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The Professional Experience of Governance and Incentives: meeting the needs of individuals with complex conditions in primary care

The Professional Experience of Governance and Incentives: Meeting the Needs of Individuals with Complex Conditions in Primary Care Conditions in Primary Care

Research Report

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Prepared by

Fiona Ross

Sara Christian

Julie Clayton

- Faculty of Health & Social Care Sciences, Kingston University & St George's, University of London

Richard Byng

Linnie Price

- Peninsula College of Medicine and Dentistry, University of Plymouth

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Pam Smith

Helen Allen

- Centre for Research in Nursing and Midwifery Education, Faculty of Health and Medical Sciences, University of Surrey

Sally Redfern

Sally Brearley

- National Nursing Research Unit, King's College, London

Jill Manthorpe

- Social Care Workforce Research Unit, King's College, London

Maureen Mackintosh

- Faculty of Social Sciences, Open University

Address for correspondence

Professor Fiona Ross

Faculty of Health & Social Care Sciences

Kingston University & St George's, University of London

Cranmer Terrace

LONDON SW17 0RE

E-mail: fross@hscs.sgul.ac.uk

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Executive summary

Background

Rapidly changing systems of organisational governance in health and social care create uncertainty and ambiguity for professionals, teams and the delivery of care. Recent literature and empirical studies, that have explored the links between governance, incentives and outcomes, highlight the lack of evidence on the relationship between different blends of governance with professional behaviour and performance.

Aims and objectives

The purpose of this study was to explore the professional experience of evolving organisational and governance structures in the context of primary health and social care and in relation to the management of long term conditions. The objectives were to describe the governance and incentive arrangements in the three health and social care sites at the level of the organisation, team and the individual; to explore the views and emotional experiences and reactions of staff to the organisational priorities and funding arrangements for care; and to develop hypotheses and empirically grounded models for organisational development in the management of long term conditions.

Methods

The study was conducted by a multidisciplinary research team with service user representation, working with the local health and social care sectors in three case study sites in London, Surrey and the South West. The work was undertaken in three phases over two years comprising:

Phase 1: Service Users Reference Groups (SURG) in each case study helped us to develop vignettes illustrating their experience of living with long term conditions to provide an authentic context for the interviews. We looked at long term conditions through two tracer conditions and therefore invited service users with physical conditions and non psychotic mental health illness to take part (32 in total). Contextual analysis of the organisational context of the three case study sites including: documentary analysis and interviews with senior staff (32 in total) took place in phase 1. The approach to working with service users was informed by service user representatives with a national perspective, which we called the national SURG. This group met twice during the project.

Phase 2: comprised in depth interviews with a total of 56 health and social care professionals engaged in the development of local policies and the delivery of care for people with complex long-term illness–specifically focusing on our two tracer conditions. The interviews were informed by extracts of the vignettes developed by the service user reference group to

explore views on team performance, incentives and the experience of managing ambiguity and complexity in care delivery in the context of organisational change and new partnerships.

Phase 3: analysis within cases (localities) and across cases (sites) was undertaken to build the hypotheses and develop theoretical ideas about the mechanisms and incentives that have an influence on the outcomes within the specific organisational contexts. Feedback of the case study findings in each site to SURG and key PCT stakeholders took place to facilitate the refinement of our working hypotheses for supporting organisational development in the sites and elsewhere. These hypotheses are set out in a form that can be tested in practice.

Findings

Multiple perspectives and an absence of a coherent narrative on governance and incentives emerged from the manager and professional interviews. The gap between the policy rhetoric with the professional experience of trying their best to meet the expectations of service users keeping going and getting the job done within a culture of constant change are key issues emerging from the three themes: risk, diversity, ambiguity and conflict. The messages from this study are:

- There is much policy talk around governance and incentives and as many different views. The findings suggest on the whole a misalignment between the policy language and narrative of governance and incentives with the views of what matters to professionals who were struggling to make sense of, interpret and apply the directives in the delivery of care.

- Professionals held multifaceted views of incentives: it was not a case of 'one size fits all'. Although for some groups financial incentives were recognised as rewards for specific behaviours there was also a clear understanding of the other social, professional and moral levers that exist to improve organisational performance. It is therefore impossible to come up with general incentives for all professionals: rather incentives need to be tailored for different groups and to the contexts in which they work.

- There was a strong ethos of wanting "to do a good job" and many examples of demonstrable commitment and loyalty to the service and to patient care. Professionals were supportive overall with the general direction of policy, for example, changing the system of care to provide more choice, care closer to home, and integrated pathways between services and there were positive stories about the impact of policy change on service improvement for people with long term complex conditions. However, the other side of this was that financial drivers were often seen as perverse and targets inflexible and inappropriate for complex long term conditions and that it did not seem to be anyone's business to "make sense" of these policies to practitioners.

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- There was a dissonance in the way that policies were seen to be interpreted and applied locally; the managers considered that part of their role was to act as a buffer for practitioners, which is a contrast to the ambiguity experienced by professionals; who often reported feeling overwhelmed by a welter of audits and reviews as well as managing the time lag between being told what to do and having the resources to do something about it.

- We found that increased pressure in the work environment creates additional stress and dissatisfaction, which suggests that the conceptual thinking around incentives should take more account of the emotional domain. The discourse on incentives was expressed differently across professional groups. Although resources or the lack of them can be seen as a catch all; it is the way that resources are distributed, which was seen as contradictory and being out of line with the policy imperatives. Time and expertise featured as a major issue, which is of course related to resources. Professionals highlighted the quality of the interaction necessary to build trusting relationships, which was highly valued by service users.

- Balancing individual rights with risk avoidance in the context of new models of partnership and team working was a major preoccupation of professional staff. However, there was a variety of professional perspectives expressed on risk and a tendency for all professionals to consider themselves less risk averse than others.

- The diversity theme emphasised the advantages for practitioners as well of service users of integrated team-working, which suggests that governance and incentives are inextricably linked by the way in which people connect with, contribute to and benefit from organisations.

Implications

The findings suggest that governance encompasses more than formal, legal and reporting structures and that multiple levels of power operate in complex organisational and professional relationships. Therefore policy development to enhance incentive systems needs to take account of the heterogeneity of professional identities and interests in primary care and the important contribution that support, leadership and encouragement can make to professionals working lives.

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The Report

1 Introduction and background

1.1 Introduction

Rapidly changing systems of organisational governance in health and social care create uncertainty and ambiguity for professionals, teams and the delivery of care. Recent literature and empirical studies, that have explored the links between governance, incentives and outcomes, highlight the lack of evidence on the relationship between different modes and blends of governance and professional behaviour and performance. The purpose of this study is to explore the professional experience and associated emotions of evolving organisational and governance structures in the context of primary health and social care and in relation to the management of long-term conditions.

1.2 Policy overview

Rapid developments in government policy have dramatically changed the primary care landscape over the last ten years. These changes form the backcloth to this study. Here we highlight some of the main policy drivers that have influenced the organisational context of the management of long-term conditions. The case for shifting the balance of care from hospital to primary and community care has been argued by different political voices over the last forty years, gathering force recently through the modernisation of funding and commissioning of primary care (DH 2000), the New General Medical Services (GMS) Contract, Quality and Outcomes Framework (DH 2003), payment by results (DH 2002) and practice based commissioning (DH 2005). Introducing new financial incentives to encourage provision of personalised and tailored care nearer to where people live is predicted to set up tensions and inevitable instability within the system as the income and competitiveness of acute hospitals is put under pressure (DH 2006).

The Darzi recommendations for London take these ideas forward by focusing on clinically led care pathways with care delivery managed by experts in the community to achieve improved health outcomes (DH 2008). Reactions from part of the medical profession over polyclinics and the role of GPs in this new framework has perhaps masked the response of others to the opportunities presented for the development of new sorts of teams and enhanced roles to achieve flexible and patient-centred care. It is the tensions that arise from these policy and organisational changes, new systems of governance and incentives and the way that different professionals make sense of them in their daily working lives caring for people with long-term conditions that is the focus of this study.

1.3 The management of long-term conditions in primary care

This study focuses on the professional response to these different modes of governance and incentives through the window of the management of long-term conditions. Key components of care for long term conditions include self-care, provision of appropriate information, specialist input and review. Interventions to improve management and outcomes need to be embedded in effective collaborative relationships between health and social care and through teamwork. Growing evidence from North America suggests that team-based interventions in long-term conditions are associated with better patient outcomes and the involvement of nurses in assessment, treatment, self-management, support and follow-up has been linked to improved professional adherence to guidelines, patient satisfaction, clinical health status and use of health services (Wagner 2000). However, more work needs to be done to identify the way in which incentives are linked to different components of teamwork, organisational collaboration and the individual.

We focused on the management of people with complex physical and mental health conditions for the following reasons:

- the policy priority to reduce hospital admissions, particularly for individuals with highly complex long-term conditions (DH 2004);

- the requirements for improved self-care, better information systems, improved working relationships between specialists and generalists (Wagner 2000) and systems for proactively organising care (Dixon et al 2004) exemplifies the complex interaction between the management of long-term conditions and the local implementation of governance and incentive arrangements;

- while the NHS, both centrally and locally, has developed many new policies and funding arrangements such as the new GP contract, disease specific services and policy guidance for mental health, it is uncertain how they will interact and how they will successfully span organisational boundaries between primary and acute care or variable local contexts;

- the management of long-term conditions is the focus of role innovation, for example, community matrons leading proactive case management of people with unstable and/or complex conditions (DH 2004).

This project focuses on how new policies for incentives and governance have an impact on improvements to care for these patients and explores the relative effectiveness of these arrangements in practice and the interplay between personal, professional and organisational dimensions.

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1.3.1 Individuals with complex physical conditions

Individuals with one serious long-term condition are likely to have co-morbidity, receive care from many practitioners in the community and be prescribed a range of medications and other treatments (RCGP 2003). General policies affecting governance and incentives are likely to have direct effects and also interact with related policies such as for community matrons and the new GP contract aimed specifically at people with long-term health conditions. England does not have systematic implementation guidelines for people with long-term conditions apart from the NSF for ongoing neurological problems (DH 2005). While shared care has been advocated, specialist primary care collaboration has not been specified. Of Wagner's key components of the management of long-term conditions, only 'review of care', through the Quality and Outcomes Framework of the GP contract has been incentivised. This has been addressed solely through general practice contracts, with no specific guidance to link in with wider community teams such as district nurses and therapy teams. The other community based policy for long-term conditions, community matrons, has been targeted at 'revolving door' patients and does not clearly set out the relationships with general practice, (Gravelle et al, 2007), which has caused tensions as both have a remit to coordinate care.

Those with long-term conditions including stroke, diabetes, heart failure and chronic lung disease are at risk of neglect, social isolation, and hospital admission. Co-morbidity is common (DH 2005). Chronic obstructive pulmonary disease (COPD) is an example of a chronic disease which involves both primary and secondary healthcare and where good quality support and care in the community can significantly improve the quality of life for patients while reducing pressures on inpatient care (Kok and Hewitt 2003). The NICE (2004) guidelines for best practice suggest that local health communities should review their existing practice for the management of COPD against this guideline as they develop their Local Delivery Plans. These innovative approaches to care and care-co-ordination involve new demands and often some ambiguity for staff in health care and social services as they navigate change, which is one of the concerns of this study.

1.3.2 Individuals with long-term mental illness

Care for those with long-term mental illness (LTMI) is an area which exemplifies the complex interaction between the management of long-term conditions, the development of local services in response to national policies and the implementation of governance and incentive arrangements. Those patients with relatively straightforward common mental health problems are generally cared for by primary care teams. Adults of working age with psychosis and bipolar disorders are normally cared for by specialist teams in the community under the Care Programme Approach. Those with significant disability but with a non-psychotic diagnosis, sometimes referred to as the

'neglected majority', have less clear care pathways (Sainsbury Centre for Mental Health 2005). Most are cared for completely by primary care. The most severely ill are normally seen regularly by specialist teams, and may not have engaged with primary care. A less severely disabled group are often seen only briefly by specialist teams and intermittently by primary health care teams, as well as having occasional involvement with the voluntary sector and other providers. The new contract for GPs only provides incentives for improving the care of those with psychosis and new episodes of depression and for dementia. The Increasing Access to Psychological Therapies (IAPT) programme promises money and high quality therapy for those with recurrent depression, chronic anxiety and post traumatic stress disorder, but staff training starts in late 2008, with increased access in only some PCTs by 2010. There is no up to date 'Policy Implementation Guidance' for Community Mental Health Teams, and 'currencies' have been based on cost per contract rather than any payment for specific interventions or outcomes achieved.

This study explored the extent to which self care is encouraged, communication and collaboration between professionals and teams and the extent to which physical health problems are successfully addressed. Previous research by this group has shown that different systems for review and inter-professional working are required to improve reactive and proactive care for this group of patients (Byng 2004). It is important to examine how new policies for incentives and governance have an impact on improvements to care for these patients.

1.3.3 Social care and integrated working

Commonly, management approaches to long-term health problems require engagement with social care services, those supplied directly or indirectly through public funds, those paid for by individuals or their families, or those provided by family and other members of social networks (carers). Policies for health and social care increasingly emphasise that professionals should work together to promote choice, independence and well being; with new emphasis on this being promoted though the 'policy of personalisation' (HM Government 2008). For social care services, most of which are provided by carers and the private sector, rather than directly by local authorities, there are imperatives to work together at several levels. These include commissioning of services, and partnership working which Glasby and Dickinson note is no longer an option but 'a core part of all public services and all public service professions' (2008, p17). However, it is increasingly recognised that although integrated working and partnership are widely lauded, there is little evidence from social care that they really achieve better outcomes for individual service users and that a more critical approach to the subject may be appropriate (Glasby and Dickinson 2008 p90).

This study focuses on three case study sites with changes taking place or being considered in social care in all three. Some of these were being driven by central government, such as the policy attention to outcomes and to what personalised care might mean in practice. Others have related to growing financial pressure on local government around the rising costs of social care, the steady upswing in demand (largely due to an ageing population), and resulting increases in the threshold for publicly funded social services (increasing the eligibility criteria, see Commission for Social Care Inspection 2008). Central government has been keen to respond to these difficulties and espouses new interest in prevention, with a set of pilot programmes seeking to discover how prevention could help manage demand and improve quality of life (Partnerships for Older People Projects 2006). As with many initiatives, these programmes necessarily take a long term view and their impact is not yet known. These emphasise multi-agency working and collaborations. Less evidently cooperative have been other incentives operating at the interface of local government and the NHS, such as reimbursement or the fining of local government (since 2003), if a person is deemed to be staying in hospital longer than is necessary clinically and where the delay in discharge is attributable to local government.

1.4 Conceptualising governance and incentives

1.4.1 Governance

Over recent years the NHS has faced a veritable barrage of changes in governance arrangements as policies support decentralisation (Peckham et al 2007), public involvement (DH 2006), constant adjustment in regulatory machinery and the introduction of targets with 'variable and often implicit' (Davies et al 1997) assumptions about incentives and how they work. Social care has been similarly enjoined to 'modernise' and there have been important shifts in the relations between the two previously separate sectors reflected in new partnerships, care trusts and arrangements for monitoring and scrutinising quality (DH 2005). These fundamental structural changes (for example shared budgets) require concomitant shifts in the organisation of teams, design of working practices and new thinking about the mix of measures needed to embed change. Although there may be general acceptance of the reasons for these changes, recent surveys suggest that staff feel under pressure (CHI 2003; 2004). The 2007 NHS staff survey reported that only 26% of staff thought that their Trust valued their work with only 22% thinking that communication with senior management was effective (Health Care Commissions, 2008). However, 71% said that their individual manager encouraged team working. This raises important questions about needing to understand the complexity and multiple characters of governance changes and the intended and unintended incentives these produce as they have an impact in a locality or on a particular service.

Governance is often viewed as multi-layered, complex and elusive within the context of organisational change in health and social care. For this study we have adopted Davies et al's (2004) definition of governance that it is the way "in which organisations and the people working in them relate to each other". This allows us to ask questions about structures, processes and workforce relationships that encompasses multiple actors, sites and mechanisms. Here we are interested in how managers and professionals conceive governance, what aspects they see as legitimate and where there are differences between them.

1.4.2 Incentives

The idea of incentives is deeply embedded in the structures of NHS reform introduced after 1997 (DH 2000). This follows from the urgent and continuing concern from the government and specifically the Department of Health over just what the levers for change are and how demonstrable performance improvement can be achieved in order to tackle uni-professional 'silos' and inappropriate work practices that have arguably resulted in variable standards.

However, the Davies et al (2005) wide-ranging recent review of literature across a number of disciplines argues that although there is a stream of work represented in the fields of sociology, political science, law and management studies that is converging on a less individualistic approach there is no single way forward for the study of incentives. They argue it can be linked to new explorations of professionalism and professional identity within the context of changing organisational boundaries and expectations, while taking account of the shift from a public to a commercial ethos embedded in a range of financial incentives and exemplified by contracting arrangements such as the quality and outcomes framework, payment by results and more recently practice based commissioning.

Some economists recognise that incentives for professional change are not always dominated by financial objectives and that although financial incentives matter - and can be strong - they may also become perverse, undermining and conflicting with social and professional motivations (Mackintosh 1999). The importance of harnessing the participation of the workforce, building trust and teamwork in change and quality improvement (Berwick 2003) and recognising that teams can function as communities of learning and innovation (Ledema et al 2005) suggests that incentives may be multifaceted and complex and may also evolve over time. For the purpose of this study we have adopted the Davies et al (2005) definition of an incentive as a reward for a specific behaviour, which acts as a lever on the individual and the organisation. These may include not only economic incentives (payments or opportunities to reduce costs) but also moral, professional and social inducements to behave in particular ways (Davies et al 2006, p2). The qualitative design of this research has allowed us to explore some of this complexity from the perspective of the practitioners

and in particular the interplay between governance, complex incentives and the related emotional dimensions (Mackintosh 1992; Smith et al 2002; Smith and Bryan 2005) and how they influence patient care (DH 2000; DH 2004).

1.5 Partnership and teamwork

Partnership is a key component of new governance arrangements, which may generate conflict, ambiguity or trust (Mackintosh 1999). In primary and social care, partnership and teamwork have been constrained by the existence of different contractual and structural arrangements, for example general practitioners have traditionally managed small businesses while district nurses, practice nurses and social workers, in the past, have had different employers (Goodman et al 2003). Both Smith (1992) and James (1993) acknowledge the difficulties and demands of such tensions while Pescosolido (2002) describes the necessity for the emergence of leaders to manage group emotions particularly in times of ambiguity, for example, during the process of strategic change in nursing organisations (Furne et al, 2001) and to reconcile the expectations of staff trying to meet government directives (Smith and Bryan, 2005).

Linked to partnership there is a growing literature that questions the evidence for effective teamwork in different settings. West and colleagues (2004) assert that our knowledge is deeper than just having faith that teams work, but that effectiveness is predicated on factors such as organisational commitment, leadership, clarity over objectives and co-ordinations of different and distinctive professional contribution (Poulton and West 1999, West 2004). A recent systematic review shows there is some evidence that interprofessional educational interventions have an impact on outcomes, for example professional collaborative practice, patient satisfaction and fewer errors (Reeves et al 2007). In a limited observational study Bower et al (2003) suggest that there are important relationships emerging between team structure, process and outcome that may have an impact on quality outcomes; for example where team climate was rated highly there was a positive association with chronic disease management, increased patient satisfaction and self reported innovation. However, more needs to be done to understand these relationships and in particular, how, why and when teams are effective in delivering integrated care (Zwarenstein 2000, West et al 2004). This is particularly relevant in the care of people with long-term conditions. In our study we explored the issue of teamwork in relation to how practitioners perceived the effectiveness of their care. However, we were limited in how far we could look at this within the context of dispersed team relationships between professionals working in the field of long-term conditions, because the current measurement tools of effectiveness only apply to well-defined teams such as those professionals working alongside and together with a general practitioner in primary care.

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1.6 Emotional labour

The concept of 'emotional labour' defined as 'the induction or suppression of emotions to make others feel safe and cared for' (Hochschild 1983) offers a device to analyse care and the management approaches required to sustain it. It has been shown that the recognition and use of emotions are integral to the development of emotional intelligence within individuals and organisations to solve problems, facilitate learning and manage change (Goleman 1995; Huy 1999). Raffaeli and Worline (2001) identify "emotions as the central tenet in the future of organisations" (p12). Taylor (2006) argues that the emotional toil of caring for people in sickness and as they die is rarely referred to in policy even though stress is inevitable when working with sick patients and their relatives. Clearly partnership is a key component of new governance arrangements and central to the performance of teams who may be navigating complex emotions to deal with issues of ambiguity, trust and conflict (Lorentz 1989; Mackintosh 1992; Smith and Bryan 2005).

Local response to national agendas results in rapid change which may become the rule rather than the exception in complex community initiatives (Connell and Kubisch 1998). Change has been shown to generate a range of emotions and profoundly affects whole organisations particularly during transition (Slater 1998, Welchand Bryne 2002). The emotional effects of change are often overlooked even though judicious attention to emotions has been shown to facilitate organisational learning as part of the change process (Huy 1999). Leaders need to be aware of these processes and to be able to exercise the authority to create the systems that can then be employed to recognise and manage the emotions generated as a consequence of change at all levels and cultural contexts of an organisation.

1.7 Involving service users in research

User involvement in research has become a policy imperative. Indeed active participation in commissioning, undertaking research and disseminating findings has been encouraged (DH 2001), even though it is recognised that it is an underdeveloped area where the evidence of effectiveness is contested (DH 2005). The issue of service user involvement in research raises important debates, exposing real tensions between cultures of knowledge and difficulties of language and definition. There is conceptual confusion over the use of overlapping terms such as "consumer", "patient and public involvement" and "service user". Beresford (2007) notes this lack of consistency over terminology and goes on to say that while "the government has begun to talk in terms of "patient and public involvement", the term most often employed is service user involvement. This tends to mean people who use, have used or are eligible to use health and social care services, particularly on a long-term basis" (Beresford 2007). The term service user was used in this study to include people with a long-term

condition and their carers. The term 'carer' refers to individuals who support them outside paid roles such as family members or friends.

The meaning of involvement is also discussed as problematic in the literature. Hierarchies of involvement have been described such as Arnstein's (1969) celebrated ladder of citizen participation, which has been reinterpreted by Boote et al (2002). This helpfully sets out a continuum from researcher-led, for example, invitations to service users to be involved in research as a member of an advisory or reference group, participating in data collection (Elliott et al 2002), or disseminating research findings (Flaskerud and Anderson 1999), to models of consumer-led and controlled research. However, there are difficulties with classifications of involvement in terms of functional roles which, as Beresford (2005) argues, ignores the organic and dynamic nature of changing relationships between professionals and service users that can be a powerful contributor to change.

1.8 Summary

In summary, this study builds on an interdisciplinary approach (informed by researchers with backgrounds in medicine, nursing, economics and sociology) and sets out to map professional experience and the changes as they are seen on the ground, taking into account that professional identity is not a single entity amongst primary health and social care professionals. The study responds to the observation that there is a "rather small amount of work at present concerned with frontline professionals and the mindsets that they bring when faced with policy levers with in-built assumptions about incentives which suggests that there is scope here for more study (Davies et al 2004: p80). The study involves three PCTs in three different geographical locations framed by complex governance arrangements where the external context, funding histories and working relationships are different. The selection of these "cases" allows us to compare the perceived incentive structures and responses within each context. The study design emphasises both theory development and empirical work, partnership working with the research sites; service user involvement; and the generation of practical models for local organisational development and national dissemination.

1.9 Structure of the report

This report is divided into six further chapters:

Chapter 2 outlines the methods used in the study

Chapters 3 – 5 report the findings of the study as follows:

Chapter 3 reports on the outcomes of the service user groups and the development of the vignettes

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Chapter 4 provides the contextual analysis of the three sites and the findings from the senior manager interviews

Chapter 5 reports on the findings from the interviews with health and social care professionals

Chapter 6 draws the findings together into conclusions and presents working hypotheses and practical models for local implementation

Chapter 7 presents reflections on the methods and implications for policy, practice, education and research

2 Methodology

2.1 Overview

This was a three-centre study exploring the professional experience of governance and incentive arrangements in relation to the management of patients with long term and complex conditions in health and social care. By professional experience we refer to personal and emotional responses as well as perceptions of performance and effectiveness of practitioners (clinically based) and managers (senior and locality based).

The objectives of the study below encompass the organisational context (1-3); the impact of governance and incentives on care within and across the case studies (4-6) and the development of hypotheses about how findings in the individual case studies are transferable to other sites (7-10).

Organisational context

1.   To establish and describe the governance and incentives arrangements in the three community sites at the level of the organisation, team and individual

2.   To examine the organisational objectives and targets for patient-centred chronic disease management

3.   To describe the funding arrangements in place to achieve the targets

The impact on care

4.   To identify the views of staff at each level of the organisation (management, care delivery and support) to team performance

5.   To explore the emotional experiences and reactions of staff to the organisational priorities and funding arrangements for care

6.   To investigate from the perspective of staff how the governance and incentive arrangements make an impact on performance and effectiveness

Hypotheses

7.   To develop hypotheses about how incentives and governance and the associated emotional work relate to improvements and problems of care provision

8.   To investigate how the impact of governance and incentive arrangements are dependent on context

9.   To examine how different governance and incentive arrangements interact and interconnect

10.   To develop practical models for local implementation

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2.1.1 Rationale and conceptual framework

There are some methodological issues inherent in exploring the impact of a range of policy issues, operating in different contexts, on outcomes for patients with long term conditions. A quantitative study would not have been able to measure the range of factors and causal mechanisms or the outcomes with sufficient validity and precision to develop statistical models. Instead this study has drawn on Realistic Evaluation (Pawson and Tilley 1997), which provides a framework for examining the interaction between varied contexts and mechanisms at play at an organisational and professional level. We maintained a focus on practitioners' experience of ambiguity and conflict (Mackintosh 1992; Goleman 1995, Huy 1999; Smith and Bryan 2005), which are seen as key intermediate processes between the operationalisation of governance and incentive policies at team level and the outcomes in terms of patient care.

Preliminary work was undertaken to develop a conceptual framework (Figure 1) that would support the design and analysis throughout the study. This framework was informed by the background literature on the incentive effects of different forms of governance (Davies et al 2004), organisational factors and performance (Sheaff et al 2004), the impact of decentralisation policies (Peckham et al 2005), frameworks for understanding teamwork (Mitchie and West 2004) and collaboration (Hudson et al 1999).

The conceptual framework, represented by a layered egg, illustrates the multiple and intertwining layers of governance and incentives which influence professional and service users experiences at national, organisational and professional levels. At the centre of the egg is the service user's experience of care woven in a figure of eight with the professionals' experience of governance and incentives. We set out to explore with professionals what motivated them to provide care as defined by service users. Therefore we were interested in the key influences operating at the interface of professionals' and service users' experiences. The outermost layer of the framework represents the national policy directives and targets which we explored in terms of how these impact on local initiatives for governance including professional roles, organisation of services and incentives for those working within the system.

Figure 1. Preliminary Conceptual Framework
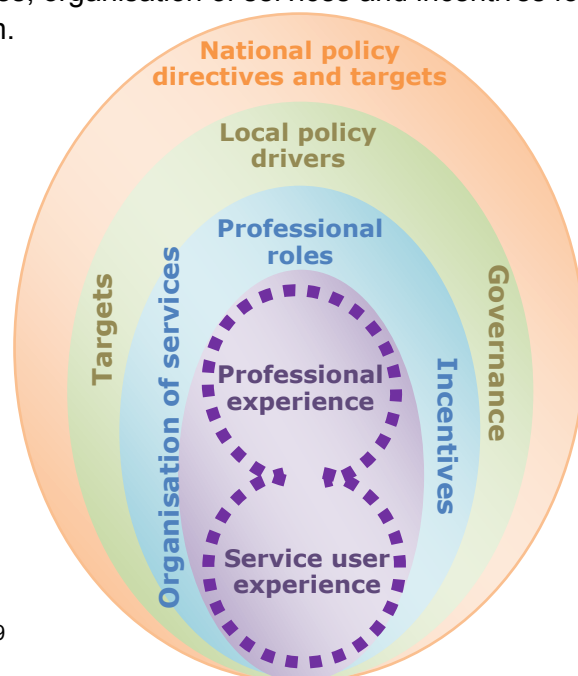
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2.1.2 Project phases

There were three phases to the study shown in Figure 2.

Figure 2.   Flowchart of the three phases of the study

Three case studies sites: A, B and C

PHASE 1

Service User Reference Groups (SURG)

Aim: to develop and refine vignettes/stories based on personal experiences

One national SURG group: 6 members

Three local SURG groups: 10-12 members each

Contextual analysis

Aim: to describe governance arrangements and funding mechanisms

Methods:
- interviews with key senior staff
- documentary analysis

Selection of two localities and associated health and social care teams responsible for individuals with:

1. **Long-term mental health problems**

2. **Complex physical conditions**

PHASE 2

Aim: to explore how staff make sense of and perceive the impact of policies, governance and funding arrangements
Method: Interviews with 20 health and social care professionals in each site

PHASE 3

Aim: to analyse the findings within and across the case-study sites
Method:
- cross-case analysis
- discussion with each SURG group and expert panel
- preliminary feedback to practitioners and managers of 'frameworks for good practice'

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Each of these phases is discussed in detail in this chapter. Because the study design is complex an overview is provided in the next two paragraphs, which illustrates the figure above. In the first phase a national service user reference group (SURG) was established with membership drawn from national bodies to work with the research team to inform the development of methods, analysis and local and national policy development and dissemination. In addition local SURG groups were set up in each site to help the team develop stories (vignettes) focusing on the experience of living with a long term condition. In conjunction with these groups in-depth contextual analyses provided information about the localities as well as how policies were implemented and what outcomes for care were intended.

Interviews with practitioners were undertaken in phase 2. We used these interviews to look through a window onto the effects on care of incentives and governance. By ascertaining the views of a range of informed participants, case studies were developed which enabled the complexity of the processes in play to be understood. The cross-case analysis then enabled us in phase 3 to generate hypotheses based on middle range theories (Merton 1957) about how the different mechanisms of governance and incentives appeared to make an impact on practice and performance and how these mechanisms appeared to work in different circumstances.

2.1.3 Settings, participants and partnerships

The research teams set up partnerships for the study with three local Primary Care Trusts: two inner city (Sites A and C) and one semi-urban (Site B) and their local authority partners. These formed the case study sites providing diversity in organisational structure, population characteristics, local policy implementation, patient and public involvement and relationships with local authority partners. The engagement was based on a willingness to participate in the research as an equal partner to promote organisational learning; evidence of current activity in developing new case management systems for reducing hospital admissions; and a variety of partnership arrangements and leadership styles which reflected observations at the start of the study that there were connections between the way staff are managed and outcomes (CHI 2003, 2004; Cornwell 2004).

Our key informants included staff at different levels within a single locality and from a range of occupational and professional groups and a selection of staff in new roles e.g. community matrons, nurse consultants, and mental health workers*.* The selection criteria for each of the phases are described in more detail later on in this chapter. The study was informed by and grounded in the experience of a service user reference group (SURG) and had input from key stakeholders from each of the case study sites including senior managers, key practitioners such as general practitioners, service users, and patient and voluntary groups and expert advisers.

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### 2.1.4 Research Governance

The project obtained ethical approval from Wandsworth Local Research Ethics Committee in June 2006. Research Governance approval was obtained from the relevant bodies in all three sites before the research got underway.

2.2 Phase 1: Investigating the context of care

The objectives for phase 1 were as follows:

1. To establish and describe the governance and incentives arrangements in the three community sites at the level of the organisation, team and individual

2. To examine the organisational objectives and targets for patient-centred chronic disease management

3. To describe the funding arrangements in place to achieve the targets

Phase 1 was divided into three stages of investigation:

- What is the context of care from the perspective of service users?

- What is the nature of the context in each of the three sites in relation to governance and incentives in the context of long-term complex conditions?

- What are the views and perceptions of senior managers?

- The methods for these are discussed in detail below.

2.2.1 Service users views of the context of care

In the first phase of the study, Service User Reference Groups (SURG) were established which worked in a consultative and advisory way with the research team to inform the development of methods, analysis and local and national policy development and dissemination. This enabled the research to be grounded in the reality of the service user experience. There were three local groups (one in each case study site) and one national group with members drawn from national user representative groups.

The National SURG group

The purpose of the national group was to gather individuals with a wider perspective on issues pertinent to users and to have a role in disseminating the findings to consumer groups.

Four members were recruited from an existing SURG group that was established to guide and advise on a previously completed study (Smith et al 2007) that investigated the evidence base for service user involvement in nursing and midwifery research (led by Ross). These service users were members of the national SURG group based on their membership of service user organisations and participation in network or partnership groups relevant to service development and organisation in nursing, midwifery and
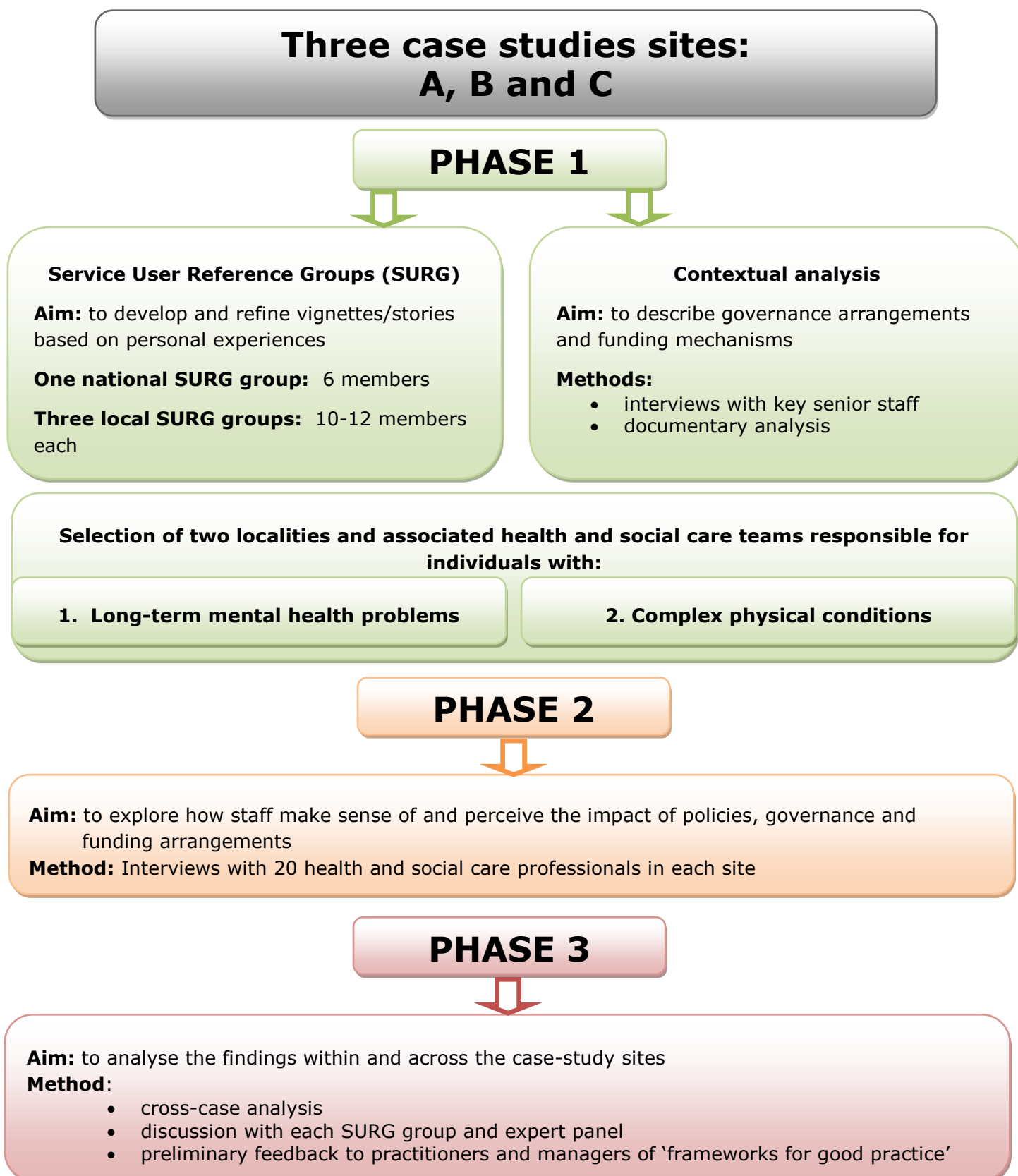
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health visiting. Thus these individuals were familiar with and experienced at representing the wider, national perspective at this type of forum. Two further members were also recruited though contacts of the research team.

Members were approached and invited to participate directly. They attended two meetings and a fee of £100 was paid for each day plus expenses and refreshments.

At the first meeting the group advised on how the local SURG groups should be recruited and how best they could be facilitated. They challenged the research team to rethink the sequence of the study. Originally our intention was to have the SURG groups after the contextual analysis was complete. They pointed out that this would be a missed opportunity and that using service user generated stories to provide a focus and ground the interviews with managers was just as important as with practitioners. At the second meeting the group advised on how the locally based patient stories or vignettes should be refined into a standardised approach for use in the interviews with professionals.

The Local SURG groups

The aim of the local SURG groups was to develop vignettes from individuals' experiences of living with a long term condition.

Three locally based SURG groups were recruited within each of the PCTS. Different methods of recruitment took place in the three sites including: introduction through the Patient and Public Involvement (PPI) leads; recruitment from local GP practices; recruitment from local voluntary organisations; and snowballing of contacts via recruited individuals. Letters of invite were circulated to contacts and interested individuals then returned a slip to the project team who then contacted them directly.

Members were recruited to the local groups on the basis of:

- an agreed selection criteria (below)
- their ability to sit through a three hour meeting: based on their own judgement
- Local SURG participant selection criteria

Exclusion and inclusion criteria for the local SURG meetings were discussed and finalised by the PEGI team. Criteria for participants with long-term physical conditions were that they should be homebound (able to leave home only with support), not bed-bound, and to have one or more of the following conditions plus another condition which could include the following or be different, such as multiple sclerosis or arthritis; COPD, diabetes (with complications including renal failure, impaired vision, peripheral vascular disease, peripheral neuropathy, ischemic heart disease), heart failure and angina. Participants should have minimal cognitive impairment, be able to give a clear account of the effects of their illness on their circumstances, experiences and functioning (ie no language impairment or confusion and

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proficient in English), have no psychotic illness (though they may have long-term mental conditions), and have the physical capacity to attend.

Criteria for participants with mental health problems were that they should have one of the long term non-psychotic disorders with a substantial disability and duration of two years or more (including frequent recurrences or stable problems requiring ongoing medication or support), for example recurrent or continuing major depression, severe anxiety, panic and phobic disorders, obsessive-compulsive disorder, post-traumatic stress disorder. Participants with long-term mental health problems may well have a history of self-harm and/or suicide attempts and are likely to have more than one of the above problems and may also have long-term physical conditions. In order to meet the criteria there should be a level of current or fluctuating disability defined as being unable to fulfil any one of the following; hold down a job, maintain self-care and personal hygiene, perform necessary domestic chores, participate in recreational activities, make and maintain trusting relationships with others. They should not have a psychotic condition (schizophrenia, paranoid psychosis, manic-depressive psychosis, psychotic depression), have a learning disability, be currently severely distressed, be likely to exhibit bizarre, embarrassing or violent behaviour, or have significant cognitive impairment. Participants should be able to give a clear account of the effects of their illness on their circumstances, experiences and functioning (ie no language impairment or confusion and proficient in English), and have the physical capacity to attend.

The local SURG members were offered a £100 fee (following INVOLVE guidelines) for their involvement in each meeting and reimbursed for expenses incurred. Meetings were held at a variety of venues that provided parking, good transport links and disabled access, e.g a local library, university space and a health centre. Refreshments were provided at the meetings.

Format of the local SURG meetings

Each of the SURG meetings was facilitated by Sally Brearley who is a member of the research team and Honorary Fellow in Patient and Public Involvement in the Faculty of Health and Social Care Sciences and Vice Chair of a PCT Patient Forum. In addition there was co-facilitation by another member of the research team. Ground rules were established at the beginning of the meetings for participants (service users, members of the research team and at the feedback meetings representatives of the PCT).

Small group work was used to discuss common experiences and challenges of people with long-term, complex needs in relation to receiving services, quality of care and participation in decision making. Participants were asked, prior to the meeting, to think about significant experiences and the ways in which professionals responded and how it felt for them. Three questions were used to generate discussion about both good and not so good experiences:

- Can you think of any occasions when you felt your care was really good?
- Can you think of any occasions when you felt your care was not so good?
- What do you think could be done to improve things?

Participants were asked to note their experiences on stick-it notes and to discuss them. Themes were then identified from the discussions that illustrated shared decision making with patients and carers about care, participation of service users in local policy and service development. These themes were then validated with the participants at each of the meetings.

These themes were used by the research team to develop two standardised vignettes; one representing the experiences for individuals with complex physical conditions and one for those with complex mental health conditions. Vignettes have been defined by Finch (1987:105) as "short stories about hypothetical characters in specified circumstances, to whose situation the interviewee is invited to respond". As a research tool the vignette enables wide-ranging exploration of attitudes, perceptions and beliefs among a diverse group of professionals (Hughes and Huby 2002). We drew on previous experience of working with service users (a consumer panel) to develop a vignette from data generated in interviews with older people and carers in a study on falls, which was used to focus a series of questions in an interview with professionals from health and social care (Ross et al 2005, Richards et al 2007). In PEGI, rather than using the vignette as a tool in the interview, we used it to draw attention of our respondents (managers and practitioners) to the central questions and concerns of the research. By sending the vignettes in advance of the interview with the information sheet and referring to it in the interview we aimed to:

- encourage respondents to "enter imaginatively into the issues" (Richards et al 2007:344) facing people with long term conditions;
- stimulate thinking in the professional interviews about similar cases that could be drawn upon and discussed in relation to the influences, both positive and negative, of the professionals' experience of governance and incentives.

Feedback to members

A newsletter was produced summarising the outcome of the first meeting and circulated to all SURG group members (Appendix 1). Follow-up meetings took place with each of the local groups to feed back the preliminary findings from each of the case studies. At these follow-up meetings the members gave their views on the findings and advised on how best they might be disseminated locally.

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2.2.2 Contextual analyses of the three sites

The purpose of the contextual analysis was to describe governance arrangements that were explicitly and implicitly used to influence professional activity, their funding mechanisms and processes in relation to care of long-term complex conditions.

Incentives are referred to in this phase as levers for change in the understanding that motivations for professionals are mixed and not necessarily dominated by financial objectives and that although financial incentives matter they may also become perverse, undermining and conflicting with professional motivations.

The complex, multi-layered and elusive concept of governance includes the important issues of contractual and structural arrangements and collaborative partnerships in health and social care.

In each site there was an investigation into:

- the local interpretation/implementation of policies and practices related to governance

- the partnerships in place (to include formal and informal partnerships, staff deployment across health and social care, perceived barriers to partnership working, joint arrangements for monitoring and scrutinising quality

- the range of incentives in operation and planned

- the organisational framework for delivering patient-centred care to individuals with long term complex conditions)

- the funding arrangements in place to achieve the targets (to include contracting systems and funding streams, financial decision making in relation to priorities and targets)

The contextual analyses were sub-divided to:

- reflect the PCT, team and practitioner levels

- attempt to lay out the assumptions, logic and ambitions that key-decision makers have drawn upon to 'theorise' about how the operationalisation of various policies are intended (if at all) to improve care

Each of the site descriptions was presented to senior and middle level managers within each site to ensure it generally reflected their understanding. Cross-site comparisons were then made to ensure all relevant issues were covered in each site and site specific processes clearly documented.

Documentary analysis of organisational policies

Access to Trust and Local Authority policies, statements and guidelines relating to the following preceded the interviews:

- clinical governance and professional supervision

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- contracting systems for practice based commissioning and service level agreements

- recent re-organisations

- long-term complex conditions

- partnership frameworks with health/social care and or the independent sector and local service re-configuration

- quality monitoring and auditing processes

- staff training development and appraisal systems

- public and patient involvement

- sources of funding

- financial decision making in relation to priorities and targets, audit processes, management support and accountability for staff performance, performance related incentives

Relevant information was extracted from these documents to contribute to the contextual analysis output.

Collection of publicly available and routinely collected outcome data
There were also initial plans to collect data from a number of other sources:

- analysis of Health Commission staff survey data for each PCT under study

- hospital admission data for people with long-term complex physical conditions, long term mental illness and other groups with long- term complex needs regarded as important by Trust partners

- re-admission rates of the same clinical groups

Although staff survey data was available, it was not possible to collate the data meaningfully within the sites due to incomplete coverage of the whole 'virtual team' and lack of co-terminosity (across the MH Trust and PCT): comparison between sites would not therefore have been appropriate. Hospital admission and re-admission data were not well coded by long-term conditions. For example, those with heart disease and diabetes admitted with pneumonia were not consistently coded as having a long-term condition; so again, neither site specific nor comparative analysis were considered valid by the PCTs.

2.2.3 Views of key senior staff

The purpose of the senior manager interview (appendix 2) was to :

- identify the assumptions, logic and ambitions that key–decision makers have drawn upon to 'theorise' about how the operationalisation of various policies/ practices/ways of working are intended (if at all) to improve care

- to expand the mapping from the documentary analysis and to fill in any ' gaps' : where information has not been available

The schedule was used in a flexible way with different individuals. Preparation was done as to the role and responsibility of the different interviewees so that appropriate probes could be made.

A health economist on the team undertook interviews with finance directors in each site. This interview (appendix 3) had additional questions which explored:

- the funding arrangements in place to achieve the targets (to include contracting systems and funding streams, financial decision making in relation to priorities and targets)

The schedule was piloted with a member of the project's local advisory group. Potential participants were identified through a combination of purposeful sampling and recommendation through 'snowballing'. They were approached by telephone, email or letter with an invitation to take part, a summary of the project, an information sheet, copies of the vignettes, a list of the relevant national policies and a copy of the interview schedule. Each interview lasted between 30 and 70 minutes and was tape-recorded with permission. Recordings were transcribed verbatim by an assistant and checked for accuracy by the interviewer.

A selection of transcripts was interrogated in each of the sites against 20 categories of interest that emerged from questions in the interview schedules for example: care of LTC, change and staff motivation. Each researcher developed a list of potential micro-codes that encompassed their data. These micro codes were then discussed and amended to accommodate the data emerging across all three sites. A single, integrated coding framework containing these micro codes (Atlas codes) was then developed for use across the sites (appendix 4). This framework contained 23 categories of interest and 83 associated micro codes. Each of the interview transcripts were coded electronically against this coding framework through the data handling package Atlas-ti. The findings for each site were written up using these Atlas codes as a guide.

A site description was drawn up for each case study and these were presented to senior and middle level managers to ensure they generally reflected their understanding.

2.3 Phase 2: Views of health and social care professionals

The aim of phase 2 was to explore how professionals make sense of and perceive the impact of the policies, governance and funding arrangements that are intended to shape the activities of their organisations in relation to patient centred issues in the management of long term conditions. The objectives were:

1. To identify the views of staff at each level of the organisation (management, care delivery and support) on team performance

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> 2.   To explore the emotional experiences and reactions of staff to the organisational priorities and funding arrangements for care
>
> 3.   To investigate from the perspective of staff how the governance and incentive arrangements make an impact on performance and effectiveness

The researchers worked with local managers to select a locality and associated health and social care teams within each of the three PCT case study sites. A purposeful sample was sought ensuring an information rich and diverse group of experienced professionals and non-professionals. The localities were sampled pragmatically on the basis of:

- advice and direction provided by the Trust Senior Managers (so as not to compromise and overburden teams already engaged in other Trust-led initiatives)

- relatively stable and well staffed teams (although these may not be a representative sample it meant that we were not evaluating the effects of poor recruitment and retention and subsequent low morale)

- commitment to developing new initiatives around long term conditions

- an established partnership agreement with social care.

Contact was made, through introduction from PCT and LA managers to the team leaders and general practitioners within the localities. The teams included social service teams, district nursing teams and community mental health (or primary care liaison) teams. Other relevant practitioners, such as community matrons, COPD specialist nurses, working in the area but part of teams from wider geographical areas were also identified.

A sample of 1–3 professionals from each team involved in the care of each patient group in each locality was interviewed. Team managers stressed the importance of both confidentiality and the need for honesty in order to make the research worthwhile. Interviewees signed consent forms regarding confidentiality. They were offered the opportunity to disclose sensitive information about close associates in a way which ensures the data do not become part of the case study but could be used in the phase 3 analysis. This technique had been used successfully by the applicants in a previous multiple-case study (Byng et al 2005).

Interviews with health and social care professionals

The aim of the interviews was to capture:

- emotional experiences and reactions of staff to organisational priorities and funding arrangements

- perspective of staff on how governance and incentive arrangements make an impact on performance and effectiveness

Also to:

- make an assessment of team effectiveness

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The following areas were covered in the interview schedule (appendix 5):

The individual

- the availability of emotional support with the organisation;

- the opportunities for development, promotion and career advancement;

- the impact of governance arrangements and external and internal targets on partnership working;

- the effect of personal, professional and organisational priorities on autonomy and job satisfaction

- Delivery of care

- readiness to involve patients/clients/carers in care decisions;

- how staff make sense of the resourcing for the activities

- Organisational issues

- how funding shapes what is done;

- what the perceived incentives and constraints are with regard to funding

Perceptions of teamwork

We intended to use the Aston Team Performance Inventory (ATPI) to measure team performance building on previous experience (Ross et al 2000). The ATPI is a validated instrument of team effectiveness that measures 16 dimensions of teamwork (West et al 2005). It has been developed from two previous measures that assessed team climate and capacity to innovate (Poulton and West 1999) and from a programme of work in nearly 600 organisations lead by Michael West (West and Field 1995, West et al 2003). The ATPI sets out to measure team function and performance (group potency, team leadership, reflexivity, satisfaction, innovation, team viability and inter-team relationships) taking into account the organisational context (Aston Organisation Development 2005).It provides comparisons with national norms generated by the Aston Business School.

During the early phase of the research we worked with a member of the Aston Business School for a session on understanding the ATPI and its application, which is limited to:

- clearly defined teams with an identified (named) team leader whose Performance is evaluated as part of the process. However, in our study the professionals interviewed work often in more than one team for example, a community matron will identify with a number of teams

- teams with a maximum membership of 15

- operating within a defined boundary therefore not suitable for teams working across boundaries in health and social care

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Given the "virtual" and dispersed nature of teams working across boundaries of health and social care with people with long term conditions it became clear that the ATPI in its present form was not appropriate in this study. The Aston group were not in a position to work with us to adapt the schedule and pilot an adapted schedule with us. We therefore decided not to proceed with the ATPI but to focus our assessment of teamwork on the qualitative interviews with practitioners. Questions were incorporated into the interview schedule as follows:

Q: Do you consider that you work in a team to deliver care to individuals with LTC?

With probes: *Who is in this team?*

How does it function?

Do you consider that this team works effectively?

How does team-working impact on your care delivery?

Case Studies: primary analysis

The interviews were recorded and transcribed verbatim. Respondents were sent transcripts and asked to comment and add to the data or make corrections and clarifications. The transcripts for all three sites were coded in a co-ordinated way expanding on the framework developed in Phase 1 with a minimum of additional site specific codes. The emphasis was on identifying lower level codes which represent the detail of:

- the positive and negative outcomes of care

- the formal and informal mechanisms by which policies for governance and incentives are operationalised at team level

- other intervening processes, such as 'emotional labour' and the contexts which are felt to be relevant to good and bad outcomes

- case studies for physical and mental health care were then developed by the researchers in each site. The case studies followed the following structure:

- changes in care provision in LTC and the perceived impact on patients, professionals and the organisation

- aspects of good care (identified from SURG); the nature and impact of; what factors facilitate and restrain

- how governance is perceived; ways it is operationalised; and how and in what ways it makes an impact on performance?

- the incentives/disincentives for professionals to provide good long-term care and the facilitators and barriers for this

- the views of staff on team performance

- the emotional experiences and reactions of staff to the organisational priorities and funding arrangements for care

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Feedback to sites

Preliminary feedback to practitioners and managers took place in each of the three sites. They were sent the draft case studies in advance of the meeting. The meetings were facilitated by Sally Brearley. They were an opportunity for respondents to:

- discuss the findings as a whole, and areas of contention in particular,
- develop prototype 'frameworks of good practice' for the implementation of policies related to governance and incentives, and
- help shape the way in which services are developing in their own site.

Adjustments were made to the case studies following the meetings. The prototype 'frameworks of good practice' discussed in the meetings from across the sites were combined and sent along with the adjusted case study to each site. They also formed the basis of the data used in the phase 3 analysis.

2.4 Phase 3: Cross case analysis

The objectives for this phase were:

1.   To develop hypotheses about how incentives and governance and the associated emotional work relate to improvements and problems of care provision

2.   To investigate how the impact of governance and incentive arrangements are dependent on context

3.   To examine how different governance and incentive arrangements interact and interconnect

4.   To develop practical models for local implementation

This involved identification of hypothetical statements leading to the development of middle-range theories and practical models to benefit practitioners, managers and policy makers by focusing on:

- the interactions between and interconnectedness of different governance and incentive arrangements – both conflicts and positive synergies
- the context dependence of the impact of governance and incentive arrangements
- the associated emotional work related to improvements and problems of care provision
- development of practical frameworks for good practice

The cross case analysis generated statements to enable development of middle range theories that increase understanding of the impact of governance targets and organisational incentives on staff performance, experiences and patient outcomes. Analysis across sub cases (3 localities) and cases (3 PCTs) involved identifying the mechanisms and processes that

have an influence on the outcomes within the specific contexts studied to address the questions:

- how do governance and incentives relate to improvements in care delivery?

- how are the impacts of governance and incentives dependent on the ontext?

- how do different governance and incentive arrangements interact and interconnect

- Initially themes and prototype middle range theories emerging from analyses of the data, along with those resulting from the discussion of stories, above, were taken and developed inductively by being interrogated against the case studies and the accounts of practitioners in the original transcripts in a process similar to analytic induction (Byng et al 2005). These made up the final middle range theories for dissemination.

2.5 Summary

The design of the study involved collecting data on the views of patients, senior managers and practitioners, in order to develop preliminary 'middle range' theory about the local interpretation and impact of national governance and incentivisation policies. We studied three centres providing care for individuals with complex long-term conditions in health and social care using a multi-layered design to ensure that contextual process and outcome issues could be explored in depth. Extended interviews with a multi-disciplinary 'virtual' team of practitioners from different organisations eliciting their views about how local implementation of policy had an impact on quality of care formed the core of the research.

Service users were prominent in shaping the questions asked of health and social care professionals and preliminary feedback of case study findings to practitioners and managers served to validate the findings and involve respondents in the research.

The generation of often preliminary hypotheses and middle range theory from the cross-case inductive analysis is the first step prior to further research for developing more robust, generalisable theories.

The next three chapters present the findings from both the analysis of the context and the interviews with health and social care professionals.

3 The context of care: views of service users

3.1 Introduction

Locally based Service User Reference (SURG) Groups were recruited in each of the three sites as described in Chapter 2. This chapter describes how service users perceived the context of care and how these views were translated into the vignettes which were drawn from in later phases of the project.

3.2 The format of the local SURG meetings

Thirty-two service users with long term physical and mental health conditions attended the meetings in total; 14 with a physical condition; 15 with a mental health condition; and 3 carers of individuals with a physical condition.

> **Attendance at local SURG groups**
>
> Site A: 12 service users and 1 carer
>
> Site B: 6 service users and 2 carers
>
> Site C: 12 service users

The meetings were all facilitated by Sally Brearley who is a member of the research team and Honorary Fellow in Patient and Public Involvement in the Faculty of Health and Social Care Sciences and Vice Chair of a PCT Patient Forum. Up to four further members of the project team also attended each of the sessions which took place in suitably accessible local settings and were scheduled from midday to 4pm. The sessions began with a buffet lunch during which payments were made for time and expenses; any questions were answered; and consent forms were signed.

The meetings began with introductions and explanation of and agreement to some basic ground-rules (Table 1). These ground rules were taken from Shaping Our Lives: National User Network documentation. Participants were invited to add to these ground rules as they felt appropriate.

Table 1.   Suggested ground rules for the local SURG

- Respect that each person needs to join in the meeting
- Respect and value that everyone is different and will think differently about things. We are happy that everyone is different and thinks differently
- Listen to each other

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- Only one person speak at a time

- When you speak you need to say your name and to raise your hand or do whatever you can to let others know you are the speaker

- Do not interrupt the speaker. If you need to, ask the chair-person.

- Use plain and simple English. Do not talk for too long, and talk slowly.

- If you don't understand what someone is saying, please ask them to repeat it or explain it. You are probably not the only person who doesn't understand.

- Be aware that covering your mouth when speaking might make it difficult for people to read your lips or hear what you say.

- Use words in full, like Shaping Our Lives instead of SOL.

- In any reports or discussions after the event do not use people's names when personal things have been discussed, for example when people talk about something that has happened to them in confidence.

- Be polite, don't be rude to each other. If you disagree about something concentrate on the thing you are talking about not the person involved.

- Switch off mobile phones

The structure of the afternoon was then explained and participants were invited to allocate themselves to one of two smaller groups; one focusing on the experience of having a long term mental health condition and the other focusing on the experience of having a long-term physical condition.

These two smaller groups were facilitated by a member of the project team; an additional member of the team also joined the group to take notes of the discussion and provide any assistance required. Participants were asked to give examples of and discuss their experiences around the following questions:

- Have there been occasions when you felt your care was really good?

- Have there been occasions when you felt your care was not so good?

- What do you think from your perspective could be done to improve things?

The participants were asked to note down key points on post-it notes and then discuss these points with the group. Help was provided for those who found writing difficult due to their condition. Each of the three areas of interest were discussed for a twenty minute period. The groups then broke for refreshments. During this time the post-its and discussions were summarised for a brief feedback presentation which was recorded. Participants were invited to contribute any further views and clarification to this session.

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Participants were asked for feedback on their experience of being involved in the group and this was overwhelmingly positive:

- *It's been great to have an opportunity to have my voice heard and to think that it may make a difference for others in   the future*

- *I have enjoyed hearing that others have similar experiences to me; I don't feel quite so alone now*

- *I have learnt a lot about what services are available for me and met some very nice people*

3.3 Themes emerging from the SURG groups

An analysis of the transcripts from each of the three SURG groups was undertaken by members of the research team who had been present in the smaller groups. Several elements emerged across both the mental health and physical condition groups which were seen to constitute or contribute to both good and not so good care. Those elements perceived to be important for good care are summarised in table 2 below.

Table 2.   Summary of service users' views of good care

Mental Health Conditions	Physical Health Conditions
Service users' experience of good care	
Communication: information and explanation • Good quality listening • Not being rushed, • Assumptions not being made • Good communication between professionals and primary and acute sectors	**Communication: information and explanation** • Clear and timely information giving and explanation • 'If I know what is going on I feel more positive and in control'
Ways in which professionals behave • Professionals and key workers going beyond their remit "never giving me the feeling that I am a nuisance"	**Ways in which professionals behave** • Interpersonal skills valued such as "gentleness", inclusiveness and being respectful of patients, and "to each other" • Attitudes of professionals: 'she treats me as a person and takes time with me'
Access to services • Access to services when they are needed: offering a safety net	• Good care is about having "time": getting the details

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Continuity • Seeing the same person: not having to start from scratch each visit which can be painful	right and when "everything kicks in" **Individualised and responsive care** • Approach and care tailored to the home environment • Having someone with an overview **Involvement** • Feeling involved in my care and in control of myself and my future

The SURG group members told us many stories about how the 'ways in which professionals behave' is important to them and this was for both mental health and physical condition groups. For example they appreciated 'friendly' professionals who had the time and willingness to listen and explain things to them; professionals who are patient, non-judgmental and respectful.

They also told us stories in which they had received good care because they had felt involved with decisions around their care for example in drawing up care plans and identifying achievable goals. They described this as empowering and gave them a sense of worth and control. They also appreciated having someone in a position to co-ordinate the diverse group of services that they had contact with: 'a single figure with an overview'.

The groups also told us that they considered continuity of care and communication between professionals to be important. For example, participants described how they felt it was important to build relationships with their care professionals so that they did not have to 'start from scratch' on very visit.

Participants spoke positively about occasions where care was tailored to their own needs in their own environment and where communication was good both between them and the professionals involved in their care but also between professionals and organisations. Members of the mental health group appreciated having access to services when they were in crisis as they provided a 'safety net' for them and prevented further decline.

The SURG groups also discussed their experiences of 'not so good care' and elements of these are summarised in table 3. They described occasions in which they had difficulty 'accessing services'. For example they talked about difficulties in making appointments with GPs. The mental health group in particular reported finding it difficult to negotiate with the 'gatekeepers' who were perceived to be the surgery receptionists, especially when they were feeling vulnerable. The physical condition group described the abrupt withdrawal of services at the end of a set period of rehabilitation and the feeling of loss associated with this. The closure of mental health day

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services in favour of entering mainstream activities was not seen as favourable by members of the mental health groups; they considered the benefits of spending time with other individuals who had similar experiences to outweigh any benefits of integration.

Participants described occasions where continuity of care had not been good; where they have been in crisis and had to see a GP or other professional who they are not familiar with and how this caused them anxiety. We were also told stories of professionals giving conflicting advice and not communicating well which shook their confidence. There was often no-one person who they considered to be co-ordinating their care and taking an overview.

We were told of occasions where professionals were not perceived to behave well; occasions where participants in the mental health groups had felt stigmatised and 'a burden' which did not result in a positive and therapeutic interaction. Participants also described assumptions from professionals that medication 'is the be all and end all' when navigating a crisis. Some members of the physical conditions groups described occasions where professionals had not been respectful of their homes.

Table 3.   Summary of service users' views of less good care

Mental Health Conditions	Physical Health Conditions
Service users' experience of less good care	
Communication: information and explanation • Conflicting advice from different professionals **Ways in which professionals behave** • 'Every health problem is seen as part of my mental health problem; I am exasperated!' • Not being taken seriously; feeling stigmatised; and a burden • Assumptions that medication is the be all and end all **Access to services** • Access to services limited by attitude e.g. gate keeping; availability e.g. shortage of social workers; rationing of services e.g. reductions in access to emergency care	**Communication: information and explanation** • Not understanding the system e.g. community matron "don't understand her purpose" • Lack of explanation leads to feeling blocked by the system e.g. "can't do this because of that" **Ways in which professionals behave** • Professionals who are offhand and who do not want to listen to your view • 'Professionals who do not respect you or your property' **Access to services** • Problems making GP appointments • Rehabilitation services stopped certainly after the allocated 6

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• Having to be in crisis before access to services is granted	week period irrespective of further need
Continuity • no-one is monitoring the overall picture • a high turnover of CPNs	**Individualised, flexible and responsive care** • "Little things get forgotten"

There was some very positive discussion in the SURG groups as to how things could be improved and these suggestions are summarised in table 4. It was considered that communication and access to information could be improved by having 'folders' signposting what services were available to individuals with long term conditions.

The key to improving the ways in which some professionals behave was seen to be training; with the underlying ethos of 'treating people as you would want to be treated' and taking account of each service user as an individual. It was suggested that it may be beneficial if expert patients were involved in training sessions with professionals where they could relay experiences from the service user perspective. A change towards more positive risk taking amongst currently 'risk adverse' professionals was seen to be beneficial for the future. Incentives to keep staff in post were seen as necessary to help improve continuity.

Flexible access to services in the future was viewed positively including more specialist day care services for mental health groups.

Table 4. **Summary of service users' views of how care could be improved**

Mental Health Conditions	Physical Health Conditions
Service users' views of what would make care better	
Communication: information and explanation • A folder containing services that are available to you	**Communication: information and explanation** • A folder containing services that are available to you
Ways in which professionals behave • "Treating people like you want to be treated" • For professionals to give time to listen	**Ways in which professionals behave** • Treating patients as individuals • Taking account of individuals • Involve expert patients in training for health professionals • The "common denominator is training"
Access to services • More day care, specialist services, talking therapies and	

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comfortable environments where people can feel safe (half way houses)
- Training for GP receptionists (gatekeepers)

Continuity
- Continuity of care and more face to face contact
- Incentives for CPNs to stay in post

Individualised, flexible and responsive care
- Individual, whole person, flexible care
- Move from being risk adverse to more positive risk assessment

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Access to services
- Flexible access to services

Individualised and responsive care
- Put "people first" – "treat patients as individuals and with dignity"

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3.4 Developing the vignette

The themes that arose from the SURG groups were used by the research team to develop two vignettes; one representing the experiences for individuals with complex physical conditions and one for those with complex mental health conditions. Both positive and negative experiences of care were included within the vignettes.

Vignettes have been defined by Finch (1987:105) as "short stories about hypothetical characters in specified circumstances, to whose situation the interviewee is invited to respond". The purpose of these vignettes was to provide a context to respondents within the interviews for senior managers and to be drawn from in the interviews with professionals.

The first step in developing the vignette was to present all the themes that arose for each SURG group and begin to construct a viable pathway through as many issues (both positive and negative) as possible on a single A4 sheet. A first draft of each vignette was agreed amongst the researchers and then presented to the National SURG group for their advice on the content and authenticity. The National SURG group provided useful advice and the vignettes were amended accordingly and circulated to the national and local SURG group members for their comments on the accuracy and authenticity of the vignettes. This process was seen as part of the validation of the vignettes. The vignettes were considered to be a good reflection of the experiences described in the SURG groups. The vignettes are shown in the following two sections of this chapter to give a context to the remainder of the report.

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3.4.1 Vignette 1: Long-term mental health condition

John is 44 years old and has suffered from clinical depression for the past 15 years. He has been admitted to the acute admissions ward having attempted suicide on two occasions and he was discharged 22 months ago. John lives on his own, finds it difficult to cope, has little social contact and is unable to work. John had been assigned to a CPN who was very supportive and encouraging. However his CPN has moved to a different job and John has had only intermittent contact with different 'stand-in' CPNs for the past six months. There has been no recent review of John's condition and he is feeling increasingly depressed and vulnerable and is unsure where to turn for help.

Where to turn: reaching crisis point

John was worried that he would have to hit rock bottom again before he got any help. The worst-case scenario would be to end up in the acute ward again where he had felt nervous of the other patients many of whom were aggressive. It would be so good if there were a 'halfway house' or 'safety net', where he could go to get the help and support to recover in a quiet, therapeutic environment. John tried to contact a CPN but was unable to reach anyone.

Access and continuity of care

John was feeling increasingly desperate but had enough insight to know that he needed help and telephoned the surgery, which was a huge step in his fragile condition. He was told by an abrupt receptionist that he would have to ring at 8am the following morning to make an appointment with his GP. John felt dejected and anxious but telephoned again at 8am to find the line permanently engaged. Finally, he got through only to be told that all the appointments with his own GP were now full and he would have to see someone else. John was disappointed since he knew his GP quite well and they had a good supportive relationship.

Contact with health professionals

John arrived at the surgery early. His past experiences with GPs had been mixed and there had been many times when they had not had the time or willingness to listen to his concerns and had simply looked at his history and suggested he increase his medication. Little did they know how long it had taken to find an effective medication at a dose that didn't give him unbearable side-effects and that the way he was feeling was much more than medication alone could deal with. How could he possibly start to explain this in ten minutes to someone he had never even met before. John entered the room and was pleasantly surprised when the GP rose and shook his hand whilst introducing himself. The GP was patient and non-judgemental as John described how he felt. John was conscious of the time but the GP reassured him that they would take the time it needed to sort things out. John felt that the GP had understood his problems and that they

had worked together to find an appropriate way forward. The GP made John another appointment for the following week to review the situation. As John left the surgery, he felt that he had been listened to. What was it, John wondered, that enabled this GP to be so helpful whilst so many others in the past just had not been?

Ongoing care

John's GP acted quickly and made a referral to a CPN who rang John within 24 hours and arranged to visit at a convenient time. John was distressed though when the CPN was over an hour late so they arranged he would telephone in future if he was running late. Together they compiled a care plan which helped John enormously as it provided him with a focus giving him small goals at a time. It also gave him a sense of achievement in terms of his progress which increased his confidence.

The GP, CPN and John had a meeting to review how things were going. It was thought that the meetings with the CPN could be reduced and that John might benefit from sessions with the counsellor at the surgery. The CPN also identified what services were available in the community and John was surprised at what was available for him. The CPN explained that some of the local day services were actually closing because it was felt that individuals should attend 'mainstream activities' alongside other members of the community. John wondered whether this social inclusion was a good idea since he had spent most of his life feeling like the 'odd one out': it sounded attractive to spend some time with others who had the same condition and who might understand how he was feeling.

John also had a visit from a support worker who worked with him to see whether he was receiving the correct benefits and managing his money. This had been helpful as John had always been anxious about this. Life seemed much easier to John with this little bit of support and he felt secure that he could ring his CPN at any time should any further issues arise.

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3.4.2 Vignette 2: Long-term physical condition

Jean is 66 and has had high blood pressure and diabetes for many years for which she takes regular medication. She lives with her husband, Jim, who is 74 and who has health problems himself. They live in a three bedroom house in a semi-rural location. They have a son who lives over four hours drive away. A year ago, Jean had a stroke and was admitted to the local hospital.

Discharge and rehabilitation

After three weeks in hospital, Jean was considered well enough to be discharged. Her mobility was still limited so an OT made an assessment and ensured that aids were in place for her at home. As a result, Jean was confident that she would be able to manage at home with Jim's help.

On returning home, Jean found that she was in fact relying heavily on Jim's help but her confidence was increasing. Jean appreciated the way in which her physiotherapist, who visited twice weekly, always explained things to her as it made her feel involved in her rehabilitation. She was also respectful of their home which was in contrast to stories from friends who had received care from professionals who had been off-hand and grumpy: better training should provide care professionals with more empathy and respect Jean always thought.

Three weeks after being discharged from hospital Jean suddenly felt very low. Fortunately the physiotherapist picked up on this during her visits and gently suggested that Jean might want to talk to someone about how she was feeling. She referred Jean to a counsellor at the surgery which was very helpful for both Jean and Jim.

End of rehabilitation

After six weeks, Jean's normal period of rehabilitation came to an end but she was unprepared for how quickly her services were withdrawn. For the first few weeks she felt quite bereft of support and the social interaction that the visits had provided. However, between them, she and Jim were just about able to manage and they soon adjusted to a routine that worked reasonably well but meant huge reliance on Jim who continued to be unable to leave her on her own for any length of time.

An ongoing struggle...

Over the past six months though Jean and Jim have found it increasingly difficult to manage as Jean has deteriorated; she can only walk a few paces without stumbling. Jim's health has also deteriorated with the strain of being a full-time carer and they are both feeling increasingly isolated. Jean's diabetes has also become more difficult to control and her GP and consultant have been giving her conflicting advice about her medication which has shaken her confidence in them.

Jean and Jim were feeling increasingly desperate about their situation and

were unsure where to turn for help. Jean telephoned the surgery and was told she would have to call back at a certain time the following day. Jean remembered a time when GPs would come and visit day and night but now it seemed far more difficult and there was a strong expectation that Jean should make it to the surgery. She felt increasingly dejected as everything in her life seemed to be an uphill struggle.

Finding support

Jean got an appointment with the GP the following day and was able to get to the surgery in a taxi with Jim's help. They were both relieved at how friendly the GP was and how he seemed to have time to sit, listen and understand their problems. The GP suggested that someone could visit them and put together a care package for them. This case manager (CM) visited Jean and Jim two days later. Jean felt really involved in drawing up the care plan with the CM and was impressed at how resourceful the CM was with her suggestions as to how they should draw on the strengths and resources of her family but not overburden them. She also gave them information about services that were available to them and they were amazed that they had not been given this before. Social services referred the couple to the integrated community equipment service to suggest any further alterations to the house that might make it easier for Jean to cope. The social worker suggested that Jean consider Direct Payments which would enable the couple to buy some social care, but they were rather disappointed that amount on offer was very little in their position.

The CM continued to visit Jean and Jim to make sure that their care package was working well. After a couple of months her visits reduced although reviews were planned. Jean and Jim felt confident that they could contact her at any time to discuss any further issues as they developed.

3.6 Summary

The SURG groups successfully fulfilled their objectives of eliciting service users' experiences of health and social care services locally, providing rich data for use in later stages of the PEGI Project. Several themes identified within the SURG discussions and reflected in the two vignettes were used as discussion points within the interviews with health and social care professionals. These broad themes included are shown in Figure 3. The following chapter describes the context of the sites in more detail.

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Figure 3.   Themes emerging from the local SURG groups

Organisation of services

| ACCESS | CONTINUITY | SUPPORTING INDEPENDENT LIVING |

Ways in which professionals behave

| APPROACH | INVOLVING SERVICE USERS | COMMUNICATION |

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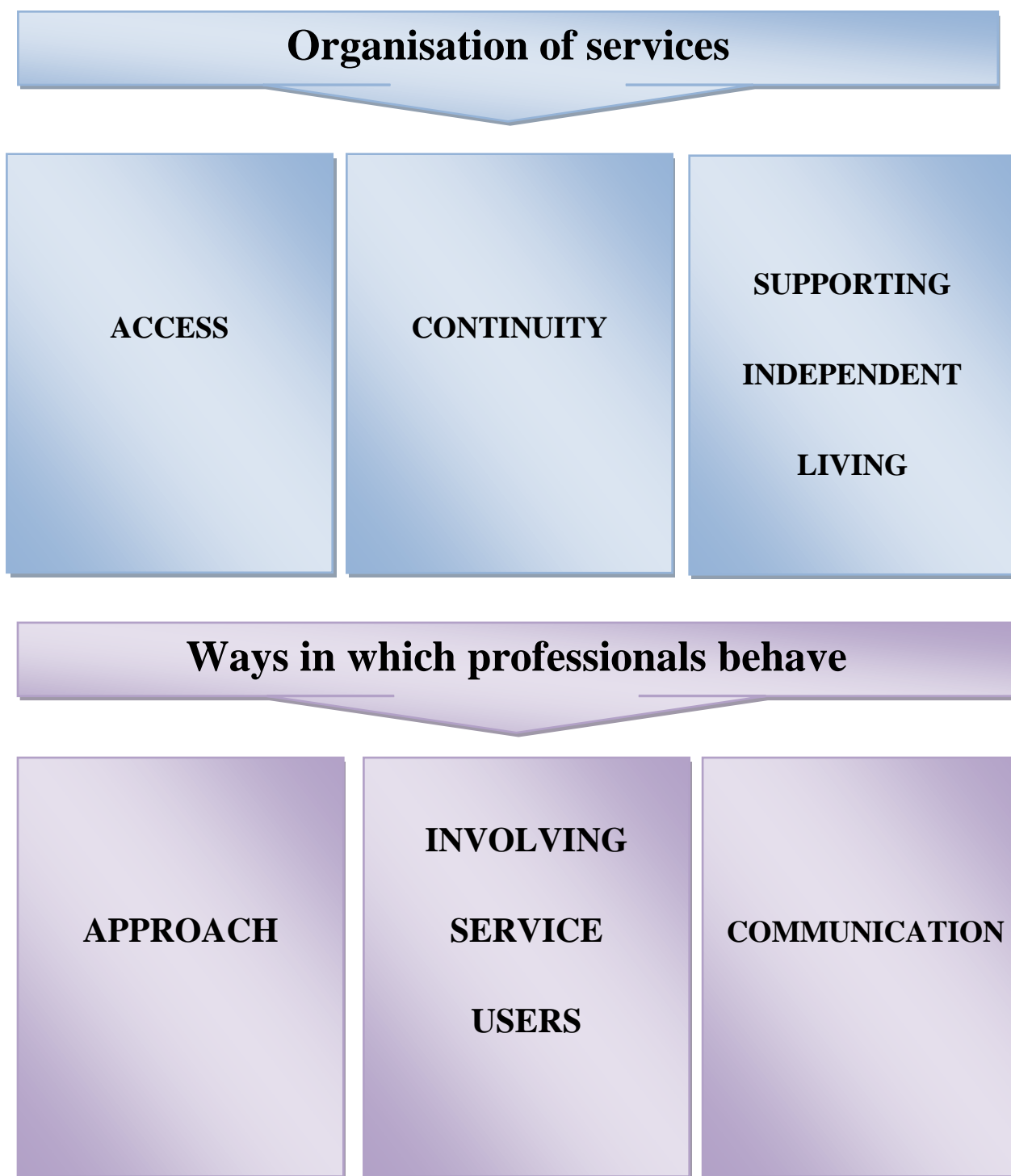
4 Conceptual analysis

4.1 Introduction

This chapter reports the findings from the contextual analysis of the three study sites for Phase 1 of the study. The first section of the chapter contains a summary of the contextual analyses and the second section details the findings from the interviews with senior managers and identifies the assumptions, logic and ambitions that key decision-makers have drawn upon to 'theorise' about how the operationalisation of various policies are intended (if at all) to improve care.

4.2 Contextual analysis

A detailed site report containing a full local contextual analysis was produced for each site by the researchers. The data for these was obtained through documentary analysis as described in Chapter 2. These reports were disseminated locally to the PCTs through presentations to Long Term Condition Strategy Groups and in one site a presentation to the Trust Board. Summaries from these site reports are presented here to give an overview of the case study contexts.

Site A: Contextual Summary

Background

Site A is based in one of the largest of the inner London boroughs and includes an area covering approximately 13.4 square miles and a population of approximately 265.000. The population is 66% white, 12% Black Caribbean, 9% Black African and 3.8% South Asian. There is a predominantly young population with an average age of 35, against a national average of 39. Seven of the 18 wards are among the most deprived in England.

Health and Illness

There are high rates of CHD, cancers, mental health problems, stroke and teenage pregnancy in the site.

The key commitments for 2006/2007were based on the four key aims of the White Paper, 'Our Health, Our Care, Our Say: a new direction for community services (2006):

- Develop better prevention and early intervention services
- Give service users more choice and a louder voice
- Do more on tackling inequalities and improving access to

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          community services

- Provide more support for people with long-term needs.

Mental Health

There is a significantly higher than average incidence of mental illness; predominantly psychosis. The Mental Health Partnership Board brings together the Local Authority, PCT and MH Trust to oversee provision and development of mental health services.

PCT

The PCT was set up in 2002. There are a total of 50 GP practices with a total registered list size of 273,750.

Priorities during 2006/07

- Delivering financial turnaround
- Delivering health and service improvements
- PCT Fit for Purpose, organisational development and restructuring
- Planning and risk management
- Financial turnaround

In 2006/07 the PCT experienced significant financial pressures and ended 2006 with a deficit of £3.1 million. For 2007/08 the PCT submitted an operating plan that was in financial balance but which set out challenging effective referral management and other savings plans which included improving the effectiveness of the health economies spend on medicines, an efficiency review of provider services and the monitoring of all service level agreements to ensure value for money.

Long-term conditions

The strategy over the next five years is to offer better, more effective, services to people with long term conditions. The Expert Patient Programme is designed to empower patients to manage their own healthcare. Under the New GMS Contract GPs have targets to show they are undertaking levels of care for patients with long term conditions, and a programme for training Community Matrons is underway with the remit to manage people in their own home, to support self management and to reduce hospital admissions.

Under its target for 'Improved management of long term conditions' there is a Local Area Agreement 2006-2009, which sets out a three point plan: reducing the number of unplanned admissions to hospital by at least 1% per annum; increasing the number of people diverted at A&E to intermediate care or other community services; and increasing the number of people supported by intermediate care services in their own home.

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Partnership working

The site's geography lends itself to partnership working as the PCT is co-terminous with the borough. The key partnership is between the PCT and the local Borough. Joint commissioning between the council and the PCT began in 2005. In the PCT partnerships range from population-based disease prevention through to single assessment processes and care plans drawn up with individual clients, as well as joint work on children's services, neighbourhood renewal and health inequalities, community development work, joint commissioning of adult community care and an intermediate care team.

Clinical Governance and professional supervision

The *PCT Clinical Guidelines Policy (2004)* provides a system for managing the implementation of national clinical guidelines and guidance such as NICE and NSFs and a system for ratifying local clinical guidelines for adoption and implementation within the Trust. The PCT Board and the Professional Executive Committee are accountable for all clinical governance activity and for staff and patient safety.

There is a Clinical Governance Committee and a number of sub-groups which co-ordinate specific areas of clinical governance activity and report to the Clinical Governance Committee:

- Forum for Learning and Action Group (FLAG)
- Clinical Risk Group
- Complaints and Quality Patient Information Group. Use of Information Group
- Learning and Development Group
- EARACE - Enabling audit, research and clinical effectiveness group.

Commissioning

Site A's *'Commissioning and Choice Strategy',* published in 2004, aims to provide a clear strategic direction for the next five years (2004-2009) to ensure the PCT commissions services both effectively and appropriately. The PCT uses approximately 70% of its annual budget commissioning care from external providers. They also have contracts with over 30 acute trusts and arrangements with neighbouring PCTs. PMS and GMS contracts are held with 50 GP practices, together with community dental and pharmacy contracts and a range of voluntary sector contracts covering substance misuse, palliative care, learning disabilities, mental health and HIV prevention treatment and care.

Contracting systems for PBC and service level agreements

Four commissioning clusters have been set up in site A. Finance, commissioning and public health directorates at the PCT have worked together to devise 'indicative' budgets for each practice. Some practices are enthusiastic, but it is thought that probably the majority were prepared to sign

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up for indicative budgets but, at the time this contextual analysis was taking place, were unclear as to how else they would be actively involved.

Incentivising change

There are three mechanisms for incentivising change:

1. Implementing Payment by Results to support patient choice, provide strong incentives for efficient use of resources and give 'market leadership' to a particular provider.

2. Devolving budgets to a neighbourhood or practice.

3. Pursuing joint commissioning arrangements and closer alignment with Social Care and Health.

The PCTs strategy to align incentives states that it is essential that the PCT is able to implement a pathway of care for a particular condition and it may be that allocating financial incentives at different points of the care pathway is the best way to do this (the GMS contract has already started the process).

Quality monitoring and auditing processes

The PCT is committed to developing a robust clinical audit and effectiveness program as part of the process through which the Trust can discharge its duty to ensure high quality services and continuous improvement

Staff Training, development and appraisal schemes

The PCT is committed to promoting best employment practices through the review of policies and procedures, providing advice, support and guidance, access to learning and development opportunities, and implementing the following national human resource initiatives:

- Improving Working Lives

- Electronic Staff Record

- Agenda for Change

A core training programme has provided approx 2, places on courses in: IT skills; clinical updates; personal and management development; and workshops,

Appraisal

Effective staff appraisal is identified by the PCT as important for managing performance and meeting the priorities of the organisation, and all staff are involved in end of year appraisal discussions. Appraisal policy has been updated to include the KSF and to clarify the process and supporting paperwork. An Appraisal Guide has been developed which outlines the key stages of the appraisal process.

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Site B: Contextual Summary

Background

The organisation and delivery of health and social care in Site B was undergoing a fundamental restructuring at the time of the study. This restructuring involved the creation of a county wide single organisation PCT that could work preventatively and more effectively manage long-term illness. This restructuring involved the amalgamation of five former PCTs.

The new PCT serves a population of over a million people and in 2007 had around £1.2 billion to spend on local healthcare.

Collaboration with partners

In order to provide a complete service to patients, the PCT works closely with partners in social care, the voluntary sector, local boroughs and hospital colleagues.

In 2007 the PCT has started to work much more closely with local GPs in 'practice-based commissioning', which means that GPs are helping to decide and plan what healthcare services are needed in their local areas. 156 GP practices operate within the PCT. The national drive towards a more patient-centred and marked-oriented structured healthcare provision has also resulted in the establishment of a separate social enterprise group to provide healthcare. This is a not-for-profit, limited liability company under contract to provide community nursing and therapy services on behalf of the PCT. The contract is similar to those held by GP surgeries (a specialist medical services contract).

The PCTs Health Economy now comprises four acute trusts, one third of an ambulance trust, one mental health trust, one PCT and an increasing range of private providers. Despite the consolidation of organisations, the IM&T infrastructure remains fragmented along previous organisational lines.

- PCT service development priorities 2007-2008

- Commissioning intentions 2007/2008:

- Early analysis shows no further capacity required for 18 weeks - evidence of over provision

- Seeking a 9% reduction in elective activity

- 10% reduction in new outpatients

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- Upper quartile performance in new to follow up

- Non-elective no higher than 05/06

- A&E attendances no higher than 06/07

- Developments in community/primary care

- Further efficiencies in mental health

- Non elective

- Roll out Paramedics in primary care

- Roll out COPD service

- Roll out falls diversion services

- Pilot care call

- Pilot Urgent Care Centre

- Enhanced Hub for Health – triage and signposting

- General Practice A&E avoidance schemes – especially children

- Mental Health

- FT status

- Implementation PBR

- Development of mental health services in primary care

- Budgets 2007/2008 budget setting arrangements are interim to "pave the way" for "fair share" in 2008/2009

Site C: Contextual Summary

Background

Site C is based in the largest city on the south coast, with a population of 246,000. Five percent of the population is under five, 19.5% under 15, and 21% over 60. There is very little ethnic diversity, with 97% of the population describing themselves as 'white British' or 'white Irish' in the 2001 census, and fewer than 4% of people born outside the UK or Ireland, although the ethnic minority population is growing.

Parts of the PCT are in the 'most deprived' national quartile for all deprivation indicators, and overall it is the 76th 'most deprived' area in England. There are marked disparities within the city between the least and most deprived wards. In the case of health, for example, while 20% of the population has a limiting long-term illness, the figure is 28% for the most deprived ward and 18% for the least deprived ward. Thirty-

seven per cent of households contain one or more members with a limiting long-term illness.

The Local Authority

The City Council is a unitary authority. The Council overall was judged to be improving adequately and demonstrated a two-star out of a possible four-star overall performance in the 2005 Comprehensive Performance Assessment. The Council has eight strategic objectives; improving health and wellbeing; developing a prosperous economy; promoting community safety; raising educational achievement; promoting inclusive communities; developing an effective transport system; maintaining a clean and sustainable environment; and stimulating culture and leisure activities.

Social Care

Social care in site C has been limited by financial and capacity difculties; some plans to improve services have been postponed while others have progressed at a pace slower than anticipated. Because of a low baseline starting point for some adult social care services the site continues to remain behind comparators.

Adult Social Care

The stated aim in developing adult social care services is to move from a focus on intensive support and prevention to positive promotion of 'well-being, choice and control', independence and community engagement'. It is working corporately and with partners to deliver national priorities and objectives for adult social care, relevant National Service Frameworks and local strategic objectives. The pace of change towards the strategic objectives has been constrained by the severe financial position of the council and its partners, and raising of the threshold for service access to FACS levels (fair access to care) of eligibility to "substantial and critical" has been one consequence, meaning that many users with moderate needs will have fewer services.

The cost of both intensive social care and home care remain high. There has been a shift in 2005/6 towards greater use of block contracts and the independent sector for domiciliary care and a fall in the relative use of more expensive in-house provision of domiciliary care and residential care in favour of the less costly independent sector. Increasingly the in-house services are being used to support service users with complex and challenging needs, but indicators of care management presented a mixed picture in 2005/6, with a fall in the percentage receiving a review of their needs. Indicators on Intermediate Care are difficult to compare, but they do suggest a comparatively high number of people in residential settings receive council funded care at home to facilitate hospital discharge and rehabilitation. However the number in non-residential settings who did so was the lowest in the country.

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Mental Health

The strategic vision for social care delivery to people aged under 65 who use Mental health services in 2006/2007 is to move from an inpatient to community based provision. The last SCIE Inspection Report suggested that the number of adults with mental health problems helped to live at home per 1000 population was low and falling. Social Care practitioner staff are co-located with Health colleagues and work in multidisciplinary teams. Currently the site is formalising a whole systems approach to Mental Health Services Older People which connects the complete care pathway from inpatient care to supported community living. This care pathway is inclusive of services such as preventative work and engaging with service users who can be difficult to reach.

Long-term conditions

There are a number of developments in services for individuals with LTCs. These include an expanded use of brokerage to ensure that contracts for day care, supporting people and domiciliary care are maximized, the reorganization and expansion to four posts of third tier management to ensure more capacity to address issues around intermediate care, and joint working with the PCT on mental health. In addition, a permanent First Response Team ensures a faster response to new referrals. Procurement processes have been better aligned, with standardised terms and conditions to improve joint commissioning and better connections between floating support and domiciliary care contracts.

Partnership working

The council is working with partners to deliver national priorities and objectives for adult social care, relevant National Service Frameworks and local strategic objectives. The pace of joint commissioning has been slow but steady. Closer working arrangements have been developed with partners in the health sector, and the Mental Health Partnership is a pilot implementation site for the government's policy on delivering mental health services.

Primary Care Trust

The PCT was established in April 2001 and gained teaching PCT status in April 2003. The PCT serves a population of 240,000 people, covering an area of 16 square miles, and shares the same boundary as the City Council. The health community is facing considerable financial challenges and is implementing a financial recovery plan. The PCT is responsible for providing primary care and a range of community services, including intermediate care, rehabilitation and healthcare for older people. It also provides mental health and learning disability services for adults and older people under joint management arrangements with the City Council social services.

The core objectives of the PCT are; commissioning a primary care led NHS; achieving financial balance; offering choice to people; maintaining independence; and user and care involvement. An estimated 60% of the population will have a long-term condition. Of these, 74% will have more than one LTC and 26% of these will have three or more LTCs. Up to 10% of all those with a LTC will need active case management.

The Integrated Service Improvement Plans (ISIP) are the strategy by which national service frameworks for LTC management are translated into local policy, incorporating the priorities of 'Our Health Our Care Our Say', drawing on the national service framework for LTC management, and adapting the Kaiser model. They have the dual aim of improving health and wellbeing by shifting service provision closer to home, and optimizing health and social care resources by concentrating limited capacity.

Area Redesign Board (ARB) coordinates new initiatives reflecting national priorities in relation to LTC management. and take responsibility for their governance and evaluation, including financial evaluation.

Service reorganisation in the PCT (at present excluding mental health) will change commissioning practices for LTC management. The strategy for coordination of LTC management resulted in the appointment of LTC Managers which fulfill the role of 'Community Matrons' as laid out in the NHS Improvement Plan in 2004, but will not take that job title. A jointly chaired Commission will oversee the integration of LTC management.

4.3 Findings from interviews with senior managers

Eleven senior managers were interviewed in site A ; nine in site B ; and twelve in site C. They were from a range of senior management roles and the majority were from the PCTs with a few from the local authority. In addition the finance directors in each site were interviewed by the health economist on the team (Maureen Mackintosh).

The interviews provided the background with which to interpret the later findings from the phase 2 interviews with professionals.

- The discussion of the findings from these interviews is organised under three headings:
- partnerships and change
- incentives at the individual and team level
- organisational level incentives

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4.3.1 Partnerships and change

The different, but interrelated infrastructure issues of partnership, organisational change and financial stability were key features described by the finance directors in all three sites. Making sense of these challenges for primary care and interpreting them in ways that could provide strategic and operational direction for improving quality of outcomes for complex conditions came through the interviews strongly.

Infrastructure

Organisational reconfigurations and mergers provided opportunities for new collaborations but created difficult challenges too, such as the stress of insecurity and the rapid pace of change. For example, coterminosity with a county council was regarded as helpful but it left a very large and unwieldy organization. Although managers described a number of well-established partnerships, speed in achievement of targets varied across different sectors. Social services, being ahead of the PCT, was one example, and there was some reluctance to take responsibility for change in other sectors. In one site, negotiating the tricky terrain in establishing successful partnership-working was said to require staff to act as change agents and to be free to bypass organizational and financial impediments and to be supported in this endeavour by their line managers. Elsewhere, staff were seen to be so daunted and overloaded by the numerous targets, audits, reviews and restructuring that they were finding it difficult to cope with change and resented what they saw to be a ritualized 'tick-box' culture. Involving frontline staff in the changes right from the start was emphasized in order to 'embed' partnership-working into the organization.

One manager identified the change from provider to commissioner as unsettling for GPs and as having a negative impact on practice staff.   GPs had to get to grips with learning a new role which, for some, was said to be a welcome challenge but, for others, was stressful. Taking over the management of patients with diabetes from the hospital consultant was given as an example.

Partnership-working was, however, universally considered to be key to achieving effective care for people with long-term conditions, even if the process was expensive, slow and painstaking, because of the requirement for integrated cross-sector and cross-level working aided by standardized technology. For example, an expanded governance role was seen as essential in standardizing needs assessment, health equity audits to address inequalities and promoting similar management procedures, recruitment strategies, resource systems and service delivery across the organization. Both patients and practitioners could be adversely affected by poor governance practices and procedures, such as duplication of procedures because of poor record-keeping. Some respondents described problems when different agencies tried to work together. Others saw the solution to be in replacing senior managers with joint positions in order to create a

culture of joint ownership of partnership agreements and service delivery initiatives. However, success of joint posts was seen as difficult in the current financial climate. Mental health was given as an example of disjointed partnership-working with an over-dominance by health models and agendas over the social work perspective. Another manager gave intermediate care as an example of partnership-working having a detrimental effect on development of effective care pathways: the complexity of the intermediate care system made it difficult to integrate every aspect so that services for admission, discharge, rapid response and continuing care tended to operate independently of each other when integrating and simplifying the patient's journey was the goal.

In the past, organizational boundaries were seen to have caused separate and independent operation, varying growth, multiple often incompatible standards across organizations (PCTs, mental heath trusts, acute trusts, GP practices, voluntary organizations) and duplication in costs. One manager highlighted the financial challenge in achieving integrated working when the county council and PCT have different budgetary procedures. To combat this separateness, site B created the Community of Interest Network (COIN) that joins all previous sites in the county together to develop new services, extend the reach of existing services and take advantage of new technologies across the county. COIN is in the process of development and so its effects are not yet known. Teething problems include, for example, overcoming incompatible information systems which were set up, we were told, without thought for cross-communication. Respondents were frustrated about the need to concentrate on information technology incompatibility which inevitably diverts attention away from achieving improvements in care. Site C had developed a four-way partnership between the housing department, health, social care and the voluntary sector to develop an accommodation strategy for people with a dual diagnosis. The site also had a joint commissioning strategy for substance misuse with service delivery provided by a partnership of police, probation, health, social care and voluntary agencies, the whole being managed by the multi-agency Drug Action Team.

Two different models of service integration identified by a social services manager were an 'operational structure' and a 'top-down structure'. The former was described as a flatter structure that integrates all health and social rehabilitative services at all levels of management and delivery of care. The latter is more hierarchical, with integration of health and social services at director and management levels but separation of the two functions at care delivery level. Views about which model worked best varied.

A shared vision

Sharing the responsibility for provision of good quality care was considered to be essential to partnership-working. Managers felt that incentives concerning finance, information-sharing legal requirements in policies and

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being seen as a successful rather than a failing organization strengthened a shared vision. Client-centred care was seen as the important focus and any barriers still existing could be broken down. Sharing records and the single assessment process to avoid wasteful duplication and unnecessary intrusion for patients would benefit from electronic systems but they need a shared level of communication across systems and organizations that take time to set up.

On the other hand, examples were cited where succeeding in sharing a vision for care was not easy, for example, it was reported that social services and GPs still clashed over whether a client should be maintained at home rather than moved to a nursing home. The self-employed status of GPs with their different financial incentives could conflict with the priorities that motivate contracted health service employees. It was pointed out that the most meticulously formulated written care policies can be left gaining dust on shelves if no-one has the drive to put them into action.

Maintaining relationships through change

Successful personal relations were seen as essential in achieving effective working partnerships across former boundaries but were hampered by organizations still in periods of destabilization and flux: financial change, former managers leaving and new ones arriving and knowing whom to talk to in different sectors. Mutual trust was highlighted as crucial in overcoming cultures of rivalry and mistrust between organizations and takes time to build. Moving towards effective partnership-working was seen to be contingent on good leadership that includes imagination, vision and commitment to drive projects through. All sides of a successful partnership were said to need authority and flexibility to make decisions and act promptly to avoid loss of momentum in the care of a person with a long-term condition. Willingness to take risks was seen as a natural companion of power and authority and supported risk-taking would enable staff to create imaginative new ways of delivering care. A paradox highlighted by one manager was that partnership-working is best achieved by the leadership and risk-taking behaviour of visionary individuals acting autonomously yet this could be at the expense of clarity in governance procedures in the initial experimental stages if managers are not kept informed.

Ongoing communication

There was consensus that the key to effective partnership-working is good communication between individuals dedicated to working together. As one manager said, 'If you want people to work together, get them to talk to each other' and face-to-face discussions were regarded as essential for overcoming unnecessary 'red tape' and any residual feelings of mistrust. Good communication, between health and social care teams in particular, would move client care from 'problem-shunting' to 'problem-solving', as another put it, to ensure that the problem becomes mutually owned. It was

not always the case, however, that systems were in place to enable information across sectors to be shared. One manager explained, 'the computer people were not talking to the commissioning people who were not talking to the clinicians', which made the task for the project manager assigned the job of integrating the system impossible.

Locating professionals physically in the same place promoted shared decision-making on service users' needs: locating CPNs with GPs was one example given by a mental health manager.

Resource issues

Development of financial structures with pooled budgets within an integrated service was considered necessary to promote best practice with authority and freedom to be flexible identified as key components. Partnership agreements on finance and fines for delayed discharges were seen as crucial to ensuring a care pathway ending in optimal rehabilitation and independent living. However, although integrated working between health and social care was said to have been progressing well, there was the view that current financial restraints were stifling creativity and leading to a backward slide into independent 'silos'. We were told that clinicians were often providing good care in spite of policy drivers such as *Payment by Results (PBR)*. Another problem was the difficulty of forming effective partnerships when governance requirements of different contractors for example, the voluntary sector work in different ways.

4.3.2 Incentives at individual and team levels

This section focuses on the perceptions held by managers of what motivates staff to provide good care for people with long-term conditions. This analysis is framed within, and linked to, the views of the overarching financial incentives at both institutional and contractual levels provided by the finance directors which are developed in the following section 4.3.3.

Financial reward

Financial reward was identified as an important incentive, but was limited to GPs who had to be 'aspirational' in their working practices for other staff to recognize financial reward as a motivator. One view regarded the recent increases in funding to the NHS as an incentive for people working at all levels and *Payment by Results* was said to provide the way in which primary care can identify the funds it needs to develop its out-of-hospital services. By contrast, another view was that *PBR* had the perverse policy effect of increasing length of hospital stay. A senior manager identified the *Quality Outcomes Framework (QOF)* and *Practice Based Commissioning* (PBC) as potential rewards in that more care for people with long-term conditions will be available in the community and money saved will be reinvested into additional services and staff although there was concern that *PBC* could destroy local policies and the impact on mental health services would be

minimal. A major concern was that there was no incentive at local level to keep expenditure within budget because savings were said to be used to bale out over-spending PCTs and not reinvested locally.

A view specific to substance misuse services argued that risk-averse government policy drivers ignore the success of innovative models of care used in other countries. A commonly-held view was that service changes posing as improvements for reasons of political expediency could be perceived as cuts in resources or were not sensitive to patients' needs: *Fair Delivery of Best Value* was given as an example. Budget pressures were said to militate against long-term planning, encourage short-term solutions and risk the likelihood of savings being reinvested inappropriately. There was also the view that the common disease-specific targets and financial incentives caused funding allocation difficulties for people with long-term conditions who needed hospital admission: disentangling the funding needed for someone with multiple sclerosis or a long-term mental health condition could be a nightmare, for example. Resentment by staff in acute services when much-needed funds are transferred to community services was anticipated and the time lag between knowing what to do and being given the funds to do it was said to be extremely frustrating for managers as well as clinicians. It was pointed out that reducing hospital stay could limit the focus to a single admitting condition, so neglecting the whole health picture of a person with complex needs. Others were finding the number of initiatives in place to interpret and execute the policies too complex and overwhelming.

One view was that personal pay was exaggerated as a motivator and inequity in pay was seen by others as a demotivator causing perceived low status and low self-esteem: for example, community psychiatric nurses resented being paid less than occupational therapists for doing similar level work, and additional qualifications, like nurse prescribing, did not attract more pay. The result could be loss of demoralized staff to early retirement or a reduction in effort when at work. *Agenda for Change* was believed to have demotivated staff because it had created the circumstances it intended to eliminate: practitioners doing the same job not having parity in pay and conditions.

Recognition

Achievement, allegiance and influence were described by one manager as the three most important non-financial incentives for staff. Recognition at work from managers, colleagues, service users and society in general was seen as the key to motivation of staff as well as being a crucial aspect of financial reward. Documentation such as performance statistics, audits, reports and league tables were described as being incentives if the feedback was positive but had a demotivating effect if feedback was negative or absent. An example of how to use recognition of good work as a motivating factor was to run regular conferences to celebrate effective practice.

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Personal development

Managers emphasized the importance of explicit career pathways for all staff together with opportunities for training and development. A survey in site A in 2006 reported that 71% of staff in the PCT had received training, learning or professional development in the previous 12 months which had improved performance and keeping up-to-date. Recently however, there had been a reported cut in the training budget. Training was seen to promote and update individuals' skills and competence and thereby improve their clinical confidence especially when moving into new ways of working and expanded roles. Effective practice conferences also support personal development which can be integrated into the organization's nursing strategy. Work satisfaction was described as the result of a successful personal development programme and was seen as a major incentive. Human relations managers expected an electronic version of the *Knowledge and Skills Framework* to be instrumental in supporting the governance of personal development plans from both the employees' and managers' perspective.

Job satisfaction

Seen as a key element of job motivation, satisfaction in doing a good job for patients with long-term conditions and enabling them to stay at home was regarded as the reason many staff chose this kind of work. A mental health manager described staff being motivated by the recently introduced flexible and person-centred way of working in the community because of the close contact with service users it allows. Another manager emphasized the importance for staff in being empowered to shape their job and work conditions. Feeling that they have to conform to 'the bureaucratic system' without question, is a strong demotivating factor. Systems were thought to be working to deliver good care despite rather than because of policies and incentives according to one view. This was seen to be due to the professional ethos of staff at ground level who would pull out all the stops to solve problems for service users. Involvement in practice-based commissioning initiatives at local level, such as a multidisciplinary service for musculoskeletal care, was identified as a great motivator in one site.

Leadership and management

Good leadership and management were described as having a crucial effect on staff motivation and were often highlighted in staff surveys. To be effective, managers must, it was said, show their presence as leaders and explicitly recognize the value of employees' work. It is not enough to assume that workers know their value without being told and reinforcing the message on a continuing basis was considered essential. The leader who takes risks and empowers staff to find ways of improving their practice was seen as extremely motivating. The culture of the organization was described as one of the most important motivating factors for the frontline workers who wanted autonomy but only within their sphere of competence:

encouraging professionals to make referrals within appropriate guidelines was one example. Lack of support, ineffective communication and ambiguous guidelines on what is expected of them were seen as deficiencies although some managers sought to protect staff from the reality of the current financial situation. A middle manager gave monthly feedback reports to community matrons on unnecessary hospital admission rates, seeing them to be largely responsible for any reduction. This feedback was regarded as a strong incentive and demonstrated support for this new role.

The results of the 2006 Healthcare Commission Staff Survey in Site B reported a score of 3.35 (on a scale of 1-5) for the category on staff satisfaction with various aspects of the work including management support. This score was reported as statistically significantly lower than the 2005 score and below average for England. Managers acknowledged the difficulties staff were working under and described them as disillusioned and unclear about what was expected of them.

Team and colleagues

Team-working with supportive colleagues was regarded as a staff motivator of prime importance and involved partnerships and multi-agency working. The process of problem solving of a complex issue by the multidisciplinary team was seen as unique for every service user and left a tremendous sense of achievement when successful. Working together in intermediate care teams was given as an example. Support for team-working can be complex particularly for staff who cross boundaries in their work. An example was given of the community psychiatric nurse located in a GP practice who needed support from the multidisciplinary primary care team and also the mental health team located elsewhere. Isolating staff from their profession will not work, we were told, and so location of specialist staff needs careful thought. A solution identified was to retain the specialist's professional identity through supportive clinical supervision.

Work environment

Improving the immediate environment was seen to have a positive effect on staff. One manager described having invited staff to suggest improvements to their physical working environment. They ran workshops, identified priority themes and developed action plans to implement the ideas. The result was that staff felt involved, motivated and empowered to make a difference, they said. In contrast, wider work environmental factors such as staffing levels and workload, were criticized. Feeling under-resourced, under-valued and working where no-one is interested in what you are doing, were common disincentives.

Role

Distinguishing role as a motivating factor was identified through provision of empowerment and independence. If staff are given the opportunity to work independently they were motivated to do a good job, we were told. The

increase in the number of people with long-term conditions who are managed primarily in the community has given practice nurses, for example, greater autonomy and responsibility; the result has been a sense of professional pride. GPs were reported as finding that initiatives such as *practice-based commissioning* have given them increased authority to develop services as they think fit.   However, as one manager pointed out, a new role such as nurse prescribing would be rewarding only if it carried formal recognition of status and financial reward. As mentioned earlier, financial recognition for people doing similar-level jobs does not always occur.

Ethos

Altruism was seen as the central ethos of the work, an essential motivator for job satisfaction and something managers said they looked for when recruiting staff. Words they used to describe altruistic values in staff included being caring people with a conscience whose work was life-enhancing rather than governed by instrumental values, such as pay. But there can be ambivalence for staff: a social services manager described the dilemma for the social worker who is driven by altruism but has to remove children from their families. Making a difference to health outcomes, addressing health inequalities and effective use of resources were identified as motivators although there was a view that new policies could prevent rather than facilitate professionals in providing good care: disillusion with excessive paperwork that accompanies new policy was given as an example.

4.3.2 Organisation level incentives: financial drivers

Four main themes emerged from the interviews with the directors of finance:

- the commissioning role of PCTs (now handling in 2005/6 80% of the whole NHS budget)

- the impact of payment by results (PBR), still only in use in the acute sector, and moving towards uniform national prices

- the effects of GP Practice-Based Commissioning (PBC) (still in embryo)

- and joint working with social care

All of these are described at a time when many PCTs were merging and many had severe deficits (two out the three case study sites). It was certainly a challenging and complex context for delivering health care as one of the interviewees expressed:

We are having to think about how are we are using the reforms? How are you using payment by results, practice-based commissioning, joint health and social care teams..a whole raft of other things…How do you see them linked?

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This section begins with discussion around PBR, because it seems to have seen major changes that have influenced other budgets and have shaped relevant PCT activities.

The impact of Payment by Results

This is widely seen as a misnomer, because it is more accurately payment of acute providers (hospitals) by activity. The big change has been that, starting with elective surgery, the NHS has:

Turn[ed] a reference cost, a national average reference cost, into a tariff'.

From the point of view of the PCT this reduces the workload, since they no longer need to negotiate prices per activity, while for the acute trust, it forces them to try to work within the national tariff.

For the PCTs, the change has created financial instability:

Q. So PBR hasn't made your finances more unstable?

A. Oh yeah, it's made it much more unstable

The danger all interviewees saw was that funds would be drawn into the acute sector by the PBR system. The more activity in hospitals, the higher the payment required from the PCT:

In terms of the acute contract … with payment by results it is governed by what actually presents at the hospital …It's an open-access blank cheque

There was some feeling expressed that the incentives implicit in this payment system changed the hospitals' attitude and behaviour:

You are giving the hospital the incentive to worry about cost-efficiency, the cost of services … You are giving the hospital another incentive which is not necessarily the one you want, you are giving the hospital an incentive to maximise income…. which is the perverse incentive'

At the moment the financial mechanisms are there largely to support the acute sector and I use the word 'commercialise' – the way they do business.

The incentive issue here, therefore, is that the hospitals have an incentive to raise activity and extract the maximum funds from the PCT, potentially undermining funding for other non-acute activities.

Keeping people out of hospital

One of the finance directors emphasised, however, that the benefit of PBR from the point of view of the PCT was that it provided a financial incentive to try to keep people out of hospital, which could also be good for patients:

They [PBR] focus on the money following the patient…. [so] the economic driver is, 'How do we find ways of spending less on this?'.

This policy focus on trying to keep people out of hospital reappeared in all three interviews; it was a strong common thread. One PCT is a Health

Reform Demonstration Site; these are trusts that volunteer to bring together the various reforms and show how they can work together. The project that was being undertaken focused on reducing payments for hospital care:

An example might be, we want to have a reduction in emergency bed days. ..it would link with the public service agreement target around 5% reduction in emergency bed days …it's something that ties the health and social care community together …from domiciliary care right through to aftercare…

The incentive for PCTs is that the fewer emergency admissions, the more funds the PCT retains to spend on other forms of care. One PCT was using:

What we think is quite an innovative process …whereby a GP [team] inside the hospital employed by us …work with [the referring] GP about other alternatives …we call them an Acute GP Service …our non-elective admission rates have shown a reduction

The incentive, another interviewee emphasised, is to be able to improve care rather than just to save money per patient:

My hunch is that there are a small number of patients with particularly difficult long term conditions for whom the focus is likely to result in better care but won't save any money. But that there is another tier of people with slightly less difficult conditions for whom more attention will result in both better care and less cost

A third noted the importance of these financial calculations:

Being able to demonstrate the value for money, financial gain, associated with changes has to be done on a specific patient basis.

Practice Based Commissioning

While PBR thus provided an incentive for the PCT to concentrate on supporting people outside hospital, two of the interviewees argued that this was not the case with the GP contract. On the contrary, the GP contract was rigid, so the PCT could not reallocate funds from GP activity to other ways of caring for people outside the hospital setting.

Practice-based commissioning was not effectively in operation in any of the three areas: one PCT had given out the first indicative budgets the previous week. The new GP contract itself was felt by interviewees to constrain PCT initiatives, because no money could be saved by keeping people out of GP surgeries. GPs' income is influenced by the QOF targets:

If they hit their targets …they get paid for it [by the PCT] …the regime is not a flexible one that says, 'Well OK, if we change the inputs we want to change the outputs.'

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Therefore:

You can't release the saving to use in a different way. It's exactly the same as saying, 'Well as a result of developing chronic management systems, how many referrals / attendances to the GP practice do you avoid?' …Where's the financial benefit to …. a PCT for going down that route? ….we are now spending £2 instead of £1.

This interviewee felt strongly that this perverse incentive was a problem for developing management of chronic conditions at home: a PCT that tries to achieve it loses financially since they still have to pay the GPs exactly as before while adding extra services.

Another described the inflexibility in relation to acute payments:

I am effectively paying a block contract for GP care and an out-of-hours service, and if the patients choose not to use that and to turn up at A&E I am paying for it twice, and I can't transfer that burden back to the GPs because there is no contractual mechanism for that.

On the other hand, PBC once implemented would give GPs an incentive to collaborate with PCTs in keeping patients out of hospital, since some of the savings can return to the practice, and the GP practice can provide some of the alternative services directly. This is also not without its perverse incentives, since the move into more GP provided services means:

They are commissioning and they are providing – interesting governance issues associated with that.

Another agreed that:

Clearly it links to the GPs' income, so it links to the GMS contract …[there is] a focus from GPs on 'What can we do in primary care ourselves?'

A third expressed mixed feelings:

I think it (PBC] has the ability to change practice quite profoundly …but the worry I have is… how the governance arrangements should work, so that …this is about benefit for patients not benefits for GPs.

Funding chronic care and mental health

The PBR system applies to date only to acute care, though all interviewees perceived strong pressure to extend it to mental health and chronic care. At present they are funded in two ways: through a block contract with a mental health trust for a specified level of services over the year; or provided in-house on the basis of a budget.

The interviewees were divided over the prospects of extending PBR to these fields. They all thought it was very difficult to define activity appropriately, but one interviewee thought it necessary to try because of the need to know '*where the money is going and how it is going'.* Another interviewee was

worried however by the potential incentives generated in mental health: an acute trust being paid, say, by bed-days would be:

Less inclined to make sure clients moved on appropriately … My incentive isn't to help with that process. It is when you are part of the same organisation.

The arrangements for mental health varied between PCTs. Two have contracts with mental health trusts, and one has the mental health services in-house: the PCT includes mental health. One interviewee was a strong proponent of this arrangement:

One of the benefits we have in being a commissioner and a provider of mental health services in one organisation is that mental health actually has a really high priority within this organisation

Some incentives are beneficial too. So if commissioners succeed in moving patients from expensive non-local placements, the financial savings come to the local services. It also helps innovation:

It almost acts as a kind of incubator, so we can move stuff really quickly because we control the commissioning and the provision'

Neither of the other two PCTs expressed this sense of control over mental health funding and commissioning.

Joint working with social care

Inevitably the finance directors views of partnerships was coloured by their personal roles and pressing priorities in the organisation. Two of the respondents were relatively new or temporary appointments and had little knowledge of joint working with local authorities and were concentrating on managing multiple major contracts with acute providers and GPs:

I am not at all clear what arrangements are in place with [the local authority]….. that hasn't even surfaced on my agenda yet!

One interviewee was however very positive, feeling that :

I think we are on the cusp of something [good] in our partnership arrangements, particularly with Social services.

He thought however that one thing that was slowing it down was the local authority's struggle with the purchaser/provider split, something that the PCT was also struggling with, but trying not to worry too much about at the same time.

Deficits, financial risk and managing reforms

There seemed to be general agreement that the new governance and contractual arrangements had increased financial risk, as suggested above. Two of our PCTs were struggling with deficits, the other was not. The PCT without a deficit was actively seeking to build up quite substantial financial reserves, knowing that a drop in funding growth was coming towards them.

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The other two were trying to deal with the deficit, and each had a recently arrived finance director, both temporary appointments.

The PCT manager whose optimistic statements about joint working were just quoted worked, perhaps predictably, for the trust without a deficit. This is also the trust with the simplest structure of contracts, since the mental health services are in-house. The area is a unitary local authority, with co-terminous boundaries with the PCT, and the relative simplicity of the structure was clearly valued:

Think it's very helpful …without some of the synergies …the sort of structures you would need to manage significant multiple providers….we'd struggle …within the affordable envelope.

The other two PCTs were indeed struggling with multiple providers, among whom it was more difficult to create synergies:

Increasingly people need to learn to wear multiple hats.

Increasingly you are getting an open system with a multiplicity of providers, and the purchaser…still has a fixed budget

In circumstances where the financial position was difficult, as it was in these two, the scale of change could seem very risky:

I think the problem with the Health Service is that it doesn't do pilots very well. It likes to go to full blown implementation and then work back at a later date

Whereas he wanted to see more careful experimentation with getting incentives right, so that people could take risks in trying new approaches:

It is about trying to find some mechanisms that reward and incentivise people to do things differently and give people the ability to actually modernise and innovate

It was the manager in the simpler structure who found it most likely that this kind of scope could be found.

4.4 Summary

Partnership-working is key to achieving cost-effective and holistic care for people with long-term conditions. Collaboration appears to work successfully in well established partnerships in which front-line staff have been involved from the start and changes are introduced gradually. Successful partnerships have formal written partnership agreements with clear governance requirements. Less successful partnerships can be hampered by reluctance to change, staff feeling daunted by what seems like a deluge of targets, audits and reviews, incompatible information systems or a frustrating time-lag between knowing what to do and receiving the resources to do it.

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Sharing the responsibility for provision of good quality care through joint management posts emerges as essential to successful partnership-working. Managers occupy the key leadership role in making partnerships work. They achieve this by motivating staff through the incentives of regular two-way communication, feedback on achievement of targets and allowing staff to be autonomous within their sphere of competence. Recognition at work from managers, colleagues, service users and society in general is a strong motivator for frontline staff. Effective interpersonal relations, mutual trust and willingness to take risks are essential in achieving effective working across former boundaries but are hampered by organizations still in periods of destabilization and with independent management systems. Successful communication between health and social care teams moves client care from 'problem-shunting' to 'problem-solving' and mutual ownership of the problem.

The motivators and incentives were described in various ways and operating at a number of levels for staff, but can be summarised as a "feel good factor" of doing a good job. In addition the need for colleagueship, a sense of belonging, purpose, self-esteem and pay were emphasised. The current climate of turbulence, with rapid turnover of senior staff and lack of resources to implement policies, managers described as extremely frustrating for staff, the effects of which could be increased sickness and absenteeism. The effect of incentive schemes on the organization was seen to be positive and far-reaching, covering areas such as efficiency, accountability, governance and management, so long as capacity and resources for coping with the changes were in place.

5 The professional experience

5.1 Introduction

The aim of this chapter is to report the findings of the cross case analysis of the interviews with health and social care professionals. Fifty-six health and social care practitioners were interviewed in total: 19 in site A, 19 in site B and 18 in site C. These professionals had various roles within the community teams and included: community matrons, community nurses, GPs, specialist nurses, practice nurses, physiotherapists, occupational therapists; members of the community mental health and crisis teams and social workers.

The 56 interview transcripts were coded using the universally agreed coding framework and analysed for the local site analysis and reports. The researchers working in the three case study sites then met with the project co-ordinator and an external advisor to discuss common emergent themes for the cross case analysis. This process gave us confidence that we had identified themes that were justified in terms of their depth of significance to our objectives and demonstrated coverage across the sites. Three key themes emerged as prominent: risk, diversity and ambiguity and conflict. The emergent issues within these themes will be discussed in detail within this chapter and are presented in Figure 4. The quotes in this chapter are labelled with an A, B or C referring to their site of origin thus giving a sense of the context within the cross case analysis.

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Figure 4.   Themes emerging from the cross-case analysis
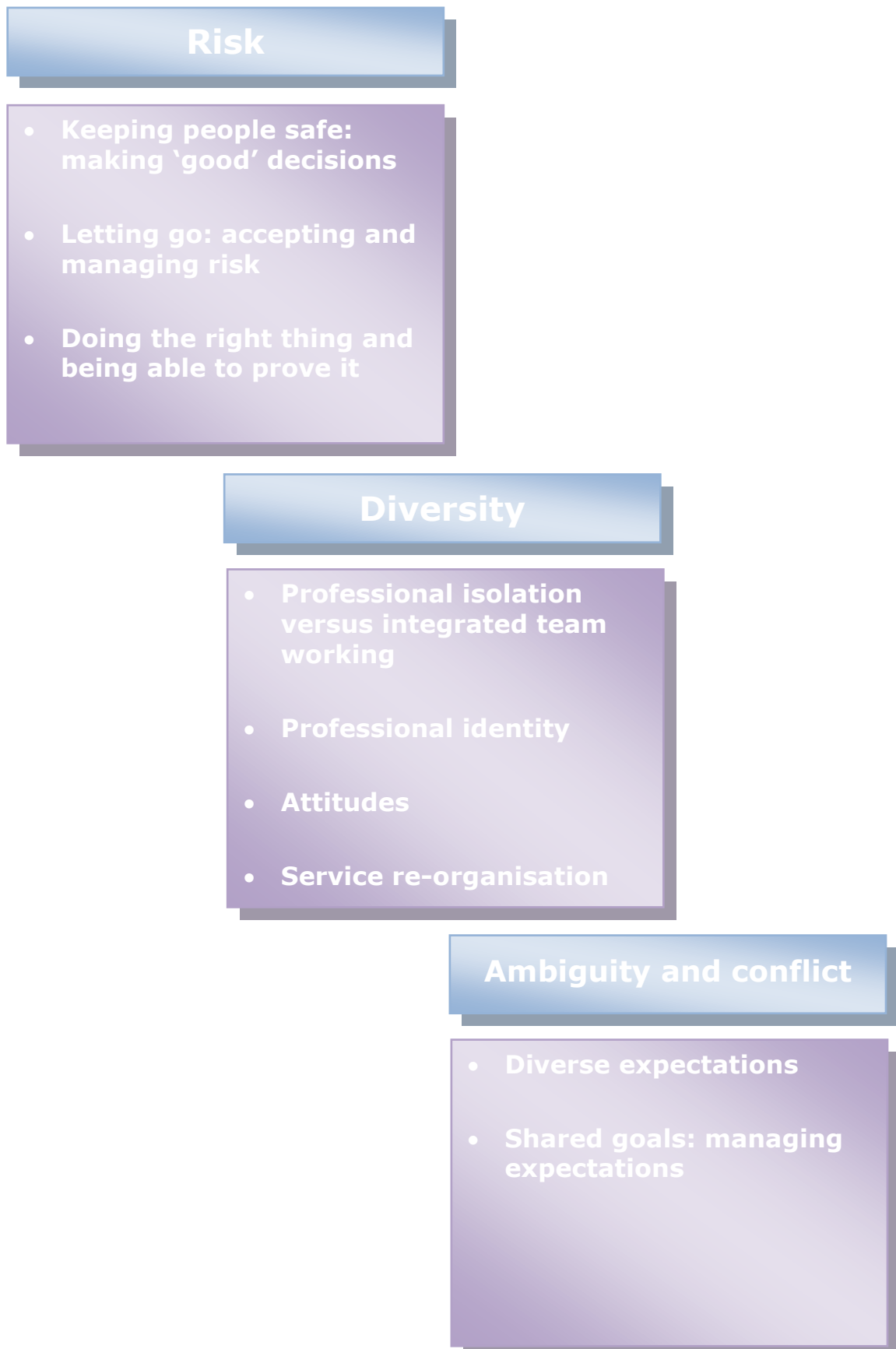
Risk

- **Keeping people safe: making 'good' decisions**

- **Letting go: accepting and managing risk**

- **Doing the right thing and being able to prove it**

Diversity

- **Professional isolation versus integrated team working**

- **Professional identity**

- **Attitudes**

- **Service re-organisation**

Ambiguity and conflict

- **Diverse expectations**

- **Shared goals: managing expectations**

5.2 Risk

The two overarching policy drivers of care closer to home (and thus out of hospital) and of multidisciplinary working to promote co-ordinated care and social inclusion, has resulted in the formation of new teams and an emphasis on independent living 'out of hospital' across each of the three case study sites. This has challenged traditional ways of working and brought the issue of risk to the forefront of practitioners' thinking particularly in sites A and B which were undergoing considerable change. These changes raise issues for staff about how they react to and perform within the changed systems, including within professional-patient interactions, within professional groups and across interdisciplinary teams. Inevitably the emotional work required to manage the risks and 'do the right thing' is considerable.

Risk therefore framed the context in which practitioners viewed the impacts of changes in care delivery and was considered in terms of risk to both patients' safety and to professionals with respect to litigation. The discussion of risk is organised under the following headings:

- New teams and roles: implications for risk
- Keeping people 'safe'; making 'good' decisions
- Letting go: accepting and managing risk
- Doing the 'right' thing and being able to prove it

5.2.1   New teams and roles: implications for risk

Over the last years several new teams as well as roles have emerged in each of the case study sites. Some, such as the Home Treatment Teams (HTT) in site A, are explicitly designed, based on central policy guidance, to provide alternatives to care for people with mental health problems. Others such as the Rapid Intervention Treatment and Assessment (RITA) teams in site C have emerged as a response to preventing admissions for frail elderly people. There has been a related expansion of new roles supporting admission prevention, early discharge and case management. These changes have implications related to risk for the professionals involved as well as for those in other teams. Firstly, the very disruption to existing services of the apparently constant redesign carries operational risks.

Corporate caseloads (defined by localities rather than GP practice) have had an impact on how district nurses work with GPs. High caseloads and responsibility for more than one practice were described as having caused fragmentation of once close relationships and discontinuity in service provision. A practice diabetic nurse described the impact the change to 'corporate caseloads' for district nurses had had on care:

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'We always had two nurses for years that were attached to us and now they are not. They no longer work from a base in the health centre'.

Probe: So has that affected working relationships?

'Yes, it has because if the district nurses were popping in and out you'd say "Oh, can I just ask you…" Or she'd say "Oh, I saw Mrs so and so" and you could discuss their long term condition together. Or she'd say "Oh, I have seen this patient and their blood sugars are up, what do you think?" You know, that sort of thing. Whereas it's much more difficult to do that now' (A01:specialist nurse).

This loss of personal relationship with district nursing arising from organisational change was acute in site A and noted by a GP as having consequences for patient care:

'District Nurses have stopped being attached to practices ….and actually that seems, for the patient, or certainly for us, it seems to be much more inefficient….things take longer to get done and things fall through the net. I can't remember ever a time when I did a referral to a district nurse and what I asked for wouldn't happen, and now I have had to write to the supervisor about two or three things in the last six months, about stuff that actually didn't happen at all' (A02:GP).

This Health visitor in Site B considered the relocation of teams of district nurses and health visitors to different sites away from GP centres had led to poor communication:

'We used to have our district nurses based at our surgery, which was great because we could then have very close communication with them and we still do have close communication with them, but they're now based at our local cottage hospital so it's, it's a bit less easy to have a chat with them because you now have to pick up the phone and try and find them, rather than just stick your head in their office and see if they're there'. (B01: HV).

There was a perception in site A that continuity of care had been compromised by workforce re-designs leading to fragmentation:

'Having a holistic pathway of care involves people from consultants all the way through to care assistants….we remain very fragmented and very uninvolved and I think if we ….had something called co-operative commissioning, if we had a budget that ….was co-owned by primary and secondary care and …maybe with Social Services as well, that we are all responsible for this budget…' (A03: GP).

Secondly continuous change and re-organisation was seen to have consequences for disrupting professional relationships. This reflects findings from phase 1 that professionals who had known each other a long time were more likely *to:*

'network effectively….it's just easier with people that you know very well' (A04: Physio).

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Resources

The development of new roles raised issues for some respondents about the impact on other services and therefore risk. For example, the limited funding for social care has resulted in tightening the eligibility criteria for those with less than severe conditions. Where social care services should be in place to complement the community matron role, their lack was seen to compromise the innovation:

'*…we go to see somebody and actually, amazingly, the reason perhaps that they are not managing all that well is because they are not known to Social Services and they have not got a care worker, and ……they are not really managing very well because the support networks around general day to day things, things like with their shopping and meals….just general personal care, are not even being addressed. And obviously we would try and encourage the person to be optimally independent but if they are struggling and so short of breath that they do need some help…..if they have not got the services in place that would mean that they are supported in a good support network …..then, in a sense, they are set up to fail in a way'* (A05:CM).

For others the changes in the eligibility criteria for receipt of care in mental health in site C has resulted in community mental health teams picking up the pieces:

'*one of the problems is that they are, due to their budget pressures, narrowing and narrowing their criteria and it does allow people to slip between….those who have slightly odder, slightly more unusual problems to slip through the net. We find that they are being, locally, increasingly ruthless at withdrawing services and that really leaves us holding the baby as we are nowhere near as ruthless as they are…it increases our costs because we are providing home care for people whose problems are for instance just vulnerability from a variety of problems, you know, not particularly high IQ, physical frailty, some mental health problems and ….whereas previously we might have shared the costs of that, we are being lumbered with all of the costs'* (C01:CMHT).

Finally the raised criteria for social care meant that practitioners in site C considered they were '*going in at crisis point'* and unable to work preventatively*. (C06: CPN).*

The benefits and downsides of crisis teams

The development of crisis teams, designed primarily to prevent admission, could have generated significant concerns from the practitioners within them looking after people at home who would once have been in hospital. However, such worries were rare and generally practitioners in these teams were advocates of the new way in which care was being provided. Instead it was often practitioners in pre-existing teams who felt concerned about risks resulting from the formation of new teams and in site B there was one

practitioner who described anger among non-crisis team members whose rights of admission had been taken away and that this new team had disrupted integrated working across teams.

Providing a good service may be hindered by the lack of integration between different parts of the mental health service; the 'right' to admit a patient to in-patient services has been delegated to one or two teams within Site C such as the Crisis team:

'Well we work with the Crisis Avoidance Treatment Team(CATT); if we need to get somebody into hospital we can't approach the hospital ourselves, we need to get the CATT team involved. If somebody rings but we perceive that they require hospital treatment or we need to monitor them on their medication for a period of a week, two weeks, home treatment, then we will get the CATT team involved' (C02: CPN).

This right to admit meant that historically mental health nurses would have been able to recommend admission and now they could not. The senior mental health nurse we interviewed regretted this loss:

'Yes, the whole thing on paper looks wonderful, but individual clients don't fit the boxes and, um, again, if you don't have responsibility for an admission, it's much more difficult to then make the case for admission. For example, if you know someone very well you might know that actually this person is going to relapse very quickly and they're going to become very unwell, if we nip it in the bud now that might, that would be much better for them, but if, if, the other person I'm speaking to only can see them there and then, it's difficult to make that case when perhaps beds are at a premium. So those are the sort of difficulties I think we would, we have' (C03:CPN).

Practitioners reported a rupture (in sites B and C) in mental health services, 'the mental health gap', between the well resourced Home Treatment Teams (HTT), whose remit is to reduce admissions, and the less well resourced Community Mental Health (CMHT) and Primary Care Liaison Teams (PCLT). While resources are redirected to reducing admissions, some practitioners in the PCLT in Site C felt there was a deficit of services to support people with long term mental illness who were not at immediate risk of admission, and felt that the lack of preparedness of community services for the reduction in hospital stays was particulary salient for this client group.

Other mental health service practitioners in Site C noted the service gap where access criteria were so circumscribed as to deny services for many people with need, suggesting that the focus on avoiding admissions was having an adverse effect on other mental health service users. They argued for earlier intervention and more services at a less acute phases of illness.

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5.2.2 Keeping people 'safe': making 'good' decisions

Keeping individuals safe and free from harm is a fundamental responsibility for health and social care practitioners and underpins much of the work in long term conditions in primary care. Safety was identified as an important factor in the acceptance of change by practitioners; particularly in mental health where in addition to risks of deteriorating illness, a patient may be a risk to society or a risk to themselves. For this reason the management of an individual's safety is a key theme underpinning mental health care provision.

A safe environment

The environment was described as an essential factor in relation to an individuals' safety. Frail older people, for example, were considered to be at risk for their safety; living at home 'unsupervised' and in a possibly 'risky' environment:

'one of the things that have got worse in the last two years is access to Social Services, so again, if you are talking about this highly-ill co-morbid group at home, then this last year across the country, most local authorities have restricted even more access to home helps and …so I think that is likely to have a serious impact on people's health and people's ability to look after themselves…. I think they will have to spend money on carers for themselves more.., it will be less easy for them to have baths, they will be more likely to slip out of the bath and there will be all sorts of impacts I think that will make life much harder for them. I am sure everyone accepts that that's the case.' (A07: CM).

When required, a safe environment (whether this be at home or in a health care setting) was seen as essential during particularly vulnerable phases of a long term illness trajectory. For mental health users these 'safe' environments ranged from:

- having their own accommodation but with ongoing support from a housing support officer and the MH social worker:

'I am still seeing her, even though she is in the unsupported accommodation in a one-bed roomed flat. And then the scheme, they have got another housing support officer that supports them, so she's seen once a month by them and I see her once every four weeks as well, so she is in accommodation now for 11 months, yes, and she has no sign of relapse. She is very very well, she is on top of her bills, she is saving up her benefits to pay her bills so she is always on time……… So if there wasn't a single flat, I don't know what could have happened to her mental state; I don't know how it would … it was just fortunate she is in this accommodation'. (A08: SW).

- to 'safe houses' where they could be allowed to 'be mad' over a period of time safely as described in the vignettes generated by the local SURG groups :

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> *'a halfway house' or 'safety net' where he could go to get the help and support to recover in a quiet, therapeutic environment'   SURG: MH Vignette*

- and to sharing activities with individuals with similar problems which itself challenged the current drive for 'social inclusion' at all costs: as described in the vignette:

> *'The CPN explained that some of the local day services were actually closing because it was felt that individuals should attend 'mainstream activities' alongside other members of the community. John wondered whether this social inclusion was a good idea since he spent most of his life feeling like the 'odd one out'; it sounded attractive to spend some time with others who had the same condition and who might understand how he was feeling' (SURG: MH Vignette)*

Provision of a safe environment outside the home was not always thought possible in all the sites because of changes in provision, reconfiguration and 'withdrawal' of services. This was seen to have an impact in terms of increased risk in being managed in the community setting.

Good decisions

Practitioners are required to make decisions at critical points when the level of risk has become too much and a crisis has taken hold which would have in the past necessitated admission to a hospital. The introduction of crisis or home treatment teams aims to keep individuals out of hospital by supporting them through a crisis at home.

There was some debate amongst the respondents as to how referral decisions are made, raising such questions as:

- who is involved in the decision making?

- how is risk interpreted? : when is a crisis a crisis?

One of the particular problems identified with individuals with long term non- psychotic conditions was that it was:

> *'difficult to identify when someone with severe depression was in crisis, as opposed to someone presenting with psychosis' (A08: community team).*

Are there differing perceptions of need and therefore risk?

Different professionals were seen to have different perceptions of risk.

> *'by having a general referral system within community mental health teams, the patient could be assessed by a social worker one day and another patient by an OT the next day, and have very different needs identified because each professional was alert for and assessed needs differently due to their professional training' (C04: community nurse).*

Individual nurses from different branches of nursing said that while disciplines within health and social care approach risk in different ways,

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some disciplines were more or less comfortable with risk. As this community matron explains:

'*Many of the other disciplines are quite risk-adverse and say "Oh no, you know, they can't do this, they can't do that. They can't do this, they can't do that." "Well, have you tried? Have you asked?" You know, and I mean we know that some discharges will fail, but if you mitigate the risk as much as you can patients deserve a chance. That's what I mean the number of times we have "I really want to go home, I really want to go home, I really want to go home." And we're all like "Huh, she's going to be a disaster." But you've got to let them, they're not cognitively impaired, they can make their own decisions. And it's what you put in place, but that freaks a lot of people out and they, they back off, they don't want to help, which doesn't make it particularly easy and I think on a personal…I would say that many people in Social Services are quite risk-adverse, but I think that is probably around their own threat of litigation?. I think, I think Health has a lot more power, so to speak, people trust Health more than they do with Social Services, they feel they can beat Social Services with a stick, although Health has had its own fair share of beating' (B03: CM).*

Perceptions of risk also appeared to differ with experience with the more inexperienced feeling more risk averse and this was particularly considered to be the case in site B.

How meaningful are patient choices?

It appears that admission to hospital is refused unless the level of risk is high or there is some medical reason for admission. This contrasts somewhat to the past practice, particularly in mental health, where admission to hospital was an accepted route. The question that the current system poses is whether a decision not to admit negates any sense of choice on the part of a patient who may feel unsafe, suicidal or in need of further referral. In site C there it was considered to be a question over whether this system actually encourages precipitation into induced crisis:

'*you have to be really mad and in decline to get to go somewhere 'safe'*(B04:CPN).

Some patients or clients, particularly those with mental illness, were reported to prefer being treated in hospital, and this could cause tensions between practitioners' and individuals' views of the latter's best interests.

'*I think with some of the older patients who have been service users over the years, perhaps they need to adjust to that and I think that's been a bit difficult for some people, where traditionally they would go into hospital and they might have an expectation that that's going to happen if they become unwell. So I think that's been quite tough for that group of people. I think certainly where it comes to hospital admission with some of the patients that we see who wants admission, they don't have admission and I think there is a tension, definitely' (C05: PCT MH).*

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More than one practitioner across the sites argued strongly that for people with enduring mental illness who were becoming unwell, staying at home was sometimes not the most therapeutic option. There was felt to be a real need for a 'halfway' option, which was neither home nor hospital, such as the provision of crisis beds for patients or clients in this situation.

'*Although we are also obviously trying to… we are hopeful about crisis beds because that would be, that's something at the moment that is in 'planning/about to happen'. That would be brilliant, because hospital isn't always the answer, sometimes people just need to be out of home'* *(C06:CPN).*

It was also acknowledged that little support was available for carers, and that a hospital admission was sometimes the most desired outcome when carers were no longer able to cope.

Caring for people at home carries risks to both practitioners and service users, which practitioners must assess, especially in relation to the advanced skills and new procedures which *care in the community* demands of them. Resources and support must be in place to minimise risk. This community matron, made the assumption that fulfilling the PCT requirement for 'modules' to ensured competency and confidence implicitly, minimised risk:

'*…. thinking about clinical governance, quality of care is really … I suppose the PCT naturally sending us to do the four modules which are compulsory for the role actually ensures then that we are properly trained, we are actually competent in what we are doing and that we have got the confidence to actually go out and use the knowledge and skills that we acquire from the course'* *(A09: CM).*

There was though some concern that training had not kept pace with this requirement for safe practice in site C. But, others disagreed over the appropriate place for providing somewhere safe for patients. In this quote the social worker uses the word 'container services' to describe a service which contains the patient and makes them feel safe:

'*So although they closed down the old day hospital - apparently that was a wonderful service too, but I think it's probably also a bit of a containment service and I really, [know] container services; if somebody is going to go somewhere, you know, they are better off sitting in a pub if they are going to go… because people can be contained in the pub with their friends; they don't need to go to a service to go, you know… to do that'* *(B07: SW).*

And he further justifies this approach by saying that it is inappropriate to admit a patient to a service on the basis of safety if there is no risk; that the risks of admission are equally profound because they become dependent.

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What factors encourage good decision-making?

It emerged that in order for 'good' decisions to be made around risk there were strong views about the need for good levels of:

- continuity

- relationships between professionals

- resources

Continuity

Continuity of care was considered important by service users, managers and practitioners alike, across the three sites for people with complex, long term conditions such as diabetes. Transfer between the increasing number of community teams, either stepping up or down the intensity of care was seen to create risk in terms of longitudinal continuity through:

- loss of tacit knowledge

- loss of trusting relationships

- loss of written clinical information

A community psychiatric nurse (CPN) described the difficulty of working with clients' GPs. Lack of, or one sided, communication between the MH team and the GP about a client's medication for a physical condition posed a potentially risky situation:

'We really need to work with the GPs, we do need to because we are doing one thing and then the GPs are doing another thing. Yes, we do send letters, we make it a point of duty to send letters…..because they go to the GP for other physical stuff, so you would expect the GP to observing as well, as they visit them…and then if they have got concerns then they could liaise with us. But no, we have to do the liaising all the time with the GP' (C10:CPN).

With so many different professionals involved, it was acknowledged that an ongoing relationship with at least one individual in a co-ordinating role was important for high standards of individualised care to be delivered. In mental health services, the care co-ordinator should theoretically stay involved when the HTT or in-patients services are providing more intensive care. Some respondents indicated that the crisis teams had actually reduced the level of continuity with the GPs and community care teams. There was some suggestion that referral to these teams disrupted ongoing relationships but it was not clear that this was any more so than during admission to a hospital setting.

Longitudinal and personal continuity is important in ongoing personal care. There is less perceived risk in decision making when a practitioner is familiar with patients, their symptoms and their ongoing history. Patients can be acutely aware of this as illustrated in the MH SURG vignette:

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> *'all the appointments with his own GP were now taken: John was disappointed since he knew his GP quite well and they had a good supportive relationship....how could he possibly explain everything in 10 minutes to someone he had never met before'   SURG MH Vignette.*

From the point of view of this practitioner, knowing patients over a period of time meant having a perception of their 'norm', making for more effective decision making:

> *'You know what your patient is normally like, you have some idea of the environment they are coming from and that puts you in a better position both to treat the illnesses that come out of their circumstances, but also to be aware when something has changed' (A11: community team).*

However there are many challenges to seamless care:

> *'So seamless care, we've had, well, for one reason or another through the changes in rapid response…. there's been a lot of staff movement, a lot of unhappy staff who've been showing their feelings by walking, so clients have had no continuity of support' (B08: MH practitioner).*

And for one GP in site B, the GP contract was another example of the government's inflexibility in policy:

> *'And a lot of GPs were already using deputising services anyway, but the government made it a bit all or nothing so that if you opted out you had to opt out of doing any out of hours, so that suddenly all the Saturday morning surgeries ceased because if you opted out you opted out and you couldn't say "Well, I'd like to carry on doing my Saturday morning surgery please." Because if you carried on doing one bit you had to carry on doing all of it. **…** so now the government are saying "Well, all you horrible GPs who opted out of providing twenty-four hour care, we want you to do it all because that's what patients want." And in fact the government's surveys show that actually it isn't what the patients want, the patients are actually quite happy with the arrangements that they've got with seeing their GPs and don't particularly want their GPs to work evenings. A lot of people would rather take time off work to come to their GP than, you know, taking time out of their evening to come to see their GP' (B09: GP).*

The consequence of this inflexibility made this GP feel that patients had lost out on continuity of care:

> *' what I do think is more of a problem is the sort of emergency out of hours because I think that can then be very patchy because you're then seeing and being seen by doctors who don't know the patient, who haven't got access to the records that, when I did my training and we did our own out of hours, if I got called to see someone in the night I'd go via the surgery and pick up their records, so I had their records with me. You know, these days you can do it electronically, but if you're an out of hours doctor you don't, you're reliant on what the family or the patient can tell you, um, and that's always been a bit of a problem in out of hours' (B09: GP).*

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Relationships between professionals

In addition to continuity, the nature of the relationships between the different professionals emerged as important. If the relationships were deemed good, subsequent communication and sharing of information was often good. The dynamics of these relationships are discussed in more detail in the diversity theme. Many good working relationships between professionals were described which were considered beneficial to both client and professional. Suffice to say here that several elements were considered crucial to good quality care delivery including:

- mutual respect

'*Having a good relationship between doctor and mental health professional, being able to ring up and chat about individuals, having a mutual respect, has made a huge difference to my handling of mentally ill patients. Knowing that when there is something desperate, that someone will be out there to hear me. And for the sake of the patient, obviously, but developing a kind of respect so that at various levels of mental ill health, stress, whatever, that you can work out a plan for the different types of patients, you work out an appropriate intervention' (A12: community team).*

- good communication particularly at the interface of services to avoid poorly prepared and risky discharges

Communicating and sharing information reduces repetition for the patient; they feel they are listened to and that someone knows about their situation. Concerns were expressed in Site A's LTC strategy document that "Implementation of the Single Assessment Process may fail so that care does not become fully integrated" and that this has implications for risk to the delivery of services to people with LTCs. The single assessment process means

'*[You] wouldn't need to start from scratch every single time with every patient. And I think they would feel that we actually knew something about them…' (A14: nurse specialist).*

- good co-ordination led by case managers with knowledge of all the services

'*I think we, as physio's, have worked very, very hard to cross that interface and engage with what's going on out there….we do feel sometimes that the PCT feels that maybe we are a bit hospital-centric, and we are not at all, we are trying to engage with everybody – just going back to this loop with long-term conditions …you have got to be able to intervene at whatever stage the patient is at, and its having those contacts there……because the community matrons were physically working with us I think it sort of clarified the roles and it just made such a difference somehow……the respiratory consultant nurse ….took the initiative to have all of them (CMs) for a week at a time…work with us whether it be in the chest clinic or going out on visits, seeing patients in the wards, and that built relationships*

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really, really well, as well as being a sort of educational thing' (A14: physio).

Site A's Long Term Conditions Strategy states that 'co-ordination of care between specialist mental health services and primary and secondary care is critical in supporting people appropriately when they are most vulnerable

- time to initiate and build relationships with other professionals

'Time constraints had led to mental health team meetings in one surgery being abandoned for the time being. These had not only provided support in that cases could be discussed in a multidisciplinary environment, but also meant that work with families could be co-ordinated which could have implications for issues around risk and child safety' (A14: community nurse).

Although some professionals viewed liaison meetings more negatively:

'yet another meeting on top of a busy caseload! ; the whole day can be taken up liaising' (C08: CMHT).

5.2.3 Letting go: accepting and managing risk

A key policy shift over the past few years has been towards individuals taking increased responsibility for their own care and for that care to take place within their own home environment. This inevitably requires professionals to be able to manage a certain level of risk at more of a distance within their everyday work. The consequences of 'letting go' is allowing individuals to take risks, but this may have implications for the professional:

'I would say that we are encouraged to take risks with clients in the interests of their, you know, being able to learn from experiences and not being too curtailing of their personal freedoms. But if anything goes wrong, ..watch the flashy lawyers and barristers and the inquiry and all the rest of it…..' (A15: SW).

The nature of those risks were perceived are of the following type:

- risks of working with patients' own decisions associated with assessing risk such as mental capacity i.e. whether patients are able to make meaningful choices and decisions about complex issues

- differences in perceptions of need; the role of the professional to guide them through

- what happens when someone makes the 'wrong decision'

- when and where to refer

- choice and empowerment embedded by clinicians but who may be nervous about taking therapeutic risk because of governance policies and fear of litigation.

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The risks inherent in encouraging patients in self care were mediated, in this GP's view, by NICE guidelines:

' *I mean there are risks, you know, if they are in NICE guidelines then you can feel all right about doing it, it wouldn't be wise to do these things if there wasn't reasonable evidence that they made a difference, but there are risks in it certainly and there are risks in everything'(A16: GP).*

Accepting risk

'Making good decisions' was articulated differently across the professions as covered in section 5.2.2. It is not surprising then that balancing the avoidance of risk to managing uncertainty and being able to let go was alluded to in different ways. Here the emphasis is on the extent to which patients influenced the decision to enable more self care opportunities. As the following quote illustrates, the GP feels that the demand for involvement has come from patients but that there are restrictions on their ability to be involved: mainly those of patient's knowledge (education) and the professional 'allowing informed decision making'. Her use of the term maternalistic is interesting as it is not often a term associated with medical practice:

'I think patients like to be involved. I think they have a right to know what's wrong with them and what can be done about it and I think that the days of maternalistic medicine of sort of "Well, we know best" have gone and I think that's right. I think it should be a partnership, but it's not a completely equal partnership because patients don't know what's available for them or what are the sort of expected ways of treating the things, so we have to, we have to educate there as well and then allow them to make an informed decision. I mean we do get patients who come with a piece of paper, cuttings from the newspaper saying "Can I try this one? Can I try that one?" But equally, not all medicines are appropriate for the individual and I think, you know, we're the ones that are trained for that, so we're the ones who ought to be advising. So I think you can have discussions about what sort of treatment they ought to be receiving, but when it actually comes down to prescription I think that's my job' (B11: GP).

One of the occupational therapists we interviewed felt differently from this GP; she said that occupational therapy practised from the belief that:

'patients know their needs and that the OT worked with them within this knowledge to find 'common' ground': (B12: OT)

Relinquishing professional responsibility: transferring responsibility

Giving someone responsibility for when they should start medication, what dose they should take and when they should take it raises questions about risk, although this was perceived to be mitigated by having the time to provide good information. Practitioners need time to provide opportunities to ask questions:

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> *'Clients are 'not always as interested as they purport they are in surveys….and don't have enough information to make all the decisions….I still don't know that we have enough time with clients to …explain all of the treatment options in great detail' (A17: community team).*

However, no amount of time will succeed if patients are *'unrealistic about what they want to achieve'* (C18: SW).

Supporting self care was seen by professionals as a joint process, which involved professionals transferring some element of responsibility for decision making to the patient or client:

> *'We shouldn't be thinking about more and more intensive professional input, we should be thinking about how to support people to look after themselves…..and that means giving them clear information, giving them support when they need it….shared decision making and increased responsibility for taking over some of the decisions themselves' (A19:GP)*

> *'There is a real deficit in our ability to motivate patients to look after themselves, I don't know how best to do it, it's a particular interpersonal skill…' (B13:GP)*

But it was acknowledged that professionals often find this transfer of power difficult to achieve as it challenged many of the most basic principles of their training and professional identity:

> *'It's training about quite basic attitudes, so it's actually quite likely not to work because what you are talking about is saying to people "Trust the patient, give them the skills to look after themselves, give them powerful drugs that they can use when they need it, not when you prescribe it", and it's a very different way of working I think. You really have to change quite a few basic assumptions that you have as a professional…….there are very few of us that actually major in this approach' (A20: GP).*

This nurse compares the power base when working in hospital and the patient's home:

> *'looking back to my district nursing days, although it was very different because you were in the patient's home and so it was a different relationship, the power base was very different to hospital, I still think you did go in there with that sort of arrogant professional attitude that "We know what's best for you and would be surprised if a patient would snap back and say "Actually I know what's best for me." So I think actually, um, it really made you think about "Well, what does the patient want?" (B14: community nurse).*

Transfer of power to the client is not always possible or wise. A social worker supported the concept of choice but pointed out that there were times, when clients felt suicidal for instance, when, for the safety of the client and others, choice had to be withdrawn, at least for a period of time:

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> '*According to legislation and organisational policies we should be involving clients. I would say that on the whole we do try to involve them. Occasionally its not feasible to leave all the choice to the client, there are some situations, perhaps for their own safety or the safety of others it's just not feasible*' (A21: SW).

> '*For instance, the client is saying "I want to overdose, I feel so depressed I can't cope any more, I am going to take my own life....We have to take that choice away from them, the choice for them to keep their own medication, we have to remove that from that point in time. Not forever, but....at that material point in time*' (A22: specialist nurse).

The professionals interviewed for this project all had very clear, positive views about patient involvement and the majority believed that, with a few exceptions, encouraging patients and clients with long term conditions to be more involved in their own care was key to improving confidence, self esteem and quality of life. In other words, it was seen as the way forward and could be achieved through joint discussions and decision-making. This team manager described how patients and family members were involved in the planning of care:

> '*So it's changed that, it's evolving and we actually get them to sign the care plan and that they understand what's going on and I mean encourage family members also to write in the notes if there's anything they want to know. So I really do feel that the continuity for those people is there and it's preventing crisis management and it's a more co-ordinated caseload management and around enabling as well. Rather than creating independency, it's around promoting as much self-care as you can*' (B10: community manager).

The outcomes of involving patients in their care were usually positive, according to this community matron:

> '*I think when people can manage their condition better I think generally it lends itself to them feeling much better about themselves, they have better self-esteem, are hopefully less depressed, less anxious, more controlled, more empowered*' (A23: CM).

This psychotherapist saw patient involvement as fundamental to the therapeutic process:

> '*by definition I am involving my patients. If they don't get involved nothing happens. I am just the catalyst that helps it along*' (A24: community team).

The point about 'nothing happening' without patient/client involvement was considered essential for ensuring future quality of life, according to this professional:

> '*well obviously it empowers [patients] to make some decisions, it actually helps them I think function in the world around them, it helps them*

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recognise their own abilities and not disabilities, it helps them I think make plans for their future knowing they can manage whatever is going to come along. I think it enables them to continue to function in society, maintain their lifestyles, those sorts of things which I think are very important' (B15:MH worker).

Patient involvement and choice, although they were mentioned as part of the changing culture of care for long-term conditions, did not actually feature prominently in practitioners' responses to the question of changes in care provision. When they did arise there was a degree of scepticism. One practitioner felt that the notion of patient choice was a bit of a spin, deflecting attention from structural aspects of patients or clients' experience over which they had very little control. Another felt that given a cash limited health and social care economy, offering people choices could unrealistically raise their expectations.

Professionals talked about what needed to be put into place to support patients in looking after themselves. This included help with medicines management, signposting to other services, giving them adequate information, helping them understand what their choices were and training health professionals in the interpersonal skills necessary to do this.

'Good care is allowing someone the 'dignity of deciding what they need and what they are happy with….it's trying to provide a service that allows them to make decisions about their lives' (A25: CM).

An important element of the community matron role is to equip patients, especially those with conditions such as diabetes and COPD, to better understand and manage their condition and this involves directing people to useful services, providing information and supporting them in self care.

Control of medicine management requires good information on, how and when to take it and was regarded by community matrons as key to reducing hospital admissions.

This physiotherapist regarded motivation as a necessary requirement for encouraging involvement by service users:

'Being well motivated to enable patients to be more self-caring and take control of their lives….it is, to a degree, within your personality, isn't it? I think generally physiotherapists are very well motivated to make a difference….I don't think we should be doing the job if we are not, you know, devoted to make change….its the positive feedback we get from patients…making a difference' (A26: physio).

Involving patients means that the professional uses negotiation skills:

'I will always say to someone, 'Why do you want to be in hospital, why do you think you need that?' and they will say 'Because I can't cope.' 'So what are you going to do in hospital that you won't do..?' 'Well I will go to the safe house for two or three days.' Or 'Why don't I have the CATT team

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come and see you twice a day and give you your medication and make sure you are OK…'. (B16: MH worker).

Supporting risk management: resources training and supervision

Governance was seen as a means of setting clear parameters for good practice although it was perceived sceptically by some as *'another expectation in an already overburdened agenda'.* They criticised the perceived policy that 'one size fits all' and what they described as the additional bureaucracy accompanying standardised protocols and having to follow NICE guidelines.

Resources were seen to be woefully insufficient. For example:

* the policy drive towards offering Cognitive Behavioural Therapy (CBT) in practices for people with depression but not training enough CBT practitioners

* staffing levels linked to targets (e.g. A&E admissions avoidance) but are not taking into account procedures to ensure full recruitment so that the figures cannot be met

Training for acquisition of new skills was regarded as inadequate:

* clinical governance was perceived as being properly trained; therefore competent and having the confidence to go out and use the knowledge and skills required in different roles

* difficulty finding time for training

The community matron role is relatively new and Site A was in the process of increasing these roles in line with government policy. Many community matrons have been recruited from the district nursing staff and have needed to develop old or learn new skills in order to practice. Extra training in areas such as independent prescribing was described as confidence building and staff welcomed the opportunity to learn and practice new skills.

A good allowance for study leave and other activities like audit and research equipped this doctor *'with more information, more skill, it adds to my skills and a range of expertise'* (A27:GP). Having a challenging role was what kept him improving his skills and expertise.

Support and supervision were described as enabling professionals to cope with the stress of working in today's health environment. The frustrations of the work were described by one community matron as like being on a 'rollercoaster'. There were different definitions of supervision: as well as clinical supervision, it was used in the broader sense of caring for staff and providing support.

Although they were clearly enjoying their new role and relishing being able to work closely, over time, with complex cases, community matrons particularly in Site A described working with people with long-term

conditions as *'difficult and draining and emotionally taxing'*. This is picked up in more detail in Section 5.4.

Emotional aspects of risk

One of the issues this study intended to explore was how staff reacted to the organisational priorities and working within a changing context. Staff were quite clear that supervision was a key element in containing these anxieties. Containment is a useful way of thinking about coping with emotions which naturally arise within caring for patients (no matter what their diagnosis). Many of the staff described feeling (and in some cases) providing a sense of containment through their supervision. In other words, the supervisor attended to the emotions evoked through practice and organisational change;

'If you can't cope with the job it's often of your own creation. Because we have a nurse manager and we have supervision… I mean supervision has been around, I think it's quite important. That's another model that will be there for a while. You know, you can bring that to supervision and you can bring that to your manager. If you don't want to bring it to either, that's your choice; and if nothing happens, that's your choice as well' (B30: community nurse).

The emotions evoked in practice are illustrated in the following quote where the CPN suggests that rather than seeing people as mad and the professionals as sane, we should see ourselves as all mad:

'When I worked in the mental hospital in 1979, there were thousands of patients there; you thought they were mad and you were sane, but in fact we were all mad really' (B32: CPN).

This empathy with people with mental health problems was expressed clearly by several participants:

'But I have got past that feeling of pity; I don't pity my clients at all because that patronises… they are people… and in fact in mental health I was quite surprised when I come in, because I didn't realise that mental health was just the same as mainstream. People with mental health problems can … be as normal as you and I, with an illness, with difficulties and maybe just haven't been given that push, that advantage, earlier on' (B34: CMHT).

The effect of working in a stressful environment sometimes seems overwhelming as this care manager describes her sense of things 'crashing in' and her responding by being 'a bit robotic'

'if people are stressed and you say, hang on, you know what if it was you, what if it was your mum? what would you do? what would you want? … and they calm down because you do get it in your day-to-day experience too. The risk is that everything crashes in and you don't think and because you become a bit robotic' (B35:OT).

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And again later in the same interview, this OT said that at team meetings sometimes the stress about patients can become too much and the staff can moan and reflection is needed to defuse the situation:

'It's that kind of slow drip rather than big bang every six months; it's just whenever the opportunity arises you do it [reflection]' (B35: OT).

The impact of change on emotions

The rate of change and the number of new initiatives created feelings of being overloaded and overwhelmed by staff as this mental health nurse describes:

'The one drawback I think there is, is that they (the changes) are all coming out at the same time and I think people feel overloaded. There seems to have been over the last two or three years, we have just been bombarded with them, and I mean I know I certainly got to a point of thinking - where are we now? I felt if I heard one more new initiative, I thought I was just going to give up because I just couldn't cope with any more' (B36: CPN).

However, it seems that stress is reduced if the reasons for change are more clearly explained*:*

'It doesn't feel like that now because things have become much clearer. I think if you understand why things are being done it helps so much, and I think that's what was lacking' (B36:CPN).

5.2.4 Doing the 'right' thing and being able to prove it

Staff considered that in the current climate, they needed to be transparent and 'auditable; and as one social worker described, 'bulletproof':

'If you are bullet-proof … if you compute… I have computerised everything ……I have learnt that doing something the easy way will come back and bite you and it does to my work colleagues time and time again…. there's no easy way of doing it' (B09:CPN).

Professionals appeared to be very aware of litigation and the perceived risk to their professional standing and reputation if things went wrong. As one of the community matrons observed, practitioners use training and their own judgments as ways to maintain safe standards which reduce risky practice.

A major influence on risk was the recently introduced Mental Capacity Act, which means a service user can discharge himself and place himself on the street in a situation the social worker finds unsafe but is for the patient his choice:

'If a gentleman just wants to up and leave where he is at the moment, [he] has the capacity to do that. And regardless that I was telling everybody that although he had the capacity to do it, his mental health might mean that you know, he won't get on very well, I am told that… well regardless whether you make the assessment that he might not get on very well based

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on past history, he has a right and choice to have that opportunity to make that mistake, and I … that kind of freed my feeling that you know, I am leaving somebody quite in a desperate situation. It's not desperate to them because they are quite used to living on the streets, taking heroin, drinking, living in the cold, being kicked, being spat on by members of the public, you know.

I am not used to that, so I will always try and fight somebody not to have that, but the Capacity Act enables people to carry on with kind of resistance which .. I suppose that's a choice isn't it? Although I sometimes wonder… I just think it's an excuse just to give people … not to provide a service basically. I always feel that that undermines it all for like their community care. Get people out in the community - is it because to give them choice, or is it because you know…? This argument has been done over and over and I don't want to reignite it' (B02: CPN).

5.3 Diversity

Four themes relating to diversity in professional roles emerged from the cross-case analysis, which are described as follows:

• Professional isolation vs integrated team-working

• Professional identity

• Attitudes

• Service reorganisation

The phase 1 findings revealed that partnership-working was considered to be key to achieving cost-effective and holistic care for people with long-term conditions. Successful partnerships have formal written agreements with clear governance requirements and pooled budgets. Less successful partnerships can be hampered by reluctance to change, staff feeling daunted by what seems like a deluge of targets, audits and reviews, incompatible information systems or a frustrating time-lag between knowing what to do and receiving the resources to do it. Sharing the responsibility for provision of good quality care through joint management posts was regarded as essential to successful partnership-working.

The single assessment process was given as an example of a successful partnership initiative that has solved the problem of duplication of procedures and records. Effective interpersonal relations, mutual trust and willingness to take risks were regarded as essential in achieving effective working across former boundaries but were hampered by organizations still in periods of destabilization and with independent management systems.

Financial reward was identified as an incentive for GPs rather than other staff although the increase in funding allocated to primary care was identified universally as an incentive. Attention by managers to personal

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development and career pathways of staff through training, supervision and conferences was seen as a strong motivator that enhances job satisfaction.

Integrated team-working with supportive colleagues was identified as a motivator of prime importance for staff. By contrast, factors contributing to demotivated staff with a resulting negative impact on patient care were described as:

- a culture of constant change and targets

- insufficient resources

- staff shortage leading to overload, stress and burnout

- tension at the interface between services.

The themes discussed below reveal considerable congruence between the views of professional staff working at the frontline and the organizational culture described by managers in phase 1. Views of staff were often extremely positive although further action led by managers was seen to reduce the more negative experiences and improve outcomes for clients with long-term conditions.

5.3.1 Professional isolation vs integrated team-working

Integrated team-working was seen as desirable. When it works well it was described as having a number of functions: providing support, preventing isolation and providing a learning environment within which professionals feel they can become better practitioners. At an organizational level, team-working was said to provide stability, which benefits both staff and patients.

Working as a team was enjoyable when seeing someone recover could be 'celebrated' by the whole team together.

These two doctors were enthusiastic about the 'shared vision' of successful integrated team-working though they had different views on the process involved. The psychiatrist took an authoritarian leadership role to motivate and manage what was described as 'my' team:

'What has enabled me recently to provide good care is having clarity about what this team is actually for….what our role is in the food chain, and that has really helped me motivate my team, guide my team, direct my team, and also myself, to, you know, have a sense of purpose' (A27: community team).

Whereas this doctor in intermediate care took more of a democratic, consensus approach to team-working:

'It's good to work with a team where you can agree on how you work together and having that kind of support that you fit in with what each other feels is needed. And I find it great to be with these professionals in other branches of medicine who can actually point out things that I wouldn't

necessarily notice….I am not trying to walk them [clients] up and down and I am not watching them feeding, I am not changing their incontinence, and having people who point these out and say "we should be doing something about this" actually helps me to be a better doctor…. and together with their work and perhaps if I have something to offer, then you feel like there is a joint effort, that someone has improved.' (A28: Doctor).

The ease with which new skills can be learned by working closely with professionals from other disciplines was raised by this social worker working in a home treatment team:

'People are generally very keen to share their knowledge and to share information. And perhaps that's because we see ourselves as being part of the same team' (A29: SW).

There were many illustrations where integrated teamworking was successful and enjoyable. One nurse, for example, maintained that providing a range of services in the GP surgery, such as 'bloods' and foot care, and enabling people to make appointments where everything was done at the same time:

'helps people who are essentially housebound. What was not raised, however, were the potential disadvantages of locating services in one large centre if it means greater expense and longer travel time for clients who have to arrange their own transport (A30: practice nurse).

This diabetes nurse spoke of the rewards in terms of colleagueship when integrated team-working is working well:

'It's a really nice environment, I feel I am very privileged to work here, they are a good bunch…and they have got a good ethos, and so therefore everybody is pulling in the same direction, so it doesn't feel like I am on my own' (A31: specialist nurse).

A GP in site C emphasised the need for support and respect for each other:

'I am extremely well supported and I have a wonderful bunch of doctors and nurses and the staff here. We on the whole do look after each other, particularly in crises we are very nice to each other and very careful with each other' (C09: GP).

Integrated teamworking is more likely than isolated working to be able to provide holistic care. Many professionals considered the best outcome for people with long term conditions to come from a holistic approach to their health and well-being. Building a good relationship over time with an awareness of all aspects of a patient's life was important to this district nurse who thought it not only provided an extra dimension to their practice but improved patient outcomes in the long term:

'It's the continuity of dealing with the same patients over a period of time…it just evolves really.' (A31: community nurse).

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Local initiatives specifically mentioned by practitioners in Site C as positive changes affecting their work were a home treatment team, the appointment of a long-term conditions manager, the opening of a local care centre and the imminent changeover of the district nursing service to a 24-hour service.

A minority view was that the changes had not affected practice at all:

'*In terms of what I do, the structure is constantly evolving around me, but the nuts and bolts of seeing people remains much the same. In all honesty I don't think there is a significant difference in terms of providing care, between now and maybe 10 years ago'   (C10: CMHT).*

For the majority, many aspects of changes in care delivery were regarded positively. Community care for people with long-term physical conditions was felt to be an opportunity for practitioners to learn new skills, and to enhance career development and raise the profile of their profession, particularly for nursing, as well as being better for patients. Change in itself could be regarded as a positive and stimulating aspect of the job. Continuing care was felt to be an excellent service and integrated care management was also regarded positively as a general principle:

'*I can only see it from the positive at the moment in what I found by working in this particular way, is that I can support the clients through the system, where they might have got held up or blocked because I can negotiate with the other agencies and understand what they are talking about. I can also come back to my agency and explain to them why things aren't done as well. And this misunderstanding about it's their responsibility, no it's your responsibility diminishes because it's really lack of understanding, so I can straddle both now and I can explain both sides. And also I can support the process through the system because I understand the system, on a wider scale than would normally be, for our may be social workers and community care workers who are doing care management. They only see a part of it, where I see a much longer process and can interject within that process to move people and get them through the system where they would have got blocked before. And maybe I can also advocate for their case along the way' (C11: SW).*

Not everyone subscribed to the view that full integration of services was the best model:

'*I wouldn't like to see Social Services and the NHS fully integrated. I think that slight tension between them does two things. I think firstly it develops a little bit of conflict which is no bad thing and I think the other thing is, it allows Social Services and presumably the NHS to be able to spread their wings a little bit further with regards to say adult protection, housing, voluntary groups. And I think the expertise is sufficiently pooled, but I think there would be duplication were we to become fully integrated. I know that's the model and some people regard it as an inevitability, but I can't help but think it could be a little bit of a mistake' (C12: SW).*

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Commitment to the principle of integrated teamworking does not mean that it is always achieved. Teams that do not work well together were thought to have a negative impact on clients, creating what was termed 'flash over' when mental health clients noticed a 'bad' atmosphere which left them feeling unsettled and distressed. In one site continuous and close co-working was thought to lead to high levels of stress, and personality clashes were not unusual. Professionals were also dependent on other colleagues working efficiently and on pulling their weight. If this didn't happen it could impact on their work. In another site, practitioners found integrated teamworking was not working: they described practice as fragmented and disjointed, with confusing systems of access to services. Gaps and lapses occurred in service provision for maintaining people at home when they become acutely ill and the ability to provide a rapid and reliable response would break down.

Reasons given for this failure focused on contextual features of the organization as well as problems among team members. Contextual features included: scattered service locations, insufficient and frequently changing staff and a pace of change regarded as too rapid and unnecessary. Mutual respect amongst different professionals was sometimes lacking and functional relationships would break down. The result could be weariness in practitioners who lacked motivation to keep track of a system that they saw as complicated, counterintuitive and operating at the expense of ensuring a properly staffed service. There was felt to be a real need for a period of stability, to slow down and see what works:

'… certainly in my own caseload and within our team, I find some of these care packages very fragmented. And to maybe get a social care package it's very difficult for me to initiate that or instigate that. It has to go through a whole referral process which is laborious and tedious and repetitive, so that makes that very difficult. And also accessing even within our own trust the therapy services, to enable people to stay at home. I find the system very confusing and if I find the system confusing, I am sure most other people do as well because I have worked here for a long time. I think because there are lots of little pockets of therapy. There's a therapist that works with this onward care team, there's one that works with complex discharges, there is one that works with RITA, there's one that works with Reablement and they are all managed differently. So I just find it very difficult' (C13: Community nurse).*

Learning of a new service was not always well-communicated:

'… you will find that there is a team that has sprung up probably six months ago that no one has ever heard of. And it's the luck of the draw that you know about it' C14: social worker).*

Keeping track of new policies in continuing care when they emerge 'every six weeks or so' was becoming impossible for some amassing up to ten folders of information.

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A negative outcome observed of the rapid pace of change and innovation was that some policies were issued but never implemented. Government policy on integrated care was given as one example. *New Ways of Workin*g was another.

Fragmented care packages and cumbersome and repetitive referral processes occurred with isolated working practices. Physiotherapy and occupational therapy services were described as 'thin on the ground' and a community matron described the difficulty in getting these services to respond to referrals. By contrast, a community psychiatric nurse found it very easy to gain access to other professionals; response to clients in mental health was rapid and their needs would be met. This difference between services may reflect different levels of resource availability in mental health compared with general health services or, perhaps, a difference in perception of client need by the professional in receipt of the referral.

Integrated teams with the specific remit to prevent hospital admissions understood that they were privileged in terms of resourcing, staffing and recognition, and that this had a positive effect on team spirit and performance, an effect which was enhanced by having clear targets and outcome measures. A cohesive and stable team was regarded as a supportive environment in which to work. Stability and maturity, in terms of low turnover and high levels of experience and skill positively affected team cohesiveness and effectiveness, as did good management, defined as supportive, fostering feelings of being trusted and respected, flexible, effective at providing information, 'fighting' for resources and recruiting appropriate staff. The opposite effect also operated, with poorly resourced teams with less concrete objectives experiencing low cohesion, poor management and poor effectiveness. Team support could be informal and *ad hoc* or structured into regular meetings. Supervision was a major and highly valued source of support. Local authority staff in integrated teams managed by health staff said they lacked team, management and supervisory support.

A perception among health professionals was that social work was 'laden' with paperwork and this made working as partners between health and social care agencies difficult because of the inflexibility of social work systems.

Others working in teams where the paperwork was shared or who had clerical support, found it less burdensome. Effective electronic systems for recording information were also appreciated. Nevertheless, the ubiquity and volume of paperwork remained a major problem, exacerbated when there was inadequate computer access.

Lack of harmonisation between health and social care targets, eligibility criteria and governance requirements was seen as a challenge for integrated working. Health staff perceived the local authority as too target-focused,

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with frequently changing targets and eligibility criteria. This was felt to affect access to services for some people who were not accorded priority by the targets. Duplication of paperwork was identified as an inevitable consequence of isolated working:

'*We have just had a meeting this morning and at the moment they're looking at integrating their files, i.e. there will be one medical file, one care coordinator's file and one psychology file. They will all be together. But Social Services are not interested in taking part in that because of their performance indicators. They can't, they apparently cannot pull their performance indicators from health's. So it may be a case of nobody's recording ethnicity or something, and therefore you are left to do a whole set of other paperwork' (C15: CPN).*

In general, the view was that the partnership afforded by integrated team-working was a model that could successfully deliver good care to people with long-term conditions. Few practitioners thought it always worked effectively, however. Problems could occur at every level so interfering with continuity, for example: GPs refusing to refer clients to community teams or to make home visits; referrals not followed up by the community mental health service or difficulty in accessing the team; interface difficulties with the acute team or home treatment team; and interface difficulties between health and social care (different working practices and styles of management, different criteria for governance and client eligibility, incompatible IT systems).

5.3.2 Professional identity

Different approaches used by practitioners from different professions in the same team could hinder integrated team-working even though both were committed to high quality care. This community psychiatric nurse described the nurse's tendency to do things for the client in contrast to the social worker's efforts to promote the client's independence:

'*I think the nurses go a little bit more…to meet the clients, pick up prescriptions and collect medication but SWs say the client should go themselves' (B11: CPN).*

The differences in approach could be resolved if nurses and social workers had training opportunities like doctors in F2 training posts do. A GP referred to the:

'*positive' experience of having to spend four months in general practice settings during training   to improve their understanding of the different primary and secondary care cultures'(A31: GP).*

Another difficulty, raised by an occupational therapist, was whether a 'general referral system' within community mental health teams made variation in assessment by different professionals potentially unsafe. If one patient could be assessed by a social worker one day and another patient by

an occupational therapist the next day, they could have very different needs identified because differences in training meant that each professional looked for different needs and assessed them differently. Shared training could resolve this problem and could avoid the risk of incomplete assessment done by practitioners from one profession.

Most practitioners recognized that continuity of care, duplication and having to be assessed or cared for by a number of different practitioners, who often did not communicate with each other was a real or potential problem for clients. Integrated team-working was not happening, as this nurse observed:

'In fact one nurse went in with the district nurse as part of her induction, to a patient who was having six different services in and none of them were talking to each other. Some people have voiced the fact that if they have got a carer going in and then a district nurse and then maybe later in the week a phlebotomist needs to go to take blood and then they have… and they will say 'I am fed up with people coming through my front door' and some people do voice their frustrations' (C16: community nurse).

It was anticipated that a newly appointed long-term conditions manager would be successful in reducing the 'stream of professionals' attending each client. Another potential solution suggested was to weaken professional boundaries so that practitioners could perform roles now performed by different services. A common set of notes would also help achieve continuity of care delivery and prevent duplication.

5.3.3 Attitudes

There was a view in mental health that professionals in other services do not appreciate the changes made in mental health services and continue to stigmatise clients:

'I think, um, there is, you know, for someone that self-harms and goes down the surgery to be patched up I think some professionals are quite ignorant towards what they're dealing with and I know comments have been made. But it is, it's making it an awareness that these people don't really want to be like this, you know, and it's just part of them as they are, you know, and generally something has happened to them to be that way as well' (B12: CPN).

GPs were singled out as being particularly behind the times in their attitudes:

'Historically, once in mental health service patients could be there forever. The service had changed to allow a mental health problem to be temporary episode but this change was difficult to implement because of attitudes towards mental illness among GPs' (B13: GP).

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And also in their understanding and appreciation of the value of new roles such as the community matron:

'The introduction of community matrons in Site A has been problematic, with GPs initially resistant and exhibiting a lack of understanding of their role '(A31:CM).

Poor attitudes between professionals from different services can lead to breakdown in communication (poor communication is also addressed under the earlier theme of risk). One view was that interprofessional communication has become fragmented, because the time and resources needed to set up or attend team meetings was lacking. This inadequate communication was said to be adversely affecting outcomes much more than in the past when it was accepted as essential to the provision of a good service to clients.

There was some evidence that interprofessional team meetings were necessary in addition, rather than instead of, the traditional practice of meetings held by each profession independently. Much as each profession may prefer the comfort and security of traditional practices, time and resources would be saved and communication would be improved by replacing single-profession meetings with multiprofessional team meetings.

An example of the security afforded by the uniprofessional meeting was couched in terms of colleague support by this community matron who explained that four community matrons working together had built a team 'camaraderie' where they felt relaxed about asking each other 'silly questions' without feeling they might be judged by their peers:

'It's supportive being part of a small little team of community matrons and lifestyle assistants … who are doing the same job … we are in the same boat and they would also understand some of the frustrations…I think being in this role as community matron has been a bit of a rollercoaster and people initially were highly sceptical of it actually, and that was difficult … just sort of working in a role where people weren't sure really what you were doing and the usefulness of it' (A32: CM).

For a new role still feeling its way in what may seem a somewhat inhospitable environment, it is understandable that community matrons' main support comes from other community matrons with whom they are able to 'de-brief' and reflect on practice in an informal way. The need for similar meetings for professionals in established roles is more questionable. Ground rules made explicit in multiprofessional team meetings would prevent loss of self-esteem, lack of trust and lack of respect amongst workers from different professions.

5.3.4 Service reorganisation

Professionals acknowledged the need for reorganization of primary care so that the right person did the right job. A GP believed that primary care is

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now organized in a way that allows professionals to give people time and the GP is not always the best person to provide care. An essential element of moving care into the community is the creation of new roles, such as the community matron, and reorganized services, such as home treatment teams that are time-limited but can give clients as much time as is needed within the allotted time.

According to a social worker, home treatment teams in mental health had the resources and flexibility to give clients the time they needed compared to the larger caseloads of the more impoverished general mental health services. This view was endorsed by a consultant psychiatrist who emphasised the focus of the home treatment team on client selection and flexible treatment options:

'Selecting the right patients who actually have the possibility of benefiting from the interventions that we have available…and being realistic when there isn't a team that matches a patient, and finding a solution which may need to be more creative' (A33: community team).

Resolving conflict

By contrast, the lack of appropriate services to refer long term complex mental health users to was identified as a particular problem. It was felt that referrals could be made to services such as counsellors but that after a six week treatment time the patients were 'bounced back' to square one with the health professionals looking for suitable options.

Signposting and provision of information repeatedly emerged as key issues and were perceived to be a benefit of the community matron role. Information was not considered available on the diverse services available. There were folders available with service information but it was considered that these became out of date very quickly. If there is an expectation for self referral there needs to be adequate signposting.

5.4 Ambiguity and conflict

The different and sometimes divergent expectations of professionals, patients and carers in terms of care delivery emerged as an important theme. The discussion of the ambiguity and conflict that arose is organised under the following headings:

- Diverse expectations
- Shared goals: managing expectations

5.4.1 Diverse expectations

There are differing expectations at all levels:

- for example policy makers vs professionals

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- professionals vs professionals

- professionals vs service users.

These expectations were not always seen to be totally compatible.

What is expected of professionals?

Practitioners in site A reported being put under severe pressure to perform within certain targets that they did not always support and that were not always good measures of their work:

'What worries me particularly is the expectations…that what I do can always be measured with some outcome measure and I think we are moving towards a time when people will be looking and wondering about one's effectiveness in terms of outcomes measures; that's a worrying development…and it seems to be a rather crazy misunderstanding of what the kind of work I do is about, that it can't always be quantified on a 34 item questionnaire' (A34: community team).

As one GP points out these papers are not always explained and communicated clearly by the PCTs and that a level of engagement is necessary*:*

'Nobody tells us about them and the PCT hasn't made it its job to engage with clinicians …my guess is that successful PCTs are much better at engaging practices and ….having a dialogue with them and saying "this is something that we all want, isn't it? Let's try and see how we can work on it together" and some PCTs are better at doing that than others' (A35: GP).

Interpretation of policies seemed to differ amongst professional groups, for example:

'the interpretation of policy differs depending on professional background of those in 'top management' (e.g. nursing/social work). It can be a struggle to work with this'(A36: SW).

It was clear that professionals considered the targets and guidelines are simplistic and didn't acknowledge the complexity of long-term conditions*:*

' More and more policy directives (eg NICE) assume people only have one condition, but mental health complex. 'What is often not acknowledged by all these policies is often the people we are dealing with have personality difficulties and it's not that easy to meet recommendations because of the very nature of the work we do' (A37: community nurse).

It was seen as the manager's job to implement new policies and to keep staff informed of changes in practice and expectations:

'the task of managers is to implement policies, 'and it's about how do we get that filtered down' – need how to communicate policies to staff. Was better when worked in social services: 'we had to do it and show we'd done it.. and it was just more structured…' in health 'I don't think we had time to

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> *look at policies in that detail. We might be told "there is a change to a process because of a policy", but we wouldn't link it…we wouldn't really be made aware of the whole thing' (C38: specialist nurse).*

Respondents universally reported the benefits of clarity over what was expected from them:

> *'It's nice to have the awareness of what the expectations are because then…you can see that you are working towards them. And I think as well you can obviously support your staff and develop them more and they are more knowledgeable if they are actually going out and there is a change to the service' (B15: community nurse).*

Implementing policies and meeting targets successfully was reported to depend on adequate staffing to be able to actually achieve them and having the systems and resources in place to enable staff to meet them.

Expectations of rewards

The introduction of clear financial incentives emerged as a powerful incentive for improving practice, especially for GPs:

> *'[Iona Heath in her BMJ articles] accuses us of being mechanistic and I think those are elements, but I also know that before I had those clear incentives I knew I should do these things, but the evidence is clear I didn't do them as well as I am doing them now……if you have a system in which primary care are self-employed entrepreneurs….then financial incentives are going to be a key way of doing it….and love and care and doing a good job and all of that is important, and peer review is important and doing better than our neighbours and thinking about the best thing for the patients is essential, and we are not just mercenaries but its not as powerful an incentive, I'm afraid, as financial ones, in my view' (A35: GP)*

Others saw the rewards of working with complex cases in broader terms:

- Governance: one size does not fit all; bureaucratic expectations and how these don't necessarily 'fit' professional expectations

- The emotional work of dealing with complex cases in a complex system can result in positive feelings of empowerment and achievement as well as negative feelings of anger, resentment and emotional withdrawal.

For employed staff on fixed salaries, professional and personal incentivisation to involve patients in choices and to work in a multi-disciplinary team were seen to be enhanced by providing:

- excellent supervision and support

- flexible unified record systems; support and positive approbation for making autonomous decisions

- systems for learning from individual and system errors

- and systems of feedback relating to targets which encompass both the individual practitioners motivators as well as corporate requirements.

For individuals who are self employed, the above appeared to hold true but systems for developing them may need to be incentivised within contracts or broader frameworks for professional practice or being part of the NHS/social care system.

Further incentives relating to specific system and patient level targets relating to the specific requirements of contracts may augment performance in key areas.

Such specific targets have the potential to divert resources (financial, workforce and emotional energy) from the broader agenda of achieving flexible individualised care.

Time: Conflicting demands

A strong view from service users in the SURG groups was that they appreciated professionals who were friendly, who had the time and willingness to listen and explain things to them and who were patient, non-judgemental and respectful. The changes in service were seen to have had an impact on how professionals are expected to work and this reportedly causes emotional stress.

Using time effectively was said to save time in the longer-term and improve patients' outcomes.   The view was widespread that time had been eroded over the years through constant policy changes that contradicted earlier policies. Related to policy changes were demands of 'paperwork' which were seen as excessive. A social worker said he could just about cope with the demands of paperwork together with the needs of clients and any slack in the system had long since disappeared.

Too much paperwork was raised as a constant bugbear. New computer systems, noted particularly within one mental health trust, did not work properly and made documentation time-consuming and frustrating. This CPN attributed low morale among nurses to increased paperwork and fewer and more inexperienced staff:

'Too much paperwork and too much "tick boxing" eats into time available for patients' (A36: specialist nurse).

GPs also criticised the 'tick box' approach to target-setting and its impact on quality of care. Time spent gathering information required by the Quality and Outcomes Framework was seen to have a negative impact on the quality of consultations, as this GP said:

'QOF can predominate your approach to LTCs. Following this agenda means no time for 'creative' questions …something that can unlock their [clients'] own capacities' (A37: GP).

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The New GMS Contract, which came into effect in 2004, requires GPs to gather information on patients in order to achieve set targets, which determine how they are remunerated. Whilst acknowledging that evidence based incentivisation is useful in that it sets basic standards, there is some disquiet about its impact on holistic care particularly in site B. A practice nurse thought incentivisation could divert professionals from identifying what was really worrying the patient. A support worker agreed, adding that time to establish relationships with clients and carers was important, especially if the assessment asked intimate and possibly intrusive questions:

'On the whole it is going to be a signposting and making them aware, but also making them aware they can always come back to me if there is a problem, it is a shame really because I think, you know, it takes people a lot of time to open up' (B17:CMHT).

This specialist nurse agreed that priorities had shifted in site A from focusing on the client's needs to an information gathering exercise, although she was quick to say that she could work autonomously and her time was not restricted:

'I sometimes think, from a personal point of view, when you look at a person's consultation, you have got all this information of what you have collected on them, you know, whether they smoke and all this sort of thing and then at the very bottom is actually why you have made contact with them and sometimes you wonder whether the priorities are quite right… in that it's about gathering information rather than…… me talking to the patient about what is the problem, or what is the worry. I mean I don't think it is, I think it's just the way it looks when you record the information like that …'(A38: specialist nurse).

District nurses, particularly, were finding that lack of resources, time, and low staffing levels were making their job highly stressful, if not virtually impossible, and this was having a big impact on levels of job satisfaction. This district nurse was aware that she was not performing at the level she considered necessary to provide good care. Not only did this result in a lack of job satisfaction but it meant she was often unable to sort out problems straight away and had to take them back to the GP surgery and leave someone else to deal with it:

'I am always rushed and going on to the next job and may be the patients can actually… notice…you know, that little special 10 minutes/15 minutes that you would sit with them, sort out a problem' (A39: community nurse).

Time for adequate professional patient interaction

The ideal length of a consultation with a client varied for different professionals. A high-quality consultation didn't necessarily have to be a long one, according to one GPs view. By identifying and focusing on the issues that were most important to the clients and by controlling time in such a way that they felt listened to, a good outcome could still be

achieved.   The nature of the GP consultation was important to service users, however. It was clear that spending sufficient time with clients to understand and meet their needs was essential and that quality of contact with a client was more important than its length:

'if you don't care then any amount of time is time not well spent!' (B19: social worker).

In site C, most health workers felt they could give more time to clients in the community than they could in a hospital setting and felt very positive about that, feeling that this enabled them to take a more individual and person-centred approach that was relevant to a person's individual needs and situation. However, a balance was required between giving clients enough time and coping with other aspects of the job such as the paperwork, attending meetings and maintaining and updating skills:

'Giving time to clients has a negative effect on the member of staff. Because you accumulate masses and masses of notes and paperwork so you just take all that home then, and do that rather than it impacting on the actual physical care that you are giving somebody' (C18: CPN).

Time for reflection had disappeared, according to this worker:

'Because you need time to think and reflect and make sure that everything is clearly explained. Which does take time and I think that's the problem, you don't have thinking time any more. You know, it's really hard to find a moment to really consider the options and the different choices' (C19: SW).

The best way of balancing the demands of the service against sufficient time for high-quality contacts with clients may lie in continuity of contact. An hour may not be needed if a professional-patient relationship develops over *accumulated* time even if each individual appointment is only 20 minutes, as this GP suggested:

'You know, when I see people with recurrent depressive illness they, they often like to stick to the same doctor because actually they don't want to have to revisit it every single time and explain why they're feeling like this or what's happened to them. So I do think that's important and I think it's important, for families to know the carer, the health provider' (B21: GP).

He added that a barrier to establishing good relationships and assessing the whole family was seeing patients in the surgery rather than visiting them at home. Mental health professionals believed that the amount of time given to those seeking help, especially during the initial stages of care, could have a direct impact on how well the client fared in the long term:

'First of all that improves the patient's engagement [with] the service' (A40: Doctor).

A community psychiatric nurse augmented the point by emphasising prevention: having time to address all aspects of a client's life enables them to take the holistic approach needed to prevent relapse.

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Many practitioners expressed ambivalence because they saw governance as necessary yet described it to 'gets in the way' of good care:

'I suppose the paperwork side of things feels like it gets in the way. I mean taking the step back from it and seeing it as part of the whole system, then you can see the place for it, but when you're there trying to do the stuff, it actually feels like it's actually not to do with the patient, it's to do with telling everybody else what I've done with the patient, which everybody else does need to know, and so it's important. But you know, it feels like it gets in the way' (C20; CPN).

Using time effectively was perceived to save more time in the future and improve patients' outcomes despite time being perceived to be consistently 'crimped' over the years through different policy changes.

5.4.2 Shared goals: managing expectations

Good care was defined as helping patients feel happier in themselves with the aim being to improve well being. This doctor thought good care came from not necessarily curing an illness but helping someone through a crisis and enabling them to feel that life was still worth living:

'its always nice to have people say what a good doctor you are….but it feels a bit hollow if you are actually not achieving very much and I do like to see people actually getting better and being happier in themselves and achieving things….it's not necessarily curing an illness but coming through a crisis, feeling well, feeling that life is worthwhile again. And we don't necessarily achieve that by curing people…because a lot of the time you can't cure' (A40: GP).

However, it was clear that it requires perseverance to work with someone with a long-term condition over time and to accept the limitations of what can be achieved:

'It's quite interesting to get to know somebody, understand them, get to the bottom of their problems and start the thing off. It's slightly less fascinating to flog it through to the bitter end…..it's something that we're working on within our team' (B22: CMHT).

A question asked in Site B was how you come to terms with not being able to effect a cure when this is what the 'medical model' is effectively built around. The view in mental health was that the 'family care model' was more appropriate for people with long-term conditions but was not usually part of service delivery which was obsessed with getting the job done in the shortest possible time.

We were told that, with long term complex cases generally, the 'resolution model' of care provision does not apply. This can be stressful if all parties do not fully acknowledge this. It can be disheartening over a long period of time for health professionals:

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'who feel they are there to 'cure' or resolve patients' problems being unable to do so' (B23: GP).

Building therapeutic relationships

Building a relationship of trust and having a good idea of what a patient is normally like made it easier to treat patients effectively:

'I belonged to a practice when the patients were like a family …and you took a pride in being part of the community and there was a trust between patients and doctors that came out of knowing each other, knowing where you have come from, experience of previous treatment…trust is the real underpin, you know what your patient is normally like, you have some idea of the environment they are coming from and that puts you in a better position both to treat the illnesses that come out of their circumstances, but also to be aware when something has changed' (A42: GP).

Professionals working in mental health services across the three sites emphasised that their training and the way they practised were built on the principle that they were non-judgemental, patient and respectful towards their clients:

Generally in MH larger caseloads mean less time to give people but the nature of HTTs means they have more flexibility and more resources' (A43: SW).

'selecting the right patients who actually have the possibility of benefiting from the interventions that we have available…and being realistic when there isn't a team that matches a patient, and finding a solution which may need to be more creative' (B24: CMHT).

This CPN considered that changes to the way mental health services were now organised in his area had impacted on the way he worked and reduced the stress of having to cover all the specialties alone:

'I suppose a big change more recently is going into the specialties, having assertive outreach, home treatment teams, continuing care assessment, brief treatment, now that's changed from when it was more generic where you had a caseload and you did... well you had a day where you were on duty where you get all the intake, the assessment of brief treatments… you did your continuing care cases, you had some forensic cases, you had a real mixed bag. Now it's much more focused. That's a change for the better because it was extremely stressful working in that environment where we had to hold so much work and do all the crisis… What helped is by having home treatment teams, it has reduced the stress of the work because I was a CPN 15 years ago and if somebody broke down on your caseload, you had to clear your diary of all your appointments, try and manage as best you could on your own - it was very stressful' (A44: community team).

It seems that despite the stress of change, service users can benefit from the changes

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5.5 Summary

The three key themes of risk, diversity and ambiguity and conflict that emerged from the cross-case analysis of the interviews with health and social care professionals contain elements that overlap to some extent although they have been presented separately in this chapter for clarity. Both risk and diversity, for example, address roles and team-working but their consequences vary according to the subject of the specific theme.

Risk emerged as theme of major importance across all three sites because of its impact on the move from care in hospital to care at home. Practitioners working in the community are having to grapple much more than before with the implications of risk-taking as they are working in new kinds of teams (eg crisis intervention) and contribute to service change through role innovation. They have to strike the right balance between overprotection and allowing service users discretion in decision-making and know when, as a last resort, over-rule a patient's choice if harm would ensue. They also have to keep a verifiable audit trail of the reason for actions taken if things go wrong. Views differed between different practitioners and different services, and there was some difference in emphasis across the sites, but there was consensus on the importance of encouraging service user involvement in and choice over decisions about care. Risks accompanying involvement could be overcome, we were told, with full continuity of care, through maintaining relationships between professionals and adequate support with respect to resources, supervision and staff training.

The diversity theme emphasised the advantages, for practitioners as well as service users, of integrated team-working. In general, the view was across the sites that the partnership inherent in integrated team-working delivers good care to people with long-term conditions and that separate professional identities prevent successful integration. Weakening professional boundaries and expanding skills that traditionally 'belong' to one profession, enhance the quality of the service user's experience and the team-working morale of professionals. Supportive inter-professional team meetings provide the means of encouraging effective integrated team-working and breaking down barriers between practitioners with different histories, professional perspectives, educational backgrounds and working practices.

The ambiguity and conflict theme focused on perceived work pressures and rewards. Pressures included the difficulties of meeting management expectations for outcomes-based targets which were regarded as not always appropriate for people with complex and long-term conditions. There was also considerable criticism that staff were not adequately informed by management about new policies or, if they were informed, there were not enough staff to implement the policies.

Financial incentives were seen as a powerful reward by GPs although other practitioners focused on broader incentives like the feeling of achievement gained from successful management of complex cases. Conversely, anger, resentment and emotional withdrawal could be disincentives in cases of perceived failure to achieve or under-achievement. Effective supervision, support and encouragement to learn from mistakes, as well as a flexible, unified record-keeping system, could allay negative emotions as evidenced in site B.

Increasing pressures of work overload, resulting from perceptions of constantly-changing policies and paperwork and lack of time to do the job properly was reported as causing emotional stress and dissatisfaction. Practitioners knew that service users valued staff who gave them enough time to express themselves and patience in explaining everything they needed to know without being judgemental.

Continuity of contact over time was regarded as essential for good practice though was often not achieved. Practitioners saw continuity of care as more achievable with the 'family care model' for long-term conditions than the 'medical model' or 'resolution model' much favoured by short-term target-driven managers. Time and expertise in building a relationship of trust with patients/clients and colleagues was considered essential to achieving successful therapeutic outcomes. Devoting resources, such as those awarded to the Home Treatment Team in mental health, was identified as a means of achieving such outcomes for patients and practitioners.

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6 Making sense of professionals' experience of governance and incentives

6.1 Introduction

The aim of this chapter is to explain and interpret our findings in relation to the objectives of the study and to set out our final conclusions. Firstly we have summarised the key messages from the large qualitative data set, derived from multiple sources (service users, senior managers and practitioners) in the three case study sites (objectives 1-6). These findings are incorporated into a framework illustrating the multiple and intertwining layers of governance and incentives as reported by respondents. In the second section we move towards developing and interpreting the findings. This is done by drawing out key themes from the cases and stripping out the specific detail to allow us to make sense of the impact of governance targets and organisational incentives on how managers and practitioners perceive performance and its relationship with patient outcomes. We have integrated the managers' and practitioners' views to inform our understanding of governance and incentives at the level of the organisation, team and individual practitioner. In doing this we acknowledge the complex and dynamic interplay between the contextual domain and the mechanisms that may influence outcomes (objectives 7-9). In the final section of this chapter we present our concluding remarks which highlight the key messages to be taken forward by practitioners and policy makers (objective 10).

6.2 Summary of key findings

The context

Sites A and C were in the inner city and Site B was semi-urban. Site A had suffered financial instability and had been in turnaround during the life of the project and Site B was undergoing an extensive re-organisation. In both this had resulted in top-level staff changes resulting in managers feeling unsettled and demoralised. It was evident however that the external political and financial climate settled in both sites towards the end of the study. Site C was more stable throughout with relative financial stability and a smaller amount of change and re-organisation. There were initiatives underway in all three sites to support people with long term conditions including the Expert Patient initiative, the new GMS contracts and the introduction of partnership working and new service and role development such as community matrons. Future strategies were planned to maximise social care and health partnerships in order to benefit patients and increase cost effectiveness. Managers were of course aware of the bigger picture compared to the practitioners, for example the pressures on the PCT to

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meet government targets. They were able to present a less conflicted picture of the effects of the changes simply because they were not delivering care on the frontline.

Service users' perspectives

Despite the three different financial and organisational contexts, there was remarkable resonance in the views of service users across the sites and these have been described in detail in chapter 3. Certain elements emerged across both the mental health and physical condition groups that were seen to contribute to both good and not so good care in terms of organisation of services and ways in which professionals behave (Fig 5).

Figure 5.   **Themes emerging from the local SURG groups**

Organisation of services		
ACCESS	CONTINUITY	SUPPORTING INDEPENDENT LIVING

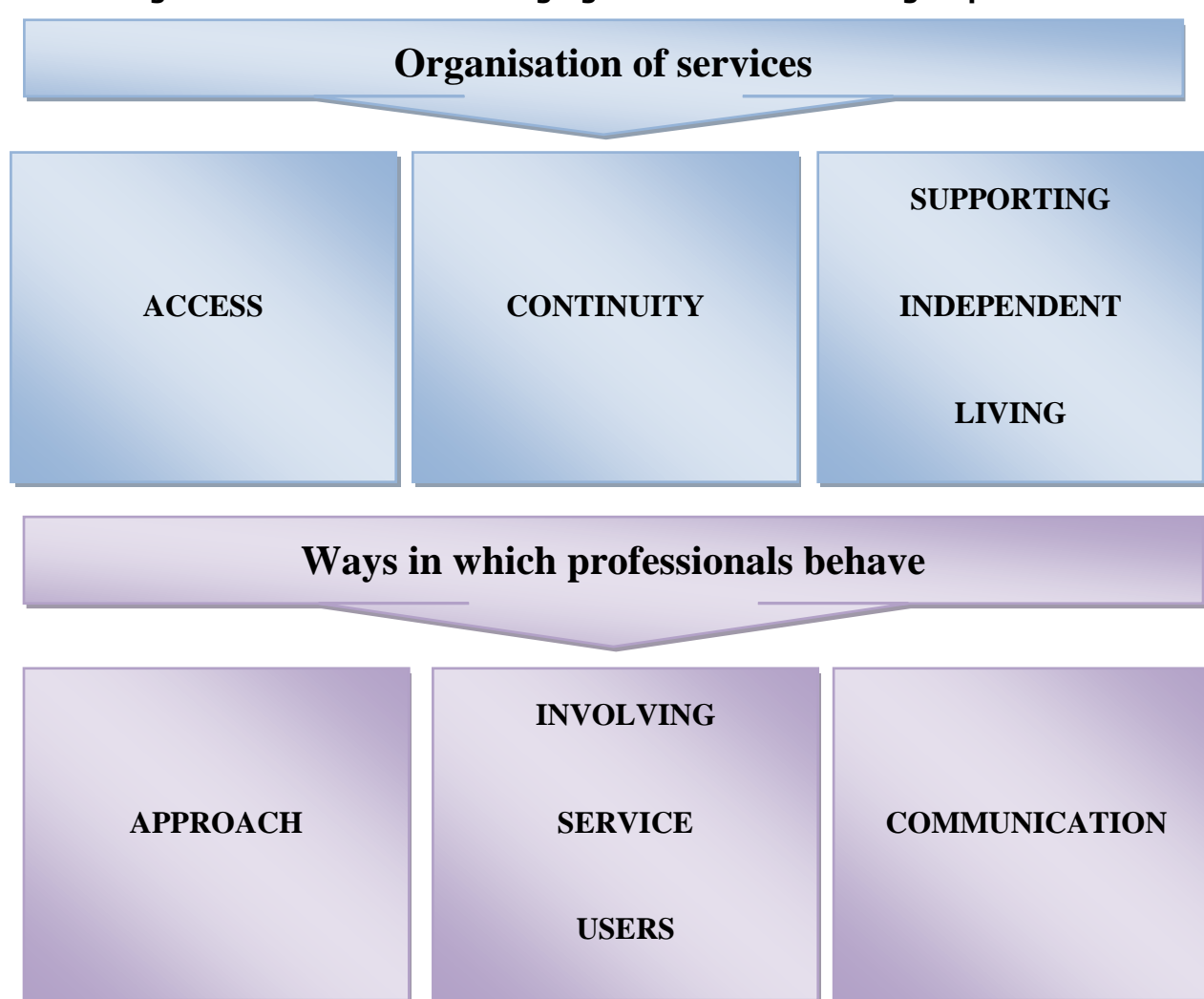| Ways in which professionals behave		
APPROACH	INVOLVING SERVICE USERS	COMMUNICATION

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Senior Managers' perspectives

Interviews with senior trust managers reflected the concurrent organisational turmoil and uncertainties regarding the development of new structures and procedures particularly in sites A and B. The data presented organisations in flux. And in these sites the managers' concerns were on three essential functions:

- ensuring business continuity (providing and commissioning)
- financial savings
- keeping up morale through change

Several themes are described in detail in chapter 4 which emerged strongly across the sites from the senior managers' perspectives including:

- Partnership working being key to cost-effective and holistic care for individuals with long term conditions
- Clear benefits of joint management posts
- Important leadership roles for managers in partnerships

A number of important motivators and incentives operating at a number of levels for staff, for example support, professional ethos and autonomous working

Practitioners' perspectives

The interviews presented in chapter 5 were with practitioners from a wide range of disciplines and organisations, working with and contributing to care of people with long term conditions, The three themes of risk, diversity, ambiguity and conflict (Figure 6) were inevitably overlapping and differed in emphasis depending on the professional perspective and particularly in relation to the setting in which they worked (whether with people with mental health or physical health problems).

Figure 6.   Themes emerging from the professionals interviews

Risk	Diversity	Ambiguity and conflict
New teams and roles: implications for risk	Professional isolation versus integrated team working	Diverse expectations
Keeping people safe: making 'good' decisions	Professional identity	Shared goals: managing expectations
Letting go: accepting and managing risk	Attitudes	
Doing the right thing and being able to prove it	Service re-organisations	

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In summary the main points from the findings were as follows:

Theme 1: Risk

Risk emerged as a key theme in the professionals' interviews reflecting the pressure of policy and organisational change that has resulted in new forms of service delivery. Managing individual expectations and perceptions of professional risk within a new team or partnership inevitably raises uncertainties and emotional work, which illustrates the interconnection between themes.

The key features in the *risk* data concerned a recognition of the importance of shifting from a more paternalistic approach to patient care to one focused on engagement with service users' preferences and decisions. However, promoting independence, or letting go, was counterbalanced with anxieties about safety and in particular how and when to provide care and support on some occasions for some people, particularly where the illness was intractable.

A feature of the interviews was some negativity towards the way these changes in teams and introduction of new teams threatened established ways of working and relationships with existing and continuing service users and their carers. For example, there was frustration expressed around the role of the mental health crisis teams and the perceived loss of autonomy to admit patients to acute psychiatric in-patient wards. Concerns with risk were also expressed in interviews when discussing training of different professional groups and how this shaped and affected their approaches to assessment.

Lastly, 'doing the right thing and being able to prove it' were emphasised as practitioners expressed awareness of increasing litigation and the need to 'be safe' as well as an awareness that being accountable entailed more bureaucracy. However, there did appear some generational differences in the interviews over the issue of whether governance was merely a paper exercise to 'cover your back'.

Theme 2: Diversity

The theme of diversity covered views and experiences of working in teams and partnerships and perceived impact on care and professional identity. Different perspectives between and about other professionals were described under the heading of attitudes, which encompassed views on shifting boundaries as old roles were seen to disappear and services reconfigured as a result of changing organisational governance. For example, the redesign of teams and new ways of working along with the relocation of teams, were seen to lead to a loss of shared team knowledge, which practitioners felt could have implications for client care. In addition, practitioners expressed concern that this restructuring of teams had not seemed planned or supported in a human sense. A consequence of this lack of support and planning was that practitioners expressed concern over

retaining their own professional identity in new teams; especially for district nurses and mental health teams. Staff were concerned with how services were delivered, in particular, the location of teams, the formation of new teams and service models; who delivered the services, for example, the introduction of triage by nurses in primary care; and the perceived merging of professional boundaries particularly in mental health.

In addition, poor attitudes to mental health patients across some professional groups and teams were felt by mental health practitioners to lead to poor care delivery to this group of patients. This was felt to be particularly strong amongst general practitioners.

Theme 3: Ambiguity and conflict

Given the change in governance arrangements such as new partnerships, different delivery models and reconfigured teams it is not surprising that a dominant theme was related to the emotional consequences of dealing with change, ambiguity and conflict. Managing diverse expectations and endeavouring to define shared goals created anxieties and emotions for individual practitioners. Some practitioners described themselves as being at their own limits of coping with the emotions raised by the stresses of restructuring and continual re-organisation. While support was reported to be available, it was not *seen* to be available in all areas and therefore managers were not always perceived as supportive during a period of service change.

While practitioners felt that the organisational and service changes in the care of long-term conditions was necessary in many cases, they also felt some ambivalence towards these changes. For example, while professionals were positive about involving patients in their care, there were concerns around the best way of doing this, balancing the rights and risks of the individual for independence and ensuring safety especially in complex situations, the meaningfulness of choice if services were restricted and tested; the mental capacity of patients to make meaningful and 'safe' choices; the differences between professional and patient defined need. More fundamentally, practitioners felt that time with individual patients had been reduced and that their role had become a signposting one rather than a therapeutic one; although some therapeutic interventions were allowed within the new structure.

Perceived barriers to providing 'good' services included: a lack of time; relentless targets needing to be met; reconciling different philosophies of service between teams; and the lack of integration between teams. These barriers were responsible in practitioners' eyes for the withdrawal of services and loss of workforce capacity in primary care for example through reductions in district nursing, and home care through the introduction of mechanisms such as increased eligibility criteria.

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6.2.1 An illustrative framework

We initially presented a conceptual framework in chapter 2 (Figure 1) and this has developed over the life of the project into the illustrative framework shown in figure 7. This framework captures our findings and the multiple and intertwining layers of governance and incentives reported to us by the managers and professionals in their interviews. At the centre of the framework is the service user's experience of care woven together in a figure of eight with the professionals' experience of governance and incentives. This is intended to represent the notion that inevitably the experience of professionals is influenced and shaped by their interactions and relationships with service users as well as the teams and organisations within which they belong. The professionals' experiences are shown to be influenced by the three key themes emerging from the cross case analysis: risk, diversity and ambiguity and conflict. The outer layers of the egg or framework represent the links between the external environment and the inner layers, for example, the outermost layer represents the national policy directives and targets, which the participants described as having an impact on local drivers and ultimately on the changing shape of partnerships and organisations within which they worked. The next layer in (blue) illustrates the local initiatives, which were seen to have an impact on governance, including professional roles, organisation of services and incentives for those working within the system.

It is our view that this framework helps to conceptualise the different layers and features of governance and incentives as experienced by professionals and the possible links between them. However, it is not suggesting direct causal or linear relationships – more a way of thinking about the practical implications that might be helpful in service development.

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Figure 7.   An illustrative framework for the experience of governance and incentives in primary care
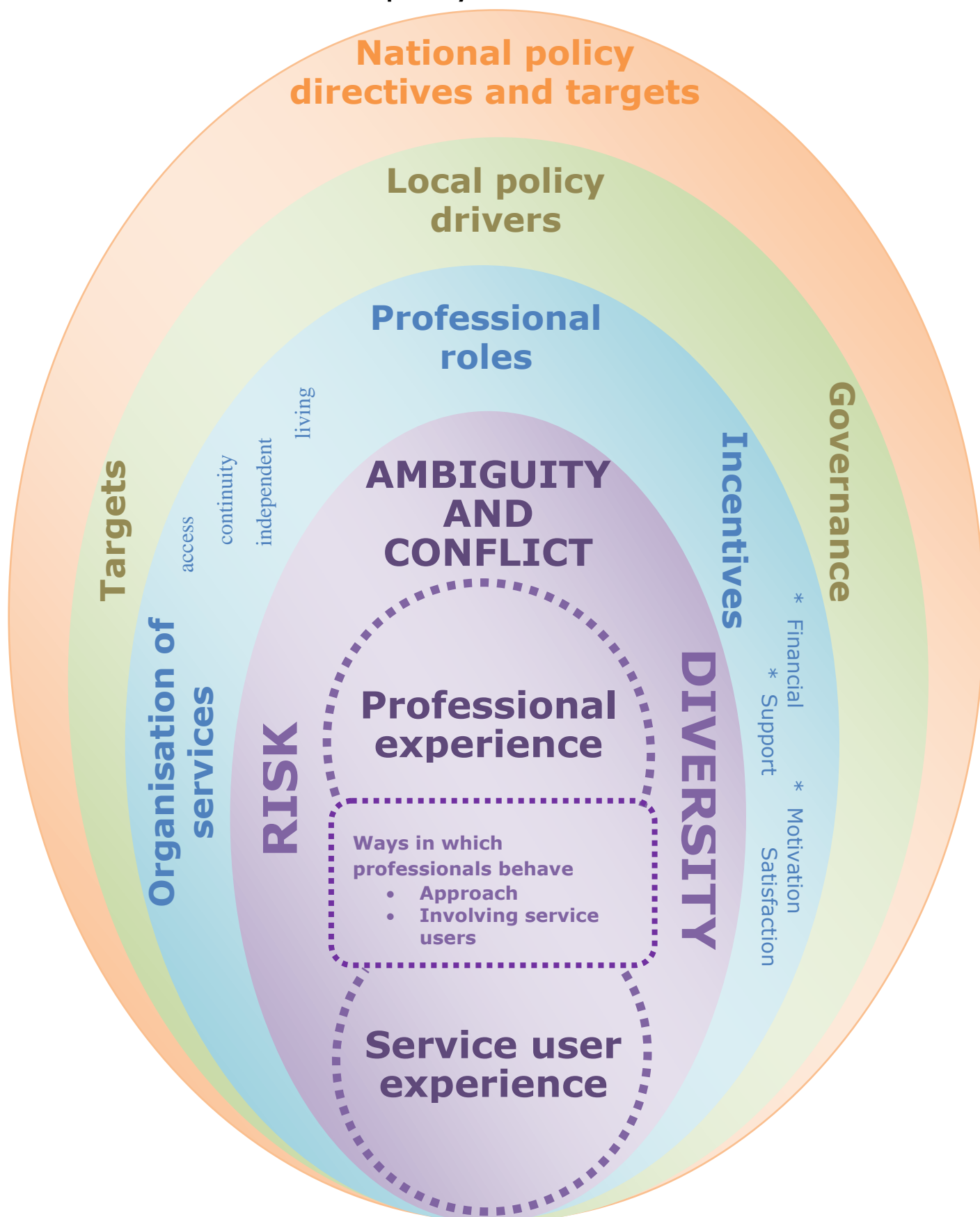
6.3 Developing and interpreting the cross-case analysis

This section of the chapter addresses objectives 7-9 of the study by integrating the findings from the interviews with managers and professionals in order to explain the way in which the new models of governance and incentives are having an impact on the way in which professionals experience their working lives and the extent to which they are able to make sense of the changes in relation to their contribution to care of people with long term conditions. To achieve this we asked three key questions of our findings/data:

- How do governance and incentives relate to improvements in care delivery?

- How are the impacts of governance and incentives dependent on the context?

- How do different governance and incentive arrangements interact and interconnect?

In order to answer these questions we have borrowed ideas and principles from realistic evaluation. Although we have experience of this method (Byng et al 2005) we have not followed it slavishly. This is for two main reasons: the first is that our study is not directed at any single or combination of interventions in the way that the word is usually understood. Rather we are looking at the effect of disparate policy changes that impinge on the organisational context of professionals' working experiences and lives in relation to long-term conditions. The second reason is that in previous work we have found that the separation of context from mechanisms can impose somewhat arbitrary decisions in the analysis and may cloud the identification of any association with outcomes (Byng et al 2005).

We have adopted, however, the realistic evaluation approach of building context-mechanism-outcome configurations which we refer to as hypotheses that emerge from the data that require future testing. We use the term hypothesis to refer to the statements from the data that reflect the objectives of the study, which are written to make sense of the ambiguity and complexity that surround governance and incentives. This process of hypothesis-building and development of middle-range theories across the three very different case study sites enables us to take meaning from the data and translate it into messages to inform practice and organisational development. These messages relate to local interpretation of national policies particularly in relation to long-term conditions.

6.3.1 How do governance and incentives relate to improvements in care provision?

Our exploration of the findings with regard to this question is structured under the following headings:

- Partnerships
- Continuity and teamwork
- Risk management
- Emotional work dealing with complex cases
- Bureaucracy

Partnerships

Successful partnerships were described as having formal agreements with clear governance arrangements for example joint working models and joint appointments. This is in contrast to unsuccessful ones which were seen to be hampered by reluctance to change, staff feeling daunted by what seemed contradictory financial policies, a deluge of targets, audits and reviews, incompatible information systems or a frustrating time-lag between knowing what to do and receiving the resources to do it. Ferlie and McGivern (2003:11) in their review of the relationships between health care organisations question the relative balance between the three governance mechanisms of hierarchy, markets and networks, which constitute "plural modes of governance" and which can result in competing and distracting agendas (Fitzgerald et al 2006)**.**

The impact of decentralisation (Peckham et al 2007) and the financial reforms on improving organisational performance and professional behaviour was seen as patchy resulting sometimes in a mismatch between external and local target setting, which hampered change (Bridges and Meyer 2007) or produced perverse incentives particularly in the organisations experiencing cost pressures. Perverse incentives identified by managers were:

- Service reductions couched as reforms
- Denying patients hospital admissions they need Incentives fostering a disease-specific model rather than a holistic model of health
- The complexity of allocating funding
- Defensive practice
- Drivers not fit for purpose
- Inequitable pay for practitioners doing the same level job arising from *Agenda for Change*
- Longer hospital admissions resulting from *Payment by Results*

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The data from our study seem to support this wider literature and have generated the following hypotheses, which can be tested at the organisational level:

Sharing the management responsibility and demonstrating strong and committed leadership for new joint roles is essential to successful partnership working and new forms of governance

Financial structures that ensure pooled budgets for integrated services improve organisational performance; with respect, for example, to team working, role clarity and communication)

For organisations experiencing turbulence and financial instability effective interpersonal relations, acknowledging the importance of emotional work, mutual trust and willingness to take risks encourage mutual ownership of challenges and allow teams to move from "problem shunting" to "problem solving"

Continuity and teamwork

Continuity of care emerged as a strong relevant theme. The first two hypotheses refer to the importance of preserving continuity of care during a crisis or transfer of care (Humphrey et al 2002):

Access to and consultation with the professional who 'knows the patient best' in times of crisis ensure that 'good decisions' are made.

When care is transferred to a new team for a brief period, ongoing involvement of a 'co-ordinator of care' ensures against risks caused by loss of trusting relationships and key clinical information

For some situations continuity and high quality care is achieved most efficiently when the professional who 'knows the person best' can step up care with brief but more frequent contact rather than transfer to a new team:

Continuity in contact over accumulated time by the same professional in a key worker role for each client reduces the length of each individual contact and improves the quality of the client's experience

For people with complex needs integrated teamworking (different professionals in the same team) was seen as a more effective mechanism/ incentive to enhance performance and continuity of care (Mitchie and West 2004) than several professionals working from uni-professional teams. The single assessment process was highlighted from a number of professional disciplines as a mechanism to improve continuity for service users to avoid repetition of the same questions from a series of professionals all completing separate professional assessments. The SURG groups emphasised the negative effect that endless duplication had on them.

Furthermore, team-working with supportive colleagues is a staff motivator of prime importance and involves partnerships and multi-agency working.

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Staff working in multidisciplinary teams need professional leadership as well as support from their team manager:

Isolation from others working with the same patient, (as part of a uni-disciplinary team), leads to duplication of work and consequent disruption in continuity of care.

A dedicated manager and a single comprehensive set of notes will achieve continuity of care delivery and prevent duplication.

Appointment of dedicated care managers for long-term condition reduces duplicated visits by different professionals to clients.

Integrated multidisciplinary teams drawn from general practice, social care, nursing and allied health professionals are more effective in supporting physically frail and home-bound people than isolated uni-professional teams.

The healthcare reforms emphasise the need to develop new professional roles in order to foster service change. This is resulting in workforce innovations, new roles, reconfigured teams and in some cases a move to weaken professional boundaries so that practitioners can undertake roles currently performed by other professionals. For example nurses prescribing, mental health social workers making clinical assessments. Encouraging new ways of working is therefore seen as an encouraging consequence of new roles as indicated by this hypothesis:

Creation of new roles, such as the community matron, consultant nurse and clinical specialists, will ensure cross-boundary working by experienced practitioners and enhance the quality of care for people with long-term conditions.

Communication is a key part of teamwork, but it needs to meaningfully employ informal as well as formal methods for effective collaboration to take place (Reeves and Lewin 2004). Interminable formal meetings was a criticism voiced especially by workers who were reluctant to lose the security of meeting within their own profession. Professional leadership, support and identity were cherished by many, although it was suggested that focused inter-professional team meetings would preserve continuity of care:

Regular inter-professional team meetings reduce fragmented communication between team members and improve provision of a non-repetitive and seamless service.

Reducing single-profession meetings to an absolute minimum while maintaining professional contacts who are able to provide advice and support avoids the requirement for an excessive number of meetings

Explicit ground rules agreed at the start of multi-professional team meetings prevents loss of self-esteem, lack of trust and lack of respect amongst workers from different professions

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Risk management

The notion of therapeutic risk or positive risk taking has been noted in the literature, which suggests a slightly different emphasis across the disciplines: doctors appear to be influenced by defensive practice or the avoidance of litigation (Studdert et al 2005, Goodacre 2006). In the nursing literature risk is often described in terms of a management strategy as well as the need to consider risk to the user (Godin 2006). In social work there is an emphasis is on learning from mistakes in organisations (Barry 2007) Risk management was a prominent theme, perhaps reflecting recent national policy recommendations for a framework to support change in professional behaviour towards resilience, and self reliance in risk taking behaviour (DH 2007). Risk in terms of patient safety, litigation and job security frames the context in which practitioners experience and view the impact of changes in care delivery.   The following hypothesis emerged as relevant to working with changing policy directives:

Professionals' perceptions of risk don't always match policy directives and differ between different individuals depending on their experience, professional background and management support perceived.

There was a strong theme coming from the data of the role of risk taking in relation to empowering patients to participate in decision making. This discourse has probably been shaped by the critical events and crisis in public confidence following the Bristol enquiry (Coulter 2002). Issues of balancing patient safety and the acceptability of professional practice will have probably informed the views of managers and professionals and links governance and incentives. Allowing service users to make their own decisions was a risk that some professionals found more difficult than others:

Professionals experience conflict with positive risk taking ,i.e. 'learning to let go' and enabling service users to make their own decisions

Professionals who respect service users' wishes have the confidence to risk what may be considered a negative outcome

The impact of these public and professional debates has informed governance policies, which are understood to require evidence of an audit trail with defined documentation:

Proportionate documentation of risk assessment and management required to produce an audit trail for monitoring performance will maintain standards and competence in practice for the benefit of clients and to protect staff against unfair accusations of malpractice

Systems change that allows unrestricted access to care records by every team member should be supported to ensure that risk to service users, particularly during non-routine events is minimised:

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Access to care records (information about co-morbidity, functioning, expressed wishes, medication and recent contacts etc) during transfer of care and at times of crisis reduces risk and allows positive risk management (self care, empowerment, independence etc).

Similarly there was a plea within the data for time-saving compatible computerised systems for all health and social services:

Compatible computerised IT systems in all health and social services allow professionals from every service to gain access to and add information to a single record for every client thereby reducing the burden of excessive paperwork

Emotional work in dealing with complex cases

Local responses to national agendas results in rapid change, which often produces a range of emotions and can affect whole organisations particularly during transitional phases (Slater 1998, Welch 2002). The emotional effects of change are often overlooked even though judicious attention to emotions has been shown to facilitate organisational learning as part of the change process (Huy 1999). Leaders who are aware of these processes will exercise the authority to create the systems that can then be employed to recognise and manage the emotions generated as a consequence of change at all levels and professional contexts in the organisation.

Emotional labour emerged as a prominent theme with respect to multi-professional working and complex cases. This was evident from the practitioners' and managers' views. From the managers' perspective the factors contributing to demotivated staff with a resulting negative impact on patient care that demonstrate the interplay between governance and incentives were: a culture of constant change and targets; insufficient resources; staff shortages leading to overload, stress and burnout and tension at the interface between services:

Professionals, policy makers and service users have expectations of the care process which cause 'emotional drain' and disillusionment

Competing hypotheses with positive and negative elements were not unusual:

The emotional work of dealing with complex cases in a complex system results in positive feelings of empowerment and achievement as well as negative feelings of anger, resentment and emotional withdrawal.

Bureaucracy

Bureaucracy was seen by sceptics as interfering with governance generating frustration, interfering with efforts to provide client care of high quality and compromising the satisfying aspect of work for general practitioners and

others of developing and maintaining relationships (Fairhurst and May 2006):

> *The paperwork associated with governance imposed on practitioners is excessive, repetitive, cumbersome and time-consuming, and intrusive on the therapeutic relationship with clients.*
>
> *Clerical assistance to complete necessary paperwork reduces frustration for staff and gives them more time for client care.*

Rating the important but more nebulous components of quality using a tick-box approach was not recommended, and other approaches, agreed with commissioners, are required to complement the quantitative measures required for example by the Quality Outcomes Framework. These might include varied activities from measuring whether patients had acheived their desired functional outcomes, through to assessing outcomes of peer to peer reflection and supervision.

6.3.2 How are the impacts of governance and incentives dependent on context?

Our exploration of our findings with regard to this question is structured under the following headings:

- The benefits and drawbacks of centralised or specialist services
- Co-ordinated colleagueship
- Professional-service user interaction

The benefits and drawbacks of centralised or specialist services

The government reforms in primary care support service and workforce change. Resources have been made available to establish specialist teams for example in intermediate care or crisis intervention. While the additional investment was welcomed by respondents the impact on generalist or traditional services was seen to be a problem and contributing to low morale. A hypothesis was identified that welcomed the benefits:

> *Collecting together a range of services provided by an integrated team within a single large centre enables many of the client's needs to be met on the same day, so avoiding multiple visits.*
>
> *The cost and length of travel time may, however, deter clients who prefer services to be provided locally.*

The other side of the coin was that specialist teams were regarded with envy by cash-strapped traditional services:

> *Teams set up with specific targets and client groups, such as home treatment teams and crisis intervention teams designed to prevent hospital admission, enjoy enhanced resources, staffing, status and recognition which have a positive effect on team spirit and performance*

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Targets and outcome measures are easier to identify for teams with such an unambiguous focus compared to those providing general services

Co-ordinated colleagueship

Positive staff relations with mutual respect and co-ordinated care contribute to hypotheses on colleagueship. Research by Borrill and West (2003) and (Borrill 2003) reports the importance of good morale among staff and the positive effects it has on patients. The key to good morale was effective team working and the positive working relationships between all professional groups to the ultimate benefit of users. Furthermore the literature on communities of practice suggests that self-organising teams are better able to handle complexity and fragmentation particularly within the context of health reforms (Iedema et al 2005):

Professionals make good decisions where there is continuity, good relationships and resources.

Professionals communicate best where there is mutual respect, good co-ordination, time, shared goals and respect.

Embedding social care staff in health care teams was suggested as a strategy to avoid duplication of work and promote harmonious working between different professionals, while recognising the differences that make collaborative work powerful (Davies 2000):

Harmony between governance arrangements in health and social care promotes integrated team-working.

Attention by managers to personal development and career pathways of staff through training, supervision and conferences was seen as a strong motivator and a means of enhancing job satisfaction. Supervision was valued, but tends only to reach professionals in mental health and specialist services. It has been found to be a key element in containing the anxieties arising from organisational uncertainty and change, a way of helping staff think differently and to use their emotions to understand difficult situations they encounter with patients (Butterworth 2008). Supervision may provide a sense of containment by attending to the emotions evoked, providing a therapeutic and facilitative means to good working practices and teamwork (Obholzer and Zagier Roberts 1994).

Leadership was also identified as important in the interviews with managers. This is line with West et al's (2003) findings that show team leadership is associated with clear goals, high levels of participation, commitment to excellence and innovation:

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> *Successful integrated team-working provides support, enhances respect between professionals, ensures a cohesive and stable workforce, prevents professional isolation and provides a learning environment that promotes good practice.*
>
> *Services that are fragmented and disjointed, with confusing systems of referral and access to services are unsuccessful.*

Contextual features that deter integrated teamworking include scattered service locations, insufficient and frequently changing staff and a lack of mutual respect between professionals. The result can be over-stressed practitioners who lack motivation to keep track of a governance system they see as complicated, counterintuitive and operating at the expense of ensuring a properly staffed service. The assocation between change, emotions and competing values is clearly articulated by Traynor and Wade in their study of community nursing services after the first wave of health care reforms in the 1990s (Traynor and Wade 1994).

Different professional perspectives on the practice of managing care for patients with complex conditions emerged, for example the nurse's tendency to do things for the client compared with the social worker's preference to encourage independence. This can be seen as a hazard of independent working by different professionals and can be linked to the differences in perception ~~or~~of risk. Another example of this is the different assessment priorities of an occupational therapist and a social worker which can result in incomplete assessment of clients' needs:

> *Different approaches used by practitioners from different professions in the same team result in team tensions and unacceptable omissions even though all are equally committed to giving high quality care*
>
> *Shared training or periods of training spent with other professions resolves unwanted discrepancies*
>
> *Excellent leadership resolves these tensions allowing professionals to break down boundaries.*

Professional-service user interaction

Echoing the values expressed by the SURG groups,~~.~~ high quality care was described frequently in terms of the relationship with patients, within which time was an important feature. There were different views on how time could be managed to best effect and the often-held assumption that more time with service users will mean better care need not be true:

> *The quality of a professional-service user interaction is more important, than the length of the interaction*
>
> *Many brief interactions over time are more effective than longer interactions for some clients*

Other means of contact such as telephone and increasingly text message, email and web-based conversations are valued forms of interaction.

The impact of financial pressures on local authorities and competing priorities leading to changes in eligibility criteria for social care was raised across the case studies. The impact of these changes on other professionals who as a consequence found their job more difficult to do as social services support was withdrawn or reduced compromised the experience of care for service users and their families, reduced opportunities for preventive work and led to crisis intervention:

The raised eligibility criteria for social care result in practitioners responding to crises rather than working preventatively

6.3.3 How do different governance and incentive arrangements interact and interconnect?

Our understanding of governance drew on the work that Celia Davies and colleagues had recently completed for the NIHR SDO (Davies et al 2005) and others (Ferlie and McGivern 2003). This allowed us to ask questions about structures, processes and outcomes and make conjectures about the possible relationships. Both of these reviews concluded that there are gaps in the literature on the links between governance, incentives and clinical outcomes and more particularly how professional behaviour is shaped. This view is echoed in the policy literature (Liddell 2008) which argues that the rules of the game are unclear as to how the NHS can design incentives to deliver continuous improvement to patients.

We suggest that in reality it is the professionals who are enacting the imperatives of health care: they are making sense of the reforms as they have to get on with their jobs. This is illustrated by the response to financial rewards, which, not surprisingly, were strongly supported by the general practitioner respondents in the sample. For others, the increased funding made available in primary care has been valued as a collective benefit. On the whole it was striking how positive professionals from nursing, and social work backgrounds were at a personal level towards their jobs and their role in patient care even with the welter of reforms and change going on around them. There were some who saw the marked differences in salaries between different professionals doing similar work as a disincentive, leading to loss of interest and intention to leave. The following hypotheses illustrate the complexity of interaction between different governance and incentive arrangements:

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> *Professional and personal incentivisation to hold risk, involve patients in choices and work in a multidisciplinary team is enhanced by providing:*
>
> - *excellent supervision and support*
>
> - *flexible, unified record systems*
>
> - *support and positive approbation for making autonomous decisions*
>
> - *systems for learning from individual and system errors*
>
> - *and systems of feedback relating to targets which encompass both the individual practitioners' motivators as well as corporate requirements.*
>
> *For individuals who are self employed the above hold true but systems for developing them may need to be incentivised within contracts or broader frameworks for professional practice or being part of the NHS/social care system*
>
> *Further incentives relating to specific system and patient level targets contained in the requirements of contracts augment performance in key areas. Although such specific targets have the potential to divert resources (financial, workforce and emotional energy) from the broader agenda of achieving flexible individualised care*

6.4 Developing practical models for local implementation

The final objective of the PEGI study was to develop key policy messages to inform the implementation of innovative governance arrangements. Part of this process was to work with the three case study sites to develop practical models for local implementation. In this section we discuss this process under the following headings:

- Model of engagement with service users

- Authenticity of access and continuity

- Cultures of risk

- The paradox of involvement

6.4.1 Model of engagement with service users

It would have been premature to develop practical models from the findings without taking these back first to the service users for confirmation and advice. Therefore we set out to explore the extent to which we could connect the emerging themes with the views and experience of our SURGs in order to help us think about how this would inform practical models. In each site we held meetings with the local SURG and invited stakeholders from the PCT e.g. Director of Public Health (Site A), senior manager from

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social services (Site B) and senior operational and commissioning managers (Site C). All the meetings were facilitated by Sally Brearley with guided discussions around:

- the key emergent messages

- what had been found

- whether the findings ring true

- if anything was missing

- the way forward for practice.

Issues that emerged from these discussions are set out below in terms of authenticity of the findings, different cultures of risk, and the paradox of involvement in governance.

6.4.2 Authenticity of access and continuity

The themes of access and continuity clearly resonated with all the SURGs. Indeed care was described as like a game of snakes and ladders with blocks to getting help when needed and pathways accessed with an element of luck (Site C). "How does it all link together?" "Where is the GP in all this?" (Site B). All of the groups suggested introducing some kind of a care navigator role. This was variously described as a personal health care "sat nav" system, (Site C), better "signposting" (Site A) and having a "help point like in Tescos" (Site B).

An accessible one-stop shop, resource and information point, advice point/care navigator would support service users through the system especially during constant change.

6.4.3 Cultures of risk

The service users in all groups identified with the theme of risk. They described experiences of receiving care from professionals working within different risk protocols, for example one woman told us about the health and safety rules that impose constraints on staff in sheltered housing and its impact in terms of how far they can help after a fall. There was awareness of the inconsistencies between professional cultures about the management of risk particularly between health and social care and between acute and mental health care, which makes for ambiguity and discontinuity for service users.

Risk management within governance frameworks when made accessible to service users increases opportunities for participation. This is already national policy(DH 2007)

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6.4.4 The paradox of involvement

Service users were sensitive to the issue that professionals are sometimes disengaged and overwhelmed by change. There were strong metaphors used to describe feelings of disempowerment of patients, e.g. the revolving door with a myriad of different professionals coming into the home to give care and having the effect of making patients feel as if they were "standing naked" telling their story over and over again, (Site C). However, there was another side to it and paradoxically service users suggested that the professionals themselves may be losing out, because of the loss of the developing relationship, the lack of time to understand through communication and the bureaucratic preoccupations that get in the way of integrated working (Site B).

Governance frameworks and incentive systems that value the central interpersonal relationship and the encounter between service users and professionals avoid disempowering patients and professionals.

6.5 Conclusions: the meaning of governance and incentives for professionals in primary care

In this chapter we have explored our findings and presented key messages for future policy development around governance and incentives in primary care. By unpacking and critiquing incentives from the perspective of professionals knowing what works best for whom, how and where, we have provided insight into what policies need to be addressed in order to be effective and responsive to the contexts in which they are operationalised. This understanding is vital in ensuring that the most appropriate modes of governance and incentives are utilised which will lead to increased motivation and job satisfaction amongst clinical staff. This in itself is known to lead to improved clinical performance and thus better care for patients as well as improved retention and commitment to the NHS.

In terms of the concepts of governance and incentives several messages emerge from this study:

- There is much policy talk around governance and incentives and as many different views. The PEGI study attempted to unravel and understand the extent to which these views are interconnected or were misaligned. The terms governance and incentives are in themselves redolent of jargon and tend not to speak directly to practitioners on the ground, although our interviews suggest that this may be a generational thing and newly qualified staff are better informed about the political context of their work. Thus our findings suggest on the whole a misalignment between the policy language and narrative of governance and incentives with the views of what matters to professionals who were struggling to make sense of, interpret and apply the directives in the delivery of care.

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- Professionals held multifaceted views of incentives: it was not a case of 'one size fits all'. Although for some groups financial incentives were recognised as rewards for specific behaviours there were also clear understanding of the "moral, professional and social levers" (Davies 2004) that exist to improve organisational performance. It is therefore impossible to come up with general incentives for all professionals: rather incentives need to be tailored for different groups and to the contexts in which they work.

- There was a strong ethos of wanting "to do a good job" and many examples of demonstrable commitment and loyalty to the service and to patient care. Professionals were supportive overall with the general direction of policy in terms of changing the system of care to provide more choice, care closer to home, and integrated pathways between services and there were positive narratives about the impact of policy change on service improvement for people with long term complex conditions However, the other side of this was that financial drivers were seen as perverse and targets inflexible and inappropriate for complex long term conditions and that it did not seem to be anyone's business to "make sense" of these policies to practitioners.

- There was a dissonance in the way that policies were seen to be interpreted and applied locally. the managers considered that part of their role was to act as a buffer for practitioners, which is a contrast to the ambiguity experienced by professionals who often reported feeling overwhelmed by a welter of audits and reviews as well as managing the time lag between being told what to do and having the resources to do something about it.

- We found that increased pressure in the work environment creates additional stress and dissatisfaction and would suggest that the conceptual thinking around incentives should take more account of the emotional domain. Diverse incentives were expressed in a variety of discourses across professional groups. Although resources or the lack of them can be seen as a catch all – it is the way that resources are distributed, which was seen as contradictory and being out of line with the policy imperatives. Although this was seen as a problem, it was by no means the only thing. Time and expertise featured as a major issue, which is of course related to resources. However, professionals had a sophisticated understanding of what they wanted out of more time, emphasising the quality of the interaction necessary to build trusting relationships, also of course, highly valued by service users.

- Balancing individual rights with risk avoidance in the context of new models of partnership and team working was a major preoccupation of professional staff. However, there were different professional perspectives expressed on risk and a tendency for all professionals to consider themselves less risk averse than others.

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- The diversity theme emphasised the advantages for practitioners as well of service users of integrated team-working. This leads us to conclude that governance and incentives are inextricably linked by the way in which people connect with, contribute to and benefit from organisations and supports the Davies (2004) definition of governance as the "way in which organisations and the people working within them relate to each other".

- A good place to start is thinking about governance in terms of the service user requirements in order to manage and align their expectations. Starting at the central aspect of care will mean appropriate questions are asked, that organisational structures will be shaped and influenced and that organisations will be truly 'fit for purpose'

In conclusion our findings suggest that governance encompasses more than formal legal and reporting structures and that multiple relationships are played out between governance and incentives. Our findings can contribute to and inform the development of supportive frameworks for professionals within primary care organisations in flux. It is important that policy, organisations and managers acknowledge the contribution that supportive structures and strong professional values, that resonate with service users expectations, can bring to quality services and build this into future incentives.

7 Reflections on methods and implications for policy, practice, education and research

7.1 Introduction

The final chapter reviews the approach and methods used in this study and it discusses the implications for the development of policy, practice, education and research as primary care organisations change, government reforms embed and professional roles evolve.

7.2 Evaluation of methods used

In this section we identify some of the tensions that arose for us in the conduct of the research. Exploring perceptions and expectations of governance and incentives from the perspective of professionals from different disciplines confronted in their daily lives with enduring challenges of long-term conditions is inevitably complex. Our approach to the study took account of this and we were not surprised to have to address methodological challenges during the course of the research. Some of these challenges and tensions are discussed below set out as issues for discussion.

7.2.1 Allowing variation across case studies with the overall methodological framework

The case study sites were selected on the grounds of their diversity and variability in the experience of local policy development for the professional management of long-term conditions. It is not surprising then that this contextual diversity on occasion influenced the progress and alignment of the case studies against milestones. For example organisational change in two out of the three PCTs in the early phase of the study lead to changes in key stakeholders, delays in obtaining research governance approvals and ambiguity for the researchers. These tensions presented challenges to the overall design, which were discussed and resolved through team meetings, telephone and or email. The role of the project co-ordinator was crucial here. Together with the principal investigator she brokered decisions, agreeing modifications that were acceptable to the researchers and stakeholders in the case study sites to avoid compromising the overall study design.

7.2.2 A continuous thread throughout the study – working with the service user reference group

The SURG enabled the study to be embedded within the experience of people with long-term conditions. It was a thread that went throughout the project, described by one of the researchers: "like the writing that goes all the way through a piece of seaside rock". However, we had known that, in a project focusing on the views of professionals, it would not be straight forward to have a strong service user input: most service users being blissfully unaware of the detail of the policies driving ongoing change. Instead of attempting to obtain service users' views on the implementation of policy we used their expertise in the care they had each received (experts by experience) to lay out what good and not so good care for people with long-term conditions looked and felt like.

Our first meeting was with a group of five service users who represented national patient or lobby groups in mental health and long-term conditions such as Diabetes UK, London Voices and The Clifford Beers Foundation. At this meeting they challenged the research team to rethink the planned sequence and original intentions to only use the vignette in the professional interviews. Their suggestion was to do the work earlier with the local SURGs and develop the vignettes for the manager interviews as well. This required some modification to the timetable. While acknowledging the tensions involved in making such changes, the preparedness of the research team to be influenced by the advice of the service users reflects the value attached to the relationship and the role they can play in enhancing the study design to better reflect the concerns of "how it is" for them.

7.2.3 Developing the vignettes from service users' perspectives

The two vignettes were constructed from the themes and stories shared by the SURG groups in each case study site. They drew from patient experiences of what it is like receiving services, illustrating some successful and unsuccessful aspects of a complex long-term mental health and physical condition. We departed from the original purpose, which was to use the material in the vignette to guide the interview and allow the respondents to move rapidly through the issues. The reason for doing it differently was because of the broad issues reflected in the vignette and wanting to avoid the possibility of foreclosing important themes by channelling participants' responses. Instead we employed it more as an ice breaker and as part of the context setting. The senior managers were sent the vignette prior to their interviews as a means of bringing their attention, at least partially to the detailed ups and downs of individuals' care; several said how useful they found it. In the professionals' interviews it was used at the mid-point to provide a break and refocus their thoughts. One

unanticipated, but perhaps obvious benefit was that it kept the research team thinking about outcomes and quality of care.

7.2.4 Measuring performance in borderless teams

In the methods chapter we report our decision not to use the ATPI instrument to measure team performance as it was inappropriate for assessing teamwork in the context of dispersed, virtual teams. By dispersed and virtual teams we mean individual professionals employed and located in a variety of organisations and teams from health and social care who, while all participating in the care of a particular patient group, may only come together at work from time to time. Although the ATPI is a well respected measure of team performance it has only been validated for bounded core teams of a maximum size of 15 and therefore we judged it not appropriate. Therefore our assessment of teamwork for people with long-term conditions is limited to our analysis of the discourse on partnership, collaboration, working together etc.

7.2.5 Diversity and convergence in the analysis

The analytical strategy had to take account of different levels of analysis. The coding framework was developed by the researchers in each case study site who had been steeped in the data collection and had a deep familiarity with the contextual issues as well as the data. Discussion of specific issues to do with coding took place with the project co-ordinator and drew on the expert advice of SJR. The tension here was related to anxieties from individual case study sites around sacrificing some of the rich detail within a coding framework that had to work for all datasets. We addressed this through discussion and reaching consensus. The cross case analysis was undertaken by SC and SJR as a separate process, taking the analysis to another level.

This approach was new to us and arguably raises issues of fidelity and authenticity and ownership. It certainly produced tensions for the three researchers who were intimately involved in the case study sites having operationalised the study design, built relationships with stakeholders, established and nurtured the service user reference groups, collected the data and undertaken detailed site analyses. The resources planned for the study allocated funds for the cross case analysis to be completed by the project co-ordinator (SC) together with SJR. This meant that the site researchers had to 'let go' as their contracts came to an end. This novel approach to qualitative analysis was high risk in that it was a challenge for the researchers in phase 3, but arguably allowed a greater rigour and higher level of analysis than would not have been possible any other way. During the preparation of this report we have taken the cross case analysis back to the site researchers as a measure of validation. They have all supported the analysis as resonating and confirming with their own interpretation of the data.

Finally the generation of hypotheses and middle range theory from the cross-case analysis provided an element of theoretical generalisation that invites testing in further research. As noted above, audit ability and validity of the analytic process was sought through scrutiny of the hypotheses by all members of the research team and any disagreements were discussed and resolved.

7.2.6 Feedback to stakeholders and dissemination

Feedback took place during the study at several time points and in different forms that was tailored to local needs. For example the arrangements for the setting up and final feedback meetings for the SURG groups differed across the case study sites – researchers undertook to tailor their feedback to SURG groups to meet local expectations taking into account confidentiality and sensitivity.

Feedback to the PCT was determined by its priorities and organisational concerns as well as the relationships that the researchers had. For example in Site C the research leader is a GP and member of the PCT's Professional Executive Committee; he was therefore able to feedback emerging findings into both commissioning and operational management processes. In Site A the key support of the Director of Public Health facilitated a presentation to the Executive which then created opportunities to influence the development of the long-term conditions strategy. In Site B the findings were fed back in a meeting with several senior managers who plan to integrate the findings into the LTC strategy.

By incorporating a flexibility into the study design we were able to exploit opportunities to feedback in ways that met local needs as the opportunities arose. However, despite the willingness of the research team and interest of key PCT staff in the research, there is a structural gap between academics and health and social care staff which requires time commitment and resources to bridge and establish immediate local impact.

7.3 Implications for policy, practice, education and research

7.3.1 Implications for policy

The data has informed our view that governance encompasses more than formal, legal structures and reporting relationships to include the agencies, tools, techniques and processes which those working within a delivery organisation must respond. Therefore separating governance and incentives into some kind of linear relationship would have been simplistic and arbitrary, telling us little about the chains of command and patterns of influence which are embedded within complex systems. Our data suggests that governance operates at multiple levels of power. It intersects with different perspectives and interests. Finally governance arrangements that

do not explicitly provide opportunities for the professional and service user voices will be disconnected and will result in contradictions in purpose and incentive systems.

In the context of primary care systems there is no linear relationship between governance and incentives (expectations, diversity, priorities and employment contracts) as understood by managers, professionals and validated by service users

Policy development to improve incentive systems needs to take account of the heterogeneity of professional identity and interests. Although financial reward is a clear incentive for GPs, for other staff who may believe they are doing similar level work, not having financial rewards is seen as a disincentive and can lead to loss of interest.

7.3.2 Implications for management practice

Attention by managers to personal development and promoting career pathways of staff through training, supervision and conferences is a strong motivator and enhances job satisfaction.

Good managers show their presence as leaders, are explicit in recognizing the value of employees' work and providing positive feedback on performance. Risk-taking leaders who delegate power to staff to improve practice are highly motivating. They support flexible and person-centred ways of working with service users and give staff the opportunity to shape their job, its working condition and environment. This is the culture in which staff thrive.

Team working with supportive colleagues is a staff motivator of prime importance and involves partnerships and multi-agency working. Staff working in multi-disciplinary teams need support from their own professional manager as well as from the team manager.

Factors contributing to demotivated staff with a resulting negative impact on patient care are: a culture of constant change and targets; insufficient resources; staff shortage leading to overload, stress and burnout; tension at the interface between services.

Perverse incentives to good care are: service reductions couched as reforms; denying patients hospital admissions they need; incentives fostering a disease-specific model without a holistic model of health; the complexity of allocating funding; defensive/risk averse practice; drivers not fit for purpose; inequitable pay for practitioners doing the same level job arising from Agenda for Change; longer hospital admissions resulting from Payments by Results.

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7.3.3 Implications for professional practice

During the course of the study we have discussed the progress of our work with key stakeholders in the Primary Care Trusts. It was vital to the success of the study that they felt a genuine opportunity to participate and contribute. An important mechanism for this was through the site based service user reference groups, which were set up through the support and enthusiasm of key personnel in the Trusts. We have already taken back the preliminary findings from the manager and professional interviews to the service user reference groups and invited managers as a form of validation and in one Trust we contributed to the development of their long-term conditions strategy and the Trust has invited advice from some of our service users. We have produced site specific reports which will be circulated locally. Finally we plan to initiate a discussion with the NIHR SDO to explore the possibility of funding a dissemination event that would bring together key opinion leaders and the service user groups from the three case study sites so that the learning from the study can be shared and used to inform organisational and practice development.

7.3.4 Implications for education

There are implications for team building and the support for integrated working, which is posited as a government solution for meeting the needs of people with long-term conditions. Learning "with, from and about each other" (CAIPE 1997) to support collaborative practice should be implemented at all levels of pre and post qualification education.

Supervision was valued as a means of supporting professional practice in mental health services. This raises the question as to how supervision should be rolled out to support health and other professionals as a lever for professional and organisation change to meet the needs of the reform agenda.

A post qualification training period in the community to prepare new staff (similar to the F1 year in medicine) may provide supported opportunities for staff to learn about skills, attitudes, teamwork, collaborative decision making skills especially in relation to people with complex needs.

7.3.5 Implications for research

We have set out hypotheses in chapter 6 generated from the data, which can be developed into a series of research questions to address the central concerns of how professionals make sense of governance and incentives within their own worlds. These hypotheses could inform the identification of research priorities to address the question of how to effectively recognise and utilise levers for professional behaviour change to improve health outcomes for people with long-term conditions in primary care.

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Appendix 1 – SURG Newsletter

Appendix 2 Interview guide for senior managers

1) There have been lots of policy changes in the NHS over recent years, particularly with regard to governance and incentives. Which policies and drivers in particular do you think have affected the provision of care for people with long term conditions in this PCT and in what ways?

Look for concrete local examples and experiences

What are the challenges/ barriers you are facing?

2) What have been the main issues with translating government policies into local policies and practice around long-term complex needs?

Explore views on appropriateness and effectiveness of the ways policies are interpreted locally and what it is hoped to achieve

Look for concrete local examples and experiences

3) What is your experience of working in partnership with other organisations to operationalise these policies and practices?

Look for concrete local examples and experiences across, health, social, private and voluntary sectors

Have you had any experiences that suggest the need to change partnership agreements?

4) In your view, what motivates staff to provide good care for people with long-term complex needs?

Seek concrete examples to uncover what is meant by 'good care' – and whether/ how the quality of care is considered

Develop insights into perspectives on motivational drivers for staff and managers

How do the most recent policy and organisational changes affect staff in either positive or negative ways in terms of ensuring the delivery of good care

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5) In your view do existing incentive and reward schemes work to deliver good care for people with long-term conditions?

What are the incentives' effect on performance, staff experience (morale, motivation, emotional response, job satisfaction, feeling of control and doing a good job, manageability of work-load) and outcomes.

Are there perverse incentives?

Can you give me a concrete example of where mechanisms have worked well and not so well?

Appendix 3 Interview guide for finance managers

Aim of financial interviews: to establish what aspects of the financial management process/structures create incentives that influence effective care of individuals with long-term physical and mental health conditions

1) There has been lots of policy change in the NHS over recent years, particularly with regard to governance and incentives. Which policies and drivers in particular do you think have affected the provision of care for people with long term conditions in this PCT and in what ways?

Look for concrete local examples and experiences and challenges/ barriers you are faced

Probe if necessary:

How is PbC likely to influence/ influencing the funding available for long-term conditions?

Are long term conditions the subject of SLAs and /or commissioning by you? If so what issues arise

How is payment by results likely to influence/ influencing the funding available for long-term conditions?

Is the funding you use to support long-term conditions subject to meeting targets?

Are there specific finance-related performance targets in the area of close to home care? Do they affect available funds in this field?

2) Do current financial cuts, if any, tend to fall in the area of long-term conditions? MH?

Does the funding for these services tend to be 'residual'? (i.e. it tends to be the funds remaining when other higher priorities have been funded or the governments' targets for other activities met)

3) What have been the main issues with translating the government policies into local policies and practice around long-term complex needs?

Explore views on appropriateness and effectiveness of the ways policies are interpreted locally and what it is hoped to achieve

Look for concrete local examples and experiences

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4) What is your experience of working in partnership with other organisations to operationalise these policies and practices?

Look for concrete local examples and experiences across, health, social, private and voluntary sectors

Have you had any experiences that suggest the need to change partnership agreements?

Have relationships changed?

What issues arise in managing the social services/NHS budget interfaces and how do they affect long term conditions?

How is funding for community nursing and community matrons provided and managed? What are the problems?

5) In your view, what motivates staff to provide good care for people with long-term complex needs?

Seek concrete examples to uncover what is meant by 'good care' – and whether/ how the quality of care is considered

Develop insights into perspectives on motivational drivers for staff and managers

How do the most recent policy and organisational changes affect staff in either positive or negative ways in terms of ensuring the delivery of good care

6) In your view do existing incentive and reward schemes work to deliver good care for people with long-term conditions?

What are the incentives' effect on performance, staff experience (morale, motivation, emotional response, job satisfaction, feeling of control and doing a good job, manageability of work-load) and outcomes.

Are there perverse incentives?

Can you give me a concrete example of where mechanisms have worked well and not so well

Do you have the managerial space to use financial mechanisms effectively to help support the care of individuals with long term conditions?

If you had more freedom, how would you improve the incentives created through finance mechanisms, in order to support long term conditions more effectively?

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Appendix 4 Atlas codes for PEGI

1. Care Quality (Care Quality)

Q1: There has been lots of policy change in the NHS over recent years, particularly with regard to governance and incentives. Which policies and drivers in particular do you think have affected the provision of care for people with long term conditions in this PCT and in what ways?

Access to services (Care Quality;access services) e.g. Moving care into community settings; local provision; acute/community balance; intermediate care; care closer to home; equal access to services; equity in provision; services adaptive to patient needs

Supporting independent living (Care Quality; ind living) e.g. Maintenance at home; QOL; advoiding admission; assertive outreach; supporting self care; improving psychological and physical well-being; fulfilment

Involving patients (Care Quality:involve pts) In aspects oftheir own care: partners in care; empowering patients; expert patients; patient centered care. Influencing delivery of care: PPI

Integrated working (Care Quality:int wkg) joined up, seamless services; issues at the interface;communication between services; technology

Models of clinical mgt (Care Quality: models man't) Approp care pathways; holistic care; care management; community matrons

Supported and empowered staff (Care Quality:staff supp) Environment supporting positive risk and 'thinking outside the box; power to make decisions/prioritise;clinical leadership; peer review and reflective practice; skill development; performance indicators

Finance and comissioning (Care Quality:finance/comm) *using budgets for best effect; PBC; targets*

> ### *Atlas Codes for 'Care Quality'*
> Care Quality:access services
> Care Quality:ind living
> Care Quality:involve pts
> Care Quality:int wkg
> Care Quality:models man't
> Care Quality:staff supp
> Care Quality:finance.comm

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2.	National Policy (National Policy:)

Micro-codes here for EACH national policy discussed even if other aspects have been picked up in the previous question.. Within these codes we can put data on HOW they are perecived to have impacted on the provision of care for people with LTCs as per the question. This enables us to answer what the intentions of policies are perceived to be.

PBC (National Policy: PBC)

PbR (National Policy: PbR)

OHOCOS (National Policy:OHOCOS)

Nice (National Policy: Nice)

QOF (National Policy: QOF)

NSFs (National Policy: NSFs)

NHS Plan (National Policy: NHS Plan)

Commissioning a Patient-led NHS (National Policy: Com PLNHS)

Other (National Policy: Other)

Atlas Codes for National Policy
(National Policy: PBC)
(National Policy: PbR)
(National Policy:OHOCOS)
(National Policy: Nice)
(National Policy: QOF)
(National Policy: NHS Plan)
(National Policy: NSFs)
(National Policy: Com PLNHS)
(National Policy: Other)

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3. Policy Implementation (Policy Implem:)

Q2: What have been the main issues with TRANSLATING government policies into local policies and practice around long term complex needs? The micro-codes here are about the issues/challenges TRANSLATING the national policies into locally implemented policies...

local relevance of policy (Policy Implem:local relevance) e.g. rhetoric and reality

clarity over purpose of national policy (Policy Implem:clarity)

implications for staff (Policy Implem:implic'ns staff)

local environment factors (Pol Implem:local environ) e.g. resource issues; history; 'where they are at' etc

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Atlas Codes for 'Policy Implementation'
Policy Implem:local relevance
Pol Implem:clarity
Pol Implem:implic'ns staff
Pol Implem:local environ

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4. Partnership and Integrated Working (Partnership)

Q3: What is your experience of working in partnership with other organizations to operationalise these policies and practices?

Infrastructure (Partnership:infrastucture) e.g. issues arising from differences in systems; risks to this; attitudes, history, fear; understanding each others' roles; managerial support; leadership/direction.

A shared vision/mission (Partnership:shared vision) Building functional effective relationships; risks to this; attitudes, history, fear; understanding each others' roles; managerial support; leadership/direction.

Maintaining Relationships through change (Partnership: rel'ships change) *e.g. through changes of staff, policies, boundaries*

Ongoing communication (Partnership:communication) *e.g. meetings; keeping contact; sharing information; informal/formal contact*; documentation; involving all parties; joint forums

Resource issues (Partnership:resources) Issues arising from pooled budgets; budgetary decisions;

Atlas Codes for 'Partnership and Integrated Working'
Partnership:infrastructure
Partnership:shared vision
Partnership:rel'ships change
Partnership:communication
Partnership:resources

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5. Motivation of staff to provide good care (Motive)

Q4: In your view, what motivates staff to provide good care for people with long-term complex needs?

REWARDS (Motive Rew:)

Financial reward (Motive Rew: finance) *pay; cash incentives*

Recognition (Motive Rew: Recognition) Amongst peers; by employer; feeling valued and appreciated

Personal development (Motive Rew: PD) training; opportunities for the future; equiping individuals with the skills for good practice

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Job satisfaction (Motive Rew:job sat) *personal satisfaction; effectivness*
SUPPORT (Motive Support:)

Leadership/management (Motive Support: lead'ship) feedback on performance communication; motivation; conflict resolution; good management/leadership; supervison;maintaining enthusiasm

the team/colleagues (Motive Support:team) e.g. support from colleagues, the team, how it works and its effectivness;models; relatrionships   **ENVIRONMENT (Motive environment:)**

The work environment (Motive environment: wk env) creativity; risk; fear; uniforms; having a say; independence and responsibility; resources (staff, equipment etc) ; documentation

Role (Motive environment:role) *Status; authority*

ETHOS (Motive ethos) individuals' personal ethos (Motive ethos) alturism; profssionalism;engaging in the future; public service ethos; providing good care

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Atlas Codes for 'Motivation (positive) of staff to provide good care'
Motive Rew: finance
Motive Rew: recognition
Motive Rew: PD
Motive Rew: job sat
Motive Support: lead'ship
Motive Support: team
Motive Environment: wk env
Motive Environment: role
Motive Ethos

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6.   Demotivators, staff. (Demotive:)

(Note: this reflects Julie's comments.)

REWARDS (Mot Neg Rew:)

Financial reward (Demotive Rew: finance) *pay; cash incentives*
1. **Recognition (Demotive Rew: Recognition)** *Amongst peers; by employer; feeling valued and appreciated*
2. **Personal development (Demotive Rew: PD)** *training; opportunities for the future; equiping individuals with the skills for good practice*
3. **Job satisfaction (Demotive Rew:job sat)** *personal satisfaction; effectivness* **SUPPORT (Mot Neg Sup:)**
4. **Leadership/management (Demotive Supp: lead'ship)** *feedback on performance communication ;motivation; conflict resolution; good management/leadership; supervison;maintaining enthusiasm*
5. **The team /colleagues (Demotive Supp: team)** *e.g. support from colleagues, the team, how it works and its effectivness;models; relatrionships* **ENVIRONMENT (Demotive env:)**

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6. **The work environment (Demotive env: work env)** *creativity; risk; fear; uniforms; having a say; independence and responsibility; resources (staff, equipment etc); documentation*
7. **Role (Demotive env:role)** *Status; authority* **ETHOS (Demotive Ethos)**
8. **individuals' personal ethos (Demotive Ethos)** *alturism; profssionalism;engaging in the future; public service ethos; providing good care*

Atlas Codes for Demotivator, staff
Demotive Rew: finance
Demotive Rew: Recognition
Demotive Rew: PD
Demotive Rew:job sat
Demotive Ethos
Demotive Supp: team
Demotive env: work env
Demotive env:role
Demotive Supp: lead'ship

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7. Leadership and Management (Leadership)

There are other leadership micro categories: under staff motivation 'leadership/management' with an emphasis on support; under supported and empowered staff (emphasis on clinical leadership and leadership impacting on performance) and under partnership under 'a shared vision' (emphasis on leadership supporting integrated working); and under change in 'management of change' focusing specifically around change. Have therfore **focused** the codes here on style/approach and incentives for leaders and managers which was data which might not be captured in the other codes and is interesting contextual information.

Leadership/management approaches (Leadership:approach) e.g. styles; engaging, respecting; problem solving

Leader/manager motivations/incentives: what shapes their approaches (Leadership:motive/incent) e.g. movers and shakers; quick wins

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Atlas Codes for 'Leadership and Management'
Leadership:motive/incent
Leadership:approach

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8. Change

Impact and outcomes of change (Change:impact/outcomes) *Include for whom and what the impact is:* e.g. Uncertainty; fear; weariness; change of roles/identities
1. **Management of change (Change:man't of change)** e.g. a vision of change; preparing and involving staff; communicating the purpose and benefits of change; supporting through change

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2. **incentives for change (Change:incentives)** what are the incentives for change; how do they promote change

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Atlas Codes for 'Change'
Change:impact/outcomes
Change:incentives
Change:man't of change

9.Policy Incentive Effects (Policy Incent Effects:)

Q5:In your view do existing incentive and reward schemes work to deliver good care for people with long term conditions?

Impacts on practitioners (Policy Incent Effects:pract)

impact on organisations (Policy Incent Effects: orgs) e.g. accounatbility, governance, management, efficiency; targets, comissioning

impact on service provision (Policy Incent Effects:serv prov) e.g. impact on service users/patients, quality of care

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Atlas codes for 'Policy Incent Effects'
Policy Incent Effects:serv prov
Policy Incent Effects: orgs
Policy Incent Effects:pract

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10.   Policy Disincentives

Impacts on practitioners (Policy disincentives:pract)

impact on organisations (Policy disincentives:orgs) e.g. accounatbility, governance, management, efficiency; targets, comissioning; resources

impact on service provision (Policy disincentives:serv prov) e.g. impact on service users/patients, quality of care

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Atlas codes for Negative Policy Effects
Neg Policy Effects:pract
Neg Policy Effects:orgs
Neg Policy Effects:serv prov

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11. Perverse Incentives (Perv Incent)

Examples of when the policy incentives work in ways that are opposite to what the policy was intended for.

1. **Conflicting interests (Perv Incent:interests)** e.g. Hip teams vs patient choice; primary care needs to keep patients out of hospital whereas PBR encourages admissions

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> **2. Reaching minimum targets (Perv Incent:targets)** e.g. tick boxing and its impact on quality care
> **3. Bureaucracy vs good care (Perv Incent:bureaucracy)**
> **4. Specific policies (Perv Incent:spec policies)[LP]**
> **Spontaneous refs to specific policies associated with perverse incentives**

Atlas codes for Perverse Incentives
Perv Incent:spec policies
Perv Incent:targets
Perv Incent:bureaucracy
Perv Incent:interests

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12 Financial Issues (Finance:)

Awating advice from Maureen

13 Governance (Governance:)

(explicit references to governance)

Styles of Governance (Governance: styles)

Other (Governance: other)

Atlas codes for 'Governance'
Gov: styles
Gov: other

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14 Vignette Discussion (Vignettes)

Any direct reference/discussion of the vignettes. No sub-codes.

Atlas code for 'Vignette Discussion'
Vignettes

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15. Miscellaneous

For all those difficult to code items, use memos (when you've found out how to do this please let me know) to record why you coded it here.

Background macro- codes for each site: to be completed for all sites

Job description

[Job description is a self-explanatory code, which will be useful for comparing the views of people in similar across sites as well as comparing the views of people with different sorts of responsibilities].

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Role

[People's descriptions of their roles. Possibly useful for cross-site comparison - do people with the same or similar job titles do the same thing?]

Local environment organizational

[Aspects of the organizational environment such as financial position, coterminosity of LA and health boundaries, separate mental health trust, historical relationships e.g. between social care and health.]

Local environment wider

[Factors likely to impact on morbidity, service provision etc such as demographic, employment factors, epidemiological, deprivation levels, political, geographical].

Organisation LA

[Participant is Local Authority (Social Care) employee]

Organisation PCT

[Participant is PCT employee]

Appendix 5 Phase Interview Guide

Approx One hour duration

Require: Consent form

Voice recorder

SURG newsletter to be circulated in advance of interviews

Aim is to capture:

emotional experiences and reactions of staff to organisational priorities and funding arrangements

perspective of staff on how governance and incentive arrangements make an impact on performance and effectiveness

Also to:

make an assessment of team effectiveness

Probes need to be used by the researchers which are site specific in some questions

Section A: Setting the scene

Interviewer to explain the background to the study and the nature of the LTCs we are interested in:

When we refer to LTC we are interested in:

- physical conditions such as diabetes, stroke and COPD where individuals are mostly homebound as a result of this condition

-long-term non-psychotic conditions, for example, chronic and relapsing depression, PTSD and personality disorders

1. What is your role, briefly, in relation to individuals with LTC?

Section B: Changes in care provision and the impact on patients

2. There has been much debate over the past few years with respect to the provision of care to individuals with LTC. From your experience what changes, if any, have there been in how care is delivered to individuals with LTC and the subsequent outcomes for patients? *(reiterate the MH/Physical groups that we are interested in as above)*

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For each change discussed probe:

In what ways has care delivery changed?

What do these changes mean in terms of outcomes for patients?

Questions from Section C (below) if a particular issue is raised here e.g. supporting independent living, involving patients in their care…

Are these changes attributable to policy changes? If so which policies?

Each site needs to prepare a list of the changes introduced in the care of LTC highlighted in the senior manager interviews and probe the impact of these as above if NOT volunteered here by the interviewee. *E.g. we have heard that x is being implemented here, does that make a difference to you in practice and if so how…….*

Section C: Aspects of good care

3. We have talked about changes in the provision of care to individuals with LTC and the subsequent outcomes for them. We asked three groups of service users with LTC to identify what they perceived to be aspects of good and not so good care. The groups identified specific areas of practice some of which we haven't yet discussed and I would like to get your perspective on these:

The following questions need to be covered here if NOT already discussed above. These questions need to be asked ABOVE in Q2 if they are raised as part of the changes described so that there is not repetition

3a) Our SURG group told us stories about how the '**ways in which professionals behave'** is important. For example they appreciated 'friendly' professionals who had the time and willingness to listen and explain things to them; professionals who are patient, non-judgmental and respectful.

In your day to day work, do you consider you are able to give sufficient time to your patients and their carers?

Has this changed over the last few years? If so, why?

What factors affect the amount of time you are able to give?

In your view what impact does this have on outcomes for patients?

3b) The SURG group told us stories in which they had difficulty **'accessing services'.** For example they talked about difficulties in making appointments with GPs, abrupt withdrawal of services at the end of

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rehabilitation, closure of MH day services in favour of entering mainstream activities.

From your experience, are patients able to access services adequately?

What factors affect the access patients have to services?

Do you feel there is equity of access to services?

In your view what impact does access have on outcomes for patients?

In your view how does providing services locally impact on the outcomes of people with LTCs?

Do you consider that providing services locally is always better for patients?

3c) Our SURG group told us stories in which they had received good care because they had felt **involved with decisions around their care** for example in drawing up care plans ad identifying achievable goals. They described this as empowering.

From your experience, how much are you able to involve patients/carers in care decisions?

What factors affect this?

In your view what impact does this have on outcomes for patients?

What do you consider to be the benefits of supporting people to manage their LTCs?

3d) Our SURG group also told us stories of how they considered **continuity of care and communication between professionals** to be important. For example service users described how they felt it was important to build relationships with their care professionals so that they did not have to 'start from scratch' on every visit. They described occasions where they have been in crisis and had to see a GP or other professional who they are not familiar with and how this can cause anxiety. We were also told stories of professionals giving conflicting advice and not communicating well which shakes service users confidence.

How far do you feel there is continuity of care provided to individuals with LTC?

What would you say are the main issues around providing seamless care for people with LTC?

What are the issues for staff in working together to provide seamless care?

What are the outcomes for patients?

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Section D: Governance and incentives

4. In what ways do the governance requirements in this organisation impact on your day to day work?

What impact do targets /policy directives have on your role?

Have you had to change the way you work? In what ways?

In your view how do the issues we have discussed impact on the outcomes for individuals that you care for with LTC?

5. What are the different ways in which you were encouraged/incentivised to do good job?

What factors encourage and enable you to provide good care to individuals with LTC?

How do these incentives affect the care you provide to individuals with LTC?

Use all of the questions below if not already covered and <u>also examples</u> for your particular site

Making a difference

Do you consider you are able to have an impact on individuals' lives?

What do you consider are the key factors which affect the level of impact you can have?

Satisfaction

What aspects of this job/role do you find satisfying/dissatisfying?

What is it about this organisation that would/wouldn't make you want to stay?

Support

What support is available to you within this organisation?

- support from colleagues?

- support from managers?

Is there any additional support you would like to have?

Personal development

What opportunities are there for development, promotion and career advancement? Are these sufficient for your needs?

Was your preparation for this role sufficient?

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6. What do you consider are the affects of constant change on the care you are able to provide?

What factors help/hinder you through these changes?

In your view what impact does this constant change have on outcomes for patients?

Section D: Team work and partnership

7. Do you consider that you work in a team to deliver care to individuals with LTC?

Who is in this team?

How does it function?

Do you consider that this team works effectively?

How does team-working impact on your care delivery?

8. In what ways do the collaboration and partnership arrangements between health and social services impact on the way you work?

Have these relationships changed over the past few years?

What would you say are the main issues around providing seamless care for people with LTCs? How are these managed and is this effective?

Section E: Future vision

9. If you could change one thing in the future about the delivery of care to individuals with LTC, what would it be?