). Although it appeared that they were all on board with CPA, consultants still faced barriers in their respective areas. Supported by the consultants interviewed the Trust Deputy Director for Learning Disabilities indicated that consultant psychiatrists "*have driven it (CPA), but we have quite a few new consultants, learning disability consultants, who I don't think have much influence really…they're told by the local community teams it's a resource issue. They don't have the staff to be (CPA) coordinators. They don't have the admin resource to support it. They don't have the documentation*" (T1: 314).

In all localities learning disability consultant psychiatrists took a lead in the CPA implementation process and attempted to champion it in their front-line areas (A4: 347; A5: 118). Due to the nature and seniority of their positions they managed to raise the profile of dual diagnosis clients' needs (e.g. C2: 229, 241, 329) often using that seniority to place clients on CPA and trying to get other psychiatrists and social workers working with them to act as care coordinators. They were also seen as having the authority to argue with commissioners in order to get funding for specific clients needs (A2: 530). This set an example of how CPA could be used by all staff as a powerful bargaining tool. However consultants generally had less direct involvement with clients which limited the impact of this approach (B1: 252).

With such a heavy reliance on psychiatrists as a primary method of implementation (A5: 119) there were often difficulties when they left post. For example in Locality D the consultant's pending maternity leave was expected to impact on CPA implementation in the locality (D2: 100). She was seen by her Steering Group colleagues as the primary person responsible for implementing CPA in the locality's front-line services (D1: 125). However despite her anticipated departure the locality had made no provision to ensure that work she had done on CPA implementation in the locality would be carried on.

Of the four groups of key people above it appeared that although most participants complained of a lack of senior Trust-level management support, it was in fact the learning disability consultant psychiatrists and appointed project leads who were most able to drive through the CPA agenda either overtly (as project leads did) or by stealth (as consultants attempted to do) at a locality level. Either way, their impact was evident across the localities with individual consultants able to implement CPA in small pockets of front-line teams whilst project leads were able to have a wider impact across entire localities. Their efforts at implementing CPA were however most effective when senior Trust and learning disability managers offered their support and when mental health staff based within learning disability services were open to looking at, and using, CPA as an approach to care.

### 7.4.5. Clients, Carers and the Voluntary Sector

The engagement of clients, carers and their respective representative organisations in the CPA implementation process was seen by senior Trust managers as a very important issue. However when it came to practicalities the Trust CPA Compliance Manager acknowledged that the localities were having difficulties with no actual dual diagnosis clients engaged on any of the local Steering Groups (T2: 90).

All the localities offered financial incentives to clients and carers in an effort to encourage engagement with local Steering Groups. These incentives included a small payment or the refund of expenses incurred by participants in attending meetings. In many cases the offers of financial incentives simply were inadequate both in terms of monetary value but primarily because people like carers had more pressing responsibilities than attending meetings i.e. they had caring responsibilities.

However even when a carer presented themselves as available to assist there were issues with accessibility. For example, in Locality E, a carer who wanted to attend the local Steering Group had been identified. However, English was not her first language and an interpreter would have been required to enable her to engage fully in the process. This possibility had been dismissed by the Steering Group who reportedly felt that this would take up too much of their time in meetings. Her offer to participate had therefore been declined (E5: 100). In view of the lack of a client or carer representative, the locality placed a bid with the local PCT for monies to employ a full-time advocacy worker. The outcome of this bid was not yet clear.

There were however a number of client and carer organisations involved in three of the local Steering Groups (in Localities A, B and E). Once involved it was important that continuous efforts were made to keep them engaged in the process. Advocacy groups had agreed to attend Steering Groups in all of the localities but in many cases did not regularly attend meetings, or in the cases of Localities C and D disengaged altogether. In part the Trust senior managers felt that this was due to the expectations that these groups placed on local Steering Groups and what they anticipated achieving versus what the Trust and local Steering Groups anticipated being able to do. The CPA implementation process was slow and arduous and without a joint perspective on what was realistic to achieve, and a lack of financial support, there was disengagement from the process by the various voluntary agencies: "*well they all have different expectations…again its differing priorities. A lot of (localities) have lost their learning disability development fund money, where their advocacy groups would be funded from, so they can't come. They don't have anybody to send*." (T1: 252).

To maintain engagement with the voluntary sector some Steering Groups, and in particular in Locality A, were flexible in how they communicated within their meetings and how they informed others of their work. In these Steering Groups there were efforts to create a culture of transparency and openness with the gentle challenging of the status quo e.g. Steering Group minutes were produced in simple easy-read formats and kept to the point with no acronyms or jargon. There was encouragement within the groups to have a client focus and show willingness to hear what clients' perspectives were on the work they had achieved. This engagement led to more feedback from clients being taken on board in the policy implementation process and illustrated to front-line professionals that CPA was a process which clients themselves wanted and were involved in.

However open channels of communication were not present in all localities and some continued to use a lot of jargon which was difficult to comprehend. This meant that meetings were inaccessible and, as in Locality E, no time was taken by the Steering Groups to explain the meaning of what was being discussed (E5: 16, 31, 249). The result of this inaccessibility was that the voluntary sector representative often did not understand what was being discussed and did not address this as an issue within the Steering Group. This was because she did not want to appear "*stupid*" to the other professional representatives (E5: 30).

### 7.5. Traditional Professional Roles and Cultures

Although key people were continuing to drive the CPA agenda forward within their spheres of responsibility there continued to be wider hurdles to this process across the localities. The primary issue was the level of wider commitment to the process particularly because of, what was viewed by respondents as, incompatible traditional professional roles and cultures between health and social services.

Within learning disability services a new care planning process, as part of the overall *Personalisation Agenda* (DH, 2007), had become a primary focus for learning disability services and was perceived to have displaced CPA implementation as the focus of social service attention: "*the Personalisation Agenda has been huge in the last three years for them and they've just become so focused on that and mental health seems to have taken a bit of a back burner really.*" (T1: 90).

Considerable resources had been spent by the PCTs across the localities working on this new agenda, and there was a view that they were hesitant to undo the work that they had achieved in implementing this system so that they could then implement CPA so soon afterwards (B5: 368; D1: 333). Separate to the fact that many resources had been invested in this process, and that the *Personalisation Agenda* was a competing priority for CPA implementation, there was also a view that *Personalisation* was fundamentally different to CPA; *Personalisation* like care management supported individual budgets (i.e. what clients want) whereas through CPA funds were viewed as being allocated based on professionals' decisions about client need (T2: 283). This difference brought to the fore the fact that health and social services had different cultures and ways of working (T3: 74). They were seen as separate frameworks and it was felt by respondents that there was an overall lack of clarity around how compatible they were with each other (T2: 291; T3: 486; A5: 234; E1: 200).

At a front-line level the practical implication of these different frameworks across health and social services was the ability of staff to use them to support traditional cultural and professional role boundaries. There was a general acknowledgement across the localities that the implementation of CPA would challenge the historical professional roles of some staff (by for example expecting social workers to assess and monitor their clients mental health rather than refer to psychiatric services) and due to a lack of understanding around CPA would potentially cause some culture clashes between professionals (T3: 150) particularly when it was viewed as a "*mental health way of doing things*" (E4: 125). Attempts to implement CPA into a care management environment were described by one respondent as "*kind of feels like a big turf war*" (E4: 255).

Although doctors had been singled out by Trust level interviewees as being potential barriers to CPA implementation because of their medical model approach to mental health care (e.g. T2: 125) the findings from this study suggest that learning disability nurses and their social work counterparts (both employed by learning disability services), were actually more resistant to CPA, particularly when there was an expectation on them to take on a care coordination role. In general it was reported that these professionals appeared to lack knowledge around the role of the care coordinator (A5: 425). Social workers in particular were seen as professionals who did not "*buy into*" the concept of CPA (A4: 380), which it was suggested had led to some of them refusing to care coordinate: "*It was very difficult to get some of my colleagues in social services to accept responsibility to be CPA care coordinators. I mean they refused sometimes*." (B4: 97).

Like the other localities, respondents in Locality E recognised that CPA challenged the traditional roles and practices within learning disability services and that staff were not keen to take on the care coordination role (E2: 343; E3: 238). However, unlike the other localities, Locality E had taken a more radical approach to the issue. Job descriptions were reviewed and traditional roles and alignment to what were described as "*old*" models of working (E3: 224) were challenged. Alongside restructuring the learning disability team worked with its social workers to enable them to "*recognise silos within our disciplines*" and move towards a CPA approach (E1: 553). Staff roles were broadened and as a result it was reported that a number of learning disability nurses had left the team as they objected to working with CPA (E1: 542, 576). However work and dialogue with professionals was ongoing in the locality and they aimed to illustrate that CPA was everyone's responsibility with any professional able to take on the role of care coordinator (E4: 52, 160). Locality E was the only locality to have reviewed its CPA policies and procedures to determine how its processes could be used to meet the *Personalisation Agenda* and requirements within social services (E1: 486).

### 7.6. Education & Training

To support staff in understanding how CPA could benefit their clients, staff education, organised by consultant psychiatrists and CPA project leads, had occurred in some of the localities. It focused on how a failure to implement CPA could potentially mean that professionals were acting outside of the law – thus taking a stick rather than carrot approach focusing on why professionals should work through CPA rather than how. In Locality C, for example, it was expected that this education, which took the form of general advice or 'drop-in' lunches rather than organised classes, would challenge traditional professional ways of working and open discussions at a local level around which professional was best placed to care coordinate individual clients (C4: 145).

Formal CPA training comprising more formal classes covering CPA processes, legal issues and professional roles had been developed by the Trust CPA Compliance Manager who worked with local team managers, who were then expected to cascade it to front-line staff. However there were some deficiencies in content – despite acknowledgement that there were clients with learning disabilities within mental health services, this training had no specific focus on dual diagnosis clients and faced considerable obstacles to roll out. Due to the size and number of staff within the Trust and with many teams working relatively autonomously there was no overall strategy to ensure that the training was delivered to everyone, or to find out if it was effective. Attempts had been made by social services across the localities to access the CPA training programme offered to mainstream mental health services. However social service respondents in the localities commented that the Trust's training department had refused their staff access to this training on the grounds that its limited resources needed to be prioritised for Trust employees and since learning disability staff were not Trust employees it had no obligation to provide such training to them (D2: 185, 223; E2: 138).

Instead the Trust focused on educating social services at a strategic level to highlight the importance of CPA for dual diagnosis clients within learning disability teams. This included raising awareness of, and placing emphasis on, national policy in the area and indicating the consequences to services of failing to meet this client groups' needs. It was anticipated that pressure at this level would then cascade down through the partner organisations to their front-line teams. The lack of an overall strategic drive to educate staff across mental health and learning disability services may account for the varying levels of importance attached to educating and training staff on CPA seen across the localities. Although there was some general training on the mental health issues of clients with learning disabilities organised by the Trust, and education on learning disability issues for mental health staff organised by social services, this training did not relate specifically to CPA and many front-line teams, particularly in Localities B, C and D, did not take this up. Learning disability services in these areas were reported to be suspicious about the potential vested interests of the Trust in offering such training (e.g. C1: 216) although it was unclear what these vested interests might have been.

In Locality A where there was a formalised training programme in learning disability services it focused on what CPA was and how it would benefit dual diagnosis clients, centring on the overlapping similarities that CPA had with the *Personalisation Agenda*. Particular emphasis was placed on the role of the care coordinator showing that much work already carried out by learning disability staff could be classed as care coordination (A2: 123, 498). The training was provided to all new learning disability staff in the locality on their induction programme and educational forums aimed at all staff were set up as an informal way to show how CPA was needed for this client group. These forums were well attended by Trust mental health staff but there was poor representation from learning disability nurses and social workers.

Like Locality A the other localities had more informal-type ‘training’ available to staff which took the form of leading by example in front-line areas. Mental health staff, particularly learning disability psychiatrists and psychologists, were encouraged to use CPA within their teams to illustrate how it could be used to reduce risks and provide comprehensive care without adding extra administrative or other time consuming burdens. The underlying strategy was to gently challenge preconceptions about CPA and through the sharing of mental health staffs’ experience and knowledge enable learning disability services to view them and CPA as a useful resource. It was unclear how effective this form of training was or what overall impact it had on the implementation process.

In general, although training needs had been identified, front-line learning disability staff and PCT commissioners were widely reported to have little or no knowledge about mental health issues, CPA, national policy on CPA, or awareness of any legal obligations on them to implement it (A4: 142; A5: 36, 43, 124, 287). This led one respondent to question how effective any training strategy was and how its impact was measured particularly when working with such large and disparate organisations; *“every car has got seatbelts, but is everyone wearing them?”* (A3: 333).

### 7.7. Administrative Support

Another way that the Trust aimed to reduce resistance to CPA implementation was to reduce the administrative burden that CPA had previously been accused of placing on professionals. Administrative support was cited as a challenge in the earlier literature on CPA implementation in the literature related to this topic; both in terms of partnership working and in the implementation of CPA in the 1990s. The present study identified that these continued to be issues for professionals who were working through CPA processes.

Trust management acknowledged that front-line mental health staff were “sick to death” of the growing administrative procedures associated with CPA (T2, 140). They were addressing this issue by creating new CPA procedures aimed at reducing the level of paperwork, making CPA more responsive to client need and taking the focus away from formalised meetings to the daily interactions between client and professional (T2: 142). It was anticipated by the CPA Compliance Manager that this would enable the streamlining of documentation and CPA processes: “*we’re trying to sort of find a middle way through saying that all these things have to be on the form for all sorts of different reasons…but they’ll apply to different people in different ways, using creativity, using it in the simplest way possible…and if it’s not relevant for that particular person, there’s no need to write something about it*.” (T2: 218).

In terms of administrative support Localities A, B and E had all appointed a CPA administrator in learning disability services. Their role was to reduce any extra bureaucracy burden CPA processes caused staff. This included organising meetings and staff diaries and being responsible for the organisation of clinical databases and registers for clients placed on CPA.

Locality E's administrator had a dual role, that of CPA administrator to reduce the burden of CPA paperwork (thus reducing the ability of staff to complain about bureaucratic burden) and as administrator for the local CPA Steering Group which involved taking and distributing meeting minutes (E1: 510; E4: 170). However questions were raised about the efficiency of the administrative processes in the locality by the learning disability consultant psychiatrist who often found that CPA meetings with clients did not have the appropriate paperwork completed (E3: 616).

## 7.8. The Implementation of CPA for Particular Client Groups

Although there were wider issues for CPA implementation as outlined above, CPA was in fact being implemented quite consistently across all localities for two particular groups of dual diagnosis clients; those admitted to mainstream mental health in-patient services and those who presented with potentially high risks to themselves or others.

### 7.8.1. Dual Diagnosis Clients in In-patient Settings

All learning disability clients admitted to mainstream mental health services, managed by the Trust were 'placed on' CPA as part of an ongoing process to engage all mental health staff to sign up to CPA for this client group (T1: 281). This occurred across all localities and training programmes were available to help mainstream staff work with this client group.

Locality A was unique in the Trust in that alongside mainstream services it also had a specialist in-patient unit specifically to cater for dual diagnosis clients. All clients admitted were automatically placed on CPA but like mainstream services in the other localities there was no CPA follow-up on discharge back to local learning disability services (A4: 492). However the presence of the unit and its role in placing clients on CPA was seen as setting a good example by the local learning disability team manager (A4: 492) and was recognised for this work at Trust level (T1: 273; T2: 340) and by staff in other localities (e.g. B2: 142). Part of the strength of the unit was that it was funded solely by the Trust and was independent of social services.

The Trust had total governance arrangements over it and was thus able to avoid any potential resistance to CPA by learning disability staff: "*They don't work with the local authority. They are pretty much hospital (i.e. Trust) based. So they can decide when to implement it and how to implement it*" (D2: 323).

However the presence of this unit in the locality also meant that there was no impetus in either mainstream mental health or community learning disability services to address CPA for this client group. It was reported that as a result Trust mainstream services received less support from learning disability services when these clients were admitted to their in-patient units or community services. This was because learning disability services did not see a role for themselves or a need to participate in discussions around CPA for these clients once the clients were no longer their primary responsibility (B2: 145, 340).

In Locality C dual diagnosis clients had been accessing beds in Trust in-patient services since CPA was first introduced in 1990 (C3: 266) and had been placed on CPA when admitted. However, as in all the other localities, this was not followed up on discharge back to community services unless the clients were discharged back to Trust community mental health services.

### 7.8.2. High Risk Dual Diagnosis Clients

Dual diagnosis clients who presented with an increased risk to self or others were also 'placed on' CPA in all localities. This occurred because they were taken on by mental health services or a court had ordered mental health service input. However once NHS mental health services were involved with the client, the local authority learning disability services frequently withdrew their support because they then deemed the clients problems to be primarily a mental health, rather than learning disability, issue (B1: 210).

A number of Serious Untoward Incidents (SUI) had occurred in Localities B and E which highlighted the fact that many high risk clients were not receiving appropriate care through CPA. (SUIs are investigations which occur following an event in which a client is placed at risk because of e.g. a failure to provide appropriate services or e.g. professional errors. They are illuminating because they identify gaps in care and service provision which then enable services to respond to ensure that similar incidents are not repeated).

In Locality B it was reported that a SUI led to a social worker facing disciplinary action (B4: 110) and illustrated the potential outcome for staff failing to implement CPA properly for a high risk client (B1: 80, 110). A second SUI in the same locality led to an independent investigation when learning disability services refused to take on a client with mental health problems. The result of the investigation and a subsequent court case meant that learning disability services were legally obliged to provide ongoing support to the client. However it still took these services 18 months after this time to actually do this because of a general reluctance to work with dual diagnosis clients and in particular clients who received support from mental health services. As the mental health chair of the Steering Group in Locality C identified the problem was that she could "*name various cases whereby the learning disability service, if we (mental health services) offer a service, they just drop them. So it's not partnership working*." (B3: 56).

In Locality E another SUI investigation was carried out when a high risk dual diagnosis client was refused access to the mental health in-patient intensive care unit at a time of crisis (E1: 147; E3: 280). As a result a review of in-patient services was carried out. Subsequently two in-patient wards were identified to receive special training in dealing with dual diagnosis clients should they be admitted and from where they would be placed on CPA.

The complete discharge of clients to mental health services once they were placed on CPA became a prominent issue in Locality D when a new community forensic residential hostel for high risk dual diagnosis clients opened in the locality. In the event of a client from this hostel becoming unwell they would have to be admitted to the locality's in-patient unit. Alongside the hostel pushing for open channels of communication across mental health and learning disability services (D4: 256) the very presence of the hostel ensured that health and social services worked together and "*created a lot of work in terms of making sure we've got clear understandings about policies and procedures*" (D1: 31). If a client was admitted to in-patient services they would be placed on CPA. However, once discharged there were no support mechanisms provided through CPA in the community, unless Trust community services continued to be involved with the direct management of the client's care.

### 7.9. Conclusion

This chapter has highlighted the key factors influencing the implementation of CPA for dual diagnosis clients across each of the five localities within the Trust. Against the backdrop of the multiple contextual issues discussed in Chapter 6, the locality level factors affecting implementation were all influenced by and deeply interconnected with each other.

Particularly important to this picture was that there did not appear to be the fundamental structures in place (e.g. access to finances and resources, information technology systems) upon which shared visions, strategies, policies, etc, could be undertaken to make the implementation process successful. As a result there was an over reliance on key individuals to drive the implementation process, a system which itself was overly susceptible to staff turnover, the complexity of working across multiple organisations with competing priorities, and a lack of support from senior managers within the Trust, local authorities and PCTs. With a lack of investment, both financially and otherwise, all of these factors combined to create an overall picture which was disparate, with no actual clear and consistent implementation of CPA throughout the Trust. Even in the localities where local Steering Groups had managed to implement CPA, this was only occurring in isolated situations and was not happening across all front-line line teams, meaning that implementation was either non-existent in some localities or patchy in others.

However, what was interesting was that the Trust was successful in implementing CPA for two particular groups of dual diagnosis clients: those who were admitted to

Trust in-patient services and those who presented with an increased risk to themselves or others. This is discussed further in Chapter 8.

The next chapter brings the findings together and discusses these in relation to the aims and objectives of the study and explores their relationship with the literature presented in previous chapters.

## Chapter 8: Discussion

### 8.1. Introduction

This chapter brings together the findings from the current study and discusses these in relation to the literature presented in previous chapters. The fact that the implementation of CPA for dual diagnosis clients presents with a similar picture to that of its original implementation in the 1990s is discussed and comparisons are drawn between the current study and that of North and Ritchie (1993) to explore the similarities and differences between the implementation processes in the intervening years. The findings are then discussed in relation to the literature on organisations and partnerships. The impact that the *Greenlight Framework* (DH, 2004) had on CPA implementation is also explored. The implementation of CPA for dual diagnosis clients who presented with high risk or required an in-patient admission is then discussed and the reasons why CPA was more likely to be implemented for these particular client groups, but was less likely for those who presented with fewer risk issues, is explored.

The purpose of this study was to explore the factors influencing the implementation of CPA for dual diagnosis clients from a meso-level perspective through:

1. The description and comparison of local approaches to the introduction of CPA for dual diagnosis clients in selected localities.
2. The identification of the various factors (including organisational, contextual and partnership related factors) that appear to have influenced the implementation process in the different localities.
3. An exploration of how key factors identified as important by participants appeared to help, hinder or otherwise affect the implementation of CPA for this client group.
4. The investigation of whether, and how, these issues were acknowledged and dealt with by those involved in the implementation process.

It was anticipated that this study would uncover the processes that occurred at a strategic level within mental health and learning disability services during the interpretation, and then application of national policy to the local context. An understanding of these processes was anticipated to contribute to knowledge by providing empirically grounded evidence on how CPA implementation has progressed for dual diagnosis clients; on whether the factors influencing implementation were similar, or different, to those factors influencing its original implementation in the 1990s; and on whether there were any particular facilitators or barriers to CPA implementation specific to this client group.

However, there were a number of limitations to this study which may have an impact on the findings.

This was a small-scale study which was conducted within a single mental health NHS trust. However, although this was a single trust with its own particular challenges, the findings seem likely to apply to other trusts wherever the contextual and specific local factors identified in this study also pertain. These factors would seem highly likely to be general across the NHS at the present time.

The disparate picture of service provision to dual diagnosis clients may also make generalisations difficult. However the contrast in service type and availability illustrates the complexity of providing care for this client group, even within a single trust. It may also be an indication as to why dual diagnosis clients find it so difficult to access appropriate mental health support when required (as discussed in Chapter 2), and more importantly, why implementing CPA for them was found to be so difficult.

Although key senior staff from a senior Trust level (e.g. Trust-level Directors) participated in the study, there was no equivalent representation from local authorities or Primary Care Trusts in any of the localities. This may be explained by the fact that there was a perception amongst participants that the responsibility for implementing CPA fell primarily on the Trust. However key senior people from both health and social services did participate at locality level, providing a balance between the views of both, and enabling an exploration of the factors affecting implementation from the perspective of each service.

Despite numerous efforts, no single locality was able to furnish a full set of documentary data for analysis, as requested by the researcher. This limited the data which could be abstracted from the documentary analysis. However the inability of the localities to provide such documents was in itself an interesting finding and indicated that there were administrative processes related to CPA implementation which were lacking across all localities.

Despite these potential limitations, the factors found to affect CPA implementation in this study bear some similarity to those found by North and Ritchie (1993), as is discussed in this chapter. The fact that both studies identified similar issues would indicate that there is validity in the findings of the current study.

## 8.2. The State of CPA Implementation for Dual Diagnosis Clients

The findings from this study indicate that the implementation of CPA for dual diagnosis clients took a similar route to that in the 1990s. A range of strategies were employed by the five localities involved in the development and implementation of the policy within their respective catchment areas. These strategies varied from locality to locality and although the main thrust for implementation came from the Trust, the manner in which services worked together varied by locality. For example in two localities mental health and learning disability services did not work together at all on CPA implementation; in another, services worked independently of each other, whilst in the remaining two, services had worked, or were working, together from the beginning of the implementation process.

As a result, work on implementing CPA through local Steering Groups, and progress with the actual implementation of the policy itself, was variable. Even where CPA policy had been implemented it was only being used in practice by a few front-line teams, rather than across all services within a given locality. So although there were pockets of successful implementation across the localities it was apparent that there was in fact quite limited progress overall.

There were however two interesting exceptions to this disparate picture. Dual diagnosis clients who were admitted to Trust in-patient services, and clients who presented with high risk issues, were both getting their care provided through CPA across all localities. These exceptions are discussed in section 8.6.

## 8.3. The Key Factors Affecting CPA Implementation at Locality Level

The purpose of this study was to explore the factors affecting the implementation of CPA for people with a dual diagnosis and, in the process, to consider how this process may echo or differ from earlier experiences of implementing CPA when it was originally introduced for mental health clients in the 1990s. As noted in Chapter 3, some of the most valuable insights about implementation of CPA in the earlier phase come from the study undertaken by North and Ritchie (1993). It is therefore appropriate to compare in some detail the findings of the present study with those of North and Ritchie. This comparison is helped by the fact that in a number of ways the design and coverage of the two studies was quite similar (see table 8.1).

| **North and Ritchie (1993)** | **Current Study** |
|---|---|
| Research conducted across four health authorities and their respective social service departments (seven in total).<br>Exploratory and investigative in form so as to be responsive to events occurring in each locality. | Conducted across a single NHS mental health trust and its respective local authorities (five in total).<br>Single case study design with multiple embedded units of analysis.<br>Explanatory in nature. |
| Localities chosen by the Department of Health to reflect differences in geographical location, type of catchment areas, coterminosity with social services and a history of working with psychiatric services. | The Trust chosen for this project was typical of other trusts in that it was working on the implementation of CPA for dual diagnosis clients. However it was unique in that it had five separate localities, each of which were aligned to different local authorities and which were at different stages of CPA development and implementation. These localities were working relatively independently of each other and one of them had a close relationship with central government. |
| Explored CPA implementation from the perspective of its development and its operation in front-line teams. | Explored CPA implementation from the perspective of its development at a strategic level. |

| | |
|---|---|
| Two phases:<br>Phase one interviews were conducted with those involved in determining CPA policy and preparing for its implementation. The majority were attendees at local working groups and mainly at management level within their profession.<br>Phase two interviews were conducted with operational staff at a front-line level and included ex-patients, carers and the voluntary sector. | Two phases:<br>Phase one interviews were conducted with Trust key informants and the chairpersons of local Steering Groups from each of the localities. Policy and Steering Group documents were also reviewed at this stage.<br>Phase two interviews were conducted with local Steering Group members which included voluntary sector representatives. |
| Interview participants identified and approached by senior management in each respective organisation. | A purposive approach to sampling was taken with potential participants identified through the researchers' attendance at local Steering Group meetings, analysis of local documents and through identification by Steering Group Chairpersons in each locality. |
| A total of 169 unstructured interactive interviews with 33 interviewed twice or more. | A total of 26 semi-structured interviews. Each respondent was interviewed once. |
| Data were collected from local policy documents related to CPA. | Data were collected from Trust and locality-level policy documents related to CPA, locality and Trust-level CPA Steering Group minutes and through the administration of the Partnership Assessment Tool. |

| | |
|---|---|
| Systematic analysis undertaken using a broad thematic framework. | Systematic analysis undertaken using Framework analysis. |

**Table 8.1: Comparison of the design features of the present study with that of North and Ritchie (1993)**

It should be noted, however, that there were some important differences in the broader context within which CPA was being implemented, on the two occasions 15 years apart. At the time of implementation in the 1990s the Conservative Government was nearing the end of its term in power, whilst this study was undertaken against the backdrop of a Labour Government for 14 years. Under their power The New NHS (DH, 1997) was introduced and reinforced by a *'modernisation agenda'* (Department of the Environment, Transport and the Regions (DETR), 1998), which involved the restructuring of the NHS around one of its founding core objectives: that access to care would be based on need and need alone (Oliver, 2005). This restructuring took the form of the creation of Primary Care Groups (later to become Primary Care Trusts), the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (which later became known as the Care Quality Commission), all established to improve the quality, efficiency and consistency of care provision within the NHS. The overall aim of the Blair administration at this time was to reduce inequalities, extend choice and quality whilst increasing autonomy, accountability and efficiency (Oliver, 2005) across health and social services. To achieve this, the government appealed to "the principles of territorial equality and universalism" in the delivery of local services and made it clear in doing so that it did not "welcome variation in performance" (Brooks, 2000, p596).

Underpinning these expectations, greater joint working was promoted between health and social services, with local plans to improve services for those with mental health problems. In fact partnership between the two was seen as a central tenet in the health policy of the government at the time, with funding to be used to rectify gaps in service provision within local mental health services (Peck and Parker, 1998). With Labour announcing that CPA was an integral part of the National Service Frameworks at the time, the integration of CPA and care management processes further cemented this partnership. These and many of Labour's other healthcare initiatives, came with various amounts of additional funding, and whilst in power Labour claimed that the NHS received treble the investment than that which it had received before (UK General Election website, 2010).

Despite these changes and the level of financial investment in services the present study was undertaken at a time of global economic recession in which many NHS and social service departments were beginning to make deep financial savings in order for them to reduce budget deficits whilst continuing to provide services. It was into this much-changed NHS that the more recent phase of CPA implementation for dual diagnosis clients was taking place.

With recognition that data for this study were collected three years ago it also needs to be acknowledged that in the 1990s, as in more recent times, the implementation of CPA occurred within the context of massive, wide-scale and continual policy change within the NHS. As already mentioned there was some tension between health and social services at the time of data collection as social services had just completed the implementation of the *Personalisation Agenda*. CPA was therefore seen as yet another competing priority which had the potential to undo the work previously undertaken in implementing *Personalisation.*

Although these agendas may be seen as competing, Duffy (2010) on the other hand challenges that assumption. He identifies that the principles of both are broadly consistent, especially in relation to the allocation and role of a lead professional (or care co-ordinator). He argues that balancing both professional and client expertise leads to a new form of partnership or ‘co-production’, in which the skills of both are equally important in enabling clients to lead fulfilling lives. He does however acknowledge that the complexity of many clients’ needs is often hampered by the similar complexity observed within the statutory organisations which are charged with providing their care. Duffy suggests that a way to challenge this is to work with clients in implementing policy from the ‘bottom-up’, rather than attempt to provide services through current organisational structures and processes, to consider what the clients themselves want and need, and respond to that in a flexible way which reduces service duplication and complexity. Despite this rhetoric this may however be a moot point as such an approach to care delivery, which focuses on client need first and foremost, with services built up and policies implemented around those, has already been suggested in previous CPA policy and consultation documents (e.g. DH, 2006, 2008, 2009). At the time of the present study such suggestions have not been heeded.

A further key difference between implementation in the 1990s and the present was that at the time of its implementation in the 1990s, CPA was an entirely new initiative, whereas on the second occasion it was not. Rather, it was an extension of a form of service provision that had already become established practice for other client groups and had been central to mental health service provision since the 1990s.

Although CPA had become established practice, there were a number of similarities between the findings of the present study and those of North and Ritchie (1993) regarding both barriers and facilitators to CPA implementation twenty years apart.

One of the first of these was that North and Ritchie found that CPA had been implemented to varying degrees of completeness in three of the four health authorities participating in their study. None had fully implemented the policy, a finding later supported by a review of five social service departments made by the Social Services Inspectorate (DH, 1995c). This picture is similar to the state of implementation across the localities in the current study.

A further similar finding was that there was an overlap of initiatives in which staff, both in the 1990s and in the present study, identified with either a care management or CPA model of care. Although the present study was not exploring CPA implementation specifically from a systemic or clinical level it could be suggested that some of the findings, related to a lack of staff engagement in the implementation process, may point to issues around alignment to the traditional professional roles and cultures. This study identified that CPA was seen by social service respondents as a Trust, and therefore a health service, initiative. However it could also be suggested that the reluctance of social services to implement CPA, so soon after implementing the *Personalisation Agenda*, may, along with it being viewed as a competing priority, have had to do with professionals in that service identifying that CPA derived from, and therefore aligned to, principles more associated with a medical model of care as opposed to those which had a more social model background. Such an argument is supported by the vast literature on the topic of health versus social care models and how the protection of professional boundaries by staff impacts on the very models within which they work. In fact this issue was previously identified as impacting on CPA implementation in the 1990s (Simspon et al, 2003b) and there is no evidence to suggest that this subject has been resolved in more contemporary circumstances.

In the 1990s the issue of traditional roles and cultures was addressed through the integration of CPA and care management processes for generic mental health and social services, and through the creation of the care coordinator role (NHS Executive & Social Services Inspectorate, 1999). However at the time of the present study this type of integration had not occurred between mental health and learning disability social services. It may be that a similar process of integration between mental health and learning disability social services would equally be of benefit.

However attempts were made to address staff roles through education and training in order to demonstrate that there was a need for CPA, illustrate how it could improve their ability to provide client care, and allay fears around associated bureaucracy and role erosion (a finding similar to North and Ritchie). However this study also identified that, although it did provide benefits, such training did not have to take place through formal educational sessions. Informal teaching through demonstration in practice, networking meetings and lunches were also seen by respondents as ways in which staff could be educated about CPA in a non-formal environment, and were held by respondents to be as important as more formal educational processes, which were often lacking due to insufficient access to resources or because the Trust did not have any responsibility to train non-Trust staff.

Two further similarities between the two sets of findings (and with the DH, 1995c) are the need for staff commitment and the need for the implementation process to be overseen by leaders. Such individuals needed to carry sufficient authority within their own, and partner, organisations so that decisions could be made on the implementation process. This level of authority was seen to represent a level of organisational commitment to the process, which then could filter down into front-line teams at an operational level. While North and Ritchie made reference to 'lead officers', respondents in the present study specifically identified senior management, project leads, consultant psychiatrists and mental health staff working within learning disability services as important in using their role, authority and networking skills, to aid the implementation process. These individuals enabled the demonstration of what was described by respondents as 'good-practice' in relation to the implementation of CPA, whilst also allaying the fears of other colleagues and professionals that CPA would add a further work burden.

Consultant psychiatrists in particular were identified by North and Ritchie as not engaging with the implementation process and indeed as being reluctant to use it as an approach to client care (a finding also supported by e.g. Schneider et al, 1999). They were thus seen, at that time, as barriers to the implementation process. In contrast, in the present study, the consultant psychiatrists were found to be key to pushing the CPA agenda within their respective spheres of responsibility. One possible explanation for this difference could be that as CPA has become embedded within mental health practice in the intervening years, it has become the approach through which mental health professionals, including the consultants, unquestionably provide mental health care.

A number of the factors which arose in the 1990s did so as, at that time, both mental health and social services were new to, and inexperienced with, implementing and applying CPA to client care. There was therefore a need, at that time, for further direction, support and guidance, from the Department of Health which was reinforced by what North and Ritchie described as 'lead development' at a local level which would provide examples of good practice and were anticipated to reduce inconsistent interpretation of the policy across localities. However as CPA has become embedded within mental health practice over the past 20 years it may be suggested that such guidance and clarity from the Department of Health was no longer required, at least from the mental health services perspective whose experience with CPA over the intervening years has perhaps negated this need.

Apart from the exceptions mentioned, which are attributable to specific differences in the context of implementation, the issues that were problems for the last round of implementation in the 1990s still appear to persist. Whilst it may be clear what would be helpful with the implementation process (i.e. identifying facilitators and dealing with barriers), the notable thing from both studies is that the desirable conditions for implementation are often absent, or only patchily present, and many of the barriers that existed in the 1990s still remain. In many respects one could therefore suggest that rather little has changed on the ground over the past 20 years. If the lessons learned from the 1990s were understood, they have not been applied. Hence, the overall finding from both studies is that implementation was only partially and patchily achieved.

### 8.4. The Generic Contextual Factors Affecting CPA Implementation at a Strategic Level

The disappointing progress with implementation noted on both occasions may arguably not be entirely attributable to the topic-specific barriers already discussed. A key difference between the two studies was the level of the analytic lens applied. The present study differed from North and Ritchie's (1993), since it also took account of generic issues affecting organisational change and partnership working. Using this analytic lens, this study identified a number of more generic contextual factors operating at a strategic level which inhibited the development of the type of organisational change and the type of partnership working that CPA implementation required. Although these issues were not specific to CPA implementation they influenced the background environment into which CPA was to be implemented and therefore had a major bearing on the success of the process. These particular contextual issues, which were discussed in Chapter 6, are outlined in table 8.2.

- A lack of finances and resources;
- Competing multiple priorities;
- Poor information sharing processes and information technology infrastructure;
- Organisational complexity;
- A lack of governance and accountability structures; and
- The turnover of staff, particularly in learning disability services.

**Table. 8.2: Generic factors influencing the implementation of CPA**

Although listed separately, these factors formed part of a complex picture in which each was highly interconnected to the others. Consequently deficiencies in one factor impacted directly on all the others, and subsequently on the implementation process.

One of the primary factors was an overall lack of finances and resources. In practice this meant that there were limited resources which services could invest in the implementation process as the allocation of resources was prioritised. This had an impact on for example the ability of localities to appoint CPA project leads or provide CPA training, i.e. those factors which did have a direct impact on the implementation of the policy itself. At a strategic level it also meant that the Trust had to prioritise where it invested its finances. One direct result of this prioritisation was that finances were more likely to be invested in projects in which the success of the Trust was in some way measured.

The lack of resources also meant that some of the structural differences between organisations, and in particular their information sharing processes and information technology structures, could not be appropriately and thoroughly addressed by the isolated attempts made at a local level to streamline and improve their compatibility. The numerous partners with which the Trust needed to work in partnership, and over whom it had no governance or accountability arrangements, further compounded the complexity of the situation. This may be illustrated by the fact that it had five local authorities with which to liaise, each with their own learning disability services, which were further divided in number at a locality level and then again by specialty area and/or demographic area. The composition of staff and the way in which they worked with dual diagnosis clients within these teams also varied. These very disparate service scenarios meant that the ability to implement CPA in any consistent and stable fashion was extremely limited. Even in teams where the Trust had developed a close relationship with individuals keen to implement CPA, the process was often hampered by these individuals leaving post.

The impact of these meso-level factors, and in particular the lack of finances and resources available to health and social care organisations in the current economic climate, was recently identified by the Audit Commission (2011) as hampering these organisations' attempts to provide joined-up and integrated care. Although the Managing Director of the Commission (in O'Dowd, 2011) acknowledged that the integration of care was a viable and more economical option for providing care to clients, the evidence to date suggests that smooth integrated care provision remains patchy with "considerable local variation" (p7844).

The combination of these generic factors had a direct bearing on individual localities in their attempts to implement CPA policy and in particular their ability to develop a shared vision, a level of shared understanding and commitment, operational policies, etc (i.e. the key factors influencing the policy implementation directly, as identified in Chapter 7). One could therefore propose that the identification of these generic factors further upstream within the organisations indicates that it was highly probable that the implementation of CPA was going to face many barriers because the context into which it was expected to be introduced had numerous problems which had not been appropriately addressed at that strategic level before work got underway in the localities.

The key new contribution of the present study is this insight: that many of the problems experienced with CPA implementation were not specific to CPA or the particular client group, but were about introducing change across complex organisations, at particularly challenging times. Acknowledgement of these contextual issues is crucial as they indicate the need to consider the macro- and meso-level when planning and implementing new policies, and not just to take a micro-level perspective.

### 8.5. The Diversionary Effect of Targets on CPA Implementation

As previously mentioned, there were some elements of CPA related policy which did appear to work well. The first of these was the *Greenlight framework and audit toolkit* (GLTK)(DH, 2004). At the time of this study the Trust and its partner organisations were working on achieving the targets set out within the toolkit. A key difference between this particular policy and CPA was that there were targets attached to the implementation of the framework with points awarded to the Trust on their ability to meet these. Although the implementation of CPA was a key indicator within the GLTK, it did not appear that CPA itself was prioritised to the same extent as the actual toolkit.

The targets in the GLTK were set by the Department of Health and their achievement, or lack thereof, was monitored by the Care Quality Commission (CQC). The use of targets in health care, particularly as a form of performance management, is not new and in fact was increased and strengthened under the previous Labour Government in an attempt to increase alignment between national policies and local action in key priority areas (Ham, 2009). As Van Harten and Gunning-Schepers (2000) (see table 8.3) indicate, there are numerous benefits to setting targets which help provide focus to health policy initiatives so that there is more consistency across underexposed areas of health care, and which in turn, helps with the allocation of limited resources to areas which are not achieving well.

| Policy Development Stage | Benefits | Drawbacks |
|---|---|---|
| Formulating targets | • Gives insight into health of population,<br>• Reveals gaps in knowledge,<br>• Gives insight into consequences of alternative strategies,<br>• Increases transparency of health policy,<br>• Ensures consistency among several health programmes,<br>• Shows up deficiencies in health policy,<br>• Stimulates debate. | • Makes it impossible to argue that there is no rationing,<br>• Increases political accountability,<br>• Assumes a malleable society,<br>• Oversimplifies policy field,<br>• Risk of setting easily measurable targets,<br>• Neglects other important issues. |
| Implementing targets | • Inspires and motivates partners to take action,<br>• Improves commitment,<br>• Fosters accountability,<br>• Guides allocation of resources. | • Frustrates when there are too many and too ambitious targets,<br>• The technical and planning process could be seen as an end in itself,<br>• Resource allocation could become inflexible. |
| Monitoring and evaluation of targets | • Supplies concrete milestones for evaluation and adjustment,<br>• Provides opportunities to test feasibility of targets,<br>• Provides opportunities to take action to correct deviations,<br>• Exposes data needs and discrepancies. | • Attention could be given to measurable issues only,<br>• Additional data and research could be needed. |

**Table 8.3: Benefits and drawbacks to targets in health policy (adapted from Van Herten and Gunning-Schepers (2000))**

The targets set out within the GLTK appeared to provide some of the benefits as outlined in table 8.3, but it was also apparent that there were a number of drawbacks. Ham (2009) has described how the embedding of targets within policy can potentially lead to a “situation of priority, overload and initiative conflict” (p210). As the GLTK had targets embedded within its framework the implementation of CPA (which had no such targets) did not receive the same level of attention, since implementation efforts and resources were directed to other more pressing areas i.e. the achievement of those key target areas set out in the GLTK. One of those key resources, which directly impacted on CPA implementation, was the time and effort of staff working on the local CPA Steering Groups whose attentions were diverted to the GLTK targets. In fact in some localities the focus of the local CPA Steering Groups had almost been completely diverted from CPA implementation to achieving the GLTK targets.

Alongside targets distracting from other priorities Mannion et al (2005) have also indicated that, as they frequently do not take into account local contextual issues or mitigating variations beyond the control of local management, managers may purposefully manipulate and misrepresent data so as to be ‘seen to do the right thing’. The prime reason for this, they suggest, is that targets can create what they call ‘tunnel vision’, in which services focus on the target to the exclusion of other equally important issues which are not measured in the same way [a view also supported by Van Herten and Gunning-Schepers (2000)].

Although CPA implementation was a target within the GLTK, it is apparent from this project that the full implementation of CPA had not occurred across any of the localities. However data obtained from the documentary analysis indicated that the GLTK assessments for each of the localities appeared to show that CPA processes were in place (‘green’ status) or partly in place (‘amber’ status) for dual diagnosis clients. The wording of the toolkit enabled a degree of flexibility in interpretation and it was suggested that this enabled localities to describe CPA as a system which the Trust had in place, rather than a process which was occurring at an individual client level, a point raised by for example respondent D2 (D2: 199). Thus localities were able to meet particular targets in the toolkit through flexible interpretation of the wording without necessarily having implemented CPA across all front-line teams.

It is interesting to note that respondents offered completed GLTK toolkit assessments to the researcher in all of the localities. This was in contrast to the fact that no full set of Steering Group minutes for the previous 18 months prior to data collection was obtained from any locality.

This flexibility in interpreting how targets were understood and reported in fact previously occurred for CPA in its original round of implementation. With funding available for meeting the target of implementing CPA for eligible users, Simpson et al (2003a) suggested that this led, at that time, to managers who “were keen to emphasise 100% coverage ‘regardless of the service provision that such statistics masked’” (p496).

### 8.6. The Implementation of CPA for Particular Client Groups

As mentioned earlier, progress with implementation varied not just between localities, but also between different client groups. In all the localities, there was evidence of greater success for those who were admitted to mainstream in-patient services and clients who presented with a high level of risk to themselves or others. In both these circumstances the client either had clear mental health problems and/or risk issues and their care was managed by the Trust, which provided care through CPA processes. Although at first glance it may appear that services were complying with policy around implementing CPA for those with the highest need, as outlined in *Refocusing CPA* (DH, 2008b), on closer inspection this was not straightforward.

For the Trust to take responsibility for dual diagnosis clients care, provide in-patient services and place clients on CPA, there needed to be clear, diagnosable mental health issues or behavioural issues which were serious enough to present a level of risk in some way. Although this could be seen as a good example of ensuring that those with the most need received the care they required, it did raise three important issues. Firstly, it was unclear what support was offered to the high-risk clients placed on CPA and managed by Trust services in meeting the learning disability component of their issues. Secondly, it was unclear what support was offered to clients whose mental health issues were not very obvious or easily diagnosable and thirdly, what mental health support was being offered to those clients whose mental health problems were not so severe as to present a risk to themselves or others. The Trust did not appear to provide care to dual diagnosis clients with less severe or less obvious mental health problems and so these clients remained the responsibility of learning disability services where they were less likely to be placed on CPA. Clients discharged back to local learning disability teams from Trust in-patient services, where they had been placed on CPA, did not receive any follow-up or ongoing care through CPA, unlike those who were discharged back to Trust community services.

Another possibility related to why these clients were not placed on CPA may correlate with the positional power of learning disability clients in society. Section 7.4.5 identified the difficulties that localities had in engaging clients in the implementation process or even in local Steering Groups. Other attempts at engaging dual diagnosis clients and their carers in the process of service development and review within the Trust had also previously failed. For example, the Trust had attempted to gather clients' views on mental health and learning disability services so as to develop a future care pathway strategy which took into account clients' own personal perspectives. Despite appointing someone to lead this particular audit and the creation of a questionnaire for this purpose, the Trust managed to garner only three carers and clients views. The Trust was therefore aware that there was an overall lack of a 'client's voice' in the development of mental health and learning disability services, not just in the CPA implementation process.

Although this may in part be explained by the difficulty in identifying these clients (as outlined in Chapter 2 and supported by a lack of information within the Trust about how many clients had a dual diagnosis), there was no sense that that lack of engagement, and therefore a need to address this, was in any way prioritised by the respective partners. This is despite repeated drives by the Department of Health in pushing services to engage clients in processes which impact on their care, including policy development and implementation.

On the other hand one of the key strengths of the voluntary and community sector is the level of engagement that such organisations have with their client base. Conversely, it is this prioritisation of client engagement which in fact also partly inhibited these organisations engagement with the CPA implementation process. Voluntary organisations took considerable time to engage and get feedback on the implementation process from their clients. However the statutory services involved were faced with tight deadlines and targets, meaning that frequently feedback was too slow in coming back from the voluntary sector to be considered, before services had moved onto the next agenda item/target. Without any active, and more importantly realistic, attempts to engage the client perspective their views were not elicited, at either that meso-level, or at a clinical level where previously mentioned communication difficulties often prevented access to appropriate services. In short, there did not appear to be a ‘client voice’ in any process which involved the implementation of this policy which inevitably would impact on their care.

As discussed in Chapter 2, dual diagnosis clients are more frequently referred to psychiatric services for challenging or difficult behaviours than for any potential underlying mental health issues. The latter often go undetected and untreated. For clients with less severe, or less obvious, mental health issues this study found that these needs were not, or were rarely, met through CPA processes. Although this in part this may relate to the ongoing difficulties services have in identifying and diagnosing any mental health problems, it appeared that it was more likely to be because they were not deemed to be unwell enough, or at risk enough, to warrant Trust intervention and care through CPA. In fact this particular issue was not unique to this round of implementation. Schneider (1993) also found during the original implementation that some mental health clients, who were identified as not having high needs, were denied access to care under CPA.

Coming full circle to the case study I outlined in Chapter 1, this situation may explain the circumstances surrounding the care offered to Ahmed. He had been known to learning disability services for a number of years and it was suspected that he had an underlying mental illness but he was not seen or taken on by the mental health team until he posed a serious risk to others. When that happened mental health services were quick to respond, offering an immediate assessment and an in-patient bed in mainstream services. However when the risk was less immediate and Ahmed was discharged back to the community, services were slow to respond to meeting his other, less pressing, needs. In this example CPA was in reality implemented as a tool to monitor Ahmed's whereabouts, safety and risks as much as it was about actually meeting his needs. However once the risk issues were less prominent, the urgency of meeting these needs became less pressing.

### 8.7. Reflection and Concluding Remarks

The findings from this study highlight a number of factors at a meso- and locality-level which impacted on the implementation of CPA for dual diagnosis clients. However these findings should not be viewed in isolation from, or be seen as mutually exclusive to, those issues occurring at a systemic or national level, as well as those at the front-line.

The difficulty is that services, in their current form, appear to maintain the status quo. Having separate organisations, each with their own agendas, governance arrangements, financial structures, etc adds weight and support to the perspective that health and social services are two separate entities and therefore professionals working within these work, unchallenged, to either a health or social model of care.

Although there have been numerous and often parallel policies which need implementation across health and social services, the work of Duffy (2010) for example, shows how by taking a client-centred perspective and developing services from the 'bottom-up' may in fact enable policies to be more responsive to local and individual clients' needs. However the new Health and Social Care Act (DH, 2012), hailed as the way forward for the NHS by the current government, and which focuses on the integration of services to meet client need, from what they argue is the 'bottom–up', may in fact cause further problems to the implementation of policies such as CPA.

Recent reports from the King's Fund and Nuffield Trust (Ross et al, 2011; Goodwin et al, 2012), which were part of the government's consultation on the new Act, make reference to the introduction of a "programme approach to care". Hailing the benefits of this "new" case management approach across the NHS there was no indication, or even acknowledgement, of any lessons learned from the implementation of CPA into mental health services in the 1990s, or indeed from this round of implementation for dual diagnosis clients. The documents startlingly lack any indication of previous implementation issues that such case management models may bring and, considering the numerous arguments mentioned in this text around which model of case management CPA hailed from, and subsequent difficulties associated with that, there has been no specific identification of which model this particular *programmed approach to care* will follow.

The framing of the study, using the organisational change and partnership working literature, enabled more generic factors influencing policy implementation to be identified. It is plausible that other policies, requiring the same type of organisational change and the same type of partnership working, may also face similar problems with implementation. Therefore it is recommended that, in future, such contextual factors are identified and addressed by those allocated the task of implementing policy at a locality level.

Another means of addressing the issues identified in this study may, especially considering the current economic climate, be the integration of mental health and learning disability social services so that care may be provided through a single agency with the sole responsibility for clients' welfare. The benefit of a single organisation taking responsibility for this client group was illustrated in this study by the fact that the implementation of CPA was partly successful for those who presented with an increased risk and/or required in-patient services, but who were also under the direct care of Trust services without social service input.

Considering that CPA implementation was partly successful for these groups it could also be suggested that a blanket policy for CPA implementation covering all dual diagnosis clients across health and social services is not pursued and instead efforts are focused solely on those who present with a high risk or have complex needs. Further guidance may be required for services in defining these client groups so that there is consistency in the application of CPA to these groups nationally.

However, considering the extent of the problems associated with implementing CPA over the past 20 years, the number of times that the policy has been altered, adapted, and refocused, perhaps the more daring and yet appropriate solution may be to abandon the policy completely, and then from a perspective which is truly client focussed, start again from the ‘bottom-up’. Indeed considering the evidence from the 1990s, and from this study, it would be advisable to do just this so as to prevent the 20 years of problems seen in mental health services, occurring across the wider NHS as outlined by the changes in the new Health and Social Care Bill. In returning to the drawing board it is argued here that, considering the mounting evidence the way forward is not to continue adding patch after patch onto a fundamentally flawed system, but to be truly daring and start over.

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## Appendix 1 Literature on the implementation and clinical effectiveness of CPA

**Implementation literature:**

| Author | Study Details | Key Findings |
|---|---|---|
| Bindman, J. Beck, A. Glover, G. Thornicroft, G. Knapp, M. Leese, M. & Szmukler, G. (1999) | A study to describe and evaluate the practical application of CPA and supervision registers using a questionnaire survey of key informants in mental health trusts and an analysis of aggregated data by health authorities.<br>100% response rate from 180 trusts. | 83 of the trusts reported the number of clients on CPA.<br>Of 170 trusts who gave description of their tiers they found variable implementation of tiers ranging from one (5%), two (36%) to three (59%) tiers of CPA being used.<br>Widespread variation in use of CPA.<br>Local application of CPA was variable with prioritization not based on need. |
| Gilleard, C. (1995) | Audit of clients notes to determine whether CPA being implemented for clients discharged from a single mental health unit which served two London boroughs. Notes first audited in 1991 with a second audit in 1993 following revision of local guidelines. In total 1373 client case notes reviewed with 9 key standards monitored. | In 1991, 46% of clients had no CPA and only 25% of those only met minimum standards (i.e had appropriate paperwork completed, care plan developed, named keyworker, planned review date).<br>By 1993 this had improved to show that 75% of notes met minimal standards, 78% of clients had a CPA care plan and 97% a named keyworker. |
| Horder, W. (1998) | Small scale empirical study within a single inner-city district in which 9 different types of professionals (nurses, doctors, social workers, occupational therapists) were interviewed attempting a representative sample.<br>Attempted to evaluate CPA and the role of mental health social workers and the role of keyworkers under CPA.<br>District was atypical sample as social workers not integrated into the multidisciplinary team. | Nurses did majority of keyworking.<br>Clients had a keyworker and a social worker allocated in many cases.<br>Divergent views on role of keyworker.<br>Staff felt needed wider skills to carry out role.<br>Care management seen as duplicating keyworker role. |

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| North, C. & Ritchie, J. (1993) | Supported by the DH this explorative study carried out in 2 phases investigated the planning and design of CPA as well as the operation of CPA at the front-line level to identify factors that facilitated or inhibited its implementation.<br>Four health authorities and their related social service departments were chosen by the Department of Health to be studied.<br>169 key stakeholders, including carers, clients, the voluntary sector, senior managers and professionals were interviewed.<br>Data were analysed using a broad thematic framework. | Some of the key findings included (please also see Chapter 3):<br>Need for lead development.<br>Need for further guidance from DH.<br>Overlap between initiatives, including care management.<br>Misunderstanding of complexity of CPA.<br>Insufficient resources.<br>Need for ongoing support to maintain impetus of implementation.<br>Need for driving force at management level.<br>Need for administrative support.<br>Need for clarification on who could be, and the role of, a keyworker.<br>Good communication between agencies. |
| Pyszora, N. & Telfer, J. (2003) | Study to estimate number of inmates per year which could be expected to be placed on enhanced CPA in Belmarsh prison.<br>Limited to case notes of inmates known to have mental illness and known to mental health team. 91 prisoners identified. | Potential resource implications.<br>Issues around keyworking responsibilities within a prison system. |
| Royal College of Psychiatrists (1996) | Inquiry set up to study circumstances leading up to homicide or suicide by people with a mental illness and to identify factors in client's management which may be related to the deaths.<br>Data collected from Home Office files with further data gathered via questionnaires to professionals working with clients and which was supplemented by respondents comments and observations.<br>Report does not claim that the sample is representative or that it is an epidemiological research project. | Based on 39 cases of homicide nationally of which 16% had an active care plan, 48% a care plan which was not implemented and fewer than 50% had a nominated keyworker.<br><br>Of the 240 cases of suicide nationally 33% had an active care plan, and just under 50% had a nominated keyworker. |

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| Schneider, J. (1993) | Case study of 3 contrasting health districts consisting of 60 semi-strucuted interviews with psychiatrists, local authority managers and keyworkers. Questions asked about attitude to CPA and its use in practice.<br>Mental health component of community care plans also reviewed for a one-in-two sample of local authorities.<br>Not representative of national picture. | CPA implemented selectively and not applied to all new patients seen by services.<br>Burden of resources to implement CPA e.g. staff time.<br>CPNs most likely to be keyworkers.<br>Variation in interpretation of their role in CPA by local authorities.<br>Local authorities aware of CPA but not changed in any significant manner to accommodate it.<br>Staff concerned with problems of: allocation of resources, gatekeeping, bureaucracy, confidentiality, clients depending on staff,, rigid interpretation of staff roles,<br>At same time staff felt it may close holes in the net between services, integrate services, promote consistency and quality, enable clients and improve staff morale. |
| Schneider, J. Carpenter, J. & Brandon, T. (1999) | A qualitative and quantitative survey in 1997-98 of 183 NHS trusts in England providing mental health services.<br>Response rate of 79% (n=145) who rated involvement of professionals in CPA processes (care planning, keyworking, reviewing). Documentary analysis of local policies and documents also took place. Validation by expert reference group. | 56% ha changed CPA processes to align with care management models.<br>95% had tiered CPA system in place.<br>CPNs took lead on CPA in most trusts with 90% frequently attending CPA meetings.<br>88% trusts had guidelines on who could keywork clients.<br>Client involvement far from universal.<br>Joint-working for CPA facilitated by co-terminous boundaries, commitment of staff and consultant psychiatrists, presence of CPA administrator and manager, good information systems and formalized procedures. |

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| Simpson, A. Miller, C. & Bowers, L. (2003a) | A critical review of key events, audits, reports, research and policies which shaped CPA with the aim of describing and evaluating its introduction, implementation and development. | Critical of the manner in which CPA was implemented with the following factors impacting on that process: no additional funding for implementation; little or no staff training; the 'imposition' of the policy into services; CPA failed to build on knowledge, skills and abilities of workforce that was already available; seen as bureaucratic by staff; duplication of work; seen as part of a blame culture; no underlying model or philosophy of care. |
| Simpson, A. Miller, C. & Bowers, L. (2003b) | Discussion paper presenting wider literature on case management and identifies and considers principal models which may have informed the development of CPA. | Concluded that CPA continued to have ongoing problems with its implementation 10 years after its original introduction. It was argued that CPA was not fit for purpose and was a faulty version of a true case management model. It also lack an underlying philosophy which could unite health and social care staff. |
| Simpson, A. (2005) | A multiple case study of seven community mental health teams over two years to explore the factors facilitating or inhibiting the ability of community psychiatric nurses to fulfill their role as care coordinators.<br>Undertaken between 1999 and 2001 using participant observation, semi-structured interviews and document review. | Nurses experienced an extra 'burden' of work as a result of taking on care coordinator role, including increased bureaucracy and heavy workloads. They felt unable to provide psychosocial interventions and felt that the care coordinator role and that of community psychiatric nurse were at times competing. |
| Social Services Inspectorate (SSI) (DH, 1995c) | An inspection to evaluate the contribution of social service departments to CPA.<br>Inspection of 5 social service departments from across the country by 2 inspectors each who used 11 standards and criteria to determine contribution.<br>Data collected through the review of local policies, individual care plans and case notes, interviews with clients and carers, random selection of social work files, interviews with managers from services and operational staff. | Only 1 locality had a formal inter-agency agreement between health and social services.<br>In the other 4 localities there was commitment to introduce CPA but beyond initial work there had been no follow up.<br>2 localities had no lasting results from this initial work.<br>Problems with number of partners and attempts to have a unified policy across all health authorities and social service departments.<br>CPA not fully operational in at least 2 localities.<br>Lack of clear joint direction from senior managers leaving practitioners to implement it as best they could.<br>Need for appropriate allocation of resources. |

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| Warner, L. (2005) | A literature search on material published since 1980 on case management and CPA from articles in the USA and UK. 29 articles retrieved and reviewed out of 300 identified initially.<br>Other articles found through cross-referencing, as well as resources available at the Sainsbury Centre for Mental Health, and national documents and policies on CPA. In total 99 further documents retrieved through this method.<br>No comment or summary added to the literature. | Literature reviewed presented under following headings:<br>The development and implementation of CPA.<br>Supporting the implementation of CPA.<br>Evaluating the implementation of CPA.<br>CPA as a performance indicator.<br>National performance management.<br>Clients experiences of care planning and CPA.<br>Findings on CPA from homicide inquiries.<br>CPA in risk assessment.<br>Discharge planning and continuity of care.<br>Comprehensive care plans. |

**Clinical effectiveness literature**

| **Author** | **Study Details** | **Key Findings** |
|---|---|---|
| Aslan, M. (2002) | Editorial/discussion piece. | Discusses how CPA is not an inclusive process taking inclusion and recovery into account. |
| Burns, T. (1997) | Editorial in the British Medical Journal. | Discusses differences between care and case management and CPA. |
| Burns, T. & Liebowitz, J. (1997) | An overview of how CPA was implemented within a single small community mental health team. Findings difficult to generalize. | CPA only used for those with complex needs.<br>CPA reviews held as part of team meetings.<br>CPA reviews resource intensive.<br>Clients not attend CPA meetings. |
| Commission for Health Improvement (CHI) (2003) | Data gathering exercise from Commission for Health Improvement based n 4 sources of data; 35 clinical governance reviews (representing half mental health trusts in England and Wales), 2 investigations into serious failings, a report on safeguarding for children and a self audit of child protection arrangements. | No specific figures given but states that large numbers of clients not placed on CPA, allocated a care plan or keyworker.<br>Continued resistance by staff to CPA and its associated documentation.<br>CPA practice remains inconsistent across trusts. |
| Cornwall, P.L. Gorman, B. Carlisle, J. & Pope, M. (2001) | A study to evaluate the changes in the operation of a community mental health team five years after the implementation of CPA. Cross sectional and longitudinal study between 1992 and 1998.<br>Study carried out in a single mental health team and data were collected from questionnaires sent to 17 keyworkers gathering data on each of their clients who they had face-to-face contact with in the previous 3 months. | 334 clients in active contact with the team.<br>Increase in home treatment use but not hospitalization.<br>Client group focus unchanged since 1992 i.e. most severely unwell. |

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| Downing, A. & Hatfield, B. (1999) | A study to evaluate the initial working of CPA in the psychiatric unit of a general hospital.<br>The study examined the care plans of clients discharged the unit over a three-month period. Along with interviews of keyworkers using a standard questionnaire designed for the purpose.<br>Small scale study with 35 participants interviewed. | All clients had a named keyworker. The majority of whom were nurses or social workers with interventions they instigated tending to be based around own professional background.<br>The involvement of all clients and a significant proportion of cares (15 out of 22) participated in the care planning process.<br>Evidence of multi-disciplinary input into care plans.<br>Readmission to hospital indicated that 17 out of the 35 were readmitted at least once within 6 months of discharge.<br>No clients lost to follow up in period of study. |
| Easton, E. & Oyebode, F. (1996) | Letter to editor of BMJ reporting on audit of implementation of CPA in their trust in Birmingham. Focus on administrative demands and opinions of practitioners regarding CPA. | Findings from their study unpublished but in their letter they state: CPA increased workload disproportionately to perceived benefits – with increase in workload die to administrative demands which took away from client care. |
| Kessler, I. & Dopson, S. (1998) | Uses CPA to examine the difficulties of implementing change in the NHS. Discussion document.<br>Draws on research and teaching activities with NHS managers as part of a wider research project. | Localities unable to shape implementation of CPA.<br>DH data collection on CPA focused more on process than outcome.<br>Lack of awareness by psychiatrists about medico-legal implications of CPA.<br>Lack of client involvement in CPA process. |
| Mace, C. (2004) | Discussion of a survey of consultants in psychotherapy. No details given on methodology, rigour, numbers staff involved, etc. | CPA implementation remained uneven.<br>CPA processes added time burden.<br>Threats to confidentiality.<br>Concerns about negative impact on therapeutic relationship of therapists keyworking clients. |
| Marshall, M. (1996) | Editorial in the British Medical Journal. | Critique of Governments introduction of CPA and care management into British health and social services. |

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| Marshall, M. Gray, A. Lockwood, A. & Green, R. (2001) | Cochrane Review.<br>To determine the effects of case management as an approach to caring for severely mentally ill people in the community. Case management was compared against standard care on four main indices: (i) numbers remaining in contact with the psychiatric services; (ii) extent of psychiatric hospital admissions; (iii) clinical and social outcome; and (iv) costs.<br>The inclusion criteria were that studies should be randomised controlled trials that had compared case management to standard community care; and had involved people with severe mental disorder. | Case management increased the numbers remaining in contact with services.<br>Case management approximately doubled the numbers admitted to psychiatric hospital.<br>Except for a positive finding on compliance, from one study, case management showed no significant advantages over standard care on any psychiatric or social variable. |
| Philpot, M. Hales, H. Sheehan, B. Reeves, S. & Lawlor, M. (2001) | To determine the rates at which clinical teams within one NHS trust placed older people on a Care Programme Approach (CPA) register and to examine the degree to which clinicians' use of the register conformed to trust policy.<br>Two retrospective case notes surveys were carried out 6 months apart.<br>Twenty-one patients were registered during the first survey period (3 months) and 56 during the second (6 months). Results were compared with 22 and 45 control patients, respectively.<br>Feedback to clinicians was undertaken after the first survey and this was included in the discussion section of article. | CPA patients were more likely to have involvement of social services, a history of previous admissions, a longer period of contact with the service and greater psychotropic drug prescription than controls.<br>At the second survey only social services involvement and the proportion of patients living alone differentiated the two groups.<br>The results also found variability in the use of the CPA register and the application of the defining criteria in an old age psychiatry service.<br>Some consultants believed that no clinical benefits to patients were derived from the use of the CPA register and that in one borough social workers would only assess those patients placed on the register.<br>The rate of CPA registration following the initial feedback by one team rose dramatically to include nearly all patients referred to the service, while registration in another team virtually ceased. |

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| Simpson, A. (2005) | A small scale study reporting on the factors facilitating or hindering CPNs in their role as care coordinators in meeting their clients' needs.<br>Based in 1 NHS trust in which the mental health teams were in developmental stage of adjusting to new teams.<br>A multiple case study methodology in 7 sectorised community mental health teams over two years.<br>Data were collected through participant observation, semi-structured interviews (23) and documentary analysis. | CPNs accepting of new focus on clients with severe and enduring mental illness.<br>Workload pressures (increased demands rather than increased caseloads) meant CPNs felt had limited time to engage in therapeutic interventions e.g. less face-to-face time with clients.<br>CPNs felt role restricted and often ignored their skills which they had developed.<br>Initial confusion as to what keyworking role would involve but also associated the role with additional duties and a perceived sense of extra responsibilities.<br>Increased bureaucracy – paperwork, reduced time with clients further.<br>Role blurring as a result of taking on new demands. |
| Tyrer, P. Morgan, J. Van Horn, L. Jayakody, M. Evans, K. Brummell, R. White, T. Baldwin, D. Harrison-Read, P. & Johnson, T. (1995) | 400 clients from inner-city area randomized into two groups of 200 clients each. One group received close supervision by a named keyworker (as recommended by CPA), the other received standard health and social service care.<br>Outcomes were recorded after 18 months and data for analysis was available for 393 clients. | Of 197 allocated to standard care 32.5% were lost to follow-up compared with 20.4% receiving close supervision.<br>24% of total client group had hospital admission. Those close supervision were more likely to be admitted than those under general care (30% v 18%).<br>Admissions most likely to be arranged by psychiatric nurses (mean 0.64).<br>Admission length of stay similar across both groups but because more admissions had by closely supervised group 68% more bed days were used by them compared to non-supervised group (5037 days, mean of 25.7 compared to 2994 days, mean of 15.2). |
| Wallace, J. & Ball, C.J. (1998) | Review of case notes of all patients over 65 on CPA register under care of old age psychiatry within a single trust.<br>Represents findings at local level. | Relatively small number of clients on register.<br>Involvement of carers and professionals in CPA meetings but lack of GPs in attendance. |

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| Wolfe, J. Gournay, K. Norman, S. & Ramnoruth, D. (1997) | Qualitative study using structured interviews with 80 clients who had received in-patient treatment from three mental health units and were subject to CPA. Followed up after 3 months and their case notes also reviewed to audit CPA processes.<br>Eight-nine per cent (n=71) of original sample completed first interview and 71% (n=57) the second.<br>Local sample. | More than half sample not involved in their own care planning process.<br>Carers not involved in care planning.<br>Nearly half did not know who their keyworker was.<br>Majority of clients' keyworkers were nurses (74%) with social workers having virtually no keyworking role.<br>Low client contact through CPA – averaging one contact per month. |

**Appendix 2 Literature on partnership working**

| Author | Study Details | Facilitators | Barriers |
|---|---|---|---|
| Amery, J. (2000) | Reported on a case study of inter-professional collaboration in a Health Action Zone in Luton. Methodology not included in study report. | Shared aims, objectives and outcomes.<br>Identification of milestones.<br>Sufficient power and authority of member representatives.<br>Awareness of each other's cultures.<br>Minimal competition.<br>Joint training, secondments or shadowing opportunities. | |
| Andrews, R. & Entwistle, T. (2010) | Empirical study of 46 state-provided service departments in Wales, including education, housing, and welfare benefits, etc). Only 3 were social services and there were no health service representatives. | Trust.<br>Alignment of goals.<br>Good communication.<br>Strategic focus. | |
| Armistead, C. & Pettigrew, P. (2004) | Using action-inquiry the researchers held two half-day workshops and seminars with approx. 50 participants each. All participants were involved in partnership working in the fields of health, social care, education and business. | Clear shared purpose.<br>Trust, respect and understanding for all partners.<br>Good leadership.<br>Partners with appropriate authority to make decisions on behalf of respective organisation. | Cultural and power differences especially in relation to including the voluntary sector. |

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| Asthana et al (2002) | A review of the literature to create a conceptual framework for partnership working to feed into empirical research which used semi-structured interviews and a self administered questionnaire with documentary analysis. | Geographical ad political context.<br>Inputs to partnership:<br>• Recognise need<br>• Access to resources<br>• Leadership & management support<br>• Organisational ethos.<br>Processes of partnership:<br>• Conflict resolution & consensus building<br>• Knowledge & information sharing<br>• Networking<br>• Accountability arrangements. | |
| Callaghan, G. Exworthy, M. Hudson, B. & Peckham, S. (2000) | Interviews with shadow board members and key stakeholders from a single Primary Care Group exploring its relationship with social service departments across four localities in two regions of England. The number of interviews is not mentioned. | Access to resources.<br>Geographical coterminosity.<br>History of joint-working.<br>Horizontal and vertical communication.<br>Significant individuals or champions. | Staff not having power to make decisions on organisations behalf.<br>Different organisational cultures.<br>Different organisations accountability structures. |
| Cameron, A. & Lart, R. (2003) | Systematic review of the literature leading to in-depth review of 32 studies reporting on factors promoting and obstacles hindering joint-working at strategic, operational and commissioning levels across health and social services. | Realistic aims and objectives.<br>Clarity around roles and responsibilities.<br>Strategic support and commitment.<br>Co-location.<br>String management and professional support.<br>Access to resources and personnel.<br>Past history of joint-working.<br>Trust and respect.<br>Joint training. | Different organisational priorities/agendas.<br>Professional stereotypes.<br>Different professional cultures.<br>Constant re-organisation.<br>Lack of coterminosity.<br>Financial uncertainty. |

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| Cameron, A. Macdonald, G. Turner, W. & Lloyd, L. (2007) | 126 semi-structured interviews across 6 pilot areas covering health, social service, housing and voluntary sector. | Shared understanding of need for partnership.<br>Shared aims and objectives.<br>History of joint working.<br>Clear governance and management accountability.<br>Including voluntary sector as equal partner. | Reluctance to work with voluntary sector.<br>Lack of information sharing. |
| Challis, D. Stewart, K. Donnelly, M. Weiner, K. & Hughes, J. (2006) | Cross sectional survey design involving 2 postal questionnaires sent to 130 English Local Authorities and 11 Trusts in Northern Ireland. 77% response rate in England and 100% response in Northern Ireland. | | Mistrust.<br>Threats to professional identity.<br>Information sharing (confidentiality). |
| Dowling et al (2004) | Literature review of peer-reviewed publications on partnership working since 1997. Thirty-six articles reviewed in total. | Process success:<br>• Engagement & commitment<br>• Agreement on purpose for partnership<br>• High levels of trust, reciprocity & respect<br>• Good financial climate<br>• Suitable institutional & legal structures<br>• Wider partnership endeavours<br>• Satisfactory accountability arrangements<br>• Adequate leadership & management. | |

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| Evans, D. & Killoran, A. (2000) | Reports on the realistic evaluation of a two year Health Education Authority programme. Data collected over a two year period and used semi-structured interviews (number unknown) and non-participant observation across five different projects. | Shared strategic vision.<br>Good leadership and management.<br>Good relationships and local ownership.<br>Accountability arrangements.<br>Organisational readiness.<br>Responsiveness to a changing environment. |  |
| Glasby, J. & Lester, H. (2004) | Drew on a narrative review of the literature focusing on 43 documents discussing partnership working between health and social services in the UK. Commissioned by the National Institute for Mental Health. | Shared vision and philosophy.<br>Clarity of roles and responsibilities.<br>Appropriate incentives and rewards.<br>Accountability for joint-working.<br>Key power brokers.<br>Leaders.<br>Co-location.<br>Trust.<br>Resources. | Fragmentation of responsibilities.<br>Different IT systems.<br>Information sharing (confidentiality).<br>Different funding mechanisms and resources.<br>Professional and cultural differences.<br>Status and legitimacy of partner organisations.<br>Different organisational accountability arrangements. |
| Glendinning, C. Hudson, B. Hardy, B. & Young, R. (2002) | An evaluation of the impact of the Health Act flexibilities on 32 partnerships using the Partnership Assessment Tool to carry out a postal survey and a repeat survey 18 months later. 15 Partnerships responded. This was supported by 10 in-depth case studies with further follow up at 3 sites. | Equal levels of commitment.<br>Perceived equity of finances.<br>Coterminosity of boundaries.<br>Senior managers with clear vision and strong commitment.<br>History of previous joint working at organisational and personal level.<br>Joint training.<br>Appropriate legal & financial frameworks.<br>Willingess to commit resources. | Different financial accountabilities and planning cycles.<br>Short term funding for long term partnership.<br>Poor administrative support to manage finances.<br>Different professional and organisational roles and cultures.<br>Organisational turbulence.<br>IT technical barriers.<br>Poor information sharing (confidentiality). |

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| Hamer, L. & Smithies, J. (2002) | Drawing on experience of 400 partners attending events organised by the Health Development agency and upon 16 case studies from different local authorities seeking to explore key challenges and opportunities for improving integrated planning across Local Strategic Partnerships. | | Lack of coterminosity.<br>Balancing strategic versus local priorities.<br>Different accountability arrangements.<br>Clarifying key roles and leadership arrangements.<br>Different planning cycles.<br>Working with voluntary sector in meaningful way.<br>Creating joint budgets and joint appointments.<br>Lack of resources.<br>Sharing information across boundaries.<br>Short term solutions for long term goals. |
| Hardy, B. Turrell, A. & Wistow, G. (1992) | Draws together the theoretical, conceptual and empirical literature on interorganisational collaboration. Provides a framework on which to help understand how these facets come together in order to understand collaboration from organisational perspective. | Single organisational framework.<br>A dedicated project leader.<br>Decentralised control of resources.<br>Common budget. | |
| Hardy, B. Mur-Veemonu, I. Steenbergen, M. & Wistow, G. (1999) | An analysis of the English and Dutch health care systems. Although not informed how this analysis carried out. Primary focus on the integration of services – rather than solely partnership working. | | Different accountability arrangements.<br>Different funding arrangements.<br>Separate hierarchies.<br>Lack of coterminosity. |

| | | | |
|---|---|---|---|
| Hardy, B. Hudson, B. & Waddington, E. (2003) | Nuffield Institute at the University of Leeds worked within the Strategic Planning Taskforce of the Office of the Deputy Prime Minister. Researchers selected 24 pathfinders to work with and develop their partnerships and findings from project helped develop the Partnership Assessment Tool (PAT) which had six key indicators for assessing effectiveness of partnership working. . | Recognise and accept the need for partnership.<br>Develop clarity and realism of purpose.<br>Develop and maintain trust.<br>Create clear and robust partnership arrangements.<br>Monitor, measure and learn. | |
| Higgins, R. Oldman, C. & Hunter, D.J. (1994) | Carried out by the University of Leeds over 18 month period to evaluate the Rothwell Community Care Project – a local experiment on inter-agency collaboration. Used 46 individual and group interviews, documentary analysis and attendance at key project meetings. Interim findings externally verified. | Staff commitment.<br>Joint training.<br>Clarity and specificity of aims and objectives.<br>Clarity around joint management arrangements.<br>Clarity around resource availability at outset. | Cultural and professional differences.<br>Lack of information sharing due to confidentiality.<br>Staff turnover.<br>No delegation of necessary powers to team manager.<br>No extra funding or resources for project. |
| Hiscock, J. & Pearson, M. (1999) | Empirical study of 2 health districts in North West England. Used a case-study methodology with 98 in-depth interviews across 4 sites identified through purposive sampling. | | Working in parallel.<br>Lack of communication.<br>Power struggles.<br>Accountability arrangements.<br>Preoccupation with own organisational issues. |

| | | | |
|---|---|---|---|
| Holtom (2001) | Used framework from Wistow & Hardy (1991) to explore joint-working between primary care health and social services in one geographical area. Then used semi-structured interviews to study partnership practice from local perspective – within the framework. | As with (Wistow & Hardy, 1991) as used this framework to verify their theory. | |
| Johnson, P. Wistow, G. Schulz, R. & Hardy, B. (2003) | Drawing on the theoretical literature and an empirical study consisting of interviews with 22 health and social service managers from two rural and two urban areas of England. Services were working with different client groups including frail elderly, those with learning difficulties and mental health problems. | | Cost-shifting.<br>Purchaser-provider split.<br>Political issues.<br>Staff turnover.<br>Professional and cultural differences.<br>Power differences within and between partner organisations. |
| Joint Improvement Team (2009) | A comprehensive literature review carried out by the Joint Improvement Team of the Scottish Government's Health Directorate. The number of articles reviewed not identified but there were a total of 158 references in the published document on partnership working. | | Lack of outcomes.<br>Different decision-making processes.<br>Lack of communication.<br>Funding streams or lack of monies.<br>Poor information sharing.<br>Lack of time.<br>Roles and behaviour of partners.<br>Different professional skills and knowledge. |

| | | | |
|---|---|---|---|
| Jones, N. Thomas, P. & Rudd, L. (2004) | Empirical study reporting on 27 interviews with mostly senior managers across local and health authorities and NHS trusts who were working with mental health services in Wales. | Personal skills of key people.<br>Coterminosity and/or close proximity.<br>Identifying the need to collaborate.<br>Staff secondments between agencies. | Different cultures and values.<br>Lack of communication.<br>Staff turnover.<br>Lack of communication. |
| Marks, L. (2007) | Documentary analysis of the 25 Local Strategic Partnerships in North East England, supported by 8 semi-structured telephone interviews with national and regional stakeholders and 11 representatives from the voluntary and community sector. | | Poor communication.<br>Limited role of voluntary sector.<br>Sharing of information (confidentiality).<br>Different accountability arrangements.<br>Including voluntary sector as equal partner.<br>Lack of understanding of roles and purpose within partnership.<br>Local authority dominance on issues.<br>Competing priorities.<br>Hierarchical personal and organisational relationships. |
| Pavis, S. Constable, H. & Masters, H. (2003) | An ethnographic study for a health review project employing a social constructionist perspective. Three types of data were collected and analysed: 19 qualitative interviews with key personnel, documentary analysis of meeting minutes and other relevant documents, and participant observation at steering group meetings. | Good communication between partners.<br>Good pre-funding relationships. | Multiple and competing aims and objectives.<br>Staff turnover.<br>Type and level of power held by partners. |

| | | | |
|---|---|---|---|
| Peck, E. Towell, D. & Gulliver, P. (2001) | Reviewed the integration of the NHS and social services in Somerset. Used qualitative semi-structured interviews and likert-scale questionnaires. | Shared culture.<br>Unified vision.<br>Common language and values. | Professional and cultural barriers or more specifically medical versus social models of care. |
| Rummery, K. (1999) | The researcher carried out a number of interviews (number not reported) across seven sites with stakeholders from primary care health and social services who were involved in the commissioning of social care services. | | Different financial models of commissioning.<br>Professional accountability.<br>Organisational accountability.<br>Lack of user/carer involvement. |
| Rummery, K. & Coleman, A. (2003) | Reporting on the 1st phase of a 3 year longitudinal quantitative and qualitative study on the development of partnership working between social services and Primary Care Groups (& Trusts)(PCG/T). A 15% representative sample of English PCG/Ts. | Investment in managerial support.<br>Joint training.<br>Time to develop trust, shared values & relationships.<br>Ability to work outside organisational limitations.<br>Clear, achievable shared goals.<br>Commitment and ownership.<br>Acknowledge need for partnership and commit to it.<br>Jointly lead partnership process. | Different accountability arrangements.<br>Perceived organisational capacity.<br>Preoccupation with clinical issues.<br>Different access to funding from government.<br>Lack of coterminosity. |

| | | | |
|---|---|---|---|
| Secker, J. & Hill, K. (2001) | Focus group discussions with 128 participants across a purposive sample of 21 statutory and voluntary organisations in one county. Seven of the 21 had explicit mental health remit but none of these were from statutory mental health services. Research guided by an interview schedule. | Development of good informal networks. | Lack of information sharing.<br>Role boundary conflicts between agencies due to lack of resources.<br>Interprofessional differences of perspective (medical v social model).<br>Unrealistic expectations of each others agency. |
| Sharples, A. Gibson, S. & Galvin, K. (2002) | A purposive sampling of 15 workers and 11 clients in four focus groups. A purposive sample from a single 'floating support' scheme funded by social services. | Clarity of roles and responsibilities. | Professional and cultural differences.<br>Information sharing (confidentiality).<br>Prejudice of working with voluntary sector.<br>Power differences between partners and organisations, especially the voluntary sector. |
| Stewart, A. Petch, A. & Curtice, L. (2003) | Reported on the Joint Future Group – a review of practice in integrated working in Scotland commissioned by the Scottish Executive. Used 9 cases studies representing a wide geographical area. | Pooled budgets.<br>Unified arrangements for decision-making.<br>Clarity and understanding of roles.<br>Clarity of procedures.<br>Good communication.<br>Joint commitment.<br>Early involvement of all stakeholders.<br>Strong senior management.<br>Reward staff.<br>Joint training initiatives.<br>Trust<br>Creation of positive team culture. | Lack of role clarity.<br>Poor communication.<br>Lack of clarity around procedures.<br>Power imbalances between individuals and organisations.<br>Variation in local planning cycles. |

| | | | |
|---|---|---|---|
| Villeneau, L. Hill, R. Hancock, M. & Wolf, J. (2001). Also reported in Hancock, M. Villeneau, L. & Hill, R. (1997) | Commissioned by the Social Service Inspectorate and Sainsbury Centre for Mental Health. Carried out 78 semi-structured interviews with staff (from middle to senior managers) from health, social services and health commissioners from across 23 local authorities. The purpose was to develop key indicators of effective joint working in mental health between health authorities, NHS trusts and local authority social service departments. | Clearly developed strategies for joint working.<br>Joint training.<br>Networking opportunities.<br>Senior management culture of support.<br>Creating jointly agreed protocols.<br>Public acknowledgement of achievements (rewards). | Not including voluntary sector from beginning.<br>Different funding arrangements.<br>Accountability differences.<br>Different government guidance for health and social services.<br>Lack of understanding of mental health issues.<br>Lack of coterminosity.<br>Different organisation cultures, histories and financial arrangements. |
| Wildridge et al (2004) | A review of the literature on partnership working. Not systematic but use made of literature & resources available within King's Fund library. | Recognise need for partnership<br>History of partnership working<br>Mutual trust<br>Information sharing<br>Clear, consistent communication<br>Client engagement<br>Joint ownership of decisions<br>Collective responsibility<br>Addressing governance issues<br>Commitment<br>Leadership & senior management support<br>Boundary spanners. | Lack of equality between organisations<br>Under-resourcing<br>Work overload<br>Power imbalance between partners<br>Cultural clashes<br>Lack of role clarity<br>Focus on process rather than outcomes<br>Separate budgets. |

| | | | |
|---|---|---|---|
| Wistow, G. & Hardy, B. (1991) | Supported by the Department of Health this study reports on 5 projects involving collaboration across health and social service organisations. | Importance of key people.<br>Authority of organisation's representative.<br>Sharing information. | Lack of co-terminosity.<br>Fragmented responsibility.<br>Different operational systems.<br>Different planning cycles.<br>Different funding streams.<br>Different budgetary cycles.<br>Professional values and roles.<br>Elected versus appointed professionals.<br>Different status and legitimacy of partners.<br>(divided into 5 headings of: structural, procedural, financial, professional, status & legitimacy). |

## Appendix 3 Topic Guide for Phase 1 of the Study

Interviews with key informants and Steering Group chairpersons.

The following topics will be explored:

1. The role/input of the participant in relation to the CPA policy implementation process.
2. How the new system of CPA will differ from pre-existing arrangements.
3. What the local driving forces behind the CPA policy have been.
4. Where the policy implementation process is presently.
    - What work has been needed to get the process to its current stage.
5. What are the main factors (facilitators/barriers) that appear to have influenced the CPA policy process.
    - What impact they have had.
    - How these factors were identified and taken into account.
6. How the organisation has worked with partner organisations.
    - Have there been any issues and how were these dealt with.

## Appendix 4 Interview Schedule for Phase 1 of the Study

1. What role do you play in relation to the Steering Group?

   Or

   What influence does your role have on the CPA policy implementation process (PIP)?

   Or

   What part in the CPA PIP do you play?

2. In terms of the CPA PIP what do you think the local driving forces were?

3. Where is the CPA PIP presently?

4. What work was needed to get it to its current stage?

5. In what way will the new post-CPA system be different from pre-existing arrangements?

6. What were the main facilitators to the CPA PIP?

   How were these identified and utilized?

   Are they particular to your own locality or experienced elsewhere?

7. What were the main barriers to the CPA PIP?

   How were these identified and managed?

   Are they particular to your own locality or experienced elsewhere?

8. Were there any particular organizations leading the process of CPA PIP?

   Which organization?

   How did they lead?

   They face any issues – how managed?

9. Were there any particular individuals leading the process of CPA PIP?

   What was their role?

   How did they lead?

   Did they face any issues – how they managed?

10. Were there differing organizational attitudes to the necessity of CPA?

    How were these worked with?

11. Do you think there have been any particular issues related either to your own locality/or other localities which have impacted on the CPA PIP?

    What were these?

    How managed?

    Why do you think they were specific to your area/the other locality?

## Appendix 5 Invitation to Participate

*[insert date]* 2009

Dear *[insert name],*

I am a post-graduate research student undertaking a Doctorate in Health Care at King's College London. As part of my studies I am undertaking a research project in the Trust to explore the factors influencing local implementation of the Care Programme Approach, which aims to address the mental health needs of people with a learning disability.

I would like to invite you as a member of the [*insert locality name*] Joint Mental Health and Learning Disability Steering Group to meet with me for a confidential interview. The interview will last for up to 30 minutes and will be carried out at a date, time and place suited to you. You will also be asked to complete a Partnership Assessment Tool before your interview which should take no more than ten minutes to complete. I enclose an information sheet containing further information about the study's aims and objectives, together with a consent form.

I hope to commence the interviews in *[insert date*] 2009 and would appreciate if you could let me know as soon as possible if you are willing to be interviewed. I enclose a stamped addressed envelope so that you may return your completed consent form and contact details to me. If you agree to take part I will contact you within a week of receiving your agreement to make arrangements for the interview.

I have received agreement in principle from the Director of Learning Disability Services and the Learning Disability Divisional Manager for this project to proceed. The research has also received ethical approval from IRAS (Research Ethics Committee), the local R&D department and the Association of Directors of Adult Social Services (ADASS).

If you require any further information please do not hesitate to contact me on the number below.

Thank you for your time and anticipated participation in the study.

Yours sincerely,

Michael Kelly
King’s College London
Room 2.40 James Clark Maxwell Building
57 Waterloo Road
London
SE1 8WA

+44 (0)20 7848 3589
michael.kelly@kcl.ac.uk

## Appendix 6 Participant Information Sheet

University of London

## Participant Information Sheet

**Study title**
An exploration of the factors influencing the local implementation of the Care Programme Approach in the provision of mental health services for clients with learning disabilities.

**Invitation**
You are being invited to take part in the above study. Before you decide it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information.
Ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

**What is the purpose of the study?**

Aim:
This study aims to explore the factors shaping the local implementation of the adoption of the Care Programme Approach (CPA) for clients with a dual diagnosis from a meso-level perspective.

Objectives:

1. Describe and compare local approaches to the introduction of CPA for dual diagnosis clients in selected localities.
2. Identify the various factors (including organisational, contextual and partnership related factors) that appear to have influenced the implementation process in the different localities.
3. Explore how key factors identified as important by participants appeared to help, hinder or otherwise affect the implementation of CPA for this client group.
4. Investigate whether, and how, these issues were acknowledged and dealt with by those involved in the implementation process.

**Why have I been chosen?**
You have been chosen as you are a key stakeholder in the development and implementation of the joint CPA policy which is being introduced throughout the Trust and which is being analysed in this study. Your views on the factors influencing the implementation process, and your own role within that, are important to the study's success.

**Do I have to take part?**
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

**What will happen to me if I take part?**

If you choose to participate you will be invited to attend an individual interview with the researcher. This will last up to 30 minutes and will be at a date, time and venue of your choice. The interview will be audio recorded with your permission and the recording used by the researcher to transcribe the data from the interview. The tape recordings and any personal data (e.g. name, address) will be destroyed after transcription and no person-identifiable data will kept on record. All interviews will be anonymous and no person or site identifiable information will be used in the write-up. No one in your organisation will know whether you have participated.

**You will also be asked at interview to complete a Partnership Assessment Tool. This is a brief questionnaire and will take no more than 10 minutes to complete.**

Participants have the right to check the accuracy of personal data as well as their written audio transcripts and correct any errors. Should you wish to do this you may request the information from the researcher either verbally or in writing using the contact details below.

**What do I have to do?**

If you choose to take part please fill in the enclosed consent form and the researcher will contact you within a week to arrange an interview.

**What are the possible benefits of taking part?**

By taking part you will be contributing to a better understanding of the policy implementation process which, in the longer term, may benefit services for clients in your area of work.

**What happens when study ends?**

The findings will be written up as a research based thesis and submitted by the researcher for examination to achieve the Doctorate in Health Care award at King's College London. A summary of the findings will be fed back to the Trust. The findings will be presented at relevant conferences and papers submitted for publication in appropriate journals.

**What will happen if I don't want to carry on with the study?**

If you withdraw from the study all your identifiable information will be destroyed but any non-identifiable information you have provided may still be used. You do not have to give any reason for your withdrawal and you will not be contacted again by the researcher for the purpose of this study.

**Complaints**:

If you have concerns about any aspect of this study, you should contact the researcher [(020) 7848 3589]. If you remain unhappy and wish to complain formally, you can do this through the researcher's university supervisors' or King's College London Complaints Procedure.

**Will my taking part in this study be kept confidential?**

All information collected from you will be kept strictly confidential. No one within the organisation will know that you have taken part. The procedures for handling, processing, storage and destruction of your data are compliant with the Data Protection Act 1998 and King's College London's regulations on the conduct and management of research. The recorded interview will be stored until the data have been transcribed and anonymised. The audio tape and all personal data will then be destroyed. The research data will be accessed only by the researcher and his university supervisors.

**Who is organising and funding the research?**

The study is being undertaken as part of my postgraduate research degree (Doctorate in Health Care) and is supervised by Professor Charlotte Humphrey (Professor of Health Care Evaluation) and Dr. Ruth Young (Reader in Health Policy Evaluation). There is no funding.

**Who has reviewed the study?**

The study has been approved by the local Research Ethics Committee, the Association of Directors of Adult Social Services and the local Research & Development department.

**Contact Details:**

Michael Kelly
King's College London
Room 2.40 James Clark Maxwell Building
57 Waterloo Road
London
SE1 8AW

+44  (0)20 7848 3589 (W)

e-mail: michael.kelly@kcl.ac.uk

**Thank you for taking the time to read this information leaflet and agreeing to take part. Your participation is greatly appreciated.**

**Appendix 7 Consent Form**

KING'S College LONDON

University of London

## CONSENT FORM

**Title: An exploration of the factors influencing the local implementation of the Care Programme Approach in the provision of mental health services for clients with learning disabilities.**

**Name of Chief Investigator: Michael Kelly**

I confirm that I have read and understand the Participant Information Sheet (Version 2.0; dated 30/09/09) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

I understand that relevant sections of any data collected during the study may be looked at and/or analysed by the chief investigators' supervisors from King's College London. I give permission for these individuals to have access to anonymised data from my interview.

☐

I understand that the interviews will be audio recorded and that the tapes will be destroyed once they have been transcribed.

☐

I agree to take part in the above study.

☐

Name of Participant Date Signature

Job Title

| | | |
|---|---|---|
| Name of Person taking consent<br>(Chief Investigator) | Date | Signature |

**Your contact details:**

Work Address: ______________________________
Work Telephone: ______________________________
Mobile: _____________________________
E-mail address: ______________________________

## Appendix 8 Topic Guide for Phase 2 of the Study

Interviews with Steering Group members.

The following topics will be explored:

1. The role/input of the participant in relation to the CPA policy implementation process.
2. The views of the participant on how the CPA policy has been/should be shaped.
3. What are the main factors (facilitators/barriers) that appear to have influenced the CPA policy process.
    - What impact they have had.
    - How these factors were identified and taken into account.
4. How the CPA implementation process has been shaped and influenced by the various stakeholders represented on the Steering Group.
    - Have there been any issues and how were these dealt with.

**Appendix 9 Interview Schedule for Phase 2 of the Study**

Phase 2 Interview Questions

1. What role do you play in the CPA policy implementation process (PIP)?

   Or

   What role do you play in the S/Group?

   Or

   What input have you had into the CPA PIP?

2. In your view how do you think the CPA policy has been shaped?

   What factors have influenced its implementation?

3. Is the way that the CPA is being shaped how you think it ought to be?

   Why? Why not – how should it be shaped then?

4. What are the main facilitators in the CPA PIP?

   How have these been identified and utilized?

   Are they particular to your own locality or experienced elsewhere?

5. What are the main barriers to the CPA PIP?

   How have these been identified and managed?

   Are they particular to your own locality or experienced elsewhere?

6. How the CPA PIP shaped and influenced by various stakeholders?

   Any issues – how addressed and managed/utilised?

7. How CPA PIP shaped and influenced by different organizations on the Steering Group?

   Any issues – how addressed and managed/utilised?

8. From Phase 1 of this study I identified these points…….what are your views on these?

## Appendix 10 The Partnership Assessment Tool

KING'S College LONDON

University of London

### Assessing Strategic Partnership
### The Partnership Assessment Tool

In the following pages you are asked to consider a series of statements about the Mental Health and Learning Disability Partnership – as a whole – which is the subject of this study. Indicate the extent to which you agree or disagree with each of these statements by ticking the appropriate boxes.

You may wish to add additional comments or observations in the final column or on the bottom of each page.

The following is an illustration of a completed section, using as an example possible responses to Principle 1.

**Principle 1: Recognise and accept the need for partnership.**

| **To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole.** | **Strongly agree** | **Agree** | **Disagree** | **Strongly disagree** | **Comments** |
|---|---|---|---|---|---|
| **There have been substantial past achievements within the partnership.** | √ | | | | We have very strong arrangements and policies…… |
| **The factors associated with successful working are known and understood.** | | | √ | | |
| **The principle barriers to successful partnership working are known and understood.** | | √ | | | |
| **The extent to which partners engage in partnership working voluntarily or under pressure/mandation is recognized and understood.** | | √ | | | |
| **There is a clear understanding of partners' interdependence in achieving some of their goals.** | | √ | | | |
| **There is mutual understanding of those areas of activity where partners can achieve some goals by working independently of each other.** | | | | √ | |
| | | | | | |

**Principle 1: Recognise and accept the need for partnership.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| There have been substantial past achievements within the partnership. | | | | | |
| The factors associated with successful working are known and understood. | | | | | |
| The principle barriers to successful partnership working are known and understood. | | | | | |
| The extent to which partners engage in partnership working voluntarily or under pressure/mandation is recognized and understood. | | | | | |
| There is a clear understanding of partners' interdependence in achieving some of their goals. | | | | | |
| There is mutual understanding of those areas of activity where partners can achieve some goals by working independently of each other. | | | | | |
| | | | | | |

**Principle 2: Develop clarity and realism of purpose.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| Our partnership has a clear vision, shared values and agreed service principles. | | | | | |
| We have clearly defined joint aims and objectives. | | | | | |
| These joint aims and objectives are realistic. | | | | | |
| The partnership has defined clear service outcomes. | | | | | |
| The reason why each partner is engaged in the partnership is understood and accepted. | | | | | |
| We have identified where early partnership success is most likely. | | | | | |
| | | | | | |

**Principle 3: Ensure commitment and ownership.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| There is a clear commitment to partnership working from the most senior levels of each partnership organization. | | | | | |
| There is widespread ownership of the partnership across and within all partners. | | | | | |
| Commitment to partnership working is sufficiently robust to withstand most threats to its working. | | | | | |
| The partnership recognizes and encourages networking skills. | | | | | |
| The partnership is not dependent for its success solely upon individuals with these skills. | | | | | |
| Not working in partnership is discouraged and dealt with. | | | | | |
| | | | | | |

**Principle 4: Develop and maintain trust.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| The way the partnership is structured recognizes and values each partner's contribution. | | | | | |
| The way the partnership's work is conducted appropriately recognizes each partner's contribution. | | | | | |
| Benefits derived from the partnership are fairly distributed among all partners. | | | | | |
| There is sufficient trust within the partnership to survive any mistrust that arises elsewhere. | | | | | |
| Levels of trust within the partnership are high enough to encourage significant risk-taking. | | | | | |
| The partnership has succeeded in having the right people in the right place at the right time to promote partnership working. | | | | | |
| | | | | | |

**Principle 5: Create clear and robust partnership arrangements.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| It is clear what financial resources each partner brings to the partnership. | | | | | |
| The resources, other than finance, each partner brings to the partnership are understood and appreciated. | | | | | |
| Each partner's areas of responsibility are clear and understood. | | | | | |
| There are clear lines of accountability for the performance of the partnership as a whole. | | | | | |
| Operational partnership arrangements are simple, time-limited and task-orientated. | | | | | |
| The partnership's principal focus is on process, outcomes and innovation. | | | | | |
| | | | | | |

**Principle 6: Monitor, measure and learn.**

| To what extent do you agree with each of the following 6 statements in respect of the Mental Health and Learning Disability Partnership as a whole. | Strongly agree | Agree | Disagree | Strongly disagree | Comments |
|---|---|---|---|---|---|
| The partnership has clear success criteria in terms of both service goals and the partnership itself. | | | | | |
| The partnership has clear arrangements effectively to monitor and review how successfully its service aims and objectives are being met. | | | | | |
| There are clear arrangements effectively to monitor and review how the partnership itself is working. | | | | | |
| There are clear arrangements to ensure that monitoring and review findings are, or will be, widely shared or disseminated amongst the partners. | | | | | |
| Partnership successes are well communicated outside of the partnership. | | | | | |
| There are clear arrangements to ensure that partnership aims, objectives and working arrangements are reconsidered and, where necessary, revised in the light of monitoring and review findings. | | | | | |
| | | | | | |

**Thank you for taking the time to complete this assessment.**

This Partnership Assessment Tool© has been adapted from:
Hardy, B. Hudson, R. & Waddington, E. (2003) Assessing Strategic Partnership. The Partnership Assessment Tool. Office of the Deputy Prime Minister: London.

## Appendix 11 Research Ethics Committee Approval

**Outer North East London Research Ethics Committee**
Board Room A
2nd Floor
Becketts House
2/14 Ilford Hill
Ilford
Essex
IG1 2QX

Telephone: 020 7188 2259
Facsimile: 020 7188 2258

24 September 2009

Mr. Michael Kelly
Tutor in Mental Health Care
King's College London
Rm 2.40 JCMB
57 Waterloo Road
London SE1 8WA

Dear Mr. Kelly

| | |
|---|---|
| **Study Title:** | **An exploration of the factors influencing the local implementation of the Care Programme Approach (CPA), in the provision of mental health services for clients with learning disabilities.** |
| **REC reference:** | **09/H0701/91** |
| **Protocol number:** | **1.0** |

The Proportionate Review Sub-committee of the Outer North East London Research Ethics Committee Research Ethics Committee reviewed the above application at the meeting held on 24 September 2009.

**Ethical opinion**

Favourable Opinion with conditions

In discussion, the Committee noted that the members of the steering group will also be users but that the researchers haven't acknowledged that potentially vulnerable members are part of the steering group. The researcher needs to clarify this point.

**Patient Information Sheet, Version 1**
1. “Will my taking part in this study be kept confidential?” section:

The last sentence “Participants have the right to check the accuracy of data held about them and correct any errors”. The researcher needs to either remove this sentence or explain how they will do it.

Queries from the Committee regarding this process:
a) Is it only the personal data or is it also the transcripts?

b) Will the interviewee have to request it or will it be automatically sent to them?

The answer to this query needs to be added to the "What will happen to me if I take part?" section of the Patient Information Sheet

2. "Who is organising and funding the research?" section:
Amend the sentence: "The study is being undertaken by as part of a postgraduate..." to: "The study is being undertaken as part of my postgraduate…"

3. Add that this study has been reviewed and approved by the Outer North East London Research Ethics Committee.

**Consent Form, version 1.0**
1. Include that the interviews will be recorded and that the tapes will be destroyed.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Approved documents**

The documents reviewed and approved at the meeting were:

| *Document* | *Version* | *Date* | |
|---|---|---|---|
| Covering Letter | 1.0 | 17 September 2009 | |
| REC application | 1.0 | 13 August 2009 | |
| Protocol | 1.0 | 15 September 2009 | |
| Investigator CV | 1.0 | 10 September 2009 | |
| Participant Information Sheet | 1.0 | 15 September 2009 | |
| Participant Consent Form | 1.0 | 15 September 2009 | |
| Letter of invitation to participant | 1.0 | 15 September 2009 | |
| Evidence of insurance or indemnity | 1.0 | | |
| Letter from Sponsor | 1.0 | 14 September 2009 | |
| Interview Schedules/Topic Guides | 1.0 | 15 September 2009 | |
| Questionnaire: Assessing Strategic Partnership - The Partnership Assessment Tool | 1.0 | | |
| Supervisor CV - Charlotte Humphrey | 1.0 | 17 September 2009 | |

**Membership of the Proportionate Review Sub-Committee**

The members of the Sub-Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| **09/H0701/91** | **Please quote this number on all correspondence** |
|---|---|

With the Committee's best wishes for the success of this project

Yours sincerely

**Rev. Dr Joyce Smith**
**Chair**

Email: samantha.roper@gstt.nhs.uk

## Appendix 12 Research and Development Approval

**R&D CONSORTIUM**

23 November 2009

Mr Michael Kelly
Tutor in Mental Health Care
King's College London
Rm 2.40 JCMB
57 Waterloo Road
London SE1 8WA

Dear Mr Kelly

**Re: An exploration of the factors influencing the local implementation of the Care Programme Approach (CPA), in the provision of mental health services for clients with learning disabilities**
**LREC Ref: 09/H0701/91**
**R&D Reference Number: KELMC9001**

I am pleased to confirm that the above study has now received R&D approval, and you may start your research in the Trust. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

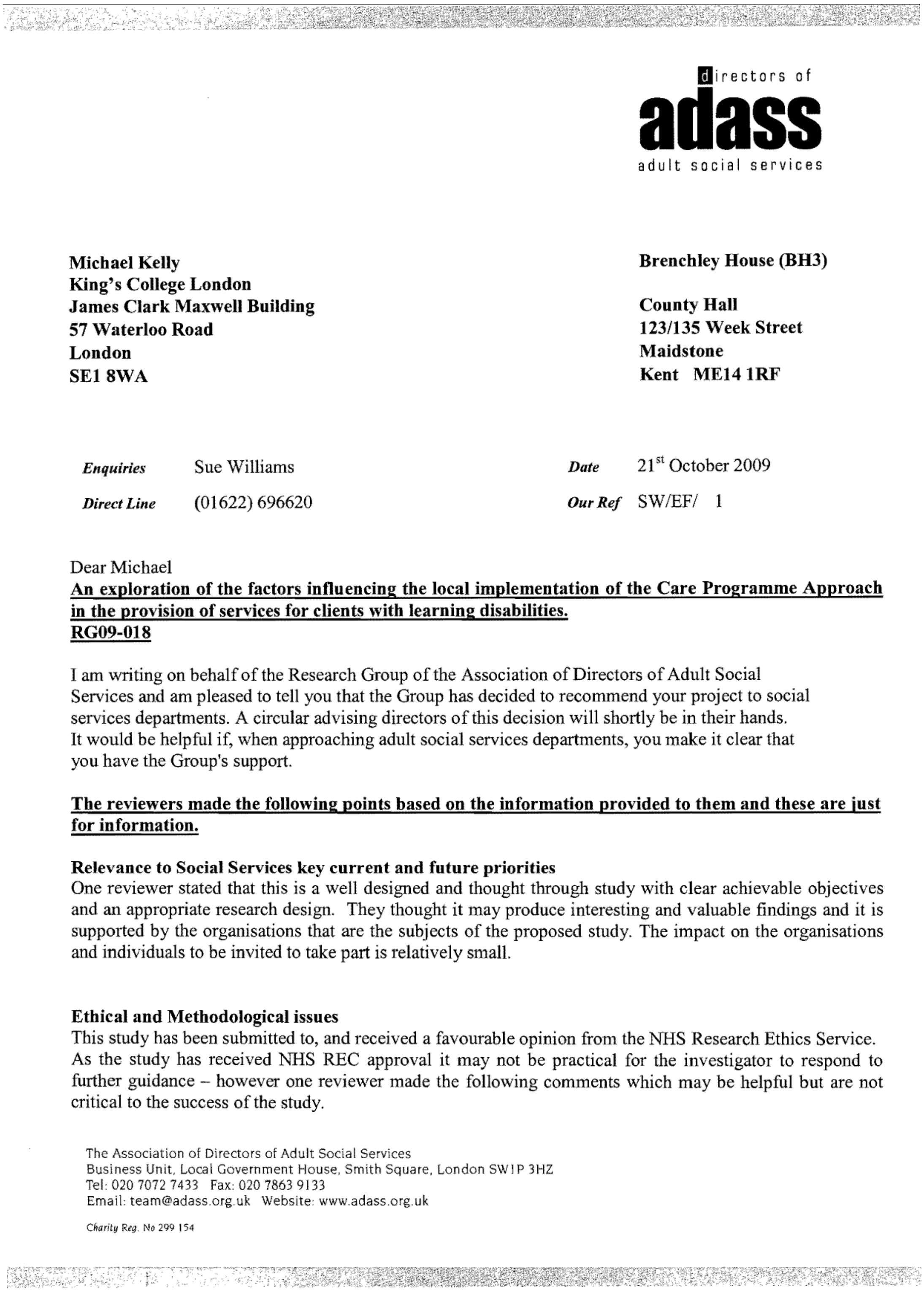
- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish

to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.

Please ensure that all members of the research team are aware of their responsibilities as researchers.
We would like to wish you every success with your project

Yours sincerely
**Research Governance Co-ordinator**

# Appendix 13 Association of Directors for Adult Social Services (ADASS) Approval



directors of
adass
adult social services

Michael Kelly
King's College London
James Clark Maxwell Building
57 Waterloo Road
London
SE1 8WA

Brenchley House (BH3)

County Hall
123/135 Week Street
Maidstone
Kent ME14 1RF

*Enquiries* Sue Williams

*Direct Line* (01622) 696620

*Date* 21st October 2009

*Our Ref* SW/EF/ 1

Dear Michael

**An exploration of the factors influencing the local implementation of the Care Programme Approach in the provision of services for clients with learning disabilities.**
**RG09-018**

I am writing on behalf of the Research Group of the Association of Directors of Adult Social Services and am pleased to tell you that the Group has decided to recommend your project to social services departments. A circular advising directors of this decision will shortly be in their hands. It would be helpful if, when approaching adult social services departments, you make it clear that you have the Group's support.

**The reviewers made the following points based on the information provided to them and these are just for information.**

**Relevance to Social Services key current and future priorities**
One reviewer stated that this is a well designed and thought through study with clear achievable objectives and an appropriate research design. They thought it may produce interesting and valuable findings and it is supported by the organisations that are the subjects of the proposed study. The impact on the organisations and individuals to be invited to take part is relatively small.

**Ethical and Methodological issues**
This study has been submitted to, and received a favourable opinion from the NHS Research Ethics Service. As the study has received NHS REC approval it may not be practical for the investigator to respond to further guidance – however one reviewer made the following comments which may be helpful but are not critical to the success of the study.

The Association of Directors of Adult Social Services
Business Unit, Local Government House, Smith Square, London SW1P 3HZ
Tel: 020 7072 7433 Fax: 020 7863 9133
Email: team@adass.org.uk Website: www.adass.org.uk

*Charity Reg. No 299 154*

1. Confidentiality may be an issue – despite the reassurances that data will be anonymised, it seems likely that some of the participants will know one another and it's quite possible that strong views or idioms used in speech will lead to defacto recognition. This is almost unavoidable in a research study of this kind – and the participants are not vulnerable individuals – risks to participants are very small – but it might be helpful to make this clear prior to interviews taking place.
2. There are a couple of small typographical errors in the partnership assessment tool. (principle 3 dependent, not dependant & principle 6 effectively, not affectively). It might have been helpful to have written something about how this data will be analysed and how it will be used to steer the second phase of the study.
3. The topic guide seemed to be on the unstructured side of semi-structured: having a *rationale* for each question might help to focus the questions i.e. 'I am asking this question because I want to find out..'. and then exploring this in more depth with some 'sub-menu' topics. Some informants may need more 'coaxing' to divulge information that would help answer the research questions – there's a risk that some interviewees might 'dry up' before having given full answers.
4. One reviewer suggested that in the letters of introduction it might be best to avoid the acronym – eg IRAS but to use the full title. However IRAS is the application system and approval is by the National Research Ethics Service, specifically The Outer North East London Research Ethics Committee

**Time staff expected to contribute to the project**
One reviewer suggested that time required to participate in this study is minimal .

**Should this project be supported by the ADASS**
Yes, reviewers recommended that ADASS support the proposal.

****

In the interests of ensuring that adult social services departments receive the maximum benefit from co-operating in research projects such as your own, the Group places great importance on disseminating findings and conclusions. It encourages researchers to find ways, including (but not exclusively) formal publication of a report, of feeding back the results of their research to participating departments. It would welcome a short summary of the findings of this project, once you have completed it, in a form suitable for distribution to adult social services departments. We would appreciate knowing your expected publishing date.

Yours sincerely

S.A.Williams

Sue Williams Research Manager

Sent behalf of Sarah Norman and Paul Najsarek Co-Chairs of ADASS Standards and Policy Committee and Research Committee

## Appendix 14 Complete Findings of the Partnership Assessment Tool

This appendix outlines the findings from the *Partnership Assessment Tool* (PAT) (Hardy et al, 2003). There are six principles in the tool:

1. Recognise and accept the need for partnership.
2. Develop clarity and realism of purpose.
3. Ensure commitment and ownership.
4. Develop and maintain trust.
5. Create robust and clear partnership working arrangements.
6. Monitor, measure and learn.

Each principle has six further sub-elements which the respondent completes indicating their level of agreement or disagreement with each. The answers given by the respondent are then scored as follows:

| | |
|---|---|
| Strongly agree | 4 |
| Agree | 3 |
| Disagree | 2 |
| Strongly disagree | 1 |

The individual score for each sub-element is then added to the scores of the other individual elements. This gives a range of between 6 -24. The sum of the scores for all the principles are then added up giving an overall partnership score. This will be within the range of 36-144.

The scoring of the PAT is divided into 4 aggregate groups which range from ‘partnership working badly’ to ‘partnership working well in all or most respects’ (see table 1).

| | | |
|---|---|---|
| Group A | ≤36 | Partnership is working badly in all respects |
| Group B | 37-72 | Partnership may be working well is some respects but these are outweighed by areas of concern |
| Group C | 73-108 | Partnership is working well but some aspects may need further exploration |
| Group D | 109-144 | Partnership is working well in all or most respects |

**Table 1: Aggregate scoring system**

In total 26 PATs were completed during the data collection process. Tables 2 and 3 indicate PAT responses by locality and by employing organisation respectively.

| Locality | Number of Responses |
|---|---|
| A | 5 |
| B | 5 |
| C | 4 |
| D | 4 |
| E | 5 |
| Senior Management (cover all areas) | 3 |
| Total responses | 26 |

**Table 2: PAT Responses by locality**

| Locality | Employer | | | Total responses |
|---|---|---|---|---|
| | NHS | Social Services | Voluntary Org. | |
| A | 2 | 2 | 1 | 5 |
| B | 1 | 3 | 1 | 5 |
| C | 3 | 1 | 0 | 4 |
| D | 3 | 1 | 0 | 4 |
| E | 2 | 2 | 1 | 5 |
| Snr Mngmt | 3 | 0 | 0 | 3 |
| Total | 14 | 9 | 3 | 26 |

**Table 3: PAT Responses by employer**

### Overall Health of the Partnerships as Revealed by the PAT

It is also possible to get an overall score for the 'health' of a particular partnership. Table 4 presents the aggregate scores and their range from the data collected in each of the localities and from senior management interviewees.

| Locality | Response Rate (%) | Individual Partner Aggregate Scores (by group) | Range of Scores by Locality | |
|---|---|---|---|---|
| | | | Range | Size |
| A | 42 | 5c | 93*-106 | (13) |
| B | 36 | 1a; 1b; 3c | 44-92 | 48 |
| C | 100 | 1a; 3c | 34*-95 | (61) |
| D | 44 | 3c; 1d | 90-109 | 19 |
| E | 42 | 5c | 87-108 | 21 |
| Snr Mngmt | n/a | 3c | 93-101 | 8 |

**Table 4: Aggregate scores and range of scores**

Key: a = ≤36, b = 37-72, c = 73-108, d= 109-144

*some respondents were uncertain as to how to answer some questions and these are classed as missing scores. However the range and size has still been calculated on the answers that respondents have given.

Range of Scores based on table 4 above:

| | | |
|---|---|---|
| 0: | none | |
| 1-9: | 1 | (senior management) |
| 10-19: | 2 | (Localities A and D) |
| 20-29: | 1 | (Locality E) |
| 30+: | 2 | (Localities B and C) |

As advised by Hudson et al (2001) a score of 19 or less is classed as insignificant. There was therefore an appreciable difference in scoring for Locality E and a significant difference in Localities B and C.

In Localities B (2 respondents) and C (1 respondent) returned aggregate scores of ≤36 (indicating that partnership working was bad in all respects) or 37-72 (indicating that partnership may have been working well is some respects but these were outweighed by areas of concern).

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| A | 2c | 2c | 1c |
| B | 1b; 2c | 1c | 1a |
| C | 1a; 2c | 1c | # |
| D | 3c | 1d | # |
| E | 2c | 2c | 1c |
| Senior Management | 3c | # | # |

**Table 5: Aggregate scores by employing agency**

# = no data collected from these agencies

## The Health of Individual Partnerships in Each Locality

This section discusses the findings from the administration of the PAT in each of the localities. The views of individual respondents, which were written by them on their PAT, are also considered.

### Locality A

| | |
|---|---|
| Potential partners: | 12 |
| Responses: | 5 |
| Response rate: | 42% |

| Principle | Respondent | | | | |
|---|---|---|---|---|---|
| | A1 | A2 | A3 | A4 | A5 |
| 1 | 17 | 20 | 21 | 20 | 17 |
| 2 | 17 | 15 | 18 | 21 | 18 |
| 3 | 14 | 17 | 14 | 14 | 15 |
| 4 | 13 | 17 | 17 | 17 | 13 |
| 5 | 17 | 17 | 16 | 17 | 13 |
| 6 | 15 | 20 | 19 | 17 | 14 |
| Scores | 93 | 106 | 105 | 106 | 90 |

**Table 6: Range of scores by respondent in Locality A**

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| A | 2c | 2c | 1c |

**Table 7: Aggregate scores by employing agency in Locality A**

Aggregate Scores

| | |
|---|---|
| ≤36: | 0 |
| 37-72: | 0 |
| 73-108: | 5 |
| 109-144: | 0 |

Range: 93-106

The PAT findings from Locality A indicated that respondents consistently felt that partnership working was working well in the locality but some aspects of the partnership needed further exploration. For example respondent A4 highlighted that there was evidence that some departments were working in professional 'silos' which meant that they were not able to work well as equal partners. According to the same respondent this was not helped by a lack of resources, whilst respondent A5 indicated that there were problems of trust between senior management and staff and poor accountability arrangements between partners.

**Locality B**

| | |
|---|---|
| Potential partners: | 14 |
| Responses: | 5 |
| Response rate: | 36% |

| Principle | Respondent | | | | |
|---|---|---|---|---|---|
| | B1 | B2 | B3 | B4 | B5 |
| 1 | 16 | 13 | 19 | 14 | 6 |
| 2 | 11 | 6 | 19 | 13 | 6 |
| 3 | 12 | 7 | 17 | 14 | 5 |
| 4 | 15 | 6 | 7 | 12 | 5 |
| 5 | 15 | 6 | 17 | 12 | 6 |
| 6 | 14 | 6 | 13 | 12 | 6 |
| Scores | 83 | 44 | 92 | 77 | 34 |

**Table 8: Range of scores by respondent in Locality B**

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| B | 1b; 2c | 1c | 1a |

**Table 9: Aggregate scores by employing agency in Locality B**

Aggregate Scores:

≤36: 1

37-72: 1

73-108: 3

109-144: 0 Range: 34-92

The findings from Locality B indicate a mixed response. What was interesting was that one of the three NHS staff interviewed held a different view of how well the partnership was working when compared with responses from the other NHS partners. This respondent (B1) felt that overall there was limited partnership working with little opportunities for networking. They felt that the aims and objectives of the partnership were not clearly defined and not all necessary partners, including the respondent themselves, were engaged fully. The voluntary sector representative, who felt that although the presence of the Steering Group indicated a level of commitment it had not been able to progress any further in the implementation process, echoed this.

**Locality C**

| | |
|---|---|
| Potential partners: | 4 |
| Responses: | 4 |
| Response rate: | 100% |

| Principle | Respondent | | | |
|---|---|---|---|---|
| | C1 | C2 | C3 | C4 |
| 1 | 18 | 16 | 17 | 18 |
| 2 | 15 | 15 | 0 | 17 |
| 3 | 12 | 17 | 9 | 17 |
| 4 | 16 | 12 | 0 | 16 |
| 5 | 9 | 12 | 5 | 14 |
| 6 | 14 | 15 | 3 | 13 |
| Scores | 84 | 87 | 34 | 95 |

**Table 10: Range of scores by respondent in Locality C**

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| B | 1a; 2c | 1c | # |

**Table 11: Aggregate scores by employing agency in Locality C**

# = no data collected from these agencies

Aggregate Scores:

| | | | |
|---|---|---|---|
| ≤36: | 1 | | |
| 37-72: | 0 | | |
| 73-108: | 3 | | |
| 109-144: | 0 | Range: | 34-95 |

In Locality C three of the respondents scored similar aggregate scores indicating that they felt partnership working was going well but some areas needed further exploration. However there was some acknowledgement that financial barriers and a lack of Steering Group meetings were an issue for the partnership (e.g. respondent C1). What was most interesting was that the Service Director for the locality was the most critical of the partnership between mental health and learning disabilities. She felt that there were many barriers and there was no motivation for staff to change the status quo. In terms of completing the PAT she felt unable to answer many questions as she felt that partnership working in the locality was so seriously lacking.

**Locality D**

| | |
|---|---|
| Potential partners: | 9 |
| Responses: | 4 |
| Response rate: | 44% |

| Principle | Respondent | | | |
|---|---|---|---|---|
| | D1 | D2 | D3 | D4 |
| 1 | 20 | 17 | 17 | 16.5 |
| 2 | 18 | 17 | 17 | 17.5 |
| 3 | 19 | 15 | 15 | 15.5 |
| 4 | 17 | 15 | 17 | 16 |
| 5 | 17 | 13 | 16 | 16.5 |
| 6 | 18 | 13 | 16 | 16 |
| Scores | 109 | 90 | 98 | 98 |

**Table 12: Range of scores by respondent in Locality D**

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| D | 3c | 1d | # |

**Table 13: Aggregate scores by employing agency in Locality D**

# = no data collected from these agencies

Aggregate Scores:

| | | | |
|---|---|---|---|
| ≤36: | 0 | | |
| 37-72: | 0 | | |
| 73-108: | 3 | | |
| 109-144: | 1 | Range: | 90-109 |

In Locality D there was recognition that further work needed to be done to develop and maintain trust in the partnership. There were no clear goals for the partnership and no mental health service back-up for learning disabilities. However overall respondents felt that partnership working was going well, indicated by their individual and overall aggregate scores.

**Locality E**

| | |
|---|---|
| Potential partners: | 12 |
| Responses: | 5 |
| Response rate: | 42% |

| Principle | Respondent | | | | |
|---|---|---|---|---|---|
| | E1 | E2 | E3 | E4 | E5 |
| 1 | 19 | 17 | 18 | 16 | 18 |
| 2 | 18 | 13 | 19 | 18 | 17 |
| 3 | 15 | 14 | 19 | 16 | 16 |
| 4 | 15 | 17 | 18 | 17 | 17 |
| 5 | 14 | 15 | 15 | 17 | 16 |
| 6 | 15 | 14 | 19 | 16 | 17 |
| Scores | 96 | 87 | 108 | 100 | 101 |

**Table 14: Range of scores by respondent in Locality E**

| Locality | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| E | 2c | 2c | 1c |

**Table 15: Aggregate scores by employing agency in Locality E**

Aggregate Scores:

| | | | |
|---|---|---|---|
| ≤36: | 0 | | |
| 37-72: | 0 | | |
| 73-108: | 5 | | |
| 109-144: | 0 | Range: | 87-108 |

Locality E, the most advanced with the implementation of CPA, showed that all partners were consistent in their views of the partnership between mental health and learning disabilities at a strategic level. However at a front-line there "continues to be a strong divide between our services" (respondent E4) which another respondent (E5) felt was not helped by a lack of irregular back-up from senior management and staff turnover.

### Trust Level Managers

| | |
|---|---|
| Partners: | 3 |
| Responses: | 3 |
| Response rate: | 100% |

| Principle | Respondent | | |
|---|---|---|---|
| | T1 | T2 | T3 |
| 1 | 18 | 21 | 23 |
| 2 | 17 | 18 | 15 |
| 3 | 16 | 19 | 14 |
| 4 | 17 | 14 | 15 |
| 5 | 17 | 13 | 16 |
| 6 | 16 | 8 | 14 |
| Scores | 101 | 93 | 97 |

**Table 16: Range of scores by respondent at Trust level**

| Site | Employer | | |
|---|---|---|---|
| | NHS | Social Service | Voluntary Org. |
| Senior Management | 3c | # | # |

**Table 17: Aggregate scores at Trust level**

# = no data collected from these agencies

Aggregate Scores:

| | | | |
|---|---|---|---|
| ≤36: | 0 | | |
| 37-72: | 0 | | |
| 73-108: | 3 | | |
| 109-144: | 0 | Range: | 93-101 |

Like Locality E senior Trust management felt that across the entire trust partnership between mental health and learning disability services was going well, at least from a strategic perspective. In part much of the focus from respondents at this level had to do with governance and accountability arrangements across and between services with many partners only engaging if it reflects on some target performance rating (respondent T2). This view was supported by the Deputy Director of Operations for the Trust (respondent T3) who felt that a lack of governance over local authorities had not only threatened some of the partnerships but had blocked progress with CPA implementation. However the respondent felt that this was not dealt with and "the issue of CPA and governance has been underplayed by the partners". An ongoing problem for the Deputy Director was the over reliance on some individual motivated partners which had been affected by staff turnover.