

# Evaluation of the Mental Health Improvement Partnerships programme

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*Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)*

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# *The Report*

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## 1 Introduction

### *1.1 Introduction to the report*

This report presents an evaluation of the Mental Health Improvement Partnerships (MHIP) programme. MHIP was a NIMHE initiative set up to help improve mental health services through partnership working across local mental health communities. This is the final report of the external evaluation of MHIP (E-MHIP) carried out by a multidisciplinary team, led by researchers at the Royal College of Psychiatrists' Research and Training Unit.

The report will describe the work that was implemented as part of the MHIP programme at the national and local levels. The context into which MHIP was placed will be explored and the impacts and outcomes will be examined. The effectiveness of MHIP at achieving these will be assessed. Implications for future improvement work in mental health services will be discussed.

The purpose of this introduction chapter is to cover briefly the relevant literature on organisational change and introduce the Mental Health Improvement Partnerships (MHIP) programme. MHIP's aims, structures and processes will be covered and a timeline of MHIP will be shown.

### *1.2 The literature*

There is a long history of quality measurement and improvement in healthcare organisations and a large and growing academic and practitioner literature. The literature describes the experiences and lessons learned in implementing quality improvement programmes (Blumenthal and Kilo 1998) as well as providing a more theoretical and analytical perspective. One of the drivers for this is to understand the organisational and cultural dimensions of quality improvement and to evaluate the causal effects and impacts of quality improvement on patient care (Shojana and Grimshaw 2005; Ovretveit and Gustafson 2002). It is not the purpose of this introduction to review these literatures, but it is important to locate our evaluation of the Mental Health Improvement Partnership (MHIP) in the context of this wider understanding.

Before doing so, it should be noted that the field of healthcare quality improvement suffers from a high degree of definitional ambiguity and

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terminological confusion. Terms like quality assurance, quality improvement, quality management, quality control, medical or clinical audit, clinical governance, benchmarking, process redesign, and so on are used fairly carelessly. The underlying activities or programmes to which they refer, whilst often share some essential common characteristics, often vary in important ways too. For example, two healthcare organisations, both implementing a total quality management (TQM) programme, may actually be engaged in quite different endeavours with different approaches, methods, measurements and results. Equally, one healthcare organisation's clinical audit programme and another's continuous quality improvement programme may, despite their different titles, have much in common in terms of their content and process. For researchers, evaluators and practitioners it is important to look beyond the labels and language of quality improvement, and to focus on the underlying characteristics and content of such programmes.

### **1.2.1 Quality improvement programmes**

Quality improvement (QI) programmes are complex social interventions. By this, we mean that they are complex and heterogeneous in nature; are used in complex and heterogeneous contexts; and have complex and heterogeneous outcomes or impacts (Walshe, 2007). First, the nature or content of QI programmes like MHIP is not a discrete, simple or unchanging intervention, like the prescription of a pharmaceutical to a patient. Rather the programme "is" a bundle of assorted interventions, used differently each time they are applied, and often changing or evolving through their implementation. This variation is not a weakness or a fault to be remedied, but probably a necessary and desirable characteristic of such programmes. Second, QI programmes like MHIP are used in highly heterogeneous contexts – different organisations, with different cultures, structures, histories and external environments. How they work is partly a product of that organisational context and some of their programme complexity arises from the tailoring or shaping of the QI programme to the distinctive organisational parameters in which it is being implemented. Thus, a QI programme which works well in one organisation, may not work somewhere else if it is unthinkingly replicated, because of the differences in underlying organisational context. Thirdly, QI programmes like MHIP have complex and heterogeneous outcomes or impacts, which are often difficult to measure or assess. While their ultimate endpoints must be improvements in the clinical quality of patient care, different programmes tackle different patient groups or quality problems and have different results. Valuing or comparing outcomes such as a reduction in unplanned readmissions to hospital, a fall in the hospital-acquired infection rate, improved patient satisfaction or knowledge, or improved adherence to treatment guidelines is difficult. Moreover, some important QI programme outcomes are organisational rather than clinical in nature – changes in the attitudes and behaviour of staff, increased capacity and capability for improvement, or organisational learning and reflection.

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## 1.2.2 Evaluating QI programmes

Because QI programmes like MHIP are complex social interventions, it is generally unhelpful to frame their evaluation around the question “does it work?”. The answer is likely to be “sometimes”, and to be of little use to researchers or practitioners in guiding the future development and use of such programmes. Rather, the question to pose is “how, when and why does it work?”:

- what are the important combinations of and connections between the QI programme itself?
- what is the organisational context in which it is used?
- what are the outcomes or impacts it produces?

In this way, research is likely to produce a more nuanced, contextualised and contingent set of findings, which are of much greater utility to those responsible for healthcare policy and practice.

This approach is widely known as realistic or theory-driven evaluation (Grol et al., 2007; Ovretveit and Gustafson, 2002; Walshe, 2007). Its rise in the social sciences over the last two decades has been in part a result of frustration among researchers and policymakers with a false dichotomy which entrapped social methodologists. On the one hand, some argued forcefully for an atheoretical approach to the evaluation of social programmes, in which the quantitative measurement of outcomes, often in the context of a controlled experiment, allowed researchers to focus on issues of causality and impact. On the other hand, some argued equally strongly for a constructionist approach to the evaluation of social programmes which saw them as inseparable from their social context and open to multiple interpretation with no one perspective being necessarily valued over others. They favoured qualitative, process-focused evaluations which eschewed notions of causality and impact and focused more on rich description and contrasting narratives. Theory-driven or realistic evaluation seeks a middle way in which social programmes are seen as having objective and measurable impacts and outcomes, but are also seen as complex undertakings which need to be seen and studied in their social or organisational context and modelled theoretically if they are to be understood – in other words, the “theories in use” should be elicited and used to inform the process of evaluation (Pawson and Tilley, 2004).

Evaluations of QI programmes in healthcare organisations have often found that their effectiveness or impact is rather limited or mixed (Grimshaw et al., 2001), and that the spread or transfer of QI initiatives from one organisation to others is problematic (Shortell et al., 1998). It might be argued that understanding the real content, context and impacts of QI programmes and seeing beyond that content to their underlying theoretical framework is essential if such evaluations are to produce findings which add to our understanding of quality improvement and enable the future design of more effective QI programmes.

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## **1.3 Introduction to MHIP**

### **1.3.1 Background**

#### ***The National Institute for Mental Health in England (NIMHE)***

In 2002, the National Institute for Mental Health in England (NIMHE) was formed to “improve the quality of life of people who experience mental distress and to support positive change in mental health services”. It reported to the Department of Health, picking up some of the remit of the disbanded NHS Modernisation Agency (MA). In 2005, NIMHE was incorporated into the Care Services Improvement Partnership (CSIP). At the time of writing, NIMHE/CSIP has eight Regional Development Centres (RDCs). Through these local development centres and national programmes of work, NIMHE/CSIP aims to support mental health trusts with policy implementation and the development of mental health services.

#### ***Development of MHIP***

Initial plans for MHIP were developed by NIMHE’s Director of Service Development. MHIP’s design was based on an improvement programme for hospitals that came from the MA, Improving Partnerships in Hospitals (IPH), and was extended in recognition of the complexity of mental health communities. The MA’s approach to improvement methodology and was heavily linked with the Institute for Health Improvement in the USA based on techniques such improvement cycles, process mapping, creativity, LEAN, appreciative enquiry. IPH, and subsequently MHIP, were base on this approach.

According to the MHIP Project Initiation Document, MHIP was intended to:

“provide NIMHE with an opportunity to reconfigure its programmes of work to respond more appropriately to the needs of local mental health systems in overcoming problems and a mechanism for the organisation to demonstrate that it is able to add value to local “clients”, as well continue as to support the development of national policy and the delivery of national targets”.

### **1.3.2 Aim and principles**

From the MHIP Project Initiation Document (Appendix 1), July 2005:

“The Mental Health Improvement Partnerships (MHIP) aims to improve the total quality of every service user’s journey throughout the mental health system. The programme will achieve this by developing the capacity and skills of local care communities in order to make fundamental improvements in the way services are provided”.

The vision was to promote a set of principles:

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- *Service user and carer focus:* "Mental health organisations will be developed which are driven by the choices and needs of all the people who use their services"
- *Social inclusion:* "The programme will enable mental health systems to develop mechanisms which actively promote social inclusion, equity, access and equality"
- *Whole systems working:* "The programme will be delivered by, with and through whole local mental health communities. All parts of the local systems will be actively engaged in shaping and delivering the work to ensure it meets the aspirations of the whole community"
- *Enabling service excellence:* "The programme will support the delivery of new models of care based on the latest evidence of effective mental health service development"
- *Promoting learning and innovation:* "Transparency and openness (sharing learning with the wider mental health community throughout the lifetime of the programme)"

### **1.3.3 The MHIP package**

The MHIP programme was hard to understand (this is discussed in greater detail in Chapters 4 & 7). It comprised schedules, tools, structures, support and resources to enable local sites to implement their improvement work.

#### ***Methods***

Sites were free to select workstreams that were relevant to their localities. They were encouraged to approach them in a manner that took account of the "Areas for Improvement":

- Strengthening local partnerships
- Quality of care
- Organisational fitness
- Service user and carer involvement

The MHIP methodology included six processes: preliminary diagnostic analysis; managing clinical processes; workforce redesign; organisational and leadership development; customised support and outlining a local timetable. This local timetable, in turn, included four phases: gaining stakeholder commitment, preparation and launch, diagnosis and solution design and the implementation phase.

#### ***Tools***

The Mental Health Service Improvement Framework (MHSIF) incorporated three components:

- Outcomes and outcome measures. Using the Balanced Scorecard approach, outcomes and outcome measures were to be linked to the four Areas for Improvement
- Information tools. The National Service Users Survey and the Service Improvement Support Tool for Mental Health (SISTMH) an online tool enabling recording and communication of progress within and across trusts
- Learning and Development package. This aspect was intended to provide the organisational development component, developing the skills through resources, events and training amongst local stakeholders to enable delivery of the service improvements.

It was intended that evaluation would take place as part of day-to-day delivery and management focusing specifically on evaluating the learning and development component of MHIP. Plans also made reference to the external evaluation of MHIP.

### ***Governance***

Governance arrangements for MHIP consisted of the following:

- National MHIP steering group, providing overall strategic leadership and was accountable to the NIMHE executive team
- MHIP Programme board, responsible for the operational delivery and performance management of the MHIP programme, accountable to the National MHIP steering group
- Programme Lead Learning Group, also including NIMHE Regional Development Centre leads and the Service Development Team leads, chaired by the NIMHE MHIP Lead Director
- Local governance arrangements included a steering group, an Improvement Partnership Agreement document, a Programme Lead, a Project Manager and an RDC Client Manager. Localities used an agreed structure, in the form of "highlight reports" to report progress up to the MHIP Programme Board

### ***Resources and support***

Support from NIMHE was to include resources to build local capacity, including up to £180 000 in cash or equivalent resource basis; dedicated NIMHE client management support, resources and expertise; and access to training. Skills and capacity were also to be drawn from the Modernisation Agency and particularly from the MA's Improvement Partnership for Hospitals (IPH) programme.

#### **1.3.4 The pilot**

The MHIP programme was launched as a pilot in four local "mental health communities" in 2004. Each of these communities comprised the area served by a Mental Health Trust; and in each community the Mental Health

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Trust was the host of MHIP programme. The four hosting Mental Health Trusts were:

- South Staffordshire Healthcare NHS Trust
- Leicestershire Partnership Mental Health NHS Trust
- South West London and St. George's Mental Health NHS Trust
- South West Yorkshire Mental Health NHS Trust

### 1.3.5 Timeline for MHIP and the evaluation

**Table 1. Key dates for MHIP and the evaluation**

Date	Event
January 2003	IPH launched in 2 pilot waves of four trusts
mid 2003	IPH rolled out in 8 waves of 20 trusts towards late 2003
late 2003	MHIP pilot sites identified Early MHIP meetings with 3 pilot sites (SSHT, LPT, SWLSG) and local Programme Leads appointed
March 2004	A 4th MHIP pilot site recruited (SWY) Chair of National MHIP Steering Group secured
April – June 2004	Local MHIP sites hold launch/consultation events Local MHIP programme workstreams identified
July 2004	First National MHIP Steering Group held MHIP Project Initiation Document signed off
August 2004	MHIP Communications Lead appointed
September 2004	MHIP Communications Strategy presented to the Steering Group
October - December 2004	Local MHIP programmes write workstream implementation plans and held workstream events and away days
April 2005	SSHT MHIP Programme Lead takes over role as National Programme Lead
May 2005	<i>Full proposal for E-MHIP submitted to SDO</i>
June 2005	New SWLSG MHIP Programme Lead begins
September 2005	New SWY MHIP Programme Lead begins
August 2005	IPH evaluation published
February 2006	<i>E-MHIP contract begins</i>
April 2006	SWLSG and SSHT MHIP Programme end reports produced
April 2008	<i>E-MHIP Final Report submitted</i>

References to the Improving Partnerships in Hospitals programme are show in grey

## 1.4 Structure of the report

This report presents the analysis and discussion of E-MHIP. Following this introductory chapter,

**Chapter 2: E-MHIP methods** outlines the aims of E-MHIP and describes the evaluation framework and tools

**Chapter 3: Context** describes the setting into which MHIP was placed in terms of potential distractions and the existing capacity to implement MHIP

**Chapter 4: MHIP structures and processes** summarises each of the case study programmes and examines how MHIP was planned, implemented and evaluated

**Chapter 5: Costs and impacts of MHIP** examines input and outcomes, in terms of impact on quality of service and on the organisations and how people worked

**Chapter 6: E-MHIP methods appraisal** describes the difficulties and modifications that were made to the evaluation methodology and reflects on its strengths and weaknesses in light of the findings described

**Chapter 7: Discussion** summarises the findings and examines their implications for future policy and practice

**Appendix** comprises a number of accompanying documents. The appendix contains the 5 MHIP case studies.

### **1.4.1 Case studies**

Five MHIP case studies were written; one on each of the four local pilot sites and one on NIMHE. In each local case study, the background to the host trust and partner agencies is presented, followed by a description of the local MHIP programme in terms of context, structures, planning, workstreams, implementation and follow-up. The programmes are appraised against the organisational standards and the outcomes are assessed. Each case study ends with a discussion where key factors are analysed in order to explain the progress and outcomes seen.

## **1.5 Chapter summary**

Quality improvement programmes are complex social interventions. In order to understand the effectiveness of such programmes, evaluations must not ask merely, "does it work?", but ask "how, when and why, does it work?".

NIMHE established MHIP to help mental health communities implement key policy and improve services. It was launched as a pilot in 2004 in four local mental health communities. The programme comprised aims and principles, a methodology framework, a collection of service improvement tools, a governance structure, and some resources and support from NIMHE.

In order to produce a nuanced, contextualised set of findings, which will be of practical use for future quality improvement programmes a methodology was developed specifically to evaluate MHIP. This is described in the next chapter.

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## 2 E-MHIP Methods

### ***2.1 Chapter introduction***

The Evaluation of the Mental Health Improvement Partnerships programme (E-MHIP) was commissioned by the National Coordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). This external evaluation was to inform future roll-out of MHIP and was carried out over a 26 month period from February 2006 to April 2008.

The evaluation aimed to:

**Aim 1: Describe the MHIP programme and the settings into which it was introduced**, covering all relevant organisational contexts, the change work carried out, from the planning stage onwards, and including the perspectives of personnel through whom the change work was developed and taken forward.

**Aim 2: Assess the outcomes and impacts of MHIP**, examining the nature and extent of changes that occurred within pilot trusts, including changes in structures, processes and outcomes. Further issues considered were the utilisation of resources, including training, finance and staff time.

**Aim 3: Assess the effectiveness of MHIP in achieving these outcomes and, by extension, gain an understanding of successful change work in general**, incorporating analysis of the active components of the change methods employed, relative to the evidence base, and the settings into which they were introduced.

This chapter will explain E-MHIP's methods in terms of the theoretical framework and tools. The phases of data collection, analysis and validation will be explained. Finally, the chapter outlines how E-MHIP followed a process of analytical induction.

### ***2.2 Theoretical Framework of E-MHIP***

#### **2.2.1 Realistic Evaluation**

##### ***Theoretical background***

Realistic Evaluation (RE, Pawson and Tilley, 2001; 2004) provided the overarching framework for E-MHIP. The Realistic Evaluation approach has as its starting point a largely generative approach to causation. This forms the underlying basis for a critical realist ontology on the nature of change within social programmes which has a complex view of causality, i.e. generating theories on how and why a programme worked, rather than merely establishing whether it worked. For example, how a programme successfully brought about a change within an organisation. The approach

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also asks questions about the 'null hypothesis', however, i.e. what the situation would be if the programme had not occurred. It could be argued that this comes more from a successionist approach to causality. The approach has some limited claims to generalization. RE attempts to define what the programme sets out to address, i.e. the problem that is to be solved. This situation is termed an *outcome*. The processes or limitations that can potentially cause this outcome are termed *mechanisms*. A key contention of RE is that it is only under certain circumstances that a mechanism will achieve its causal potential; these circumstances are termed *contexts*.

Realistic Evaluation works with open systems and a generative model of causation. It assumes that when mechanisms are activated, the outcome always depends on the specific contexts of their application. In describing a given situation, then, the basic explanatory structure **Context + Mechanism = Outcome** is used.

Policies, programmes and projects always work through participants' perceptions and choices. Whether people respond appropriately depends on many circumstances, which are likely to vary within and between cases. In order to evaluate these policies, programmes or projects effectively, it is necessary to identify these circumstances.

### ***Using Realistic Evaluation***

When analysing a change programme, once the initial problem (outcome) has been described, the next step is to generate theories of how the change programme attempted to address this problem (mechanisms). This involves establishing what new mechanisms were put in place that, in concert with previously identified contextual factors, removed or reduced the impact of the mechanisms behind the existent problem. Hypotheses are developed, based on these theories; these hypotheses are compared with actual events. By identifying what mechanisms found within change programmes have the potential to bring about positive change, and in what contexts this potential is reached, this learning can be generalised to other settings, guided pragmatically by situational features.

Realistic Evaluation is based specifically on Critical Realism. Standard tools are not mechanically applied. It rejects experimental and non-contextual approaches to evaluation. Concrete knowledge of the phenomenon being studied is relevant. Explanations thus require interpretative and qualitative research to discover the participants' reasoning and circumstances in specific contexts. The methods and techniques used have to be carefully tailored to the exact form of hypothesis underlying the specific evaluation exercise.

Within the Realistic Evaluation framework of E-MHIP, a number of data collection tools were used to investigate the contexts, mechanisms and outcomes. Standards for organisational change provided a baseline against which pilot sites' preconditions and processes could be compared. Economic theory guided the estimation of the costs of MHIP. Each of these components is described below.

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Using these tools, E-MHIP generated theories of how MHIP operated, both nationally and at the local level. These considered relevant contexts, the activities carried out and the impacts this change work had. The research involved a clear process of analytical induction, which increased the robustness of the findings (see Section 2.6 in this chapter).

### **2.2.2 Organisational change standards-based assessment**

Under the umbrella of Realistic Evaluation, the research used a standards-based approach to describe the contexts and content of the MHIP work.

Standards-based assessment is a widely-used approach which is established as the evaluation component of standards-based audit in health service quality improvement (Jamtvedt, Young, Kristofferson, O'Brien & Oxman, 1998). Standards are derived from a review of key documents, existing relevant standards and expert opinion. Services are assessed against these standards, using a mix of methods and incorporating both self and peer review. When used in service audit, plans are developed following the evaluation to assist in improving performance relative to the standards in readiness for the follow-up evaluation.

For the purpose of research, standards provide a reference point against which pre-conditions and processes can be compared. This is especially useful in studies where comparison across participating groups or communities is not appropriate. The reference point provided by standards represents a consensus of opinion in the field and can sometimes also incorporate policy.

#### ***Development of the standards***

Standards of good practice in organisational change were developed for the evaluation of MHIP. This was done by the following processes:

- 1. Review of key documents.** Academic journal articles, systematic reviews of the literature (e.g. Cochrane, NCCSDO) and other relevant sets of standards (e.g. Investment in People; Clinical Governance – Enabling Frontline Staff) were reviewed. The process was supported and guided by experts on organisational change and standards development based in the College Research and Training Unit of the Royal College of Psychiatrists.
  - 2. Consultation and editing.** The draft standards were distributed for comment amongst the E-MHIP steering group, which contained experts in organisational change, health policy and standards development. Based on the subsequent discussion, the structure of the document was agreed and certain criteria were removed, repositioned or reworded.
  - 3. Revision.** The standards were used extensively in the preparation for and during the course of the E-MHIP site visits. Alterations to the structure and content of the standards were identified as necessary from which a revised, validated set of standards would be produced.
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## ***Format***

The standards were structured around priorities identified in key documents. They comprised four sections that followed the chronological flow of organisational change:

- 1. Preconditions** summarises the organisation in terms of its “readiness for change”, as defined by its structures (e.g. leadership, communications, support) and situation (e.g. organisational turbulence).
- 2. Planning** summarises the aptness of the objectives and methods selected for the change programme, as well as the effectiveness with which the plan is communicated
- 3. Implementation** summarises the involvement and support of staff in carrying out the change programme, as well as the measurement and communication of its progress
- 4. Follow-up** summarises the extent to which the progress and impact of the change programme is reviewed and learned from

## ***Using the standards-based approach***

The standards-based component profiled MHIP across pilot sites in terms of the extent to which the change work reflected evidence on good practice in organisational change. This suited well the Realistic Evaluation approach as it generated theories of what elements of change work were truly causal in the outcomes observed. Integral to this was consideration of significant contextual factors. By extension, this approach allowed a broader consideration of what contextual factors can lead to the success or failure of organisational change methods that are generally accepted as effective.

There are a number of common criticisms of the standards-based approach. A standards-based approach is a confirmatory approach not exploratory and, as such it can miss things not anticipated in the standards, e.g. innovative practice or poor practice in an unusual area. Also, staff whose service is being reviewed can feel that they are being grilled rather than listened to and that the process is about “ticking the boxes”. Standards are biased towards things that are easy to measure. Indeed, they are selected for use in audit on this basis. Standards are therefore more likely to refer to height of fences and presence of policies than level of staff morale.

E-MHIP dealt with these issues by designing a standards-based interview schedule. Questions were designed to elicit information necessary to rate the standards but were also open enough to give respondents the opportunity for more open discussion. Furthermore, other questions were added into the schedule to ask respondents questions like “Would these things have happened without MHIP?” and “What, in your opinion, were the obstacles and enablers to MHIP?”. The interview also gave the opportunity for the respondent to speak about anything else they felt was relevant. As a broad range of stakeholders from a number of organisations were interviewed, it was possible to triangulate in order to determine how robust

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a theme was, e.g. if 3 different groups mentioned staff morale as a problem, then this might be considered a robust finding.

### **2.2.3 Economic component**

The aim for the economic component was to assess the full cost of implementing MHIP and to set this alongside information on the outcomes achieved. The objectives were to:

- estimate the 'true' cost of implementing MHIP, including both explicit funding streams and 'hidden' costs
- assess whether MHIP resources were instrumental in terms of delivering positive, measurable outcomes to service-users, staff or the organisation and whether these were perceived to be of significant benefit

#### ***Methods***

Within the Realistic Evaluation framework, the context was set by the financial situation of the Trust and the local market, including the resources, e.g. money and staff, made available to implement MHIP. What these resources "bought" or how they were used was part of the mechanism by which the programme would achieve its objectives (the outcomes) alongside the extent to which those involved perceived the resources as necessary and sufficient.

Three data collection tasks were undertaken and the resulting information was carefully merged.

- Information was collected on the money that came into each MHIP pilot site from NIMHE, from the host mental health trust and from the partner organisations and also on how this money was spent. The data came from MHIP-specific documentation held by NIMHE and the host trusts, and from the organisations' financial statements and accounting procedures.
- Some information was collected during the semi-structured interviews with those involved in MHIP in each site. This ensured that the most relevant people were asked about the financial situation and also that information was collected about attitudes to MHIP resources and the way they were used.
- Resource inputs were also identified through the E-MHIP stakeholder survey. This survey (described in further detail below and provided in Appendix 3) was broadly circulated in each pilot site. This enabled estimation of the costs of the "hidden" contributions from the many staff that helped implement MHIP but were not funded from the dedicated MHIP resources.

While cost analysis is generally regarded as quantitative research, a qualitative approach to data collection and analysis was also required. This mirrored the mixed methods used in other parts of the evaluation. For example, the themes discussed in the semi-structured interviews and the data analysis informed our consideration of the financial context and the

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attitudes to MHIP resource issues. Data from finance departments and on the income and expenditure accounts provided “hard” facts and figures about finance flows. The stakeholder survey provided respondents with the opportunity to report both figures (for example, on time use) and their perceptions of MHIP.

## **2.3 Data collection**

The evaluation was made up of two phases:

- Phase 1 – Preliminary work and exploratory visits: May 2006 – September 2006
- Phase 2 – Case studies of MHIP at national and local levels: October 2006 – July 2007

### **2.3.1 Phase 1 – Preliminary work and exploratory visits**

The purpose of this exploratory phase was to define MHIP as the basis for the more in-depth work that was to follow. Specifically, it examined the aims of MHIP, both nationally and across the four pilot trusts, and identified the sources of information that would inform the evaluation. This was achieved through analysis of key documents and face-to-face and telephone interviews.

#### ***Collection of “historical documentation”, covering the development and theoretical basis for MHIP***

At a national level, historical documentation included: relevant policy documents, such as the NHS plan; documentation related to the structure and evaluation of MHIP’s precursor, the Improvement Partnerships for Hospitals (IPH) programme; and, most directly relevant, the MHIP Programme Initiation Document (PID) and the report of the NIMHE-run internal evaluation of MHIP. At the local level, the principal data sources included the local PID, project PIDs and year-end reports.

#### ***Collection of “progress documentation”, covering the changes that occurred in relation to MHIP***

At the national level, progress documentation took the form of year-end reports and internal evaluations of the programme. At the local level, it included highlight reports prepared by each pilot trust for regularly-held meetings of local MHIP leads and project-specific updates placed on NIMHE’s Service Improvement Support Tool (SISTMH), an online service facilitating the spread of learning.

#### ***Data about outcome and changes in process relevant to MHIP***

The E-MHIP project team identified sources of data that might provide information about the local impact of MHIP. These included: data collected by trusts as part of routine central returns; data collected for more local use, e.g. as part of commissioning data sets or as part of clinical audit; the

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results of national patient and staff surveys; and data collected specifically for the purpose of defining a baseline for or for evaluating the impact of MHIP at a workstream/project level. These data included both those that related to outcomes and to processes because some local MHIP workstreams focused only on changing service processes.

### ***Semi-structured interviews with relevant personnel within the central MHIP team and across the four pilot sites***

Interviews took place either in person or via telephone over the period of May 2006-September 2006. Respondents (whether speaking from a national or local perspective) discussed MHIP as they had experienced it, in terms of the following topics: what the trust/s had been like prior to the introduction of MHIP; how MHIP was introduced, and the reasons were given for its introduction; how MHIP had been manifested, from the initial consultation phase, through recruitment and project design, to any implementation and outcomes that might have occurred.

The research team used this information to generate preliminary theories of how MHIP operated and its aims, methods and priorities across the pilot trusts. These were written into briefings for the research team prior to Phase 2 of the data collection. This information also informed the development of data collection tools and identification of people to be interviewed in Phase 2.

### **2.3.2 Phase 2 – Case studies of MHIP at national and local levels**

The five MHIP cases studies are presented in Appendix 10.

Phase 2 of the evaluation focused in greater detail on the process and impact of MHIP. In developing the case studies of MHIP at national and local levels, two main approaches were taken. Initially, a survey was conducted by distributing a questionnaire across central and local MHIP personnel. Following this, two rounds of site visits took place, incorporating one-to-one interviews and group discussions.

#### ***Stakeholder survey***

The stakeholder survey (Appendix 3) was entitled "Your involvement in MHIP" and included questions about respondents'

- background information, in terms of their responsibilities, both at time of interview and during their involvement with MHIP
  - level of involvement in MHIP work, e.g. time devoted to MHIP
  - resources provided to support involvement in MHIP, e.g. finance, training, backfill
  - perceived impacts and benefits of MHIP
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Of particular importance to E-MHIP's economic component were questions about time involvement, which were to be converted to a cost using nationally applicable hourly costs for the various staff groups.

The surveys were distributed widely across the pilot trusts<sup>1</sup>, attempting to reach everyone who was involved in MHIP project work. To that end, questionnaires were sent to senior management (e.g. Chief Executives), middle management (e.g. people directly involved in managing both the change work and the services addressed by the MHIP projects) and frontline staff. An amended version of the questionnaire was sent to carers and service users upon whom MHIP may have had an impact.

Questionnaires were completed either over the telephone, by email or on paper between January and August 2007. In some cases, potential respondents were briefed by telephone and additional briefing for some staff was provided through internal trust communications via local MHIP Leads (e.g. newsletters, staff intranet). Non-respondents were followed up to establish the reasons why they could not respond.

### ***Site visits: round 1***

The first round of site visits was carried out by the research team over the period of November 2006 to February 2007 and took the form of one-to-one interviews lasting between 45-60 minutes. Using a standards-based schedule (reproduced in Appendix 4), interviews addressed:

- relevant features of the context where MHIP was introduced and implemented and the planning and implementation of MHIP work; these questions mapped onto standards that the evidence suggested were indicators of effectiveness in an organisational change intervention
- the impacts of MHIP work, if any, on staff and service users, in terms of changes made at process and outcome levels; and whether it was felt that MHIP actually played a role in these impacts and whether any other factors, such as context, also played a part
- other change work to have occurred during and around the period in which MHIP took place

The interviews were conducted with approximately 30 staff in each trust. The focus of questions was amended to reflect the respondent's relationship to MHIP: managers were asked about the programme as a whole, whereas

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<sup>1</sup> Early in the evaluation researchers compiled a list of nearly 400 people across the pilot sites from the MHIP documentation and the standards-based interviews. By the end of this first round of interviews, only names already provided were recommended as further contacts. This meant that there was a reasonable level of confidence that the coverage was good. Attempts were made to contact everyone on the list. Those who had left the organisation proved difficult to trace as did some users and carers where data protection issues meant, quite rightly, that it was not possible to obtain contact details (23%).

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frontline staff were asked about the workstream most relevant to them. Based on responses to this questionnaire, detailed standards-based summary reports of change work in each of the trusts were generated. These summaries were used to brief the researchers for the second round of site visits.

### ***Site visits: round 2***

The second round of site visits took place over the period of March to July 2007. The visiting team comprised the full-time researchers, organisational change experts, an economist, a service user expert (all authors of this report) and a representative from one of the pilot sites. The latter were involved to incorporate an element of peer-review and to spread learning across the participating mental health communities. The second round of site visits were designed to:

- follow up on points of interest identified by the first round of site visits
- develop strong local theories of how MHIP work operated in the pilot trusts and within the central MHIP team, drawing on hypotheses generated during the exploratory phase
- collect further information on resource use to facilitate the economic component
- complete the identification and collection of data about outcomes and changes in process relevant to MHIP locally

The interviews and discussion groups were guided by a series of themes derived from the analysis of the data generated during Round 1 and validated in consultation with a group of people who made up a “sounding board” (see Section 2.5).

One-to-one interviewees were selected for their significant perspectives on the trust, MHIP and change work in general. They included: chief executives; the local Programme Lead and workstream leads; service users and carers; clinicians on whom the change work impacted; key support personnel, including clinical audit and clinical governance personnel; and key personnel in local partner organisations.

Discussion groups were set up for each workstream within local change programmes. They were composed of up to eight people, selected from different levels of the organisation operating within the workstream investigated. By having workstream-specific discussions, it was possible to assess how consistently MHIP had been manifested across separate projects and enabled a better understanding of what elements of change programmes work and for what reasons.

140 stakeholders from the local partnerships were asked questions about their experiences of MHIP and their views on organisational change in interviews lasting about an hour. Sixty-five one-to-one interviews were carried out, while 20 group discussions took place; four interviewees declined to be recorded. The roles and organisations of the interviewees are

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given in Table 2. All recorded interviews were fully transcribed and analysed.

**Table 2. Interviewee details**

<b>Professional group</b>	<b>Number interviewed and/or surveyed</b>
Mental health Trust Senior management	46
Mental health Trust Middle management	33
Mental health Trust Frontline staff	37
Primary Care Trust personnel	20
Strategic Health Authority personnel	4
Local Authority personnel	9
NIMHE/CSIP/MA	7
Voluntary Sector	11
Service users and carers representatives	25
Other	13
<b>Total</b>	<b>205</b>

## ***2.4 Analysing interview data***

### **2.4.1 Aims and rationale of the approach**

The aim of the analysis was to summarise the data into clusters of themes to inform the key research questions. In order to employ an exploratory approach, thematic analysis (Boyatzis, 1998) was used. Thematic analysis is presented as a flexible method of encoding qualitative information. Data can be organised simply or in a more complex fashion, according to a list of themes; a complex model with themes, indicators, and qualifications that are causally related; or something in between these two forms.

### **2.4.2 Developing the themes and coding framework**

Thematic analysis was used to develop the coding framework (Appendix 5) used in the analysis of interview data. Boyatzis (1998) describes 3 different ways to develop themes and code data in thematic analysis:

- theory-driven
- prior data or research driven
- inductive or data driven

In E-MHIP themes were derived from a hybrid of theory-driven and data-driven approaches. Realistic Evaluation theory was used to structure the

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coding framework around the concepts of context, mechanism and outcome. Analysis of sources other than the interviews contributed to the development of the coding framework:

- the findings of the survey
- the organisational improvement standards
- consultation with people with experience of organisational improvement
- researchers' experiences of and reflections on the site visits

A preliminary coding framework was produced, containing a comprehensive list of 42 codes. This framework was piloted by six members of the research team on three randomly selected interview transcripts. Coders looked for redundant or overlapping themes, identified gaps, and evaluated the general usability of the framework. The framework was amended and a final list of 22 codes was produced. A 15% sample were dual coded, i.e. by two researchers showing a high degree of inter-rater reliability.

The framework comprised codes relevant to MHIP's context, implementation and impact. Particularly notable sentences or blocks of texts were signposted using further qualifying codes, e.g. where an interviewee provided a personal definition or described a causal link. As analysis proceeded, concrete examples of each code were drawn from interview data to ensure the transparency of code labels.

### **2.4.3 Using the framework**

The framework was used to code all transcripts. Relevant chunks of text were categorised according to one or more codes. Coding was then entered into qualitative data analysis software (QSR, NVivo 7).

Codes relevant for each of the important topics in the literature (i.e. each of the standards) were identified. For each topic, themes within these coded datasets were drawn out and analysed to create a richer picture of what had been observed and to explore causality.

## **2.5 Validation processes**

The evaluation included a number of processes by which findings and hypotheses were validated.

### ***Peer review***

On each research visit, the team included a member of staff from one of the other MHIP pilot sites, similar to a "peer review" process.

### ***Sounding board***

The sounding board was set up to provide insight from people who were experienced in implementing change, but who were based outside of the

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MHIP settings. This insight was vital for validation of the evaluation, ensuring that the findings are generalisable and useful.

The sounding board consisted of approximately 35 members including senior managers, middle managers, frontline staff, service-users and carers from sites not involved in implementing MHIP. These people were recruited through the Royal College of Psychiatrists' Medical Directors' and Service Directors' groups and contacts via the College Centre for Quality Improvement. The sounding board validated ideas and themes at three time points during the course of the evaluation:

- 1. A virtual discussion (November – December 2006).** All members of the sounding board were sent an email asking them to contribute to an email discussion on their experiences of obstacles and enablers to change. These were checked against the data collected during MHIP.
- 2. Sounding board workshop (February 2007).** This acted to validate the hypotheses/themes generated during Round 1 of data collection which would be used to guide Round 2. The findings of this workshop were written into a paper (Appendix 7).
- 3. Improving Mental Health Services Expert Seminar (December 2007).** The local MHIP pilot teams presented their case study report to the other teams and the sounding board. This meant the research team had a high level of confidence in the case study reports as they had been checked by the teams themselves for accuracy and representativeness, but also for validity to the wider mental health service improvement community. This seminar is reported in a paper (Appendix 8).

### ***Member checking***

Following the second round of site visits, the five local case studies were completed. Member checking was carried out by sending the MHIP teams their respective reports. Teams gave feedback on accuracy of the reports and amendments were made as appropriate. These were then presented at the expert seminar detailed above.

## ***2.6 Analytical induction***

The research involved a clear process of analytical induction, which increased robustness of the findings. Analytic induction is a major logic of qualitative research. Developed most fully by Strauss and Corbin (1998), this approach to design fieldwork and analysis is one of the most influential methodologies in qualitative enquiry (Shaw, 2001). Expressed simply, the approach consists of the following stages:

- 1. A rough estimation from which a hypothetical explanation is made of the phenomena to be explained.** The first stages of the data collection strategy involved semi-structured interviews, standards-based interviews and preliminary collection of documentary and financial data. This enabled the team to develop some general hypothetical explanations
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which were used to guide the main site visits. These “themes” were validated by the sounding board to ensure their relevance and effectiveness as a research tool. At this stage, local reports were produced to brief the research team before the main site visits.

**2. Cases are studied in light of this hypothesis, with the aim of testing whether the hypothesis fits the facts of each particular case.**

The research team conducted 4-5 day visits to each pilot site to test and further explore the initial hypotheses.

**3. If the hypothesis does not fit, then it is reformulated or the phenomenon is redefined so that discrepant cases are included.**

During the visits the research team met to discuss findings and generated new hypotheses specific to each local and national pilot site. The hypotheses were refined and, where relevant, changed to fit with the subsequent data found. Five case studies were produced documenting the site-specific explanations for what was observed.

**4. The cycle is then repeated, with an emphasis on seeking to disprove the hypothesis.** This was achieved by a process of member checking; the local case study reports were sent to personnel from the sites to ensure that the findings were a true and reliable picture of the MHIP programme in that location. Where necessary the reports were adjusted to reflect better understanding. This was then followed up by an event where representatives from the MHIP pilot sites presented their case study to the sounding board and the other teams involved in MHIP. The result of this final exercise was a ratification of the evaluation’s findings which increased the confidence in the evaluation hypothesis and the validity of the findings.

## ***2.7 Chapter summary***

The framework for E-MHIP was Realistic Evaluation. A number of tools were used to investigate how MHIP was carried out nationally and locally, within each pilot site. The organisational change standards provided a baseline against which sites’ preconditions and processes could be compared. Costs were estimated and set alongside MHIP’s impacts. Data was collected through analysis of relevant documentation, a stakeholder survey, semi-structured interviews and site visits involving further interviews and discussion groups. All interview transcripts were coded using a process of thematic analysis. The generated themes were integrated into the data to provide a rich picture of MHIP and to explore causality. The research followed a process of analytic induction including hypothesis testing and validation.

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## 3 Context: national policy and local organisational settings

### ***3.1 Chapter introduction***

This chapter explores the national and local context for MHIP – both the wider setting of policies and initiatives on quality improvement and mental health services at a national level, and the way that national picture contributed to shaping the distinctive local organisational setting for each of the four mental health communities in which MHIP pilots took place. It highlights the complex, fluid and fast-changing environment and tries to draw out from our data a number of important themes or areas in which it seems these contextual factors were important determinants of the direction, progress and impact of MHIP. It concludes by reflecting on the power of context, the way that MHIP played out quite differently in the four pilot sites because of sometimes profound but unrecognised or unacknowledged contextual differences, and the need for future quality improvement programmes to take greater account of organisational context.

Analysis integrated data from a number of sources (see Section 2.5.3, Chapter 2 for method). The key data sources used in this chapter were:

- Local documentation, e.g. CHI reviews, Trust websites, etc
- Context sections of the standards-based interviews
- Qualitative data, theme 2.1 *The situation of the Trust*
- Qualitative data, theme 2.2 *The Trust's existent drivers*
- Qualitative data, theme 2.3 *The Trust's external partners*

### ***3.2 National policy: the wider context for MHIP***

In 2004, when the MHIP programme was launched, mental health NHS trusts across the country faced a wide range of policy changes and financial pressures. These included:

- Numerous government targets and initiatives, arising from National Service Framework (NSF) obligations; the New Ways of Working changes to workforce configuration and deployment and the Agenda for Change reassessment of rewards and gradings; the 10 High Impact Changes for Mental Health Services; the Choice Agenda coming from the NHS Plan
  - Pressures to improve mental health services arising from the requirements of Standards for Better Health, and the assessments by the Commission for Health Improvement (and subsequently the
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Healthcare Commission) of their performance, not least the publication of the NHS performance or “star” ratings

- The political imperative to move towards Foundation NHS Trust status, giving high performing NHS trusts greater freedom and autonomy from central government and strategic health authority control
- A wide range of local cost improvement programmes to tackle substantial financial deficits in some trusts, or more broadly across whole health economies where despite increasing resource nationally, there were longstanding and often embedded service configurations (in the acute, mental health, and community setting) which were unaffordable
- Many other locally identified targets and projects around service improvement, redesign or reconfiguration
- Substantial reorganisation and reconfiguration of the organisational structures and systems in the mental health community, with strategic health authorities being merged into a smaller number of much larger organisations (from 28 to 10), and primary care trusts being merged and reconfigured similarly (from around 300 PCTs to around 100)

In short, this was a time of systemic change, nationally and locally, and the establishment of MHIP could be construed by those involved either as yet another unasked for challenge and a further demand on already scarce and stretched management attention and capacity – or as an opportunity to tackle and address some of these important challenges, and a vehicle for change. In other words, from the outset MHIP could be problematised or seen as part of the solution to existent problems.

MHIP was an initiative of the National Institute for Mental Health in England (NIMHE) which was formed in 2002 to improve the quality of life of people who experience mental distress and to support positive change in mental health services. It reported to the Department of Health, picking up some of the remit of the disbanded NHS Modernisation Agency (MA). NIMHE itself was not immune from the picture of organisational change and turbulence outlined above, and after three years of existence in 2005, NIMHE was incorporated into the Care Services Improvement Partnership (CSIP). At the time of MHIP, NIMHE had eight Regional Development Centres (RDCs). Through these centres and a range of national programmes of work including MHIP, NIMHE aimed to support mental health trusts to implement policy and develop mental health services.

### ***3.3 National policy: the improvement movement and precursors to MHIP***

It has already been noted that NIMHE was in part created to take on the remit for improvement in mental health services which had formed part of the now disbanded NHS Modernisation Agency (MA). The MA had been responsible, over its brief existence between 2001 and 2005, for a rapid and diverse flowering of quality improvement methods, systems and approaches

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in the NHS. It had sponsored and supported an epidemic of national programmes, often involving a sample of local NHS trusts and focused around a particular methodology. One of its main priorities had been the quality collaboratives movement – the development of collaborative movements for improvement involving peer learning and shared support for problem based improvement projects across a cohort or group of NHS organisations in a particular area (for example, orthopaedics). The diversity and energy which characterised the MA's work was both a strength and a weakness, as while it encouraged innovation and bottom-up engagement, it led to complaints that programmes were uncoordinated, lacked strategic direction and support at an NHS trust level, and were conducted with little or no engagement of strategic health authorities. Latterly and somewhat belatedly, the MA restructured itself to make those connections to NHS trusts and SHAs rather clearer.

The MA's approach to improvement methodology was heavily linked with the Institute for Health Improvement in the USA based on techniques such as improvement cycles, process mapping, creativity, LEAN, appreciative enquiry. One of the MA's quality improvement initiatives in the acute sector – termed the Improvement Partnership for Hospitals (IPH) was consciously used as the template for MHIP. IPH, and subsequently MHIP, were based on this approach.

The IPH programme aimed to eliminate unnecessary waiting and improve the quality and safety of patient care by building partnerships between hospital departments. It was intended to help integrate healthcare improvement work at the local health community level and aimed to be flexible, enabling trusts to concentrate on particular areas of their organisation and implement approaches as they saw necessary. The work was led by acute NHS trusts, managed by SHAs and was conducted in collaboration with PCTs. IPH was launched in January 2003 by the NHS Modernisation Agency (MA) in four pilot sites; and it was thereafter rolled out in eight waves over two years in 20 acute trusts. The cost of delivering the programme was £29.5 million over the two years (Modernisation Agency, 2005; cited by Matrix in the IPH Evaluation Report).

The IPH programme included £180,000 funding per trust over 9 months to support service improvement work streams; Clinical Services Improvement (CSI) training; seminars by national and international experts to raise awareness, e.g. measurement for improvement and techniques such as "statistical process control"; a learning programme providing external training, e-learning materials and guidance and assistance from MA staff. An evaluation of IPH was carried out by Matrix Research and Consultancy using focus groups and a sample of service improvement leads. This concluded that IPH had effected change in the knowledge and use of the IPH improvement techniques. The most valuable aspects of the IPH were identified as the expert and motivational speakers, the training and launch events and the external analysis of trust data. Concerns with the IPH programme included the low impact and late timing of the written materials and online resources; the variable quality of the MA staff support; the marketing of the programme; and the management of the programme (i.e.

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timescales too short, communication and governance problems). The IPH evaluation was published in 2005, meaning that these important lessons were not in the public domain at the time of MHIP's inception and thus could not guide MHIP's design.

### ***3.4 National policy: the conceptualization and establishment of MHIP***

MHIP's aims and principles are summarised in Section 1.3.2 of Chapter 1 of this report.

NIMHE's Director of Service Development directed the MHIP programme. Her experience of service improvement had been developed while working in the NHS, first in a clinical role, progressing through management until finally coming to work in the Modernisation Agency and then NIMHE. While at the Modernisation Agency, she received training in key components of service improvement methodologies.

The deputy to the Director of Service Development took the role of Programme Lead. He had 10 years experience of working in the NHS, initially in research and analysis, then management and commissioning. He had direct involvement in commissioning mental health services for three years before joining NIMHE in 2003. Prior to MHIP, he led work on Booking & Choice. He too received Modernisation Agency service improvement training, along with CSI and action learning.

The National MHIP Steering Group included around 40 people providing the overall strategic leadership for the programme. External stakeholders included representatives from SHAs, the IPH programme, the Social Care Inspectorate (SCI), the Healthcare Commission and the voluntary sector. Internal members from NIMHE included the Deputy Director of Mental Health; the National Service User and Carer Leads and Directors from Regional Development Centres who were not themselves hosting an MHIP pilot.

The MHIP Programme Board, which reported to the Steering Group, was led by the Programme Lead. The Programme Board included a number of NIMHE personnel with a range of expertise and perspectives. These included the National Service User Lead; National Carer Lead; National Measures and Outcomes Lead; National Service Improvement Lead; a Service Improvement Consultant; a Communications Consultant; and the local RDC Client Managers and Programme Leads. Support was provided by information analysts, the Director of Analysis from the Modernisation Agency and NIMHE's In-patient Programme Lead.

The MHIP methodology is detailed in Sections 1.3.2 and 1.3.3 of Chapter 1 and throughout Chapter 4. Our interviews suggest that the agenda set out for mental health services, was a challenging one, both because of the range of concurrent changes and competing priorities, including financial pressures that they faced and the state or level of quality improvement capacity and expertise in mental health NHS trusts. For example:

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There was a similar programme in acute trusts that was ...very well resourced and let's do it in mental health and let's resource it. Oh but hey, we haven't got any money. Well just get on with it then.

- *NIMHE consultant, MHIP steering group*

It was challenging in other respects too - because of the changes and reorganisations which affected NIHME itself. Across many of our interviews there was a sense that the national leadership and focus on MHIP (corporately as much as individually) from NIHME had diminished following its launch, and in some ways the MHIP initiative became increasingly disconnected from or peripheral to the main concerns and drivers for NIHME and subsequently for CSIP. The national programme board seemed, from some perspectives, to have become a somewhat ritualised mechanism for oversight (and for assuring NIHME nationally that the four MHIP pilot sites were making progress) rather than a more proactive forum in which experiences were shared and collaborative support was engendered. For example, interviewees said:

Another thing that happened once the realisation dawned that a year was too short a time and they were given extra time to carry on the work, we then went into the realms of a change in the organisation that was NIMHE into being CSIP. And some of the people in the central team maybe took their eye off the ball, and the sites, I feel, got left to their own devices for a period of time, and we weren't pulling things together because we didn't attend any of those meetings for ages.

- *NIMHE consultant, MHIP steering group*

There was a lack of visibility of some of the key leaders. I mean X I like a lot, but after launching it we never heard of them again. And X, who was a significant presenter at the first event, again who I liked reasonably well, but as a national project with four pilot sites you'd have expected the leaders of that project to be a bit more visible in the programmes, and even if they weren't going to visit you on every day, whatever, when you went to the review meetings you wanted to sense that they were there in charge of this vehicle and you didn't, you got the sense it was just something they'd launched.

- *Senior management, South West Yorkshire Mental Health Trust*

I was very impressed with Leicester's stuff that was being presented at the national MHIP board, but yes, I guess you've got to, yes, you're there at programme board and you've got to fill in the bits and I suppose there's an element of I guess sexing up the dossier.

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- Local MHIP team member, South West London

### **3.5 The organisational context: the four mental health communities**

In 2004, the MHIP programme was launched in four local “mental health communities”. Each of these communities comprised the area served by a Mental Health NHS Trust; and in each community the Mental Health Trust was the host of MHIP programme. The four hosting Mental Health Trusts were: South Staffordshire Healthcare NHS Trust; Leicestershire Partnership Mental Health NHS Trust; South West Yorkshire Mental Health NHS Trust; and South West London and St. George’s Mental Health NHS Trust.

Tables 3 and 4 below provide a structured comparative analysis of the four mental health communities in which MHIP pilots took place. The first table focuses on the mental health NHS trusts concerned, and offers a brief financial and service profile of each, and attempts to identify some key or significant events in the recent history of each organisation. The second table describes the four mental health communities, shows how many PCTs and local authorities each consisted of and offers a brief view of the nature or character of the engagement or partnership between the NHS trust, PCTs, local authorities and voluntary services.

**Table 3. A comparison of the four case study mental health NHS trusts**

	South Staffordshire Healthcare NHS Trust	Leicestershire Partnership NHS Trust	South West Yorkshire Mental Health NHS Trust	South West London and St George's Mental Health NHS Trust
<b>Population served</b>	590,000	960,000+	1,000,000	1,000,000+
<b>Turnover (04-05)</b>	£81.1m	£109.3m	£96.2m	£155m
<b>Service profile</b>	Mental health and learning disability services for South Staffordshire.  214 inpatient beds on 4 sites.	Mental health and learning disabilities services for Leicester, Leicestershire and Rutland  595 inpatient beds on 9 sites.	Specialist mental health and learning disability services for Calderdale, Kirklees and Wakefield  No data available regarding number of inpatient beds.	Mental health and social care services for Merton, Sutton, Wandsworth, Richmond and Kingston.  875 inpatient beds on 8 sites.
<b>No of staff (WTE)</b>	3000+	3000+	2300	3000
<b>Structure</b>	Services organised on a directorate basis	Services organised on a directorate basis, with adult services directorate split between city and county	Services organised on a directorate basis across the area covered, with an emphasis on uniformity across PCT and LA boundaries.	Initially, services organised on a directorate basis. The trust was reconfigured into five borough-based directorates about half-way through MHIP
<b>Recent history and significant events/changes</b>	NHS trust established in 2001; it became a foundation trust in 2006.	NHS trust formed in 2002. Working towards FT. CE left in 2007. Big cost improvement programme and problems hitting targets.	NHS trust formed in 2002 from 4 previous NHS trusts.	NHS trust formed in 1994. Murder on ward of member of staff in 2003 prompted extensive reflection and change. Financial pressures led to change and recovery programme.

*Sources: standards-based interviews, site interviews, CHI reviews, Trust documentation, e.g. annual reports and website*

**Table 4. A comparison of the four case study mental health communities**

	South Staffordshire Healthcare NHS Trust	Leicestershire Partnership NHS Trust	South West Yorkshire Mental Health NHS Trust	South West London and St George's Mental Health NHS Trust
<b>No of PCTs</b>	4	6	6	4
	Merged into 1 in 2006	Merged into 2 in 2006	Merged into 3 in 2006	Unchanged in 2006
<b>PCT engagement and relations</b>	Substantial turbulence and organisational change	Substantial turbulence and organisational change; difficult relationships	Substantial turbulence and organisational change; history of distrust of mental health trust	Reasonable – and improving relationships since service reconfiguration
<b>No of local authorities</b>	1	3	3	5
	Staffordshire County Council	Leicestershire County; Leicester City; and Rutland County	Calderdale; Kirklees; and Wakefield	Merton; Sutton; Richmond; Kingston; and Wandsworth
<b>Voluntary sector engagement and relations</b>	Many voluntary organizations involved with services including MIND, Advocacy Services in Staffordshire (ASIST), the Rural Emotional Support Team (REST), Carers Association Southern Staffordshire (CASS), Citizens Advice Bureau.	LAMP (Leicestershire Action for Mental Health Project); the Voluntary Sector Mental Health Forum; The People's Forum; The Open Assembly; and the NSF Standard 6 Carers Group. Poor relationships – LPT seen as patronizing and uninvolving	Whilst a number of voluntary organisations exist in the locality, voluntary sector presence in local mental health service provision has been described as relatively weak.	Many voluntary organisations are identified locally, including Mind; the SUN (Service Users Network) Project; Richmond advocacy; Citizens Advice Bureau; and various carer support groups

*Sources: standards-based interviews, site interviews, CHI reviews, Trust documentation, e.g. annual reports and website*

### **3.6 The organisational context: key issues and challenges**

While tables 3 and 4 provide a useful and cogent summary of the characteristics of the four mental health NHS trusts and their accompanying communities who took part in MHIP, they do not necessarily explore or explain the softer or more qualitative dimensions of the organisational context and setting. The interviews highlighted repeatedly the importance, in many stakeholders' views, of these dimensions. We discuss below five areas which were highlighted in the thematic analysis:

- Readiness for change – the extent to which the organisations (and their partners in the local mental health community) were ready for, or prepared for the change processes that MHIP involved
- Leadership style and culture – the way in which people described the leadership style and culture of the mental health NHS trust, including the relationships internally (particularly between senior managers and clinicians) and the connections with the approach taken to MHIP
- Key drivers and incentives – how important priorities for the mental health NHS trust (including but not limited to the financial situation), were shaped and set externally and enacted internally, and how that played out into the development of MHIP
- Existing systems and processes for quality improvement – how established arrangements for quality improvement, clinical governance and other quality-related concerns affected or were affected by the development of MHIP
- Relationships in the mental health community – the nature of partnerships and relationships between the mental health NHS trust and a range of partners including the local primary care trusts (PCTs) who commissioned mental health services, local authorities, and the voluntary sector

### **3.6.1 Readiness for change**

The readiness for change of each pilot site was assessed using a set of organisational standards developed from a review of the literature, supported by expert opinion (see Chapter 2 and Appendix 2). None of the trusts was fully ready for change. One trust was struggling to deal with a crisis of confidence after a serious untoward incident; another was dealing with a financial crisis. Other initiatives were competing for time and resources, e.g. integration of health and social care mental health services; restructuring from service directorates to borough based directorates; the establishment of Early Intervention, Assertive Outreach and Crisis Resolution teams; work associated with applying for Foundation Trust status; New Ways of Working for Psychiatrists; major audits including Essence of Care. There were typically five other major change initiatives being implemented concurrently in each MHIP pilot site. Foundation Trust application preparation work was a clear priority in three trusts. Financial balance and national policy implementation were the main drivers for change work. In only one site did staff feel strongly that the current situation in terms of the quality of care and services was unsatisfactory and actively sought improvement through MHIP to that end. Nearly all workstreams were subject to major distractions including mergers, structural changes and financial pressures.

Of course, each of the four pilot sites was differently positioned with regard to its “readiness for change”. On the face of it, SSHT was probably the most clearly ready for and enthusiastic about change. It actively sought engagement in MHIP, and had a track record of innovation and a strong

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corporate belief in the importance of being at the leading edge of national developments, reflected for example in it being one of the first mental health NHS trusts to secure Foundation Trust status. However, it seemed that the underlying structure and systems for managing change were perhaps less robust – in terms of the capacity and capability as an organisation to ensure that change programmes were carried through and benefits realised. Much relied on – or was driven by – the enthusiasm and vision of key individuals, including the chief executive, but the extent to which that was embedded throughout the organisation was open to question. The position is nicely illustrated by some interviewees, who said:

We're nationally known for prison healthcare work, nationally known for non-medical prescribing, massive choice issue for people. I think our psychological services model is nationally known, I think choice leadership teams, you know, there's depth to what we're known for and what people come here for. FT, we are the place to learn about mutual governance. And now we're just doing the first acquisition in the NHS for an FT. So there's something about this place that says go on, let's have a risk appetite where we can do things to move it forward.

- *Senior management, South Staffordshire Healthcare NHS Trust*

So we had the capacity, we had the energy, we had the structures, we had the systems, we had the drives, we had the permission, we had the support, we had all of those different things, so if you put all those into a cooking pot you'd imagine that you'd come out with the change.

- *Local MHIP team member, South Staffordshire*

Turbulence is also good for an organisation, it shakes it up and it allows you also to appreciate the calm times, the good times. And turbulence is maybe something you have to expect on a journey. I think the difficulty is if you don't manage the turbulence effectively. And, if I can take the analogy of an aeroplane, often you've got to change altitude haven't you, so you've got to manage it. But turbulence on the whole is no bad thing because it can help you get from A to B.

- *Senior management, South Staffordshire Healthcare NHS Trust*

In contrast, LPT was perhaps the organization least ready for change from our assessment against the organizational standards, and this was confirmed by qualitative data from our interviews. This was a profoundly challenged organization, in which there was a long history of both attempted major change and resistance to change – it was a contested and conflicted domain. The opportunity to be an MHIP pilot site was seen by senior managers as a chance to remodel services to incorporate the new community teams. Many respondents to this evaluation referred to MHIP as being a “vehicle for change” and this was one of the key incentives for

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signing up to MHIP stated in the Implementation Plan. However, the financial issues and pressures existent at the time that MHIP was established seemed to come to dominate its development. Interviewees commented frankly on the problems facing the organisation:

If you read through some of our committee minutes, one of the things that's always amazed me is actually as you go further right across the page where it gets to actions and names, it gets oh dear, and this organisation has been very good at that, lots of committees, lots of groups, and the actions column, oh God, that's a bit blank. Or it's kind of like all will do it, or the committee will do, well the committee doesn't do a thing.

- *Senior management, Leicestershire Partnership NHS Trust*

This Trust has deep historical political forces with particular vested interests. So it isn't an easy organisation to bring about change in, and it isn't going to always be in agreement about its direction forward because there are these different camps and different strands.

- *Senior management, Leicestershire Partnership NHS Trust*

I know even for us in the main MHIP workstream, there was a degree of frustration from Commissioners about the pace of change in this Trust, and I think that was well, that view was probably quite widely held throughout this health community, from the SHA to the Commissioners

- *Senior management, Leicestershire Partnership NHS Trust*

The third pilot site – SWYMHT – was seen as much more ready for change, and had a track record of effective change management (people cited the reorganisation to create a crisis resolution team “overnight” without additional resources as evidence of this). Locally, there was a desire on the part of senior SWYMHT personnel to get the trust “on the map”. MHIP was seen as an opportunity to bring this about and the prospect of £170 000 support from NIMHE was seen as an additional incentive. However, SWYMHT was the last of the four trusts approached by NIMHE to pilot MHIP- it was felt, by senior personnel at the local NIMHE Regional Development Centre, that any “national” pilot should be represented by a trust in the North of England. This led to a rushed and rapid approach to engagement which, alongside challenging relationships with local partners in the mental health community, diminished its capacity for or readiness for change at that partnership level. Work that would act to support MHIP was already ongoing – for example the “open space” consultation events that ultimately guided selection of the MHIP workstreams had been arranged prior to SWYMHT's confirmation as a pilot site. However, this could be construed both as high readiness for change within SWYMHT and as a premature or rushed approach to “getting going” which would later have significant consequences.

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I think the engagement process was rushed, I don't think it was done properly... there was an awful lot of consultation and they had already started part of that process before MHIP came along and then it was re-badged as MHIP.

- *RDC personnel, SW Yorkshire*

At an early stage I should have done more work with the boards to make sure they really understood what they were engaged in.

- *National MHIP team member, NIMHE*

Finally, at SWLSG many of those we interviewed, especially at board level within SWLSG, referred to a much-publicised staff homicide in 2003 that prompted a "crisis of confidence" in SWLSG. The organisation was portrayed by many as complacent and satisfied with its own performance, and "doing OK" but not necessarily excelling. While the untoward event had prompted reflection and soul-searching, the history was one of slow and incremental service change. Moreover, as MHIP got underway SWLSG faced significant financial pressures which ran through and influenced the progress of MHIP. Many of our interviewees commented in clear terms on the sense that at SWLSG, something had to change:

When I was doing my homework for this job, everyone I spoke to and everyone who was part of the organisation knew that change had to happen. It had come, and they were just crying out for something. It was a glass of water to a thirsty man, MHIP.

- *Senior Management, South West London & St George's Mental Health NHS Trust*

At that stage, we're talking about 2004 now really, and 2005, the Trust was in significant difficulties. We'd just had the John Mayer Award incident in June 2003. It still had a huge, huge impact and still has a significant impact on the organisation. I think there were clear concerns within the board that we hadn't got the board structure right, so the management structure of the organisation was radically transformed from a clinical directorate-based organisation to a borough-based organisation which fundamentally changed every aspect of the management.

- *Senior Management, South West London & St George's Mental Health NHS Trust*

People get very demoralised sometimes because there have been so many changes happening and it's not followed through properly sometimes, and sometimes there may be a lack of consultation and it's failed as a result of that. And I think, well people's fear of change itself, and people are frightened of facing something different. I think sometimes

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there's the resistance to change where some people want to work in the way they were before.

*- Middle Management, South West London & St George's Mental Health NHS Trust*

People had been slightly complacent. They suddenly looked out and around and thought how on earth did we get to this stage where standards of care have got this bad. And, as I say, it shook this place to its core. I think at that stage people suddenly realised actually there has to be something substantial to change that. I think people were a little bit arrogant about how good this place was and suddenly they looked out and thought actually, we were good ten years ago, we were national leaders on several things, but now everybody else has caught up and overtaken us.

*- Senior Management, South West London & St George's Mental Health NHS Trust*

They were terrified and they felt insulted. You know change often makes people feel that what you're saying is that what they do now is rubbish, and we weren't saying that. But a nurse had been killed on one of the wards here, and a gentleman had been killed in Richmond Park. Those two incidents meant that we were scrutinised to death by external people, and internally. It was a wake up call because this organisation had a good reputation and because of that hadn't been scrutinising itself, it hadn't been looking at what do we do.

*- Senior Management, South West London & St George's Mental Health NHS Trust*

### ***Readiness for change: key findings***

- The sites were at different stages with regard to readiness for change
  - One site appeared ready and enthusiastic and this was communicated by senior staff
  - In the site that appeared least ready, there was resistance to change and attempts by management to effect major change
  - A rushed start in one site was to have significant consequences, despite otherwise apparent readiness for change
  - In a fourth site the host trust had a crisis of confidence due to extreme financial pressures and a staff homicide. At the time of MHIP, however, the site was aware of the need to change
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### 3.6.2 Leadership style and culture

The four pilot sites exhibited quite different leadership styles and management and clinical cultures and it was clear from our interviews that these had a profound effect on the way people responded to MHIP. For example, in SSHT the Chief Executive was a strong, even dominant figure in the organisation whose personal vision and values had become almost inseparable in his and others' eyes from those of the organisation itself. He was passionate about his vision of how mental health services should be, coming from his experiences of working in, and also using services. His personal endorsement and involvement in change work in the trust seems to have been important in motivating and enabling good practice amongst staff:

He was a very, and still is a very influential active driving force in all the projects that go on in our Trust, and he has that wonderful vision to think well, we need to do A B C to get to D E and F, and I think MHIP was one of those A B Cs. My concerns are it did what it did for his agenda and for the strategic agenda but whether it actually did what it did for actually what it was designed to do is where I have difficulty.

- *Senior Management, South Staffordshire Healthcare NHS Trust*

Some people have got respect and some people would have an element of fear of X if they were honest.

- *Senior Management, South Staffordshire Healthcare NHS Trust*

In contrast, while LPT's chief executive was keen to bring the MHIP pilot to the organisation, and was actively involved from an early stage in launch events and national meetings, the real extent of her engagement and support was somewhat disputed with some interviewees seeing her as progressively disengaged. The trust management style was seen by some as "top-down" and directive:

But I suppose sometimes, I've just got the feeling, say with X, she might say yes, that looks like a good idea or something, but then you'd go away and next time it was like she must have been told not to do that. It was like the process was being controlled from the top.

- *Voluntary sector personnel, Leicestershire*

It didn't seem anybody had the backbone at LPT to really do serious system change. And that and the fact that the MHIP community stream has taken so long and still nothing's happened

- *Voluntary sector personnel, Leicestershire*

However, in LPT the profoundly important cultural dimension – which was raised in almost every interview – was the dysfunctional nature of relations between senior clinicians and senior managers in the organisation, and the

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history of conflict, unresolved tension, disrespect and at times unacceptable personal behaviour on both sides. Interviewees commented:

I think the position in which the management of the trust are most comfortable is with token rather than an authentic involvement, and that's certainly the case in terms of clinician involvement. The sop we're thrown is that there's a lot of management stuff that needs to get sorted out. But once you've defined the options, you've effectively defined the solution, which means that we're just there to provide an appearance of agreement with what they've already chosen. It's a particular style of management that invariably produces this kind of thing, you know, so it's a mistrust of clinicians.

*- Frontline staff, Leicestershire Partnership NHS Trust*

There was no, there is no, there was no kind of forum around proper clinical engagement. Their notion of clinical engagement was what they called lead clinicians and, I have to say, we've got a real issues around the lead clinicians because actually all our lead clinicians are probably the worst clinicians you could have as lead clinicians.

*- Senior management, Leicestershire Partnership NHS Trust*

Some of these people would actually walk over the road and get hit by a truck than stay on the same side of the road and have a conversation with their clinical colleague.

*- Senior management, Leicestershire Partnership NHS Trust*

You'd have a Board Meeting with seven clinicians who could never agree with each other, and then you'd have about five managers, and those Board Meetings used to be horrendous.

*- Middle management, Leicestershire Partnership NHS Trust*

I mean relations haven't been all that good and collaboration hasn't been that good. I wouldn't blame the managers for that any more than I would the clinicians, it's six and half a dozen really. I mean there have been some quite destructive people on both sides.

*- Frontline staff, Leicestershire Partnership NHS Trust*

The cultural challenges and leadership issues were less florid and obvious in both SWYMHT and SWLSG. The picture which emerged in the former was of a strong entrepreneurial culture, with a focus on building a coherent corporate identity and sense of organisation for SWYMHT, but with a "fortress" like appearance externally, in which the trust was seen to want to dominate or lead in all engagements. What seemed internally like entrepreneurial and innovative behaviour was cast externally as about power and politics:

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Some of the significant powerful people in the trust just didn't like that way of working. They wanted to stop engagement and stop working in that transparent way....

- *Senior management, South West Yorkshire Mental Health Trust*

In contrast, SWLSG was culturally in transition, before MHIP was established. It had seen a change at chief executive level, a shift towards a more managed and less medically dominated structure and culture, and the profound cultural challenge and consequences of the untoward events referred to earlier:

So the culture was very, very inward looking and very inflexible I think, and driven by powerful individuals, and I think that the Mental Health Improvement Programme actually started the process of dismantling that.

- *Senior management, South West London & St George's Mental Health NHS Trust*

There was a view that the trust was medically dominated and not well managed because there were too many clinicians in senior sort of quasi- management posts. So I think new people brought in were brought in, in a way to sort that out, so it became a bit of a "them and us".

- *Senior management, South West London & St George's Mental Health NHS Trust*

### ***Leadership style and culture: key findings***

- In one site, the Chief Executive's ambitious visions and agenda were pervasive across all of the trust's activities, including MHIP
- Dysfunctional relationships between senior clinicians and senior managers characterised the culture in one site. Here, the Chief Executive progressively disengaged from MHIP throughout its course
- One trust could be seen as having an entrepreneurial style towards improvement. Locally this had political implications, however, as its external partners viewed it as too dominant
- Leadership and organisation was very much in transition for the site which was emerging from its own crisis

### **3.6.3 External situation/drivers**

The most commonly mentioned external challenge – presented both as a driver for MHIP and as barrier to its establishment – was the financial situation of the four mental health NHS trusts and the health economies of which they were a part. In three of the four, there were significant financial

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pressures, often arising from PCT over-commitments or from cost pressures elsewhere. These resulted in what seemed like arbitrary and unachievable cost improvement programmes being instigated at short notice. MHIP was either subverted or at least de-emphasised and deprioritised as a result. Only in SSHT was this not a key issue:

We're going to make a surplus this year apparently.  
£60,000 or something aren't we on track to at the moment?  
I think we broke even last year.

- *Frontline staff, South Staffordshire Healthcare NHS Trust*

In contrast, interviewees in all three of the other trusts spoke of the financial problems they faced and the consequences for MHIP:

I think it's a sorry state of affairs, but unfortunately a reality, that some of the change that has happened has been finance driven as opposed to service improvement driven. But that's just been a necessity for us to survive basically.

- *Middle management, Leicestershire Partnership NHS Trust*

It's the financial pressures. It's nothing to do with FT. Just breaking even at the end of the year month on month now is top of the list and everything else, well it will come later when we have time.

- *Senior management, Leicestershire Partnership NHS Trust*

There is no money and that's all there is to it. If somebody leaves now that is lost and that's it, you just don't have that replaced, it's as simple as that.

- *Senior management, Leicestershire Partnership NHS Trust*

National measures and targets – arising from the NSF, from Standards for Better Health, and other sources, were often seen more as a distraction from service improvement than as a driver for it, but it was also recognised that these mandated requirements had to be delivered in order to make the space to tackle other things – some of them through MHIP – in areas where there were not national policies and targets. MHIP objectives, locally and nationally, frequently prioritised the demands of national policy. In effect, MHIP, like many initiatives, often came to reflect attempts to meet politically-derived demands placed on the NHS.

Sometimes the things we're asked to measure are a waste of space and it's quite difficult to carve out the time and energy to measure things that are meaningful.

- *Frontline staff, South Staffordshire Healthcare NHS Trust*

What we've got to is actually not applying policy for policy's sake, so hitting the target and missing the point, but actually making sure that we hit the point and not at the expense of, not hitting targets.

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- *Senior management, South Staffordshire Healthcare NHS Trust*

One trust had already achieved Foundation Trust status, while others were working towards it, and for the latter group the preparatory work, both in order to ensure they met the financial, governance and performance requirements of Monitor and to collate and present the information needed for their Foundation Trust application was a major challenge and an important driver:

I mean obtaining Foundation Trust status last April was massive really. Just going back say three years, a lot of turbulence came out of the fact that we'd been assessed by an external organisation and found to be lacking in certain areas. You know, there was no sort of complacency about it. It gave us the opportunity to get together an action plan and deploy energy into bringing up the areas where we were below the line and get it back up again.

- *Senior management, South Staffordshire Healthcare NHS Trust*

Oh, massively important stuff is the Foundation Trust application and turning ourselves into, if you like, a viable business. So there's that change, but along with that Foundation Trust a whole number of pieces of work have to be achieved. One of those is financial balance and stuff like that. One of those is long term plan, five year planning. So you need a clearer vision and evidence of need, and those kind of business planning processes. But a third is partnership working. You don't become a Foundation Trust unless you've got your partnerships in order. If the partnership with the local authority is to be a sound partnership, the local authorities could now start saying well actually, we want stronger influence on this than what we initially had.

- *Senior management, Leicestershire Partnership NHS Trust*

In short, it was clear that there were multiple existent drivers for all four NHS trusts, and that a constant challenge was to work out how to prioritise which initiatives, opportunities or mandates they responded to, including MHIP.

We do appear to be able to cope just about with the national must-dos, the local priority must-dos, and from the organisation, from the directorates, and then the stuff that's almost local interest and what people would like to do at a much more local level because they think it might be important. And I guess they'd be the ones that would go first, in terms of our priorities.

- *Senior management, South Staffordshire Healthcare NHS Trust*

And I think that's the pressure everybody's under. It's one initiative after another.

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- *Voluntary sector personnel, Leicestershire*

It's almost taking what you could call an entrepreneurial approach to policy implementation; you can either see it as a threat or an opportunity. You have to think your head around that way because it's always going to be there.

- *Senior management, South West Yorkshire Mental Health Trust*

**External situations and drivers: key findings**

- All sites had multiple priorities to juggle; financial deficit was an issue in all but one of the sites and there was ongoing work to implement national targets
- MHIP was a programme developed to respond to politically-derived demands placed on the NHS

**3.6.4 Existing quality improvement systems, structure and activities**

All four of the pilot sites had established systems and processes for quality improvement, though their significance, organisational coverage, structures and apparent impact varied widely. However, all had been subject to Commission for Health Improvement clinical governance reviews, and most had a track record of clinical audit, nursing quality improvement, and a range of consumer or user focused improvement initiatives. So MHIP, as a new quality improvement initiative, was not breaking new ground in any of the organisations and it could be seen either as complementing or as competing with those existing improvement structures and systems. Indeed, there were two common findings across all the sites. Firstly, it was evident that existing improvement activities were often poorly coordinated and fragmented, with separate programmes, and small departments in areas like clinical audit, governance, risk, complaints and so on which were not connected and collaborating effectively. Secondly, it was clear that MHIP tended to be set up and run in isolation from or separately from these existing structures. Often an MHIP- derived service improvement team would be working in the organisation with clinical directorates or teams in parallel to and with little coordination with other quality improvement actors such as the clinical audit department. It might be argued that the "project" nature of MHIP – established with a separate set of reporting and governance arrangements at each pilot site and nationally – probably did little to encourage the integration of MHIP into quality improvement systems locally. In addition, the partnership dimension of MHIP (it was intended to be a collaboration across the mental health community) may also have made it harder to integrate it with the quality improvement systems in the "host" mental health NHS trust.

We collect a lot of information on patients for various reasons, and there's probably lots of other initiatives going

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on, like the MHIP, that collects information from patients. There's a lot of essence of care stuff going on, although we work quite closely with the essence of care lead. There'd be complaints and PALS issues that are getting raised, there are other initiatives going on, research projects going on, and they're kind of all coming in somewhere and not being fed in centrally. I think we're missing a lot of these patient priorities.

*- Frontline staff, South Staffordshire Healthcare NHS Trust*

Sometimes we're too ambitious in terms of what we try to achieve in a service improvement type scheme, and MHIP was, the way it was set up in Leicester, was a very ambitious scheme, to completely redesign, re-engineer the way our Community Mental Health Service worked, and it might have been more appropriate to target smaller schemes, smaller projects first of all to get the way of working well established, and the skills into the organisation before we then embarked upon a wider project.

*- Senior management, Leicestershire Partnership NHS Trust*

SSHT and SWYMHT had small, but well established clinical audit teams, and SWLSG had an established audit department and some existing capacity in quality improvement. All three had relatively positive clinical governance review reports from the Commission for Health Improvement, but MHIP in all three organisations was essentially a separate undertaking. LPT had a rather less well developed clinical audit department, which had been progressively diminished in size and was largely focused on compliance-related tasks (like CNST assessment), and rather less existing capacity or skills in improvement:

We did the process mapping and some statistical analysis, capacity and demand, that kind of stuff. We were pretty amateurish I think, I mean we didn't really either have the time or the knowledge to do that terribly well or terribly quickly.

*- Frontline staff, Leicestershire Partnership NHS Trust*

***Existing quality improvement systems, structures and activities: key findings***

- Existing quality improvement activities within the sites were often poorly coordinated
  - MHIP was often set up and run in isolation from these existing structures
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### **3.6.5 External partnerships and relationships with PCTs, local authorities and the voluntary sector**

MHIP was, as its name suggests, intended to be an enterprise founded on partnership. But there was a fundamental if rarely acknowledged difference between MHIP and the Improvement Partnership for Hospitals (IPH), from which much of the content of MHIP was derived. In IPH, the “partnership” referred to collaboration between acute care providers (hospitals) for the purposes of improvement. In other words, participating NHS acute trusts worked collaboratively on quality problems with others who might be geographically distant but had shared interests and concerns. IPH was a new partnership, between organisations which might not have worked together before, and for whom there were unlikely to be conflicts of interest or areas of dispute.

In contrast, the “partnership” in MHIP referred to collaboration between the constituent parts of the “mental health community” in a geographic area. This was seen as centred on the mental health NHS trust, but including the local primary care trusts (PCTs) who both provided mental health services in primary care and were the commissioners of services from the mental health NHS trust; local authorities who through their adult and child social service departments particularly (but also in areas like housing and education) were important providers of services to people with mental health problems; and the voluntary sector who both fulfilled a service user involvement, engagement, representation or advocacy role in some situations and were also part of the mosaic of service provision in many areas. The existing partnerships had a history and context of their own, involving organizations which had both some common concerns and areas of agreement and some divergent interests and perspectives and areas of potential or actual conflict or dispute.

This fundamental difference in the meaning of partnership was not explicitly recognised in the establishment of MHIP, but it presented profound challenges. In essence, the pilot sites were being asked to do two things – develop their capacity and expertise in quality improvement and develop a positive and constructive partnership across the actors in the mental health community. It has been noted above that with respect to the former aim, the four pilot sites started from different places in terms of their existing experience and expertise in quality improvement. Similarly, with respect to the latter aim, the histories, contexts and challenges of partnership in the four pilot sites were different, but often had a fundamental effect on the way MHIP developed. As one interviewee from the MHIP national team observed:

It was I think a bit naïve to assume that you could tell people to work in partnership when those partnerships didn't exist

*- NIMHE consultant, MHIP steering group*

In the voluntary sector, there were some long established and constructive existing relationships particularly in SSHT where service user engagement in the organisation itself was strong, though the organisation was perceived by

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some voluntary groups as insular and focused on Stafford (rather than the wider area it served). In contrast, voluntary organisations working with LPT reported a long history of difficult relationship and a perception that LPT patronised voluntary sector organisations:

I know there are organisations in Leicestershire who feel excluded from MHIP; voluntary sector organisations. I know that there are voluntary sector organisations that provide services who don't know what it is.

- *CSIP personnel, Leicestershire*

I mean there are several different ethnic organisations that we've tried to work in partnership with. The reality of it is we send them our literature and they send us their literature, and it doesn't really go much further than that. We've had meetings but we haven't found any practical way to work together.

- *Service user representative, Leicestershire*

Because they pulled the plug on us on the voluntary sector stream, I think as a whole organisation I've actually come out with more distrust of the statutory sector than I started with. Individuals, yes, it's been really good and a really positive experience, but what it did to me, it reinforced all my negatives about the way that the statutory sector worked with the voluntary sector.

- *Voluntary sector personnel, Leicestershire*

In three of the four trusts, the configuration (and reconfiguration) of PCTs was seen as a crucial barrier to effective partnership. The original configuration, in which mental health services were commissioned by four to six PCTs from each mental health NHS trust and those PCTs did not necessarily coordinate or make consistent the demands they placed on the mental health NHS trust was seen as problematic. But equally, the reconfiguration of PCTs, and the changes in organisational structure, individual appointments and responsibilities that resulted were seen as having caused discontinuities in approach and relationship and a hiatus in decision making and the development of mental health services:

What we've actually done I think is spend quite a lot of money on chopping and changing organisational structures and shapes. Certainly in this patch we had six PCTs, three in the north, three in the south. What was that all about? ... So I'm very critical of some of that stuff. I'd better not go too far!

- *Senior management, Leicestershire Partnership NHS Trust*

These challenges were probably most profound in SWYMHT, where many stakeholders reported a problematic and difficult relationship particularly

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between the mental health NHS trust and the six PCTs it worked with, describing them as “at loggerheads” at times:

The reconfiguration of PCTs has effectively torpedoed any kind of like further opportunistic discussion really, I think people have been worried about whether they've got jobs or not.

- *PCT personnel, South West Yorkshire*

Now there's nothing actually that holds Southern West Yorkshire together, it's not a community, it's at best three communities, there is nothing about it which hold it together apart from a Specialist Mental Health Trust. People from Calderdale have, they don't care what happens in Wakefield, people in Wakefield don't care what happens in Calderdale, but it is a mental health trust patch. So the notion of doing something jointly across Southern West Yorkshire, why would you want to do that. I mean diversity, we've got our own approach for dealing with diversity in Calderdale. In Wakefield we've got our own approach to doing it here, do you see what I mean. Why would we do it together?

- *Local MHIP team member, South West Yorkshire*

Part of the reason of getting the commissioners together was South West Yorkshire was formed in 2002/03 and we just weren't getting anywhere with them. We'd already formed that group to try and get our act together to create some kind of a collective pressure on them. Now that hadn't long been in situ when MHIP came along, a handful of months, less than six probably. So they ended up being sort of like melded together really

- *PCT personnel, South West Yorkshire*

SWYMHT published a three year development plan which they had not consulted with commissioners about. So I think there was an appropriate antagonistic sort of reaction from the PCTs.

- *Senior management, South West Yorkshire Mental Health Trust*

Because I was a commissioner my view has always been you need to do it this in partnership. Some of the people in SWYMHT were adamant this is about us controlling the agenda. Having MHIP around didn't naturally suit some of those people because it forced them to have to work in a partnership way.

- *Senior management, South West Yorkshire Mental Health Trust*

In contrast, though SWLSG dealt with a large number of PCTs and had a complex relationship with both PCTs and local boroughs, the relationships in and between these entities were better established, and the diversity of

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need had not led to a fragmentation of commissioning priorities and service expectations. However, the mental health NHS trust did choose to reconfigure its service structures, from one based around functional clinical areas to one based on geographic localities, which matched the borough/PCT boundaries:

Our commissioners are a very, very cohesive group. It's great for them because they talk, whereas nowhere else I've worked have commissioners engaged with one another as much as they do here. And so the PCTs and probably the local authorities are pretty cohesive in their views

- *Senior management, South West London & St George's Mental Health NHS Trust*

***External partnerships and relationships with PCTs, local authorities and the voluntary sector: key findings***

- Existing relationships with the voluntary sector were generally weak
- PCT reconfigurations were clearly identified as a major barrier to progress

### ***3.7 Conclusions***

The aims of MHIP were undoubtedly ambitious, especially given both the contextual challenges outlined in this chapter and the level of resourcing available to support it. There is scope to question how realistic it was to expect the four MHIP pilot sites to create or establish partnerships for quality improvement in mental health services, across anything up to ten statutory organisations (NHS trusts, PCTs and local authorities) and a range of voluntary organisations, in the space of 12-24 months, with the limited resources available, and given the concurrent challenges and demands on those organisations.

However, perhaps the most striking conclusions to be drawn from the foregoing analysis, regardless of the over-ambition of MHIP from the outset, is the power and place of organisational context in such quality improvement programmes, and the need to take proper account of context in site selection and programme design.

### ***3.8 Summary of key findings***

National Institute for Mental Health in England (NIHME) was formed in 2002. It reported to the Department of Health, picking up some of the remit of the disbanded NHS Modernisation Agency (MA). In 2005, NIMHE was incorporated into the Care Services Improvement Partnership (CSIP). MHIP was launched in 4 pilot sites in 2005 and was based on the MA's Improving Partnerships in Hospitals (IPH) programme for acute general hospital trusts.

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MHIP was piloted at time of systemic change at national and local level. NHS mental health trusts were subject to major distractions including government targets and initiatives, political imperatives such as the drive for FT status, local financial deficits and organisational instability in the form of reorganisations and reconfigurations of PCTs and SHAs. These distractions greatly reduced the communities' stability, capacity and confidence to carry out MHIP. NIMHE, itself, was also subject to organisational flux.

Readiness for change had an important influence and each site was different in this regard. One site appeared enthusiastic and ready for MHIP perhaps because such ventures fitted with leaders agendas and the ethos of the organisation at that time. Another site appeared far less ready, with existing conflict between pockets of resistance to change and attempts to make major changes. MHIP's progress in a third site suffered massively from a rushed sign up to the programme. Personnel in the fourth site were cognisant of the need to change, following some serious incidents.

Leadership style and organisational culture substantially influenced MHIP on the ground. Within organisations, senior level endorsement was regarded as a powerful force. Dysfunctional relationships and unresolved tension between senior management and clinicians created a major obstacle to change. Between organisations, power and politics, particularly between mental health trusts and PCTs, was observed to block progress entirely in some cases.

A constant challenge faced by mental health trusts and their partner organisations was to work out how to prioritise initiatives, opportunities or mandates they responded to, including MHIP. Many of MHIP's objectives, nationally and locally, came to reflect broader attempts to meet the manifold demands of national policy.

Existing improvement activities were often poorly coordinated and fragmented, with separate programmes. Small departments in areas like clinical audit, governance, risk, complaints were not connected and collaborating effectively. MHIP seldom used the quality improvement structures that existed in the sites; this further compounded the problem of limited capacity. This lack of integration can be in part explained by the fact that MHIP established its own set of reporting and governance arrangements at each pilot site and nationally.

Overall, pilot sites faced a range of concurrent changes and competing priorities and the state or level of quality improvement capacity and expertise in mental health NHS trusts was relatively poor. MHIP was insufficiently effective at recognising and addressing these contextual factors. In light of this, the aims of MHIP might be considered overambitious or even inappropriate.

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## 4 MHIP structures and processes

### ***4.1 Chapter introduction***

This chapter describes how the Mental Health Improvement Partnership programme was carried out by NIMHE and across the four local pilot sites by examining the structures and processes used to plan, implement and evaluate the work. The chapter is organised according to the areas defined in the standards for organisational change:

- Planning: consultation, communication, method selection, consideration of resources
- Implementing: change measurement, devolvement of responsibility, support and training, feedback
- Follow-up and evaluation

Each section presents findings from the standard-based interview (Appendix 4) supported by data from the stakeholder questionnaire (Appendix 3) and data from the thematic analysis of the site visit interviews (the coding framework is provided in full in Appendix 5). Each section begins by giving the data sources used and ends with a summary.

Throughout this chapter, differences between sites and between different groups of participants are compared and contrasted. The MHIP processes and achievements are compared with the original ideas, as set out in Chapter 1. Finally, the limitations of the MHIP structures and processes are discussed.

#### **4.1.1 Summary of the MHIP structures and processes against the organisational standards**

Data from the standards-based interviews and relevant documentation informed the rating of criteria and standards as either “met”, “partly met” or “not met” for each of the 15 workstreams. These ratings helped to profile the workstreams in terms of how consistent they were with what is recognised to be good practice in organisational change.

Table 5 shows the percentage of workstreams which fully met each standard.

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**Table 5. Percentage of fully met standards in all 4 sites**

Standard		% fully met
1.1	The organisation is ready for change	19
1.2	The existing organisational structure is supportive of change	23
2.1	The change programme is developed in consultation with all relevant parties	44
2.2	The needs, goals and abilities to meet these goals are communicated to relevant parties	43
2.3	The change programme uses methods that have been shown to be effective	33
2.4	All resource and budget implications of the desired change have been considered	13
3.1	The change programme includes effective change measurement and evaluation	18
3.2	Responsibility is devolved to frontline staff	29
3.3	Staff receive the training and support required to engage with the change programme	22
3.4	Staff receive constructive feedback on the progress of the change programme	30
4.1	The change programme is evaluated in terms of generating evidence & developing theory	0
	Total	21

Overall 21% of the standards on organisational improvement were fully met. Sixty two percent were partly met and 17% were not met.

Standards 1.1 and 1.2 refer to contextual factors. These are explored in Chapter 3. The remainder of this chapter examines the MHIP structures and processes against the remaining 9 standards.

## ***4.2 Planning***

### **4.2.1 Consultation in the development of the plans**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. minutes from national and local launch events
  - Relevant data from the stakeholder questionnaire
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- Questions relating to Standard 2.1 “The change programme is developed in consultation with all relevant parties” of the standards-based interview
- Qualitative data theme 3.1 *MHIP processes*
- Qualitative data theme 3.5 *Partnership working*
- Qualitative data theme 3.7 *Communication*
- Qualitative data theme 3.10 *External support*

### ***At the national level***

Initial plans for MHIP, based on the Improving Partnerships in Hospitals programme (see Chapter 1), were developed by the national MHIP Programme Director and Programme Lead. Following this, an MHIP Programme Board was recruited over a number of months; membership included the NIMHE Analysis, Service User and Carer Leads, and communications and service improvement consultants. These people stated that their role on the Programme Board was to amend an already developed plan. A NIMHE Steering Group, with an impressive membership, began to meet at the time when MHIP was launched locally and so also guided the programme development. Members of this group included representatives from SHAs, the Improving Partnerships in Hospitals (IPH) programme, the Social Care Inspectorate (SCI), the Healthcare Commission and the voluntary sector. Internal members from NIMHE included the Deputy Director of Mental Health; the National Service User and Carer Leads and Directors from Regional Development Centres who were not themselves hosting a MHIP pilot. The MHIP Programme Board also included personnel from the pilot sites.

The process by which the four sites were identified was eclectic, and non-transparent. Indeed, the MHIP Programme Director recognised that the process of selection was not well suited to a pilot:

Not really the right reasons that you would use for somebody to do some testing work

*- MHIP national Programme Director, NIMHE*

There was no open call for applications to mental health NHS trusts, and no explicit selection criteria were developed against which potential pilot sites could be rated or analysed. Of course, all pilot sites faced significant distractions and competing change agendas as outlined earlier, but there appears to have been little consideration of the localities' readiness for change prior to their joining MHIP, a theme which is discussed in considerable detail in the previous chapter. Rather, inclusion was primarily dependent on agreement to participate on the part of the Mental Health NHS Trust Chief Executive and board. While some people understood that sites had applied to participate in MHIP, personnel leading two pilot sites (i.e. Programme Leads, RDC Client Managers) stated that their trust was instructed to participate. South West London received instruction via a letter from the Department of Health. South West Yorkshire joined because of

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pressure from its local RDC on the national MHIP team. Interviewees described the selection process:

There was a debate we had before we started the MHIP programme; it would have been quite easy for us just to have picked up champion sites to prove the efficacy of the methodology but then it's easy to do it in your champion sites. And what we ended up with was a kind of a bit of spectrum. We had I think at least two, or maybe two/three sites that were actually quite leading quite strongly on this, and there was at least, definitely one site but probably two that were kind of trailing a little bit. So it was quite an interesting challenge that we had to actually try and move all of them forward.

- *MHIP national Programme Manager*

We were told to do it, yes. We'd gone from being a very good trust, national profile and suddenly, almost without us knowing something was not quite right. And so yes, we were told to do it.

- *MHIP Programme Lead, South West London*

South Staffs was the kind of well, we know that your Chief Exec has got the kind of the vision of what we want.

- *MHIP Programme Lead, South West London*

They were written to by the Department of Health and told they had to join ... they hadn't volunteered in as much as they were volunteered.

- *RDC Client Manager, South West London*

Two MHIP events took place in Birmingham in March and May 2004, attended by stakeholders from the national steering group, the local pilot sites, NIMHE and the Department of Health. The events aimed to launch MHIP and obtain input from delegates to define milestones, action plans, areas for improvement and desirable outcomes. The events successfully launched MHIP and stimulated thinking, but the detail about goals and means to reach these was left undefined. Whilst this flexibility enabled MHIP to be "tailored to local need", those who were going to be leading the programme (e.g. Chief Executives, local Service Improvement Managers) were left unsure about what the programme was trying to achieve. In turn, this impacted on how they could launch the programme locally.

there was a lot of things going round trying to get people to come along to the launch and get engaged and they're saying well what's it about, well we don't know because that's why we're launching it because we need your thoughts on what it's going to be

- *MHIP Programme Lead, South Staffordshire*

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Had more effort been invested in choosing the four sites to take part in the MHIP initiative, the pilot might have been very different. For example, undertaking diagnostic work with each site to establish how ready it was for change and taking time to understand organisational culture, leadership, capacity for improvement work and the strength of local relationships. One of the interviewees said:

It was potentially a very impressive process that could bring about a lot of real improvements in mental health services, but it depended a lot on how it was managed, how it was led and whether the sort of host context was really up for it.

- *Frontline staff, Leicestershire Partnership NHS Trust*

### ***At the local level***

Locally, consultation events took place in all four pilot sites. These events involve a broad range of local stakeholders, e.g. frontline staff, senior management figures, service users and carers, non-statutory agencies such as MIND, Citizens Advice Bureau, Local Authority, PCT commissioners, personnel from local and national NIMHE centres. In each case, the events were clearly effective at engaging and enthusing staff and external partners in MHIP.

It was an example of doing something properly in the NHS. It was saying well, let's look at national best practice and let's begin to look at the service redesign work from there

- *Frontline staff, South West London*

MHIP started really well in my opinion, and we thought our voices were heard

- *Carer, Leicester*

These events were large, but did not succeed in communicating to everyone who attended. In particular, non-management attendees described the events as "bamboozling" and complained about the use of "management-speak".

These events generated local themes which were subsequently developed into workstreams by smaller groups of people, e.g. a group of staff from the host mental health trust or the local MHIP steering group. In each site many themes aligned with existent goals and the workstreams were developed to incorporate national targets, e.g. NICE guidelines, NHS Plan. In some cases, work on these priorities was already ongoing, e.g. set-up of crisis teams in South West London (SWLSTG), the work of the Acute Care Forum in South Staffordshire (SSHT).

### ***At the workstream level***

Following these events, several smaller events based in boroughs or on workstream topics were carried out locally. Particularly amongst frontline staff, service users and carers, these were considered to be more useful

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than the very large trust-wide events, as discussions were more specific and accessible to attendees.

Stakeholder engagement was a central plank of MHIP but there was variation in the degree to which stakeholders were involved in the development of workstream priorities and plans. About one third of the workstreams were developed in consultation with all relevant parties; priorities were systematically identified and agreed by major stakeholders in about half of the workstreams; and managers involved staff in the development of the workstream initiative and agreement of team and individual objectives in one third of workstreams. A needs assessment was carried out in about half of the workstreams (e.g. by talking first hand to stakeholders) in order to inform the design of the project.

Furthermore, the development of workstreams was not always seen as a fair process. In Leicester some questioned the democracy of the process. In particular, some felt that the decision on the new model for adult mental health services had already been taken prior to the consultation. This resulted in a loss of trust in the process and a failure to maintain engagement with some partners.

they've got a solution, but they still ask you what you want and then they try and fit in what you want to their solution, which is the wrong way round.

*- Carer representative, Leicestershire*

In South West Yorkshire (SWYMHT) some local partners felt that the trust took too strong a lead at this point and so partnership was not equal.

There's an identity problem with MHIP because I think some people viewed it as South West Yorkshire Mental Health Trust.

*- MHIP Programme Lead, South West Yorkshire*

South West Yorkshire had already signed up to it and said we're going to do this anyway, so it wasn't really negotiated. So you can imagine the kind of inter-agency tensions that are created by organisations that don't necessarily consult.

*- PCT personnel, South West Yorkshire*

A further problem for this site was that, as they joined the MHIP programme late, the early processes of consultation were rushed. This prevented the development of genuine local partnerships and common understanding of MHIP:

SWYMHT had got on the MHIP programme rather at the last minute. And we're playing catch up, and so all those anxieties that other people have, "what's all this about?", "where's this taking us?" and, you know.

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... if there'd been a couple of months before that to sort those things through then what you'd have had is everybody on board with it.

- *Local Authority personnel, South West Yorkshire*

### **Championing**

The local Programme Leads and Managers were consistently identified by respondents as the champions of the work, although they emerged in different ways across the sites. In South Staffordshire, the Programme Lead and Manager were personally selected for the programme by the Chief Executive of the trust and were publicly endorsed at the launch events and were unanimously identified by local respondents as the champions. Further, the Chief Executive himself was also regarded as a champion. Whilst the equivalents in Leicester and South West Yorkshire were also the champions of MHIP, clear and continued senior level endorsement was absent, making the job of championing far more challenging. Some complained:

I have to say, if I was [involved] I would want to be in there dabbling as the Chief Exec. Wouldn't you? Wouldn't you want to stand up and say look, this is what a national pilot's done for us mate, it's been great.

- *Senior management, Leicestershire Partnership NHS Trust*

The other pilots had a Chief Exec chairing, and therefore could maintain the profile a lot longer than we could here.

- *RDC Client Manager, South West Yorkshire*

In South West London, the personnel who took on MHIP within the trust were powerful and in a strong position to champion MHIP. With regard to the workstreams, whilst all had nominated leads, not all had figures that could be identified as champions. Whilst the presence of a champion is not necessarily sufficient for a workstream to progress, where work has moved forward, respondents have commonly identified the champion as being a key causal factor, e.g. in Leicester's Older Persons' and Psychodynamic Psychotherapy workstreams.

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### ***Consultation in the development of the plans: key findings***

- MHIP was adapted from IPH, a programme for acute hospital trusts, by a small group of people without sufficient consultation
- At this stage, many people who were to be involved in MHIP were unsure about its objectives
- Stakeholder consultation events created energy, but left some delegates overwhelmed. Accommodating all stakeholder views and existing pressures was frequently difficult, if not impossible
- Poor clarity of aims and methods obstructed proper involvement of all partners
- Senior level endorsement, where present, was important for progress because it raised the profile of local champions

#### **4.2.2 Communication of plans**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. national and local planning documents
- Relevant data from the stakeholder questionnaire
- Questions relating to Standard 2.2 "The needs, goals and abilities to meet these goals are communicated to relevant parties" of the standards-based interview
- Qualitative data theme 3.1 *MHIP processes*
- Qualitative data theme 3.5 *Partnership working*
- Qualitative data theme 3.7 *Communication*
- Qualitative data theme 3.10 *External support*

#### ***At the national level***

Early plans and visions were communicated via the consultation events and a national Project Initiation Document (PID) was produced (the latest draft dated July, 2004). This was written by the National MHIP Programme Lead setting out the governance, resource and communication arrangements. The document included sections on Programme Principles, Programme Deliverables, Programme Outputs and Programme Controls. It also described the Mental Health Service Improvement Framework with a "Learning and Development Package" geared towards tackling training needs by laying out a "menu" of techniques and training resources.

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Whilst this document is comprehensive, the numerous sections, subsections and appendices make it difficult to draw out the overall messages (see Appendix 1). For example, with regard to the aims of the programme, in addition to the five programme principles, there are four national Areas for Improvement. This collection of focal points is logical and relevant for mental health service improvement but give little concrete direction on what people implementing MHIP might aim for. Whilst this flexible approach seems sensible, it may have contributed to a lack of clarity about the nature of the work.

### ***Communication of the workstream plans***

Plans were produced for all workstreams and these were understood by local leads, but less so by others involved.

Less than half of the workstreams had a highly structured project plans, with clear and measurable objectives. Staff in only four workstreams reported that the implementation plan was simple and understood. In some sites, workstream plans that set out clear objectives did not necessarily refer to the means by which these were to be achieved or evaluated. Plans in South Staffordshire were clearly laid out but included aims and objectives that were vague. This made progress hard to measure and achievements difficult to demonstrate. Half of the MHIP workstreams could be classified as “results orientated”, i.e. that it was not dictated how targets should be achieved, allowing personnel to apply the most appropriate and effective techniques for their particular situation. Mirroring the effect seen at the national level, this flexibility might have contributed to a lack of clarity about exactly what was required to be done.

Local anecdotes and experiences were used to illustrate problems and potential solutions in less than half the workstreams. Some frontline staff and service users complained of too much “management speak”. Beyond the steering group, awareness of MHIP and its objectives was usually poor. Partners outside the trust often reported that MHIP’s aims and objectives were unclear.

Overall, only one third of the workstreams had good communication from the outset. The objectives of the work, and the abilities of staff to meet these goals, were communicated in less than half of the workstreams. Less than half the workstreams appeared to offer benefit to frontline staff, e.g. the chance to deliver a better service, or improved working conditions. Two-thirds of workstreams had the advantage of requiring few or no job changes.

There are some examples of workstream plans that were clear and communicated effectively, however. For example, in SWLSG, workstream participants described plans as having clear aims and objectives, featuring detailed timetables, and identifying key processes, inclusive of planning, implementation and evaluation of changes brought by the work. Supports and resources available and the personnel responsible for each task were also described.

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## ***Communication with local partners***

Communication of local plans to a range of stakeholders was done via the local consultation events. Continued correspondence was required to maintain a broad engagement, generally on the part of the Programme Leads and their close colleagues. This involved sending out several rounds of emails and newsletters to keep people informed of plans and progress, and organising and attending meetings. Programme Leads in all sites also recall the large amount of time taken up in more informal, personal contact with stakeholders in order to build relationships necessary for partnership working. The original MHIP timescale allocated 3 months for this engagement period. However, this was demonstrated to be insufficient and this phase of the programme was extended accordingly. Respondents reflected that even this was probably not sufficient given the number of partners in question and the range of different issues to be dealt with in developing these partnerships.

I think we got the engagement wrong and as a result the whole project suffered. We didn't get it wrong - we rushed it. The conversations happened but they happened in a rushed way out of context, so there were phone calls between Chief Execs and the SHA. It was my director ringing his PCT colleague and saying look, we're going to do this, are you keen? It wasn't one to one meetings followed by people around the table getting a shared understanding of what it was that they were all signing up to and then doing that again and then doing that again.

*- RDC personnel, South West Yorkshire*

My husband worked in the building industry, and he said that it's taken him five years to get a tender from somebody that he's got to know over that time. And I think that we have to be much more pragmatic about this and think they should have spent the time in that first year building their relationships.

*- National MHIP team member, NIMHE*

MHIP provided a template for a NIMHE/MHIP Improvement Partnership Agreement to assist sites in developing local governance arrangements. The Partnership Agreement does not appear to have been a particularly useful tool, however. The value of this document has been questioned as some people did not remember signing it. Where partners e.g. personnel from local PCTs, did recall signing, they found this process came too early and they did not yet fully understand the work, the obligations or implications.

Interview respondents such as service users and those working for voluntary organisations across the pilot sites describe hearing very little about MHIP after the big launch events. For example, one carer reflected that "It seemed to die a death". Middle managers, frontline staff and service users recall how, following the launch events, relatively small numbers of people mostly from the mental health trusts were responsible for continuing

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on with the bulk of the work, whilst broad stakeholder engagement and involvement “fizzled out”. This was commonly attributed to the lack of capacity of the one or two people running each local programme to establish and maintain working relationships with such a large number of partners. This was felt by the Programme Leads but also observed by the people who were left feeling peripheral to the work.

Communication is actually a biggie, and it's programme leads, that's where we fell down with MHIP. I mean communication is legwork, but we didn't have the capacity to do that legwork.

- *Local MHIP team member, South Staffordshire*

it wasn't just me, there was the PCT people, you know, quite a few people were saying well yeah, what has happened to MHIP?

- *Frontline staff, South Staffordshire Healthcare NHS Trust*

### ***Communication of the plans: key findings***

- The MHIP Project Initiation Document, whilst highly structured, was complicated and gave little sense of direction. Aims and objectives were vague and not always linked with the methods
- Locally, communication of plans and goals to partners involved a substantial amount of work. In many cases, initial work was also required to build these relationships. The MHIP partnership agreement document was not sufficient for this
- Responsibility for leading the work and the communication of it fell on a small number of staff with insufficient capacity (i.e. time, resources)
- Following the launch and its success at raising enthusiasm, broad stakeholder involvement “fizzled out” early on

### **4.2.3 Selecting effective methods**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. national and local planning documents
  - Questions relating to Standard 2.3 “The change programme uses methods that have been shown to be effective” of the standards-based interview
  - Qualitative data theme 3.1 *MHIP processes*
  - Qualitative data theme 3.2 *Aims of MHIP*
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- Qualitative data theme 3.4 *Structured approach*
- Qualitative data theme 3.5 *Partnership working*
- Qualitative data theme 3.10 *External support*

### ***MHIP tools***

Nationally, MHIP was structured around a PRINCE 2 format, using PIDs, deliverables and highlight reports. This structure was applied to some extent in each pilot site; all sites, completed highlight reports and with the support of the Programme Lead and Project Manager, PIDS were produced in the planning of most workstreams and projects. No rationale was provided for the use of the PRINCE 2 structure. In SWLSG, the PRINCE structure was frequently used. The first MHIP Programme Lead in this trust was already trained in PRINCE 2.

She is the most organised person on this planet. So she'd put all the structures in place and she was using PRINCE2 because that's her background and she had everything all documented and all the workstreams were beautifully set up.

*- Senior management, South West London & St George's Mental Health NHS Trust*

Some managers claimed PRINCE 2 was critical to the success of work, e.g. explaining how this created resilience that enabled MHIP to survive major changes in staff. Other staff preferred to use selected PRINCE principles because they saw the whole approach as unwieldy, over elaborate or "too formal".

Unless you're actually building a building in which case if you show it to the project guys who are building a building, then we understand it from that point of view but, you know. So I find it a bit of a turn-off frankly.

*- Senior management, South West London & St George's Mental Health NHS Trust*

In South West Yorkshire, work was based on "project-based working" as opposed to PRINCE 2.

The Mental Health Service Improvement Framework (MHSIF, see Chapter 1) presented in the PID set out a range of techniques and tools that were to be used to implement MHIP locally. This included three components: Outcomes and outcome measurement; Information tools; and the Learning and Development Package. The tools had been used previously by MHIP's national Programme Director whilst working at the MA and the MHSIF was heavily based on the toolkit used in the Improving Partnerships in Hospitals programme. Aspects of the MHSIF arose in the plans in all local sites.

With regard to planning outcomes and outcome measurement, all four sites used the Balance Scorecard system, thus tying the work to MHIP priorities and ensuring that desired outcomes were considered in these terms. The Programme Lead and NIMHE Client Manager in the South West Yorkshire

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pilot were the strictest in their application of this technique; they did not move beyond the planning phase using the Balanced Scorecard as they were unable to achieve partnership, and so could not find a balance amongst the four areas it contained. This provides a good example of piloting an aspect of the MHIP programme.

The Information Tools component of the MHSIF identified the National Service User and Staff Surveys and the Service Improvement Support Tool (SISTMH) as providing useful outcome measures. Ultimately, however, no workstreams included plans to use either of these. The SISTMH online progress reporting tool did not become available until relatively late in the programme and so was not particularly useful in terms of outcome measurement.

The Learning and Development Package (LDP) offered a range of training and learning tools, from which each site and workstream could select items as appropriate. All sites took up aspects of the training. Despite references in the national PID to training needs assessment and evaluation of the impact of the LDP, local programmes did not conduct these, nor was this analytical process encouraged or supported nationally.

### ***Evaluation***

The national PID outlined plans for evaluation of the MHIP programme. Routine outcome measurement associated with the Areas for Improvement (using the Balanced Scorecard) was to be done and the impact of the Learning and Development Package was to be evaluated. The PID also referred to the external evaluation to be carried out by an independent research team. Unfortunately, decisions regarding organisation of and funding for this were delayed. There was no reference in the PID to the internal evaluation which subsequently took place.

Little local evaluation was planned. References to evaluation of MHIP in the local PIDs and implementation plans were minimal; approximately one quarter of the workstreams set out an evaluation process during the design period. An exception to this was in SWLSG, where plans and ongoing reports recognise the benefits of evaluation, e.g. use of the "Plan, Do, Study, Act" change method, inclusion in plans of a review stage.

### ***Local selection of methods***

Rationales for selection of methods and approaches were different across the sites, not least because objectives themselves differed. In general, local programme and workstream plans clearly presented techniques to be used to achieve the identified objectives. For example, identification of bottlenecks through data collection and process mapping (many workstreams), improving screening systems to reduce inappropriate referrals (Psychodynamic Psychotherapy workstream, Leicester), researching alternative models of care (Supporting Strategic Service Improvement, SW London). Use of multiple change methods is recognised as giving work a better chance of success; but, given the extra costs involved and capacity required, it is perhaps not surprising that

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workstreams were seldom planned in this way. No workstreams offered staff financial incentives.

In South Staffordshire, the methods chosen were strongly guided by NIMHE and the trust's Performance Development Team, but the rationale for selecting these methods was not communicated clearly. All workstreams in this site had support to some extent from these sources. In Leicestershire, plans identify some methods, e.g. setting standards or process mapping, but no rationale was given for their selection and little was stated about how the methods would be implemented. The SWLSG plans featured methods that suited workstream objectives, e.g. launch and governance of the work; collection of data on caseloads and waiting times; process mapping and alternative models of care and plans generally recognised the benefits of evaluation.

There was evidence of whole systems thinking in all four sites and nearly all workstreams took into account that the organisation is conceptualised as a collection of systems. The value of integrating existing structures or processes with external agencies was recognised, e.g. how mental health services are accessed via emergency departments in a crisis episode was considered; and how mental health and social services might interact more effectively in terms of care management.

Most workstreams operated in isolation, however, and opportunities were missed as a result. Black and minority ethnic issues was potentially a "cross-cutting" project, but planning did not support joint working.

We said why is this a stream, why? Why is it not just cross-cutting, it don't make sense

- *Voluntary sector personnel, Leicestershire*

This isolated working may have been due to a lack of time for staff to attend other workstream meetings. Feedback of information to other trusts was also limited.

I had been expecting that there would be much more sharing of what was going on in the other sites. It just felt that it was something that South Staffs Healthcare was doing with some interest being shown from West Midlands NIMHE. I mean I know that X would go up to the national meetings, but she found it difficult to find what to report back.

- *SHA personnel, South Staffordshire*

### ***Local selection of workstreams***

All 15 workstreams were highly relevant to local needs. Although the early MHIP aims were about establishing and developing partnerships across the mental health communities, in actuality, most workstream topics were focused primarily on improving services/systems within the host mental health trust rather than across interfaces with local partners. Four were focused on directly improving a section of the mental health service, three on service development within the trust more generally; one on improving

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access to information; one on values-based workforce; one on access to service; one on diversity; and one on patient choice. Only three were focused on improving working with local partners: one focused on commissioning; one on working with the voluntary sector; and one on integrating with social care.

Programmes might have tended to focus on the trust because projects were selected by predominantly trust staff. Projects that were dependent on partnership across a number of organisations failed to progress (e.g. all workstreams in SWYMHT) and therefore ceased or changed their goals. This shift in emphasis from partnerships *across* mental health community to *within* mental health trusts is, again, illustrative of an absence of a robust MHIP programme theory.

In line with the overall aim of MHIP, respondents in all sites and across all levels of the organisations, commonly referred to workstreams having a service user and carer focus, geared towards improving the service user experience.

### ***Selecting effective methods: key findings***

- The rationale for selection of techniques included in the MHSIF was not clear. Components, such as those for outcome measurement and evaluation, were patchily used and rarely tested out
- Workstreams were all highly relevant and techniques selected were often apt
- Project management techniques were used to structure MHIP nationally and often locally. In some contexts, this appeared to provide projects with resilience
- Whilst all local sites recognised the importance of whole systems working in their plans, opportunities were missed for workstreams to work together
- Despite the title of the programme, local plans were commonly aimed to focus on improving services/systems *within* the host trust

### **4.2.4 Consideration of resource and budget implications**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. national and local planning documents
  - Relevant data from the stakeholder questionnaire
  - Questions relating to Standard 2.4 "All resource and budget implications of the desired change have been considered beforehand" of the standards-based interview
  - Qualitative data theme 3.6 *Training and resources*
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- Qualitative data theme 3.10 *External support*

### ***At the national level***

Original plans were for each pilot to receive £180 000 from NIMHE in order to provide additional capacity across the community, but ultimately this amount varied between the sites. This change was significant, as people in each of the host trusts recalled the prospect of a financial investment to be an important incentive for getting people on board. Furthermore, this change left some people feeling disappointed and somewhat disillusioned about the programme. One of the reasons stated for the change in funding was the unplanned recruitment of a fourth pilot site, South West Yorkshire, although it transpired that this site received very little funding.

The national Programme Director had £1 million to fund the developmental stages and some extra capacity. There was no clear rationale for the sums of money; there was little consideration in the plans of the resources that MHIP would actually require. For example, there is no cost estimate of the number or level of personnel that would be required to take the work forward. Whilst this did afford the sites freedom to spend as they felt appropriate, some advanced guidance on expected costs might have been helpful.

### ***At the local level***

Local programme implementation plans showed how NIMHE funding was to be used. In SSHT the plan identified “head up” time as a key resource for staff involved in the work, but does not specify how it might be facilitated. SWLSG’s MHIP plans identified responsibilities including supporting the planning and implementation of projects, alongside the set-up of launch and consultation events, as well as service user and carer events. Overall, very little detailed consideration was given to freeing up time to permit frontline staff’s engagement, beyond a reference to clinical and managerial backfill.

At the workstream level, in only one workstream were all resource and budget implications considered beforehand. Dedicated funds and staff time were available to only three of the workstreams. Most workstreams reported that managers did not commit funds and staff time to the work. Whilst the MHIP Programme Lead and Project Manager generally had time dedicated for the work.

Chapter 5 explores in greater detail how resources were used in MHIP.

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### ***Consideration of resources and budget: key findings***

- The amount of funding received from NIMHE was varied and less than first expected. This led to disappointment and disillusionment
- At the national level, overall, there was no clear rationale either for the amount of funding or for how it should be spent
- At the local level, plans set out basic budgets but little attention was paid to the full extent of the time and resources required to implement MHIP
- Staff time was consistently identified as a key resource for MHIP, but little consideration was given to how this would be freed up. Dedicated funds/time were rarely budgeted or available
- Sites usually had a Programme Lead and Programme Manager who did have dedicated MHIP time, as well as time and support from the local NIMHE Client Manager

#### **4.2.5 Alignment of the local programmes' plans with the MHIP aims**

As can be seen from Table 6, two of the pilots focused on providing better services through increasing choice and accessibility. One pilot explicitly framed their programme in terms of delivering national targets and addressing financial issues, in order to provide better services. Piloting the MHIP approach was the focus of another site. Broadly, the local programmes and the workstreams that fed into them aligned well with the national aim and were well suited to addressing the MHIP principles (the national MHIP aims and principles are shown in Chapter 1).

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**Table 6. Focus and workstream topics across the four pilot sites**

	<b>South Staffordshire Healthcare NHS Trust</b>	<b>Leicestershire Partnership NHS Trust</b>	<b>South West Yorkshire Mental Health NHS Trust</b>	<b>South West London &amp; St. George's Mental Health NHS Trust</b>
<b>Focus</b>	The focus was on choice, information and support in making the right choices, in line with the existent agenda	Provision of better services, delivering on national targets and guidelines and addressing the financial gap	Testing out the "MHIP theory", i.e. the significance of successfully achieving outcomes by taking action in each of four the key impact domains	Underpinning key areas of a comprehensive and transformational service improvement and development programme for local mental health services
<b>Workstreams</b>	1. Acute Care <i>Acted to support the Acute Care Forum set up in 2002</i>	1. Adult Community Mental Health <i>Remodelling of adult services</i>	Year 1: Diversity*; Employment; Service Development; Mental health promotion; Access*; Services fit for purpose*; and Community capacity.	1. Access <i>Understanding unplanned/emergency access to secondary mental health services and inform the development of an improved service model</i>
	2. Transparent commissioning <i>Aimed to increase the clarity of the commissioning process</i>	2. Psychodynamic psychotherapy services <i>Waiting list reduction</i>	Due to lack of funding and capacity, three of these (*) were selected to be prioritised by the steering group	2. Supporting clinical teams to optimise their capacity <i>Six projects, all generally focused on caseload and waiting lists and times</i>
	3. Values-based workforce <i>Identified as "culture change", consistent with the existent "Choice Agenda"</i>	3. Voluntary sector <i>Working together to improve the capacity and governance of the voluntary sector</i>	Year 2: Psychiatric Intensive Care Unit (PICU); Section 136; Eating Disorders Specialist Service; CAMHS/Tier 4 services; Service	3. Social care integration <i>Reviewing and mapping the procedures and to design a new integrated system to be implemented in one borough</i>

	<p>4. Advocacy to exercise choice <i>Two major focal points: to improve service user choice, by mapping services and to increase awareness and spread of advocacy</i></p>	<p>4. Black minority ethnic <i>Assessing and improving BME access to services</i></p>	<p>Level Agreement and Performance Frameworks; Additional item in section 117; SWY wide suicide prevention strategy; Early Intervention in Psychosis Service; Psychological Services/HASCAS Review; Low Secure Service</p>	<p>4. Supporting strategic development Ensuring that Adult, CAMHS, Older Persons' and Specialist Services were integrated and localised under the new borough-based directorate structure</p>
	<p>5. Access to information <i>Consisted of a number of projects related by the theme of information access and reduction of stigma</i></p>	<p>5. Older person's services <i>To gain an understanding of effective models of care for this group and to make improvements</i></p>		

## 4.3 Implementation and evaluation

### 4.3.1 Effective change measurement and evaluation techniques

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. national and local planning documents, highlight and progress reports
- Questions relating to Standards 3.1 "The change programme includes effective change measurement and evaluation, incorporating valid performance data and honest feedback from service users and staff" and 4.1 "The change programme is evaluated in terms of generating evidence and developing theory" of the standards-based interview
- Qualitative data theme 3.1 *MHIP Processes*
- Qualitative data theme 3.4 *Structured approach*
- Qualitative data theme 3.8 *Evaluation*

#### **Outcome measurement**

Despite inclusion in plans at the national and local levels, measurement of change within the MHIP programme was weak. This was perhaps in part

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because of the existing local gaps in service improvement expertise, as noted in Chapter 3. Many workstream plans listed relevant baseline and progress measures (guided by the Areas for Improvement on the Balanced Scorecard), but these data were often not collected. In some cases formal measurement was considered inappropriate because no progress was being made. The approach most commonly adopted for measuring change was recording achievement of project milestones, detailed in the monthly highlight reports.

In South Staffordshire, for example, the Values Based Workforce implementation plan identified measures representative of the desired culture change, e.g. increasing the number of service users involved in recruitment and service delivery. These measures, however, were not recorded. Personnel involved in the workstream observed that improvement had occurred but the lack of data to support this weakens the level of certainty about this.

Our workstream was one of the hardest, because it's not easily measured, it's something that everybody realises is important but it's very, very difficult to measure.

- *SHA personnel, South Staffordshire*

Measurement, however, was a key feature of work in South West London's MHIP:

So the waiting list people measured, the CAMHS measured, the alcohol people measured, hospital at night we measured... also there is a great deal of measurement that X is doing around service user experience in its broader sense, and that is very thorough.

- *Local MHIP team member, South West London*

### **Local evaluation**

Three workstreams did not include any effective measures of improvement or evaluation. Four workstreams reported that the evaluation process was not an integrated part of the workstream. A common explanation for the absence of evaluation is that there was little change to evaluate. Staff did not always appreciate the importance of learning from workstreams that struggled to achieve their objectives. End of programme reports described progress and achievements, but not the lessons learned.

Workstreams did not usually take an iterative approach. Two workstreams were able to adapt their work in response to feedback, e.g. using PDSA. Most workstreams had a quick trouble-shooting procedure through project governance. The findings of only four of the workstreams were passed on in an easy-to-read format, e.g. via an R&D newsletter, notice boards, intranet and Internet. Although planned, no evidence could be found of workstreams being re-audited over the course of MHIP. The workstreams were not evaluated in terms of generating evidence and developing theory.

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South West London's highlight reports documented important learning points, e.g. the importance of having a communications strategy from the outset, using language that is not excessively technical and fully scoping stakeholder opinion prior to identifying goals and project measures, are identified. A good example of learning can be seen in South West London's Social Care Integration project. A report presents recommendations for future implementation of the products of this work. This workstream was also summarised using the SISTMH tool.

### ***Programme evaluation***

Whilst plans set out a pathway for evaluation of the MHIP programme, both internally and externally, there is little evidence to suggest that the evaluation process was integrated into the programme. Firstly, the internal, day-to-day evaluation of the Learning and Development Package did not go ahead to become part of any of the local programmes. Secondly, there were a series of delays with securing funding and other arrangements for the external evaluation resulting in this commencing as most of the pilot sites were closing the MHIP work and personnel were moving on. The retrospective nature of the external evaluation is a major limitation. Staff in the MHIP team in one trust queried the relevance of an external evaluation, given that the programme was now over.

SISTMH was a potentially useful resource, but many local personnel disliked the interface and queried its usability. Another major problem was that it did not become available until relatively late in the programme. The information uploaded to it was useful and communicated progress of work effectively but the extent to which this resource was used was limited, with only some individuals uploading such information. The use of this resource was insufficient to support development of a national "satellite perspective" on MHIP's progress; given its potential to do so, the lack of SISTMH uptake represents a missed opportunity.

In line with the programme's PRINCE 2 structure, all local sites produced highlight reports including learning logs, although completion of these, and attention to them, diminished over time.

South West Yorkshire partners were clear that MHIP was a pilot and therefore should test the theories and methodologies presented in the MHIP PID. This was less so the case in the other sites. Learning was limited, because no final report was produced. Some staff in South West Yorkshire observed that nationally, MHIP quickly "lost shape"; it became four trusts doing different work using different frameworks, with a failure to test the initial MHIP methodology. Because of this, the degree of cross-pilot learning was limited significantly and the central MHIP meetings did not effectively address this.

We tried to have our process, there was some fidelity to that PID, and I suppose the fact that it sits in the long grass maybe suggests that what we were testing out was this methodology and did this methodology help? Possibly not.

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- *Local MHIP team member, South West Yorkshire*

Individuals have undoubtedly learned from their experience and some of these lessons were captured by an internal evaluation run by the national MHIP steering group. Although not evident in the MHIP PID, an internal evaluation of MHIP was carried out by a member of the national MHIP steering group. This was based on a series of focus groups and summarised a wide range of local perspectives on the MHIP process. It proved impossible to run a focus group in one site, SWLSG, due to significant leadership changes at the time of the evaluation. This document provided a useful summary of local and national views of MHIP and identified some key obstacles and enablers to the initiative. By the time of its publication, broadly, the MHIP steering group seemed to have lost interest in this document. Its findings were used by CSIP to inform the design of its online service improvement guide, however.

It may be that managers did not evaluate their progress because they believed that the internal and external evaluations would do this for them.

#### ***Effective change measurement and evaluation techniques: key findings***

- Despite inclusion in plans, outcome measurement was broadly weak perhaps in part, because of the existing local gaps in service improvement expertise, as noted in Chapter 3
- The outcome measurement tools from the MHSIF were not widely used. Progress was sometimes measured by recording achievement of project milestones
- The value of evaluation was not sufficiently appreciated. Whilst plans included reference to internal and external evaluations, these were not always supported or integrated in the programme

### **4.3.2 Partnership working**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. local meeting minutes, highlight and progress reports
  - Relevant data from the stakeholder questionnaire
  - Questions relating to Standard 3.2 "Responsibility is devolved to enable frontline staff to make key decisions about the organisational intervention" of the standards-based interview
  - Qualitative data theme 3.1 *MHIP Processes*
  - Qualitative data theme 3.3 *Leadership*
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- Qualitative data theme 3.5 *Partnership working*
- Qualitative data theme 3.8 *Evaluation of the work*
- Qualitative data theme 3.10 *External support*
- Qualitative data theme 3.11 *Internal support*

### ***Devolution of responsibility***

Whilst the national MHIP team provided support and expertise, in each site, small teams, normally consisting of a Programme Lead, a Programme Manager and RDC Client Manager, ran the programmes. This devolved approach enabled programmes to be tailored to some extent to local need. One RDC Client Manager described NIMHE's role in the local running of MHIP as "to lead from behind". Whilst the RDC Client Managers themselves were heavily involved in running the local programmes, it was NIMHE's intention that MHIP should be locally owned.

There was something about giving the ownership of the whole of the mental health improvement agenda to the mental health communities themselves and give them some generic service improvement skills which actually brought together all the different components.

- *National MHIP team member, NIMHE*

Within sites, there was some further devolution of responsibility to workstream teams. All workstreams had a nominated lead, although 3 of the 15 workstreams were led by the Programme Leads and several other leads required substantial support. Many projects were led by a staff member from the mental health trust whose work or skills closely related to the topic, e.g. in SSHT, stigma in the local media was addressed by the communications officer; and work around advocacy services in a forensic service was led by a forensic mental health nurse. In 4 out of 15 workstreams, responsibility for making key decisions was devolved to enable frontline staff to make key decisions. Only about one third of the workstreams had frontline staff actively involved, e.g. in collecting data and attendance at project team meetings. Local staff felt involved and felt ownership of its objectives in just 5 workstreams; four of these were the workstreams where responsibility for making key decisions was devolved to frontline staff.

This devolution notwithstanding, in all four sites, considerable proportions of the work were carried out by the two or three people leading the local programme. This focus on a small number of personnel impacted on progress of work.

#### **When you say "we didn't have capacity", what sort of capacity would have helped?**

Probably another extra person. For a variety of reasons we lost a couple of programme facilitators, so I think that extra

person just going round and keeping people informed and getting some feedback, it was one of the biggest things.

*- Local MHIP team member, South Staffordshire*

In SWLSG, MHIP managers were central to planning, but they did not dominate the work; local staff were heavily involved in implementing and leading the work. A senior manager observed that the widespread use of PRINCE 2 provided a common culture and language which was heavily instrumental in achieving such a degree of devolvement. PRINCE 2 featured heavily in this site, partly due to the Programme Lead having had previous training and experience in its application.

### ***Working across the mental health community***

The specific pressures faced by the different groups involved often made partnership working difficult. For example, mental health trust and PCT priorities regarding finances and targets frequently differed or misaligned. Despite this, workstreams were commonly able to come up with aims and objectives that were attractive to mental health trusts, PCTs and local authorities alike. However, the looming reconfigurations of the PCTs and SHAs meant that progress even for these partnership projects was obstructed:

By this time the PCTs were fragmenting, oh God, you know, the world's falling apart. So engaging people's interest in this was very difficult.

*- Local MHIP team member, South West Yorkshire*

Partnership working was sometimes undermined by trusts dominating and directing workstreams. In Leicester, people from the voluntary sector complained that the workstream to improve working between the voluntary and statutory sectors was dominated by the trust's MHIP team. Eventually the trust announced the workstream was disbanded without consulting the lead or other workstream members.

At a group away day, X [one the local MHIP team] identified that the voluntary sector stream ought to be abolished and the other streams could converge into the community stream. That came from X, it didn't come from the floor, it came from X.

*- Voluntary sector personnel, Leicestershire*

The leads of another workstream in Leicester withdrew after a similar experience of feeling dominated leaving the MHIP Programme Lead and Manager to continue the work.

In SSHT, 3 of the 5 workstreams had external leads, e.g. from the local SHA. This brought new perspectives, but also a lack of familiarity with other people in the workstream. SWYMHT shared leadership of workstreams with local partners, but few leaders were engaged with the work. This was unexpected given the overlap of PCT and MHIP objectives, but

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understandable given PCT staff's preoccupation the reconfiguration of PCTs. The involvement of external partners "fizzled out" in South Staffordshire; again, partly because of the distraction of looming reconfigurations but also because they were not supported to be more involved.

Reconfiguration was a big thing, the reconfiguration of PCTs and things were happening in social care as well

- *Local MHIP team member, South Staffordshire*

Within the mental health trust, differences in opinion formed substantial obstacles:

There were grumblings from this side saying something's got to happen and grumblings this side saying we don't want anything to happen, but what was decided to happen nobody really wanted. So there you go. So nobody was going to be happy

- *Senior management, Leicestershire Partnership NHS Trust*

Partnership working with service users and carers was limited by the time MHIP was in its implementation phase:

There were very few service users and carers who actually led the workstreams. When you're talking about a Mental Health Improvement Partnership, they lost a real opportunity.

- *National MHIP team member, NIMHE*

Although partnership working was a central plank of MHIP, respondents indicated that the challenge of establishing these partnerships was underestimated:

I think a bit naïve to assume that you could tell people to work in partnership when those partnerships didn't exist.

- *National MHIP team member, NIMHE*

The limited capacity on the part of the small number of people leading the local programmes was viewed as causal in the restricted partnership working:

They haven't got enough capacity to keep attending meetings, and I know that I didn't have enough time and I didn't put enough emphasis on the legwork, and I know they'd have been better engaged if I'd gone to them a lot more.

- *Local MHIP team member, South Staffordshire*

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### ***Partnership working: key findings***

- Each site had a Programme Lead and Programme Manager which enabled some devolvement of responsibility
- There was far less devolvement from this level, partly due to the weak service improvement skill base across the localities. This led to high demands on a small number of personnel, which in turn, impacted on the progress of the work
- In SWLSG, a number of personnel received project management training. This meant that they had a common “language” and structured approach, enabling responsibility to be devolved beyond the programme leads
- Partnership working between different groups each with different priorities was often very difficult
- Service user and carer involvement was ultimately very limited. A large amount of work required to develop these partnerships

### **4.3.3 Expertise, support and training**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. documents relating to training events
- Relevant data from the stakeholder questionnaire
- Questions relating to Standard 3.3 “Staff have the necessary knowledge and skills to design and implement and receive the necessary training” of the standards-based interview
- Qualitative data theme 3.6 *Training and resources*
- Qualitative data theme 3.10 *External support*
- Qualitative data theme 3.11 *Internal support*

#### ***Expertise and support***

Aside from the Programme Leads and Managers whose jobs were in Service Improvement, most staff in all four sites were inexperienced in service improvement work and techniques. Given that training was a central part of MHIP, it was surprising that only 1 workstream included staff who had received training in organisational improvement interventions. Two thirds of workstreams had help from leads in constructing process flow charts and influence diagrams.

Technical support was usually provided by the Programme Lead, Project Managers and NIMHE client manager to workstream leads and their teams, to help with planning, data collection, process mapping. National NIMHE Leads in areas such as outcome measurement and service improvement

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also provided some support, although this was patchy and diminished quickly.

The NIMHE client managers were valued in terms of their expertise, but also for their moral support:

The resource that we did get from the RDC was wrapped up in X, who I have to say was very good. I mean we couldn't have made the progress we did certainly without X.

*- Local MHIP team member, South West Yorkshire*

The degree of support provided by members of the NIMHE programme board varied:

In the other areas everybody had a central NIMHE person linked in with them, and I think that some of those people were a bit more hands on than X was. I don't mean to sound sour grapey but I think that's the reality.

*- Local MHIP team member, South West Yorkshire*

Whilst all host mental health trusts had established clinical audit teams, only one workstream utilised these structures. In SSHT, one workstream worked with the mental health trust's clinical audit team in order to develop and distribute a questionnaire for an audit. In all four sites the clinical audit teams were not involved in MHIP and were largely unaware of the work that had been carried out. As discussed in Chapter 3, clinical audit teams were mostly small and were preoccupied with collecting data and providing reports for national monitoring. They had little capacity to support local clinical audit work. Programme Leads from two sites flagged up an additional problem with involving the clinical audit teams from the mental health trusts. They stated that this could place too much emphasis on the mental health trusts and would have implications for true partnership working across the external organisations.

## ***Training***

Local Programme Leads and RDC Client Managers from 3 sites, along with the national Project Manager attended the Clinical Systems Improvement (CSI) training at Warwick University. This training focused on continuous improvement, setting performance measures, Lean Thinking and Six Sigma methodologies and featured a component on educating others about these concepts. CSI was viewed positively by attendees, though many of the techniques taught on the CSI course were not new to the Programme Leads. Also, some attendees suggested the training had insufficient focus on processes and identified a major gap around service user involvement. A secondary benefit of the training was that of "bonding" the attendees; the local Programme Leads who attended CSI formed an effective working relationship. The Programme Lead and RDC Client Manager from SWY, which joined MHIP late did not attend this training and, as a consequence, missed this secondary benefit.

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Other training covered techniques such as process mapping, solution design. These were relevant to much of the work carried out locally and appear to have been helpful in supporting broad engagement in process mapping events, although these techniques were already familiar to the personnel who were leading the programmes. Seminars on statistical techniques were taken up in all four sites but as there was, ultimately, relatively little in the way of suitable data for these processes their relevance to and impact on MHIP in practice were limited. For example, in South Staffordshire, 40 managers and clinicians attended the workshop on Statistical Process Control, but had little application to the actual workstreams.

NIMHE Service User and Carer consultants were recruited to give training to local staff, service users and carers on how to carry out effective service user and carer involvement. Due to local capacity issues, only two of the four pilot sites were able to take advantage of this offer. Local staff indicated that these events had a positive effect on their understanding of the importance of attending to the views of service users and carers.

Overall, there was heavy focus of training on a small number of personnel (of whom most were already skilled). This reduced the extent to which work could be devolved out from the local Programme Leads and the likelihood of any substantial or maintained change in the local service improvement skills base. A more systematic approach to assessment of training needs would have flagged up opportunities to enhance the existent skill base and would have reduced the probability of people receiving inappropriate or unnecessary training.

In addition to these resources, SWLSG had access to the South West London Improvement Academy (run by the local SHA). This provided a range of appropriate training. SWLSG provided the most relevant training and had the highest uptake. Building skills was an important part of this MHIP programme and most respondents were clear about the training provided and skills they had acquired. This is perhaps unsurprising, given their greater level of funding and training resources available. The provision of "backfill" staff in SWLSG enabled managers and clinicians to attend training events. In other sites the lack of resources to provide "backfill" staff prevented frontline staff attending training. In SWL one third of staff received training. Only 12% of staff involved in the workstreams in South Staffordshire and Leicester had received training provided by MHIP. In South West Yorkshire the uptake was not known. Ten staff were trained to use PRINCE 2 as part of the MHIP programme in SWLSG and, as has already been demonstrated this had wide influence and application.

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### ***Expertise, support and training: key findings***

- NIMHE support was generally valued. Access to some areas of expertise, however, such as in outcome measurement, was patchy and quickly diminished
- Existing local quality improvement structures, such as clinical audit teams were hardly used for MHIP
- Programme Leads, Programme Managers and NIMHE personnel attended a training event. The content was not entirely relevant or appropriate and there was a lack of focus on service user and carer involvement
- Only 2 of the 4 sites took up the offer of NIMHE service user and carer training
- Overall MHIP did not sufficiently address the existent weakness in service improvement skills base; training focused on a small number of people
- In SWLSG, where funding and training resources were greater, the impact of the training was more clearly seen

#### **4.3.4 Feedback**

The following were sourced to inform this section (see Section 2.5.3, Chapter 2 for method):

- MHIP documentation, e.g. national and local feedback documents
- Questions relating to Standard 3.4 "Staff receive constructive feedback on the success of the change programme regularly and when appropriate" of the standards-based interview
- Qualitative data theme 3.5 *Partnership working*
- Qualitative data theme 3.7 *Communication*
- Qualitative data theme 3.8 *Evaluation*

All pilots produced monthly highlight reports throughout the course of the programme, which described the progress of the workstreams broadly relating back to their original goals. These were made available to the trust boards, the national MHIP steering group and the other MHIP pilot sites. These documents generally contained information on progress of work and some reflection. These reports enabled senior trust staff to be informed of the work and where appropriate and possible, take actions to help work go ahead. In all four sites, this line of communication up to senior management was commonly identified as the trouble-shooting procedure.

I've been used on occasions to provide a bit of muscle, a little bit of leverage, but as an Executive Director, as a member of the 'top team', the Board, obviously we made a very conscious decision we would support MHIP, we were made aware of it and we had regular updatings.

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*- Senior management, South Staffordshire Healthcare NHS Trust*

The highlight reports and the central meetings provided a structure for local teams to feed back to the National Programme Manager and other experts at NIMHE. Indeed, the programme was adapted to feedback received via this structure. For example, the length of time allocated for engagement was extended following concerns raised by the local RDC Client Managers and Programme Managers. There are examples, however, where this feedback mechanism failed to be responded to. For example, despite SWY consistently expressing concerns about their pilot, particularly in terms of lack of resources, they received no concrete help in moving the programme on from this.

I was expecting help with things like “we’ve still got no money, where does it come from?” And you’ll see in the highlight reports that I’ve written for the first six months of the project, I was pulling my hair out.

*- Local MHIP team member, South West Yorkshire*

Whilst highlight reports were shared between Programme Leads and others, their format and content did not necessarily enable lessons to be learned. They were time consuming to produce and, on occasion, felt to be a stressful distraction especially when the work itself was not progressing.

During the course of the work, most staff received some feedback on workstreams’ progress. Multidisciplinary discussion forums were used or set up in about half the workstreams to promote learning across professions and disciplines. In half the workstreams, managers regularly generated summary reports for practitioners to discuss at team meetings. Feedback about the workstreams was usually provided as part of routine trust meetings, but these were not necessarily attended by external partners. In Leicester, it was disappointing that there was little clinician involvement in these feedback meetings, e.g. the clinical lead from the service that was to be closed as part of one workstream was not included. In SWLSG updates were provided in a better way to partners, e.g. at borough board meetings, commissioning meetings, team managers’ meetings and latterly the CSDP Forum.

Programme Leads and Managers fed back on progress to the wider community through newsletters and emails and “End of Year” reports containing summaries of achievements and some reflections on the lessons learned. SSHT and SWLSG also produced “End of Programme” reports. In one site, however, the accuracy of achievements identified in the final MHIP report was questioned by some local staff, both in terms of the extent to which they could be attributed to MHIP and whether, in fact, they had been achieved at all. (e.g. “more support through advocacy”, service users and carers’ skills and abilities included in plans of care).

I thought well yes, this is a wonderful paper, you know, a publicity thing, and other things well, you know, I work in the clinical field and I haven’t seen any changes at all.

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- *Frontline staff, South Staffordshire Healthcare NHS Trust*

In many workstreams, respondents described that the work lacked a sense of “closure”. A number of senior personnel, including a Chief Executive, reflected that, in addition to the launch events carried out for MHIP, there should have been feedback events to recognise and celebrate the programme’s achievements.

If you follow it through, you’ve had some thinking time, you’ve got a launch event, you go into the project and then you have an event at the end that captures what’s taken place and the successes really. So you’ve got some closure.

- *Senior management, South Staffordshire Healthcare NHS Trust*

Although efforts were made to communicate progress, communication with external partners had deteriorated over time as had partners’ engagement with the work. Many external partners were unsure about the progress of the work and as a result, cannot always point to what MHIP achieved. For example, service users based at SWLSG had not seen the finalised pathways in the social care integration workstream. Some partners, particularly people who did not work for the mental health trust, reported “being out of the loop” and did not recall hearing anything about MHIP beyond the launch and initial meetings. This diminished presence was often attributed to lack of capacity on the part of the MHIP programme lead and project manager.

#### ***Feedback: key findings***

- Monthly highlight reports served to communicate progress to the local trust boards, the national MHIP steering group and to the other sites. The writing of these was time consuming, however, and not always felt to be beneficial
- Progress was communicated to local stakeholders via meetings, newsletters, and emails, but this was often not sufficient to maintain interest and engagement

## ***4.4 Attainment and impact of MHIP objectives***

Three types of local objectives are identified in local MHIP plans:

- **Analysis & planning** – initial work, e.g. consulting stakeholders, measuring demand and capacity, developing plans.
- **Processes** – changes in the way organisations work, e.g. setting up new structures and services, creating new partnerships.
- **Outcomes** – actual changes in service quality, e.g. providing more efficient services, improving service user outcomes and satisfaction

Table 7 shows for each site and for each workstream the objectives, whether or not objectives were attained, and whether attainment could be attributed to MHIP.

**Table 7. Attainment and impact of MHIP objectives**

Site	Workstream	Analysis & planning		Process changes		Outcome changes		Impact
		Objectives attained?*	Due to MHIP?	Objectives attained?*	Due to MHIP?	Objectives attained?*	Due to MHIP?	
South Staffordshire	1. Acute care			0/1	NA	?/2	Low	NA
	2. Transparent Commissioning			0/7	NA			None
	3. Values-based workforce			1/2	Medium	1/1	No	Low
	4. Advocacy to exercise choice			1/2	Medium	1/2	Medium	Low
	5. Access to information	1/2	High	2/3	Low			Low
	<b>TOTAL</b>	<b>1/2</b>		<b>4/15</b>		<b>2/5</b>		
Leicester	1. Adult Community Mental Health Services	1/3	High			0/1	NA	None
	2. Psychodynamic psychotherapy Services	1/2	High	2/3	High	1/1	High	Low
	3. Voluntary Sector	1/3	High	1/1	Medium			Low
	4. Services for Black and Minority Ethnic Communities	1/2	Low	0/1	NA	0/1	NA	None
	5. Older Persons' Services	1/1	High	0/1	NA	0/2	NA	Low
	<b>TOTAL</b>	<b>5/11</b>		<b>3/6</b>		<b>1/5</b>		
South West Yorkshire	1. Service development (including 9 new workstreams in year 2 in this area)			0/9	Low			Low
	<b>TOTAL</b>			<b>0/9</b>				
South West London	1. Access	11/17	Medium					Medium
	2. Supporting clinical teams to optimise their capacity	1/2		1/1	Low	1/1	Low	Medium
	3. Social Care Integration (Sutton Adult Services)	4/5						None
	4. Supporting Strategic Service Development	3/5	Low					None at time of MHIP; high potential
	<b>TOTAL</b>	<b>19/29</b>		<b>1/1</b>		<b>1/1</b>		
<b>MHIP OVERALL</b>		<b>25 /42</b>		<b>8/31</b>		<b>4/11</b>		

Overall, half the objectives focused on analysis & planning, 37% focused on processes and 13% focused on outcomes. In several cases, workstreams aimed only to agree a plan for changes to a service. SWLSG identified many analysis and planning objectives, whereas SSHT focused more on processes and outcomes.

37 of the 84 objectives were achieved. 25 of these were analysis and planning objectives, 8 were process changes and 4 were outcome changes.

Two of the MHIP workstreams had a medium impact on service quality, in terms of efficiency, service user outcomes and service user satisfaction. The remainder had low or no impact. Overall, the workstreams had a low impact. This is because few outcome focused objectives were set and attained. Also, the process objectives that were attained, e.g. reorganised services and new partnerships, did not necessarily lead to immediate improvements in service quality. It is possible that improvements to service and patient outcomes may yet develop, but few workstreams shows this potential.

Chapter 5 will examine in more detail the outcomes and impacts of MHIP both in terms of changes to the organisations and service quality.

## ***4.5 Discussion: the MHIP structures and processes***

As Chapter 3 illustrated, pilot sites were not ready for change. Over the course of MHIP, the hosting trusts and their external partners faced financial and organisational distractions. Broadly, frontline staff had neither the time nor the skills to engage in MHIP, which limited the number of people who could support MHIP effectively. Support structures such as clinical audit teams were seldom well-resourced or engaged in the work, again reducing the likelihood of work progressing.

The present chapter described the MHIP processes and demonstrated that the MHIP programme paid insufficient attention to the analysis and addressing of the organisations' contextual needs. Needs analysis prior to engaging in improvement work is recognised as key to its success (Gustafson et al., 2003).

The following areas can be used to describe the limitations of MHIP:

### ***Insufficient consideration of the challenges of partnership working***

As previously mentioned, the recruitment of pilot sites involved little more than gaining agreement from board-level personnel; minimal attention was paid to other needs of the communities that were recruited.

Despite the centrality of "partnership" to the MHIP programme, there was insufficient consideration of what is required to build and develop the local partnerships. Given the distractions, e.g. in the form of mergers and reconfigurations, and the often insubstantial links with voluntary agencies

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and service user groups, engagement and maintenance of these partnerships required a great deal of skill and attention. The short time scheduled for this task was unrealistic and whilst amendments to the schedule were made, the negative impacts of rushed engagement were felt across MHIP's lifespan. The partnership agreements between the statutory agencies were neither sufficient to define the new arrangements, nor supported suitably to ensure they were even created. The capacity required to maintain engagement of local partner organisations in MHIP was not recognised in terms of funding to supply sufficient personnel.

### ***Weak existent skill base not sufficiently addressed***

In terms of dedicated personnel, local Programme Leads, Project Managers and RDC Client Managers were generally already well-skilled and experienced and were central to the service improvements that were observed. More broadly, the number of skilled personnel, the availability of supportive structures (e.g. well resourced clinical audit structures) and time to do the work were limited. This meant that, despite the strong expertise and enthusiasm of the people leading MHIP, there was often insufficient capacity to drive the programme forward in terms of progressing project work, developing local partnerships more effectively, spreading service improvement skills and feeding into MHIP's evaluation and learning structures.

No needs assessments relating to skills was carried out, despite such a process being recognised as important for the facilitation of organisational change (Iles and Sutherland, 2001; Berwick, Enthoven and Bunker, 1992a, Berwick, Enthoven and Bunker, 1992b). MHIP focused training on a small number of personnel, i.e. mainly Programme Leads and Project Managers. Whilst some skills were acquired from this, some of this training was unnecessary, as it was already familiar to these personnel. The training offered more widely was insufficient and in many cases inapt.

### ***Inappropriate techniques***

Many of the techniques and support structures were drawn from IPH and were not always suited to the needs of the organisations involved in MHIP. Whilst some planning and organisational techniques were identified as extremely useful to guiding project work, others, such as the analytical techniques, were of very limited use, due to the nature of the data being collected. These examples strongly indicate insufficient consideration of existent needs.

### ***Insufficient capacity***

As the service improvement skill bases locally were weak, responsibility for much of the work ultimately fell on a small number of dedicated and highly skilled personnel. This insufficient capacity, i.e. in terms of time and resources, meant that the energy generated through early consultation was not effectively harnessed. Broad engagement with the majority of stakeholders external to the host mental health trusts diminished fairly

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early on, e.g. service users, carers, people from voluntary agencies. The other limitations of MHIP outlined above were compounded by the fact that those leading the work did not have the time or resource to tackle them.

It is important to recognise the aspects of the MHIP programme that were identified as instrumental in making progress:

Project management techniques, though felt to be excessive at times, provided resilience for programmes during times of turbulence.

MHIP acted as vehicle for change. Across all sites, MHIP, either as a structure or a brand, was used to drive forward existent priorities and projects.

MHIP was a spur to action. The consultation events both at national and local levels were clearly effective at engaging and enthusing a broad range of stakeholders. These events generated energy which was a potentially important driver for the programmes' and workstreams' progress. Unfortunately, in most cases pilot sites were unable to effectively harness this energy and wide stakeholder involvement dropped off steeply fairly early on.

#### **4.5.1 Implications**

It is essential that future service improvement initiatives of this nature attend more closely to factors recognised as central to service and quality improvement than was observed in MHIP. This means the contexts into which programmes are to be introduced should be assessed in terms of local capacity and relevant partnerships. Following this, contextual issues should be addressed through provision of appropriate support, training and resources, e.g. time to engage in the work. Such skills and capacity ensure the personnel leading improvement work have sufficient time to engage appropriate partners and establish a good relationship with them; produce clear concrete plans with achievable and demonstrable goals; use methods of known effectiveness; have a proper understanding of the costs involved in the proposed work; collect baseline information; and measure and evaluate achievements as the work progresses. Only through such processes can service quality be properly improved.

The overarching aim of NIMHE is to improve the quality of life of people who experience mental distress and to support positive change in mental health services. In its aims, MHIP very much set out to achieve this, but had limited success due to gaps in its approach. If NIMHE's aims are to be achieved, the science of organisational improvement needs to be appreciated and applied. Furthermore, it is vital that the lessons learned are harnessed and shared in order to inform future work.

#### **4.5.2 Summary of key findings**

The review of MHIP structures and processes in this chapter demonstrates the lack of a scientific approach in the design and implementation of the

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MHIP programme. This conclusion is supported by a number of observations:

Much of the development of the MHIP programme was done without consultation with people who would be considered experts, i.e. frontline staff, service users, carers and academics. Aims of MHIP were vague. Whilst, this was enabled flexibility and bottom-up input, the lack of clarity often left people feeling confused and overwhelmed. Service improvement techniques provided by the MHIP programme were used patchily and there was rarely a clear rationale for their use, either at national or local level. The inconsistent approach adopted towards both aims and methods makes it difficult to define the theory that the MHIP pilot was testing.

Despite the paucity of existent service improvement skills amongst personnel, no systematic assessment of training needs was done. Training to address this need was, therefore, insufficient. Outcomes of this included reduced capacity to carry out the work and in particular, weak outcome measurement during the course of MHIP, as well as little possibility for sustained change in workforce skills after the MHIP programme period.

Learning opportunities were missed. The value of evaluation was not fully recognised at the local level; nor was local evaluation sufficiently encouraged/supported by the national team.

The limited capacity of local MHIP personnel substantially restricted the progress of the work. Many of the contextual problems faced by the local programmes were further compounded by this inability of local MHIP personnel to invest further time to help resolve some of these issues. Expertise, support and training were provided by NIMHE and in some cases, sought from other sources. These were very important for the progress of the local programmes, not least in terms of moral support. Existent resources, in the form of mental health trusts' clinical audit teams were hardly utilised, however.

The MHIP programme was not geared up to deal with the complexities of the wider local contexts. Partnership working across the community was very restricted due to the different pressures and distractions faced locally.

Many of the difficulties experienced in MHIP reflect the perils of attempting to bring about change in unreceptive contexts. A consistent deficit across many aspects of MHIP was its failure to analyse and appropriately address these needs.

However, a number of aspects of the MHIP programme were identified as important for progress. MHIP acted as vehicle for change to drive forward existent priorities and projects. It was a spur to action, effective at engaging and enthusing a broad range of stakeholders early on, although in most cases pilot sites were unable to effectively harness this energy. Project management techniques, though felt to be excessive at times, provided resilience for programmes during times of turbulence.

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## 5 MHIP costs and impacts

### ***5.1 Chapter introduction***

The MHIP programme was piloted in four sites with the aim of improving the quality of every service user's experience of mental health services. In order to fund these developments, each Trust was to match with cash or equivalent resources the funding received through NIMHE. The Strategic Health Authorities (SHAs) also were to provide resources to support MHIP, and some Trusts used the programme as a means of leveraging resources in from other organisations. The result was that the total pot of resources available to each of the four pilot sites was different from the outset. These resources were also used in different ways depending, in part, on the plans for MHIP activities in each area.

In an overall context of scarce resources, current NHS resource constraints mean it is especially important to determine the total resource inputs used to generate the service improvements under MHIP, how these resources are used, to outline stakeholders' views on the resources, and to set resource inputs alongside the outcomes of the programme.

This chapter aims to pull together the evidence from the four sites and summarise some of the financial pressures the trusts were under, the market environments they worked within and sources of money available. It will provide a typical picture of the costs of implementing MHIP – one that may be familiar to those who have implemented service improvement programmes. A number of common themes about resources have been drawn out from the interviews and discussions, providing insights into how resources can best be used to support such programmes.

The impacts the MHIP programme had on the organisations in the local mental health community and on the quality of mental health services in the area are then summarised. The next section considers the information on the costs of MHIP alongside the programme's impacts. While this cannot be achieved using quantitative economic evaluation analyses, this section discusses areas where the resources absorbed by the MHIP programme have, or have not, appeared to achieve sustainable change. Finally, some implications for resourcing future initiatives are discussed.

### ***5.2 Previous research***

Quality improvement programmes have been fairly common in the UK since 1995 (Walshe and Offen, 2001) and yet there is a surprising dearth of literature on the costs of implementing such programmes. This is particularly so when set against the much greater body of literature exploring how best to implement improvement programmes and whether such programmes have resulted in any change. Such studies may be in

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their infancy (Severens, 2003) but are still far in advance of those that aim to assess the costs of implementing programmes to achieve change (Counte and Meurer, 2001).

What few studies there are tend to look at quality improvement (QI) or audit programmes (Jarlier and Charvet-Protat, 2000). Saving money is often a stated aim of QI programmes and a cost-savings approach is often taken in their evaluation. The study by Brown and colleagues is typical of this approach (2007). Their aim was to compare the costs of a QI programme to improve the management of care in diabetes outpatient services with the reduction in costs of patients' use of outpatient services and physicians' behaviour. Robinson and colleagues (1998) also take a cost-saving approach in their study of an audit programme in thrombolysis for suspected acute myocardial infarction. They used time-logs and observation to measure the inputs to the audit programme and set these against the cost per additional case given thrombolysis per year. While the data collection methods in both these studies have similar elements to that employed in the MHIP evaluation, although this takes a more comprehensive view, the end point (comparing costs) is somewhat different. Here the aim is to set the costs of MHIP in the context of impacts achieved by the programme.

### ***5.3 The financial context***

All the trusts in the MHIP programme were under considerable financial pressure at the time the various workstreams were implemented. Three of the mental health trusts each served several separately identifiable geographical areas which had different levels of resources available and/or very different demographic characteristics. This often led to what could be seen as iniquitous service provision. Historically, each trust has been the main mental health service provider and tends to have remained in a strong market position. More recently the mental health trusts have had to respond to the pressures wrought by local commissioning arrangements and their views of what services were required in the local area. In only one site was there a forum in which the mental health trust, PCTs and local authorities had worked together on commissioning issues over a reasonably long period.

In three of the sites the linked PCTs were merging, or had recently merged, into larger units. In one study of trust mergers, financial pressures were found to be a common driver, and financial savings a common, though rarely achieved, aim (Fulop et al., 2002; Hutchings et al., 2003; Fulop et al., 2005). These mergers made inter-agency relationships in the pilot sites more complex as new commissioning strategies had to be developed and uncertainties about job roles and responsibilities were common. The trusts' relationships with partner organisations were strained; described as "at loggerheads", through "weak" or "poor", to "complex but improving". Contact with voluntary sector organisations was very limited; in one site there appeared to be hardly any contact and relationships were described as weak or very poor in two others.

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Internal reorganisations were also common, with one Trust experiencing major upheavals with a move from service to locality directorates about halfway through the MHIP programme. Applications for Foundation Status were being drawn up in three sites as our fieldwork was underway, absorbing not inconsiderable amounts of energy and generating much concern. Existing financial deficits were also posing a real challenge. There were large budget deficits in two Trusts but financial constraints led to cuts in service provision and staffing in most sites.

***The financial context: key findings***

- Trusts were under considerable pressures including those coming from existing financial deficits
- External and internal organisational restructuring added further uncertainty and pressure

## ***5.4 The costs of implementing MHIP***

The approach taken in estimating the costs of MHIP activities was to focus on the first year (initially MHIP was to be funded for a year) and to look at total costs, that is to try and ascertain not only the size of the NIMHE grants and how they were spent, but also the costs of the associated NIMHE support package. Other resources leveraged in to support MHIP from the partner organisations or from within the trust itself were also included. It was expected that many of these resources would come in the form of staff support rather than financial aid and would not be recorded. The cost estimates are, therefore, drawn from a number of sources; NIMHE and Trust financial statements, interviews with staff, users and carers, and retrospective time records obtained through a survey (see Chapter 2 and the case studies in Appendix 10 for more details).

How people involved in MHIP viewed the associated resources is important. Most people interviewed had little idea about the level of resources MHIP absorbed but felt the NIMHE grant had acted as an incentive to become involved in the MHIP programme.

I'm totally ignorant of what resources it had in the first place so I can't tell you. But as a general comment there is no money and that's all there is to it. If somebody leaves now that is lost and that's it, you just don't have that replaced; it's as simple as that

- *Middle management, Leicestershire Partnership NHS Trust*

..every budget is allocated so every staff member has a job and so anything extra is more valuable... and it allowed you the flexibility to say well, just do it. If you can't do it we'll get someone in on a short term basis and just do that, and I think that really helped...

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- Senior management, South West London & St George's Mental Health NHS Trust

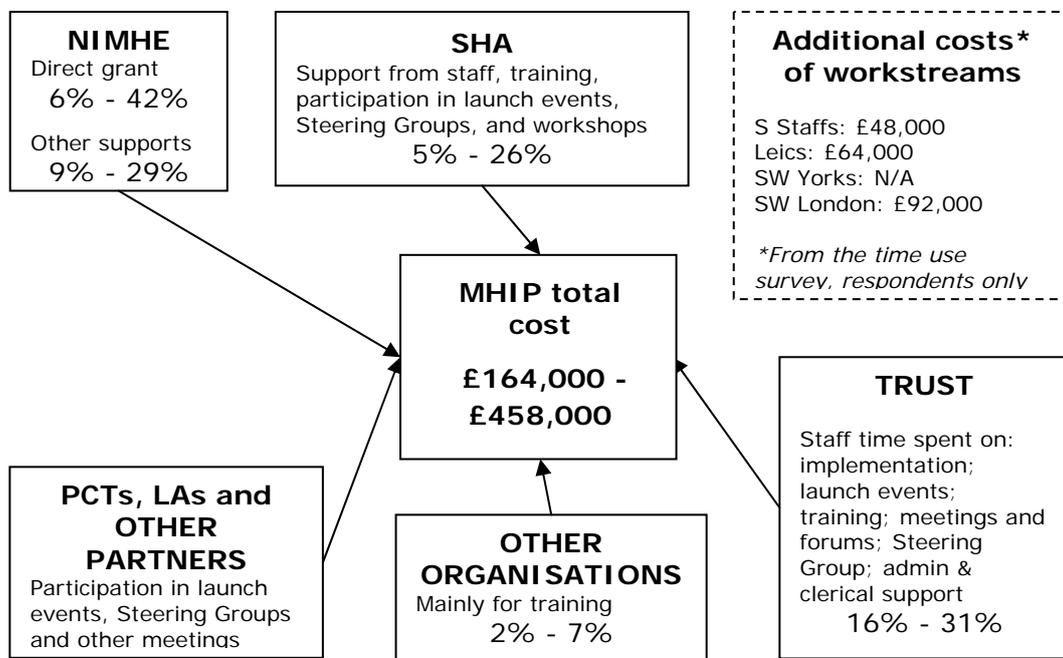
Well, I mean the fact that they gave us money was clearly a catalyst. It gave it impetus.

- Local MHIP team member, South West London

While the grant helped some trusts decide to become involved, it was not sufficient in itself. The study of the Personal Medical Services pilots in mental health care mirrored this finding; additional resources were important but positive quality improvements were also associated with clear shared aims and protocols, good team work and good collaboration with partners (Cambell et al, 2004). In reflecting on this early stage of MHIP, our interviewees found the imposed structure and the national label to be important, but in each of the sites there was also the desire to improve services.

The NIMHE grant came in addition to the usual budget and funded at least one post dedicated to MHIP activities. However, as Figure 1 shows, the NIMHE financial support, including the Launch events, contributed only between 6 and 42% of the total costs of MHIP activities. The total cost amounted to between £164,000 and £458,000 in the first year, plus the additional costs of time from front line staff and service managers who undertook work within the workstreams (Figure 1).

**Figure 1. Contributions to Year 1 MHIP costs across the four pilot sites**



NIMHE also provided a package of staff support, such as the Client Manager and the user and carer leads, training events and opportunities for meetings across the sites. NIMHE-borne costs for these other supports are estimated to amount to between 9% and 29% of the total cost. MHIP also came with

the promise of resources from the linked SHA. Commonly this was in the form of staff support for governance, although in S. Staffs, SHA staff led many of the workstreams. In two sites the SHA provided financial support as well, and good access to training in one of these. The SHA contributed up to one quarter of the total cost of MHIP in the pilot sites.

While larger sums of money could be obtained through the SHA and other partner organisations, a range of resources were drawn in from within the trust.

...But they [NIMHE] ramped down the money that was available ... it was a bit tight on the budget, but we had some really good people and we championed MHIP through things like out Clinical Governance for Real week and Clinical Governance for Real conferences... So we tried to use some of our more successful processes to bring up the content from MHIP

- *Senior management, South Staffordshire Healthcare NHS Trust*

...I think she [administrative support] was kinda slotted into work with me, because it wasn't her full-time job by any stretch... I don't know who paid for her time ... but she was certainly very helpful.

- *Local MHIP team member, South West Yorkshire*

Trusts were to match the NIMHE funding with their own resources and the main part of this was accounted for by staff time. In the site receiving only the small grant for early events, a part-time MHIP lead was funded from mental health trust resources and additional money was leveraged through the SHA allocation of the Modernisation Agency dispersal grants. The trust's contribution was about three times the NIMHE grant and the SHA contribution slightly higher. In two of the three sites receiving the larger grant, and given that only broad estimates could be made, the trust contribution exceeded the total NIMHE grant by around £30,000 and in one it fell to only just below the grant level. One interviewee commented

I think without the MHIP I wouldn't have been able to actually leave what I was doing here with somebody to cover my team and focus on that piece of work

- *Middle management, South West London & St George's Mental Health NHS Trust*

Another interviewee suggested

Considering there was very little actual real investments other than people's time from our perspective, then it was incredible good value

- *Senior management, South West Yorkshire Mental Health Trust*

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### ***The costs of implementing MHIP: key findings***

- Most people had little idea about the level of resources absorbed by MHIP
- Financial support provided by NIMHE contributed to between 6% and 42% of total MHIP activities. Other NIMHE support in the form of expertise and training accounted for between 9% and 29% of the total costs of MHIP
- Support for MHIP also came from other organisations, including local SHAs
- Host trusts' contributions, partly in the form of staff time, formed a large proportion of the resources invested in MHIP

## ***5.5 Spending MHIP resources***

Rather than looking at how resources came into MHIP, Table 8 looks at the broad areas in which these resources were spent. Few interviewed had much of an idea about the costs of MHIP; but this is not uncommon. During a high profile review of children's heart surgery services, one study found that around £1 million had been spent on the Trust's medical and clinical audit. However, the audit committee had very little control over these resources and it was impossible to track how they had been spent (Walshe and Offen, 2001). In response to a question about tracking the £90,000 NIMHE grant identified in the PID, one interviewee responded

...literally an hour ago I asked in the office what we got and that was where I got the [figure of] £40,000 ...

- *Senior management, Leicestershire Partnership NHS Trust*

In two sites, the NIMHE resources were not separately identified from the overall Trust resources managed within the Finance Department. In one site a member of the MHIP team was responsible for the budget in the first year but a record of expenditure was not available. Responsibility for MHIP expenditure was then transferred to a local PCT, although again it was not separately identifiable. In this site the organisational location for MHIP resources was seen as a way of identifying shared ownership of MHIP, rather than it being solely a Trust activity. Only in one site could we obtain copies of the MHIP cost centre accounts and clearly track how the Trust had recorded the use of MHIP monies.

Of the total resources spent on MHIP most were absorbed by governance activities and the implementation team (Table 8). The initial PIDs identified the need for a MHIP team which was to be funded through the NIMHE grant so it is not surprising to see reasonably high proportions spent here. Governance of MHIP required considerable inputs from partnership organisations in attendance at Steering Group and other meetings. Members were usually Executive or Board level in their own organisations so these were costly events and often held monthly.

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Although large contributions to MHIP were in the form of staff time “donated” by the various partner organisations, none of the sites recorded this input, or its associated costs, systematically:

... we certainly haven't measured the cost in those terms.  
We've only had direct costs

- *Senior management, South Staffordshire Healthcare NHS Trust*

Well those would have been huge

- *Senior management, South West Yorkshire Mental Health Trust*

The amount of time spent on MHIP was estimated using a survey of those involved in MHIP. Table 8 shows the number of hours spent supporting workstream activities as reported by the survey respondents. A broad estimate of the associated costs can be found in Figure 1. This represents a considerable level of input from people employed by the Trust and by partner organisations, none of whom were funded through additional external resources. It amounts to the total contracted working hours for at least one full-time member of staff in three of the four sites. However, the true figure could be far higher. Everyone who was involved in MHIP was invited to participate in the survey but the overall response rate was just 40%. The figures in Table 8 assume that the non-respondents did not spend any time on MHIP activities. Assuming that non-respondents spent just 12 hours on MHIP over the year (equivalent to, say, preparation for and attendance at three meetings), then this would amount to an additional one-third of a full-time post per site.

It is also worth noting that very few financial resources found their way to the workstreams. As the case study reports show, and as far as it was possible to track these things, this occurred in only two sites. In S Staffs some provision was made to cover expenses for user and carer attendance at meetings and a number of “awaydays” were held. In SW London some workstream members attended training events.

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**Table 8. Proportional spend of MHIP resources in Year 1**

Area of spend/site	S. Staffs	Leics	SW Yorks	SW London
Launch events, conferences, workshops	6%	9%	6%	28%
Governance (NIMHE, SHA, Steering Group meetings etc)	26%	30%	48%	40%
MHIP implementation team	44%	53%	17%	26%
Training and technical support	20%	5%	24%	4%
Service user and carer involvement	4%	3%	5%	2%
Additional staff hours on workstreams*	1290 hours	1650 hours	--	2690 hours

\*Survey respondents only: includes staff from the Trusts and from partnership organisations, service users and carers.

Perhaps the most surprising item on Table 8 is the low proportion of resources spent to facilitate user and carer involvement, no more than 5% of the total. Yet a focus on users and carers was one of the central principles underlying MHIP. Generally resources were used to compensate user/carers expenses for attending the Launch and other early events. Only in one site (South Staffordshire) do we know that it was used to support users' training and input into workstream activities, although the remuneration was low at £15 per day (at around £2 per hour this is less than half the minimum wage) plus expenses.

... to be able to spend a day and pay service users and say 'we value your opinion, we want to pay you for giving us your opinion'... it gave the message that enabled us to hear what service users and non-statutory and everybody wanted and needed to say and get heard

- *Local MHIP team member, South Staffordshire*

Only in South Staffordshire could data be obtained on the hours that carers and users spent working on workstreams and projects; 133 hours in three workstreams. On the one hand, not many users and carers took part in the survey, in part because data protection regulations made these people (quite rightly) difficult to contact. This may account for the very low figures here. On the other hand, there was evidence from the site visits that suggests user/carers participation occurred as isolated examples of good practice rather than as a pervasive influence on progress (Chapter 4). When interviewed, the NIMHE user and carer leads expressed their frustration about the lack of their time (12 days over the year) that had been allocated to the MHIP sites:

...it would have been great if [we] could have had the budget to visit all the sites on a regular basis and work with and put pressure on, and ask the appropriate questions about why

- NIMHE consultant, MHIP steering group

### **Spending MHIP resources: key findings**

- There were few records tracking MHIP expenditure
- Costs were mostly absorbed by governance activities and funding the local Programme Leads and Managers
- Considerable investments in the form of staff time were made although this was rarely recorded systematically
- Very few resources found their way to the workstreams
- No more than 5% of resources were spent on service user and carer involvement

## **5.6 Attitudes to MHIP resources**

### **5.6.1 Were the NIMHE resources sufficient?**

One of the issues early in Year 1 was that both NIMHE and the sites felt the resources available were less than they had anticipated:

...Things get tried in the acute trusts, and that's what happened with MHIP, there was a similar programme in acute trusts that was highly, very highly, very well funded, very well resourced and let's do it in mental health and let's resource it. Oh but hey, we haven't got any money. Well just get on with it then

- NIMHE consultant, MHIP steering group

I think the pilot sites expected a certain amount of money and then that wasn't the case, so I think they felt cheated at the beginning anyway in terms of their [resources], and that certainly came through in my [internal] evaluation

- NIMHE consultant, MHIP steering group

Interviewees from within the pilot sites supported this position

Yes. It was £160,000 or something, I can't remember, but it got halved and people were quite, well, how were we supposed to change things without...

- Service user representative, Leicestershire

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... it got shaved down quite a lot, if I remember rightly, but we thought it was worth doing so you make sure that you can change things round so that they happen, don't you

- *Senior management, South Staffordshire Healthcare NHS Trust*

SW Yorkshire, the site receiving very little NIMHE funding, felt keenly that

In terms of lessons learned, I would say make sure it is properly resourced. So it isn't just putting on top of people's day jobs

- *Senior management, South West Yorkshire Mental Health Trust*

To bring about large scale improvement is far costlier than anybody ever envisaged and unless you really are willing to make the true investment you often don't get the sustained change improvement that you require

- *Senior management, South West Yorkshire Mental Health Trust*

The result was that the plans set out in the original PIDs tended to be more extensive than could be achieved within the budget actually received. There was also a general recognition that the one year time-scale originally envisaged was not long enough to achieve all their aims. MHIP team members reported that they were under considerable pressure as they tried to manage the diverse workstreams and projects, sometimes within a wider service improvement portfolio or alongside financial recovery projects:

...I mean 12 months would have been okay if we didn't have five workstreams trying to do five different things...If we had one of those in a 12 month that would probably have been quite achievable, but to try and do five with the same amount of expectations that everybody had...

- *Local MHIP team member, South Staffordshire*

It was towards the end of that 12 months that all the other pilot sites said well actually it's not a 12 months exercise. It's a two year exercise and actually we've discovered it's a two years plus exercise

- *Local MHIP team member, South West London*

In the first 12 months, most sites got as far as having plans and timescales for implementation (see Chapter 4) but the funds available for the work in Year 2 were uncertain. Some Trusts managed to leverage in other resources from the SHA, but generally any subsequent MHIP activities were funded from within the Trust. NIMHE staff continued to provide some support, but this tended to be at a much lower level, perhaps just through telephone contact:

At the end of year one we were nowhere near where we were supposed to be so we had to roll on into year two, and the resources that were available for year two were less than

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50%, in fact they might have even been 30% of the original budget

- *RDC personnel, South West London*

### **5.6.2 Would more resources have made a difference?**

Although a lack of resources was often flagged in the MHIP highlight reports, there was a mix of responses around this issue. Some MHIP team members felt the scale of additional resources required was very large.

... unless we had a whole army of people doing what I was doing and sort of like engaging people and had more facilitators...potentially that would have been better than one and a half of us plus [the RDC Client Manager] trying to do five workstreams and all the – and ALL the paperwork, a huge amount of paperwork to do this project.

- *Local MHIP team member, South Staffordshire*

Some felt that more targeted expenditure would have helped, often in the early stages:

... I do wonder if there was a bit more money to grease the wheels to get people together to look at the problem, whether it might have pushed it through.

- *Local MHIP team member, South West Yorkshire*

... [The SHA] didn't buy enough [large scale data analysis] in my opinion, and it bought it too late. It should have been in right at the beginning to help us really understand what was going on and to find out what changes we wanted to make work.

- *RDC personnel, South West Yorkshire*

... I think having a bit more resource to focus on some of the developmental stuff, to have focused on the things that we wanted to do as part of this would have probably have got them through quicker.

- *Senior management, South Staffordshire Healthcare NHS Trust*

Others were less sure about the impact of extra resources:

I think sometimes when you take on extra staff to do something, it definitely becomes a project with an end point and then you go back to doing the way you did it before. I think by doing it the way we did it, it becomes part of the job and the culture changes, the practice changes, and it's not a project it's the way we're going to carry on doing it.

- *Frontline staff, South Staffordshire Healthcare NHS Trust*

But overall there was a groundswell of opinion that "backfill" resources should have been made available, particularly for staff working within the

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workstreams and linked projects. Many were doing this “in addition to their day jobs” and often without time off from their usual activities:

...I think if I said ‘Yes, there’s some backfill and you won’t have to worry about using your time... then yes, it’s going to make more people sort of want to be engaged, whereas the people who were working on the projects were giving it out of their own time.

- *Local MHIP team member, South Staffordshire*

...Because one of the things the PCT said well, where are we going to find the time to deliver on some of these? Now it would have been great if I could have said well, each of you is going to get some backfill money to have somebody at least to be a workstream lead.

- *Local MHIP team member, South West Yorkshire*

However, some interviewees held other views, although they tended to be in the minority

I think we did it when we were ready. I mean yes, there was a heavy resource in terms of staff time but it was just incorporated into the working week basically, So something else may have dropped off the edge, but you did that after five o’clock.

### **Just work harder?**

Smarter

- *SHA personnel, South Staffordshire*

And I don’t think it [more resource] would help because I don’t think you can buy the attitude and mental approach that needed to happen. And I truly think money and resources wouldn’t have helped. I mean, I don’t know would it have helped? ... But I think that is the level at which the intervention to change the system should have been, right at a deeper level. Not resource, not environment, but more the deep culturally partnership interpersonal level

- *Local MHIP team member, South West Yorkshire*

During interviews, the Client Managers generally felt that more money to give the sites a better “kick-start” would have been a wise investment, possibly investing in a data analyst for each Trust and improved capacity for data collection. They also highlighted additional work with the partner organisations, again reflected by interviewees within the sites, particularly where relationships between the partner organisations were less than ideal:

... at an early stage [we] should have done more work with the Boards to make sure they were really, really understood what they were engaged in.

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- National MHIP team member, NIMHE

### 5.6.3 Was MHIP seen as an investment?

While there was little detailed knowledge of MHIP funding or how the money was spent, a common theme was a stated desire to see improvements mainstreamed so they would have a longer life than the short-term programme. The notion of “buying” a change in working styles was important.

But I think it's a combination, isn't it, having the time and the space but actually embedding it into what you do as the day job, then you get the added benefit...

- Senior management, South Staffordshire Healthcare NHS Trust

Yes I think the challenge is to embed... isn't it, so it's not a one-off exercise but it becomes so of part of everyday practice I think.

- Senior management, South West London & St George's Mental Health NHS Trust

Views on the project management that underpinned MHIP were mixed; for some this was a sensible investment with the techniques continuing to be employed in future activities:

I remember that [PRINCE 2 training]... I have managed many projects before ... by doing the training I'm more aware of the whole system a bit more, what are the benefits realisations, more scientific...So that was a kick start really.

... We were only about 10 people or eight people trained...Now from internal resources ... there's about 50.

- Middle management, South West London & St George's Mental Health NHS Trust

So resources, the right amount of resources in the right place at the right time with the right toolkit. And I think the toolkit was right, I think the tool kit that we were offered was very good.

- Senior management, South West Yorkshire Mental Health Trust

For others it was additional pressure:

... the communications was a huge bit so [NIMHE] were always doing newsletters about writing up the workstreams, the outcome of the workstreams, planning the agendas for the workstreams ...all the different things. Writing PIDs that were coming out from - there was just a huge amount of administration and we had no administration support so there was one and a half of us doing that, it was just ridiculous.

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- *Local MHIP team member, South Staffordshire*

The idea of the short-term MHIP money having a longer-term impact through skills investment was expressed in several ways:

... to get people like X trained and a few other folk involved in that, so that they could see how service organisations might work at the sharp end is obviously helpful to do, and it starts people thinking about their own day to day existence and lives at work and whether or not they can change the way they do things. So just importing that knowledge base, to some extent, and the skills experience, was one of the reasons why we got involved.

- *Senior management, Leicestershire Partnership NHS Trust*

We used it quite early on and we keep coming back to it and certainly I'm still using some of the stuff I learnt on the CSI training.

- *Local MHIP team member, South Staffordshire*

... So I think in terms of the resource it was the sort of change management and modernising I think was very important, but I think it was also about the skills that the project bought in that in respect were probably the most critical.

- *Senior management, South West London & St George's Mental Health NHS Trust*

#### ***Attitudes to MHIP resources: key findings***

- Resources received were less than anticipated so plans and budgets were mismatched
- Although additional resources was not universally viewed as necessary or even helpful for culture change, it was frequently stated that increased backfill would have been helpful
- Some resources may have been better spent on building partnerships

### ***5.7 The impact of MHIP on the organisations***

The thinking behind MHIP appears to be that, by improving certain aspects of the way in which mental health communities operate, improved service provision would follow. Interestingly, there have been several examples in MHIP where engagement in quite straightforward service improvement work has resulted in side effects of "culture changes".

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The broad principles MHIP was to promote were outlined in the NIMHE PID (Chapter 1 and Appendix 1) and can be used to summarise the impact of MHIP on these communities:

- Service user and carer choices would drive development of the organisations
- Mechanisms would be developed to promote social inclusion
- The whole system – the mental health community – would be actively engaged in delivering the work
- The service improvements and organisational development programme would enable service excellence
- Learning and innovation would be shared with the wider mental health community

NIMHE provided both finance and personnel to implement a programme underpinned by these principles, and as described above, the host trusts drew on a range of other resources. This section considers the extent to which these resources changed the way in which people work.

The key data sources used to draw out these themes were

- the impacts section of stakeholder questionnaires
- the impacts section of the standards-based interviews
- qualitative data, theme 4.1 *Changes in how people work*
- qualitative data, theme 4.4 *Did MHIP make a difference?*

### **5.7.1 Service user and carer focus**

One priority for MHIP was to increase service user and carer involvement in the development and running of services. MHIP supported service user and carer involvement with a small amount of money and through the responsibilities of the local MHIP teams.

All MHIP launch and consultation events had good service user representation. This created a degree of excitement about the work and is felt to have influenced the direction of MHIP work. Indeed, almost all (13/15) workstreams had a service user and carer focus. This was perceived as a significant change to the kinds of objectives that would ordinarily be set in service improvement initiatives; and one that was attributable to MHIP processes:

I think it was that launch event that was very user focused that actually changed the whole tenor, and that has had an impact on the Trust ever since.

- *SHA personnel, South Staffordshire*

But for me one of the really big successes I think was the level of dialogue that we got with the other stakeholders.

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And that felt really positive, and I'd say in particular with service users and carers.

*- Local MHIP team member, South West London*

The extent to which service users and carers directed work varied from pilot to pilot. Despite the positive start to the programme, no workstreams were led by service users and service user and carer involvement diminished over the course of the pilots.

NIMHE experts on service user and carer involvement were commissioned to provide training and support across the pilot sites. Local capacity meant that only two pilots could take advantage of their skills. Survey respondents recalled these events and appear to have found them useful, though tended to view the events more as providing guidance than as training:

Service user and carer training. X and X came.

**Were they through NIMHE?**

Yes. X's the Service Improvement Lead and X's the Carer Lead, came for a day and did something with service users and carers on really sort of being involved, how to be involved, leadership.

*- Local MHIP team member, South Staffordshire*

**And did anybody come from NIMHE to do any training at all?**

Not with the People's Forum as such. We did have a Service User Lead from NIMHE who came and met with the Forum members a couple of times but they didn't actually provide any training, it was a sharing of ideas.

*-Service user representative, Leicestershire*

**Did she give any training, was that, and was that free?**

No, she came, it was at the very beginning of the MHIP around getting the carers involved, because who was the service user, I'll think in a minute, but she was the carers, she was like championing it through when it was NIMHE and not CSIP. She just came and said, told people, you know, told other carers her story about getting involved and what they could do.

*- Carer representative, Leicestershire*

The NIMHE experts felt that their input was not sufficiently valued, either by the MHIP programme as a whole or the pilot sites. They felt more resources would have allowed them to provide an ongoing supportive role across the sites:

What was quite disappointing when we had a learning event, which was held in London, which was some way after the end of the first year because they got the additional time, didn't

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they, to extend the programme, we did say to the sites when you're bringing your learning and what you've been able to achieve it would be really nice to have some service user and carer views. I think there were only two or three service users who actually invited themselves to come to the event. There was no significant input at all from any of the sites.

*- NIMHE consultants, MHIP steering group*

There were positive aspects cited. Respondents across all four pilot sites referred to an enhanced role for service users and carers in both the running of services and service improvement. A common example of this was an increase in the number of service users and carers on interview panels:

I think there are some areas that are very good and there's a service user representative on every interview panel. I know within Psychology that happens every time.

It's not just on the interview panel, it's being involved in the whole process from the beginning of the recruitment process.

*-Service user representative, South Staffordshire*

More broadly, it seems that trust personnel now pay much more attention to service users' and carers' perspectives. This can be viewed as a "culture change", possibly brought about as a side-effect of the work. This should be set against a very limited increase in the extent to which service users and carers had direct influence on services and improvement, data collection, leadership - or indeed anything beyond consultation.

I think it did up the ante around always ensuring that when you, especially when we do a biggish piece in the paper that we do have a service user and/or a carer putting their perspective, and I think that's something that just is kind of an integral part of what we do now, if we're doing a feature piece I would always anticipate having a professional's point of view, some basic facts and figures, and the service user/carer point of view.

*- Senior management, South Staffordshire Healthcare NHS Trust*

It did give a stronger user focus to the Acute Care Forum

...I think we've totally failed to get service users involved with the Acute Care Forum itself.

*- Frontline staff, South Staffordshire Healthcare NHS Trust*

Although user/carer involvement was not high, the shift in attention is attributed, at least in part, to MHIP and its consultation events. Other causal factors, such as a drive from board level, were also identified:

Some things will have got better, some things will have improved, no doubt about that. Some people who we worked with will have taken off the ideas and done them on their

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own in spite of, sorry, regardless of whether MHIP would have been there or not. Those were the kind of people who would have gone off and done the improvements anyway.

- *RDC personnel, South West Yorkshire*

The improvements, and MHIP's contribution to them, have been identified by people working in service provision and commissioning, from clinicians through to board level. The views of service users and carers proved harder to gauge, and awareness about MHIP and its impact among those interviewed was low.

Another thing is, really, we are never told about outcomes after we've had feedback. It's a terrible situation. We need to know what the outcomes are. I mean in any other situation there is a plan and then it's implemented and then you know what the result is.

- *Service user, South West London*

Nationally, it has been suggested that MHIP's limited impact on this issue led to the development of an alternative strategy, one of using dedicated training to develop service improvement expertise among service users and carers:

Providing ad hoc or piecemeal support or training for users and carers was insufficient, and we subsequently commissioned both the people you met, X and X, who actually lead a programme of leadership training for users and carers... each region has given so many places to nominate users and carers from within their local systems to act as change agents for actually receiving generic training around service improvement skills. So they're not just there as they're experts by experience but they're there because they have skills around managing change and service improvement as well, and that's a key learning and a key thing that's spawned by the MHIP programme I think.

- *National MHIP team member, NIMHE*

#### ***Impact on service user and carer focus: key findings***

- Service user and carer involvement decreased in intensity fairly early on. Very little funding was used to support training for service users and carers in service improvement skills
- Contributing to culture change in attitudes towards service user and carer involvement was identified as a "side effect" of the MHIP process

### **5.7.2 Social inclusion**

As mentioned in Chapter 4, much work was focused inward on services provided by the local mental health trusts. Similar to service user and carer involvement, social inclusion was mainly brought about through

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involvement of people from across the community during the early MHIP phases. There was generally good representation at the launch and consultation events, including people from acute services, the voluntary sector, the police, etc. Comparatively few workstreams (4/15) featured objectives related to social inclusion:

Where's the voluntary sector role, where is the education role, where is the community role, where is the church role? If you talk about mental health partnerships, these other agencies who've got a huge role to play within the community of supporting people with mental health problems.

- *NIMHE consultant, MHIP steering group*

Some progress was made in the workstreams that featured social inclusion; although given the circumstances illustrated above, it is unlikely that social inclusion itself has been extended. As with the service user and carer focus the main impact was in terms of a change in attitude – a recognition that there are benefits to obtaining engagement and input from a range of organisations. The breadth of inclusion in the consultation phase appears to have been novel in the majority of sites; and respondents have indicated that this is a process they would repeat in the future.

And actually some of the lessons we've learned from MHIP, I must say, that actually we have a stakeholder event, so it's an opportunity for everybody to get together, all from different backgrounds, and actually express any problems they've got, you know, raise any issues and actually agree a way forward... and I think people feel more relaxed and therefore more willing to be open and honest with you.

- *Senior management, South Staffordshire Healthcare NHS Trust*

### ***Impact on social inclusion: key findings***

- Few workstreams focused on social inclusion, although the consultation events represented a novel breadth of inclusion
- As was the case with service user and carer focus, focus on social inclusion reduced over time; mainly due to a lack of capacity within the local MHIP teams

### **5.7.3 Whole systems working**

Frequent remarks were made on the “siloes” nature of mental health communities and the lack of existent partnerships (Chapter 3): the relationships between key partner organisations were often weak and occasionally antagonistic.

Supported by the MHIP teams and the NIMHE Client Managers, planning events allowed attendees to gain a sense of different organisations' priorities and how they might complement each other, demonstrating

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potential links across each mental health community. The information obtained at these events certainly guided MHIP workstreams: two thirds (10/15) of the workstreams attempted to use and whole systems techniques to develop local service delivery:

If nothing else, I will treasure the memory of a mega marathon process mapping event that involved about 120 people. I think X said he hadn't done it like that before. But that was really useful because he can do it with loads of people all at once and get some really rich results. So that the quality was great, I guess we would have liked more of it. You always would.

- *Senior management, South West Yorkshire Mental Health Trust*

There was a huge mapping exercise that took on prior to that so that really crystallised some of the things that needed further attention. I presume one of the challenges but also one of the strengths was the multi-professional working and the collaboration that took place with groups not only within the trust but also outwith the trust, and I think particularly of the Police and Ambulance Services and so on.

- *Senior management, South West London & St George's Mental Health NHS Trust*

Yes, and [RDC Client Manager] was coming in as well and doing bits, and sort of coaching and doing process mapping in different places with people, and you and X and X and people were doing the process mapping, that nasty stuff. So there was a kind of coaching element to training as well as the kind of formal training

- *Local MHIP team member, South West London*

Despite these early activities, the extent to which participating communities now operate in a whole systems manner remains limited. As detailed in Table 7 (Chapter 4), few such changes were achieved: partnership working was poor at the outset and not hugely altered by engagement in MHIP. This was largely due to contextual factors (Chapter 3) and insufficient analysis of and response to these factors (Chapter 4). Respondents have indicated that greater capacity would have supported development of stronger inter-agency relationships.

Everybody agreed at the end of that that there should be a joint strategy for mental health commissioning. And I felt I'd got a hallelujah moment, and then just at the last minute, it was like right great what shall we do with this, let's get together, let's do the strategy, you know, I'll help facilitate it, but you'll never get anyone to sign up to it now because of all the reconfiguration. There's no point.

- *Local MHIP team member, South Staffordshire*

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The people that you've been dealing with for the last two years, you know, you ring up oh, they're retiring tomorrow. Well nobody told me, you know, I mean who is going to be taking this over now? So in sense that caused, it did cause us some problems because you couldn't get a decision made.

*- Middle management, South West London & St George's Mental Health NHS Trust*

**Those sort of lessons from MHIP about that partnership input, aren't being played today. They seemed to have got lost, is that right?**

No, they failed. They failed in the middle of MHIP to be honest. Once the PCTs disaggregated the ownership of MHIP from the PCTs disappeared really.

*- Senior management, Leicestershire Partnership NHS Trust*

However, again respondents from all pilot sites identified a broader change in attitude towards partnership with external organisations, in terms of, for example, recognising alternate perspectives:

**In terms of those sort of hidden costs, do you think that the outcomes justified the engagement with the MHIP programme?**

I think if you'd asked me that at the time I would have said no because we would have done this anyway. But on reflection I think what it did do, I think as I said before, it was a lever really to get people talking really and to bring people together.

*- Senior management, South West Yorkshire Mental Health Trust*

So the culture was very, very inward looking and very inflexible I think, and driven by powerful individuals, and I think that the Mental Health Improvement Programme actually started the process of dismantling that, which I think has been very, very difficult but I think is now reaping – well it certainly has brought about change.

*- Senior management, South West London & St George's Mental Health NHS Trust*

Some respondents questioned the extent to which pilots engendered true partnership working:

I'd just emphasise that a lot of people just latched on to it, it was an opportunity to develop mental health services and that's what they did. They didn't develop improvement partnerships. And because of that I think the whole thing has failed on that level. It's achieved other things but it's failed on that level, for developing an improvement partnership.

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- *NIMHE consultant, MHIP steering group*

The process mapping techniques applied in support of whole systems thinking during MHIP appear to have taken root in local service improvement processes and have had an impact on more recent local improvement initiatives:

In terms of the tools and techniques and how you analyse how your service is currently, the mapping process and things like that, I think we learned a lot from that and we do use it don't we, quite a bit, the mapping type thing.

- *Senior management, Leicestershire Partnership NHS Trust*

It's not like an end life of MHIP, and I'm sure any service which will be developed now, let's say we are going to develop a service, first of all you assess the local needs, you do a process mapping.

- *Middle management, South West London & St George's Mental Health NHS Trust*

I think that the legacy of MHIP and the restructuring has meant that we really have taken a much more defined systems approach, and I think much better clarity about roles and responsibilities and accountability in the system.

- *Middle management, South West London & St George's Mental Health NHS Trust*

I think in terms of our trajectory is to improve and that constant improvement. I suppose the legacy is that it's part of that stepped approach to continuing that trajectory. So if you plotted where MHIP was on the trajectory then it's carried that on. I would guess in terms of the sustainability of that though, I think that's the difficulty isn't it, without something concrete to take with you, so. But there are a number of people that probably have got those methodologies, and at least they're probably aware of them, in terms of if they come across an issue or a difficulty or a problem in the future they'll at least be aware of those methodologies even if personally they don't know how to use them, and there are people in the Trust that have got those skills through the process

- *Senior management, South Staffordshire Healthcare NHS Trust*

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### ***Impact on whole systems working: key findings***

- Planning for MHIP work enabled people to identify potential links with partners and this guided the development of many of the workstreams. In particular, process mapping events were very popular and successful
- A change in people's attitudes towards partnership working and recognition of others' perspectives was reported
- After early phases of planning and some implementation, the whole systems approach was neglected; work focused less on building partnerships and more on simple service improvement

### **5.7.4 Enabling service excellence**

In attempting to improve service quality through evidence-based processes and spreading service improvement techniques, MHIP was addressing recognised contextual gaps (see Chapter 3). The aims of all workstreams (15/15) across the pilot sites featured a service improvement or organisational development component.

In terms of evidence-based improvements, all pilots used MHIP to implement and/or strengthen NSF recommendations, such as Early Intervention, Crisis Resolution and Assertive Outreach. While the drive to develop these services predated MHIP, MHIP was used to strengthen their case. Priorities identified at consultation events were tied to the benefits afforded by the NSF recommendations. In doing so, it can be argued that MHIP harnessed the power of public opinion to legitimise the push for these service developments. The prevailing view across all pilots is that the progress made on NSF improvements would have happened anyway; but that they would have happened more slowly or less inclusively. The theme of MHIP as a "vehicle for change" was common across the pilot sites:

**We're very interested in actually finding out did this thing actually do you any good?**

I mean I couldn't answer that really, because there were significant other imperatives going on which had an overlap with MHIP. If these other things hadn't taken place, it could obviously be a lot clearer to evaluate the impact of MHIP but it might not have been as successful.

*- Senior management, South Staffordshire Healthcare NHS Trust*

Service improvement techniques, such as process mapping and PDSA, were new to many people involved in MHIP. While some training was provided, it was focused on the local MHIP teams, such as the Programme Leads and RDC Client Managers, with the intention that they should disseminate these skills locally. The techniques did have a clear impact on the nature and direction of several workstreams.

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In contrast, the existent culture gap around measurement was, broadly speaking, not addressed successfully by MHIP, whether through training or support from MHIP personnel. Significant efforts were made by MHIP leads; but as mentioned previously, there was insufficient capacity to embed this change across the pilot sites:

We got in as many measures as we could, and I'm more than aware there weren't enough, and the drive still to have better measures continues and we will get there.

*- Local MHIP team member, South Staffordshire*

Training events around data analysis and control such as Statistical Process Control were provided and generally well attended. Limited progress in the work coupled with the existent gaps around data collection meant this training had little impact on the way in which people worked:

I suppose we haven't actually made use of it, because we haven't had anything, we haven't had any dots to plot yet

*- Frontline staff, South Staffordshire Healthcare NHS Trust*

Data analyst support through NIMHE was to have encouraged and facilitated greater use of measurement. While this resource was potentially of great value, in many cases the analytical techniques did not fit the data available:

[NIMHE data analyst], his name was, came in and looked at it and I think he struggled because, in terms of data and improvement and looking at patient flow, he was used to looking at such bigger numbers that you know when they apply their formula for what, he looked at our little Dynamic Psychotherapy numbers and he said I can't make this make sense with some of the equations and the way that they would manipulate data.

*- Local MHIP team member, Leicestershire*

For many personnel, project management techniques were also a novelty, in terms of setting out clear plans, objectives and milestones. In one of the four pilot sites, SWLSG, a shift to a "culture of project management" was identified through the PRINCE 2 training resourced through MHIP:

We did highlight reports nationally with an expectation that the local sites did it the same way, and they did to some extent but I think the other sites did it for the national programme stuff but I don't think they did it so much internally. We did it, everything that moved had PRINCE2 on it

*- Local MHIP team member, South West London*

I think the PRINCE2 training, for instance is a, I think it was a good thing and it started well and you can see that there has been incremental progress.

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*- Middle management, South West London & St George's Mental Health NHS Trust*

In other pilots, where there was less in the way of formal training in project management, the ongoing impact has proven to be weaker:

**The new projects that you're doing, have you prepared PIDs for those and plans and outcomes?**

Probably haven't gone as far as doing PIDs for them because they tend to be very much in-house within the library, but I would guess we follow the structure of the project... I think we tend to do it more by osmosis rather than sit down and make a conscious, this is a project, and we're going to do this, this and this, because there's three of us so we work quite closely together.

*- Frontline staff, South Staffordshire Healthcare NHS Trust*

As with whole systems working, respondents across trusts reported the development of a more positive, open attitude to service improvement

**I mean if you were to sum up MHIP, what would you say that it was?**

I think it was something that said it's okay to do improvement. In fact it's positively a good thing, and you're allowed to moan about the things that aren't working in the sort of public environment.

*- Frontline staff, South Staffordshire Healthcare NHS Trust*

If increased skill acquisition was one of the mechanisms by which service excellence would be achieved, there existed a surprising gap in terms of evaluating training. No baseline measures of ability or need were taken in any of the pilot sites and there was no assessment of training events, or their long term effects on attendees' behaviour as might be expected when training is suitably evaluated (e.g. Kirkpatrick, 1994). This limits the extent to which the quality and impact of training can be assessed. From interview data and inspection of local documentation (Chapter 4), it can be concluded that formal training was focused on a small number of personnel and in some cases was irrelevant:

Being taught how to facilitate a group and how to do warm-ups, I was like "Perlease, this is not rocket science, you're really teaching your grandmother how to suck eggs here."

*- Local MHIP team member, South Staffordshire*

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### ***Impact on enabling service excellence: key findings***

- Most workstreams featured a service improvement element and all pilots used MHIP as a vehicle to implement recommendations for service excellence, e.g. from NSFs
- Some staff learned new service improvement techniques, e.g. process mapping
- The bulk of training was focused on a small number of people so the existent gap in skills was not sufficiently addressed
- Some training was not appropriate for the context or available data

## **5.7.5 Promoting learning and innovation**

Given MHIP's status as a pilot, it is unsurprising that many MHIP resources were potentially available to support learning and its communication. Local MHIP Programme Leads and RDC Client Managers were central to collecting and communicating information on MHIP's progress. Relatively few workstreams (5/15) had learning as a stated objective of the work.

Within the pilot sites, MHIP leads communicated progress and learning through team meetings, trust briefings and e-bulletins. Their limited capacity to attend meetings and produce such reports meant that awareness of MHIP across the local communities was not sustained and as mentioned in Chapter 4, many stakeholders felt MHIP "fizzled out" quite quickly.

The Local Programme Leads communicated MHIP learning to the national level through use of several administrative structures, particularly Programme Lead meetings, highlight reports and SISTMH.

Programme Lead meetings proved a useful means of spreading learning and created a sense of partnership amongst the local MHIP teams:

I think the notion of having a regular update meeting I think was quite good, and I think that was probably the major source of support that we got.

*- Local MHIP team member, South West Yorkshire*

The valuable bit was oh, you know, when I came to, a sort of month into taking on the whole of the MHIP here when James said, "Well I need an implementation plan for year 2", [MHIP Programme Lead] in Leicester said, "Oh well, I've got my implementation plan here, I'll send it to you and you look at how mine's laid out and I think," you know. So all that kind of stuff was very, very useful.

*- Local MHIP team member, South West London*

Highlight reports provided a structure within which details of and reflections on progress could be recorded but they placed a significant burden on lead

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personnel, who were already stretched beyond their capacity. Whilst reports were produced throughout MHIP's lifespan, use of certain sections of the highlight reports reduced, most notably the "learning log":

Some of the learning was captured on the highlight reports because there was an area on the highlight reports for learning and development. In the beginning I recall we filled them in quite a bit and then as time went on that reduced.

- *RDC personnel, South West London*

What we probably did not do enough, and I don't think this takes extra money, it just took planning which we didn't do enough of, was bringing them together and pulling out the learning and sharing the learning and things.

- *SHA personnel, South Staffordshire*

As discussed in Chapter 4 (Section 4.3), SISTMH was potentially useful resource, but was used insufficiently and represents a missed opportunity:

I put some of my projects into SIST with all the measurements and baseline and follow-up and all that kind of stuff, and I think Leicester was the only one that put anything in. And it kind of, it sort of died, withered on the vine. And so, and I think it was really, potentially it was something good that could have been contributed by the national programme, but actually probably the learning from that was better to keep it simple and if people are comfortable with paper and they can do it on paper and we can email things to each other then keep it simple rather than go for a web-based technical solution.

- *Local MHIP team member, South West London*

NIMHE commissioned an internal evaluation of MHIP which provides a very useful summary of local and national views of MHIP. While it was not publicised greatly, the internal evaluation has been used to inform the structure of CSIP's online guide to service improvement. This guide represents a significant potential resource, assuming it is suitably publicised.

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### ***Impact on promotion of learning and innovation: key findings***

- The central meetings attended by the local Programme Leads were very useful in terms of strengthening links across the pilot sites and giving a sense of the progress being made in the work
- Within sites, information was spread via meetings, briefings and e-bulletins but as capacity to disseminate was limited, broad stakeholder engagement fizzled out
- Highlight reports provided structure for communicating “up” but were also a burden to those that had to produce them. The use of some components diminished over time, e.g. the learning log
- SISTMH, adapted from its IPH counterpart, was potentially very useful, but proved inaccessible. There was very little information stored on this online resource
- The internal evaluation, coupled with data recorded in highlight reports, fed into a CSIP web resource providing guidance on how to carry out service improvement and organisational change

## ***5.8 The impact of MHIP on the quality of mental health services***

This section considers whether MHIP improved service quality in terms of service efficiency, clinical outcomes and service user and carer experience or satisfaction.

The key data sources in this section were

- the impacts section of stakeholder questionnaires
- the impacts section of the standards-based interviews
- themes 4.2 and 4.4 of the thematic analysis

As detailed in Table 7 (Chapter 4), the extent to which MHIP had an impact on service quality was limited. In three of the four pilots, this evaluation found progress was made in some workstreams that could potentially have such impacts. Two workstreams were assessed as likely to have a medium impact on service quality, while the remainder were likely to have a low impact or no impact at all.

### **5.8.1 Service efficiency**

As detailed in the local case studies (Appendix 10) and summarised in Chapter 4 and Table 7, the majority of impacts on service quality were at the level of service efficiency, such as reduced waiting times, or better use of data.

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They've got nurses prescribing, they've got a lead nurse that's been appointed and, most important, they operate in accordance with NTA waiting times, data quality management post created, excellent retention figures

*- Middle management, South West London & St George's Mental Health NHS Trust*

Ownership of our data and ownership, that's one of the things that's really improved the clinical team I think. I think all clinicians are much more keyed into an awareness of the waiting list. They ask for the data. If we're just a week behind giving them the data they're saying what's the data, where are we with it.

*- Middle management, Leicestershire Partnership NHS Trust*

Overall, however, there were relatively few such achievements.

### **5.8.2 Clinical outcomes**

As detailed in the local case studies (Appendix 10), Chapter 4 and Table 7, no evidence could be found of improvements in clinical outcomes that were due to MHIP. There was little measurement of baseline performance and evaluation of ongoing changes was very limited (Chapter 3). Consequently, reports on progress of MHIP work were unable to identify changes in clinical outcomes, or indeed assess the extent to which they could be tied to improvements in the efficiency. Most commentators would agree, however, that it might be surprising to detect improvement in clinical outcomes as a result of improvements to organisational pressures in short a time.

Several of the process changes achieved in MHIP were related to evidence-based NSF structures. It is therefore possible that MHIP achievements have had positive impacts on clinical outcomes. The extent to which MHIP was causal in such achievements has been questioned; understandably, this uncertainty around causality extends to any related impacts on clinical outcomes.

**What was the common strong driver then for the early intervention service?**

National target. You do it. You're told to do it, do it.

**And it really does seem to be as simple as that in all the trusts we go to.**

You must do it.

*- PCT personnel, South West Yorkshire*

### **5.8.3 Service user experience/satisfaction**

Again, due to the lack of measurement at either baseline or over the lifetime of MHIP, there were very few situations where improvements in service user experience and satisfaction could be gauged. There were

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notable exceptions. In South Staffordshire, a service user survey was carried out under as part of the Advocacy to Exercise Choice workstream. In South West London and St George's, service user surveys were already in place and used to show increased satisfaction with services, which fell within the improving clinical capacity workstream.

Most important, the clients (are) expressing increased satisfaction in the patient trust service

- *Middle management, South West London & St George's Mental Health NHS Trust*

### ***Impact on the quality of services: key findings***

- Two workstreams had a medium impact and the rest had low or no impact on service quality
- Data was available for a small number of examples of increased service efficiency, e.g. reduced waiting times, better use of data
- There was no evidence of change in clinical outcomes due to the lack of baseline or outcome measurement
- Several process changes were identified, which were linked with NSFs and so these have the potential to impact on clinical outcomes. The extent to which MHIP will have contributed will be difficult to define, however
- The impact of MHIP on service user experience or satisfaction could rarely be gauged due to the lack of measurement, although there were some exceptions to this

## ***5.9 Linking workstream resources and their outputs: two illustrations***

### **Older People's Services Workstream in South West London**

The aim of this Workstream was to develop an evidence-based model for future services in each of the five Boroughs for older people presenting with challenging behaviour, dementia and enduring functional mental health problems. This was to ensure that they would be placed in an appropriate environment to meet their needs, that they would not experience unnecessary moves, and that services were supported with expert advice. A genuine desire within the Trust to improve services drove the work but so did external pressure from commissioners asking for new service models.

**Resources:** Additional resources were leveraged in by the MHIP team from the RDC to support an assistant psychologist for six months and to hold a half-day conference. Three senior clinicians led this project and were supported by the Borough lead for older peoples' services and the MHIP project manager. This was one of four projects in the Service Development

Workstream which in total cost around £22,500 in additional staff time in Year 1.

**Activities:** Residents of local continuing care facilities were interviewed and the literature reviewed to identify alternative and best practice service models in the UK. Results were validated through the Trust's Older Person's Forum and the psychology special interest group. The findings were fed back to commissioners and through a Stakeholders' Event in January 2006.

**Outcomes:** Clear models for continuing care in older people's services were identified and stakeholders were given the opportunity to see the supporting literature review and evidence base for the proposals. There was a change in attitudes towards the provision of hospital beds for this client group. Additional resources and senior leadership helped the project to be completed more quickly.

#### **Project members commented**

The work was badged under MHIP, which was a peg to hang it on and gave the project more prominence in the trust.

It gave me a lot more connections and led to better multi-agency working.

*Data sources: Stakeholder surveys, standards based interviews, SW London Briefing Paper October 2005, Briefing for Stakeholder Conference January 2006*

#### **Launch Event in South Staffordshire**

The launch for the S Staffs MHIP took place in May 2004 at Uttoxeter Race Course and was co-facilitated by staff from NIMHE, the Trust and the Strategic Health Authority, supported by their Directors and Chief Executives. The Launch was attended by over 100 people from many organisations in both the public and independent sectors. Over a quarter of attendees were service users or carers. The aim was to explore "what the services should look like in 3 years time".

**Resources:** The launch was funded using £5,000 from NIMHE, half of which was used to pay service user and carer expenses. It is difficult to assess the total costs of this event in staff time but it is likely to be in excess of £30,000.

**Activities:** Attendees were divided into groups of 10-12 who worked together to describe "what, why, where, when" mental health services should improve and to prioritise their top five ideas. Following advice from the users' forum, service users and professionals formed separate groups.

**Impact:** Fifteen key issues were identified including commissioning, a focus on outcomes, education, and looking beyond severe and enduring mental illness. A "Eurovision" voting method enabled the facilitators to identify five workstreams.

**Interviewee comments** tended to be mixed with the Launch itself getting

good reviews but concerns were expressed about the longer-term.

It was an opportunity to hear what service users felt and said. However this raised their expectations and the outcomes were not evident; it got people thinking differently about empowerment of people who delivered and received care. From a PR point of view it raised the profile of S Staffs Mental Health Trust

Multi-agency bonding, meeting people/professionals I would not usually have contact with; no ongoing training/consulting as promised. Not kept informed of any outcomes.

It was an opportunity for general networking and reinforced the focus on service user and carer involvement, but now I am sitting here feeling clueless and uninformed, confused about what it [MHIP] was about and what happened.

Networking, joint working opportunities, lack of follow-up.

Highlighted gaps and room for improvement but had no authority. It should have been done via Strategic Health and not providers or commissioners of services.

There was a lot of energy and enthusiasm created by MHIP, particularly amongst service users and carers regarding their involvement but this was not necessarily delivered.

*Data sources: stakeholder surveys, standards-based interviews, Launch Event Initial Report and End of Programme Review*

## **5.10 Reflections on costs and impacts**

There is no doubt that a very hazy view prevailed of the financial resources allocated to MHIP with only one or perhaps two of the MHIP team in each site having any information about the size of the grant allocated by NIMHE. There was rarely any way of tracking its expenditure. Extra resources were sought and obtained in most sites, although more commonly “in kind” rather than as additional finance. Much of these resources came in the form of staff time “donated” from partner organisations for governance, and from within the trust for workstream activities. Again there was no formal recording of time spent on these activities. Many tasks, particularly those relating to the workstreams, were to be accomplished in addition to personnel’s usual activities.

Estimating the costs of MHIP has, therefore, been a complex exercise, drawing on a number of different sources. The results of our calculations – total costs of between £164,000 and £458,000 in the first year plus the costs of staff time for workstream activities – are an indication of the likely cost implications of the MHIP programme rather than a definitive figure. Although this represents a fairly small sum in the context of the total budget for a mental health trust, it is quite a large sum of public money.

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The resources were intended to generate service improvement; can links be made between the resources absorbed by MHIP and its impacts? It was not possible to undertake the type of economic evaluation commonly seen in health services, where both costs and outcomes are expressed as a quantitative figure, and cost-effectiveness or cost-utility statistical analyses undertaken. The design of this evaluation, in part a response to the lack of measures employed within the sites, does not allow such an approach. Instead, information is brought together in a descriptive manner about how the MHIP resources were spent, people's attitudes to resources, and the changes that stakeholders reported had occurred as a result of implementing MHIP. Again the five principles underpinning MHIP are used as a framework.

The service user and carer focus was the first of these underpinning principles, yet in none of the sites was the proportion of MHIP total costs dedicated to facilitating user and carer involvement greater than five per cent. At the launch and early MHIP events, users and carers were clearly involved. This level diminished over time and users and carers appeared to have very little direct influence on work. The simple explanation would be that low resources led to low outcomes; but the reality is perhaps more complex. Many of the achievements in this area were attributed to other local factors and each of these would have carried resource implications. If the research question had been "what were the total resources spent on encouraging and facilitating user and carer involvement over MHIP's first year?", we would likely have arrived at a much higher figure than that represented by the proportion of MHIP expenditure. On the other hand, there is no doubt that almost all those involved in MHIP felt that there was greater recognition of user and carer perspectives and the contribution these perspectives could make to service improvement. The MHIP focus and the fact that some resources were spent on facilitating user and carer involvement probably played a small part in what may well be a longer-term change in the organisational culture of these sites.

Few resources were devoted to developing mechanisms that would facilitate social inclusion. We could not identify any expenditure against this principle past those used to support a couple of specific workstreams and inputs into attendance from community organisations at the launch and other early events.

Although partnerships between organisations had generally been poor prior to MHIP, there is also a sense that these early events had the potential to help whole systems working through networking. This facilitated a better understanding between organisations of their respective positions and how links that could be formed. These early events absorbed a relatively small proportion of MHIP resources. Together, launch events, conferences and workshops absorbed less than ten per cent of the total costs in three of the four sites. Apart from these events and the early process mapping exercises, by the time the fieldwork started whole systems working was limited and there appeared to be little scope for "all parts of the system [to be] actively engaged in shaping and delivering the work to ensure it meets the aspirations of the whole community" (see Case Study 5 in Appendix

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10). There was, however, some suggestion that relationships had improved, not solely due to MHIP, and that there was a clearer understanding of other organisations' perspectives.

Would more resources have helped cement the early understandings and led to better and longer-term relationships? It is difficult to say; but certainly interviewees from NIMHE, RDC and the pilot sites felt that there was not a full "opt-in" from partner organisations in the period prior to signing up for MHIP and that these pre-MHIP stages had been rushed (see also Case Study 5 in Appendix 10). Perhaps more time spent (and therefore money) ensuring full understanding of MHIP's potential and getting partners on board would have meant the processes had a smoother and speedier ride.

There was strong agreement that without the incentive of additional resources the trusts would not have become involved in MHIP, albeit that many said the money was not a sufficient incentive on its own. There was also a consensus around the fact that even if service improvement activities were already planned, MHIP added impetus getting these off the ground earlier or generating an increased rate of change. Thus in terms of the fourth MHIP principle it is fair to say that the MHIP resources had a part to play in enabling service excellence through its potential for focusing resources on service improvement and organisational development towards meeting NSF service recommendations. Three factors appear to have militated against progress in this area; poor dissemination of service improvement techniques from the MHIP team to others in some pilot sites, little improvement in capacity for and poor attitudes to measurement, and the expectation that many of the MHIP workstream activities could be undertaken in addition to people's usual workload.

Training was provided in each of the sites, mainly to MHIP team members, but there were very different levels of resources spent. Training and technical support absorbed more than a fifth of the total costs in two sites and around five per cent in the other two. However, it is worth noting that although there was no formal evaluation of the training offered, many of those who did receive training considered this an investment, saying they would continue to use the techniques in their professional life as an aid to improving service provision. More problematically, if there is insufficient capacity or motivation to measure either costs or impacts then it is impossible to assess whether a service or system is working effectively and providing good quality support at an appropriate cost.

Promoting learning and innovation is the fifth and final principle underpinning MHIP and, as with social inclusion, the evaluation was unable to identify any expenditure specifically related to this principle. The Steering Groups and other within-site meetings provided opportunities for "sharing learning with the wider mental health community throughout the lifetime of the programme". Learning mainly occurred from RDC Client Managers to MHIP team members, between MHIP personnel at the cross-site meetings and from MHIP leads to other personnel involved in the workstreams. This informal learning was felt by those involved to be very useful. In contrast,

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formal mechanisms such as the “learning log” in the highlight reports were of less benefit. They were often seen as a time-consuming administrative burden rather than an opportunity for reflection between the partner organisations or within the Trust.

The above paragraphs have considered the impact of MHIP resources on process, or intermediate outcomes. Money is spent in health services not just to improve services but to improve the health and welfare of those using the services. The overarching aim of MHIP was “to improve the total quality of every service user’s journey throughout the mental health system”. Certainly, improvements in service delivery, such as reduced waiting times or better understanding of a service through appropriate data, were apparent in some workstreams. However, the limited capacity in the sites to measure baseline performance or ongoing change severely hampered efforts to assess whether MHIP resources had an impact on users’ clinical or quality of life outcomes or in the main, their satisfaction with services.

## ***5.11 Implications***

Future improvement initiatives must be appropriately resourced. This requires a broad assessment of the likely cost implications of programme requirements before it is implemented. This assessment should be available as a guide to applicants. Total costs should be considered, but perhaps also how the money might be used and where additional costs might fall.

Resources should be ring-fenced, or at the least be retained as a separate budget head (cost centre), rather than included within into the wider accounting structures. The budget should include all sources of money. In addition to ensuring that personnel and processes are supported as intended, this approach increases the sense that the initiative is valued and requires attention.

This approach allows expenditure of those resources to be planned and targeted appropriately. The MHIP evaluation suggests that investment in the early stages will help “opt-in”, enhancing support and increasing the likelihood of success. Launch events have clear benefits in terms of generating local enthusiasm, but resources should be spread throughout the lifetime of an initiative to ensure engagement and partnerships are maintained.

Training is also necessary and should be appropriate to needs (defined by tasks and through an analysis of skills gaps) and should build the capacity throughout the organisation(s) that is required to implement the initiative. Resources should also be allocated to allow staff, users and carers to participate in training, data collection and data analysis. Each of these should be seen as an investment that will help build a “culture of service improvement”.

Expenditure should be tracked over the course of improvement work. Alongside a record of staff activities, such as training, and time spent, this

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will ensure costs can be measured and set alongside the outcomes (impact) achieved.

In turn, this means baseline measures must be taken when the programme begins and outcomes should continue to be measured as the programme progresses. This will contribute significantly to an understanding of the aims and achievements of the work. It is important that outcomes are defined at the outset, but also that they are achievable given the starting point of the organisation(s) involved, the scope of the initiative, the capacity of the organisation, the work planned, and the budget.

### **Summary**

Overall, MHIP had very little impact on service quality.

MHIP had some impact on how local organisations operated, supporting services as they restructured or improved their efficiency. There was little improvement around measurement, although “culture changes” around partnership working and service user and carer involvement were identified by respondents. Questions remain on how sustainable these changes might be and indeed just how concrete these changes were.

The limited impacts of MHIP were due to a combination of context and capacity. MHIP was introduced into organisations that were already under considerable financial pressure and existing relationships with partner organisation were poor. Low capacity in skills and time were made more pressing by the extensive local work programmes devised for MHIP. There was insufficient analysis of and response to these contextual issues.

The grant accompanying MHIP was perceived as a strong incentive to engage in the work. However, most trusts were disappointed with the amount of additional money they received. In some sites it was less than half of the money they originally estimated that the work would require leading to high levels of pressure on MHIP personnel.

The bulk of the additional money for MHIP was used to employ local MHIP teams. Generally, very little money was spent supporting involvement of service users and carers, or on building local partnerships. There was little awareness or consideration of the additional costs of improvement initiatives, such as staff time spent attending meetings or undertaking activities within the workstreams. Governance costs were also high.

Significant financial and technical support was provided by other sources, such as local Strategic Health Authorities. However while work went on beyond the end of the first year, the resources available through MHIP reduced substantially from that point.

Attitudes to resources varied both within and across the participating organisations in terms of how resources might have been better used and indeed whether more resources would have been of benefit. Lack of resources and the way the resources were focused on just a few people may have contributed to the programme’s low impact, although most

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people felt that MHIP had contributed to a change in attitudes within the organisation.

Improvement initiatives must be suitably resourced and measured. To this end, resources should be targeted appropriately in terms of focus (e.g. suitable training, building capacity) and timing, and they should be tracked over the course of the initiative. Suitable outcome measures should be identified and applied, allowing a clearer appraisal of what such initiatives achieve for their considerable inputs.

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## 6 E-MHIP methods appraisal

### ***6.1 Chapter introduction***

E-MHIP set out with the following aims:

**Aim 1: Describe the MHIP programme and the settings into which it was introduced**

**Aim 2: Assess the outcomes and impacts of MHIP**

**Aim 3: Assess the effectiveness of MHIP in achieving these outcomes and, by extension, gain an understanding of successful change work in general**

In light of the evaluation findings, this chapter will appraise E-MHIP's theoretical framework and methods by describing its strengths and the challenges it faced. At the end of the chapter, the aims will be revisited in order to summarise how they have been met and how E-MHIP's method was instrumental to this.

### ***6.2 Theoretical Framework of E-MHIP***

#### **6.2.1 Realistic Evaluation**

An approach commonly adopted when using Realistic Evaluation is to start by identifying outcomes, i.e. "the problem to be solved". This approach was, however, not helpful for the evaluation, largely due to there being a large number of problems that MHIP was ultimately trying to solve; aims and objectives at the national level, and often in the pilot sites were vague and non-specific. In essence, defining MHIP's "programme theory" was difficult, if not impossible (as will be discussed further in Section 6.3.1). The approach taken, therefore, was to identify important interactions between mechanisms and contexts and the intended and unintended outcomes, in order to understand how MHIP worked.

In this way, the Realistic Evaluation approach forced the team to think clearly and critically about what part of an intervention could be considered as a change mechanism. This was at times a difficult distinction to make, but the process of undertaking the differentiation fed into the analysis and was a strength of the method.

#### **6.2.2 Organisational change standards**

The standards-based interview was an effective tool, enabling systematic collection of data on the practices employed during MHIP and the contexts in which it was implemented. On reflection, however, there were perhaps too many standards making it difficult to capture all the data within a

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reasonable amount of time with each interviewee. Furthermore, the interviews were, as would be expected, heavily centred around MHIP. This meant that several, potentially relevant contextual factors were perhaps not covered in sufficient detail. With regard to the analysis of this data, E-MHIP respondents came from a range of perspectives and organisational levels. This meant that appropriate triangulation was sometimes difficult, although the divergence in opinions and experience was an interesting finding in itself.

This process of reflection on the reliability and validity of the standards throughout the course of their use in E-MHIP was an extremely useful one. These lessons provide the opportunity to update the standards and produce a validated tool for measuring practice in organisational improvement initiatives.

### **6.2.3 Economic component**

While cost analysis is generally regarded as quantitative research, a qualitative approach to data collection and analysis was also used in the economic component of E-MHIP. This supported estimation of the 'true' cost of implementing MHIP, including both explicit funding streams and 'hidden' costs. The qualitative approach was also useful in eliciting, analysing and summarising participants' attitudes to the resources used to implement MHIP.

Few trusts or other organisations estimate the costs of change, yet change programmes are not uncommon and are often implemented in response to a new national policy or initiative. Cost estimation is detailed, time-consuming work. NHS accounting systems and practices are rarely set up to deal easily with projects such as MHIP that draw on more than one service or agency budget; their purpose is quite different. There is also very little research in this area. The research team could find no evidence of existing systematic approaches to track the costs of change or service improvement programmes.

The approach chosen was guided by economic theory and informed by previous work on cost estimation. However the somewhat amorphous presentation of MHIP meant that all three modes of data collection (documentation, interviews and a survey) were important. The two main drawbacks were the absence of "hard" data recorded by the trusts on MHIP income and expenditure, and the retrospective nature of our inquiry. In addition, the estimates of staff time spent on MHIP activities are likely to be an underestimate as the response rate to the survey, despite considerable efforts, was only 40%.

Given these limitations, E-MHIP has provided one of the first sets of data describing the resource inputs absorbed by a service improvement programme. The Realistic Evaluation approach here helped identify the costs, set the findings within context, and should help trusts and other organisations forecast the likely cost implications of local organisational change programmes.

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#### **6.2.4 Data collection**

The use of multiple sources including local documents (e.g. trust annual reports, local MHIP PIDs), national reports (e.g. CHI reports), surveys and interviews gave the highest possible level of confidence about the reliability of the data collected. A substantial amount of time was required to accessing documents and, in some cases contact details for those involved in MHIP, mostly due to the time that had elapsed between MHIP and the evaluation. The assistance of personnel from the organisations involved in the pilot was very helpful in this regard.

A criticism of the standards-based approach, noted in Chapter 2, was that of personnel feeling “grilled” as opposed to listened to. The research team was aware of this and made every effort to explain the purpose of the evaluation to all those involved. Despite this, however, the evaluation carried a heavy accreditation-like atmosphere. Although this was mostly overcome, occasionally, this resulted in personnel feeling anxious or wary of being involved in the evaluation.

#### **6.2.5 Analysis of the qualitative data**

The decision to analyse the interview transcripts was taken fairly late in the course of the evaluation, when it became clear that the data generated by the interviews was far richer and than expected. As a result, the coding framework was developed in retrospect after a significant part of the evaluation period had passed. Ideally, such a plan would be in the minds of the researchers right from the start and such a coding framework would be built up over time with emerging ideas and themes being developed throughout.

The approach taken in the interviews was essentially “theory-generating”. Interviewees were presented with a series of themes which were felt to be important and were encouraged to speak about some or all of these during the course of the discussion. These themes were generated from the preceding phases of E-MHIP and were regarded as widely relevant, including outside of MHIP (i.e. by the sounding board). Ultimately, the analysis of these interview transcripts fed into the theories about how MHIP worked. However, as these themes were broadly important for organisational change, there was a tendency at times for people to speak more generally about these and less specifically about how they related to their experience of MHIP. A “theory-driven” approach to the interviewing, where a more coherent model of MHIP was presented to interviewees, might have guarded against this but may have meant the interviewees did not consider the broader picture.

#### **6.2.6 Validation processes**

The sounding board, member checking and “peer review” element to the site visits helped to validate findings and hypotheses along the way. These processes acted as “confidence builders” during the evaluation ensuring that

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its findings and recommendations would be useful for the wider mental health service improvement community.

## ***6.3 Challenges faced by E-MHIP***

### **6.3.1 The retrospective nature of the evaluation**

The evaluation of MHIP commenced approximately 2 years after MHIP itself commenced. This retrospective approach often resulted in a blurring of peoples' memories. It was important to decipher as much as possible, what happened in each site that was due to MHIP and what change would have happened anyway as a result of other parallel and subsequent initiatives. The research team was mindful to guard against post hoc accounts that built up programme theories from changes known at the time of interview (i.e. that the change was that which was intended and was the result of the MHIP programme).

In addition to simple fading of memories and confusion, there were a number of other factors that might have caused respondents to construct accounts with particular emphases or slants. For example, it was evident during the visits that there was anxiety about feeling "evaluated". In part this anxiety might have arisen from the extent and way in which the sites were "project managed" by NIMHE. Teams were asked to report back on progress. It would appear that this created a culture where the reports were based more upon what the sites thought NIMHE wanted to hear and less upon what was actually happening on the ground in the sites themselves. It was to be expected that such behaviours would manifest in this evaluation too.

It was also evident during the visits that there was sometimes anxiety about being evaluated. For example, in one site, the style of management meant that respondents were commonly uncomfortable with speaking out about the culture of the mental health trust and so, by extension about MHIP. In another trust, there was a great degree of confidence, particularly at board level resulting in an "organisational mantra" being heard. In this site, great efforts had been made by those leading the MHIP programme to brief people prior to the evaluation and to encourage people to attribute improvements they had seen to MHIP.

The research team was mindful of these potentially complicating factors and attempted to guard against their effects. This was done within interviews by (a) encouraging respondents to think carefully about orders of events, causal links (b) by making clear our independent status and interest in learning lessons from MHIP; and across interviews by ensuring that we spoke to a wide range of people from a wide range of perspectives.

Despite these actions, it is impossible to guard completely against these constructions. The retrospective nature of the evaluation also contributed to other challenges faced with defining the programme theory; establishing the counterfactual; getting perspectives from service users and carers; and evaluating training.

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The research team reflected that a prospective evaluation would have helped to minimise the effect of these factors and so would have been extremely advantageous.

### ***Defining the programme theory***

Using the RE approach, programme theory definition is done by a process of identifying and linking important contextual factors, mechanisms and outcomes. In this evaluation, however, there were a number of difficulties with defining and differentiating which of our observations could be classed as contextual factors, mechanisms and outcomes.

For example, the consultation events run at the start of the MHIP programme were successful at engaging and enthusing stakeholders across all sites. Indeed, these events might be considered an effective mechanism to generate “energy” in a wide range of contexts. As projects continued to develop following these events, however, this outcome might have been better considered as a contextual factor. Mechanisms and contexts were commonly interchanged by respondents also; in one site a number of staff were trained in PRINCE 2 during the MHIP programme and it was reported that this structure prevented the programme losing track during turbulent times. Despite the temptation to identify this as an MHIP mechanism, further investigation revealed that those leading the MHIP programme had a prior interest in PRINCE 2 and so was more accurately regarded as a contextual factor. A third example is the common feature across the pilot sites was a weak service improvement skills base. Whilst this could be classed as a contextual factor, that MHIP was not effective in addressing this weakness (i.e. by a poor training strategy), must be considered as a negative mechanism that contributed to the disappointing outcomes of MHIP.

As these examples demonstrate, many of the difficulties with definition were overcome by thorough interviewing. Overall, however, the research team found the RE configurations (context+mechanism=outcome) not to be useful for understanding or communicating the emerging MHIP theories, given the complex and ever-changing relationships between the three components over time and from different perspectives. The theoretical standpoint provided by RE, i.e. that intervention needs to be considered according to the ways in which it interacts with the environment into which it is introduced, was entirely appropriate as the overarching framework for E-MHIP, however.

Once definitions for components are settled upon and researchers are able to define logical theories based on these, a further issue arises as to whether these can be considered as true programme theories. If these theories are produced by external observers (i.e. researchers), but do not necessarily reflect what was in the minds of the people designing and implementing the programme, can they be the programme theories?

For this reason, the theories of the individuals directly involved with MHIP were important. These theories differed massively across the organisational

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levels, between sites and between workstreams, making the definition of a single or even a finite set of programme theories for MHIP, very difficult.

As has been discussed in previous chapters, respondents referred to a lack of clarity around the ideas communicated by NIMHE to the local sites and in turn, concepts communicated across local sites. Objectives of MHIP programmes and workstreams were often non-specific and vague. This lack of clarity was facilitated by the lack of clear MHIP budgeting and data collection activity around the workstreams, resulting in little sense of what was achieved or even what was intended to be achieved amongst a broad range of stakeholders. There was, therefore, varied local understanding of the ultimate aim of MHIP. For example, for one site it was about service improvement, whilst for another it was about testing an implementation methodology (which was itself vague and unclear). Interviews with personnel at NIMHE and at local levels indicate that the theory actually changed over time; it started out to test whether the IPH programme could be adapted to mental health settings, but eventually became much more about service improvement.

### ***Establishing the counterfactual***

Originally it was planned that the evaluation would use routinely collected data to assess progress within sites using their own baselines. This was envisaged to come from local and national data sources. In practice, evaluation in this way was hardly ever appropriate. The national MHIP PID outlined ideas of the local sites using the National Service User and National Staff Surveys as outcome measures but these were not used by any workstreams in any of the sites to measure change over time. Additionally, very few projects or workstreams used locally collected data to measure change despite inclusion in plans at the national and local levels. The approach most commonly adopted for measuring change was recording achievement of project milestones. Against this background there was an increased emphasis within the evaluation upon the use of the standards based approach in order to make comparisons. In large multi-site audits, standards are a recognised method for measuring change in the form of incremental improvements against process measures.

A large amount of qualitative information was gathered by asking individuals for their change theories, and in particular, whether and how they perceived MHIP to have had an impact. Overall, however, most respondents found it difficult, and at times impossible, to give a confident and accurate estimate about the extent to which MHIP was causal in any given change. This was mostly due to the ways in which MHIP was implemented in the sites and the difficulty of clarifying exactly what change was the responsibility of MHIP and what as due to other programmes.

### ***Getting perspectives from service users and carers***

It was virtually impossible to speak to service users and carers about their involvement in MHIP. The research team identified some reasons for this. Despite service user and carer involvement being an explicit principle of the

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MHIP programme few resources were actually invested into the recruitment, engagement and support required (only 5%, see Chapter 5 for details). Another problem encountered was that contact details for service users and carers were not always readily available to the research team as trusts were not able, quite rightly, to release such information. Furthermore, as MHIP had happened months/years before, many service users and carers were not necessarily in contact with the pilot sites' services. Interviews were held with service user and carer groups in each pilot site and these discussions produced *concurrently* relevant data about processes, structures and experiences. However, very little data was gathered about how service users or carers were involved in MHIP or how processes or services might have changed as a result of MHIP.

### ***Evaluating training***

It was not feasible to assess directly the impact of training on the local health community's knowledge, capacity and skills, as was originally intended. There were two main reasons for this. First, no baseline data were collected in order to gain a clear understanding of the value added by training and second, relatively few people received training.

Instead, where possible the impact of training was described in the case studies and in other relevant sections of the report terms of the particular training programmes and their effects on the groups that received them.

## ***6.4 Revisiting E-MHIP's aims***

The aims of the Evaluation of the Mental Health Improvement Partnerships programme (E-MHIP) were met as follows:

**Aim 1: Describe the MHIP programme and the settings into which it was introduced:** the original ideas for the MHIP programme were described in Chapter 1 and the organisational contexts into which MHIP was introduced were explored in Chapter 3. Chapter 4 investigated the actual process by which the MHIP programme was implemented at the national and local levels and compared this with both the original ideas for the MHIP programme and with the standards for organisational change.

The site visits were very useful in exploring the organisational context and implementation of MHIP in each of the localities through the memories of those responsible. It was possible to identify the differences between the sites in terms of implementation process and the level of support available at different organisational levels.

**Aim 2: Assess the outcomes and impacts of MHIP:** Chapter 5 examined utilisation of resources, including training, finance and staff time and provided a detailed examination of the impacts of MHIP in terms of changes to how the organisations worked, impact on service quality and learning. Logically, in addition to this, impacts and outcomes are referred to in the other chapters which discuss the MHIP contexts and processes, and their interactions.

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The research team went to great lengths to achieve this. However, establishing causality was difficult to achieve due to many intervening variables, particular changes brought about by other policy initiatives and the lack of a separation of budgeting and recording of other resource utilization. In some of the trusts visited all modernisation initiatives were “badged” as MHIP even though they may have derived from other policies or programmes. In other trusts some staff were unaware that they had been working on an MHIP workstream, particularly in the second year when MHIP “blurred” into broader modernization initiatives.

**Aim 3: Assess the effectiveness of MHIP in achieving these outcomes and, by extension, gain an understanding of successful change work in general:** Chapters 3, 4 and 5 drew out theories about how MHIP worked incorporating analysis of the active components of the change methods employed, relative to the evidence base, and the settings into which they were introduced. This thinking will be brought together in the Discussion chapter, where overall conclusions will be drawn, and based on these recommendations for future work will be made.

This was probably the most difficult of the aims for the team to address. There was a general lack of outcomes that could be directly attributed to MHIP and that would not have occurred in any event as a result of other subsequent policy initiatives. Successful change work was difficult to perceive and where it did occur was down to individual leadership rather than organizationally driven. Mechanisms and contexts were established and linked to the evidence found. The research methodology was therefore able to determine with a good degree of reliability what the mechanisms were and the impact these made given the contexts of the national programme and the sites themselves. Of particular note is a general lack of real involvement and engagement of service users in the organisational process particularly as regards the MHIP programme.

## ***6.5 Conclusion***

The evaluation of MHIP proved to be anything but straight forward. In the end the evaluation found various hypotheses within the sites and within NIMHE, indicating that MHIP was a programme in search of a theory. Indeed the evaluation at times could be said to have ‘stress-tested’ the strength of the Realistic Evaluation approach. Nevertheless, the Realistic Evaluation framework, encompassing a number of tools provided a sufficiently flexible approach to take account of this and produce the interesting and potentially powerful findings in this report.

## ***6.6 Summary of key points***

The Realistic Evaluation framework provided a flexible approach which was able to produce interesting and useful findings. That the evaluation was retrospective made it complex and four particular challenges can be identified:

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- MHIP had almost as many theories as it had people involved in it. The definition varied from national to local level; between local sites; and between groups and individuals within local sites. Furthermore, these theories evolved over time and as a result of cultural influences
- Establishment of the counterfactual by using comparison sites or routinely collected data was not feasible. Instead, the standards for organisational change were used as a baseline by which to compare local programmes
- The evaluation was unable to properly define service users and carers' perspectives on MHIP. This was partly due to the difficulties associated with accessing these people. However, this was also due to the low service user or carer involvement in MHIP, despite the centrality of this theme in early plans
- Systematic evaluation of training was not possible as relatively few people received training and no information was available to assess properly the impact of the training that was received

The "sounding board" events and the member checking were invaluable validation processes. They helped to build confidence in the E-MHIP methodologies. These were especially important, in light of the challenges outlined above.

Many of the limitations of E-MHIP would be overcome in a prospective evaluation.

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## 7 Discussion

Three researchers independently identified themes from the case studies. These were developed during discussions with the E-MHIP steering group.

### **7.1 Themes**

#### Context

1. Insufficient local readiness for change
2. Local leadership influenced nature and progress of MHIP
3. Political agendas influenced nature and progress of MHIP

#### Mechanism

1. Lack of a scientific approach
2. MHIP was not based on theory
3. Limited range of service improvement techniques used
4. PRINCE 2 was excessive, but provided structure and durability
5. Non-specific aims and objectives were not helpful
6. True partnership working extremely difficult
7. Little service user or carer involvement
8. MHIP used as a vehicle for change
9. MHIP was a spur to action
10. Focus on too few local personnel
11. NIMHE support was valued, but inconsistent
12. Insufficient resources, hazily viewed

#### Outcome

1. Low impact of MHIP
2. Culture change
3. Learning opportunities missed

### **7.2 Context**

#### **7.2.1 Insufficient local readiness for change**

Readiness for change is an established and important factor in the success of organisational improvement work (e.g. Iles and Sutherland, 2001,

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Armenakis and Harris, 1993). Unfortunately, neither NIMHE nor the local pilot sites were considered ready for change.

Systematic analysis by NIMHE of the contexts into which MHIP was placed would have revealed strong financial pressures, poor skill base, weak external partnerships, little service user and carer involvement, and limited capacity for improvement work. Once identified, these problems could have been addressed directly, or interventions chosen that were robust enough to succeed. For example, selecting projects that were very focused and/or had a short duration. Pilot sites were not selected systematically on the basis that their readiness to change fitted the MHIP programme's expectations and requirements. Such analyses could also have been used to guide selection or provide exclusion criteria for unsuitable sites.

Locally, sites were all subject to organisational instability in the form of PCT and SHA reconfigurations and, latterly, the drive for Foundation Trust status. Organisational restructuring and local partners' different and competing priorities undermined progress in Leicestershire and South West Yorkshire. South West London, however, cleverly used the disturbance as "tension for change" (identified by Gustafson, Sainfort, Eichler, Adams, Bisognano & Steudel, 2003 as a key impetus). There was little inertia or resistance to new ideas because contextual pressures required change and the opportunity was used to push new work through.

Overall, these distractions reduced communities' stability, capacity and confidence to carry out MHIP. Moreover, staff observed that these distractions limit their activities more generally; this, naturally, has repercussions for the quality of care received by service users and carers.

Interestingly, critical problems, such as organisational instability, were common to different organisational levels. For example, whilst clinical teams were working in a context of internal re-organisation of trusts due to financial cuts; trusts were in a context of restructuring of PCTs and SHAs; and NIMHE was in a context of being subsumed within CSIP. Furthermore, each of these events had the potential to have a major impact on progress at any level. It would seem then, that for these common risks, there might be common solutions. Programmes, projects or policies might focus on promoting organisational stability and stabilising external partnerships, and place emphasis on enabling learning and follow up. Such programmes would have to move away from political agendas to recognise that such achievements and learning processes take a longer amount of time than is often given to reach government targets.

### **7.2.2 Local leadership influenced nature and progress of MHIP**

The power of leadership "buy in" and endorsement is well-established (e.g. Greenhalgh et al., 2004) and organisational improvement initiatives are more likely to succeed if there is strong leadership (Gustafson et al, 2003).

At senior and middle management level, leadership was critical to the progress of MHIP. Senior level championing was a powerful force, helping to

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bolster the efforts of the middle managers running MHIP to generate enthusiasm and communicate how MHIP fitted with values important to the trust. Chief Executives in two sites endorsed both the MHIP programme and the team. Some senior managers' agendas drove the selection of workstreams. Whilst this helped to ensure that work was focusing on the national and local priorities, this may have undermined the fairness of the wide stakeholder consultation. Even where senior level endorsement of MHIP was seen, senior managers were often distant from the work, the workers and those on who the activities would impact. This lack of close involvement would have reduced the likelihood of lessons from MHIP being learned at a senior level or elsewhere, within or beyond the trusts.

Armenakis and Harris (1993) stress the importance of the role of leaders in disseminating the "readiness message" and state this is the primary mechanism for creating change. This message should incorporate the need for change and the ability to change. The "need" part clarifies goals and gains commitment. The "ability" part builds confidence that change is possible and presumably would cover contextual problems. This kind of communication from senior level was seen in SSHT where the charisma of the Chief Executive and the organisation's existent confidence was combined with the energy generated by MHIP early on. However, this communication mainly focused on "ability" to achieve, rather than the "need" or "readiness" to change. More general, ongoing leadership style is also influential (Gustafson et al, 2003). In South West London, before MHIP, there had been clear communication from senior level about the "need" to change, i.e. in response to the serious incident. This contributed to the aforementioned "tension for change" which was eventually important for MHIP's progress. Conversely, where there was a dysfunctional relationship between senior management and clinicians in Leicester, this created a seemingly insurmountable obstacle to progress.

The influence of leadership and leadership style cannot be underestimated. The potential negative impact of dysfunctional management styles can be conceptualised as a task in its own right and should be addressed before other change/improvement work is embarked upon. It is important that senior managers are properly engaged and committed to change programmes and are able to communicate effectively with their organisations. This, in turn, is important for providing support to the middle managers who carry much day-to-day responsibility for improvement work.

### **7.2.3 Political agenda**

The MHIP programme was launched during a time of systemic change both locally and nationally. In addition to local priorities, mental health NHS trusts across the country faced a wide range of top-down pressures. These included government targets, such the National Service Framework obligations, and other political imperatives such as the drive for Foundation Trust Status.

MHIP was adapted from the Modernisation Agency's Improving Partnerships in Hospitals programme. This was done, however, with insufficient input

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from experts in mental health service improvement, e.g. NHS staff, service users, carers and academics. MHIP was managed by those following the political agenda, e.g. civil servants and ministers more familiar with policy imperatives and contracts than evidence, local need or measurement. Further, a political agenda demands quick results, whereas improving health services is a slow process that requires a long-term commitment. In this way, MHIP can be seen as a classic case of the effects of politicians' involvement in health policy.

It is reasonable to expect that experts such as NHS staff, service users and academics could have improved the programme and its local implementation. This is because, first, many experts would have been involved in the workstreams and the sites and so involving them in design and planning would have led to better engagement in the MHIP process. Second, the service users, carers and staff would also know the services and contexts very well and hence would know local needs and contextual problems. Methods (including training) could then be selected to address these. Third, academic experts would be able to share and interpret summaries of evidence on effective organisational interventions. They could also help ensure that the group followed a scientific and learning approach.

## ***7.3 Mechanisms***

### **7.3.1 Lack of a scientific approach**

Many of the themes explored in this section of the discussion are all symptomatic of the lack of a scientific approach to the design and implementation of MHIP.

In its design, MHIP borrowed heavily from the MA's programme set up for acute hospitals, IPH. Adaptation of this was done without consultation with key experts in mental health services (i.e. service managers, staff and service users; academics).

The low compliance with standards on organisational improvement (Table 5, Chapter 4) demonstrates that there was little use of evidence. No systematic analysis of trusts' support needs was conducted and therefore methods could not be chosen to address these. There was no clear theory to guide the work or rationale for selecting the five principles that were promoted. The selection of pilot sites could only be justified as pragmatic. Importantly, there was no consideration of "readiness for change".

In addition, there was no reference to research evidence on effective models of service provision, e.g. reviews of literature, and no indication that improvement methods used were evidence-based. Neither was there any obvious reflection on the challenges or limitations of identifying relevant evidence and implementing this. It was striking that clinical audit did not feature in the MHIP service improvement framework or in the training. This is an intervention of recognised effectiveness and with many years use in the NHS and where excellent guidance exists (e.g. Principles for Best Practice in Clinical Audit, NICE 2002, see Appendix 9). There was no

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training needs assessment and the training and support provided was frequently not relevant.

Largely due to these problems with the national MHIP programme, the absence of a scientific approach was seen also at the local level. Poor measurement of baselines and progress meant that work could not be data-driven, e.g. where each workstream is treated as a natural experiment. Finally, and unfortunately for a pilot study, there was little formal recording of lessons.

There are several possible explanations for this lack of sufficient scientific approach. First, if MHIP's aim was to enable rather than guide staff, e.g. where staff are given a wide range of tools and skills and then left to choose their own topics, it may be that an evidence-based core methodology and clear theory was not critical. However, this explanation is not supported by the PID or consistent with the small numbers of staff trained.

Another explanation might be that evidence from the literature was considered weak. The science of organisational improvement may still be in its infancy, but there is a growing evidence base that is relevant and accessible (e.g. Iles and Sutherland, 2001). Where more objective evidence is lacking, expert opinion is a recognised substitute. Unfortunately, there was insufficient consultation on the design of MHIP and the groups established to direct and manage the work had little or no academic representation, an important expert group.

### **7.3.2 MHIP was not based on theory**

MHIP had no explicit theoretical basis. The use of service redesign and reduction and analysis when considering components of trusts services indicates the use of a structural theory. Process mapping and care pathways work are, however, more consistent with a systems-based theory. It appears then, that MHIP used an eclectic and not single or integrative approach. Indeed, there seems to be a degree of passivity to MHIP, e.g. in presenting the MHIP improvement methodologies as a menu, rather than a more defined method. More emphasis on a systems-based approach and on context and readiness for change would have been useful.

The evaluation findings and researchers experience, however, did not fully support a contextualist position for understanding MHIP. It was clear that workstreams were destined to make little progress because of competing pressures from organisational restructuring, but it was also clear that in some cases MHIP was being adapted and exploited to an extreme. It was hard to identify any core model to protect; however, any future evidence-based intervention would do well to state parameters for local adaptation.

### **7.3.3 Limited range of service improvement techniques used**

Some of the techniques promoted by MHIP, such as process mapping and solution design were relevant to and used in many workstreams. Other techniques were seldom used. Local Programme Leads and RDC Client Managers were already familiar with these and other staff were keen to

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learn. Only a small number of suitable techniques were used. Nearly all workstreams used suitable planning techniques, but little attention was paid to measuring baselines and progress or to formal evaluation of the work.

Insufficient training in service improvement techniques across the sites was a major reason for the patchy application of service improvement techniques. Training was focused on a small number of people in each pilot site who already had some expertise in service improvement. Outside of this, very few people received training. Where training was given, again, a lack of a systematic approach to selection meant that much of it was not relevant, e.g. Statistical Process Control and analytical techniques for data analysis, and there was an insufficient focus on processes or service user involvement.

#### **7.3.4 PRINCE 2 was excessive, but provided structure and durability**

MHIP leads in South West London promoted a strong combination of project management together with devolved responsibility. This effectively engaged staff in the work and provided a robust programme that was able to withstand unexpected disturbance from changes in management. The devolvement also relieved some pressure from the leads. Ten staff members received PRINCE 2 training during the MHIP programme (a number of staff were already experienced in this technique). A clear project management culture developed; project management language was used and the principles were understood and appreciated.

Many staff, however, in this and other sites found PRINCE 2 too formal and complex for the type of work conducted. A reduced or amended version could be a great help to managers and would reduce training time and possibly cost. This might include less reporting on progress and fewer project groups established.

#### **7.3.5 Non-specific MHIP aims and objectives were not helpful**

There was not much in common with how MHIP was planned and implemented or what MHIP looked like in the four sites.

The combination of the PID's complex format, MHIP's complex structure and the use of abstract terms to describe MHIP aims, objectives and methods caused widespread confusion (The PID can be found in Appendix 1). Some considered the aim to be service improvement whereas others believed the aim was to test a method. It was not clear how the three components of the MHSIF related to the six processes of the methodology or how these promoted the five principles. At the local level, many individual workstreams had vague or overly ambitious aims and objectives. The intention might have been to find an appropriate balance of top down and bottom up during planning. However, this often left participants feeling unclear about the aims, objectives or methods, for some, even after work had finished. Participants often could not visualise the work or their role in it and so lost interest. The lack of clarity made communication of these goals to others

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also difficult, potentially causing delay, reducing the chances of goals being met (Gustavson et al., 2003 and Pettigrew et al., 1992).

It might be argued that it was the “opportunists” or the “adapters” who benefited most from MHIP; the lack of definition in aims and processes enabled MHIP to be interpreted and adapted to suit local contexts and enabled managers to target national and local priorities. To illustrate this example, two sites can be contrasted. South West Yorkshire stuck to the MHIP methodology and to the strictest definition of piloting. Unfortunately they paid a price for this; because work could not be taken forward in partnership, it was scarcely taken forward at all. South West London, on the other hand, had to change and improve across a broad range of their services. It would seem here that MHIP was an opportunity to expedite these changes. This pilot, more so than the others, had an inward focus on its own mental health trust services with very little work dependent on external partners.

Where MHIP was adapted, however, it is not clear whether useful parts were lost or retained. Participants were not aware of a specific core MHIP model or theory or any “active ingredients” to retain. This represents an important missed opportunity for MHIP, as it is now unclear which aspects were useful and important for future programmes. It is important that pilot studies are set up as scientific experiments; even within a flexible framework like MHIP, if causality is to be established, theories or hypotheses must be set out clearly and tested systematically.

### **7.3.6 True partnership working extremely difficult**

Despite the centrality of “partnership” to the MHIP programme, there was insufficient consideration of what is required to build partnerships and when they are and are not critical. First, NIMHE’s recruitment of pilot sites involved little more than gaining agreement from trust boards and little attention was paid to other local partners. At local level, many relationships with local partners were weak, e.g. due to mergers and reconfigurations, or because they never had been strong. The consultation events engendered a sense of enthusiasm, but, maintenance and development of these partnerships required a great deal of investment. The short time scheduled for this task was unrealistic and, although amendments to the schedule were made, problems remained across MHIP’s lifespan.

The host mental health trusts in each pilot were faced with a massive challenge of overcoming the complexities of the relationships with a range of partners, e.g. PCTs, service users and carers, the voluntary sector. For example, PCTs and SHAs were in flux due to pending reconfigurations. Some felt they were not properly listened to or treated as unequal partners by the host mental health trust, e.g. the large stakeholder events identified popular topics, but often the mental health trusts’ own agendas were very influential in this process. Following this, communication with partners outside of the trust deteriorated. Service user and carer representation on local reference groups and the national steering group was not sustained.

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Partnership means different things to different people. This was not explored by MHIP partners. Indeed, inclusive partnership working might not always be appropriate. One benefit of the inward focus of the work done in the South West London MHIP programme was that it reduced reliance on external partners who were in very different financial positions and had competing priorities. Less inclusive working limited potential sources of resistance.

Internal partnerships too require investment. Again, it is simpler for managers to work alone, e.g. redesigning a service, and declaring it changed without involving others and risking resistance. This is characteristic of a traditional "top-down" management style. Clearly engagement with internal or external partners is critical in sustaining improvements that affect them or require their skills, experience, co-operation or approval. Partnership for other reasons, e.g. simply to promote the principle of inclusion, may be a hindrance.

There was some evidence of inter-professional working, but this was not supported well at an organisational level. There were good working relationships between middle management and frontline staff in SWLSG. Responsibility for the workstreams was successfully devolved and many projects were run by clinical team managers. Much of the project management and trouble-shooting occurred within existing team meetings. This, however, was not convenient for external partners who found it hard to attend MHIP meetings. There is a history of failed NHS initiatives that attempted to achieve health and social care public sector agencies working together. There are lessons to learn here. Many things work against partnerships developing, such as different budgeting time scales, resource constraints, fear of putting one's head above the parapet (and getting landed with all the work), and different organisational cultures.

### **7.3.7 Little service user and carer involvement**

There was little service user or carer involvement in the workstreams and local programmes. This was surprising given that this was one of the principles being promoted. This was true even in trusts where service user involvement was reported to be established. Further, service user and carer involvement was weak at the national level. This seems to demonstrate that the two parties do not know how to work with each other and perhaps that there are poor relationships that are not improving.

In terms of training, service user involvement means many things and these cannot be taught in one module. For example, training topics might include: determining patient views on a service, views on an ideal service, working with patients from a service they have not had direct experience of, service users and carers as co-workers on projects, and questions such as should they be equal members, should they lead projects, what abilities and skills do they need.

Unfortunately, as MHIP progressed, NIMHE and local groups lost sight of the vision and principle of a service user and carer focus. The priority changed from testing a methodology and reflecting on the process, to achieving

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objectives with no fundamental rethinking in light of the principles. Insufficient time was allocated to initiate, establish and, moreover, to maintain service user and carer involvement. This should be a core principle for an NHS trust and NIMHE - everyone's business, not just someone else's job. Again, experience shows that to achieve this culture change staff members need to work with service users before they can understand the principles, techniques and benefits.

The knowledge and expertise to strengthen user and carer involvement existed within NIMHE but the opportunity to use this valuable resource was not always grasped. This was due to a lack of time to understand contexts and put them into sustainable situations before embarking on the chosen workstreams. Perhaps improving service user and carer involvement should have been a compulsory workstream for all sites as a prerequisite for signing up. This evaluation did not identify any useful outcomes for service users and carers and this makes it hard to believe that they were at the centre of the work

### **7.3.8 Use of MHIP as vehicle**

In line with research findings, MHIP was more successful when applied to existing priorities and located within existing structures. Local ownership and chances of success are optimised when proposed change work fits with both local and national priorities (Gustafson et al., 2003). This resulted in good ownership of the work and better outcomes. When MHIP was not used in this way this led to poor outcomes. Relevance of projects is viewed as central to encouraging local engagement (Armenakis and Harris, 1993; Gustafson et al., 2003).

MHIP and the energy around it were successfully exploited by leaders to drive through a local agenda. This is a sensible strategy for policy-weary managers, particularly when the intervention is loosely defined. Alternatively, managers could be faced with a policy that might not "fit" the organisation, may be irrelevant to local priorities and might take no account of local context. Implementing this would have higher costs and opportunity costs than an adapted policy. There was the potential for a clash of interest here, however. MHIP lent itself well to being local leaders' vehicle for change, but also included a wide stakeholder consultation component. This led to potential for the programme having a set of priorities that did not fit with the priorities of one of these groups.

### **7.3.9 MHIP as a spur to action**

For many, involvement in MHIP generated energy and enthusiasm; the initiative had a national profile with Department of Health backing and the exciting prospect of new partnerships. This was perhaps MHIP's greatest achievement.

Services may have been less willing to volunteer without the financial incentive, though respondents indicated that money was not the only

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driver. The opportunity to engage with NIMHE, which for many trusts was a novelty, was certainly a factor.

MHIP also acted as an ongoing drive. Programme Leads and members of the national MHIP Programme Board referred to the benefits of the network of pilot sites: the peer support provided is discussed elsewhere; respondents also identified the benefit of competition. This encouraged pilot sites to progress work and to demonstrate this progress. This competition may have been counterproductive and may have caused a shift in focus of MHIP work e.g. from partnership working to demonstrating progress.

It is undeniable that MHIP had a strong start. Much of this enthusiasm and engagement dissipated quite rapidly, however. Developing and maintaining engagement is a significant challenge (Section 7.3.6) and the capacity supported by MHIP was inadequate to meet this challenge.

### **7.3.10 Focus on too few local personnel**

Most local MHIP leads were experienced in organisational improvement and were critical to the progress of the work. These staff demonstrated initiative, resilience and commitment to the work, sometimes in the face of insurmountable contextual challenges.

Local MHIP Leads had many and diverse tasks. These were originally envisaged as being completed with NIMHE funding that was approximately twice what was eventually granted. Reductions in the size of the MHIP team meant less time was available to spend coaching workers as they acquired new skills, only having time to point people in a certain direction.

The skill base of others involved in workstreams was often weak and this was not improved by training. Neither sufficient staff time nor funds were dedicated to the work and staff had to absorb this into their existing workload. Together with a lack of capacity to do the work and little use of existing structures, such as clinical governance or clinical audit teams, this meant that the few local MHIP leads were under great pressure.

In South West London, staff had better skills and this enabled responsibility to be successfully devolved. Good use was made of locally available training resources to build on the existing skills base. Where work was devolved, promising progress was seen. Backfill staffing is critical to this succeeding, but was not often implemented, though identified in local plans. Staff need backfill cover to attend training and to be freed to conduct devolved work.

There may be a paradoxical effect of health policy initiatives that are intended to improve service but are not sufficiently funded or made locally relevant. MHIP was one of many national requirements that took time from managers that might have been spent supporting frontline staff. Diverting MHIP into a local agenda was an effective coping strategy that SWLSG employed to good effect. For sites that did not, the cost and opportunity cost probably outweighed the benefits. Where MHIP did not fit well, the increased demands on staff time and budgets may have (at least temporarily) decreased the quality of the service provided, e.g. managers having less time to support frontline staff, or frontline staff having less time

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to work with patients and associated administrative tasks. Add this to extra demands from multiple policy requirements and it can be seen that policy demands can hurt staff, service users and carers. Policy makers should specify resource requirements and could state the service implications of not meeting these.

The NHS would do well to train and nurture more managers to be skilled in organisational improvement and to ensure that there are cohorts of managers in training. The local MHIP managers were all impressive – not distant policy makers, but staff in touch with real issues and who knew their services well. These managers are a vital resource. With peer-support and expert input they have the potential to make great improvements.

### **7.3.11 NIMHE support valued, but inconsistent**

NIMHE support was valued in all pilot sites but it was inconsistent in a number of cases, with contact time reducing or disappearing over time. RDC Client managers were repeatedly identified as a key source of technical and indeed moral support; they also represented a useful bridge with NIMHE. Managers generally tend to appreciate peer-support and Programme Lead meetings with peers from other sites appear to have been particularly beneficial.

The NIMHE governance framework included the MHIP Steering Group and the MHIP Programme Board. Unfortunately these did not contribute to the programme design. Service user and carer input was not sustained and the Programme Board stopped meeting after one year. Monthly Highlight Reports were provided to the NIMHE Executive Team and the Steering Group. These reports, however, did not lead to action to address the numerous and fundamental problems, e.g. context and readiness, partnership, resource, training, measurement and learning. The Executive Team was presumably ultimately accountable for MHIP.

It may have been more effective for MHIP to focus on providing more staff with skills for organisational improvement work, rather than offering methods. Regular training would be needed as acquiring skills may take many years of learning, practice and reflection. For example, sufficient time was not available for NIMHE service user and carer leads to help train services as much as they would have liked. Staff members also need tools, time and good support.

### **7.3.12 Funding: insufficient and hazily viewed**

In the majority of cases, MHIP funding was significantly less than had been expected by pilot sites. For some, this had a significant impact on their enthusiasm for the programme. More importantly, the lack of funding limited the degree to which work progressed:

- Local MHIP teams had insufficient capacity to drive the programme, e.g. in terms of maintaining local partnerships, supporting personnel and recording progress of the work
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- There was insufficient funding to support implementation of the MHIP programme, such as maintaining partnerships, collecting data, etc. Generally, such activities were to be carried out in addition to personnel's usual responsibilities; MHIP had very few examples of providing "backfill" for frontline staff
- Insufficient resources were dedicated to involving service users, carers and partner organisations, whether in terms of ongoing events or training

Future initiatives must be appropriately funded to support implementation of the work. This funding should be clearly identifiable and dedicated to personnel engaged in the work and their requirements, such as time and training; and it should be tracked over the lifespan of the work.

There was little clarity around the financial resources allocated to MHIP work:

- Only a small number of people had any information about the grant allocated by NIMHE, or money coming in from other sources, and there was rarely any way of tracking how these funds were used;
- Little attention was paid to the "hidden costs" of change. There was no formal recording of the significant amounts of time spent by personnel on engaging in MHIP processes such as training, process mapping and data collection.

These limitations reflect a broader cultural gap around measurement in mental health services. Given that mental health services are already under-funded and these funds are diminishing over time (Lelliott, 2003; Sainsbury's Centre, 2006), it is imperative a culture is developed within mental health services that can better appraise the achievements of initiatives such as MHIP relative to their significant costs.

## **7.4 Outcomes**

### **7.4.1 Low impact of the work**

MHIP had little demonstrable impact on service quality. Work seldom progressed far enough to touch the service user; and, in several cases, it was not planned to do so.

Most impacts of MHIP were in terms of how organisations operate, e.g. changes in structures and improvements in service efficiency. Again, many of the planned changes did not materialise, due to limited capacity and contextual distractions.

Some changes did occur. Unfortunately, however, evaluation and recording of the work was generally poor. Few baseline and ongoing measurements were collected; and reflection and learning were limited. Consequently, any impacts, whether process or clinical outcome, were difficult to demonstrate or quantify. Furthermore, it was generally difficult to identify MHIP's contribution to any progress that was made.

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Future work should incorporate identification and measurement of suitable outcome measures and evaluation. Meaningful measures should address the service user and carer experience as well as clinical outcomes. Examples of this might include numbers of patients in receipt of information about side effects, or numbers of carers offered a carers' assessment. Greater engagement with local supports, such as clinical audit, would represent a significant step forward. Resources need to be provided to support this. Service users and carers, middle managers and frontline staff should be provided suitable skills, e.g. data collection and analysis, and sufficient time to make use of these skills. Such changes in capacity would increase the probability of improvements being made; additionally, it would ensure that these improvements can be evidenced.

#### **7.4.2 Culture change**

Culture change is notoriously difficult to effect and so it was very interesting to see evidence of this in the pilot sites. In Chapter 5, when considering the impacts of MHIP, shifts in attitudes in several domains, were identified. There was an apparent greater recognition of the benefits of involving service users and carers in service improvement work, of working with partner organisations partnership working and of social inclusion more generally. For some people, MHIP was their first experience of being involved in service improvement work.

Culture change did not occur directly as a consequence of MHIP, but rather as a side effect of participation in the workstreams, as well as the influence of other local factors, such as senior championing of issues, or a strong educational drive. In South West London, a project management culture clearly developed. This was due to the consistent promotion of PRINCE 2 training by middle managers and the resulting wide uptake. In South Staffordshire, a culture of service user focus clearly developed. This was due to the consistent promotion of service user involvement by the Chief Executive, himself a service user.

In these cases, culture changed when a work project with an aim other than culture change specifically required organisations to think and act differently. This is consistent with cognitive theory and behavioural theory. More can be learned about culture change in MHIP by considering South West Yorkshire's approach. South West Yorkshire did not adapt MHIP, but true to the pilot, it tested the MHSIF. It was soon paralysed as it struggled to build partnerships and this pilot paid the price of its loyalty to the PID. If improvement work is to have beneficial side-effects, such as culture change, it is almost certainly the case that progress must be made in the work itself. If no progress is made, there is no reason for personnel to think and act differently.

Insisting on the achievement of grand principles may prevent culture change and will require more resource than is usually available. Failure to achieve these grand principles can also be quite a demoralising experience. Skilling staff, providing tools to use on locally selected workstreams is a better idea and an important aspect of the MHIP approach.

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### **7.4.3 Learning opportunities were missed**

Learning from MHIP was limited. This is disappointing, given that MHIP was a pilot programme supported by NIMHE, a body that had education as one of its key characteristics.

Many supportive structures were set in place by the programme. Unfortunately, due to a lack of time, SISTMH and the learning logs in the highlight reports, were not used sufficiently. Only two pilot sites produced MHIP final reports, both of which focused almost exclusively on achievement rather than analysis of how things were achieved. Most personnel within pilot sites had no inkling of what was happening in other pilots.

The most valued learning structure amongst local MHIP personnel was the Programme Lead meeting. NIMHE/CSIP personnel frequently stated that direct communication of this sort is the most effective method of sharing learning. Peer support is not, however, sufficient to protect against organisational turbulence and consequent shifts in personnel. Ideally, this knowledge and expertise should be retained in reports and guidelines; furthermore, these documents need to be disseminated appropriately. This could substantially reduce the likelihood of repeated errors and reinvented wheels. The internal evaluation of MHIP is an example of a useful document of this nature, but it does not appear to have been “pushed” as a product. Timing is also important; the evaluation of IPH was published too late to be of use to those designing or implementing MHIP.

Local managers and organisations such as NIMHE should actively encourage the learning of lessons from improvement work.

Service users and carers, frontline staff and middle managers should be given time to engage in identifying the key learning points from improvement work. These lessons should then be applied to ongoing and new work, locally and nationally.

## **7.5 Conclusions**

This evaluation found that MHIP failed to meet the majority of its objectives and had very little impact on service quality. Quality improvement programmes are, however, complex social interventions and so evaluations should identify mechanisms and contexts rather than simply outcome.

At senior and middle management level, leadership was critical to the progress of MHIP. Senior level championing was a powerful force. Many of the difficulties faced by MHIP reflect the perils of attempting to bring about improvement in unreceptive contexts. MHIP failed to identify and address these. Programmes, projects or policies might focus on promoting organisational stability and stabilising external partnerships.

One major obstacle was that MHIP was managed and directed by those following the political agenda, e.g. civil servants and ministers, rather than one based on addressing (genuine) needs. There was insufficient consultation on the design of MHIP and the groups established to direct and

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manage the work had little or no academic representation, an important expert group.

MHIP did not use a scientific approach. There was no systematic analysis of trusts' support needs and therefore methods could not be chosen to address these. There was no clear theory to guide the work or rationale for selecting the five principles that were promoted. Little attention was paid to measuring baselines and progress or to formal evaluation of the work. Organisational interventions were not selected on the basis of their effectiveness. The selection of pilot sites could only be justified as pragmatic. Learning from MHIP was limited. This is disappointing, given that MHIP was a pilot programme.

MHIP was more successful when applied to existing priorities and located within existing structures. MHIP and the energy around it were successfully exploited by leaders to drive through a local agenda. This is a sensible strategy for policy-weary managers, particularly when the intervention is loosely defined. Sites that did not divert MHIP into a local agenda probably found that the cost and opportunity cost outweighed the benefits.

Future initiatives must be suitably funded to support implementation of the work. This funding should be dedicated to personnel engaged in the work and their requirements, such as time and training. It is imperative mental health services develop a culture that can better appraise the achievements of initiatives such as MHIP relative to their significant costs.

The non-specific MHIP aims and objectives were not helpful. In terms of theory, more emphasis on a systems-based approach and in particular context and readiness for change would have been useful. The authors' findings and experience, however, did not fully support a contextualist position for understanding MHIP. In some cases MHIP was being adapted and exploited to an extreme. It was hard to identify any core model to protect; however, any future evidence-based intervention would do well to state parameters for local adaptation.

Most local MHIP leads were experienced in organisational improvement and were critical to the progress of the work. These managers are a vital resource. With peer-support and expert input they have the potential to make great improvements. A lack of capacity to do the work, however, and little use of existing structures, such as clinical governance or clinical audit teams, meant they were under great pressure. The skills base of others involved in workstreams was often weak and this was not improved by training. It might be more effective to invest in the long term training and development of new cohorts of managers skilled in organisational improvement, rather than simply providing infrequent and ad hoc training to a broad range of staff. Project management training had significant benefits in one pilot. More broadly, PRINCE 2 was excessive, but provided structure and durability to the work.

Despite the centrality of "partnership" to the MHIP programme, there was insufficient consideration of what is required to build partnerships and when they are and are not critical. Mental health trusts dominated some local

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partnerships and communication with partners outside of the trust deteriorated. There was surprisingly little service user or carer involvement in the workstreams and local programmes. This evaluation identified very few useful outcomes for service users and carers and this makes it hard to believe that they were at the centre of the work.

## ***7.6 Recommendations***

### ***National***

- Readiness for change must be appreciated and assessed
- There should be less restructuring, which would provide more organisational stability and stability of partnerships
- Theory, aims, objectives and methods of organisational improvement programmes should be clearly specified
- Project management methods provide some resilience. PRINCE 2 is too formal and excessive. SDO should consider funding work to develop and test a simple project management method for health services
- Improvement initiatives should come with dedicated and tracked budgets operated as separate cost centre accounts within the organisation
- National organisational improvement initiatives should take a scientific approach. At a minimum they should take into account the latest evidence, e.g. from a literature review, be measurement or standards-based and ensure that lessons are learned. Proposals could be subject to academic peer review
- The NHS should invest in training cohorts of managers in organisational improvement to improve capacity for this type of work
- Organisational improvement as a science needs to be advanced and promoted. Consideration should be given to establishing a national collaborating centre for organisational improvement, e.g. along the lines of the NICE Collaborating Centres

### ***Organisational and clinical team***

- Organisational improvement work should be integrated with clinical audit and governance structures
  - Each quality improvement initiative should be evaluated
  - Suitable measures need to be identified and data routinely collected to identify planned and unplanned change
  - Frontline staff, service users and carers should have dedicated time to engage in organisational improvement work
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## 7.7 Future research

- Project management of change initiatives

While PRINCE 2 provided valuable structure and durability, it was excessively bureaucratic and a significant drain on resources. Future work should develop a simpler project management system for health services.

- The active components of organisational interventions

MHIP is a complex intervention with many components. There is a need to understand which of these are critical to the success of an organisational intervention. For example, was MHIP's "spur to action" instrumental in the work's early progress? Is project management as important as project methods? Can cultural change be effected directly, or is it better achieved as a side effect of other work that demands relevant behaviours?

- Partnership working

There exist several examples of MHIP work that foundered because leaders were focusing excessively on forming partnerships, as well as several examples where work progressed effectively in the absence of partnership. Research should identify the type of work and contexts that benefit from partnership versus leadership working.

- Harnessing turbulence

One pilot site made good use of significant contextual difficulties, harnessing them to create a culture that was enthusiastic for change. A greater understanding of how this can be achieved reliably (and when it is optimal to do so) would be extremely useful in guiding other organisations facing similarly challenging situations.

- Building organisational resilience

This study concluded that all pilot sites faced significant organisational changes over the course of MHIP. Such changes are unlikely to halt in the foreseeable future; an important question is how best to develop organisations that can continue to operate and improve in such challenging times. Such research would investigate devolvement of responsibilities and skills and development of a culture of project management.

- Middle management needs

A study to identify the training and support needs of middle managers working in organisational change would be crucial to the development of future training programmes. An evaluation of attempts to improve change skills would then help inform the evolution of this programme.

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# Appendices

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**Addendum**

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The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk).