Evaluation of the Chief Nursing Officer's Review of Mental Health Nursing in England

Report to the Department of Health Policy Research Programme

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The views expressed in this report are those of the authors and do not necessarily represent the views of the Department of Health.

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EXECUTIVE SUMMARY

Background

The Chief Nursing Officer's Review of Mental Health Nursing in England was published in 2006. The Review took evidence from a wide range of people with a stake in mental health nursing and published seventeen recommendations and associated 'making change happen' actions to guide the implementation of the Review in Mental Health Trusts (MHTs) and Higher Education Institutions [Universities] (HEIs). Alongside the Review report, the Department of Health also published a 'self assessment' toolkit for MHTs and '*Best Practice Competencies and Capabilities for Pre-registration Mental Health Nursing Education'* for HEIs. This report presents the findings of a systematic evaluation of the impact of the Review in MHTs and HEIs in England. The study was funded by the Department of Health Policy Research Programme.

Aim

The aim of the research was to evaluate progress towards, and impact of, implementation of the CNO Review recommendations in MHTs and HEIs

Objectives

1. To establish progress and strategies for implementation of recommendations and accompanying guidance
2. To identify facilitators and barriers to implementation
3. To examine the impact of implementation on user/carer experiences, mental health service outcomes, organisational structures, roles, relationships, staff recruitment and satisfaction
4. To explore the relationship between organisational ownership, implementation progress and impact
5. To explore modifications of recommendations for diverse populations e.g. older adults, children, BME groups
6. To highlight areas of good practice and positive outcomes including effective strategies used to facilitate implementation

Methods

The study was conducted in three phases. Phase one was a baseline survey of sixty-eight MHTs and fifty HEIs (offering mental health nursing pre-registration education programmes) in England. Phase two was a series of in-depth, instrumental case studies using semi-structured interviews and focus groups with selected managers, nurses, service users and carers in six MHTs and focus groups with academics, service users, carers, students and clinicians in six HEIs in England. Phase three was a repeat survey of

the MHTS and HEIs sampled in phase one fourteen months following the phase one survey.

<u>Results</u>

Phase 1

Forty-two (63.6%) MHTs and forty (80%) HEIs responded to the phase one survey. The CNO Review stimulated specific activity in all organisations responding to the survey with all having made some progress in the implementation of the recommendations and accompanying suggestions (*'making change happen points'*). Eleven of the recommendations were ranked similarly in terms of priorities by Trusts and HEIs though there were also some differences in priorities between Trusts/HEIs in Recommendation 12 - *Improving inpatient care* - rated as priority 1 by Trusts and priority 13 by HEIs, Recommendation 3 - *Providing evidence-based care* - rated as priority 10 by Trusts and priority 3 by HEIs, Recommendation 12 - *Improving recruitment and retention* - rated as priority 16 by Trusts and priority 9 by HEIs and Recommendation 15 - *Working effectively in multi-disciplinary teams* - rated as priority 11 by Trusts and priority 5 by HEIs.

Whilst all organisations ranked highly the importance of adopting both recommendation 1 (*Applying Recovery Approach values*) and recommendation 5 (*Strengthening relationships with service users and carers*), progress with their implementation was rated low in Trusts and HEIs. In terms of specific implementation activity, 91% of Trusts responding to the survey indicated that implementation of the CNO Review recommendations were either built into overall organisational strategy or had led to the overall Trust strategy being reviewed. Only 9% reported 'little' or 'no' implementation activity. 82% of Trusts had set specific implementation target dates with 58% considering it likely that they would meet overall targets by due dates. 90% of HEIs responding to the survey indicated curricula had been reviewed in response to the CNO Review recommendations and the *'Best Practice Competencies and Capabilities for Pre-registration Mental Health Nursing Education'.* Key aspects of curriculum development activity were focused around '*Increased user involvement in courses' and 'Strengthening partnership working with practice'.* In Trusts the overall lead for implementation was most commonly the Director or Assistant Director of Nursing and within HEIs the lead for implementation was most commonly a lecturer.

'*Organisational engagement'* and *'Staff commitment and motivation'* were seen as common facilitators in responses from Trusts and HEIs. Other facilitators were identified as *'joint working approaches'*, *'harmonization with other national policy initiatives'*, *'performance monitoring'* and *'input from users and carers'.* Common barriers included *'competing priorities'* and *'lack of funding/staffing issues'*.

Phase 2

Among MHTs the Review was considered acceptable but there was little evidence of the recommendations being implemented directly as a result of the Review. However, there was evidence of actions that fitted with most of the 16 Review recommendations that applied to MHTs. However, these appeared to be driven primarily by other policies. The lack of response directly related to the Review in many Trusts was attributed in part to the lack of defined targets linked to the Review, funding, and a lack of external monitoring of implementation of the Review recommendations. Priority was afforded to urgent local crises/events and national targets. In addition, the Review accorded strongly with the current direction of activity as it closely reflected other health and social care policy, and this appeared to give it validity within many Trusts. Many nurses interviewed in Phase 2 reported a lack of awareness of the Review; yet when the researchers introduced them to the Review, they welcomed it and wished they had had previous knowledge of it. There appeared to be a lack of strategic leadership towards implementation of the Review in many of the MHTs sampled in phase 2. Despite this, there were individual champions in some Trusts who were attempting to use the Review for strengthening and galvanising the nursing profession for the benefit of services users and carers. Service user and carer involvement in plans to implement the Review recommendations were negligible.

Most HEIs reported they welcomed and accepted the recommendations of the Review and presented evidence of change, some of which they attributed to the Review recommendations directly, others they stated would have occurred irrespective of the Review. The Review has acted as a catalyst that has driven reviews of pre-registration mental health nursing education. It has provided a useful benchmark that HEIs have used to map current curricula with the recommended competencies and capabilities identified in the Review as best practice in the education of mental health nurses. A notable impact of the Review in many HEIs was the re-focus of curricula to put recovery at the forefront of educational approaches and to increase the involvement of service users, and to lesser degrees carers, in most aspects of educational activity. Implementation of the Review recommendations in HEIs was helped by a strong commitment among academic staff, and strong partnership working between academics, clinicians, service users and, to some degree, students. These activities helped HEIs make steady progress towards addressing Recommendation 14 of the Review; strengthening pre-registration education. Implementation of the Review recommendations presented several challenges to HEIs, the most notable of which was persuading non-mental health academic colleagues of the value of the Review. Despite the positive response to the Review recommendations among most HEIs, there were several barriers that occasionally blocked attempts to follow through with implementation. Where a recommendation was not implemented, participants were able to give an account of how they had considered the recommendation and their reasons for choosing not to implement it. This was largely as a result of the team being critical of the values that underpinned it.

Phase3
There was a reduction in the response rates in phase 3; 37 (55%) MHTs, 27 (54%) HEIs completed the follow-up survey compared with 42 (63%) MHTs and 40 (80%) HEIs that completed the phase one survey. Recommendation 1 - applying recovery approach values – was ranked as less important at phase 3 to MHTs, (dropping from rank 3 to 7); recommendation 5 – strengthening relationships with service users and carers became the highest ranked priority for Trusts. In terms of progress on implementing recommendations, MHTs reported making most progress with recommendation 5 (ranked 1 at phase 2), but little progress on recommendation 1 (ranked 16). In 9 out of 16 recommendations, MHTs reported making positive progress. The most progress reported by MHTs was implementing Recommendation 8 – providing psychological therapies; the least progress was implementing recommendation 10 – recognising spiritual needs. In HEIs, recommendation 3 – promoting evidence-based care was rated as the highest priority, shifting 2 places by phase 2; recommendation 1 was the least ranked priority by phase 3, a drop of 14 places in terms of priority ranking. The major change HEIs reported in phase 3 was increased service user involvement in curricula; the involvement of other stakeholders such as clinicians also improved.

Conclusions

Implementation of the CNO Review of mental health nursing in England varies. In MHTs there is evidence of acceptance of the Review and some evidence of subsequent actions to implement the Review recommendations, but these are not widespread and there was little reported evidence that changes were directly attributable to the Review. Implementation of the Review recommendations appears to be hampered by an overall lack of an evidence-based implementation plan at both the national and local level. A lack of strategic nursing leadership in some MHTs appeared to be associated with a lack of implementation as the Review appeared to be subjugated by competing Trust priorities and a lack of awareness of it among mental health nurses. Whilst many MHTs reported making progress towards implementation of the Review recommendations when surveyed, detailed case studies with selected Trusts did not always support this finding. In HEIs there are many examples of the Review steering revision of mental health nursing education curricula, most notably in shifting the focus of education towards recovery approaches, as evidenced in phase 2, and working in partnership with service users, carers and other stakeholders in many, if not all, aspects of education, as evidenced in all phases.

Recommendations

In light of the findings of this evaluation of the CNO review of mental health nursing, the researchers make the following recommendations.

1. Mental Health Trusts and Higher Education Institutions adopt a systematic and evidence-based approach to implement the Review recommendations. Such an

approach is likely to include: ensuring that all nurses are aware of the Review, conducting a baseline assessment of existing practice, assignment of a dedicated lead for implementation and financial resources to assist implementation, development of an action plan to steer implementation, dissemination and implementation of the plan, and ongoing monitoring, audit and review of progress.

2. Mental Health Trusts incorporate the Review recommendations in their business plans and ensure regular review at Board level

3. Mental Health Trusts map the Review recommendations against other policies they are pursuing

4. The Department of Health publishes a Review Implementation Guide along the lines of the 2001 Mental Health Policy Implementation Guide to assist Mental Health Trusts implement the Review

5. The Department of Health considers setting up an English National Implementation Group (ENIG) with Local Implementation Groups in each SHA to report annually to the ENIG on progress towards implementation of Review recommendations. The LIGs can also provide guidance and assistance to Trusts and HEIs on implementing the Review recommendations.

6. The Care Quality Commission and Monitor considers progress in Trusts' implementation of the Review recommendations as part of its annual assessments of Trusts

7. Mental Health Trusts identify a lead mental health service user and carer to lead the user and carer involvement in the Review recommendations. This is best done by contacting organisations who demonstrate best practice and can provide training and support these leads.

8. Mental Health Trusts and Higher Education Institutions involve Mental health service user and carer *groups* in the strategic implementation of the Review recommendations.

9. The National Institute of Health Research considers funding a programme of research designed to investigate the impact of interventions to implement the Review recommendations

10. The CNO requests a annual report from Directors of Nursing and Heads of Academic Divisions in Universities on progress towards implementation of the Review recommendations

11. The DH sponsors an annual conference in which examples of good practice towards implementation of the Review recommendations can be diffused

12. The Nursing and Midwifery Council and the DH incorporate HEIs' progress towards implementation of the Review recommendations in their quality assessments of pre-registration mental health nursing education.

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CHAPTER 1: BACKGROUND, AIMS AND OBJECTIVES OF THE STUDY

Background

1.1. Mental health problems and disorders account for 13% of the burden of disease across the world, and in high income countries, the estimate increases to 23% with such problems and disorders being the most common cause of disability and premature death (World Health Organisation [WHO], 2004). Since the publication of '*Mental Health: New Understanding, New Hope*' (WHO, 2001a) there have been concerted efforts internationally to promote mental health, reduce the burden of mental health problems and increase the social inclusion of people living with such problems (WHO, 2001b). In the UK, since the 1999 National Service Framework (NSF) for Mental Health (Department of Health [DH], 1999) and other National Service Frameworks (DH, 2001, DH/Department for Education and Skills [DfES], 2004), mental health has become one of the Government's national health priorities (DH, 2004; DH, 2006). Within UK NHS mental health services, mental health nurses (MHNs) make up the largest proportion of the professional workforce, making them pivotal to the delivery of the National Service Framework (NSF). Mental Health Nursing takes place in an increasingly wide variety of practice contexts and rapid developments in mental health and social care policy, research and service delivery within the last 10 years, have significantly impacted upon the work of MHNs.

1.2. There has been an increased emphasis on partnership working with service users and carers (NHS Executive, 2000), the patient choice agenda is now central to service and care delivery (Care Services Improvement Partnership [CSIP]/National Institute of Mental Health in England [NIMHE], 2005), and new roles, new ways of working and new types of services have proliferated DH, 2003a, DH, 2003b; DH, 2003c; DH, 2005). Staffing challenges within mental health services, together with further opportunities to extend nursing roles raise important issues as to the most effective use of the resource of MHNs (DH, 2006a; Sainsbury Centre for Mental Health [SCMH], 2005).

1.3. Developments in the evidence base for practice and the increased availability of good practice and clinical effectiveness guidelines require MHNs to learn new knowledge and skills and adapt their practice accordingly (National Institute for Health and Clinical Excellence [NICE], 2003; NICE, 2004a; NICE, 2004b; NICE, 2004c; NICE, 2005a; NICE2005b; DH, 2002; DH, 2004a).

1.4. Recent legislative changes in the UK as a whole, and England in particular, including the Disability Discrimination Acts (Department for Work and Pensions [DWP], 1994; DWP, 2004), Human Rights Act (Department for Constitutional Affairs [DCA], 1998), Race Relations (Amendment) Act (DWP, 2003), Mental Capacity Act (DCA, 2005), and the revised Mental Health Act (DH, 2007), impacted MHN practice, with more legal and statutory duties. Equally important is the changing multi-cultural context of practice and the need for culturally sensitive services responsive to the needs of diverse populations [(DH, 2005a). Regarding the educational preparation of MHNs to respond to the many

challenges and opportunities, and despite recent changes, current pre-registration programmes are arguably still not preparing MHNs with the essential knowledge and skills needed to practice in current and future contexts (Jones & Lowe, 2003; DH, 2004c; Musslewhite & Freshwater, 2005; DH, 2006b; Bee et al., 2008).

1.5. As a result, the UK Nursing and Midwifery Council (NMC) announced in 2008 a review of pre-registration education for nurses. Following this review, the NMC announced that by 2015, a new pre-registration education framework will be in place. The minimum exit qualification of this programme will be a degree, current branches will be replaced with fields of practice in adult, mental health, learning disability and child health nursing, and the practice/academic components of the programme will remain at 50%.

1.6. To keep pace with and respond to this rapidly changing health care environment, MHNs must reflect upon their roles, and the values, attitudes and knowledge that underpin their practice. In April 2005, the Chief Nursing Officer (CNO) for England announced a major review of mental health nursing and the final report in 2006 [DH, 2006a] made recommendations for current and future practice and education. This was followed by subsequent publication of good practice guidance for pre-registration MHN education [DH, 2006b] and a 'self assessment tool-kit' for MHTs to assess progress [DH, 2006c].

The CNO Review of Mental Health Nursing in England

1.7. The final report of the CNO Review made recommendations for current and future practice and education. Promoting the recovery of people using mental health services is at the core of the CNO recommendations. A similar review was conducted in Scotland and reported in 2006 (Scottish Executive, 2006). Like the English review, it also has recovery at its heart. Despite some of the differences in health and social care policy and health outcomes for people using services in both countries, the reviews of mental health nursing cover similar ground in their focus on recovery, developing capabilities for the mental health nursing workforce, preparing students with the best education for practice and highlighting the importance of leadership and support.

1.8. Much has changed since the last (UK wide) review of mental health nursing in 1994; there are devolved Governments in the different countries of the UK, mental health sits near the top of the health care agenda, a National Service Framework set standards for the delivery of care, a Care Quality Commission monitors how services are meeting these standards, Nurse Consultants have appeared as National Director of Mental Health, revised Mental Health Acts and greater integration of Health and Social Care. The term SUI, or Serious Untoward Incident, has entered the lexicon of mental health. Service users and carers are, in theory, at the heart of care. Mental health nurses are now prescribing medication, working with colleagues who are also service users, and there is finally a drive to address diversity issues in service delivery. These

reviews took place in the context of work on new roles for new and existing professionals and planned reviews of nursing education by the NMC.

1.9. With the announcement of yet another Government review, it might reasonably be asked whether such reviews really change anything. The evidence following the recommendations of the 1994 review suggests that they can lead to changes: shifting the focus of mental health services to people with so-called severe and enduring mental illness, championing new PSI – Psycho-Social Intervention - roles for nurses, increasing the number of liaison mental health services in Emergency Departments, working in partnership with service users, user choice, education and service providers working in partnership in the delivery of nursing education, and the accreditation of prior learning for entry to pre-registration programmes. Whatever the level of agreement with these recommendations at the time, these issues are now part of mainstream mental health and seem, 15 years on, almost routine.

1.10. The 2006 reviews of mental health nursing in England and Scotland involved the formation of expert advisory groups that included service users, carers, students, clinicians, academics, the NMC, managers, and representatives from professional organisations. The CNO review of mental health nursing in England made 17 recommendations under three headings and these are shown in table 1

Table 1: Recommendations from the CNO Review of Mental Health Nursing in England

Category	Recommendation No.	Recommendation
Putting values into practice	1	The key principles and values of the Recovery Approach will inform mental health nursing practice in all areas of care and inform service structures, individual practice and educational preparation.
	2	MHNs will promote equitable care for all groups and individuals.
	3	All MHNs will access, understand and use evidence that can improve outcomes for service users.
Improving outcomes for service users	4	For MHNs to principally work directly with service users with higher levels of need and support other workers in meeting less complex needs.
	5	All MHNs will be able to form strong therapeutic relationships with service users and carers.
	6	All MHNs will be able to comprehensively assess and respond to service users' individual needs and identified risks.
	7	MHNs will have the skills and opportunities to improve the physical wellbeing of people with mental health problems.
	8	MHNs will contribute to an increase in the availability of evidence-based psychological therapies.
	9	For MHNs to increase the social inclusion of people with mental health problems.
	10	All MHNs to recognise and respond to the spiritual and religious needs of service users.
	11	MHNs in all settings will be able to respond to the needs of people with mental health and substance misuse problems.
A positive, modern profession	12	All individuals receiving inpatient care will receive a service that is safe, supportive and able to respond to individual needs.
	13	MHNs will improve care by developing new roles in response to local need.
	14	Nurse pre-registration education will prepare MHNs to provide effective and values-based care.
	15	All MHNs will contribute effectively to multi-disciplinary teams.
	16	All MHNs will continue to develop skills and knowledge throughout their careers.
	17	Processes, roles and systems will improve the recruitment and retention of MHNs.

1.11. Each of the recommendations was accompanied by *Making Change Happen* suggestions designed to provide more specific guidance for MHTs and HEIs to implement the recommendations.

Responses to the CNO Review of Mental Health Nursing in England

1.12. The responses to the announcement by the Chief Nursing Officer of the Review in England were mixed; an article in the Guardian newspaper (Callaghan, 2005) welcomed the review; a letter in the same outlet by Barker challenged the independence of the Review. In the *Nursing Standard* Rogers (2005), representing the Mental Health Nursing Association, welcomed the timing of the review as he hoped it would help mental health nurses address some of the challenges they had never before confronted.

1.13. When the Review report was published, it stimulated debate in the mental health nursing community. Brooker (2007), whilst acknowledging the ambitions and aspirations of the Review, argued that it was weak on implementation ideas, and failed to integrate its commissioned evidence-based literature into the Review. Brimblecombe and Tingle (2007) challenged Brooker's assertions and highlighted the positive response to the review across the mental health nursing community, whilst acknowledging the challenges of implementing the Review recommendations. Arthur (2007) considered the Review report in light of his experiences of working in education in South East Asia and the Pacific Rim, examining the state of mental health nursing in these areas and what, if anything, the Review in England could offer mental health nurses in this region. He concluded that the Review provided a set of recommendations that could 'translate into guidelines for research, education and clinical innovation' (p.332) and hoped that mental health nurses in this region would implement the recommendations. McBride's (2007) view from the USA, suggests that mental health nurses there are grappling with many of the issues raised in the CNO Review in England.

Best practice competencies and capabilities for pre-registration mental health nursing education

1.14. The best practice competencies and capabilities for pre-registration mental health nursing education developed following extensive consultation with mental health nurses in practice, mental health nurse academics, researchers, managers, service users, carers and students. They were mapped against previous work by the NMC in setting learning outcomes for pre-registration nursing programmes, the Essential Shared Capabilities for mental health practice, and the National Occupational Standards for Mental Health, published by the Department of Health in England, and competencies for mental health practice, developed by *Skills for Health.* If mental health nursing students have acquired the best practice competencies and capabilities by the time they graduate, they should be fit for practice as Registered Nurses. The three categories of best practice competencies and capabilities mental health nursing students require at the point of registration as reported in the CNO Review of Mental Health Nursing in England are shown in Box 1. The detailed knowledge and performance criteria for each of the competencies, and the respective NMC learning outcomes to which they refer, are shown in the original report

(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4135647).

Box 1: Best practice competencies and capabilities for pre-registration mental health nursing education (DH, 2006b)

Putting values into practice

Values

Promote a culture that values and respects the diversity of individuals, and enables their recovery.

Improving outcomes for service users

Communication

Use a range of communication skills to establish, maintain and manage relationships with individuals who have mental health problems, their carers and key people involved in their care.

Physical care

Promote physical health and well-being for people with mental health problems.

Psychosocial care

Promote mental health and well-being, enabling people to recover from debilitating mental health experiences and/or achieve their full potential, supporting them to develop and maintain social networks and relationships.

Risk and risk management

Work with individuals with mental health needs in order to maintain health, safety and well-being.

A positive, modern profession

Multidisciplinary and multi-agency working
Work collaboratively with other disciplines and agencies to support individuals to develop and maintain social networks and relationships.

Personal and professional development

Demonstrate a commitment to the need for continuing professional development and personal supervision activities, in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.

1.15. Prior to this Review, the last major review of mental health nursing took place in 1994 [DH, 1994] and whilst there is some evidence that the recommendations made then were linked to subsequent changes in practice, the lack of a systematic and rigorous evaluation of progress towards implementation meant that observed changes in practice tended to be impressionistic and anecdotal. Following the publication of the CNO's 2006 Review, it was recommended that there should be a formal evaluation of progress towards, and impact of, the recommendations in practice and education, hence the study reported here.

Aims and objectives of study

1.16. *Aim*

To evaluate progress towards and impact of implementation of THE CNO review recommendations in MHTs and HEIs

1.17. *Objectives*

1. To establish progress and strategies for implementation of recommendations and accompanying guidance
2. To identify facilitators and barriers to implementation
3. To examine the impact of implementation on user/carer experiences, outcomes of mental health, organisational structures, roles, relationships, staff recruitment and satisfaction
4. To explore the relationship between organisational ownership, implementation progress and impact
5. To explore modifications of recommendations for diverse populations e.g. older adults, children, BME groups
6. To highlight areas of good practice and positive outcomes including effective strategies used to facilitate implementation.

CHAPTER 2: STUDY METHODS

Design

2.1. The study was guided by a partnership philosophy in which all those involved played an active role, including service users and carers (Rodwell, 1998]. A multi-phase, multi-method approach was used to explore the various approaches taken in the implementation of the recommendations of the CNO review at different levels, by different personnel, in different departments/units, with different populations and in various organisations. This is an approach that has been used successfully by the researchers before when exploring complex phenomena in real world settings (Repper et al, 2008).

2.2. The study was conducted in three phases. Phase one was a baseline survey of MHTs and HEIs (offering MHN branch programmes) in England. Phase two was a series of in-depth, instrumental case studies (Yin, 1994) of selected MHTs and focus groups with HEIs in England. Phase three was a repeat survey of the MHTS and HEIs fourteen months following the phase one survey.

Phase 1 – Survey of Mental Health Trusts and Higher Education Institutions

Objectives

2.3. The survey aimed to gather a National picture of implementation progress of each of the CNO Review recommendations in all relevant Trusts and HEIs in England. The specific objectives of this phase were to establish:

- importance of the each recommendation, in terms of rated priorities
- implementation progress for each recommendation (including specific strategies in place, dates for completion and anticipated likelihood of achievement by target dates)
- perceived facilitators and barriers to implementation of the recommendations influencing progress both to date and in the future
- successful and less successful Trust and HEI implementers, providing a sampling frame for selection for in-depth case studies in phase two of the study

Data collection method

2.4. A structured, web-based, secure electronic survey accessed by e-mailed web link was used as the data collection tool (see appendices 4 & 5). The survey comprised Likert rating scales and some open ended questions. For Trusts, questions required respondents to rate priorities for and progress towards implementation of each of the recommendations and *'making change happen'* points. This was broadly based on the self assessment toolkit format previously developed by the Department of Health (2006b). The questions for HEIs required respondents to rate priorities for and progress

towards implementation of the specific recommendations for HEIs and subsequently published *'Good practice guidance for pre-registration mental health nursing education'* (Department of Health 2006c). In addition, open ended questions required respondents to identify perceived levels of organisational priority/ownership for overall implementation and for each recommendation whether specific implementation strategies and dates for completion were in place and the anticipated likelihood of achievement by the target date. Respondents were also asked to identify three key facilitators and barriers to implementation.

Sample

2.5. All (n=68) Trusts delivering mental health services in England were identified from the Department of Health and Health Care Commission databases. All (n=50) HEIs offering pre-registration mental health nursing courses in England were identified from the Nursing and Midwifery Admissions Service (NMAS) and University and College Admissions Service (UCAS) databases.

Recruitment

2.6. In order to ensure appropriate targeting of the survey and maximise response rates, key organisations – the Nurse Directors Forum and Mental Health Nurse Academics UK - were contacted to identify contact details for current Directors of Mental Health Nursing or organisational equivalents for each Trust and Programme Leaders for Mental Health Nursing programmes in each HEI.

Data analysis

2.7. Data from the returned e-survey instruments were stored on a secure web server and directly exported into Excel from the e-survey. The quantitative data were coded and descriptive statistics applied. Data from open-ended questions were collated and analysed using thematic content analysis (Burnard 1991) in NVivo a computer programme for the analysis of qualitative data (QSR International Pty Ltd 2007). Key themes were then checked and verified independently by individual members of the research team.

Phase 2 –Focus Groups in HEIs and Instrumental case studies in MHTs

Higher Education Institutes

Objectives

2.8. The aim of the focus groups was to explore how HEIs were responding to Recommendation 14 of the CNO review and their use of *Best Practice Capabilities and*

Competencies for Pre-registration Mental Health Nursing Education. The focus groups were guided by the following objectives.

1. To investigate knowledge of the CNO Review
2. To explore how the HEI had responded to the Review
3. To examine views about Recommendation 14
4. To identify the level of involvement of staff, students and others - service users, carers, clinicians - in prioritising, disseminating or implementing the review's recommendation in that HEI
5. To investigate changes introduced as a result of the Review
6. To examine the impact of these changes for staff, students and others
7. To explore what hindered and helped implementation of the Review Recommendations

Sample

2.9. The researchers sampled six HEIs, selected purposively based on their reported level of implementation of the CNO review recommendations in the phase 1 survey. Following analysis of the phase 1 data, the researchers ranked each HEI according to their reported level of implementation of the review recommendations. We selected the HEIs we ranked as the top three implementers, and those we ranked as the bottom three implementers. This selection matrix allowed us to compare facilitators and barriers to the review recommendations between 'high' and 'low' implementers.

Methods

2.10. The researchers emailed the contact person in each selected HEI from the information gathered from phase 1. In this email the researchers invited them, on the basis of their responses to phase 1, to participate in phase 2. We stated the objectives of phase 2 as they pertained to HEIs (see above). If we had not heard from each HEI following one week after the initial email, we sent a reminder email. We telephoned those who had not responded to the reminder email (n=1) after one week and left a message inviting a return call or email to the researchers. When after one month following the initial email we had no response from this HEI, we selected another HEI who was next on our ranked list. Once the researchers had recruited all six HEIs, a date was agreed between the researchers and each HEI to conduct the focus groups. Each focus group was conducted at the HEI. The focus groups were conducted between June and September 2008. The researchers developed a topic guide based on the objectives of the focus groups (see box 2). Each focus group was conducted by an experienced researcher; one of the focus groups was conducted by two researchers to help ensure consistency in the topics discussed and the data collected for future groups.

Box 2 Topic Guide for HEI Focus Groups

What do you know about the Mental Health Nursing Review and how do you know about it?

How has this team responded to the CNO Review?

What are your views about the Review Recommendation in relation to Higher Education?

How have staff, students and others, e.g. service users and/or carers been involved in prioritising, disseminating or implementing the review's recommendation in this University?

Tell us about changes introduced as a result of the Review?

What has been the impact of these changes for staff, students and others?

What do you think has hindered implementation of the CNO Recommendations?

What do you think has helped implementation of Recommendations?

Data analysis

2.11. The researchers adopted a template approach to the data analysis of the HEI focus groups. This approach is suited as we had *a priori* predetermined issues that we wished to explore during the focus groups with the participants (see box 2) and these formed the template to guide the discussion, engineered to address the objectives of this part of the study. This template guided the analysis of the collected data. The template approach is suited to the analysis of a range of qualitative data, whether collected by focus group, interviews or observations (Robson, 2001). In line with the template approach, the facilitator of each focus group used the same template to guide the discussion. Following digital recording of each focus group, transcripts were produced by an independent transcriber. The two researchers who conducted the focus groups read each transcript independently – a process of familiarisation with the data – and identified those areas of the transcript relevant to the agreed template and attached a code to the section identified. Following this, the researchers met to discuss the attached codes, and grouped the codes into agreed themes, and sub-categories of each theme. To address issues of credibility – sometimes referred to as reliability and validity - in the data collected we adopted several quality checks on the data. First, the two researchers independently read and coded the data before agreeing the codes and themes. Second, the researchers presented the findings to an 'external' panel in the form of the project steering group who acted as independent experts able to critique constructively, the findings.

2.12. *Mental Health Trusts –Case studies*

Objectives

[1] To explore facilitators and barriers to implementation
[2] To examine the impact of implementation on user/carer experiences, outcomes of mental health service outcomes, organisational structures, roles, relationships, staff recruitment and satisfaction;
[3] To explore the relationship between organisational ownership, implementation progress and impact
[4] To explore modifications of recommendations for diverse populations e.g. older adults, children, BME groups

Methods

2.13. This second phase of the study comprised a series of in-depth instrumental case studies (Stake 1995) based on Primary Care, Mental Health and Partnership Health and Social Care Trusts providing mental health services. The case studies were both organisational (Eisenhardt 1988, Mintzberg et al 1998), describing diverse approaches and processes for the implementation of the CNO Review recommendations, and theory-developing, using a framework approach to data collection and analysis (Ritchie and Spencer, 2002) to attempt to identify key components of successful implementation strategies and the wider organisational features that support such processes.

2.14. Case studies do not promote generalisability per se (Eisenhardt 1988), but instrumental case studies (Stake 1995) generate insights which can be 'transferred' or 'recontextualised' (Morse 1994) to other contexts and settings. It is just such insights that are required to identify common or shared principles, which nevertheless are sufficiently flexible and sensitive to promote an individual assessment of need. In this study, the potential for recontextualisation was enhanced by purposive sampling of diverse cases (Trusts). The use of a transparent and rigorous analytic approach to identify patterns and relationships, develop and test theoretical insights; within-case analyses to produce rich descriptions of individual cases and generate and, cross-case analyses to compare cases, and to develop and test hypotheses about relationships, processes and consequences (Sandelowski, 2002). Throughout the report, selected Trusts are not identified by name; however, to establish the distinct characteristics of each organisation, Trusts have been allocated a letter of the alphabet from A - F. Finally, Trusts were selected for inclusion in the study, depending on their implementation score at baseline (three relatively high and three relatively low implementers).

Data collection

2.15. Case study visits were arranged over 2-3 consecutive days with a team of 3-4 researchers including a carer researcher and a service user researcher. One researcher arranged the visits and ensured that interviews were organised with a mixed sample of people in the Trusts involved or affected by the Review.

2.16. The consistency and depth of understanding of organisational processes is enhanced by a reference to a wide range of sources and types of data (Stake, 1995). In each Trust, a snowball approach – further participants were suggested by the initial interviewees - was taken to identify the most appropriate personnel to interview always starting with the Lead Nurse. Relevant sources of documentary evidence were identified during interviews. Thus, multiple sources and types of data were included:

1. written/published policy documents (local and national) and local records of meetings, conferences, audits, and reports;
2. interviews with staff working at various levels within the organisation from Executive Directors to team leaders and front line workers;
3. interviews with staff working in related organisations (voluntary and/or private sector, education);
4. interviews and/or focus groups with people using the service
5. interviews and/or focus groups and family members ('carers').

2.17. All interviewees who participated in the in-depth case studies were guaranteed anonymity; therefore, the quotes below are not attributed to any individual. On occasion, and only, when it is relevant is an interviewee's status, role or job title accompanies a quote.

Table 2: Sample of Interviewees in Phase 2

Trust	Director/Assistant Director Nursing, Chief Executive	Nurse Consultant, Modern Matron or Head MHN	Ward, Team or Unit Manager	Specialist Practitioner, Clinical Governance	Service User	Carer	Staff Nurse
A	3	2	2	0	3	0	0
B	2	0	2	1	2	3	1
C	2	1	5	0	2	2	1
D	2	0	2	3	2	1	0
E	2	3	2	4	1	2	0
F	1	3	2	1	2	1	0
Total	12	9	15	9	12	9	2

2.18. Topic guides (one for use with people using the services and their family members, one for staff members) were developed by the whole team as a template for interviews and to ensure that all relevant areas were covered. Consistent with the Framework approach, these specifically reflected the aims of the study and the content

of the review. The main aim was to identify how the Trust responded to the publication of the CNO Review and what impact this had on local policies, procedures and practice.

2.19. These guides developed iteratively as the study progressed, with new questions added to reflect new issues and ideas raised by respondents and to test out developing hunches or ' theories' considered by the research team. It proved necessary to use these guides flexibly due to respondents' different roles, levels of understanding, and type of involvement with the Review. Where appropriate, issues were explored in depth or omitted from interviews (see Boxes 3 and 4 – interview topic guides).

Box 3. Topic Guide for Interviews/Focus Groups with Service Users and Carers

What do you know about the Mental Health Nursing Review?

- How do you know about it?
- What are your views about the Review Recommendations?
- Have service users and/or carers been involved in
    - prioritising,
    - disseminating, or
    - implementing the review in this organisation?
- Are you aware of changes in practice introduced because of the Review?
- Have these had any impact on your experience of using services/caring for someone using services?
- If so, what? how?
- What do you think has hindered implementation of Recommendations?
- What do you think has helped implementation of Recommendations?

Box 4. Topic Guide for Interviews with Service Providers

- What is your role?
- Have you heard of CNO Review?
- Are you aware of Trust Strategy in relation to Review?
- Have you received any briefings or attended any meetings relating to the Review?
- Do you know who has responsibility for the Review in the Trust?
- Do you know what the main priorities are, in terms of the 17 recommendations?
- How are these implementations being implemented?
- What if any, are the difficulties implementing these recommendations?
- How are these difficulties being overcome?
- What difference do you think the Review has made to nursing practice in your ward/area/Trust generally?
- Do staff/service users report or discuss changes in practice because of the Review?

2.20. The researchers also attended the first interview in every Trust and where possible this was a full and comprehensive interview with the Lead Nurse in which all researchers asked questions reflecting their own perspectives and areas of particular interest (service users asking about user involvement and impact, carers about carer involvement and views etc). This gave a shared understanding of the Trusts' response to the Review, and some grounding in the structures of the Trust and who held various responsibilities in relation to the Review.

2.21. The collaborative approach to the study is described above. Since previous research suggests that people who use services may be more willing to speak freely when interviewed by other people who have experience of using services, all service user interviews were conducted by the service user interviewer (with or without other member(s) of the team. Carer interviews were undertaken by the carer interviewer (again with and without other member(s) of the team).

Data Analysis

2.22. Analysis of the Trust data were continuous, starting with a group researcher meeting for reflection following each Trust visit to identify key themes and issues arising, and areas for follow up on subsequent visits and/or in subsequent case studies. This began the familiarisation process described by Ritchie and Spencer as the first part of the Framework approach to data analysis.

2.23. Four researchers - two academics, one service user researcher and one carer researcher - were involved in data analysis to ensure that the bias and/or *a priori* assumptions of any one researcher did not influence interpretation of the data. This resulted in the identification of three overarching themes: Trusts' responses to the review, impact of the Review recommendations upon service users and carers, and the implementation of specific recommendations. In each of these themes, sub-themes and categories were identified and a preliminary 'coding framework' developed (see table 3).

Table 3: Preliminary coding Framework developed through 'Familiarisation' with the data

<table>
<tr><th colspan="3">CNO Review of Mental Health Nursing</th></tr>
<tr><th>Trusts' Strategic Response</th><th>Impact on Service users and Carers</th><th>Implementation of Recommendations</th></tr>
<tr><td>Nature of Response</td><td>Knowledge of Review</td><td>Consistency of 'story' among respondents</td></tr>
<tr><td rowspan="5">Influences on Response:

- National Context
Other Policy imperatives

- Local Context
Structural changes
Competing Priorities
Resources

- Leadership</td><td>Involvement in Trust/ Review
- Factors effecting levels of involvement</td><td>How areas of work are prioritised?</td></tr>
<tr><td>Perceptions of changes resulting from review</td><td>Who is responsible for what?</td></tr>
<tr><td>Differences between service users and carers (? Treat separately)</td><td>Any monitoring/audit?

Any Board overview?</td></tr>
<tr><td rowspan="2">Feelings about involvement more generally</td><td>Workforce implications
Training
Recruitment & Retention
Support</td></tr>
<tr><td>Implementation of
-Recovery
-Equality
-Evidence based Practice
-Other Recommendations</td></tr>
</table>

2.24. This preliminary coding framework was further developed through a process of researchers' individually coding data for several randomly selected interviews and meeting together to discuss and develop a final 'index' that could be used to code the data systematically for each Trust. During the coding process, the index was modified as categories were amended, added to or collapsed.

2.25. These data was then 'charted' on a Trust-by-Trust basis (within Trust analysis). Tables were constructed to summarise the meaning of each theme and category for each Trust and specific references, quotations and examples were chosen to illustrate the themes and categories In addition, a descriptive report was compiled for each Trust to ensure that background information and local situation (needs, socio-demographic characteristics of the population, and specific features of the service) were considered.

Box 5. Final Index used to code all Data

1. Trusts Strategic Response

1.1 Approach to Implementation

1.1.1 Board Level Involvement

1.1.2 Consultation

1.1.3 Dissemination

1.1.4 Senior Nurses Forum

1.1.5 Dedicated Strategy Group

1.2 Influences on Response to Review

1.2.1 Local Factors - Involvement in development of Review

-Local 'crises; (Serious untoward incidents, critical reports etc)

- Nurse Leadership

1.2.2 National Factors – Parallel/Competing policy priorities

1.2.3 Nature of the Review – Recommended rather than required

- No linked funding,
- Consistent with recommendations of other policies
- Possibly contradicts NMC position on MH nursing

2. Implementation of Recommendations

2.1 Putting Values into Practice

- Recovery
- Equality
- Evidence Based Practice

2.2 Improving Service User Outcomes

2.3 Positive, Modern Profession

3. Impact on Service Users' and Carers' experience

2.26. This highly specific and replicable process was useful in familiarising the research team with the data and it provided a transparent account of each Trust, but it did not reflect the complexity of issues and relationships between issues and processes that became apparent as the data from subsequent Trusts were studied. Analysis proceeded through a series of meetings with additional reading, coding and analysis completed by all researchers between the meetings. In each meeting, a number of patterns emerged which were tested in subsequent cases and gradually illuminated factors influencing the manner in which the Review was treated within Trusts, and showed certain processes that either helped or hindered implementation of recommendations. Thus, far from a descriptive or chronological list of events occurring in each Trust, the cross case analysis gave rise to a more complex picture in each of the three main areas of analysis: Trusts' responses to the Review; Impact on service users and their family members Implementation of Specific Recommendations. The results of this cross-case analysis form the findings presented in Chapter five.

Phase 3 – Repeat survey of MHTs and HEIs sampled in Phase 1

2.27. The aim of Phase 3 of the study was to evaluate progress towards and the impact of the implementation of the CNO review recommendations in Trusts who deliver mental health services and Higher Education Institutions (HEIs) who deliver pre-registration mental health nursing in England and compare with the findings of the phase one survey. The follow-up survey was conducted fourteen months after the phase survey.

2.28. *Objectives*

[1] To establish a national picture of the implementation of recommendations in both Trusts and HEIs

[2] To examine key facilitators and barriers to implementation of the recommendations

[3] To identify Trusts and HEIs who have most and least successfully implemented the recommendations

[4] To explore the continued impact of the CNO recommendations after the phase one survey, and three years following publication of the CNO report.

2.29. Methods

The researchers used the same methods of sampling, data collection and analysis in phases one and three.

ETHICAL ISSUES

2.30. The Department of Health Research Governance Framework [RGF] (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962) guided the ethical conduct of the study. The Nottingham Research Ethics Committee granted ethical approval for Phase 2 on 14th February 2008 (REC ref.07/H0408/170); the Committee judged that Phases 1 and 3 did not require its ethics approval. The University of Manchester Research Ethics Committee granted ethics

approval for Phases 1 and 3 (REC ref. 07/1014/NMSW). In line with the RGF we were granted research governance approval to conduct the study in each of the selected MHTs over a period of 14 months. In phases 1 and 3, the researchers gave each HEI and MHT written information about the study and considered the return of a completed survey as an expression of consent. In phase 2, the researchers provided written information and received written informed consent from each participant in MHTs and HEIs.

PROJECT MANAGEMENT

2.31. The researchers appointed a Project Steering Group (PSG) to advise and assist the project team throughout the study. The PSG was chaired by the Principal Investigator and comprised all members of the project team in addition to a representative of the Royal College of Nursing, the Department of Health, the Mental Health Nurse Directors Forum, Mental Health Nurse Academics UK, the Association of Nurse Consultants in Mental Health, the Equality and Diversity Advisor of the East Midlands Care Services Improvement Partnership (now the East Midlands Mental Health Development Centre), and a qualitative research advisor from the Trent Research Development Support Unit. The Steering Group met Bi-monthly throughout the project. On the 16th May 2008, The Mental Health Research Network approved the study to run on the network thus allowing the researchers to access the network's support in recruiting MHTs.

CHAPTER 3: PHASE 1 RESULTS

3.1. Out of a total of sixty-eight Trusts and fifty HEIs, Forty-two Trusts (63.6%) and 40 HEIs (80%) completed the survey. Two organisations declined participation: one Trust as it employed only small numbers of MHNs and one HEI as its pre-registration nursing education contract had recently ceased. The remaining organisations did not respond to the survey.

Organisational ownership of implementation of the CNO recommendations

3.2. Around half of Trusts and two-thirds of HEIs reported having consulted with others in completing the survey. Trust responses predominantly came from Directors/Assistant Directors of Nursing. HEI responses were mainly from lecturers and teaching staff. In most Trusts the CNO review was not a standing agenda item at either Trust Boards or Senior Management Meetings (n=24, 58.5%) but was so at a lead nurses meetings (n=10) or practice development groups (n=8). For HEIs discussion appeared to be focused in programme management (n=11) and curriculum review (n=9) meetings. In both Trusts and HEIs about half of respondents were able to identify a forum in their organisation at which the CNO review had been an item for discussion. A minority of Trusts reported that little or no discussion of the review and its recommendations had taken place to date

3.3. Most Trusts reported some activity in the development of a specific implementation strategy for the CNO recommendations. In 57% of Trusts this had already been formalised and built into an overall organisational strategy. 34% of Trusts indicated that a specific strategy had been or was being reviewed. Just under half of Trusts reported having set specific target dates for implementation of the CNO review recommendations. These dates ranged from five year plans to plans which were about to be completed. Twenty-four Trusts (58.5%) considered it 'likely' that they would hit targets overall by due dates with the remainder 'neutral' then 'unlikely' (rating: very likely to very unlikely). However, seven Trusts (18%) had set no specific target dates and four Trusts (9%) reported little or no implementation activity to date. The majority of HEIs (n=26) reported either having already reviewed, and revised their curriculum in light of the recommendations with 36 (%) being in the process of doing so. A small number of HEIs reported that many of the recommendations had already formed part of their curricula prior to the review being published. The majority of HEIs identified future plans for furthering the implementation of the CNO recommendations in their organisations, mainly through review/revision of curricula. Again a number of HEIs described specific planned future areas for development.

Trust responses – recommendation priorities and implementation progress

3.4. Trusts were asked to rank all 17 CNO recommendations in terms of the priority within their organisation on a Likert scale (5 = very high priority to 1 = very low priority). The 17 recommendations were then ranked from highest to lowest importance as rated by all responding Trusts in England based on the combined scores for each recommendation from all Trusts. Trusts were also asked to rate the levels of implementation for each of the 17 recommendations and the 70 accompanying *'making change happen'* points. To establish overall levels of organisational implementation, scores for *'making change happen'* points related to each recommendation from all

Trusts were added together. This provided a proxy measure of implementation in Trusts for each recommendation. Table 4 provides a comparison of ranked priorities and implementation progress for Trusts. There were variations in levels of implementation based on the sum of accompanying suggestions with total scores ranging from 195 to 295 (mean 251.5; missing data 18/2940 cells = 0.6%). This has enabled perceived levels of implementation for each recommendation to be ranked for Trusts overall. Of the 70 *'making change happen'* points the most and least implemented are presented in table 5 with the 'total score' representing the combined scores for each point for all responding Trusts.

Table 4: Comparison of ranked priorities and implementation progress for Trusts

Recommendation (recommendation number)	Ranked Priority	Implementation Progress ranking
Improving inpatient care (12)	1	8
Strengthening relationships with service users and carers (5)	2	3
Applying Recovery Approach values (1)	3	15
Improving physical well-being (7)	4	7
Holistic assessments and managing risk effectively (6)	5	1
Promoting equality in care (2)	6	11
Providing psychological therapies (8)	7	10
Meeting the greatest need (4)	8	12
Increasing social inclusion (9)	9	17
Working effectively in multi-disciplinary teams (15)	10	2
Providing evidence-based care (3)	11	16
Responding to the needs of people with substance misuse problems (11)	12	9
Supporting continued professional development (16)	13	13
Developing new roles and skills (13)	14	6
Recognising spiritual needs (10)	15	5
Improving recruitment and retention (17)	16	13
Strengthening pre-registration education (14)	17	4

Table 5: **The ten most and least implemented 'making change happen' points from the CNO review (range 109-198, mean 154)**

Ranking	Accompanying 'making change happen' points	Total
1	All MHNs to have ready access to advice and guidance from named and designated child protection professionals and know to whom they are accountable in relation to safeguarding children (6.6)	198
2	All MHNs to have an identified professional lead who can offer support and professional advice (15.2)	194
3	All MHNs to have access to advice on how information can be provided without breaching confidentiality (5.3)	181
4	All MHNs to have access to support systems for identifying and addressing stressful situations, e.g.: opportunities to raise with managers issues that cause work stress; regular clinical supervision; advice from professional leads; staff counselling services (5.5)	181
5	All assessments to identify any risk of self harm, self neglect, abuse from others and violence towards others. Care plans to reflect these issues and this to be audited (6.2)	180
6	Modern Matrons to be given sufficient authority to ensure that cleaning standards are met and maintained, and for this role to be part of their annual appraisal (12.9)	178
7	Individual risk assessments and risk management plans in inpatient settings to include assessment of possible risk to service users posed by others (including the risk of intimidation or sexual violence), in addition to risks presented to self or others (12.1)	177
8	All MHNs to work assertively and professionally within multidisciplinary teams and to identify any factors preventing this (15.1)	174
9	All ward managers to agree with their manager any actions needed to develop their leadership skills through annual individual development plans (12.8)	173
-	To identify ways of encouraging and celebrating nursing achievement, e.g. through annual awards, publicising good practice, actively supporting publications in professional journals and conference presentations (15.5)	173
62	Service providers to consider developing local career frameworks to support education and workforce planning and career development advice (16.3)	133
-	To establish arrangements whereby the MHN workforce in the future will reflect diversity in the communities served, for example by: profiling the current workforce against the populations served; forming links with local community groups; advertising in minority publications; publicising the contribution made by existing MHNs from minority backgrounds; providing opportunities to develop support workers (2.3)	132
63	To carry out 'paper reviews' to identify and remove duplications in administrative processes and to shift routine administrative tasks to non-professionally qualified roles (12.13)	132
64	Service users to be routinely involved in the recruitment, education	131

	and assessment of all MHNs (1.6a)	
65	Inpatient services to develop arrangements to break down barriers with local communities, e.g. through: open days; inviting local media in; forming links with voluntary groups (9.2)	126
66	To consider the identification of specific time for continuing professional development for each nursing role and include within job specifications (16.4)	124
67	MHNs working in care management roles to arrange for direct payments to service users where they choose this (1.3)	117
68	Carers to be routinely involved in the recruitment, education and assessment of all MHNs (1.6b)	117
69	All new community staff to spend time in inpatient settings as part of their induction, and vice versa (12.7)	110
70	MHNs completing postgraduate level courses to produce articles/summaries of their research for possible publication and/or internal distribution (3.2)	109

Higher Education Institutions (HEIs) – recommendation priorities and implementation progress

3.5. HEIs were asked to rank 16 of the 17 CNO recommendations in terms of the priority within their organisation on a Likert scale (5 = very high priority to 1 = very low priority). Recommendation 14, which specifically focussed on pre-registration mental health nursing education, was the subject of a separate, more in-depth, exploration in the survey sent to HEIs. An overall ranking of importance of individual recommendations in HEIs was calculated based on the sum of each of the 16 recommendations for all responding HEIs. These summated scores ranged from 51 to 80, mean 67.1 (min score 16, max 80). There was considerable variation in priority ranking between HEIs and Trusts. Whilst eleven of the CNO recommendations were ranked broadly similarly by both Trusts and HEIs in terms of priorities, there were also some statistically significant differences derived from an independent samples t test between Trusts and HEIs ranked priorities for four recommendations (Table 6). Most notably recommendation 12 (*'Improving inpatient care'*) and recommendation 15 (*'Working effectively in Multi-Disciplinary Teams'*) were ranked significantly higher by Trusts than HEIs. Recommendation 3 (*'Providing evidence-based care'*) and recommendation 17 (*'Improving recruitment and retention'*) were ranked significantly higher by HEIs than Trusts.

Table 6: Comparison of ranked priorities of main recommendations for Trusts and HEIs

Recommendation	MHTs	HEIs
Improving inpatient care (12) (p = <0.001)	1	13
Strengthening relationships with service users and carers (5)	2	1
Applying Recovery Approach values (1)	3	2
Improving physical well-being (7)	4	10
Holistic assessments and managing risk effectively (6)	5	=5
Promoting equality in care (2)	6	4
Providing psychological therapies (8)	7	8
Meeting the greatest need (4)	8	15
Increasing social inclusion (9)	9	=8
Working effectively in multi-disciplinary teams (15) (p = 0.042)	11	=5
Providing evidence-based care (3) (p = 0.006)	10	3
Responding to the needs of people with substance misuse problems (11)	12	14
Supporting continued professional development (16)	13	=11
Developing new roles and skills (13)	13	=11
Recognising spiritual needs (10)	15	16
Improving recruitment and retention (17) (p = 0.006)	16	9
Strengthening pre-registration education (14)	17	-

3.6. Recommendation 14 of the CNO Review specifically focussed on 'Strengthening pre-registration education' and included four accompanying '*making change happen points'*. Based on feedback from the service user and carer groups on the study steering group, one of these *'making change happen points'* which originally referred to service user *and* carer involvement in curriculum as a single recommendation, was split into two separate components for the survey; one referring to service users and one referring to carers. HEIs were asked to rate their progress towards implementation for each of these five *'making change happen'* points on a Likert scale (5 = full implementation; 1 = no implementation). These ratings were then combined to provide a measure of overall HEI implementation of recommendation 14 with scores ranging from 16 to 30, mean 21.1 (min score 6 to max 30). Each of the five *'making change happen'* points was then ranked from highest to lowest implementation (Table 7). HEIs were also asked to rate their overall progress towards the implementation of each of the six main themes from '*Best practice competencies and capabilities for pre-registration mental health nurses'*

(Department of Health 2006c). Table 8, ranks the six main themes in terms of most to least implemented in all HEIs. Overall implementation scores for each HEI were also calculated based on adding implementation scores for all six components for each HEI. Scores ranged from 20 to 30, mean 25.1 (possible scores from 6 to 30).

Table 7: HEI implementation of Recommendation 14 'Strengthening pre-registration education' - 'making change happen points'

Ranking	Accompanying suggestions (making change happen points)	Total
1	14.1 Higher education institutions (HEIs) to review pre-registration programmes to meet minimum competencies as set out in 'Best practice competencies and capabilities for pre-registration mental health nurses'.	166
2	14.3 Service providers and HEIs to develop strong co-operative relationships to improve educational outcomes.	156
3	14.2 HEIs to consider adopting a range of different approaches to placements to improve benefits for students, e.g. longer placements and client attachment.	155
4	14.4a Higher education institutions to involve service users in every aspect.	146
5	14.4b Higher education institutions to involve carers in every aspect.	122

Table 8: HEI implementation of 'Best practice competencies and capabilities for pre-registration mental health nurses' themes (highest to lowest implementation)

Ranking	Main competencies	Total
1	Communication	179
2	Values	176
3	Psychosocial care	168
-	Risk and risk management	168
5	Multidisciplinary and multi-agency working networks and relationships	161
6	Physical Care	151

Reported implementation facilitators and barriers – Trusts and HEIs

3.7. Respondents were asked to identify three key factors which they considered had facilitated or acted as barriers to the implementation of the CNO recommendations to date and similar factors which they considered would influence future implementation progress (Table 9). In Trusts, there was a strong consensus that "*organisational engagement with the review recommendations*" was the most important implementation facilitator for progress both to date and in the future. Almost all respondents identified elements related to this theme. Trusts' views of engagement were characterised by a 'top - down' approach encompassing various elements such as: formal embedding of the implementation into the organisation's overall strategy or business plan, strong leadership and management support, a shared ethos with the recommendations, a willingness to promote discussion, consultation and feedback, and the provision of resources for development. Trusts reported 'harmonisation [of the CNO Review recommendations] with other national policy initiatives' as the second most important implementation facilitator to progress to date and for future progress;

> *'In the main the CNO recommendations are reflected in general mental health policy and cross referenced with the Standards for Better Health Framework'* (Trust 21).

3.8. In contrast to Trusts, HEIs identified key facilitators to implementation as factors that appeared more collaborative and inclusive in nature. An approach to "joint working" within and without the organisation" was most commonly identified by HEIs as a key facilitator. Almost half of responding HEIs identified the "input of users and carers" as a second key facilitator to implementation of the recommendations, especially linked to their input to curricula development.

3.9. Key factors considered to be barriers to implementation of the CNO recommendations were identified by both Trusts and HEIs. Trusts and HEIs reported a range of 'competing priorities' as a key barrier, with three quarters of respondents agreeing, for example:

> *'The fact that it* [CNO Review recommendations] *has had to compete with several other mainstream / must do initiatives including those against which the Trust's performance is more directly assessed (e.g. Clinical Negligence Scheme for Trusts, Standards for Better Health). Although these do sometimes match or significantly overlap (e.g. clinical supervision) there can sometimes be a conflict of competition for limited resources, including line managers' time'* (Trust 7).

> *'An NMC decision to move towards a generalist rather than branch specific training'* (HEI 13)

3.10. About half of the Trusts and a number of HEIs responding viewed '*lack of funding*' as the second most common key barrier to implementation. About a quarter of Trusts responding reported a '*lack of ownership of the recommendations outside the nursing profession*' as a third key barrier to implementation. A third key barrier to implementation identified by HEIs, again relating to users and carers, was the practicalities of involving such groups in educational settings, particularly with regard to difficulties in providing financial remuneration to individual users and carers without affecting state benefits.

Table 9: Key facilitators and barriers to implementation identified by Trusts and HEIs

	Implementation Facilitators		**Implementation Barriers**	
	Trusts	**HEIs**	**Trusts**	**HEIs**
For Progress to date	Organizational engagement with the review recommendations (36)	Joint working approaches (24)	Competing priorities[1] (29)	Competing priorities (16)
	Harmonization with other national policy initiatives (8)	Staff commitment and motivation (16)	Lack of funding (16)	Staffing issues (15)
	Staff commitment and motivation (7)	Input of users and carers (14)	Lack of ownership of review recommendations outside the nursing profession (11)	Logistics of involving users / carers in educational settings (9)
For Progress in Future	Organizational engagement with the review recommendations (30)	Partnership working (15)	Competing priorities (14)	Competing priorities (16)
	Harmonization with other national policy initiatives (10)	Review and monitoring of performance against recommendations (15)	Lack of funding (14)	Lack of funding (7)
	Development of joint working (6)	Links with users and carers (11)	Lack of national drivers to encourage implementation (5)	

[1] This category included elements such as being overloaded with national policy initiatives, local changes and a perception that the CNO review priorities potentially conflicted with those of the NMC review of pre-registration nursing.

Summary of findings from phase 1

3.11. The survey clearly indicates that the CNO Review has stimulated specific activity in all organisations responding to the survey with all having made some progress in the implementation of the recommendations and accompanying suggestions (*'making change happen points'*). 11 of the recommendations were ranked similarly in terms of priorities by Trusts and HEIs though there were also some differences in priorities between Trusts/HEIs. Statistically significant differences between Trusts and HEIs ranking of priorities of the 16 common recommendations emerged in the following areas:

- Recommendation 12 - *Improving inpatient care* was rated as priority 1 by Trusts and priority 13 by HEIs *($p = 0.006$)*
- Recommendation 3 - *Providing evidence-based care* was rated as priority 10 by Trusts and priority 3 by HEIs *($p = 0.006$)*
- Recommendation 17 - *Improving recruitment and retention* was rated as priority 16 by Trusts and priority 9 by HEIs *($p = <0.006$).*
- Recommendation 15 - *Working effectively in multi-disciplinary teams* was rated as priority 11 by Trusts and priority 5 by HEIs *($p = 0.042$)*

3.12. Whilst all organisations ranked highly the importance of adopting both recommendation 1 (*Applying Recovery Approach values*) and recommendation 5 (*Strengthening relationships with service users and carers*) in terms of implementation progress these were rated low in Trusts and HEIs. In terms of specific implementation activity, 91% of Trusts responding to the survey indicated that implementation of the CNO Review recommendations were either built into overall organisational strategy or had led to the overall Trust strategy being reviewed. Only 9% reported 'little' or 'no' implementation activity. 82% of Trusts had set specific implementation target dates with 58% considering it likely that they would meet overall targets by due dates. 90% of HEIs responding to the survey indicated curricula had been reviewed in response to the CNO Review recommendations and the 'Best Practice Competencies and Capabilities for Pre-registration Mental Health Nurses' (DH 2006c). Key aspects of curriculum development activity to date and planned were focused around '*Increased user involvement in courses' and 'Strengthening partnership working with practice'.* The survey highlighted differences between Trusts and HEIs in terms of the level/seniority of the organisational lead for implementation of the recommendations. In Trusts the overall lead for implementation was most commonly the Director or Assistant Director of Nursing and within HEIs the lead for implementation was most commonly a lecturer.

3.13. In terms of perceived facilitators to implementation to date and for progress in future of the review recommendations, a range of factors was identified. '*Organisational engagement'* and *'Staff commitment and motivation'* were seen as common facilitators in responses from Trusts and HEIs. Other facilitators were identified as *'joint working approaches'*, *'harmonization with other national policy initiatives'*, *'performance monitoring'* and *'input from users and carers'.* A range of factors was identified as actual or potential barriers to implementation of the recommendations to date or in the future. Common barriers in responses from Trusts and HEIs included *'competing priorities'* and *'lack of funding/staffing issues'*. This Phase of the study enabled the identification of a sample of HEIs (n=6) and Trusts (n=6) to be selected for Phase 2, in-depth case studies, over the next 9 months. Each sample was drawn from 3 each of those HEIs and Trusts scoring high and low on implementation progress.

CHAPTER 4 – PHASE 2: RESULTS OF HEI FOCUS GROUPS

4.1. A focus group was conducted in each of the six HEIs[2]. The number of people attending each focus group ranged from eight to sixteen. The mean number of participants per focus group was 10. Table 10 shows demographics of participants attending each focus group in each HEI

Table 10: Demographics of HEI Focus Group Participants

HEI	Participants (n)	Academics	Clinicians	Students	Service users	Carers
A	12	11	1	0	0	0
B	9	4*	3	0	2	0
C	8	5*	0	2	0	0
D	8	5	0	2	1	0
E	16	5	4	3	2	2
F	11	6	1	0	4	0

*Joint academic/clinician post

4.2. The themes and sub-categories of each theme from the analysis of the focus group data are shown in appendix 1 and described below.

Use of CNO Review recommendations

4.3. For many HEIs, the CNO review and the accompanying *Best Practice Competencies and Capabilities for Pre-Registration Nursing Education* arrived at a timely moment, as they were reviewing their curriculum. Both documents provided a benchmark against which curriculum reviews could be mapped. Thus, the review's value as a guiding framework to assist in curriculum review was evident. Some HEIs acknowledged that they had started to implement changes in their curriculum before the publication of the Review. The content of the Review, had, however affirmed these HEI's current practice. An important use of the Review recommendations was in strengthening the case for change in most HEIs, especially in providing evidence in the face of opposition to changes in the mental health branch curriculum from staff in other branches. As one HEI stated:

> *"It enabled us to back up, provide evidence for one of the things we wanted to do……."* (Academic, High implementer)

4.4. With one exception, the Review was welcomed and accepted by HEIs. Where the recommendations were rejected, it was reported that this was due to a lack of faith in the relevance of what was recommended.

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[2] None of the included HEIs in phase two were the employers of any of the researchers

Impact of CNO Review

4.5. Some HEIs stated that their intention to implement changes to their curriculum, changes that would have occurred irrespective of the Review. For others, however, the Review provided the impetus for curriculum review. For the most part, HEIs had service users, and to a lesser degree, carers, involved in the various aspects of the design, development, delivery, or evaluation of their curriculum either through consultation, collaboration or working in partnership. Nevertheless, the arrival of the Review appeared to increase the involvement of service users and carers. During the open consultation for the Review itself, a majority of those who responded to the consultation criticised the lack of sufficient attention to physical health care in mental health pre-registration curricula. A notable impact of the Review recommendations in HEIs was to strengthen the physical health care input into curricula. Service user involvement has been widened past consultation and a more strategic approach has been adopted. Overwhelmingly, the greatest impact of the Review was in helping HEIs put recovery at the forefront of revised curricula. This was arguably the central and key recommendation of the Review and an area in which many HEIs were struggling.

> *"We were not very strong on the recovery sides of things. So started to look at that......"* (Academic, high implementer)

Challenges to implementation

4.6. Despite the Review being largely welcomed and accepted by most HEIs, many encountered significant challenges when attempting to implement the recommendations. Despite widespread criticism of the 'biomedical model' in mental health nursing education, some HEIs recognised that this approach was driving mental health nursing curricula. Therefore, for these HEIs, a challenge was in switching from biomedical approaches, to what HEIs perceived was a recommended recovery approach. The recovery approach was viewed as representing a challenge for practice areas which remained medically dominated. The students desire to fit into a team may override their motivation to challenge medicalised practice.

4.7. The theory/practice divide in nursing education is a long reported refrain when people comment upon the relevance of nursing education to practice. Mental health nursing is not immune to this issue. Among the HEIs who participated in the focus groups, many identified incongruity in the expectations of academics and clinicians to how curricula should be fashioned as a significant challenge to implementing the Review recommendations. The tensions aroused by this incongruity, was evident in some of the focus groups where clinicians and academics were present. In one HEI, considered as a low implementer of the Review recommendations from the phase one survey, the negative perception of the recommendations was a challenge to their implementation of the Review. Competing demands and pressures, usually in the form of NMC requirements, QAA reviews and general administrative loads were also a challenge for some HEIs, but this was not a widespread issue. The most significant challenge facing

the HEIs who participated in the focus groups was in overcoming resistance from colleagues in other branches, who many saw as driving the curriculum for mental health nursing. This was evident in one HEI where there was no invited representation from mental health in the Curriculum Advisory Group.

> *"It's been a little difficult to persuade some of our colleagues in the other branches…."* (Academic, high implementer)

Working in partnership

4.8. Three sub-categories were apparent from the data under this theme. In HEIs the Review prompted the development of partnerships, strengthened existing partnerships or expanded partnerships. It was clear from the focus groups that most HEIs had well established partnerships with several stakeholders including service users, clinicians and community groups. Where possible, these partnerships where confirmed by the stakeholders present at the focus groups; indeed their presence at the focus groups attests, perhaps, to the strength of the partnerships. Partnerships with students were less well developed and strategies for consultation and feedback with this group were limited. For the most part, HEIs appear to interpret the partnership working aspect of the Review recommendations to refer to working with service users, and it is in this area that partnerships developed mostly, even in HEIs who appeared from their responses to the phase one survey to be low implementers.

> *"Service user involvement was already strong here…….it was not across the board the way it is now"* (Academic, low implementer)

Facilitators to implementation

4.9. There was a general consensus that the review and recommendations were reflective of the direction of contemporary mental health services and focused on the key areas for development. The importance placed on physical health was particularly valued.

4.10. To help facilitate the implementation of the Review recommendations HEIs identified several factors to varying degrees. An ongoing view among some HEIs was the need for commitment from academic and clinical staff and a clear vision as to how to accommodate the Review recommendations. The values of the 'team' and the focus of the review on recovery enabled the uptake of the recommendations in many HEIs. The personal motivation and interest of the lecturer was seen as essential to aiding implementation. Competing cultures in education and practice was evident, therefore students may not observe theoretical principles of recovery in practice. Transfer of recovery principles into practice was seen as difficult.

4.11. In most HEIs, participants alluded to the partnerships they had formed, or strengthened as instrumental in their facilitation of the Review. Crucial to this were the partnerships formed with clinicians and service users. An issue that emerged across most HEIs that helped the introduction of the Review was acceptance of the recommendations among the team, as illustrated by the following quote from a service user.

> *"I do think the recommendations very good, very thorough and very well thought of"* (Service user, high implementer)

Barriers to implementation

4.12. In many respects, HEIs struggled to identify barriers to implementation in the focus groups, such was, for the most part, the positive view they expressed about the Review. Nevertheless, when prompted, the barriers identified were around the clash of academic/clinical cultures around the purpose and nature of pre-registration education, mentioned by one HEI to rejection of the recommendations, a common refrain in another. The rejection centred on the perceptions of the relevance and development of the recommendations, a clash with the views of many of those attending the focus group and, it appeared, a general unease with the perceived top-down nature of the process. In one HEI, the team were critical of certain aspects of the Review and were therefore, sceptical of full and unquestioned implementation. Concerns included:

- Focus on nursing as opposed to multi disciplinary working. Many post-reg causes are multidisciplinary and it is acknowledged that other professions may not understand the values of recovery in the same way.
- Focuses on people with serious mental health problems at the expense of other client groups such as dementia.
- The content of the review was nothing new and therefore had limited impact as some lecturers already adopted these principles to guide their teaching.
- Question the political and economic agenda for the recommendations in light of drive to get people off benefits. Suggest its focus on younger people and short term interventions may be due to this agenda as it neglects groups who may not ever be economically productive.
- Focuses on psychological therapies which moves emphasis away from the caring role of the nurse

4.13. Criticisms voiced by another HEI were a lack of focus on common mental health problems, lack of acknowledgement of skills needed to physically respond to violence and aggression, a desire to have gone further with psychological therapies and, a view that the Review expected too much from a newly qualified nurse

4.14. Recommendations are made without guidance on implementation therefore this could lead to patchy and varied interpretation within other HEI's and Trusts. There was

a view expressed by one HEI that the recommendations are vast and therefore there are competing areas of priority. It is acknowledged that time is limited and the curriculum is in danger of becoming overcrowded or a tick box mentality is initiated where all is covered but nothing to a sufficient degree. Some lecturers viewed aspects of the recommendations as too difficult to implement and therefore did not intend to follow through. The main barrier to implementation among most HEIs was resistance to change among colleagues, illustrated rather colourfully by the following comment.

> *"The reason I don't do some of this is because I can't be a&%$d"*
> *(Academic, low implementer)*

Changes attributed to the Review recommendations

4.15. Most HEIs were able to identify changes that had been implemented which they attributed directly to the Review recommendations. In some cases these changes may have been introduced without the Review, in other cases, the Review was the impetus for these changes. Of the changes identified, some linked directly to Recommendation 14, e.g. longer placements and use of client attachment. The major changes that HEIs attributed directly to the Review were, a review of the values driving the education, increases in service user involvement in the curriculum and the incorporation of the recovery approach.

> "*Some of the changes we made come into place in September...... a module which has been about care implementation is now called support and recovery*"
> *(Academic, Low Implementer)*

Responses to Recommendation 14

4.16. Recommendation 14 of the Review focussed on pre-registration MHN education and recommended:

1. HEIs review pre-registration programmes to meet minimum competencies as set out in 'Best practice competencies and capabilities for pre-registration mental health nurses'.
2. Service providers and HEIs develop strong co-operative relationships to improve educational outcomes
3. HEIs consider adopting a range of different approaches to placements to improve benefits for students, e.g. longer placements and client attachment
4. HEIs involve service users in every aspect
5. HEIs involve carers in every aspect

4.17. The evidence from the focus groups suggests that HEIs are addressing these issues. As noted above, it is apparent that most HEIs were reviewing their curriculum,

using the B*est practice competencies and capabilities for pre-registration mental health nursing education* as a benchmark, there are improvements in the involvement of service users in many aspects of the curriculum design, delivery and evaluation, although not all aspects have service user involvement. The involvement of carers is less developed, although there is evidence of this from at least two the HEIs sampled in this study. Alternatives and additions to traditional forms of providing students with clinical experience are not very well developed.

Differences between 'high' and 'low implementers'

4.18. The researchers acknowledge that their typology of 'low' and 'high implementers' are a little crude, based as they are on HEIs' self-report responses to the phase 1 survey. Nevertheless, there is some evidence to support the typology from the focus group data. High implementers were more likely to accept than reject the Review recommendations. There were differences in the values and attitudes of staff and other stakeholders between low and high implementers towards the Review and in their approach to mental health nursing education in favour of the high implementers as characterised by their responses to the phase one survey. With regards to partnership working, it appeared from the focus group data that were stronger partnerships between academics, service users, students and clinicians in most HEIs; but there was some evidence that this was more advanced in the high implementers. In the high implementers, there was evidence of stronger leadership in diffusing the Review throughout the department, and acting as a catalyst for the implementation of the Review recommendations. Finally, commitment expressed through a willingness of academic staff and others appeared to discriminate between low and high implementers.

Summary of phase 2 findings from HEIs

4.19. In general, HEIs welcomed and accepted the recommendations of the CNO Review in England and presented evidence of change, some of which they attributed to the Review recommendations directly, others they stated would have occurred irrespective of the Review. The Review has clearly acted as a catalyst that has driven reviews of pre-registration mental health nursing education. It has provided a useful benchmark that HEIs have used to map current curricula against the recommended competencies and capabilities identified in the Review as best practice in the education of mental health nurses. A notable impact of the Review in many HEIs is the re-focus of curricula to put recovery at the forefront of educational approaches and to increase the involvement of service users, and to lesser degrees carers, in most aspects of educational activity. Implementation of the Review recommendations in HEIs seemed to be facilitated by a strong commitment among academic staff to the key principles of the review and its recommendations, and strong partnership working between academics, clinicians, service users and, to some degree, students. These activities helped HEIs make steady progress towards addressing Recommendation 14 of the Review; strengthening pre-registration education. Implementation of the Review recommendations presented

several challenges to HEIs, the most notable of which was persuading non-mental health academic colleagues of the value of the Review. Despite the positive response to the Review recommendations among most HEIs, there were several barriers that occasionally blocked attempts to follow through with implementation. Where a recommendation was not implemented, participants were able to give an account of how they had considered the recommendation and their reasons for choosing not to implement it. This was largely as a result of the team being critical of the values that underpinned it.

CHAPTER 5 – PHASE 2: RESULTS OF CASE STUDIES OF MHTS

5.1. The aim of the case studies in phase two was to investigate the impact of the Review in MHTs from the perspectives of mental health nursing senior managers, mental health nurses, service users and carers. As described in chapter two, six Trusts were selected for inclusion in phase 2 of the study. Table 11 shows key characteristics of each of the Trusts

Table 11 Key characteristics of MHTs in who participated in phase 2

Trust	Status	Population	Demographic and socio-economic status of local population	Special Characteristics	Healthcare Commission Status[3] (2007/08): Annual Healthcare Rating
A	Foundation Trust (2007)	816 000	South East, Suburban, , Mainly affluent with pockets of deprivation and disadvantage	Trust hosts a shared services organisation compromising facilities, financial and health informatics	QS[4]: Excellent UR[5]: Excellent
B	Foundation Trust (2007)	1.4 million	North West Largely urban but has large areas of sparsely populated uplands, Levels of deprivation in some areas among the highest in England	Trust is located in a diverse geographical region covering 3069 square kilometres	QS: Excellent UR: Excellent
C	(Partnership) Foundation Trust (2008)	530 000	South West, Rural, Mainly affluent with concentrated pockets of deprivation	A Partnership Trust providing both mental health and social services	QS: Excellent UR: Good
D	Primary Care Trust (2006)	300 000	Midlands, Urban, High levels of deprivation in concentrated areas	Mental health responsibilities no longer provided by PCT, a new Trust has been created to provide local services in 2008	QS: Fair UR: Good
E	Combined Mental Health Trust (1994)	463 000	Midlands Urban/Rural mixture Affluent in rural conurbation, but urban area has high levels of deprivation and child poverty	Trust hosts a shared services organisation compromising Health and Safety, estates and health informatics	QS: Good UR: Good
F	Foundation Trust (2007)	1.4 million	Outer London, Suburban Situated in one of the most affluent areas of England with low levels of deprivation	The Trust provides Secure and Rehabilitation services for a neighbouring region	QS: Excellent UR: Good

[3] The Healthcare Commission was replaced with the Care Quality Commission (1st April 2009)
[4] QS = Quality of Services
[5] UR = Use of Resources

Trusts' Responses to the Review

> *"We were doing it all anyway [the CNO Review]. Maybe it has put a bit of extra wind in the sail but it certainly did not build the boat. I suppose in some ways it was pleasing and what was pleasing about it is that it said what you wanted it to say; it was very confirmatory".*

5.2. The CNO review was published in Aril 2006 and distributed to key people in mental health Trusts. One of the first questions that the researchers asked the nurse leads in participating Trusts was about their initial response to the Review. It met with overall agreement but with what appeared muted enthusiasm as described by this nurse consultant:

> *"Well, I suppose it arrived on our doorstep and we had to think, how do we get it out there? We were aware that nursing staff are pretty overwhelmed by policy and so we asked ourselves, do we make a song and dance about it, do we throw it out (...) or do we just check out what we are doing? We decided to focus on content rather than the vehicle. We decided to check out that we were doing what it said but not to make a big deal about the whole document".*

5.3. This quotation was typical of the response that met publication of the Review – and it hints at the reasons for this. These related both to the context into which the Review was launched, with competing and parallel pressures in new policies, changing structures and untoward incidents, reports etc. They also related to the nature of the Review itself, providing a series of recommendations rather than requirements (with no attached funding), which were seen largely as confirmatory rather than radical and challenging. Further analysis of these factors illuminates the impact of the Review in particular, but may also throw some light on issues related to policy implementation more generally.

Strategic Response

5.4. All of the Trusts had considered the CNO Review at Executive Board level. In some, it was given perfunctory approval, in others a more formal implementation process was set up with Board oversight. Board members who were interviewed expressed the unanimous view that much of the development recommended in the Review was already underway because of other initiatives, so it did not in itself merit a separate programme of work:

> *"Well, I suppose, from my point of view, I mean, I would sit here and probably say we haven't done this directly under the CNO umbrella, I think what we've done is a lot of different service improvements initiatives, most of which would be based on all those recommendations which are in it. Therefore, we have not actually put together this sort of master plan, as it were. A lot of the areas of discrete work streams monitored for a number of different other areas as you*

can imagine; clinically effectiveness, local implementation, groups, clinical effectiveness groups, committees, sort of under that umbrella".

5.5. Table 13 summarises the various dissemination and implementation approaches adopted. Three of the six Trusts embarked on a formal consultation process with staff to elicit views and opinions on the implementation of the Review and two of these Trusts held a Conference or Seminar to publicise and discuss the Review Recommendations. These appeared to set up some early momentum and served to celebrate existing good practice in line with the Review but this momentum appeared to have slowed in the two years that passed before our visits and were often hazy memories.

5.6. Copies of the Review or Executive Summary were emailed out to all staff in five of the six Trusts. Although one Trust provided a limited number of hard copies for staff this did not appear to have made much difference to staff's familiarity with the Review. One Trust held focus groups to get feedback from frontline staff to ascertain the priorities the Trust should adopt. Three Trusts produced self-assessment rating scales to determine how well they were implementing the recommendations, and in one of these Trusts, the scale was used as part of an overall strategy for implementing the CNO Review. As will be seen below, regardless of the dissemination approach used, many of the people interviewed across all Trusts had no recollection of the Review or of the precise recommendations.

Table 12: Processes for dissemination & implementation of the Review in MHTs

	Processes for dissemination & implementation				
Trust	**Consultation**	**Dissemination**	**Senior Nurses Forum**	**Dedicated Strategy Group**	**Monitoring or Audit to assess implementation**
A	No	Review e-mailed to all nursing staff and Review was tabled for discussion at various meetings	Yes	No – but Review was tabled at professional advisory committee to make sure recommendations were being implemented	No stand alone monitoring system for CNO Review in place
B	Consultation Event led by Asst Director of Nursing	Review e-mailed to all nursing staff	Yes	No	No –but the Trust has an overall strategic plan which is audited and monitored
C	Focus Groups in four different localities of Trust	Review e-mailed to all nursing staff	Yes	Yes – Trust produced an Action Plan determined by the priorities identified by Focus Groups – but not exclusive to CNO	Yes – Action Plan had identified dates when outcomes were to be measured with key individuals responsible for

				Review	meeting the targets
D	Consultation Events throughout Trust	60 hard copies delivered to staff Review e-mailed to all nursing staff Half-Day seminar for Nursing staff.	Yes	Yes – with about 20 members who were responsible fro framing Trust strategy	Yes – the Trust produced a self-assessment profile based on the recommendations with individuals given responsibility for key recommendations to report back progress six monthly
E	Director of Nursing responded via Modern Matron Group	CNO Review disseminated through the Modern Matron Steering Group	Yes	No	No specific monitoring of recommendations but monitoring of performance is routine using a balanced score card system
F	Consultation taken among lead nursing strategy group	Conference was held to launch Nurse strategy	Yes	No but recommendations were integrated into overall nurse strategy and Trust completed a self-assessment rating scale	Yes – the self assessment rating scale will be audited periodically

Local Context

Structural changes

5.7. Four significant factors appeared to have /were reported as having an impact on the implementation strategy of the Trusts. First, there was the move towards Foundation Trust status. As table 14 below indicates all but one Trust had gained or was moving towards Foundation Trust status. This required investment of an enormous amount of time, effort and resources – inevitably meaning that other priorities were, not neglected, but given less consideration:

> *"I think in hindsight we probably could have done it better [the implementation of the CNO Review] and at that time, we were going to foundation. We were beginning to go to foundation status, we were also reorganising the whole of the trust, so I was thinking in terms of reflection, a huge amount has gone on and at the same time, trying to draw up an agenda for nursing has been quite challenging*".

Table 13: Structural Changes in Trusts' Organisation

Trust A:	Established in 2001 gained Foundation Trust status in 2007
Trust B	Established as a trust in 2002 gained Foundation Trust status in 2007.
Trust C	First Partnership Trust to be established in England (April 1999) bringing together both mental health and social services. Gained Foundation Trust status in 2008.
Trust D	In 2008, Trust D merged with a neighbouring trust, in part, to allow the new organisation to apply for Foundation status.
Trust E	Trust E does not have Foundation Status but is a Combined Healthcare Trust.
Trust F	Trust F is a Partnership Foundation Trust and was established in 2007

Competing Crises

5.8. The second factor affecting the strategy to deliver the CNO Review was the prioritisation of urgent actions arising from crises such as a SUI (Serious Untoward Incident) or a critical report that demanded response from a Trust. Some members of staff interviewed were reluctant to talk about particular incidents in detail, but it was apparent if there was a SUI, it invariably followed that action was taken to improve services and learn from mistakes made. The urgency with which such events were treated is demonstrated in the following quotation:

> *"In November 2007, there was a major incident and that just seemed to wake everybody up. You know, so of course, there was a major investigation. Very, very quickly, you know, people were saying, oh my God and, the place had been neglected, for whatever reason … I think that with a lack of leadership on the wards, and ownership, there was quite a significant vacancy factor, quite a high level of multi-agency staff or bank staff. In addition, a core of staff on the ward was working excessive hours".*

5.9. Another member of staff commented:

> *"So there's an issue around patient safety. An untoward incident or something like that, or if something happened, then there would be a real push (...) something happened, practice needs to be changed or whatever reason, maybe not always for the better, but at least a change".*

5.10. In addition, from a senior member of staff:

> *"But what we did was … there was a very unpleasant homicide which we had quite a few years ago in one of our areas, and from that, it was one of these famous things about, you know, you're not communicating, and the local authority and ourselves and the police hadn't been communicating very well (…) that particular family. Moreover, what we found was that the people involved, the staff involved, did not know how to share information, so they did not do it. And they were frightened of being, you know, breaking confidentiality…"*

5.11. Finally, one practice development nurse suggested:

> *"To be honest, I think my role has more come from the knee-jerk reaction of enquiries and I have seen a lot of introduction of new policies and procedures and you can chart it back to what went wrong. This sadly is always the case".*

5.12. Likewise if a Trust had received an unfavourable report from one of the statutory bodies responsible for monitoring performance and service provision, it really concentrated the minds at the top level:

> *"We did really badly on the Healthcare Commission Review [of acute in-patients services] so it came out as 'weak'. So on the back of this and with the value of hindsight, we developed a real, and got a very, very well developed action plan, in response to the Healthcare Commission Review".*

5.13. Reacting to SUI or unfavourable reports is a significant feature of the NHS, however, the time and resources required to react to particular issues mean that other competing priorities are pushed further down the list.

Involvement in Consultation

5.14. The third factor that was reported as having an impact on strategy related to the Review and its recommendations was the extent to which Trusts had participated in the review process during the consultation period. In some Trusts, key personnel responded, sometimes, quite extensively to the consultation for the Review. This early participation in the process, in at least one Trust, provided the catalyst for the overall strategy adopted:

> *"I mean, generally, on a personal and professional level, I do tend to be somebody who just takes an interest in such matters. So when the consultation came out, I responded as an individual person, as well as on behalf of the bigger organisation, and so, for me, it was an exciting opportunity because, really,*

> *mental health nursing, I think has drifted. I think the last review, was in 1994. Therefore, it was a great opportunity, so the consultation asked all the questions that were very reasonable to ask if you were looking at it from a mental health nursing perspective. Therefore, when the consultation documenting electronic email came out, I did, in my leadership capacity then, in 2006, profile it in the organisation and encourage people to respond to the consultation. They could do that individually or they could ask or send me any comments and I would send it in as a job lot so to speak. Therefore, the consultation in our Trust was probably quite active from my recall" (MHT Champion for CNO Review).*

5.15. Nonetheless, it was also important that people identified in Trusts to champion the Review were given support and leadership guidance from the top, as the interviewee from above points out:

> *"Therefore, consultation-wise, it was a great opportunity and at that point, in time, I had a director who I was reporting to who was generally very positive in terms of oh, this is an opportunity to get nursing on the map. I think that is important because there is often a struggle, when you are trying to lead such developments up and running".*

Leadership

5.16. The aspect of influence and leadership appeared to be the final, and perhaps most crucial determinant, affecting the response of Trusts to the CNO Review. During the period of the CNO Review launch in 2007, three of the six Trusts had a Director of Nursing in permanent positions with the remaining three Directors working in an "acting" capacity:

- Trust A: Acting Director of Nursing
- Trust B: Director of Nursing (Acting in post from September 2006 substantive post January 2007) in place
- Trust C: Acting Director of Nursing
- Trust D: Director of Strategy and Innovation (Executive Nurse)
- Trust E: Director of Nursing in place
- Trust F: Director of Nursing in place

5.17. These temporary arrangements appeared to lessen the voice of Nurses at Board level. As one interviewee put it:

> *"I was aware of it because I had been on the DH nursing advisory development group. I was not on the steering group for setting up the Review, but I was aware of it that way. We as an organisation have gone through a number of problems with our Director of Nursing. In that, I think, when it first came out in*

> *2006, I do not know if we had one. I think s/he was out on secondment and we had somebody in post with the title of Assistant Director of Nursing. So that time was a very difficult time and yes very little was done around, the review when it was first published*".

5.18. Another interviewee commented:

> *"Well, they must have heard about it all [the CNO Review] because they are in the same position as I was, (...) coming in here but nobody was driving it, and I suppose that is the thing. I think that's key. Nobody would take responsibility in this Trust for it".*

5.19. The absence of a Director of Nursing, or a Nurse Lead, at Board level was not necessarily indicative that the voice and values of nursing would be ignored or by-passed. However, it is evident that for the CNO Review to be implemented successfully, Nurses needed strong, effective and consistent leadership at Board level, which was not always apparent.

National Policies

5.20. Whilst competing priorities in the local situation often took precedence over the Review, parallel imperatives at a National level were already shifting nursing practice because many of the Recommendations reflected current mental health and social care policy. For example, Recovery, Social Inclusion, Equality, Evidence-based practice, and user and carer involvement are all essential components of modern mental health services as set out initially in the NHS Plan (DH 2000). This is reinforced in many subsequent mental health and social care policies (e.g. National Standards, Local Action, DoH, 2004a; Improvement Plan of 2004; Creating a Patient-led NHS: Delivering the NHS Improvement Plan, DH, 2005; Our Health, Our Care, Our Say, DH, 2006; Cabinet Office Strategy Unit 2005 report Improving the Life Chances of Disabled People). These same values are also reflected in existing guidance on skills and training for mental health workers (e.g. Ten Essential Shared Capabilities, DH, 2004; the Improving Access to Psychological therapies Programme and New Ways of Working) and profession specific guidance (e.g. Royal College of Psychiatrists, 2008; 2009; British Psychological Society, 2000; College of Occupational Therapists in Mental Health, 2006). The same values – Recovery, inclusion, equality, citizenship, collaboration and empowerment - underpin thinking on future mental health policy not just in the UK (e.g. Sainsbury Centre for Mental Health Making Recovery a Reality [SCMH 2008]. London: SCMH; The Future Vision Coalition [2008] A New Vision for Mental Health, Scottish Recovery Network (SRN) (2007) '*Recovering Mental Health in Scotland'*, SRN; Social Exclusion Unit (2004) Mental Health and Social Exclusion. SEU, Office of Deputy Prime Minister; DH (2007) Breaking down barriers.

5.21. One Director of Nursing captured the dilemma of these parallel imperatives:

> *"The response that took place in this Trust and I suppose linked to what happened across the economy was that there has been a number of issues that we have been following since around 2000. We closed a large institution here in 2001. We opened a series of new services from 2001 onwards and, we have taken account of the review of mental health nursing but how can I say this?*
>
> *There is a difficulty in not soiling nursing so we have had to look at this in terms of the context of new ways of working, the national service framework, you know, the ten shared capabilities. So we've actually pulled all of that together and just in terms of reminding myself before the interview today, I just pulled off the ten shared capabilities again, and if you look at the seventeen recommendations within the CNO review, the majority of that was taken further forward within this particular document. We, how can I describe this? We worked through a number of different initiatives; we have not just slavishly followed one particular toolkit".*

5.22. The CNO Review might be seen as simply adding to a united movement away from a sole focus on symptoms, deficits and dysfunctions and the treatment of problems (whether via psychological, pharmacological or systemic means) towards a focus on individuals' strengths and possibilities. Away from a system in which decisions about what people need are made exclusively by professionals to a culture in which individuals have choice and control; and away from a focus on looking after people to a focus on providing the support that people need to look after themselves. As just one of many different reports, guides, policies all pointing the same way it is inevitably difficult to attribute change to one specific event or document. However, what appears to weaken the influence of the review further is its status as 'recommended' rather than 'required'.

Nature of Review: Recommended rather than required

5.23. Although the Recommendations of the Review are consistent with overall policy, in themselves they appeared to carry little weight: they are not a part of accountability structures; they are not a part of commissioning guidance and they bring no linked funding. Trusts often therefore saw them as little more than guidance.

> *"For example, we have, you know, twenty three independent prescribers, we've got advanced nurse practitioners, we've got three nurse consultants, you know, we've got a strategy for engaging with BME and diverse groups. So if we go through, you know, we've actually delivered what is actually within the toolkit but it's been done more in the round and it's been done because, two reasons. One, we've wanted to make that change but two, the commissioning environment in terms of the way that we've developed new services and new teams has dictated that we've had to work differently".*

5.24. Their impact was further reduced by the absence of specified targets indicating or defining the meaning of different recommendations. For example, within the Review, Recovery is stated to mean, "working towards aims that are meaningful for service users, being positive about change and promoting social inclusion for service users and carers". Such a loose definition might lead one Trust to assume that nurses are fully implementing a Recovery Approach whereas another Trust might interpret this in a very different way and consider itself to have a great deal more work to do before they could boast of nurses implementing a Recovery Approach. A further example arises in relation to spirituality, which was narrowly defined by Trusts who believed they were performing well, whereas those participants who were more self-critical had a much broader view of the values emanating from adequate attention to spiritual needs.

5.25. The lack of definition or targets is perhaps most obvious in relation to social inclusion, which received little attention in any of the Trusts: assessment of personal goals and identification of community-based opportunities to fulfil these goals was rarely mentioned. Indeed as one Acting Director of Nursing indicated often in Trusts the CNO Review was not being reviewed or monitored as a stand-alone document:

> ***Question***: *"So you will already have done that but is there any internal monitoring or review of progress against any of those recommendations?"*
> ***Response***: *"Not explicitly under a CNO umbrella."*

5.26. Since the only evaluation of the recommendations is voluntary self-evaluation, and recommendations are not linked to clear outcome indicators or performance targets it appears that the priority given to them is diluted. This is demonstrated by the comments of another Director of Nursing:

> *"What we do try and do with this type of thing [CNO Review], rather than take it as an isolated thing on its own, and look at it discretely and just do it at a micro-level we try and bed these types of things in stuff that we're doing already. Because unless you do that, you have a load of different action plans that do not necessarily fit together. So we try and embody it in, and embed it in what we're already doing, in terms of strategy (...)".*

Nature of the Review: Maintaining the Status Quo?

5.27. All interviewees were positive about the content of the review: they recognised that the recommendations were based on good practice; they found it confirmatory, encouraging, affirming and they felt that it reinforced the role and identity of mental health nurses:

> *"I've got to admit, I mean, it was one of the documents which you know, like initially, when you sort of printed it off and thought, Oh no, look at all the pages. But I was actually sort of very pleased about it, because I was thinking there was a sort of, in lots of ways, getting back to basics, but in other ways, actually*

> *sort of saying, you know, let's give ourselves a vision of what we want to do and how we want to get there. And so I felt that it was actually quite a common sense document really, and I know that having spoken to a few other professionals in the early days and they were sort of rolling their eyes a bit and Oh no, not something else. I said, No, this is sensible; you need to take a bit of a look at this because this actually does say many of the things that nurses have been saying for a long time. Particularly those nurses who are involved with saying about how do we drive the profession forward"?*

5.28. Whilst this may have been a key strength of the review it may, paradoxically, also be its main weakness: since it is not specifically challenging or radical, it does not promote debate or resistance or even alert much notice. It is all too easy to respond to blandness with further blandness (see Brooker, 2007) and 'not make a big fuss about it' as this nurse consultant describes:

> *"I suppose the content is in keeping with the zeitgeist at this Trust, what we had to do was to make sure it is the business that we are doing. In fact, most of it is core trust business. So we didn't need to really make a big fuss about it as far as nurses in the trust are concerned".*

5.29. In all but one Trust, the response from managers was to confirm that they were able to 'tick the CNO Review Box' because it overlapped with so many other policies and what they were doing already:

> *"I think it pulled together a whole list of work streams. Which were, most of them were being worked on before the [CNO Review]? I think it just pulled them all together for the first time. It probably has not had a real significant bearing on those particular work streams. It's perhaps reinforced what we were already doing and perhaps sort of said, well, try this and then we can say, well, look, we're already thinking along those lines so, we can, we're doing that, as it were. Like, I mean, I am looking at new roles, yes, we are actually looking at band four roles, we are actually looking at the role of nurses when they have completed their non-medical prescribing, for example. We are looking at reward structures behind some of these extra skills. So, but again, we were already looking at that career pathways we are looking at as well at the moment".*

5.30. Whilst the Review was clearly in line with the general movement in mental health and social care – and this is confirmed further in the recent publication of the 'New Horizons' consultation paper (DH, 2009), perhaps it did not go far enough in defining and pushing forward a distinctive role for mental health nurses in this new culture of Recovery, Inclusion, Partnership working and individual choice and control.

Conflicting messages about Mental Health Nursing

5.31. Whilst attention to the Review may have been distracted by competing imperatives and promoted by parallel requirements, several nurse leaders appeared to struggle with publicising the Review and this may have been due to the potential for confusion and for raising false hopes among the nursing workforce in light of other factors, such as the NMC consultation document on pre-registration nursing education which some saw as heralding the demise of mental health nursing as a distinct profession. This generated debate within the profession (see Stickley, Clifton, Callaghan et al 2009, Hurley, and Ramsey 2008) which centred on whether the mental health nursing branch would survive or whether it would be replaced with a more generalist programme. The outcome of the NMC consultation appeared to alleviate these concerns when it was announced that a mental health field of practice branch was likely to remain in place, in the foreseeable future (NMC 2008). Nevertheless, some doubt was cast in the mind of at least one senior nurse regarding the future of the profession:

> *"The other thing is that there's a massive contradiction at the top in terms of how we should be translating the CNO review to people on the frontline. What I mean by that is I was concerned with the NMC consultation about mental health nursing and the imminent threat to mental health nursing. The fact that what this seemed to be suggesting was that mental health nursing was going to vanish in some kind of genericist model. Whereas we'd got, on the other hand, the CNO review which was strengthening specialist mental health nursing, there seemed to be a real contradiction in the essence of these two important documents and as far as I was concerned, I didn't know what message to give to people on the frontline. Certainly, I didn't want to give a mixed message and as far as I was concerned, the fact that the NMC review came straight after the CNO review really did detract from its strength".*

5.32. One interviewee thought that the nursing profession was/is going through bit of an identity crisis now:

> *"I think, nurses at the moment, in mental health, are somewhat less sure about their role than they are in perhaps some of the other professions".*

5.33. Several interviewees in the Trusts brought up the debate about mental health nursing versus a generic nursing profession. Clearly, there was some confusion and concern about the status of the profession and some ambivalence about the usefulness of the Review in resolving this confusion. This had the potential to weaken the messages in the Review and may have affected people's commitment to implementing its recommendations.

Efforts to increase the impact and influence of the review

5.34. Whilst the issues alluded to above may have afforded the review relatively low status at Board level, the varied responses within Trusts demonstrated ways in which highly motivated and committed mental health nurses tried to increase the influence and impact of the document by making sure the Review was given serious consideration:

> *"So, consultation-wise, it was a great opportunity and at that point in time, I had a director who I was reporting to who was generally very positive in terms of Oh, this is an opportunity to get nursing on the map. I think that's really important because that's often a struggle, when you're trying to lead such developments…"*

5.35. Indeed throughout the six Trusts selected for this study there was evidence that individual champions or groups such as the Senior Nurses Forum put in measures to increase the impact of the Review or, at least, get it noticed. In one, Trust, which covers a large geographical area, they held focus groups in four different localities. Feedback from the focus groups then went to the Professional Nursing Advisory Group and the outcomes were drafted into an Action Plan. Nonetheless, it still required the Nurse lead to drive the Plan forward, which was acknowledged by one Nurse in the Trust in question:

> *"I think everybody contributed [to the Action Plan] but I would say the Lead Nurse pulled it together, and he was definitely central to how it looked in the end. I think he put in a huge amount of work in his own time to make that happen, because of the other commitments that were going on at the time for him".*

5.36. In another Trust, one Director of Nursing used the Review as a catalyst for the further development or review of the existing Nursing Strategy:

> *"The review itself was a springboard to give permission, if you like, to work on some of the things that have been thought of prior to that review. … You seize those permissions and actually, you apply that in any context where it actually comes up, you know, so with the changing nature of the way that the NHS works, the strategic objectives that this organisation and our commissioners, we are able to use the CNO review to shape our workforce, you know, to meet those demands".*

5.37. On another occasion, one Trust seized the initiative to get the Review into the mainstream:

> *"We took the CNO review and we integrated that into our nursing strategy. The other thing that we were mindful of is that in that context we wanted to kind of launch that so we did have a conference. That was three years ago and it relates to the nursing strategy and also to the CNO review and we integrated that with focus groups we met with lead nurses, we met with different groups of people and representatives and we amalgamated that and that was sponsored and led by our Director of Nursing at the time".*

5.38. Furthermore, one nurse leader believed staff in this particular Trust paid much more than lip service to the values and principles underlying the CNO Review:

> *"One thing I will say to you, you will get this as you go through our organisation. I think if you go through the seventeen recommendations individually, you will find that actually what is in there and in the ten essential capabilities is actually culturally embedded throughout the organisation. Moreover, people would feel that is part of the values of this organisation rather than an externally driven report. I think, I hope, you know, when you've finished, your two days with us, you know that would be the feedback you'd given, because we push the boundaries out, I think, quite a bit in some of the areas and the way that people , behave (...) we've got some great teams".*

5.39. Although most Trusts did not have a dedicated work stream directly related to the Review this did not necessarily weaken its' impact or influence. Directly or indirectly, the Review was often used as a vehicle for reinforcing and reiterating the values that mental health nurses should have.

5.40. Although many Trusts did take great strides to maximise the impact of the review by organising conferences, having focus groups, setting up strategy groups and involving many Senior Nurses, these measures tended to be short lived. Once the Review was integrated into Nursing Strategies, most Trusts did not have any specific long-term plans to keep the initial momentum going and take the CNO Review to the next level.

Power, status and silence

5.41. Mental Health Nurses belong to the largest group of healthcare professionals delivering mental healthcare services. Despite this numerical advantage, Mental Health Nurses do not necessarily have the same power, influence and status as some other healthcare professionals. This often meant that the voice of mental health nurses were silenced to the extent that more powerful 'others' were in a position to influence the direction of the CNO Review strategy. As one Acting Director of Nursing, when asked about the awareness of the CNO Review, stated:

Question: "What about the board does the board have an awareness of the nurse agenda?"

Response: "Well, yes, I mean, I am in the Acting Director of Nursing post, it [the CNO Review] was certainly tabled there. They did get a summary paper, which reduced it. Which is often all that they require?"

5.42. Although a summary paper does not necessarily mean a report or initiative is automatically reduced in importance, it does however, often indicate that the nursing agenda is given less consideration than others. In essence, the Board and individuals on the Board have the power to promote or relegate the nursing agenda to a summary paper or to receive the fully-fledged document. Indeed, in another Trust the Nurse Lead suggested the changing nature of organisational structures and individuals impacted on the difficulty of having a consistent and high profile for nursing:

"We were going through an organisational review, an integrated business plan was being developed and also there were huge changes in terms of where people sat within the organisation. Finally when we did have an opportunity to take that forward, [the CNO Review] all the places were changed completely so we had different service managers, different directors with slightly different titles, also working to an integrated business plan that would probably only last a year whilst we got foundation trust status and then shifting across into that process."

5.43. The organisational and individual changes that took place often meant that opportunities were missed in some Trusts to take forward the CNO Review, since it was not considered a priority area. This often meant that various nurse champions had to be creative in how they kept the Review active, more often than not this was done by integrating the review into existing work streams.

5.44. All of this relates more to the nature of the 'vehicle' than to the content of the review: discussion has referred to the document as a whole, its overall characteristics, status and impact, rather than the specific recommendations and the finer response in each area. The following section begins to further unpack the influence of particular recommendations on specific areas of practice.

Implementation of Recommendations

"This review aims to improve the outcomes and experience of care for service users and carers, and acknowledges and cites much current good practice. The recommendations made provide guidance for the development of mental health nursing over the next 10 years, starting from today". (CNO Review 2006)

5.45. It is explicit from the above statement that delivering improved outcomes for service users and carers over the next ten years is central to the CNO Review recommendations. To deliver these outcomes, therefore, it is important that Trusts put in place measures to implement the recommendations. In this section of the report, the intention is to provide a snapshot of how the six selected Trusts have thus far implemented the 16[6] recommendations emanating from the CNO Review. This overview stems from interviews conducted with staff working in the Trusts at different levels and in different specialised services.

5.46. There are, however, limitations to this overview. First, many of the interviewees had not seen the Review, or even if they had, were not familiar with some or all of the individual recommendations. Secondly, most Trusts did not have any dedicated Action Plan, which monitored the progress for implementing the recommendations. Therefore, the overview is general in nature and attempts to capture an overarching snapshot of how Trusts are performing as a whole, rather than how individualised services or units are making progress on a particular recommendation.

5.47. Nonetheless, when shown the recommendations it was clear that most interviewees recognised the values and principles underpinning the recommendations. This meant that interviewees could comment on the progress made by their Trust in implementing each recommendation. Although there were differences of opinions and emphasis among staff about how organisations were implementing the recommendations, most, if not all interviewees recognised that the recommendations were commensurate with the underlying philosophy of the services that the Trust they worked in was attempting to provide. Table 14 below provides an overview of a how each Trusts was performing in relation to each of the sixteen recommendations. The data in table 14 were extrapolated from the data collected from the interviews an focus groups in phase 2 and mapped, where possible against the Review recommendations.

[6] Although there are 17 recommendations, recommendation 14, strengthening pre-registration education is applicable to Higher Education Institutions only.

Table 14 Implementing the review recommendations in MHTs

Recommendation	Trust	Trust response
1. The key principles and values of the Recovery Approach will inform mental health nursing practice in all areas of care and inform service structures, individual practice and educational preparation.	**A**	Embedded in organisation (but variation between services), used in care plans and star worker system on acute wards, meaning contested among staff
	B	Limited but increasing training on recovery throughout Trust. There was general awareness of recovery among staff; different services appeared to be applying their own version of recovery
	C	There was a strong focus on recovery in the Trust and all staff had received some training
	D	Recovery was well established in the Trust (e.g. local recovery forum was in place) particularly at the strategic level, some staff were ambivalent abut recovery approach
	E	Recovery values were recognised throughout Trust, but there was little unanimity about how these values could be applied.
	F	The Trust was promoting the recovery agenda and training was being rolled out to all staff, application of recovery was patchy
2. MHNs will promote equitable care for all groups and individuals	**A**	Staff were aware of some equality issues, but appeared vague about how they delivered equality
	B	Evidence of significant progress in promoting equality
	C	Sense of lack of progress – mixed sex wards was a concern
	D	Staff aware of importance and evidence of progress in Trust
	E	General awareness among staff and evidence of measures in place to promote equality
	F	Evidence of recent initiatives to promote equality of care
3. All MHNs will access, understand and use evidence that can improve outcomes for service users.	**A**	Staff felt they were providing evidence based care –supported by nurse consultants.
	B	This was a strong feature throughout Trust – obligatory for staff to supply references for interventions, when planning care in some services.
	C	Has only very recently improved –Trust has started to implement evidence based policies (e.g. preventing falls linked to the NSF).
	D	The Trust over the past few years had made vast strides to provide care that was evidenced based.
	E	Evidence-based care has improved within the Trust over the past 4-5 years – one community team has an EBP meeting every week.
	F	Evidence-based care was linked to the recovery approach.

4. MHNs to principally work directly with service users with higher levels of need and support other workers in meeting less complex needs.	**A-F**	This was the one recommendation where there was unanimity in response. Most staff interviewed believed that mental health services and nurses attempted to address the needs of service users with the most complex requirements. But this recommendation did not figure high up the agenda in priorities of improving outcomes – response was rather mooted.
5. All MHNs will be able to form strong therapeutic relationships with service users and carers.	**A**	Staff considered they were making good progress on strengthening relationships with service users and carers – new systems were being put in place.
	B	There was a feeling among staff that relationships with service users was good- but provision for carers need improving. Geographical location of Trust identified as a problem in engaging carers.
	C	Most staff believed the trust had very good provision for meeting the needs of service users and carers – going back at least five years.
	D	It was generally considered among staff that the Trust was very good at establishing relationships with service users and carers (e.g. carers were given a careers assessment).
	E	Relationships with service users and carers had greatly improved but some members of staff thought the Trust (in some services) could make more effort at engaging service users/carers.
	F	The Trust had many recent initiatives in place to strengthen relationships with services users and carers and there was a feeling service users and carers were more included in influencing practice.
6. All MHNs will be able to comprehensively assess and respond to service users' individual needs and identified risks.	**A**	All staff interviewed thought the Trust put a strong emphasis on continuously managing risk effectively.
	B	There has been a big improvement within the Trust to manage risk effectively, which was initiated due to a gap in staff practice.
	C	There was a push on to improve the overall assessment and care planning process.
	D	The Trust had a robust auditing system in place to manage risk effectively.
	E	The Trust was considered to be managing risk effectively in most service areas.
	F	Risk assessment central to service user care and staff felt confident Trust was doing this well.
7. MHNs will have the skills and opportunities to improve the physical wellbeing of people with mental health problems.	**A**	Trust had a very rigorous and well established approach to improving physical well being.

	B	Much improved in the past six months – some service users have much better access to GP as a result of one initiative.
	C	Only recently had the Trust started to make provision (in the form of better training) for improving physical well-being.
	D	Recent improvements noted such a Clinical Skills Facilitator in post to deliver physical assessment skills.
	E	Was not previously high on the Trusts agenda but there have been recent initiatives (dual trained nurses) indicating the Trusts is making vast inroads in this area.
	F	All service users given initial physical assessment followed-up again at six months.
8. MHNs will contribute to an increase in the availability of evidence-based psychological therapies.	**A**	Happening to an extent – but there are long waiting lists when referring clients to psychological therapies.
	B	Long waiting lists and lack of qualified staff noted as a barrier to providing appropriate psychological services.
	C	Trust had demonstrated a strong commitment (over the past twelve months) to improve provision of psychological therapies – but there still significant gaps in some services.
	D	There was a feeling the Trust was making very good provision in providing psychological therapies (e.g. CBT forum established).
	E	The Trust has made very good inroads into providing psychological therapies particularly around staff training.
	F	There were some gaps in services but the Trust making good provision in providing psychological therapies.
9. MHNs to increase the social inclusion of people with mental health problems.	**A**	Social Inclusion in the Trust was not well understood – Nurse Consultant had begun the process of demystifying the term to staff.
	B	Some staff had received training on increasing social inclusion – others were less certain the Trust had measures in place.
	C	Social inclusion was seen not as a priority recommendation among staff.
	D	There appears to be an awareness of social inclusion in the trust but no major initiatives were in place.
	E	Staff did not feel social inclusion was high on the Trust agenda but there was recognition it was an issue to be addressed.
	F	Some services in the Trust making provision for increasing social inclusion.
10. All MHNs to recognise and respond to the spiritual and religious needs of service users.	**A**	Most staff recognised that the Trust had made strides towards recognising the spiritual needs of all service users and not just those within the Christian community – which was the focus previously.

	B	It was considered among staff the Trust had a good record in recognising spiritual needs of service users and progress was accelerating forward at the same time.
	C	Did not appear to be a priority – although there was some evidence that provision was improving (e.g. a spiritual forum was being established).
	D	Spiritual needs were being addressed but there was a sense that a more focused strategy was required and was in the process of being adopted.
	E	The Trust had a good record at recognising the spiritual needs of all service users.
	F	The Trust was making real strides in recognising the spiritual needs of all service users (e.g. it was considering how different spiritual models could be incorporated into initial assessments.
11. MHNs in all settings will be able to respond to the needs of people with mental health and substance misuse problems.	**A**	There was a recognition among staff that the Trust was made improvements in this area.
	B	There was a feeling the Trust had regressed on this issue over recent years, but had very recently begun to respond to the needs of people with substance misuse problems.
	C	Staff thought the Trust were meeting these needs adequately.
	D	The Trust has recently put in place measures to improve awareness and training for mental health nurses to respond to the needs of people with substance misuse problems.
	E	There was recognition the Trust had over the past years improved services to meet the needs of people with substance misuse problems, although key individuals were driving the process.
	F	The Trust is very good at responding to the needs of people with substance misuse problems.
12. All individuals receiving inpatient care will receive a service that is safe, supportive and able to respond to individual needs.	**A**	Inpatient care was seen to be steadily improving but it was considered an area that required extensive remedies.
	B	The provision for inpatient care was considered to be fair, but certain facilities could be vastly improved.
	C	The Trust had made progress to improve inpatient care particularly over the past three years and provision among staff was considered good.

	D	The Trust had put in place strategies to improve inpatient care which were well recognised and appreciated by staff.
	E	There was a feeling that inpatient services had been neglected over the years with the focus being on community services, but the Trust had, to an extent, started to redress the balance.
	F	Inpatient services (in particular acute) were experiencing pressures and recently financial and personal resources have been targeted to address these issues.
13. MHNs will improve care by developing new roles in response to local need.	**A**	The Trust had an excellent record on developing new roles and skills for mental health nurses.
	B	Most staff thought the Trust made excellent provision for staff to develop new roles and skills.
	C	Staff felt the trust were quite supportive in developing new roles and skill.
	D	It was considered the Trust was quite proactive in developing new roles and skills for Nurses.
	E	There were many opportunities for nurses within the trust to develop new roles and skills, but promotion opportunities were limited.
	F	Initially there was a challenge around developing new roles (particularly) from other professions but nurses are becoming more confident in taking on new roles.
15. All MHNs will contribute effectively to multi-disciplinary teams.	**A**	Staff considered this area to be a particular strength of the Trust.
	B	MDT working is a standard feature throughout the Trust, but senior Doctors tend to dominate and nurses are not always listened to.
	C	MDT working was effective throughout the Trust – although it was acknowledged that many services had adopted to their own style of working which was sometimes confusing.
	D	MDT working has improved throughout the Trust particularly in the past two years.
	E	There was recognition among staff that MDT working has very effective throughout most areas of the Trust.
	F	Good MDT working in the Trust noted, particularly around CPA.
16. All MHNs will continue to develop skills and knowledge throughout their careers.	**A**	Trust was good at supporting continuing professional development and indeed because many staff had progressed this caused some recruitment problems at lower level.
	B	Considered to be a particular strength of the Trust – staff felt well supported in professional development.
	C	There was a gap but the Trust has recently put in measures to meet staff needs including using e-learning.

	E	There was an indication area is covered well but the Trust is putting in better systems to support continuing professional development.
	F	Trust is very good at supporting continuing development, but sometimes-frontline workers struggled to find the time to take advantage of the support.
		There were many funding opportunities available within the Trust, however, some people felt that staff were not very well supported in their professional development requirements.
17. Processes, roles and systems will improve the recruitment and retention of MHNs.	A	This was a problem area in some Trust services and many initiatives were being put in place to improve outcomes.
	B	The Trust had some problems recruiting and retaining staff particularly in some of the more specialist areas – but were striving to improve.
	C	Not a problem many members of staff stay with the Trust for many years – although demographic time bomb may kick-in over the next few years.
	D	There were no significant problems with recruitment and retention in the Trust.
	E	The Trust had no problem in recruiting and retaining staff, indeed many advertised posts had multiple applicants.
	F	Not a significant problem but many nurses due to retire in the next 3-5 years and the Trust had measures in place to replace this shortfall.

5.48. The commentary in this part will NOW focus on the three themed sections of recommendations in the review:

- Putting values into practice,
- Improving outcomes for service users,
- A positive, modern profession.

Putting values into practice

<u>Recovery</u>[7]

5.49. All Trusts had started the process of implementing recovery-based values in some way. As expected, each Trust was at a different juncture on their recovery journey and there was evidence that some Trusts had made a significant investment of time, money and resources to incorporate recovery values into their services:

- All Trusts had implemented some recovery training to all clinical staff.

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[7] Our operational definition of recovery was guided by that in the CNO Review Report. The researchers recognise, however, the contested issues around the nature and meaning of Recovery for different people.

- Many Trusts had brought in outside experts to facilitate these training programmes and some Trusts were using service users and carers to provide input on training.
- One Trust had links and a shared post with the local University Recovery Centre,
- One Trust had established a recovery forum,
- Several Trusts have held conferences with papers on recovery, and
- In one case, a DVD was produced for staff to provide information around recovery approach values.

5.50. A Nurse Consultant neatly encapsulates the nature of recovery in most of the Trusts:

> *"It is not embedded enough. Nevertheless, I think, I think that will come, I think it is coming, and I have been actually quite impressed. Saddened at times but quite impressed on another level at how much people are using the principles of recovery approach. What I see my role is saying (…) this is nothing new, you are already using these principles, you are just not linking them to the recovery approach that is within, you know, the CNO review and all the other things that we are working with now. In terms of embeddedness, I think we still have a way to go, but I do think, I think we will get there, and I think, you know, we are partly there already".*

5.51. A Modern Matron in another Trust thought that particular Trust was already there:

> *"I think the recovery model and the approach is a fantastic one and it sits very well with a lot of the work that I'm involved in around CBT and LP, you know, (…) instilling hope, looking at how you move people on and about wellness. So yeah, I am doing a lot of that in the acute inpatient service around, (…) groups".*

5.52. In another Trust, a Nurse Practitioner thought the recovery approach was working well in the community:

> *"I think there is quite a wide understanding of recovery, certainly within my own team, it's, you know, going into people's houses when they're acutely ill and seeing the person , within their family, within their social structure, the neighbourhood, good and bad, … is that, you know, you take a completely different approach to something ".*

5.53. These quotations reveal the different interpretations of recovery and the different expectations of interviewees. Others were more reticent about recovery particularly around the meaning and nature of the approach as one Assertive Outreach Team Manager indicated:

> *"I think part of the difficulty is people say, oh, yeah, well, we subscribe to the recovery model; I still struggle to identify exactly what a recovery model is because it is a much-individualised thing anyway".*

5.54. A ward manager working with older people agreed:

> *"I think people do interpret it quite differently. In addition, that was quite a challenge where we were because we are saying recovery with our patients with dementia is not about getting them better, it is about getting them to meet their sort of optimum level of functioning really. Whereas many staff said, we cannot do that because our patients are confused. It is difficult to engage them but you still can try to get them to function at the ultimate level within their Phase of their illness".*

5.55. Since the Review itself gives little detail or definition of Recovery, and there is little consensus about what it 'looks like' in practice, it is not surprising that such varied opinions about implementation were voiced. It is interesting however, to note that one Nurse Consultant raised the question of feasibility of implementing Recovery in in-patient settings:

> *"In-patient care, as a service, I do not think we have thought through exactly what we are there for; we are still struggling to define the role and function of in-patient care. We still do not know how recovery can be implemented in that environment, particularly where we are an agent of control, where people are on a section, where we are containing them, we are not sure how we can implement recovery. Moreover, I do not think anybody else is either. It is an area that has not been thought through yet".*

5.56. Linked closely to Recovery is increased collaboration with service users and carers. This approach acknowledges the expertise that experience of mental health problems and of using mental health services brings to making decisions at a service level as well as at an individual level. Most interviewees at all levels and in all Trusts thought that that their organisation had made great strides, in developing opportunities for service user and carer involvement.

> *"… We have a very strong user movement here, we have carers as well, and we are very strong. I think over the last five, ten years, it has actually grown quite a lot. I think, like any Trust, we probably felt it originally, as being just a critical aspect as opposed to, let's work together to improve the services that you as service users want. We as a Trust need to be big enough to say yes, okay, we got it wrong, what do we need to do? I think that has developed. Moreover, there are many user forums; there are many presentations and lots of involvement. We've got user representations on the ward and in the centres out*

in the community, that people can access, we've got close links with carers, we've got good links into carers' assessment teams, things like that. So it has grown beyond all recognition from, even when I started in this job seven years ago".

5.57. Nevertheless, in several Trusts, staff felt that carers were less involved in services and received less support for their own needs:

"If I am being very honest, I think carer provision here could be probably, could be better, I am not even saying probably, it could be better, there is no two ways about it".

5.58. Another senior nurse agreed:

"We are not there at all for carers actually and we are very conscious of that. There is a carers' worker and she has just recently come on to the acute care forum, to give it more of a focus around carers. She has started one evening a month on a Wednesday, just to be there, you know, for carers, but that is something that we do have to develop, definitely".

5.59. The complexities of user and carer involvement and some of the barriers were well recognised: difficulty recruiting people willing and able to participate; providing them with training and support, providing meaningful responses to heterogeneous vies and expectations and organising this in a manner that goes beyond tokenism. As one nurse consultant commented, these challenges could not be ignored or avoided:

"We have the acute care forum and two service users and two carers' places have been ratified on that. I have to say they are not fully established because people find it difficult to attend, we have had some turnover, service users have been readmitted, we have not found a second carer. However, I take that seriously, I provide support, feed back the members, make sure that people have a chance to say their piece and that it is put into the minutes. Nevertheless, I would say that user and carer involvement, it is all very well saying you have it but its complex. Service users are heterogeneous, user and carer involvement is not easy and to say, to say to do it does not give any idea about the extent of implications and complications. I suppose what I would say though, is that we have to walk through that minefield rather than avoid it".

5.60. Other staff members recognised the contradictions between mental health law (increasing control) and policy (increasing choice) and found that balance difficult to achieve in practice:

> *"Service user involvement is a particular interest of mine. I have to be somewhat cautious not to take a too radical view really, because sort of, one of the problems with psychiatry is that there are many conflicting arguments. On the one hand, we want service users to have control and direction, and on the other hand, they [the state] want services to control the population in terms of not being ill and destructive or whatever (...) and it is a difficult and sometimes impossible balance. I think it's perhaps one that you're more acutely aware of from a nursing point of view, and because of your, you know, sort of, that sort of more personal relationship, that you have with service users and carers, it is that, it's incredibly difficult one. I mean, my own, my own dissertation for the masters is around social focus v therapy, which is very much about service user empowerment, using their direction, and using strengths and resources and coping with what they have. And so, and I think that's the predicament that the trust has, is that whilst we use, you know, service users, carer views, it wants to take on board what they're saying but then there's also a state expectation that service users don't have control to take all the responsibility that goes with it".*

Evidence-based practice

5.61. All Trusts were in the process or had established mechanisms for providing evidence-based care. There were a few innovative features, such as referencing care plans, and some Trusts were using Nurse Consultants to ensure services and practice was evidence-based. There was, however, some feeling that there was a lot of rhetoric around evidence-based practice, as one senior Nurse commented:

> *"I think ... up until very recently, we spoke a lot about evidence based care but, you know, if we were tested on it, I don't know how well we do. Having a nurse consultant in post, has, has put more of an emphasis on us striving to be evidence based in many of the things that we do. Therefore, that is something that we are definitely growing into".*

5.62. This view was echoed in another Trust where a Nurse Consultant thought the problem was in supporting nurses after they had the evidence-based knowledge:

> *"I suppose another area, research, and our ability to be able to sit down now as a group of nurses and say – Actually what does the evidence base, or what does research say about recovery. Things like we know we have the psychosocial intervention course which is the MSc. We know that out there we have excellent funding. We have excellent opportunities for people to be released but actually people qualify and they have no support afterwards. My view is supervision, supervision, supervision, you know. If you want somebody to undertake some of the evidence based kind of interventions that you know there is an evidence base of over twenty-five years to say that it works. Then why are*

> *we not investing in proper follow up supervision when we are spending 15 to 20 thousand pounds on an MSc"?*

5.63. This was a common theme and many interviewees thought the use of supervision could be utilised much more to support nurses in providing evidence-based practice; and indeed to provide support and mentoring for nurses, to write for publication, for skills escalation and to provide a strong motivated workforce. Therefore, providing the evidence-base does not appear to be enough, Trusts need to invest in systems that offer support and supervision to enable the evidence to be put into practice.

Promoting equality in care

5.64. The final recommendation concerning values did not register highly with most of the interviewees. This was not because it was a neglected area but because many staff thought there was good provision to promote equality in care; senior members of staff in particular were very aware of the public sector legal obligations that Trusts must meet to ensure that equality and diversity are promoted throughout the Trust. One Acting Director of Nursing summarised the areas covered:

> *"Equity of access, well, they cover a certain geographical area, they do have various teams, which you might know as assertive outreach teams, assertive care teams that look at being inclusive in who they pick up and they look at the hard to reach communities, service user groups as well. Most groups have BME (Black Minority Ethnic) development workers. So most localities have those, because I think we found, certainly in some of the areas of high ethnic mix, the number of patients we have is not representative at all, based on the local population. I mean, an average across the trust, for example, people from an Indian or Pakistani area, they represent about eight percent of the people we see, whereas the population in the Trust area is about thirteen percent. However, that is the average. In somewhere like XXXX, it is probably nearer thirty, thirty-five percent. Therefore, that is something we are aware of. Age, we try not to run an age-specific service. At the top end, we have an older adult service but there is not an automatic transition at sixty-five or anything".*

5.65. All Trusts were certainly putting in measures to promote equality in care, however, because these public sector requirements were recent many of the initiatives and actions had not filtered down to frontline staff, a ward manager commented:

> *"No, I have not seen too much about equality, no. It is certainly something that is talked about but there is nothing specific that I am aware of, that is driving it forward ... They've done some equality and diversity training, certainly I attended some last year. However, I certainly think that is all".*

5.66. Among staff interviewed it seemed that the values recommended in the Review were being given serious consideration for some time before the Review as published so the Review was considered confirmatory rather than innovatory. Although many members of staff had not heard of the review, or if they had, most were not familiar with its content, they were undoubtedly familiar with the values it commends. This was also the case for the second themed section: Improving Outcomes for Services Users.

Improving outcomes for service users

5.67. Improving outcomes for service users is the central aim of the CNO Review, in this themed section there are nine recommendations aimed at achieving this goal. One of the recommendations strengthening relationships with service users and carers has already been discussed above in the relationship it has with recovery. All Trusts in this study thought they were improving outcomes for service users overall. That is not to say, however, that all services within each Trust are giving equal priority to each of the recommendations. Also some recommendations such as 'improving inpatient care', 'meeting the greatest need' and 'increasing social inclusion' presented more of challenge to most Trusts, whereas recommendations such as 'improving physical well-being' and 'providing psychological therapies' appear to be well catered for in most of the Trusts. Nonetheless, there are marked differences sometimes between and within services in the Trusts in meeting these recommendations.

Meeting the greatest need and increasing social inclusion

5.68. These two recommendations (see Table 14 above) above all of the others were the most difficult to assess in terms of staff attitude. When shown the recommendations most interviewees did not register an much of an interest or understanding in these particular areas. Most interviewees assumed they were meeting the greatest need of services users and that their work would automatically focus on working with service users with higher levels of need, although there was no quantifiable evidence to support that this was happening. In relation to social inclusion, the difficulty here was how staff understood what the term social inclusion meant. As one nurse consultant commented:

> *"I mean, I think, again, I see my role as somebody that is going to help facilitate understanding of social inclusion. I think social inclusion; nurses do not understand what it means and tend to run a mile. So it's a bit kind of demystifying, this isn't something that has come from a group that you have to have a masters degree in to understand, it's about making it real, about making it practical, and just helping people to demystify what some of the terminology is that's used really".*

5.69. Meeting the greatest need and increasing social inclusion were viewed as low priority recommendations and probably the most misunderstood of all the recommendations and did not really figure on the radar of most interviewees.

Improving physical well-being and providing psychological therapies

5.70. In contrast, two recommendations that interviewees believed they were making very good progress on was improving physical well-being and providing psychological therapies. One nurse practitioner when asked about improving physical well-being and providing psychological therapies was emphatic:

> *"They are fantastic at that (...) having a big drive towards physical health and psychological therapies now."*

5.71. Indeed improving physical well-being was something that most members of staff thought had improved in recent years:

> *"If I give you an example of that, shall I, in terms of physical healthcare in mental health. Well, you know, the emphasis is on that in the review, but, we've already got regular checks for diabetes, we've got the smoking cessation programme, we've got screening of new patients as they come into the wards, we've got physical health checks of all people in the service and we're doing education for GPs about diabetes, weight problems and neuroleptics. I do not have to justify that anymore. I can say, yes, that is exactly what the CNO review says so we are on the right line".*

5.72. One ward manager commented how psychological therapy services were improving:

> *"We've got some access to psychological therapies, I mean, we are quite lucky in that we have a medical director who really believes in the psychological therapies for older people, and I think without him we'd be in a much worse position, but there's certainly not an equitable service across the trust at the moment. Again, the adult services will take the lion's share of what's on offer".*

5.73. This demonstrates an improvement, but again it highlights the variation among different service providers. Nonetheless, many interviewees echoed these views, which emphasised the strides Trusts had made in improving physical well-being and improving psychological therapies. It was not possible to attribute these improvements to the CNO Review. Many of these improvements had been ongoing within the Trusts and given impetus from recent reports and initiatives such as the IAPT programme and the

Choosing Health (DH, 2006) document. Nonetheless, there was recognition among staff of considerable improvement in these areas.

Improving inpatient care

5.74. The one area in this section which staff had reservations about was - improving inpatient care. Many interviewees thought that the provision for inpatient care has been neglected over recent years and that front-line workers were sometimes battling against the odds to keep services afloat.

> *"I think, from my perspective, what depleted inpatient services, was when the functional teams were set up, many very experienced inpatient staff jumped over to crisis teams, and I think that, for a while, that has left inpatient services short. Because years ago, it used to be seen to be desirable to be, a head of, you know, inpatient services or a ward manager, in the acute services, but now it is more desirable to become a CPN or a mental health team manager or something".*

5.75. Another interviewee agreed and thought that inpatient wards were over reliant on Band 5 staff nurses who often did not have the role models on the ward to look up and aspire to:

> *"I think they have been greatly neglected [inpatient services]. I mean, if you take an acute admission wards now, here, there is one band seven who is a ward manager and is very much a ward manager, not a charge nurse or sister, because of an expectation they would manage and do the performance management stuff. Then you have a deputy ward manager and then you go to band five newly qualified staff, but no role models. I just do not understand that really".*

5.76. Another senior nurse captures some of problems inpatient services have recently experienced due to lack of resources and low staff morale:

> *"I looked at it and thought, My God, I would not allow anybody belonging to me to be admitted here. That was how bad it was. ... It was, like, the carpet on the bedroom floors, which, well, I do not know how long it had been there. There was one patient in particular being cared for in a room that you would not have, you would not have put anybody in. It was so bad and there was quite an authoritative attitude from the staff, you know, where, I'm the staff and you're the patient".*

5.77. In this particular Trust, however, improvements to inpatient services have been introduced which appears to be the case with most Trusts, where improving inpatient care has become more of a priority in recent times. As one senior practitioner pointed out:

> *"There was a huge neglect of in-patient care in mental health services, which changed drastically when the government decided to address it several years ago. I think the in-patient care; the journey for patients has improved. We are giving a much better quality of care for them. ... Certainly, there's a much, much better quality of care from an in-patient point of view, the journey's getting much smoother, and it has needed to."*

Holistic assessments and managing risk effectively

5.78. This was another recommendation where staff spoke quite openly about recent improvements and good practice in providing holistic assessments and managing risk effectively. In one Trust the improvement occurred because there was a noticeable gap in staff training:

> *"It was highlighted recently there were gaps in our training levels for newly qualified nurses in particular. Therefore, we ran a couple of courses recently, which is specifically aimed at risk assessment training. We used this tool. It is a multi-disciplinary tool, so you have to have at least three disciplines there to do it. The current roll-out is getting everybody to (...), in fact, everybody is now trained up in that, and now, and, it's a case of making sure that every single patient has that risk assessment completed, and, it's so important that for any more referrals, what have you, that has to be completed before the referral can be looked at".*

5.79. Another ward manager believed that providing holistic assessments and managing risk effectively were routine practices that all nurses should and were doing:

> *"Well, holistic care is what we aim to offer, that, you know, particularly with mental health, we know that, everything about a person's environment, their lifestyle, their family, their work, everything, their beliefs, we have to have a holistic approach in order to incorporate all their needs. Then risk assessment is just an ongoing process from the minute they are admitted to us, until discharge, you know, the whole time they are our clinical responsibility, our risk is being evaluated continually".*

5.80. There was certainly a strong feeling among interviewees that Trusts in the past few years had put in place measures to manage risk effectively, however, these

measures were ongoing and more often than not, they preceded the CNO Review or followed an SUI, but improvements nevertheless.

Recognising spiritual need

5.81. At the outset when asked if Trusts were recognising spiritual needs many interviewees gave a positive reply, however, the replies tended to talk about religious beliefs rather than spiritual beliefs. There was, however, recognition that Trusts had, at least, began the process of moving the boundaries beyond religion, toward a more spiritual dimension, as one nurse commented:

> *"Again, that's something now, I think, which is sort of more, it's highlighted more than ever before. Certainly, when I started my training, people were either sort of atheist, Christian, or Roman Catholic, that tended to be it. Whereas now, obviously, we have a very diverse cultural group, and we have to understand people come in with very, very different spiritual and cultural beliefs. So, and we try and incorporate that into, you know, their spiritual beliefs will affect how they view, perhaps their mental illness, how families manage that, so it has really quite, you know, a massive effect".*

5.82. Not all interviewees shared the above optimism that Trusts were effectively meeting the spiritual needs of service users. One nurse consultant thought the Trust needed to take a much more radical approach to meeting spiritual needs:

> *"I think spirituality means so much more than that, it means connections; it means connections with others, connections with the community. I mean, we are getting religion just about right. If we took, look at spirituality in terms of religion, we have a chaplain and he does a lot of staff support and he supports patients and we are giving him a much bigger profile. He did run a spiritual staff support group but it was poorly attended, so that has filtered out. I suppose, in terms of spirituality, we struggle at a meta-level with spiritual health because people at the board think boxes are ticked, when actually, they're only meeting cultural needs, not spiritual needs. It is easy to meet religious needs, cultural needs but it is not easy to identify what people's spiritual needs are and ensure that their whole wellbeing is attended to".*

5.83. In another Trust, there was evidence that service users had picked up the gauntlet and influenced how spirituality should be recognised in one service:

> *"So for example, in the champion group … it was the service users that that wanted the spiritual group, so I know, every month now, a group meets for, regarding spirituality, and from that then, we opened a sanctuary which is a room designated for quiet time".*

5.84. Not all Trusts or indeed services within Trusts were fully implementing this recommendation of meeting spiritual needs; however, clearly the debate has shifted from 'just providing a chaplain' to developing a greater understanding and more nuanced understanding of meeting spiritual needs.

Responding to the needs of people with substance misuse problems

5.85. The final recommendation in this section, responding to the needs of substance misuse, many interviewees spoke about gaps in services, but equally there was a recognition that provision had improved in recent years. One ward manager commented that taking account of people with substance misuse problems was central to the care programme approach in one particular service:

> *"Part of the holistic approach, just one of the other aspects, unfortunately, most of it, well, not most but many of our patients do have substance misuse problems. So, trying to think, I mean, it's, it's in every document that we have for like, programme approach, we had a section on it, so it would soon get picked up on, whether we are doing, or we should be doing it in that respect".*

5.86. Although in another Trust, there was a fear there was a gap in services:

> *"So I think, there's probably a gap there between dual diagnosis and who's who, because it's very easy to say, Well, it's your, that's the major problem and you need to have them. And then substance misuse say, well, you know, mental health is a big concern, and that's what I think it (...) relapsing so I think there's a definite gap and there should have been a dual diagnosis, you know, policy developed a long time ago which never really happened".*

5.87. Another interviewee reinforced this comment, although this particular Trust was attempting to improve provision:

> *"Substance misuse, it is an area we are trying to work on in the Trust. It is something we are not particularly good at, we have a substance misuse service, but they do not always cover the dual diagnosis side of things. So we are seeing, well, as I am sure you know, an increasing number of people admitted to the wards with a mental illness and a substance misuse problem".*

5.88. Responding to the needs of people with substance misuse was one of the recommendations where gaps were noted in service provision, but there was general agreement that Trusts had attempted to improve services, although the extent of the improvement Trusts instigated tended to depend on the priority a particular issue was given at senior level.

A positive, modern profession

Improving recruitment and retention

5.89. This leads onto the final themed section A positive, modern profession. As indicated above some, but not all Trusts, were having difficulty in recruiting and retaining staff particularly within inpatient services. It should be noted not all Trusts had problems with recruitment and retention and difficulties around these issues tended to be localised. For example, Trusts in more affluent areas where unemployment was low, and the local economy was strong, tended to have more difficulties recruiting newly qualified members of staff because there were alternative well-paid employment prospects.

5.90. One ward manager pointed out some of the local difficulties:

> *"We are very, very short-staffed now. We have five qualified nurse vacancies. We have managed to just fill support worker vacancies through an open recruitment day. Therefore, that was fortunate. The skill mix is not as good as we would like it to be, we would like to see it developed. That is a bit unfortunate because we did have a fair few very experienced staff, through natural progression, they have moved on and so we are now in a process of building up our team again".*

Another senior nurse suggested that the demographic time bomb could cause problems in the not so distant future:

> *"It's a big issue [recruitment and retention], we know, and I think its 243 of our nurses will be retiring in the next three to five years because of Mental Health Officer Status, so we've had to look, that is why part of our next strategy is work force is one of our key areas. The reason we do that then is with the rotation scheme, we advertise twice a year when the nurses are due to qualify. We know we are swamped with applicants, which is great so we are putting money out of our bank and agency pot to recruit so we can skill up our staff now".*

Developing new roles and skills and supporting continuing professional development

5.91. Despite some local recruitment and retention problems, most Trusts had put in place measures to support nurses in their continuing professional development and to develop new roles, skill, and interviewees provide good evidence of support in these areas as the following comments demonstrate:

"I think, well, I've touched on it before, they get more training possibilities here, and opportunities than most other places and it's one of the things that does attract people to work in here".

Question*: "Do you think this is an area in general where nurses can develop new roles and skills?"*

Respons*e*: "Without a doubt, I think that there are new roles and skills again coming back to the therapies, CBT, talking therapies, extended roles for in-patient nurses, which is all out there now. I mean, we've got several nurses downstairs that have (...) one of them has taken on ECT role, as I said, drug and alcohol, so, yes, I do think so".*

"We have, obviously, Continuing Professional Development so we have personal development plans. Now, of course, they need to link in with the clinical skills framework, so that is done. I hope that and people are, you know, very, very rarely are people told that they can't actually go on specific training, if they show an interest, then we try and support that development for them".

5.92. These comments reflect how most of the interviewees viewed these recommendations and overall most nurses were positive that the nursing profession was well situated to move forward into the modern era. This is not to say everything was perfect, far from it sometimes. Often there were limited financial resources to improve services, some staff spoke about a lack of leadership within the profession, and others were concerned about the future of the profession in the changing healthcare landscape. Nonetheless, many of the interviewees were positive about the profession; and they thought Trusts were now in a better position, from previous years to improve outcomes for services users and carers' experiences – which we turn to now.

Impact on Service Users and Carers experience

5.93. The CNO Review "... aims to improve the outcomes and experience of care for service users and carers..." so an important aim of the research is to assess the extent to which service users and carers

- knew about the review
- had been involved in implementing the review, and most importantly,
- could perceive any of the recommended changes in services.

Who, How and What to research?

5.94. We worked collaboratively as a research team with service users and carers to design a research method that would best capture the experiences of service users and carers, through focus groups and individual interviews, asking questions that related to

experience generally as well as specifically inquiring about any knowledge about the Review and its recommendations.

5.95. The first problem we encountered lay in arranging interviews with service users and carers. Without exception, the Trusts were not able to arrange for groups of service users to be interviewed in any situation. This was in spite of offers of support to invite service users to speak to them beforehand, meet them wherever it suited them, payment, reassurance that they did not need to have prior knowledge of the Review and assurance of anonymity. Ultimately, all Trusts arranged interviews with two or three willing service users and carers. Although there was a good mix of users and carers, they were, on the whole, white, British and middle aged. Many of the people nominated as carers were also service users but this dual status was rarely acknowledged by services – even though the people themselves felt that it increased the challenges that they faced and reduced the impact of their voice.

Rhetoric vs. Reality in Service User Involvement

5.96. All staff interviewees on all sites explained the developments in user involvement, there was some pride taken in the systems for joint interviewing, joint training and service users on various committees. When asked about the benefits of this involvement however, the general consensus was that this is now a requirement or a way of meeting targets; few interviewees saw it as a way of improving services.

5.97. Despite the rhetoric about involvement, in reality, none of the Trusts had a user and carer involvement strategy (although several said these were in development) and those service users and carers who were interviewed were confused about: what involvement is , why involvement happens, how they should behave, what they need to know, how best to contribute, whether it makes any difference and whether it is worth the effort (several had given up when their voices were not seen to make a difference). They felt that others were reluctant to get involved because of similar questions.

> *"But I don't know why, what I could do which would be beneficial to the trust".*

5.98. These questions seemed to have been exacerbated by the move to Foundation Trust status, which had changed their roles and seemingly reduced the opportunities for involvement. Although several said they were 'members' of the Trust, and others had been invited onto governing committees they felt that the additional formalisation of processes had reduced flexible and informal approaches to get involved at a practical level. Indeed several spoke of involvement being 'side-lined' with recent structural changes.

> *"Well, with the move to FT status it doesn't exist anymore but it was a board where a mixture of managers, clinicians, service users and carers and, was open to the public, for part of it, and oh, report to the provider board, about proposals*

> *of things or actually figures, things like suicides and untoward incidents and things are brought to the board and discussed and ways forward discussed, and things like that. But now it's been replaced by the trust board, and the new partnership trust board and a lot of their energy's taken up in that".*

> *"They're running at a hundred miles an hour with foundation trust status, they're big, busy, they're on the go, fire-fighting all the time. In addition, the opportunity to stand back and say, I wonder what we perhaps ought to be doing that we are not doing? How can we make this a better service? What could we do? ... like many organisations this day, they are running almost like postmen are supposed to, apparently, run instead of walk. And if you're running, then you can't plan".*

5.99. Service users and carers generally fell into two groups. Service users who had been involved for many years and spoke of improvements in services over a long time period since they last had experience of inpatient treatment, and the more recent recruits who were more progressive, more critical, had more recent experience of using services. Carer interviewees were either people who have been professionally trained and are used to operating in business meetings or many were parents, whose children have developed Mental Health problems. They have struggled to cope with caring for their relatives, often without much help from the system which they felt should have offered them information and support. Now that they are involved they are keen to contribute their experience and knowledge so that improvements can be made, and frequently work hard to try to achieve this. The second group of carers were largely people who have been in the MH system for many years. Often they are both service users and carers and they are less familiar with business meetings, but tend to have wider networks, and a closer knowledge of the system. They too are keen to contribute, work hard but are often less optimistic about outcomes.

5.1.1. People had generally become involved through personal requests and recommendations by staff that saw it as a way of helping them as well as bringing a new voice to bear:

> *"... once finding and recognising myself as a carer, I think that old saying of If you can't beat them, join them, came to play and I met with two particular workers ... who recognised that the patient, being my son, had a supportive family and that they should be brought in and they should be given information and ultimately will help the patient … if you want to get involved and you can help and you see areas that could be improved, they are more than welcome and they have been very, very good in opening the door and saying Yes please, what can we do to help? What can we do to change? And that's been amazing".*

"they did have a meeting locally to try and drum up some enthusiasm and get somebody to sit as the representatives. They didn't manage to get a carer so I was, you know, asked would I like to do it so that's how it came into being".

5.1.2. The problem with this haphazard procedure means that changes in staff affect the continuity of involvement:

"this director then left....we got into a little bit of limbo."

"...she told us about the Chief Nursing Officer's report and ... I produced a little report, sent it to a few people who I thought would read it, who were in, who meet on the provider board, I had some feedback but everything has, how can I put it, because of the partnership procedure (merger), everything's gone quiet, if you like".

"...between the lady who was the director leaving and (...) taking over, (...) took over in the interim and decided that she would split the group".

5.1.3. They agreed to become involved as a way of improving the system and spoke of various involvement roles: interviewing staff, training, sitting on committees and groups (e.g. Acute Care Forum). However, they all spoke of the difficulties meeting increasing demands for involvement from a limited pool of willing people, and most spoke of the slow pace of change and small reward for their work. Only a small minority received payment for their involvement. Sometimes involvement has been a useful process for the person concerned, giving them a sense of value and self worth, and helping them to come to terms with the role of carer that has been thrust upon them. It has given them access to information and a clearer understanding of services.

<u>Awareness of the Review and its impact</u>

5.1.4. Most of the interviewees had heard of the Review – usually because they were informed of it when picked to be interviewed for the research, as described by someone involved in the HEI Focus Groups as well as the Trust Case Studies:

Question: *"When did you first hear about the Review?*

Response: *"Some time last year, I think it was, there was a focus group at the university and I was invited to take part in that and we used user and carer representatives and someone from. I think it was Nottingham University or one of the universities because Nottingham University was mentioned but a couple of others were mentioned and they were travelling round several chosen universities and they were talking to. I suppose everybody, professionals and as well they did an interview with users and carers and they asked us what we*

thought and I think I was chosen because I had the relevant experience because things have changed in the last few years"

Question: *"So you participated in a focus group about the Chief Nursing Officers Review?"*

Response: *"Yes and we had an extremely nice letter and I was sent a copy and it said we were very knowledgeable at the university of (...) which I put down to our back ground in recovery"*

5.1.5. One person had been involved in the consultation process and met the CNO during this process. However, none had been specifically involved in the implementation of Review recommendations.

5.1.6. When asked about changes or improvements in services over the past two to three years, service users and carers described the satisfaction of being involved in relatively small initiatives with individual members of staff or groups. These included:

- Involvement in Audit

  "They have let me as the carer (lead for it), so I have done a flier inviting all carers that are interested in doing this audit to get in touch with the trust. Therefore, we will have so many that will do the audit and we will have some (...) so many of them that will look at the tool with the right questions to ask".

- Pathway for carers within Acute Care

  "I find that there are a lot of good things happening individually but it's not joined up. ... I'm the lead to put together a service pathway for carers to see what people are doing, to see what's currently available, and then, to try and cherry-pick from those areas to say "Well, actually, there's quite a lot being done on individual ward basis that is quite good and other people could benefit from that". And then the idea is to try and roll it together and then roll it out".

- User involvement in staff induction and Service user and carer involvement in staff interviews

  "Well, mainly, now, what happens, I do inductions for staff, that I give a short résumé of my experiences within mental health to perspective staff and I've been (...) interview panels and, well, whatever else they want to ask me to do ... So it's that sort of involvement".

- Development of information resources

  "the website for service users of early intervention so that's the whole of Lancashire ... what's basically been done in the past, the website's been kind of built by the secretary so it's just like bits coming all over the place, (...) so they scrapped that, commissioned me to come in and do something from like a service users' and carers' perspective and it's, what I try to do is like not, like what I've

seen in other trusts actually, just becomes a dumping ground for reports and things that aren't particularly relevant".

- Service User and Carer Involvement in training

  "Yes, I'm training for that, I go on the programme and also the New Ways of working programme, I'm trained to facilitate that and that was the trust and that was done with all the professional people came along, heads of departments in the main, and representatives".

- Training as aid to own recovery as well as improving awareness for nurses.

  "I have been asked to do a half day on the sort of carers' perspective or family perspective to students to nursing staff. Which I think is, I am honoured to do it and I think it is really, important. I had an amazing feedback from the presentation that I did here, where...It was for the rehabilitation wards so we had everybody from the, had a good turnout and we had people who were the carer support right through to the director of psychiatry. So, and staff nurse and everything in between, so that was useful".

- Creating a video about the experience of carers:

  "Carers from (...) did a video, trying to get across to the nursing staff of how it feels to be a carer..."

- Providing a critical voice within services:

  "We [the PPI Forum] were highlighting different things every time. One of them was, for instance, patients complaining about not getting any breakfast in the morning. When we queried with the manager, he said " Well, we only get enough money for one loaf of bread in the morning for breakfast". Anyway, they eventually got two loaves of bread instead. But that were one of the things PPI forum picked up on".

  "We're a firm believer of hearing what life is like from the persons experiencing it, i.e. the patient. And it's been very helpful, we were successfully managed to get a (chaplain) co-ordinators put in place, we managed to get advocacy services put in place which were resisted very strongly at the beginning ... we have a meeting every week that, ourselves, because we're limited in time, we go along every four weeks, and there is a room, dedicated room where anyone voluntarily can come along, and they have an opportunity to say whatever they like, what is good about the unit, what the ward, what is bad about it, what they'd like to change, what they think is good ... there is always a member of staff present as well, notes are taken, and from that, as one can imagine, you get a variety of opinions".

  "The Patient Experience Group is looking at the whole of patient experience and that meets about quarterly, it's chaired by the deputy chief executive and there are other members, senior members of staff. And that's where service users, like me, can raise whatever we want".

5.1.7. In the absence of service user and carer involvement strategies however, there were no clear, comprehensive and costed plans for involvement. Nor was their evidence of involvement specifically related to the Review Recommendations. Nevertheless, when asked about general improvements in the quality of care, there is evidence of improved levels of service in some of the Trusts visited:

> **Question**: *"What about the mental health services run by this trust would you say there has been a difference there in the way you or your son has been treated there in the time you have been involved as a carer"?*
>
> **Response**: *"Yes, the first time round that he was sectioned, he had to go out of county he had to go to Luton and Dunstable to get a secure unit ....come back till Easter, that was a long way of travelling and the bed purchased out of county. This time though, it was very serious, he was sectioned and they could cope with him at the local hospital in the acute ward. I think they are coping with more serious cases in the hospital. I think perhaps that is right because there is other ways of doing respite, or dealing with people who have had some upset that they need some time to recover".*

5.1.8. Furthermore, there is some evidence of influence from PPI on wards:

> *"We always said that before the PPI forum was abolished, that mental health services are going to suffer in the interests of these links (...) we need to get up and do something. We were highlighting different things every time, (...) we go to the same unit, two or three times, and different things would be brought up. One of them was, for instance, patients complaining about not getting any breakfast in the morning. When we queried with the manager, he said, well, we only get enough money for (...) a loaf of bread in the morning for breakfast, and if there were someone that (...) took three or four slices of toast, the rest went without".*

5.1.9. However, repeatedly there were very low expectations of carers interviewed.

> *"And with the resources that they do have they do a fantastic job, it's, I feel very bad criticising the things that don't happen, simply because I see the people who are doing what they can with what they have and it's a crime".*

5.1.10. There was little evidence of systematic involvement in either teaching or audit. Those that mentioned it suggested it was haphazard and, with one exception, was under control of staff. We could find little evidence of an infrastructure to support engagement either internally or provided externally.

Summary of Phase two findings

5.1.11. Among MHTs the Review was considered acceptable but there was little evidence of the recommendations being implemented directly as a result of the Review. However, there was evidence of actions that fitted with most of the 16 Review recommendations that applied to MHTs. However, these appeared to be driven primarily by other policies. The lack of response directly related to the Review in many Trusts was attributed in part to the lack of defined targets linked to the Review, funding, and a lack of external monitoring of implementation of the Review recommendations. Priority was afforded to urgent local crises/events and national targets. In addition, the Review accorded strongly with the current direction of activity as it closely reflected other health and social care policy, and this appeared to give it validity within many Trusts. Many nurses interviewed in Phase 2 reported a lack of awareness of the Review; yet when the researchers introduced them to the Review, they welcomed it and wished they had had previous knowledge of it. There appeared to be a lack of strategic leadership towards implementation of the Review in many of the MHTs sampled in phase 2. Despite this, there were individual champions in some Trusts who were attempting to use the Review for strengthening and galvanising the nursing profession for the benefit of services users and carers. Service user and carer involvement in plans to implement the Review recommendations were negligible.

CHAPTER 6: COMPARISON OF FINDINGS BETWEEN PHASE 1 AND PHASE 3 SURVEYS

6.1. Thirty seven (55%) Trusts and twenty-seven (54%) HEIs completed the phase three survey fourteen months following the phase one survey. The researchers compared the findings between phases 1 and 3 of the surveys. Table 33 presents the e-survey responses from Phases one and three.

Table 15: E-survey responses from phases one and three

Phase	Organisation	Response
One	MHT HEI	42 (64%) 40 (80%)
Three	MHT HEI	37 (55%) 27 (54%)

6.2. In order to compare the results from both Phases, independent t-tests were used, which compared the mean of each response for all those who responded at phase one and / or phase three. Paired t-tests were used to compare the organisations who responded at phases one *and* three, in order to determine if there were any changes over the 18 months between e-surveys. Independent t-tests and paired t-tests were used to compare the three themes and 17 recommendations for all organisations, plus 70 accompanying '*making change happen*' points for Trusts and six '*best practice competencies*' for HEIs at both phases (see appendices four and five for further details).

Trusts – recommendation priorities and implementation progress

Trust ranking of priorities for each of the CNO recommendations.

6.3. Trusts were asked to rank all 17 CNO recommendations in terms of the priority within their organisation on a Likert scale (5 = very high priority to 1 = very low priority) (table 34).

Table 16: Comparison of phases one and three in the overall ranking of Trust organisational priorities for the 17 CNO recommendations

Recommendation (CNO review number)	Phase one ranking	Phase three ranking	Comparison (07/09)
Improving inpatient care (12)	1	3	-2
Strengthening relationships with service users and carers (5)	2	1	+1
Applying Recovery Approach values (1)	3	7	-4
Improving physical well-being (7)	4	5	-1
Holistic assessments and managing risk effectively (6)	5	2	+3
Promoting equality in care (2)	6	4	+2
Providing psychological therapies (8)	7	10	-3
Meeting the greatest need (4)	8	9	-1
Increasing social inclusion (9)	9	6	+3
Working effectively in multi-disciplinary teams (15)	10	11	-1
Providing evidence-base care (3)	11	8	+3
Responding to the needs of people with substance misuse problems (11)	12	13	-1
Supporting continued professional development (16)	13	12	+1
Developing new roles and skills (13)	14	17	-3
Recognising spiritual needs (10)	15	16	-1
Improving recruitment and retention (17)	16	15	+1
Strengthening pre-registration education (14)	17	14	+3

6.4. Using independent t-tests, analysis of the three themes showed no statistically significant associations in responses between Phases one and three. Also, when analysed by individual recommendation using independent t-tests, there were no statistically significant associations between the responses from both phases.

Trust progress with implementing the CNO recommendations

6.5. Trusts were asked to rate the levels of implementation for each of the 17 recommendations and the 70 accompanying *making change happen points*. Table 35 outlines the Trust ranking of each of the 17 recommendations according to implementation progress and the comparisons for both phases.

Table 17: Implementation of CNO recommendations for Trusts based on the ranking of accompanying suggestions (*making change happen points*) (full implementation to no implementation)

Recommendation (CNO review number)	Phase one ranking	Phase three ranking	Comparison(07/09)
Strengthening relationships with service users and carers (5)	3	1	+3
Providing psychological therapies (8)	10	2	+8
Working effectively in multi-disciplinary teams (15)	2	3	-1
Holistic assessments and managing risk effectively (6)	1	4	-3
Improving inpatient care (12)	8	5	+3
Improving physical well-being (7)	7	6	+1
Promoting equality in care (2)	11	7	+4
Responding to the needs of people with substance misuse problems (11)	9	8	+1
Strengthening pre-registration education (14)	4	9	-5
Supporting continued professional development (16)	14	10	+4
Developing new roles and skills (13)	6	11	-5
Recognising spiritual needs (10)	5	12	-7
Increasing social inclusion (9)	17	13	+4
Meeting the greatest need (4)	12	14	-2
Providing evidence-base care (3)	16	15	+1
Applying Recovery Approach values (1)	15	16	1
Improving recruitment and retention (17)	13	17	-4

6.6. Analysis of the recommendations using independent t-tests shows that there are no statistically significant associations between those responding at Phase one and / or Phase three. This is despite some considerable movement for 'providing psychological therapies' (an increase of eight places from Phase one to Phase three) and 'recognising spiritual needs' (a decrease of seven places from Phase one to Phase three). When analysed by *accompanying suggestions*, independent t-tests indicated two statistically significant associations[8] between the responses at Phases one and three.

6.7. Further analysis using paired t-tests indicated that there was a statistically significant difference for 'improving recruitment and retention' (p=0.038) for those replying at Phases one and three. In addition, analysis of the accompanying suggestions using paired t-tests highlighted two further statistically significant associations between Phases one and three[9].

Trusts' implementation strategies for the CNO review recommendations

6.8. Trusts were asked to outline their organisation's strategy for implementation of the CNO review. Twenty-three (57%) Trusts at Phase one and 15 (54%) Trusts at Phase three reported that this had already been formalised into an overall organisational strategy. Fourteen (34%) Trusts at Phase one indicated that the strategy had been or was being reviewed compared to ten (33%) at Phase three. Four (9%) Trusts at Phase one and four (13%) Trusts at Phase three reported a lack of formal strategy to date.

6.9. Twenty-five Trusts (60%) reported having set specific target dates for implementation of the CNO review recommendations at Phase one, compared to 28 (76%) Trusts at Phase three. Responses ranged from plans which were about to be completed to longer term five-year plans. Seven (17%) Trusts at Phase one and two (7%) Trusts at Phase three reported that no specific dates had been set. Twenty-four (57%) Trusts at Phase one and 15 (41%) Trusts at Phase three considered it 'likely' that they would achieve the target date (rating: very likely to very unlikely).

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[8] Managers and staff to discuss how positive risk management can avoid producing unnecessarily defensive practice and the results of this to be reflected in policies and processes and managed through local governance (*included in recommendation 6*) (p=0.011); Inpatient services to develop arrangements to break down barriers with local communities e.g. through: open days, inviting local media in; forming links with voluntary groups (*included in recommendation 9*) (p=0.038).

[9] MHNs working in care management roles to arrange for direct payments to service users where they choose this (*included in recommendation 1*) (p=0.022); All MHNs to have access to advice on how information can be provided without breaching confidentiality (*included in recommendation 5*) (p=0.031).

Higher Education Institutions (HEIs) – recommendation priorities and implementation progress

HEIs ranking of priorities for each of the CNO recommendations

6.10. HEIs were asked to rank 16[10] of the CNO recommendations in terms of the priority within their organisation on a Likert scale (5 = very high priority to 1 = very low priority). There were variations in these ranked priorities for the HEIs based on the sum of the 16 recommendations. An overall ranking of importance of individual recommendations for all responding HEIs in England was calculated (Table 36).

Table 18: Overall ranking of HEI organisational priorities for 16 of the CNO Recommendations

Recommendation	Phase one ranking	Phase three ranking	Comparison (07/09)
Strengthening relationships with service users and carers (5)	1	3	-2
Applying Recovery Approach values (1)	2	16	-14
Providing evidence-based care (3)	3	1	+2
Promoting equality in care (2)	4	4	-
Holistic assessments and managing risk effectively (6)	5	5	-
Working effectively in multi-disciplinary teams (15)	-	6	-
Providing psychological therapies (8)	7	10	-3
Increasing social inclusion (9)	-	7	-
Improving recruitment and retention (17)	9	12	-3
Improving physical well-being (7)	10	8	+2
Supporting continued professional development (16)	11	14	-3
Developing new roles and skills (13)	-	11	-
Improving inpatient care (12)	13	9	+4
Responding to the needs of people with substance misuse problems (11)	14	13	+1
Meeting the greatest need (4)	15	2	+13
Recognising spiritual needs (10)	16	15	+1

[10] Recommendation 14, 'Strengthening pre-registration education' was treated as a separate question for HEIs.

6.11. Independent t-test analysis showed that there were no statistically significant associations in responses for those who responded at either Phase. This is despite considerable movement for 'applying recovery approach values' (decrease of 14 places at Phase three) and 'meeting the greatest need' (increase of 13 places at Phase three).
6.12. Further analysis using paired t-tests for those who responded at Phases one and three also failed to detect any statistically significant associations.

HEI progress with implementation of CNO recommendation 14, 'Strengthening pre-registration education'

6.13. Recommendation 14 of the CNO Review focussed on '*Strengthening pre-registration education'* and included five accompanying suggestions (*making change happen points*). E-survey participants were asked to rank their progress towards implementation for each of the five *making change happen points* of recommendation 14, from the fullest to the lowest implementation. The results showed that little had changed in terms of ranking between Phases one and three.

6.14. Using independent t-tests to explore HEI's responses to recommendation 14 ('*Strengthening pre-registration education*') at Phases one and three, the results indicated no statistically significant associations between Phases. Independent t-tests of each individual recommendation within '*strengthening pre-registration education*' show that with regards to point 14.3[11], there was a statistically significant association in ratings between Phases one and three (p=0.009). More specifically, paired t-tests found a further statistically significant association for those who replied at Phases one and three with regards to point 14.1[12].

HEI implementation of 'Best practice competencies and capabilities for pre-registration mental health nurses'

6.15. HEIs were asked to rate their overall progress towards the implementation of each of the six main themes from *'Best practice competencies and capabilities for pre-registration mental health nurses' (Department of Health 2006c)*, on a Likert scale (5 = full implementation to 1 = no implementation). The results show little difference in ranking between Phases one and three with 'communication' rated the highest and 'physical care' the lowest.

Overall HEI implementation of Recommendation 14 and 'Best practice competencies'

6.16. A combined score of implementation progress for Recommendation 14 **and** the 'Best practice competencies' was calculated to provide an estimation of overall HEI

[11] Service providers and HEIs to develop strong cooperative relationships to improve educational outcomes through involving all nurse lecturers with healthcare providers (p=0.041)
[12] HEIs to review pre-registration programmes to meet minimum competencies as set out in *Best practice competencies and capabilities for pre-registration mental health nurses* (0.011)

implementation for each HEI. A maximum score of 60 (full implementation) and a minimum score of 12 (no implementation) was possible. Overall implementation scores ranged from 35 to 53 (mean 43.7) for Phase one and 39 to 59 (mean 48) for Phase three.

Curriculum development / revision activity related to the review recommendations and pre-registration 'Best Practice Competencies'

6.17. Over half of HEIs in both Phases reported either having already reviewed or revised their curriculum in light of the recommendations or were in the process of doing so. The results are presented in Table 37, together with a number of specific areas or activities related to curriculum development or delivery.

Table 19: Curriculum development / revision activity related to the review recommendations

Phase one: **progress to date on implementation**	**Phase one:** **frequency**	**Phase three:** **progress to date on implementation**	**Phase three:** **frequency**
Review of curriculum carried out	26 (65%)	Curriculum development / review	15 (56%)
Curriculum already reflected recommendations and few changes needed	4 (10%)	Change in specific modules	12 (44%)
Revision of curriculum completed or in progress	36 (90%)	Programme revalidation	8 (30%)
Specific revisions to curricula		**Specific revisions to curricula**	
Increased user involvement in course design, delivery or assessment	8 (20%)	Increase in service user and carer involvement	9 (33%)
Mapping of curricula to best practice competencies and capabilities	6 (15%)	-	-
Strengthened partnership working with practice	6 (15%)	Wider involvement e.g. stakeholders and Practitioners	9 (33%)
Inclusion of the recovery approach	5 (13%)	Greater emphasis on recovery	6 (22%)
Increased emphasis on physical care training	2 (5%)	Greater emphasis on physical care	6 (22%)
Creation of new staff roles	2 (5%)	-	-
Development of longer placements	2 (5%)	-	-
-	-	Increased use of personal tutors and mentors	3 (11%)

6.18. Fifteen (36%) Trusts in Phase one and 10 (37%) Trusts in Phase three suggested a further need to revise and review the current curriculum.

Reported implementation facilitators and barriers – Trusts and HEIs

6.19. Respondents were asked to identify three key factors which they considered had facilitated CNO recommendation implementation progress to date and three key factors which they considered would facilitate future implementation progress.

Factors facilitating implementation progress for Trusts and HEIs

6.20. Several key factors regarded as facilitators for the implementation of the CNO recommendations were identified by both Trusts and HEIs, as presented in table 38.

Table 20: Key facilitators to implementation identified by Trusts and HEIs

	Rank	Implementation Facilitators (frequency)			
		Phase one MHTs	**Phase three MHTs**	**Phase one HEIs**	**Phase three HEIs**
For Progress to date	**1**	Organizational engagement with the review recommendations (36)	Nurse involvement (14) Other strategies / reviews (14)	Joint working approaches (24)	Commitment & enthusiasm of mental health team (17)
	2	Harmonization with other national policy initiative (8)	Role of the Trust (13)	Staff commitment and motivation (16)	Support / partnership with the Trust & stakeholders (14)
	3	Staff commitment and motivation (7)	Senior level / champions (11)	Input of users and carers (14)	Impact on the curriculum (16)
For Progress in Future	**1**	Organizational engagement with the review recommendations (30)	Trust support (16)	Partnership working (15)	Developing relationships (17)
	2	Harmonization with other national policy initiatives (10)	Workforce & role development (15)	Review and monitoring of performance against recommendations (15)	Support & commitment of department (9) Curriculum & Programme development (9)
	3	Development of joint working (6)	Progress & performance (10)	Links with users and carers (11)	Clinical influences (4) Impact of other frameworks (4)

Factors perceived as barriers to implementation progress for Trusts and HEIs

6.21. Key factors considered to be barriers to implementation of the CNO recommendations were identified by both Trusts and HEIs in Phases one and three (Table 39).

Table 21: Key barriers to implementation identified by Trusts and HEIs

	Implementation Barriers (frequency)			
	Phase one Trusts (n)	**Phase three Trusts (n)**	**Phase one HEIs (n)**	**Phase three HEIs (n)**
For Progress so far	Competing priorities[13] (29)	Competing priorities (14)	Competing priorities (16)	Time and resource constraints (15)
	Lack of funding (16)	Trust / organisational structure (13)	Staffing issues (15)	Difficulties with the curriculum (13)
	Lack of ownership of review recommendations outside the nursing profession (11)	Leadership & ownership issues (12)	Logistics of involving users / carers in educational settings (9)	Staff issues (10) Involvement of service users and carers (10)
For Progress in Future	Competing priorities (14)	Competing priorities (11)	Competing priorities (16)	Staff demands and pressure (10)
	Lack of funding (14)	Resources & training (9)	Lack of funding (7)	Curriculum and timetabling (7)
	Lack of national drivers to encourage implementation (5)	Workforce (14)	Limited skills base of staff (3)	Reviews and inclusion (3) Payment for service users and carers (3) Local and national influences (3)

Organisational Ownership within Trusts and HEIs

Implementation lead

6.22. Twenty-three (55%) Trusts in Phase one and twenty (54%) Trusts in Phase three identified an individual or individuals in their organisation with specific responsibility for overseeing the implementation of the CNO review recommendations. Fifteen (38%) HEIs and 7 (26%) HEIs in Phase three identified an individual, or individuals, in their organisation with specific responsibility for overseeing the implementation of the CNO review recommendations.

[13] This category included elements such as being overloaded with national policy initiatives, local changes and a perception that the CNO review priorities conflicted with those of the NMC review.

Forums for discussion

6.23. Respondents were asked to identify whether the CNO recommendations were a specific agenda item on relevant committees within the Trusts. The CNO review was not a standing item at either Trust Boards or Senior Management Meetings in 24 (59%) Trusts in Phase one and 24 (65%) Trusts in Phase three. The CNO review was not a standing item at branch / team, course or programme committee in 25 (60%) HEIs in Phase one and 17 (41%) of HEIs in Phase three.

Table 22: Key findings from Phase 1 and Phase 3

Key findings of Phase one	Key findings of Phase three
A total of 42 Trusts (63%) and 40 HEIs (80%) completed the survey for Phase one.	A total of 37 Trusts (55%) and 27 HEIs (54%) completed the survey for Phase three.
Whilst all organisations ranked highly the importance of both adopting Recommendations 1 (*Applying Recovery Approach values*) and 5 (*Strengthening relationships with service users and carers*); there has clearly been some difficulty in implementing these for both Trusts and HEIs.	There were differences in the Trusts between the priority given to each recommendation and the implementation progress. For example, out of all of the recommendations '*applying Recovery Approach values*' was given a ranked priority of 7, but an implementation progress ranking of 16. Alternatively, '*providing psychological therapies*' was given a ranked priority of 10 but an implementation progress of 2. There are therefore discrepancies between the level of priority given and the implementation progress of each recommendation.
Trusts and HEIs broadly agreed on the importance of each of the CNO recommendations, with the exception of four items which they significantly differed on: Improving recruitment and retention (17) *(p = 0.006)* (ranked 9 by HEIs and 16 by Trusts) Providing evidence-based care (3) *(p = 0.006)* (ranked 3 by HEIs and 10 by Trusts) Working effectively in multi-disciplinary teams (15) *(p = 0.042)* (ranked 5 by HEIs and 11 by trusts) Improving inpatient care (12) *(p = <0.001)* (ranked 13 by HEIs and 1 by Trusts)	Trusts and HEIs broadly agreed on the importance of each of the CNO recommendations, with the exception of two items which they significantly differed on: Applying Recovery Approach values (1) (*p=0.003*) (ranked 16 by HEIs and 7 by Trusts) Providing evidence-based care (3) (*p=0.004*) (ranked 1 by HEIs and 8 by Trusts)
Using a paired t-test, there was a statistically significant association with regards to '*improving recruitment and retention*' (17) at Phases one and three.	Using a paired t-test, there was a statistically significant association between HEIs at Phases one and three with regards to '*strengthening pre-registration education*' (14).
A range of factors were identified which were perceived by Trust responders as facilitating the implementation of the CNO review including: 1. '*Organizational engagement with the review recommendations*' 2. '*Harmonization with other national policy initiatives*' 3. '*Staff commitment and motivation*'	A range of factors were identified which were perceived by Trust responders as facilitating the implementation of the CNO review including: 1. '*Nurse involvement / Other strategies / reviews*' 2. '*Role of the Trust*' 3. '*Senior level / champions*'

A range of factors were identified which were perceived by HEI responders as facilitating the implementation of the CNO review including: 1. ‘*Joint working approaches*’ 2. ‘*Staff commitment and motivation*’ 3. ‘*Input of users and carers*’	A range of factors were identified which were perceived by HEI responders as facilitating the implementation of the CNO review including: 1. ‘*Commitment & enthusiasm of mental health team*’ 2. ‘*Support / partnerships with the Trust & stakeholders*’ 4. ‘*Impact on the curriculum*’
A range of factors were identified which were perceived by Trust responders as barriers to the implementation of the CNO review including: 1. ‘*Competing priorities*’ 2. ‘*Lack of funding*’ 3. ‘*Lack of ownership of review recommendations outside the nursing profession*’	A range of factors were identified which were perceived by Trust responders as barriers to the implementation of the CNO review including: 1. ‘*Competing priorities*’ 2. ‘*Trust / organisational structure*’ 3. ‘*Leadership and ownership issues*’
A range of factors were identified which were perceived by HEI responders as barriers to the implementation of the CNO review including: 1. ‘*Competing priorities*’ 2. ‘*Staffing issues*’ 3. ‘*Logistics of involving services users / carers in educational settings*’	A range of factors were identified which were perceived by HEI responders as barriers to the implementation of the CNO review including: 1. ‘*Time and resource constraints* ’ 2. ‘*Difficulties with the curriculum*’ 3. { ‘*Staff issues*’ ‘*Involvement of service users and carers*’

CHAPTER 7: DISCUSSION

7.1. The aim of this study was to evaluate progress towards and impact of implementation of The Chief Nursing Officer's Review of mental health nursing in England in Mental Health Trusts and Higher Education Institutions. The objectives were to:

1. To establish progress and strategies for implementation of recommendations and accompanying guidance
2. To identify facilitators and barriers to implementation
3. To examine the impact of implementation on user/carer experiences, outcomes of mental health, organisational structures, roles, relationships, staff recruitment and satisfaction
4. To explore the relationship between organisational ownership, implementation progress and impact
5. To explore modifications of recommendations for diverse populations e.g. older adults, children, BME groups
6. To highlight areas of good practice and positive outcomes including effective strategies used to facilitate implementation

<u>Progress and strategies for implementation of recommendations and accompanying guidance</u>

7.2. From the results of phases one and two, and despite some of the criticisms of the CNO Review recommendations (Brooker 2007), this research clearly demonstrates that the review has prompted specific activities in the majority of HEIs responding to the survey and developments consistent with the Review recommendations are evident in all MHTs. . All organisations have made some progress in the implementation of the recommendations and accompanying '*making change happen*' points, although there was some variation in terms of specific recommendation priorities within and between Trusts and HEIs and progress on implementation has been greater for some recommendations than others.

7.3. It is interesting to note that whilst both Trusts and HEIs ranked the importance of recommendation 1 (*Applying Recovery Approach values*) and recommendation 5 (*Strengthening relationships with service users and carers*) highly (in the top three for Trusts and top two for HEIs), there has clearly been some difficulty in implementing recommendation 1 for Trusts – ranked 15 in terms of implementation progress. There has been considerable emphasis for a number of years in UK mental health policy on a shift from traditional 'illness-oriented' approaches to care towards more client-centred, recovery-focused approaches (Department of Health 2001). Repper and Perkins (2009) argue that implementing such a shift presents real challenges as it requires fundamental attitude change and a re-conceptualisation and redesign of mental health services and systems. The results of the surveys support this in that although Trusts identified it as a priority recommendation, implementation progress was generally rated as low. Whilst

this could be seen as reflecting a dissonance between priorities and implementation it may equally be reflective of the enormity of the task.

7.4. In marked contrast to this discrepancy between reported priorities and implementation progress, in relation to recommendation 5 (*Strengthening relationships with service users and carers*) progress on implementation was reported by Trusts as high in comparison with other recommendations. For HEIs, though this recommendation was ranked as number 1 priority, when asked to rate implementation progress against the 5 specific *'making change happen'* points from the pre-registration education recommendation (14.1), '*involvement of service users*' was ranked 4th and '*involvement of carers*' 5th , with the practicalities of involvement being identified as a key challenge. This is despite service user and carer involvement being a key area of reported curriculum revision. However, in terms of specific plans for future curriculum revision, HEIs reported that further work in this area would continue to be a priority.

7.5. In terms of the ranked importance of each of the CNO recommendations, whilst these were broadly similar for Trusts and HEIs, statistically significant differences were noted in four items. '*Improving recruitment and retention'* ($p = 0.006$) and '*providing evidence-based care*' ($p = 0.006$) were ranked higher by HEIs; *'Working effectively in multi-disciplinary teams'* ($p = 0.042$) and *'Improving inpatient care'* ($p = <0.001$) were ranked higher by Trusts.

7.6. These differences may be reflective of different agendas for Trusts and HEIs as well as different interpretations of the focus and responsibility for implementing each of these recommendations. Recruitment and retention of nursing students generally in England and the wider UK has been a significant problem for HEIs for a number of years. Recruitment and retention of students by HEIs has become increasingly important (Buchan & Seccombe 2006; Pryjmachuk et al 2009), particularly since changes to the funding models, introduced as part of a Standard National Contract in England between NHS commissioners of Education and HEIs implemented since 2006, means that under-recruitment and subsequent attrition from pre-registration nursing programmes carry significant financial penalties. Whilst there have been some challenges for recruitment and retention of qualified nursing staff for some Trusts in some particular parts of England, notably London, the fact that HEIs identified this as a significantly higher priority area than Trusts may reflect the financial risks associated with poor recruitment and retention of students.

7.7. The significantly higher ranking of *'working effectively in multidisciplinary teams'* by Trusts is likely to be reflective of the policy and practice emphasis on multi-disciplinary working and new roles and ways of working which has increasingly characterised the organisation and delivery of mental services over the past decade in the UK (Jones 1996; Department of Health 2007b). Whilst it can be argued that such a strong policy imperative should be seen as central to pre-registration mental health nursing education the findings from this survey clearly seem to indicate either that other aspects are seen as a higher priority by HEIs or that there is a belief that this is already addressed within curricula. Improving in-patient care has received much attention in the UK in the last 10

years. These results suggest that *'Improving in-patient care'* is a clear priority for Trusts but were significantly less important in HEI's rankings (13th). Given that most newly qualified staff begin their careers in these environments perhaps HEIs need to consider strengthening their educational and research programmes to enhance the skills, knowledge and attitudes of pre-registration students and staff to help them for this challenging role.

7.8. The results from the selected HEIs and MHTs in phase 2 show a slightly different picture. In most HEIs there was evidence that the positive results from phase one were evident when these HEIs were scrutinised more closely. For the most part, HEIs were using *'Best Practice Competencies and Capabilities for Pre-registration Mental Health Nursing Education'* to good effect and mostly to guide curriculum reviews. This is not surprising, the competencies and capabilities incorporate NMC learning outcomes, which drive all pre-registration curricula in the UK and so the general acceptance of the Review is likely attributed to this. Recommendation 14 of the main Review report is also being addressed by most HEIs. However, there is little progress on some the suggestions, notably in relation to having a single mentor, and adopting alternatives to traditional clinical placements. Regarding the former, there was little enthusiasm for this in most HEIs as they remain concerned that students should have access to a range of mentors to provide variety in style and learning. Different mentors bring different perspectives to students was a common refrain, and this viewed positively. Implementing client attachment poses considerable challenges for most HEIs and MHTs and it was apparent that some HEIs were considering this with their partners, but little substantial progress was evident. Again, this is unsurprising, despite the promise of client attachment reported from empirical literature (Turner et al., 2004), the same authors highlight the importance of careful planning, implementation and evaluation.

7.9. In MHTs, there was a different picture towards the implementation of the Review recommendations in phase 2. Whilst the positive results from phase one among HEIs were largely confirmed in phase 2, this pattern was not evident strongly from the phase 2 case studies on MHTs. There is evidence of changes in MHTs in areas that the CNO Review recommends, e.g. improving physical health care, access to psychological therapies and providing spiritual care. However, it was hard to find evidence that attributed these changes to the CNO Review in most Trusts. It seems that other policies appeared to influence these developments. It is possible, of course that the CNO Review recommendations may have influenced the development of the other policies. For example, the Improving Access to Psychological Therapies (IAPT) national initiative stems from policy work of Layard and his colleagues at the London School of Economics. It is possible that Layard took account of the CNO Review when forming his ideas, but there is little evidence that this is the case. From a pragmatic view, it may be less important what factors prompted Trusts' attention to these issues, as long as the issues are being addressed.

Facilitators and barriers to implementation

7.10. A range of factors were identified which were perceived by respondents as facilitating the implementation of the CNO review including; organizational engagement with the review recommendations, joint working approaches, harmonization with other national policy initiatives, and staff commitment and motivation. Likewise a range of factors were identified which were perceived by respondents as barriers to the implementation of the CNO review including; competing priorities, lack of funding, and staffing issues. The surveys in phases 1 and 3 highlight the differing organisational importance placed on implementation of the review recommendations. Most Trust responses were completed by Director of Nursing or equivalent senior staff whilst in HEIs completion of the survey was most often by Lecturers. This may highlight disparities in the two different types of organisations, with mental health nursing only occupying a small part of the HEIs focus but a major part of Trusts. It was also of note that whilst in Trusts the CNO Review recommendations were often part of an overall organisational strategy and discussed at senior level meetings, in HEIs the responsibility for implementation and forums for discussion tended to be at the branch or programme level rather than at a more senior level.

7.11. At the time that the phase 1 survey was being undertaken the NMC which regulates nursing in the UK was undertaking a national consultation on the future framework for pre-registration nursing. A key question within this consultation related to whether the separate nursing branch structure (Adult, Mental Health, Children's and Learning Disability nursing) should continue at pre-registration educational level. There was a strong feeling at the time amongst many mental health nurses that the NMC may decide to move towards a generalist approach to pre-registration nursing education despite many arguments against this from mental health nurses (Hurley & Ramsay 2008). This was highlighted in a number of HEI and Trust responses as a barrier to implementation of the review recommendations under *'competing priorities'* and in particular for HEIs, the re-design of curricula based on the *'Good practice guidance for pre-registration mental health nursing education'* (Department of Health 2006c) which resulted directly from the CNO review. The NMC subsequently confirmed that the four branches of nursing would remain a key part of pre-registration curricula and registration in the UK, though re-named as 'fields of practice' (NMC 2008). However, it is clear that the question mark which hung over the future of mental health nursing specific pre-registration education and the continued recognition of this branch/field of nursing may have been a potential limiting factor or barrier for implementation of the review recommendations and educational guidance for HEIs.

Impact of implementation on user/carer experiences, outcomes of mental health, organisational structures, roles, relationships, staff recruitment and satisfaction

7.12. Despite the responses to the survey in phase 1, implementation of the Review in all MHTs in phase 2 was limited so the aim of the research in this part of the study shifted. We originally intended to examine relative progress among recommendations

and clarify the strategies that facilitated and hindered their implementation. Since few of the interviewees were familiar with the Review and strategies specifically aimed to implement Recommendations were rare, the primary aim of the site visits became focussed on understanding the factors effecting Trusts' response to the CNO Review as a policy document.

7.13. A number of influential factors were identified at a local level. Competing priorities such as the all consuming move towards Foundation Trust Status and the urgent need to respond to Serious Untoward Incidents or critical reports of the Trust (e.g. poor HCC survey results) clearly distracted attention away from the Review. However, National health and social care policies and guidance over the past decade all support the general direction of the Review. Paradoxically this appeared to weaken its impact: in all MHTs in phase 2, the Review met with an immediate reaction from the Board that it fitted with current direction so no specific response or dedicated strategy was seen to be needed.

7.14. Perhaps the reason for the low level response to the Review lies in the very nature of its content. As a series of *recommendations,* it does not necessitate performance management towards specified targets; as a set of *values,* it does not require behavioural change as much as a cultural shift in the ways mental health nurses work. This cultural shift – a movement towards greater collaboration with service users and carers so that best evidence is available to service users to make decisions as part of their personal recovery journey – is proving a huge challenge for mental health services (Shepherd, Boardman and Slade, 2009). The move towards a Recovery focussed approach threatens the traditional medical powerbase within mental health services: as service users[14] take greater control of their own symptoms, treatment and lives as a whole, their natural allies are not the doctors who treat their symptoms but the mental health nurses who travel with them on their journeys towards (re)gaining fulfilling lives. Perhaps this is an underlying reason why the CNO Review has not been fully embraced: if the recommendations are pursued in full then it has the potential to make mental health nurses – the largest workforce in mental health services - a real force to be reckoned with.

7.15. Although few interviewees were familiar with the Review recommendations, all were asked about progress with the implementation of recommended practices. Many were already underway as a result of other initiatives and requirements. What became clear was the potential value of the Review as a guide for practitioners: on seeing the Recommendations for the first time they found them reassuring (as they reflected many aspects of current work) but also useful as a template for future development. Nevertheless they were also quick to speak about the barriers to the full implementation of recommendations: lack of resources, problems with retention and recruitment resulting in reliance on bank/agency staff, increasing acuity of patients resulting in constant fire fighting and little time for therapeutic activity, resulting in low morale, increasing awareness of service users rights meaning that paperwork must always be

[14] Some who identified themselves as service users were also carers and vice-versa

completed to 'cover our backs'. A negative picture was repeated again and again – and this was corroborated by the accounts of service users and carers. They too were unaware of the Review, they too found it a reassuring and helpful document, and although they could see some changes for the better, they were all too aware of the pressures on staff. In fact, their own situation and the barriers to their involvement closely reflected the barriers and blocks for staff as shown in table 41.

Table 23: Comparisons of Nurses and Service Users and Carers on barriers to implementation

Nursing staff		**Service Users (n=12) and Carers (n=9)**
Recruitment problems		Recruitment problems
Retention problems mean high turnover of staff and use of bank or agency staff		Retention hampered by health problems and carer responsibilities
Resources – limited time, little training about Review, policy is not a priority compared with needs of clients		Resources – limited time, no training in policies, current priorities focus on foundation trust status
Bureaucracy – increasing paperwork make hands on care more difficult	**parallel experiences in trying to effect change or make their voice heard**	Bureaucracy – formalisation of involvement with FT status feels as though it is sidelining involvement and co-opting users' voices, reducing critical potential
Morale low as unable to work in ways they want due to low staffing levels and acuity of patients		Morale low as involvement opportunities ever changing and rewards – in terms of positive changes – slow
Communication – not told about policy developments, circular emails all too easy to ignore		Communication – Do not routinely get information about policies introduced in Trust.
Sense of powerlessness: no systems for front line workers to get their voices heard. cannot make a difference anyway, their voice is not heard and if it were this is not number one priority.		Sense of powerlessness: systems for getting their voice heard seem to have diminished or diluted with Ft status. Too often people say yes but nothing changes.
Where to start?		Where to start?

<u>The relationship between organisational ownership, implementation progress and impact</u>

7.16. Since the Review offers a vision of mental health nursing for the next 10 years, it has to be asked, why have those leading mental health nursing, working at senior levels in Trusts, not realised the potential of the Review? What are the reasons why a document which provides clear direction (consistent with all other extant mental health

policy) and a defined and distinct role for mental health nursing not been used to develop nursing, justify new approaches and interventions, demonstrate the importance of nursing in making a reality of Recovery?

7.17. Some of the answers became apparent in the MHTs during phase 2. First, of all at Executive level, mental health nurses were employed in three of the six sites and one of these three was not a qualified mental health nurse. On the other three sites, temporary, 'acting' nurses were holding the posts. This inevitably weakened their voice and influence on the Trust Board. In addition, processes and practices at Board level served to negate the impact of the Review: priority is afforded issues that are: part of accountability structures, bring funding with them, and result in reported comparison with other Trusts. None of these pertains to the Review. With shortage of time available in board meetings professional issues were presented as an abbreviated report rather than as an issues for full consideration and debate. In addition, Professional developments are not seen to be the concern of the board but of the lead for that profession. Thus it took a strong and determined nursing voice to make the content and recommendations of the Review a priority at Board level.

7.18. Clearly, for the Recommendations to be implemented it took more than Board level support: nurses at all levels in the Trusts needed to see the Review as an opportunity to recognise, redefine and develop mental health nursing to its full potential. This did not happen in any of the MHTs sampled in phase 2. Where practice development was taking place, it could not be attributed to the Review even though it might match the Review recommendations. This might give a further clue to the problematic nature of the Review as a Policy document: it was a generic document, non-specific, largely lacking definition, targets or behaviours, yet very broad with 17 different areas for development. Without a clear strategy document for the Trust as a whole, with implementation plans specifying an achievable number of targets for each part of the service, the Review requires an overwhelming range of action and it is perhaps easier to ignore completely.

Modifications of recommendations for diverse populations e.g. older adults, children, BME groups

7.19. Promoting Equality and Diversity in mental health care has been on the national mental health agenda for some time. It was, therefore, not surprising to find examples of initiatives in this area in many Trusts. The Review recommendation regarding equality and diversity was received as confirming in many Trusts work that had being going on for some time. There was, therefore, little evidence of the modification of the Review recommendations for diverse populations. The implementation, or otherwise, of the Review recommendations in MHTs, did not pay particular attention to this issue. It would appear that this was due to MHTs meeting the requirements of the national promoting equality and diversity agenda as directed in other policies.

<u>Good practice and positive outcomes including effective strategies used to facilitate implementation</u>

7.20. Despite some of the negative pictures there were examples of good practice in many services throughout the selected Trusts, which we might learn from. There were individual champions in some Trusts who were determined to use the Review for strengthening and galvanising the nursing profession for the benefit of services users and carers. There were scores of good examples, of high quality nursing practice in some services throughout the Trusts, where practitioners were providing high quality nursing care that was often leading edge. Finally, there was recognition among practitioners that the CNO Review was a useful tool for identifying the core values and principles of the profession. If only nurses were told about it!

7.21. In the HEIs, evidence of good practice and effective interventions to implement the Review recommendations took several forms. Leadership from Division/Departmental Heads appeared to facilitate implementation, as did academic leadership from Programme Leaders. Acceptance of the review as a tool to implement changes, especially in putting recovery at the forefront of curriculum developments, and working in partnership with service users, carers and clinicians appeared to enable HEIs to implement the Review recommendations. The presence of the Review had a catalytic effect that helped many HEIs to pursue changes to their curriculum. Although some of these changes had been planned before the Review was published, it helped ensure the legitimacy of the proposed changes, and the likelihood that the changes could be implemented, even in the face of resistance.

Evidence-based policy implementation

7.22. Policy implementation is an inexact science, but there is fair degree of published literature that presents varying degrees of evidence as to what facilitates the implementation of policy (DH, 2001, NICE, 2007), good practice guidance (NICE, 2007), clinical guidelines (NICE, 2007), and interventions that change clinicians' behaviour (Robertson & Jochalin, 2006). This evidence is relevant to how organisations might implement recommendations and actions such as those reported in the CNO Review of Mental Health Nursing. It is worth mapping this evidence against how the Department of Health addressed the implementation of the Review and how the MHTs and HEIs in this study addressed the recommendations and actions of the Review.

7.23. In 2001, some eighteen months following the publication of the National Service Framework for Mental Health in 1999, the Department of Health published a Mental Health Policy Implementation Guide designed to facilitate the implementation of key aspects of the NSF. Six key questions are suggested to aid the implementation of policy and we have adapted these to our consideration of the national implementation of the CNO Review. This is shown in table 42.

Table 24: Evidenced-based policy implementation – mapping the national and local actions in relation to the CNO Review of Mental Health Nursing

Criterion	DH actions in relation to CNO Review	MHT Actions	HEI actions
Who is the review for?	The report of the CNO Review makes it clear that this was a Review of mental health nursing with 17 recommendations; 16 for MHTs; 1 for HEIs with suggested actions that MHTs and HEIs can take to implement the recommendations.	There was some evidence of actions designed to inform staff of the Review through emails and the identification of a named lead, but this was not evident across the board.	There is evidence of wide diffusion of the Review and the Associated *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education.*
What is the Review intended to achieve?	The inclusion of recommendations, suggested actions, self assessment toolkit and *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education helped make the intentions of the Review apparent*	CNO Review task forces in some MHTs to get the message of the Review across and decide actions to address recommendations with a dedicated lead.	Many HEIs mapped current curricula against *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education*
What did the DH, MHTs and HEIs do to map existing actions against Review recommendations and actions?	The provision of self assessment toolkit and *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education*	There was some evidence of the use of the Self-assessment toolkit, but this was not widespread	There was strong evidence of the strategic use of *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education*
How does the Review relate to other policies?	Inclusion of references to other policies and evidence underpinning recommendations and actions. *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education* incorporated NMC learning outcomes, Essential Shared Capabilities and Skills for Health Specialist Capabilities	Little evidence of systematic action to incorporate Review into other policies; Review more likely to be subjugated to other policies.	Some evidence of incorporating actions into external assessment of education by Quality Assurance Agency.
Operational Procedures for implementing the Review	Diffusion of Review report and associated self-assessment toolkit and *Best Practice Competencies and Capabilities for Pre-registration mental health nursing education*	Named implementation lead and action plans, but not widespread	Mapping existing curricula, implementation of accepted changes especially in relation to recovery, partnership working with service users and (to a lesser extent) carers
What further evidence is referenced to support implementation of the Review?	Inclusion of references to other policies and evidence underpinning recommendations and actions, but little systematic 'policy implementation' recommendations and actions.	Little evidence of systematic 'policy implementation guidance or evidence' to enable implementation. Evidence in one MHT of the Review being kept low profile.	Little evidence of systematic 'policy implementation guidance or evidence' to enable implementation.

7.24. In relation to National policy implementation guidance, there is some evidence that the actions of the DH, some MHTs and many HEIs in response to the CNO Review have helped the implementation of the Review recommendations. However, there is little evidence that the process of addressing the Review recommendations followed the systematic approach used in the implementation of other mental health policies. This was not the case in Scotland.

7.25. When the CNO Review of Mental Health Nursing in Scotland was published (Scottish Executive, 2006), the Executive set up a National Implementation Group (NIG) and Local Implementation Groups in each Health Board reporting annually to the NIG. The report was published with a delivery action plan with timelines for the achievement of he recommended actions. In pursuit of these actions, each Health Board had a dedicated person responsible for reporting to the CNO on progress with the actions, and this formed the basis of an annual report published from the Scottish CNO's office, and an annual conference showcasing examples of the recommendations in action. It is not evident from the annual report of a direct link between the actions in practice and the Review. Nevertheless, there is evidence from personal communications with those involved, of a systematic and strategic approach to implementation of the Review.

7.26. The review of published evidence of interventions that change clinicians' behaviour that Robertson and Jochalin (2006) reported, and which NICE incorporated into its Guidance on how to change practice (NICE, 2007) identified barriers to change and evidence-based solutions to overcoming these barriers. These are shown in figures 2 and 3.

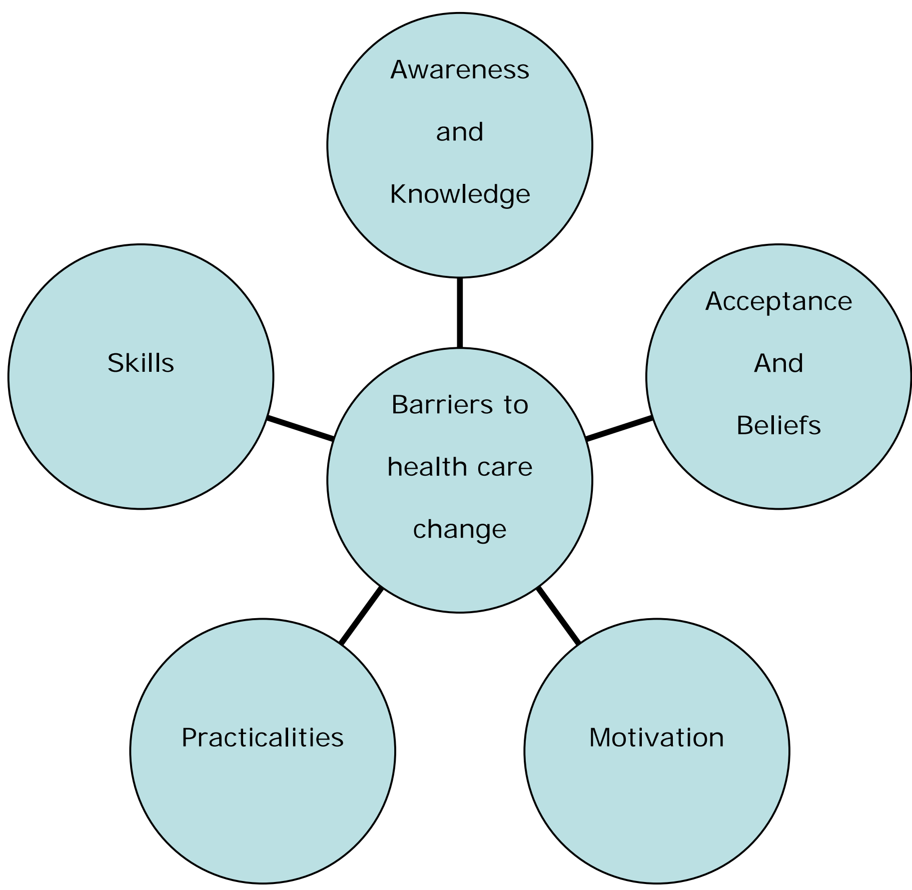

Figure 1: Evidence-based barriers to health care change

7.27. There is evidence from the data collected from MHTs and HEIs in this study of some of these barriers. Among MHTs, the practicalities of incorporating the CNO Review recommendations into competing policies and agendas were a struggle. A lack of awareness and knowledge of the Review was apparent in many MHTs, even among senior nurses. The apparent lack of motivation among the latter may have hindered the implementation of the Review in Trusts. Significant barriers to change were related to acceptance and beliefs about the Review in some HEIs.

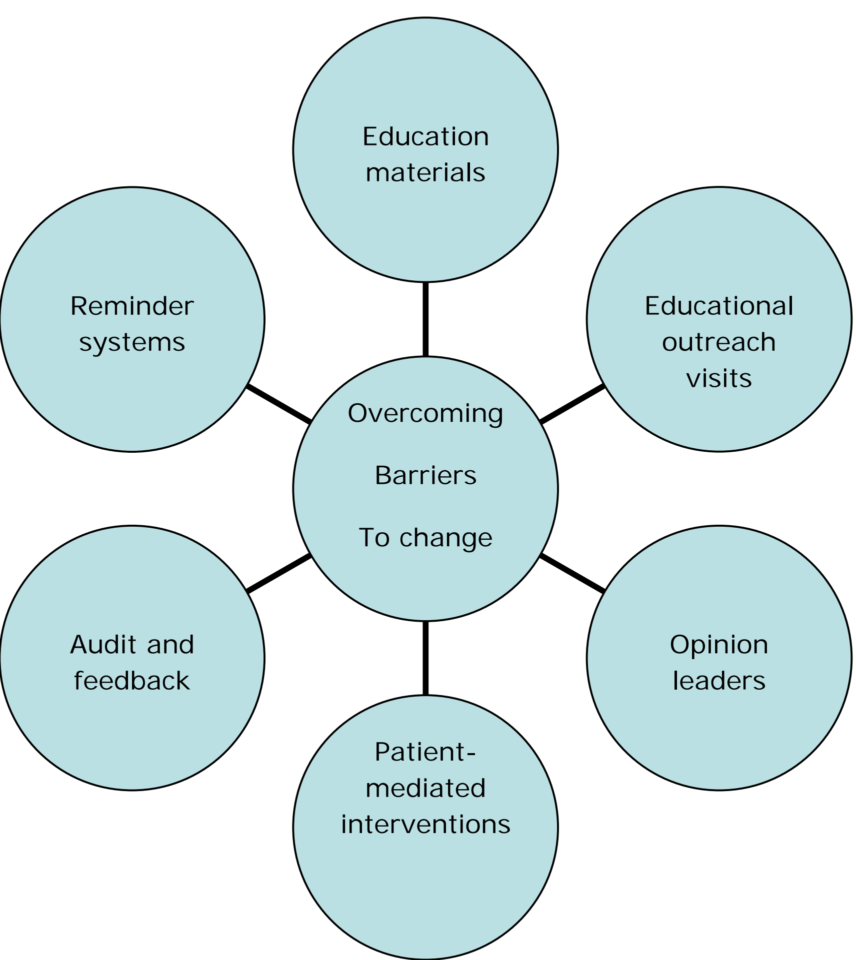

Figure 2: Evidence-based solutions to overcoming barriers to change

7.28. There is little evidence among the MHTs and HEIs in this study of awareness of the evidence shown in figure 3, or of using this evidence to implement the CNO Review recommendations. The use of a named lead in some MHTs and HEIs to guide the implementation of the Review may be akin to the role of an opinion leader, and the mapping exercises through the use of the self-assessment toolkit in some Trusts, and *Best Practice Competencies for pre-registration mental health nursing education* in many HEIs may be evidence of audit and feedback.

7.29. In 2005, NICE published guidance for implementing public health services (NICE, 2005) that are useful to consider in relation to the national and local implementation of the CNO Review recommendations. This guidance is preceded by six broad principles of implementation:

1. Broad support and clear leadership
2. Dedicated resources
3. Support from other stakeholders, e.g. other members of the MDT
4. Financial Planning
5. Systematic Approaches to Implementation
6. Evaluation, update and feedback

7.30. The CNO Review Report was launched by the then Minister of Health and the Chief Nursing Officer, thus providing evidence of support and leadership at the national level. The commissioning of this research is evidence of evaluation, update and feedback. There is little evidence of principles 2-5 at the national level. There is some evidence among MHTs and HEIs of these principles in action in response to the CNO Review, but it is not widespread.

7.31. The process that NICE recommends for implementing policy begins with two fundamental questions: Is the Review relevant? If no, NICE recommends this is recorded on a risk register and no further action is recommended. If yes, NICE's recommendations for implementation are shown in figure 4.

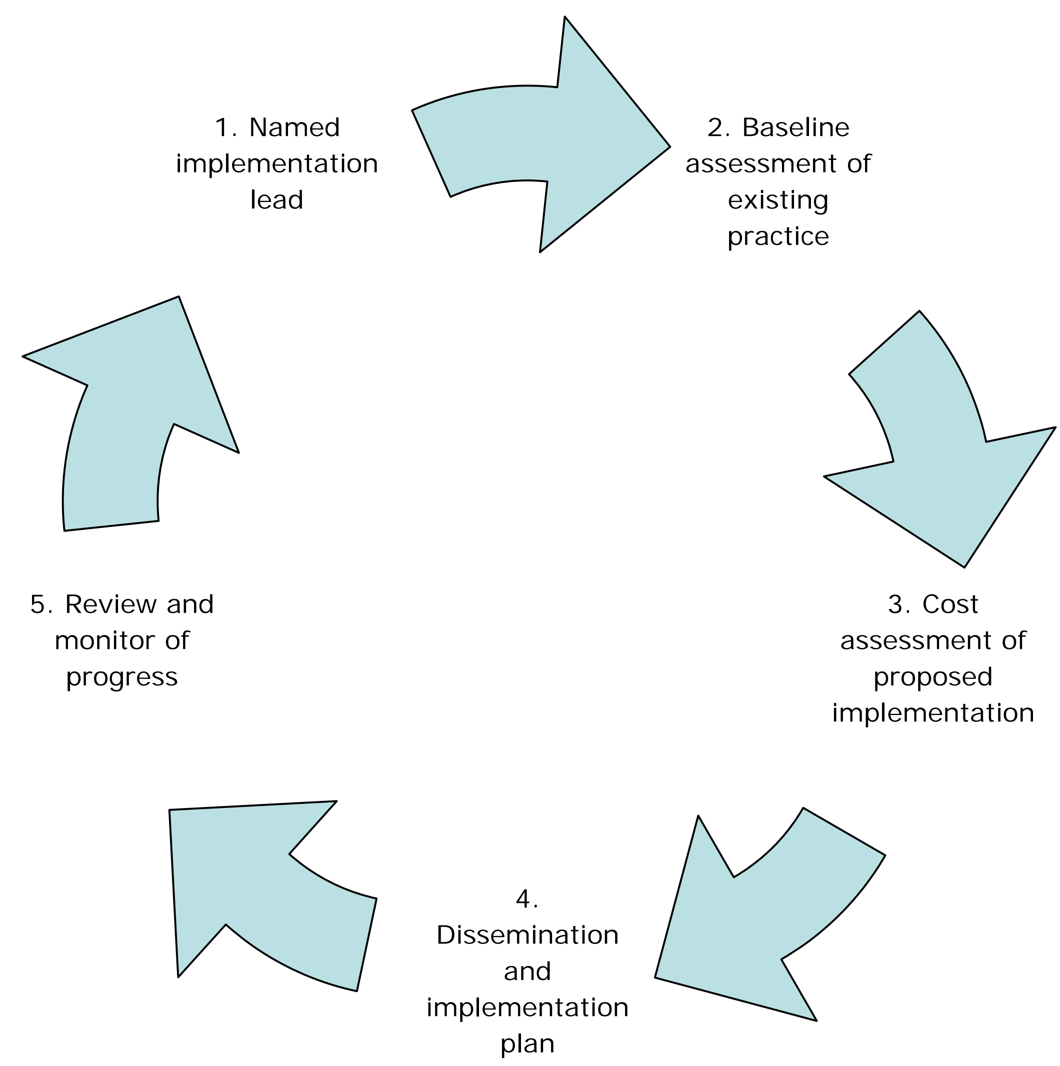

Figure3: Process for implementing public health policy

7.32. The naming of an implementation lead, the use of the self-assessment toolkit and a review of progress reported by some Trusts, suggests systematic approaches in some areas, but this was not widespread. A good practice example is at Nottinghamshire Healthcare NHS Trust where the Review had an executive sponsor in the form of the Executive Director of Nursing, a named lead who as an Associate Director of Nursing, the use of the self-assessment toolkit to assess baseline performance, the development of an action plan owned by the Trust Board and monthly monitoring review of progress by the Nursing and Allied Health Professions Executive Group. In many HEIs, there was evidence of a systematic approach in the

form of a named lead, the mapping of existing curricula against the Review recommendations, an implementation plan and reviews of such plans.

Understanding change in organisations – theoretical approaches

7.33. Four main theories are evident in the literature to guide our understanding of how change, such as the implementation of the CNO Review recommendations, appears to occur in organisations such as MHTs and HEIs.

7.34. The focus of *Systems theory* [ST] (Checkland, 1981) is on the relationships of different parts of an organisation; change in one part such as the implementation of the CNO Review recommendations, requires consideration of its impact upon other parts of the Organisation to which nursing relates and which are likely to be affected by any change to nursing. Implementation of the CNO Review recommendations, although directed at mental health nursing primarily, impacts inevitably upon other aspects of the infrastructure of MHTs and HEIs. Within ST, implementation of the CNO Review recommendations would require a multi-agency approach whereby nurses would be working in tandem with other professionals, service users, and carers to consider the impact of implementing the recommendations on other services.

7.35. In *Organizational Development Theory* [ODT] (Garside, 1998), change is considered as a discrete episode understood through the prism of behavioural sciences, a focus on human processes and an assumption that change requires congruence between individual/discrete and organisational plans. Within ODT, implementation of the CNO Review recommendations may be seen as a discrete goal. The task of the organisation is to determine how congruent this goal is with the plans of the larger organisation.

7.36. Complexity Theory [CT] (Plsek & Greenhalgh, 2001) recognises that an organisation is a dynamic, complex entity. Employees interacting with each other in an innovative way produce change through understanding the organisation's processes and structures and considering what works well and needs improving. Implementation of the CNO Review recommendations using CT requires recognition by nurses that implementing the Review recommendations will improve practice, a thorough understanding of the factors that promote and inhibit change in their organisation, and the use of this information to foster the implementation of the Review recommendations.

7.37. Finally, in *Social Worlds Theory* [SWT] (Tovey & Adams, 2001) change happens through negotiation and renegotiation between the internal world of the organisation, e.g. meeting patients and staff expectations, and the external world,

e.g. the regulatory system imposing targets that may not concur with the goals and expectations of the internal world. In SWT, the CNO Review recommendations may be seen as targets imposed by an external entity. If the recommendations are seen as incompatible, then implementation of them may occur only through a process of negotiation and renegotiation with the DH.

7.38. Not surprisingly, given the lack of systematic approaches to implementation of the Review recommendations in most MHTs, there is no evidence of the application and use of organisational theories being used to guide MHTs' practice in relation to the CNO Review. There is evidence from the findings reported here that could be explained by the theories described above. For example, where there was evidence of the Review recommendations being addressed by MHTs, this was driven entirely by mental health nurses, with few signs of a consideration of multi-agency involvement. Hence, implementation resulting from the Review was limited. In many HEIs, where there was more implementation resulting from the Review, there is evidence of working in partnership with other branches to consider the impact on those branches of the recommendations. This is compatible with Systems Theory.

7.39. Organisation Development Theory is apparent where there is evidence of many of the Review recommendations being implemented because they were congruent with MHTs integrated business plans even if these plans were driven by other policies. This was also the case in HEIs especially in relation to reviewing curricula to incorporate Recovery approaches, a goal that was congruent with most HEIs plans.

7.40. Evidence of Complexity Theory arises in some MHTs and many HEIs from our findings. Where there evidence of the Review driving change it was led by local 'champions' recognising the value of the CNO Review, accepting the recommendations and assuming, or being charged with, responsibility for the implementation of the recommendations. These champions had a sound understanding of their organisations and knew the processes that would enable implementation.

7.41. Few respondents in this study perceived the CNO Review recommendations as part of an external world imposing a set of targets they needed to follow. The converse was the case in MHTs, where most respondents in Phase two suggested that the recommendations were more likely to be implemented if they were required. However, it appears that in some MHTs, the decision to implement the Review recommendations was prompted by the invitation to participate in the Review evaluation. This hints at Social Worlds Theory in action.

Convergence of findings between the phases of the study

7.42. Phase 1 of the research was an e-mail survey in which all MHTs and HEIs in England provided a self-assessment of their progress towards implementation of the CNO Review recommendations. A limitation of this approach is that it relies on respondents to give an honest and informed account, with little opportunity to corroborate their responses. Phase two of the research provided an opportunity to examine in some detail the experiences of the CNO Review in a selected example of MHTs and HEIs, all of whom had responded to the phase 1 survey. As findings from phases 1 and 2 show, there is some concordance between the responses to phases 1 and 2, most notably in relation to issues that facilitated and hindered the implementation of the Review recommendations. In HEIs, the concordance was stronger; in MHTs, there was evidence of incongruity between phase 1 and 2 responses. This incongruity may have arisen for several reasons. The phase 1 survey required a response from an individual, whereas the phase 2 responses included several people who were more representative of people who work in, use or collaborate in the provision of services in both MHTs and HEIs. It is also possible that the individual who responded in phase 1, was not present in phase 2. This is more likely the case in MHTs; during phase 2 we discovered that in three Trusts, there had been a change to the director of nursing between phases 1 and 2. The use of the methods used in phase 2, and the involvement of more representative samples in this phase allowed the researchers to corroborate some of the responses received in phase 1. The use of the typology to categorise MHTs and HEIs as 'high' or 'low' implementers on the basis of their responses to phase 1 is supported by the levels of concordance between phase 1 and 2 responses in HEIs, but not in MHTs.

The significance of the study's findings

7.43. There have been three reviews of mental health nursing in the past 30 years; the first two covered the whole of the UK, the 2006 Review focussed on England only, owing to the nature of the devolved governance between the countries of the UK. This is the first comprehensive and systematic evaluation of the impact of the Reviews of mental health nursing. The study has provided evidence of the impact of the Review in mental health nursing practice and education, identified factors that have facilitated the implementation of the Review, as well as issues that have hindered the implementation of the Review. From these findings, it is possible to identify how to further improve the implementation of the CNO Review in England. It was envisaged by the DH it may take between 5 to 10 years for the Review recommendations to be realised in full. We are close to the end of the third year since the Review report was published. Therefore, against this background, there are encouraging signs of progress towards the implementation of the Review in both MHTs and HEIs. Judging by the progress evident from the phase 3 survey findings,

the CNO Review, as well as this evaluation of the Review, may have provided impetus for renewed attention to the recommendations and actions. The response rates to the surveys in phases 1 and 3 are impressive.

Limitations

7.44. Notwithstanding the significance of the findings of this study, there are several limitations evident in a study of this nature. Surveys are subject to errors of sampling, coverage, measurement and non response (Dillman 2000). Online surveys have been criticised as particularly susceptible to sampling and coverage error (Koch and Emrey 2001) though since this survey aimed to recruit a population of which all the members were known and could be targeted, the opportunity for such self selection bias was vastly reduced (O'Neill and Penrod 2001). The potential for measurement error due to poor presentation of the study instrument including design, length and complexity (Reips 2002) was also minimised by keeping the questionnaire simple with minimal downloading time (Mertler 2003, O'Neill et al. 2003). It has been suggested that non-response error or drop-out rate for web-based surveys is affected by a number of factors interacting in complex ways. However much appears to rest both on the subject matter of the survey and participants' intrinsic motivation for its completion (O'Neill and Penrod 2001, O'Neill et al. 2003). The above average response rates to surveys - 63.6% for Trusts and 80% for HEIs in phase 1; 55% for MHTs and 54% in phase 3 - suggests that respondents were generally interested and motivated to take part in the study. The use of a web-based questionnaire to undertake the surveys presumed both access to email / internet and adequate levels of computer literacy amongst the study population. It may be possible that some non-respondents, despite being high level managers in the public sector, may have been discouraged from responding due to the format of the instrument. Although the web-based survey instrument had limitations, it was nonetheless a useful tool for this study and may have been particularly effective because it was used to reach a known, specialist sub-group whose members were likely to have both email and internet access (Reips 2002, Truell et al. 2002). Sampling bias cannot be ruled out in the phase 1 and phase 3 surveys. It is possible that the people who responded on behalf of the organisations represented their own views and not those of others in the organisation. We minimised this effect by seeking the views of the Nurse Directors Forum and Mental Health Nurse Academics UK on who might be the best person to whom we should email the surveys and by asking respondents to canvass and incorporate the views of others in their organisation who they believed could give an informed view prior to returning the completed survey.

The selection of the samples for phase 2 was purposive and based upon responses to phase 1. Thus, we cannot claim that those whom we selected for phase 2 were

representative of all MHTs and HEIs who could have been selected for this phase. Nevertheless, there is evidence of congruence between the findings of phases 1 and 2, and this resolves some of these potential limitations.

Implications of the findings for mental health practice, education, management and research

7.45. The CNO Review was designed to provide mental health nurses with guidance to develop the practice of mental health nursing for the foreseeable future. It has given mental health nurse leaders a steer against which to lead the developments of practice. It has provided mental health nursing educators with a framework to help ensure that students at the point of registration have the competencies and capabilities that will make them fit for practice. Finally, the Review has provided mental health nursing researchers with potential research questions that if investigated, may add to our knowledge of the effectiveness of mental health nursing interventions.

7.46. There is some evidence from the findings of this study that many mental health nurses, at different levels in Mental Health Trusts and Higher Education Institutions, are using the Review to further the practice and education of nurses. However, responses to the Review vary across the country, and there remain opportunities to further implement the recommendations. The findings here suggest a need for a more systematic approach to the implementation of the Review in Mental Health Trusts, a need for stronger leadership at the highest level of Trusts to steer this implementation, greater ownership of the Review among mental health nurses, a collaborative approach towards implementation which sees mental health nurses working in partnership with service users, carers, other professionals and stakeholders, and a commitment to a programme of actions to implement, support, monitor, audit and evaluate progress using the best available evidence for how effective policy implementation is possible in organisations. The findings from this evaluation of the Review have given mental health nurses data against which they can prioritise actions to aid further implementation of the Review.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

Conclusions

8.1. Implementation of the CNO Review of mental health nursing in England varies. In mental health Trusts there is evidence of acceptance of the Review and some evidence of subsequent actions to implement the Review recommendations, but these are not widespread. Implementation of the Review recommendations is being hampered by an overall lack of an evidence-based implementation plan at both the national and local level. A lack of strategic nursing leadership in many mental health Trusts is thwarting implementation as the Review appears to be subjugated by competing Trust priorities and a lack of awareness among mental health nurses. In Higher Education Institutions there are many examples of the Review steering revision of mental health nursing education curricula, most notably in shifting the focus of education towards recovery approaches, and working in partnership with service users, carers and other stakeholders in many, if not all, aspects of education.

Recommendations

8.2. In light of the findings of this evaluation of the CNO review of mental health nursing, the researchers make the following recommendations.

1. Mental Health Trusts and Higher Education Institutions adapt a systematic and evidence-based approach to implement the Review recommendations. Such an approach is likely to include: ensuring that all nurses are aware of the Review, conducting a baseline assessment of existing practice, assignment of a dedicated lead for implementation and financial resources to assist implementation, development of an action plan to steer implementation, dissemination and implementation of the plan, and ongoing monitoring, audit and review of progress.

2. Mental Health Trusts incorporate the Review recommendations in their business plans and ensure regular review at Board level

3. Mental Health Trusts map the Review recommendations against other policies they are pursuing

4. The Department of Health publishes a Review Implementation Guide along the lines of the 2001 Mental Health Policy Implementation Guide to assist Mental Health Trusts implement the Review

5. The Department of Health considers setting up an English National Implementation Group (ENIG) with Local Implementation Groups in each SHA to report annually to the ENIG on progress towards implementation of Review recommendations. The LIGs can also provide guidance and assistance to Trusts and HEIs on implementing the Review recommendations.

6. The Care Quality Commission and Monitor considers progress in Trusts' implementation of the Review recommendations as part of its annual assessments of Trusts

7. Mental Health Trusts identify a lead mental health service user and carer to lead the user and carer involvement in the Review recommendations. This is best done by contacting organisations who demonstrate best practice and can provide training and support these leads.
8. Mental Health Trusts and Higher Education Institutions involve Mental health service user and carer *groups* in the strategic implementation of the Review recommendations

9. The National Institute of Health Research considers funding a programme of research designed to investigate the impact of interventions to implement the Review recommendations

10. The CNO requests a annual report from Directors of Nursing and Heads of Academic Divisions in Universities on progress towards implementation of the Review recommendations

11. The DH sponsors an annual conference in which examples of good practice towards implementation of the Review recommendations can be diffused

12. The Nursing and Midwifery Council and the DH incorporate HEIs' progress towards implementation of the Review recommendations in their quality assessments of pre-registration mental health nursing education.

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APPENDICES

Appendix 1

Themes and sub-categories from HEI focus group data in phase 2

Theme	**Sub-categories**
Use of CNO recommendations	Mapping/Benchmarking Guiding framework Affirmation of current practice Strengthening the case for change
Impact of CNO review	Impetus for curriculum review Increased involvement of service users and carers Putting recovery at forefront of revised curricula Strengthening physical health care input into curricula
Challenges to implementation	Overcoming resistance Switching attention from biomedical approaches Competing demands and pressures Incongruence between clinicians and academics' expectations Perception of review recommendations
Working in partnership	Prompting the development of partnerships Strengthening existing partnerships Expanding partnerships
Facilitators to implementation	Commitment Partnerships Strategic vision Acceptance of review Values of team Focus of review
Barriers to implementation	Clash of academic/clinical cultures Resistance to change Competing policies Lack of funding Rejection of recommendations
Changes attributed to the Review recommendations	Introduction of recovery approach Review of values Increased physical health care component Use of client attachment led by service user Better placement assessments Longer placements and modules Joint appointments with practice Service user involvement in staff appointments Increase student involvement in curriculum planning

Appendix 2

Aids to implementation to date (MHTS):

1. In Trusts, there was a strong consensus that "***nurse involvement***" and "***other strategies / reviews***" were the **most important** facilitators for implementation for progress to date, reported by over half of the Trusts:

   "*Involvement of the whole nurse directorate team.*" (Trust 64)

   "*Driven and led by nurses.*" (Trust 74)

   "T*he legislation changes i.e. new MHA.*" (Trust 68)

   "*Other strategies, reports NWW, education productive development, productive series and RCN Clinical Leadership Program.*" (Trust 86)

2. "***Role of the Trust***" was the **second most important** implementation facilitator to date:

   "*Support at Board level.*" (Trust 71)

   "*Sign up and support of the Trust Board.*" (Trust 75)

3. For Trusts, "***senior level / champions***" was the **third key implementation facilitator** to date:

   "*An identified senior forum to regularly discuss with occasional half-day workshops.*" (Trust 78)

   "*Key champions for certain areas of focus, e.g. Recovery, Physical Health, Spirituality, CBT.*" (Trust 84)

   "*The champion/leadership input of the Professional Lead for Mental Health Nursing.*" (Trust 85)

Aid implementation to date (HEIs):

1. For over half of the HEIs, "***commitment and enthusiasm of the mental health team***" was reported as being the **most important** implementation facilitator to date:

   "*Acceptance by the MH team as a whole of the principles of the review.*" (Trust 95)

   "*A committed enthusiastic mental health team who are proactive in believe in the recovery based approach to practice.*" (Trust 104)

   "*Staff commitment & enthusiasm.*" (Trust 106)

2. "***Impact on the curriculum***" was rated as the **second key implementation facilitator** by over half of the HEIs:

   "*Good evaluation systems - that enable continuous review of the modules.*" (Trust 94)

   "*The constant review of teaching sessions in line with new practice.*" (Trust 110)

   "*The sign posting by the CNO report of the content of the pre-reg curriculum.*" (Trust 112)

3. HEIs put forward "***support / partnerships with the Trust & stakeholders***" as the **third key factor** to aid implementation to date:

   "*Good partnership with local mental health trust. Key staff have enhanced this such as OQME manager at trust and Practice Placement Managers.*" (Trust 99)

   "*Collaboration with key stake holders e.g. Local Trust, clinicians and service users.*" (Trust 108)

Aid implementation in the future (Trusts):

1. "***Trust support***" was reported to be the **most important** implementation facilitator for progress in the future for Trusts:

    "*Requirement to provide regular reports to Trust Board.*" (Trust 71)

    "*Continued investment in services by PCTs.*" (Trust 82)

    "*Trust Board level support.*" (Trust 85)

2. The **second most frequently cited factor** which was considered as aiding the progress for future implementation was "***workforce & role development***":

    "*The establishment of forums to develop new roles including assistant and advanced practitioners.*" (Trust 81)

    "*Development and appointment of the two new nursing leadership roles.*" (Trust 95)

3. The **third most important** barrier for future implementation was "***progress & performance***".

    "*Changes in culture and practice to support nurses in their education and development i.e. protected time for this.*" (Trust 74)

    "*Continued monitoring of progress and review with services electronically updating plans which are available via the Trust intra net site.*" (Trust 75)

Aid implementation in the future (HEIs):

1. In terms of the future, "***developing relationships***" was considered as the **most important** implementation facilitator for progress in the future:

    "*Good relationships with clinical partners and user, carer groups.*" (Trust 90)

    "*Strong partnerships and commitment.*" (Trust 98)

    "*Continued close collaboration with key stake holders.*" (Trust 108)

2. "***Support & commitment of department***" and "***curriculum & programme development***" were put forward as the **joint second key factors** for future implementation:

   "*Team who are committed to ensuring the programme that is developed is in keeping with recommendations.*" (Trust 94)

   "*Support for the review by the MH team as a whole.*" (Trust 95)

   "*Flexible approach to programme development within the university.*" (Trust 90)

   "*Review of Pre-reg Nursing Programme.*" (Trust 96)

3. "***Clinical influences***" and "***impact of other frameworks***" were rated **joint third** facilitators for future implementation:

   "*University and local mental health trusts recognition of need for longer clinical placements and move towards this.*" (Trust 99)

   "*Local structure that enables those with general nursing background to be far more involved in the teaching of physical care and interventions.*" (Trust 114)

   "*Best Practice Guidelines & Mental Health Nursing Skills - John Playle et al.*" (Trust 104)

   "*National drive for implementation monitoring – this is accessible to all.*" (Trust 110)

Appendix 3

Barriers to implementation to date (Trusts):

1. Trusts reported that "***competing priorities***" was the **key major barrier** to implementation to date:

   > "*The fact that it* [CNO recommendations] *has had to compete with several other mainstream/must do initiatives including those against which the Trust's performance is more directly assessed (e.g. CNST, Health Care Commission, Standards for Better Health). Although these do sometimes match or significantly overlap (e.g. Clinical Supervision) there can sometimes be a conflict of competition for limited resources, including staff and managers time.*" (Trust 78)

   > "*The organisation understandably is driven by the priorities of the regulator and the commissioners, this has made it difficult to engage the Trust in the priorities outlined in the CNO Review.*" (Trust 90)

   > "*Conflicting demands and immediate priorities that distract from longer term strategic delivery.*" (Trust 92)

2-3. The **second and third most reported** barriers for Trusts were "***Trust / organisational structure***" and "***leadership & ownership issues***" respectively:

> "*Organisational restructuring.*" (Trust 67)

> "*Preoccupation with organisational reconfiguration rather than on care - professional silo's remain.*" (Trust 70)

> "*Not having all the stakeholders around the table at one time. Leading to fragmentation.*" (Trust 63)

> "*Lack of meaningful ownership at senior organisational level.*" (Trust 85)

Barriers to implementation to date (HEIs)

1. With regards to the HEIs, over half reported that "***time & resource constraints***" was the **major barrier** to the implementation of the CNO recommendations to date:

> "*Pressures on time within the curriculum hours.*" (HEI 89)
>
> "*Time - the time to review teaching materials and curriculums.*" (HEI 110)
>
> "*Resource issues such as limited face to face teaching time available.*" (HEI 90)

2. In addition, just under half of the responders also suggested that "***difficulties with the curriculum***" was a **second key barrier**:

> "*Lack of robust MH influence in our degree programme (due to the small numbers of MH students within this programme, but these numbers are increasing).*" (Trust 95)
>
> "*Fitting in with an adult and children's nursing curriculum.*" (Trust 109)

3. "***Staff issues***" and "***involvement of service users & carers***" were considered the **third most important** barriers to implementation to date by HEIs:

> "*Shortages of staff in clinical areas.*" (Trust 89)
>
> "*Changes within the MH team with new lecturers arriving and more experienced ones having left.*" (Trust 107)
>
> "*Not doing as well with user/carer involvement as we could have done (e.g. selection, assessment, paid members of staff.*)" (Trust 95)
>
> "*Persuading the university to pay reasonable fees to services users and carers for their work.*" (Trust 109)

Barriers to implementation in the future (Trusts)

1&2. In terms of barriers to implementation in the future, Trusts highlighted "***workforce***" followed by "***competing priorities***" as **key** in inhibiting future implementation of the recommendations:

> "*Further reduction in nursing workforce...Failure to attract and retain high calibre practitioners.*" (Trust 72)
>
> "*Potential workforce crisis, with high numbers of experienced nurses retiring, and fewer nurses in training.*" (Trust 92)

> ***"Continued competing priorities." (Trust 64)***

> *"Competing priorities sometimes affect implementation of new strategies."* (Trust74)

3. "***Resources & training***" were rated as the **third** key barrier for future implementation:

> *"Resources - for training and protected learning time."* (Trust 72)

> *"Insufficient address of resource requirements."* (Trust 85)

Barriers to implementation in the future (HEIs):

1. In terms of barriers considered as hindering future implementation, just under one third of HEIs reported that "***staff demands & pressure***" was the **most important**:

> *"Demands on staff - both university and clinicians - such that the requirements of the CNO review become an additional burden."* (Trust 95)

> *"Level of criticism received can be very off putting."* (Trust 109)

2. HEIs suggested that "***curriculum & timetabling***" was the **second most important** barrier for successful future implementation:

> *"Timetabling and compatibility with other programmes."* (Trust 90)

> *"Time and space for thoughtful curriculum development is always at a premium."* (Trust 103)

3. "***Reviews & inclusion***", "***payment for service users & carers***" and "***local & nationals influences***" were equally rated as the **third most important key barriers** for future implementation:

> *"Endless reviews of nursing."* (Trust 99)

> *"Paying service users and carers for their work and acknowledging this."* (Trust 109)
> *"Joint working with local NHS Trusts is not always easy when you get different people all the time."* (Trust 109)

Appendix 4

1). Level of organisational priority for overall implementation.
Please rate the following 16 CNO recommendations in terms of priority within your mental health pre-registration nursing programme(s). Please note Point 14. 'Strengthening Pre-registration education' has been removed from this question.

Themes & recommendations		Priority				
		Very low priority	Low priority	Medium priority	High priority	Very high priority
Putting values into practice	1. Applying Recovery Approach values	☐	☐	☐	☐	☐
	2. Promoting equality in care	☐	☐	☐	☐	☐
	3. Providing evidence-based care	☐	☐	☐	☐	☐
Improving outcomes for service users	4. Meeting the greatest need	☐	☐	☐	☐	☐
	5. Strengthening relationships with service users and carers	☐	☐	☐	☐	☐
	6. Holistic assessments and managing risk effectively	☐	☐	☐	☐	☐
	7. Improving physical well-being	☐	☐	☐	☐	☐
	8. Providing psychological therapies	☐	☐	☐	☐	☐
	9. Increasing social inclusion	☐	☐	☐	☐	☐
	10. Recognizing spiritual needs	☐	☐	☐	☐	☐
	11. Responding to the needs of people with substance misuse problems	☐	☐	☐	☐	☐
	12. Improving inpatient care	☐	☐	☐	☐	☐
A positive, modern profession	13. Developing new roles and skills	☐	☐	☐	☐	☐
	15. Working effectively in multi-disciplinary teams	☐	☐	☐	☐	☐
	16. Supporting continued professional development	☐	☐	☐	☐	☐
	17. Improving recruitment and retention	☐	☐	☐	☐	☐

2). Please identify your organisation's progress towards implementation of recommendation 14, *'Strengthening pre-registration education'* in the CNO review.

	Implementation				
	None	Limited	Some	Reasonable	Full
14. Strengthening pre-registration education	☐	☐	☐	☐	☐
14.1 Higher education institutions (HEIs) to review pre-registration programmes to meet minimum competencies as set out in *Best practice competencies and capabilities for pre-registration mental health nurses*	☐	☐	☐	☐	☐
14.2 HEIs to consider adopting a range of different approaches to placements to improve benefits for students, e.g. longer placements and client attachment.	☐	☐	☐	☐	☐
14.3 Service providers and HEIs to develop strong co-operative relationships to improve educational outcomes through: involving all nurse lecturers with healthcare providers, e.g. in clinical care, practice development or research; identifying an MHN to act as mentor for each student for the entire period of pre-registration training; involving clinical staff in teaching; high level co-ordination and co-operation between organisations; shared posts.	☐	☐	☐	☐	☐
14.4a Higher education institutions to involve **service users** in every aspect of education, including: recruitment; curriculum planning; teaching; student assessment.	☐	☐	☐	☐	☐
14.4b Higher education institutions to involve **carers** in every aspect of education, including: recruitment; curriculum planning; teaching; student assessment.	☐	☐	☐	☐	☐

3a). Please identify your organisation's progress towards implementation for each item and their relevant knowledge and performance criteria from the '*Best*

practice competencies and capabilities for pre-registration mental health nurses'.						
Themes & recommendations		**Implementation**				
		None	**Limited**	**Some**	**Reasonable**	**Full**
3a.1 Values	Promote a culture that values and respects the diversity of individuals, and enables their recovery.					
3a.2 Communication	Use a range of communication skills to establish, maintain and manage relationships with individuals who have mental health problems, their carers and key people involved in their care.					
3a.3 Physical Care	Promote physical health and well-being for people with mental health problems.					
3a.4 Psychosocial care	Promote mental health and well-being, enabling people to recover from debilitating mental health experiences and/or achieve their full potential, supporting them to develop and maintain social networks and relationships.					
3a.5 Risk and risk management	Work with individuals with mental health needs in order to maintain health, safety and well-being.					
3a.6 Multidisciplinary and multi-agency working	Work collaboratively with other disciplines and agencies to support individuals to develop and maintain social networks and relationships.					
3b. Did you find any of the factors described above particularly challenging?		**Yes**		**No**		
3c. If so which ones?						

4. Please could you outline specific steps taken in your organisation in relation to implementation of the CNO review:	
i) To date?	
ii) Proposed?	

---

5) Please could you identify 3 key facilitating factors which you consider:	
i) Have aided the implementation of the CNO recommendations to date?	
ii) Will enable further implementation where necessary?	

6. Please could you identify 3 key barriers which you consider:	
i) Have hindered the implementation of the CNO recommendations to date?	
ii) Will hinder further implementation where necessary?	

7 i) Has your curriculum been reviewed specifically as a result of the CNO review of mental health nursing?	Yes	☐	No	☐
7 ii) Have amendments been made to your curriculum as a result of this review?	Yes	☐	No	☐
8a) Has one person been appointed by your organisation to lead the implementation of points raised by the CNO review?	Yes	☐	No	☐
8b) If so what is the job title of this person?				
9a) Has the CNO review become a standing item at either branch/team, course or programme committee?	Yes	☐	No	☐
b) If so please could you describe the committee(s)				

10) Please expand on any issues which you feel are relevant to this evaluation which we have not asked you?				
11a) Have you consulted with others when completing this survey?	Yes		No	
b) If so who? (please indicate role(s); job titles)				

12) About you:	
i) Name	
ii) Telephone Number	
iii) Email address	
iv) Position	
v) HEI	
vi) Course(s) you represent	
Please click on the button to submit your responses	Submit

Appendix 5

1). Level of organisational priority for overall implementation.
Please rate the following 17 CNO recommendations in terms of priority within your organisation.

Themes & recommendations		Priority				
		Very low priority	Low priority	Medium priority	High priority	Very high priority
Putting values into practice	1. Applying Recovery Approach values	☐	☐	☐	☐	☐
	2. Promoting equality in care	☐	☐	☐	☐	☐
	3. Providing evidence-based care	☐	☐	☐	☐	☐
Improving outcomes for service users	4. Meeting the greatest need	☐	☐	☐	☐	☐
	5. Strengthening relationships with service users and carers	☐	☐	☐	☐	☐
	6. Holistic assessments and managing risk effectively	☐	☐	☐	☐	☐
	7. Improving physical well-being	☐	☐	☐	☐	☐
	8. Providing psychological therapies	☐	☐	☐	☐	☐
	9. Increasing social inclusion	☐	☐	☐	☐	☐
	10. Recognising spiritual needs	☐	☐	☐	☐	☐
	11. Responding to the needs of people with substance misuse problems	☐	☐	☐	☐	☐
	12. Improving inpatient care	☐	☐	☐	☐	☐
A positive, modern profession	13. Developing new roles and skills	☐	☐	☐	☐	☐
	14. Strengthening pre-registration education	☐	☐	☐	☐	☐
	15. Working effectively in multi-disciplinary teams	☐	☐	☐	☐	☐
	16. Supporting continued professional development	☐	☐	☐	☐	☐
	17. Improving recruitment and retention	☐	☐	☐	☐	☐

2). Please identify your organisation's progress towards implementation for each item in the CNO review.

Themes and recommendations	Implementation				
	None	Limited	Some	Reasonable	Full
1. Applying Recovery Approach values					
1.1 MHNs to use clinical supervision to reflect on how their clinical practice can best incorporate recovery values.					
1.2 MHNs to fully take account of the service user's own meaningful aims in the assessment, care planning and Care Programme Approach processes with which they are involved and for this to be audited.					
1.3 MHNs working in care management roles to arrange for direct payments to service users where they choose this.					
1.4 Service providers to review operational policies and philosophies for services in which MHNs work to ensure that they support them in delivering care based on recovery principles.					
1.5 All educational/training programmes for MHNs to be reviewed to reflect recovery principles as expressed within the *Ten Essential Shared Capabilities*.					
1.6a Service users to be routinely involved in the recruitment, education and assessment of all MHNs.					
1.6b Carers to be routinely involved in the recruitment, education and assessment of all MHNs.					
	Implementation				
	None	Limited	Some	Reasonable	Full
2. Promoting equality in care					
2.1 All MHNs to use supervision and annual appraisal to reflect on their role in tackling inequalities in care and demonstrating non-discriminatory practice.					
2.2 Nursing strategies to reflect the need for MHNs to engage actively in practices that reduce inequalities in care, for example by: encouraging reporting of inequalities in service provision; advocating for service users where they may be disadvantaged.					
2.3 To establish arrangements whereby the MHN workforce in the future will reflect diversity in the communities served, for example by: profiling the current workforce against the populations served; forming links with local community groups; advertising in minority publications; publicising the					

contribution made by existing MHNs from minority backgrounds; providing opportunities to develop support workers.					
2.4 All MHNs to receive diversity and anti-discrimination training (including cultural competency) every three years.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
3. Providing evidence-based care	☐	☐	☐	☐	☐
3.1 MHNs to use clinical supervision to support the use of evidence in practice.	☐	☐	☐	☐	☐
3.2 MHNs completing post-graduate level courses to produce articles/summaries of their research for possible publication and/or internal distribution.	☐	☐	☐	☐	☐
3.3 To review nursing strategies and research strategies to ensure that they include reference to processes that will support nurses engaging in research activities.	☐	☐	☐	☐	☐
3.4 To review all nurse consultant roles to ensure that they are contributing to research, either directly or through supporting others.	☐	☐	☐	☐	☐
3.5 To identify a nurse with a special interest in research to act as a 'champion' and encourage and support other MHNs in engaging with research.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
4. Meeting the greatest need	☐	☐	☐	☐	☐
4.1 Service providers to review current nursing roles and evaluate whether these make best use of the range of nursing skills, i.e. that nurses focus on working directly with individuals with higher levels of need in terms of acuity, severity or complexity, and/or support other workers to meet less complex needs.	☐	☐	☐	☐	☐
4.2 To identify processes/changes required to enable MHNs to work in such ways.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
5. Strengthening relationships with service users and carers	☐	☐	☐	☐	☐
5.1 All assessments by MHNs to: identify any carers and how their needs will be assessed; or assess the needs of any carer and then produce a care plan.	☐	☐	☐	☐	☐
5.2 Wherever possible service user choice to be supported,	☐	☐	☐	☐	☐

e.g. in MHN key worker gender preference.					
5.3 All MHNs to have access to advice on how information can be provided without breaching confidentiality.					
5.4a MHNs to have access to written information for **service users**, including on: services; medication; diagnoses/problems.					
5.4b MHNs to have access to written information for **carers**, including on: services; medication; diagnoses/problems.					
5.5 All MHNs to have access to support systems for identifying and addressing stressful situations, e.g.: opportunities to raise with managers issues that cause work stress; regular clinical supervision; advice from professional leads; staff counselling services.					
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
6. Holistic assessments and managing risk effectively					
6.1 All assessments to take into account that people have interrelated psychological, social, physical and spiritual needs. Care plans to reflect these issues and this to be audited.					
6.2 All assessments to identify any risk of self-harm, self-neglect, abuse from others and violence towards others. Care plans to reflect these issues and this to be audited.					
6.3 MHNs to actively engage with service users in devising risk management plans whenever possible and this to be audited.					
6.4 All MHNs to know and act upon local 'vulnerable adults' policies and this to be incorporated into inductions for new employees.					
6.5 Managers and staff to discuss how positive risk management can avoid producing unnecessarily defensive practice and the results of this to be reflected in policies and processes and managed through local governance systems.					
6.6 All MHNs to have ready access to advice and guidance from named and designated child protection professionals and know to whom they are accountable in relation to safeguarding children.					
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
7. Improving physical well-being					
7.1 MHNs to have the appropriate competencies to support physical well-being through: assessment of current capabilities in teams and developing team-based training based on local need; and/or developing individual					

development programmes based on individual appraisal utilising the Knowledge and Skills Framework.					
7.2 MHNs to be able to: refer on to medical or other primary care staff in response to evidence of unmet physical health need, arranging support as required to ensure services are then actually received; or arrange for further investigations themselves.					
7.3 MHNs to identify the need for and provide, or refer for, health promotion information and activities required to support physical well-being.					
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
8. Providing psychological therapies					
8.1 To evaluate current competencies in foundation skills for engaging psychologically with people with mental health problems, by using the Knowledge and Skills Framework and setting up individual or service-wide development programmes as required.					
8.2 Service providers to identify with commissioners the future service arrangements required to meet the need for psychological therapies in all settings.					
8.3 Service providers to identify arrangements required to support MHNs to contribute to meeting local need for psychological therapies, including: type and level of skills required in each service; how skills and knowledge will be developed; how clinical supervision will be ensured; what changes in service organisation and practices will be required to ensure skills can regularly be applied in practice; 'champions' to support developments.					
8.4 All MHNs due to attend training in psychological therapies to formally identify with their manager how they will apply new skills in practice and how supervision will be provided.					
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
9. Increasing social inclusion					
9.1 Service providers to develop arrangements to fight stigma at local level, e.g. through: media communication arrangements (including highlighting excellent nursing practice); links with local schools, colleges and employers; open events; allowing use of meeting rooms by non-mental health community groups when unused.					
9.2 Inpatient services to develop arrangements to break down barriers with local communities, e.g. through: open days; inviting local media in; forming links with voluntary groups.					

	Implementation				
	None	Limited	Some	Reasonable	Full
10. Recognising spiritual needs					
10.1 Service providers to ensure all MHNs have accessible sources of information/advice regarding religious/spiritual issues, e.g. information directories and access to experts and/or faith community representatives.					

	Implementation				
	None	Limited	Some	Reasonable	Full
11. Responding to the needs of people with substance misuse problems					
11.1 All MHNs to have access to sources of specialist advice on working with people with dual mental health and substance misuse problems.					
11.2 All MHNs to have received training on dual diagnosis issues, including: recognition; assessment (physical and psychological); motivational interviewing techniques; availability of resources.					

	Implementation				
	None	Limited	Some	Reasonable	Full
12. Improving inpatient care					
12.1 Individual risk assessments and risk management plans in inpatient settings to include assessment of possible risk to service users posed by others (including the risk of intimidation or sexual violence), in addition to risks presented to self or others.					
12.2 To develop good practice agreements, in conjunction with service users, which clearly state what service users can expect to be available to them, and what can reasonably be expected of service users at night time.					
12.3 To implement 'protected time initiatives' on all inpatient units.					
12.4 To introduce practices to reduce absconsion from unlocked wards, e.g. through: the introduction of signing in and out books; the identification of individuals at high risk of absconding and providing them with targeted nursing time; the careful breaking of bad news.					
12.5 To develop clear agreements with local police on the level of priority for requests to find people absent without leave based on their level of risk.					
12.6 Service providers to develop shared roles between inpatient and crisis/home treatment staff.					

12.7 All new community staff to spend time in inpatient settings as part of their induction, and vice versa.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
12.8 All ward managers to agree with their manager any actions needed to develop their leadership skills through annual individual development plans.	☐	☐	☐	☐	☐
12.9 Modern Matrons to be given sufficient authority to ensure that cleaning standards are met and maintained, and for this role to be part of their annual appraisal.	☐	☐	☐	☐	☐
12.10 To review career pathways for nurses in patient/acute care in the context of service user and staffing needs, so that a rewarding career structure is available to attract and retain experienced MHNs.	☐	☐	☐	☐	☐
12.11 To review how non-professionally qualified roles can make a greater contribution to care, directly and indirectly, and the developments needed to support this.	☐	☐	☐	☐	☐
12.12 To consider developing a range of specialist clinical interests for individuals in teams (e.g. psychological therapies, substance misuse issues or spiritual issues) as a means of: providing a valuable resource for the team; developing networks of expertise and links with specialist services; supporting individual professional development and job satisfaction.	☐	☐	☐	☐	☐
12.13 To carry out 'paper reviews' to identify and remove duplications in administrative processes and to shift routine administrative tasks to non-professionally qualified roles.	☐	☐	☐	☐	☐
12.14 Modern Matrons, with ward managers, to lead on ensuring that all service users are treated with dignity and respect, and service providers to develop specific means of supporting and monitoring this.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
13. Developing new roles and skills	☐	☐	☐	☐	☐
13.1 Service providers to put in place arrangements to support the implementation of nurse prescribing based on local need, taking into account the potential for service redesign and skill mix review, using both supplementary and independent prescribing arrangements.	☐	☐	☐	☐	☐
13.2 Service providers to evaluate senior nursing posts, such as nurse consultant roles, as part of a wider review of senior clinical roles, taking into account factors such as: service user need; the need to develop new services and introduce new skills; the need for flexibility of staff to meet future changes; the need to create rewarding career structures; legal developments (e.g. planned changes in mental health law,	☐	☐	☐	☐	☐

non-medical prescribing and Working Time Directives); plans for new ways of working for different professions; shortages of any particular profession/skills; the need to create strong clinical and professional leadership.					
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
14. Strengthening pre-registration education (14.1/14.2/14.4 have been removed from this questionnaire)	☐	☐	☐	☐	☐
14.3 Service providers and HEIs to develop strong co-operative relationships to improve educational outcomes through: involving all nurse lecturers with healthcare providers, e.g. in clinical care, practice development or research; identifying an MHN to act as mentor for each student for the entire period of pre-registration training; involving clinical staff in teaching; high level co-ordination and co-operation between organisations; shared posts.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
15. Working effectively in multi-disciplinary teams	☐	☐	☐	☐	☐
15.1 All MHNs to work assertively and professionally within multi-disciplinary teams and to identify any factors preventing this.	☐	☐	☐	☐	☐
15.2 All MHNs to have an identified professional lead who can offer support and professional advice.	☐	☐	☐	☐	☐
15.3 Nursing strategies to define how professional leadership skills will be developed and ensured for the future.	☐	☐	☐	☐	☐
15.4 To review all induction programmes to ensure that the range of professional roles is understood by all employees, and consider other means such as shadowing and shared educational events.	☐	☐	☐	☐	☐
15.5 To identify ways of encouraging and celebrating nursing achievement, e.g. through annual awards, publicising good practice, actively supporting publications in professional journals and conference presentations.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
16. Supporting continued professional development	☐	☐	☐	☐	☐
16.1 All MHNs to engage in regular clinical supervision from a suitably trained supervisor and this process to be audited.	☐	☐	☐	☐	☐
16.2 All MHNs to actively seek to develop skills and knowledge through utilising electronic and other resources to	☐	☐	☐	☐	☐

identify the evidence base for practice.					
16.3 Service providers to consider developing local career frameworks to support education and workforce planning and career development advice.	☐	☐	☐	☐	☐
16.4 To consider the identification of specific time for continuing professional development for each nursing role and include within job specifications.	☐	☐	☐	☐	☐
16.5 Service providers to discuss with SHAs means by which the availability of secondment of support workers for nurse training can be maximised.	☐	☐	☐	☐	☐
	Implementation				
	None	**Limited**	**Some**	**Reasonable**	**Full**
17. Improving recruitment and retention	☐	☐	☐	☐	☐
17.1 Service providers to review current arrangements supporting the recruitment and retention of MHNs with reference to recommendations in *Recruitment and retention of mental health nurses: Good practice guide.*	☐	☐	☐	☐	☐

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3) Please outline your organisation's strategy for implementation of the CNO review and targets for completion?

	Very Unlikely	**Unlikely**	**Neutral**	**Likely**	**Very Likely**
3ii) Please rate the likelihood of achieving the target dates?	☐	☐	☐	☐	☐

---

4) Please could you identify 3 key facilitating factors which you consider:	
i) Have aided the implementation of the CNO recommendations to date?	
ii) Will enable further implementation where necessary?	

---

5. Please could you identify 3 key barriers which you consider:	
i) Have hindered the implementation of the CNO recommendations to date?	

ii) Will hinder further implementation where necessary?				
6a) Has one person been appointed by your organisation to lead the implementation of points raised by the CNO review?	Yes		No	
6b) If so what is the job title of this person?				
7a) Has the CNO review become a standing item at either Trust Boards or Senior Management Meetings?	Yes		No	

b) If so please could you describe the committee?				
8) Please expand on any issues which you feel are relevant to this evaluation which we have not asked you?				
9a) Have you consulted with others when completing this survey?	Yes		No	
9b) If so what are their job titles?				

10) About you:	
i) Name?	
ii) Telephone Number?	
iii) Email address?	
iv) Position?	
v) MHT/PCT?	
11) Do you have any feedback on this questionnaire?	
Please click on the button to submit your responses	Submit

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