Practice Development with Individuals:
A Realistic Evaluation with Occupational Therapists

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DECLARATION

I certify that all material in this thesis which is not my own work has been identified and that no material is included for which a degree has previously been conferred upon me.

……. (signature)

ABSTRACT

Significant investment has been made to develop the practice of health care professionals in order that service users are offered evidence-based care. This investigation is a 'Realistic Evaluation' (Pawson and Tilley 1997) undertaken to form an illuminative case study of a particular change initiative for a specific professional group (occupational therapists) in one organisational structure. A practice development programme was available to all members of this group and sought to enable participants to use contemporary theory and standardised assessments routinely in their work.

The aim of this research was to gain an in-depth conceptualisation of the *mechanisms* which when activated within particular environmental *contexts* supported individual practitioners to embed their learning into their daily practice. The latter was considered the desired *outcome.* Mixed methods of data collection were used to gain understanding of how engagement in a practice development programme concluded for different individuals who were employed within the same NHS Trust.

The results suggested that *mechanisms* supporting practice development can be identified and when activated act as catalysts for practice change. It was also evident that the immediate environmental *context* and the person's attributes had an influence upon an individual's capacity to activate mechanisms. Furthermore, the level of engagement in the same baseline practice development opportunity varied for different individual practitioners. The conclusion of this thesis is that differentiated PD needs to occur in order to maximise practice change across people and places. The Individual Practice Development Theory (IPD) presented in this thesis represents an original contribution to knowledge. Using the IPD theory in practice could enable best use of learning opportunities, ensure the judicious use of resources and raise the quality of service for service users.

KEY TO ABBREVIATIONS

Abbreviation	Meaning
AMPS	Assessment of Motor and Process Skills
CMO	Context, Mechanisms, Outcome
CPA	Care Programme Approach
CPD	Continued Professional Development
EBP	Evidence Based Practice
ICP	Integrated Care Pathway
IPD	Individual Practice Development
LREC	Local research Ethics Committee
MOHO	Model of Human Occupation
MOHOST	Model of Human Occupation Screening Tool
NHS	National Health Service
OSA	Occupational Self Assessment
OT	Occupational Therapist
	Occupational Therapy
PD	Practice Development
QI	Quality Improvement
RCT	Randomised Controlled Trial
RE	Realistic Evaluation
VQ	Volitional Questionnaire
WRI	Worker Role Interview

Chapter One - Context

1.1 Chapter overview

An introduction to the thesis, the study and its contextual circumstances is provided in this chapter. The thesis is concerned with understanding, through a Realistic Evaluation, how engagement in a particular practice development (PD) programme played out for *individual* occupational therapists. The PD programme was itself undertaken with the goal that occupational therapists would use contemporary theory and assessment tools to guide their practice. The study sought to identify the *mechanisms* which supported PD within the unique *contextual* circumstance of each participant. Furthermore the researcher sought understanding as to whether PD interventions need to be individually tailored to achieve optimum learning *outcome.* The conclusion of this thesis is that differentiated PD needs to occur in order to maximise practice change across people and places. The Individual Practice Development Theory (IPD) emerged from the data analysis and abstraction of this study and represents an original contribution to knowledge.

Detail is given about the complete structure of this thesis in Section 1.6 where each successive chapter will be introduced incrementally. Before further description of the whole study is discussed it is important to provide an introduction to the context in which the study was undertaken. This is offered in the sections which follow. A profile of the practice organisation and the academic partnership within which this research was undertaken will be provided. An overview of the PD programme will also be given (Section 1.4) in addition to a discussion about how its associated PD interventions relate to the literature (Section 1.5). This will position the rationale for the specific focus of the PD programme. The first task though is to introduce occupational therapy, occupational therapists and the profession's concern with human development and change.

1.2 Occupational therapy and human change

This section will present a brief overview of the discipline of occupational therapy, the required competencies of occupational therapists and the connection with the concept of human change. It will argue that the discipline of occupational therapy has a unique position to understand how human beings respond to change in their daily lives. As such occupational therapists need to have a particular set of competencies which allow them to support people to continue to undertake their day-to-day activities through changed circumstances. Occupational therapists need to themselves evolve their knowledge and skills over time in order to maintain their competency to practise occupational therapy.

1.2.1 Occupational therapy

The discipline of occupational therapy is concerned with helping people to do the day-to-day activities that are important and meaningful to them when they need to adapt to new or long lasting challenges (College of Occupational Therapists, 2007a). The use of the term "occupation" is confusing to some people and could imply that occupational therapists are concerned solely with the jobs that people do to achieve income (Hinojosa et al 2005). However, an established definition of the term "occupation" used by the profession is connected with how people "occupy" their time with taking care of themselves or others, leisure and work tasks (Crepeau et al 2008a). Individuals do "occupation" through the large variety of activities undertaken every day (Dickie, 2008). This is because human beings have a fundamental need for a balance of occupations in their lives in order to achieve a state of health and well being (Wilcock, 1993). Individuals' interests, roles and choices of everyday activities vary as does the nature of their challenge with undertaking everyday tasks (Kielhofner, 2008a). People who utilise occupational therapy often have complex challenges which are generally connected with ill-health, disability, environmental deprivation or trauma (Creek, 2003). Thus the profession of occupational therapy is built on the belief that enabling people to effectively accomplish daily tasks is in itself constructive and healing (Rogers, 1982). As such occupational therapy intervention supports health and well being by offering intervention which has occupation and activity as both

the means of intervention and as the outcome of intervention (Hinojosa et al 2005). Occupational therapists need to continually develop their practice in order to have the necessary skills set to provide this intervention competently (College of Occupational Therapists, 2002). Accordingly, occupational therapists need to be able to embrace change in a theoretical and practical sense.

1.2.2 Occupational therapists and change

Occupational therapists need to be skilled in designing intervention opportunities which support positive change. As described in Section 1.2.1, the occupational therapist's skill set supports individuals to reach their potential in everyday life tasks (Moyers, 2008). The concept of change for occupational therapists is central and the ability to facilitate change in and with others is an expected part of an occupational therapist's skill set (Schkade and Schultz, 2003). This unique position may make occupational therapists a slightly different group with respect to PD than a profession whose work does not require such depth of professional skill and knowledge about the facilitation of human behaviour change. One of the commonalities with other health care disciplines though is that occupational therapists are expected to update and develop their practice continually (College of Occupational Therapists, 2002). Through doing this occupational therapists maintain fitness to practice (Warne, 2002). This is likely to require occupational therapists to periodically change their own behaviour as new information about what works in practice becomes available (Taylor, 2007) or when conceptual thinking in the field moves on (Hurford et al 2007).

More detailed discussion about the theories of change will be discussed in Chapter Three (Section 3.2). This section has introduced the concepts of occupation, occupational therapy and occupational therapists unique position with regard to the challenges of change. It has been argued that occupational therapists require particular knowledge about change to deliver occupational therapy and that maintaining professional competency is important. One way to keep up to date with current concepts to deliver occupational therapy could be the understanding and application of a conceptual practice model to guide practice. This was the

position taken in the practice context being studied through this research and the rationale for this stance is discussed next.

1.3 Conceptual models of practice

This section will introduce the definition of conceptual models and discuss in what ways they may be helpful to develop occupational therapy practice. It will conclude that the three primary reasons for using a conceptual model are to facilitate robust reasoning and decision making in practice, to give structure for the development of research for practice and to provide a framework for maintaining and demonstrating professional competency. To conclude this section the specific occupational therapy conceptual model, The Model of Human Occupation (Kielhofner, 2002; 2008a), which was introduced in the research context to aid the development of practice, will be discussed.

1.3.1 Conceptual models and their use in practice

With regard to a particular profession a conceptual model delineates and defines the scope of concern for the profession (Crepeau et al 2008b). Some authors however, position the definition of conceptual models closer to practice application. Kielhofner (2004), for example, defines a conceptual model as being a collection of relatively abstract, broad theories which have a focus on identifying and solving practical challenges with service users. An occupational therapy conceptual model then will describe in detail the component parts of occupational behaviour so that stakeholders achieve a shared interpretation of occupation as therapy (Potatery Burke, 2005). However, the consistent use of conceptual models by practitioners to guide practice remains questionable (Wook-Lee et al 2008) and a source of professional debate (Craik, 2009: Boniface et al 2009).

Occupational therapists can draw from a wide range of conceptual models to scaffold thinking about practice (Melton et al 2009). However, professional autonomy to select and adapt practice models can cause confusion in the field (Duncan, 2006; Boniface et al 2008). This might be one reason why occupational therapists do not generally identify themselves as theoretically orientated

practitioners (Creek, 2003). That said, contemporary pre-registration training does involve learning about conceptual models although it has been argued that lack of experience may cause novice practitioners of any discipline to have difficulty integrating theory with practice (Benner, 1984). On the other hand, practitioners who have been qualified for several years may not have received structured training in contemporary conceptual models and would therefore be challenged to use a conceptual model (Creek, 2003). There is however compelling reason why professionals might consider becoming more familiar with the use of conceptual models and this will be discussed next.

1.3.2 Conceptual models developing practice

Conceptual models have been argued to be of critical importance to professional practice and professional development (Boniface et al 2008: Kielhofner, 2004). Three practice-orientated reasons for this have been synthesised from the literature and these will be outlined in the sections which follow. They include the need to:

- Ensure robust reasoning and decision making in practice
- Form a structure for the development of research for practice
- Provide a framework for appraising professional competency

1.3.2.1 Ensure robust reasoning and decision making in practice

Conceptual models are useful as tools for thinking and become a key element for problem setting and solving (Parham, 1984: Munoz et al 1993). Where a clinician is challenged to make sense of an uncertain situation that initially makes no sense (Schön, 1991) a robust and relevant conceptual model can assist (Duncan, 2006: Boniface et al 2009). Conceptual models bring a fresh perspective, stimulating a practitioner's understanding of a person's need at a higher level of sophistication and creativity (Kielhofner, 2004). Kielhofner goes on to suggest that practice theories can offer a means of identifying and rationalizing what is being observed and a set of ideas within which to frame practice decision making. Furthermore, Kielhofner argues that if therapists are able to use theories of practice judiciously it follows that they will be better positioned to use the associated practice skills of assessment and intervention. On the other hand if a conceptual model is used

without careful reasoning practice can become automated, impersonal and ineffective (Creek, 2003). It seems logical then that occupational therapists can become further equipped to undertake robust reasoning and decision making in practice through intelligent, judicious use of conceptual models. However, it could be proposed that in order for a conceptual model to develop as relevant for practice it needs to be connected with practice *and* have academic rigor through research. This will be discussed in the next section.

1.3.2.2 Structuring research development for practice

It has been argued that a credible conceptual model *of* practice, used thoughtfully, should link research *to* practice (Forsyth and Kielhofner, 2006). This way professional practice actions can be fully understood by practitioners and be explained well to the recipients of the service (Duncan, 2006: Hinojosa et al 2005). Crist et al (2005) take the point further to describe partnerships between academics and practitioners to undertake research in the practice setting underpinned by a conceptual model. They describe one of the benefits of this collaboration as a reduction in the perceived academic / practice gap and an empirical focus on the real concerns of the field. Conceptual models which are actively used to structure collaborative research activity are useful in the development of the field (Taylor et al 2006). Credible conceptual models, therefore, provide practice based theories in addition to evidence-based structures and solutions for the development of practice. By engaging practitioners actively in research and development with and of conceptual models collective ownership and therefore utility of the concepts might be greater (Stern, 2005). Conceptual models could also offer ways of maintaining and appraising professional practice competency.

1.3.2.3 Providing a framework for professional competency

Maintaining and demonstrating professional competency could seem like a chore if imposed by an external directive (Warne, 2002). However, if connected to material which is relevant to practice, development opportunities could be intrinsically motivating (Pépin et al 2008). The Health Professions Council (2004) sets out expected practice based competencies for occupational therapists and

other health care workers in the UK. This registrant body has identified that occupational therapists must be able to use 'the established theories, models, frameworks and concepts of occupational therapy' (p:11). This is in order to demonstrate clinical proficiency at formulating and delivering plans to meet service user need (Harries and Duncan, 2009). It appears though that not all individuals are engaged in continued development of this aspect of their practice (Creek, 2003). Indeed many disciplines are challenged to embrace the importance of 'theory' to guide practice (Nixon and Creek, 2006). Despite the acknowledged importance of infusing practice with insights derived from conceptual models and pertinent theories (Cusick, 2001: Duncan, 2006), some practitioners have expressed disillusionment with the relevance of theory to their practice (Closs and Cheater, 1999: Kielhofner, 2005b) while academics have observed that existing knowledge in the field is not being systemically applied in practice (Fisher, 1998: Wood, 1998: Christiansen, 1999). It could be argued however that a model of occupational therapy practice which facilitates problem solving around a professional domain of concern holds an important structure for practitioners to appraise their competency about contemporary theory bases. The Model of Human Occupation (Kielhofner, 2008a), which forms the conceptual model used in the research setting described in this thesis, claims to offer practitioners this opportunity.

1.3.3 The Model of Human Occupation

In the practice context studied for this research a decision was taken to use The Model of Human Occupation (MOHO) (Kielhofner, 2008a) as a way of structuring practice. The MOHO is a well known conceptual model in occupational therapy practice (Duncan, 2006). It has been applied with reported success to many areas across the world to guide and develop practice. Examples of these include practice for: people with eating disorders (Abeydeera et al 2007: Barris, 1986); people with dementia (Borell, 1994); people living with HIV/AIDS (Anandan et al 2006: Braveman et al 2006); people with severe mental illness (Aubin et al 1999: Heasman and Atwal, 2004: Kavanagh and Fares, 1995); people with chronic obstructive pulmonary disease (Chan, 2004); people with diabetes (Curtin, 1991)

and people in pain (Keponen and Kielhofner, 2006). The MOHO has also been considered across age groups and has reported relevance in services for children (Basu, 2004: Harrison and Forsyth, 2005); adolescents (Baron, 1987); adults (Braveman, 1999) and older adults (Burton, 1989 a and b).

In the fourth edition of the Model of Human Occupation text book Kielhofner (2008a) suggests that through using the MOHO occupational therapists are assisted to get a rich understanding about how their clients perform their day-to-day activities within their own environment. In a recent study Lee et al (2008) reported that occupational therapists who used MOHO acknowledged its strengths for their practice. These included support for a client centred approach, provision of a strong base for planning and monitoring treatment and also the provision of a framework for professional identity in practice. Keponen and Launianinen (2008) describe the model as helpful in teaching experienced therapists to develop further sophistication in their clinical reasoning about clients' needs. Such has been the interest in this model that international effort has been made to further develop and disseminate the theory (Bowyer et al 2008).

On the other hand Munoz et al (1993) suggested that some therapists find MOHO challenging to use. The reasons were cited as difficulty in learning and understanding the concepts in addition to difficulty in applying MOHO language in practice. Early iterations of MOHO theory were also criticized as lacking detailed explanation of some of its principal themes (Haglund and Kjellberg, 1999). However, the theoretical underpinnings of MOHO have further developed through international research effort (Bower et al 2008) and continued refinement of the initial theoretical concepts (Kielhofner, 2002, 2008a). Accordingly the concepts and their practice application have built sound credibility in the profession which is important in order that clinical governance can be ensured (Duncan, 2006). Some commentators caution the field about viewing conceptual models, such as the MOHO, as 'the panacea of perfect practice' (Harries and Duncan, 2009, p:31). However, several NHS organisations have made

commitment to the collective use of MOHO concepts within the practice setting as a way of developing practice (Parkinson et al 2008: Duncan and Moody, 2003: Forsyth et al 2005b: Melton et al 2008).

This section has argued that well defined and researched conceptual models for contemporary occupational therapy practice have utility for practice and for the development of practice. Three primary reasons for using a conceptual model have been introduced. Furthermore an example of a well regarded conceptual model, the MOHO (Kielhofner, 2008a), was introduced as the specific occupational therapy conceptual model used in the research context to aid the development of practice. This has provided some overview of the PD structure in the research context but further detail of the service structure will be provided in the next section.

1.4 Profile of the research context

A profile of the research context will be presented in this section. The characteristics of the contextual features will be briefly explained with particular reference to the impact of contemporary policy drives. It will briefly explain how MOHO was selected to develop practice and will also describe how practitioners within the practice context were supported by an academic partnership. The section will start with the practice context.

The practice context studied for this research was an occupational therapy service in a mental health and learning disabilities, National Health Service (NHS) Trust in England (herein described as The PD Trust). In general, the workforce of occupational therapists in the geographical area was stable with favourable recruitment and retention rates. However, competing policy drivers were pressurizing practitioners to expand the scope of their practice and to their extended roles beyond the specific remit of occupational therapy (Department of Health, 2000b: Care Service Improvement Partnerships / National Institute of Mental Health England, 2008). Undertaking extended roles can be a challenge particularly if changes mean that service users' access to the specific and specialist

discipline of occupational therapy is reduced (College of Occupational Therapists, 2007b). This can also have a detrimental affect on the availability of skilled workers as practice in specific techniques is required to maintain competence and confidence (Hurford et al 2007). Furthermore a forced role change can lead to staff retention issues (Hayes et al 2008). Attention to the PD opportunities for occupational therapists was therefore championed by occupational therapy leaders within the PD Trust. The researcher was also an occupational therapy leader in the PD Trust. Her status as insider researcher is discussed in Section 4.4.1.

The rationale to adopt a particular model as the overarching conceptual model to develop practice was considered by consensus of leaders and practitioners (see Section 1.5.3). The Model of Human Occupation was chosen (two years before the research commenced) as the foundation for expected practice from registered occupational therapists. However, given that research showed that therapists are challenged to learn independently to apply MOHO concepts (Munoz et al 1993: Lee et al 2008) a formal PD structure (see Section 1.5) was established to develop the use of MOHO in practice. This was undertaken in partnership with an academic unit.

Partnership was sought by leaders in the practice context with an academic unit (herein described as the Academic Unit) which was characterised by its expertise in the MOHO. The Academic Unit also had a reputation of real partnership working within practice settings. Partnership approaches to build and disseminate scholarly knowledge have been proposed as one way to develop services which have a client focus and a theoretical underpinning (Hammel et al 2001: Forsyth et al 2005a). Academics can benefit from the valuable experience of practitioners (Hammel, et al. 2001: Kielhofner, 2004: Bannigan, 2009) and service users benefit from enhanced services (Crist et al 2005: Pépin et al 2008: Melton et al 2008). As such both practitioners and academics need to give intellectual priority to elucidating the challenges of service users and developing workable solutions (Taylor et al 2005). Through collaboration between the PD Trust and the

Academic Unit a set of PD structures and interventions were agreed and a PD programme constructed. This was specifically designed to enable therapists to underpin practice with MOHO theory and to utilize MOHO assessments in their practice (Forsyth et al 2005a).

A proposal has been made in this section that there is benefit in collaboration between practice settings and academic units particularly where a focus on specific areas of practice need to be enhanced. Through this argument the contextual features of the research environment have been located with particular emphasis on the concerns of the practice setting, the conceptual model selected and the support sought through partnership working with an academic unit. The PD programme appraised in this study will be described in the next section.

1.5 The Practice Development programme

A general overview of the PD structure adopted by the PD Trust will be provided in this section. In order to further describe the PD context, the PD programme and its associated interventions will be introduced. The general rationale for and ethos of the programme will be described in the first two sections and will emphasise the development of a collaborative culture as an important feature of PD. Debate about the main PD interventions which formed the structure of the PD programme will follow. These will include: facilitated use of MOHO theory; training in conducting MOHO assessments; 'Practise in practice'; reflective supervision and building practice standards. To begin, the rationale for and general structure of the PD programme is provided.

1.5.1 Rationale

In order to promote and facilitate evidence based practice (EBP) health care organizations need to foster a context and adopt a culture that is receptive to change (Gerrish and Clayton, 2004). Collaboration between practitioners and researchers is part of this culture and is required at all stages of practice development (Kielhofner et al 2006: Crist et al 2005). This should incorporate formulating topics to be researched and including practitioners as collaborators in

the research (Taylor and Mitchell, 1990: Stube, 2005). This might be further enhanced by including other key stakeholders in this dialogue including service users and service managers (Forsyth et al 2005a: Gerrish and Clayton, 2004). Despite this rhetoric a well documented, generalized gap remains between theory and research and its practice application which is reported by academics and practitioners (Whistock, 2003). The characteristics of particular cultural contexts are as yet unknown despite research aiming to address this variable (McCormack et al 2002). Cultural contexts and the associated range of communication is certainly a part of the key dynamic to support the implementation of EBP through PD (Sandall, 1998: McCormack et al 2002). In any research it is important to understand the construction and nature of the PD concerned and this will be introduced next.

1.5.2 Structure

A PD programme should deliver outcomes which are well considered and planned in advance (see Chapter Two, Section 2.3). A PD programme should also enable practitioners to be knowledgeable about theory *and* be practically skilled (Forsyth et al 2005a) and feel empowered through the development of a shared vision for future practice (Atter, 2008). However, knowing about new knowledge does not necessarily translate to knowing how to put it into practice (Schön, 1991: Higgs et al 2001). In functional terms practice can be developed as a connected process of research being undertaken and theory being built in a cyclical manner (Peterson et al 2005). However structure and leadership is required to establish effective PD programmes (Stokes, 2004: Garbett and McCormack, 2002b: Dewing, 2008: Atsalos and Greenwood, 2001: Isted and Millsteed, 2004: Dopson and Fitgerald, 2005a) (see Chapter Three, Section 3.4). In the PD Trust a partnership steering group was established which provided a guidance and monitoring role to the development. This enabled the potential resistances and supports for change to be built into PD interventions and structures (see Chapter Three, Section 3.3). In addition to members of the Academic Unit, the steering group included key practitioners whose role was to cascade information through formal structures and to offer support, teaching and mentorship to other therapists. This approach

supported the notion that collaboration and division of labour is a productive way to facilitate change and empower a workforce (LeMay et al 1998: Eakin, 1997).

Occupational therapists in the PD Trust worked within an overall organisational framework and strategic direction. Services for people experiencing mental illness and services for people with learning disabilities were in a variety of geographical locations, urban and rural, spanning in-patient and community sites and concerning adults of different ages and with different sets of needs. Accordingly several, multifaceted PD interventions were developed from the leadership group for implementation in the wider local context. Further critique of these and other PD mechanisms are found in Sections 3.5.3 and 3.5.4 but in the next section the PD interventions used in the PD Trust will be introduced.

1.5.3 Interventions

Practice development programmes which offer multifaceted PD interventions have been established to be most effective for developing practice (Fitgerald and Dobson, 2005) (see Chapter Three, Section 3.5.4). Research also supports the importance of being responsive to local contexts (Rogers, 2003). As such, the PD interventions in this research were developed locally through joint working between managers, senior therapists, project leads and the Academic Unit. They were offered as a general set for all occupational therapists in the PD Trust to access. It was anticipated that participation in these interventions would enable therapists to underpin practice with MOHO theory and to utilize MOHO assessments in their practice. These PD interventions or mechanisms are debated further in a later chapter (see Section 3.5). In order to highlight their role as part of the local context though the PD interventions used and appraised in this research are introduced in the next sections and include:

- Facilitated use of MOHO theory
- Training in conducting MOHO assessments
- 'Practise in practice'
- Reflective supervision
- Use of practice standards

1.5.2.1 Facilitated use of MOHO theory

Therapists are obligated to seek out innovation in conceptual models of practice in, for example, practice orientated textbooks or web based information (College of Occupational Therapists, 2005). The underpinning resources for the implementation of MOHO are designed for therapists to become self taught (Kielhofner, 2008a). However, not all occupational therapists are able to independently invest time to do this despite the fact that they are conscientious about their responsibilities (Taylor, 2007: Metcalf et al 2001). This suggests that occupational therapists might find emerging knowledge more accessible if it is repackaged in a variety of ways. For example, 80% of the sample of occupational therapists surveyed in one study appealed for brief summaries of relevant practice information to be provided for them rather than them having to search the literature themselves (Bennett, et al 2003). The PD Trust offered regular discussion forums about MOHO theory which allowed critical debate, sharing of practice narratives and the development of local resource material to foster learning about MOHO theory (Melton et al 2009). Other learning opportunities were provided in the form of training courses and these will be discussed next.

1.5.2.2 Training in conducting MOHO assessments

It has been established that learning as a local group can be effective in transferring new knowledge into practice (Pépin et al 2008). In the PD Trust train-the-trainer courses had been developed and delivered locally with the aim of enabling therapists to skilfully administer MOHO assessment in practice (Forsyth et al 2005c). Furthermore, the skills of practitioners within the Trust were drawn upon to provide a variety of workshops to include both didactic and experiential teaching. The structure described by Forsyth and colleagues (2005c) explains how therapists had a short time out of clinical work to learn MOHO assessments in small groups. Time was then set to implement assessments in practice before reporting back on their new practice learning. Whilst this PD activity had a didactic training course element it also incorporated practice and feedback as part

of the learning process. The importance of practice as a learning activity will be discussed next.

1.5.2.3 'Practise in practice'

Occupational therapists and other health care practitioners with clinical responsibilities locate their priorities within direct client care (LeMay et al 1998: Metcalf et al 2001). Undertaking theoretically orientated PD interventions can be perceived as an 'added extra' to core practice rather than as an essential component to best practice (Melton et al 2003). However, in the PD Trust setting the culture supported therapists to put new knowledge appropriately into action and is described as 'Practice in Practise'. This can lead to practitioners being able to demonstrate appropriate use of theory, enhanced practice skills of staff and use resources to best effect (Pépin et al 2008). The practice field then might be conceptualised as learning environment when practice itself yields tacit knowledge (Eraut, 2000). To further enhance learning reflective supervision needs to be available and this will be discussed next.

1.5.2.4 Reflective supervision

Adopting a structured technique of reflecting on clinical scenarios as part of a discussion with experienced colleagues is a recommended format for PD activity (Paterson and Summerfield-Mann, 2006). In the PD Trust a structure for such support was established. Skilfully delivered reflective clinical supervision can help to enhance occupational therapy practice (Sweeney et al 2001c: Strong, 2009). Indeed, practice based on the idea of 'reflection in action' or reflective practice has been argued to be an underpinning mechanism of professional problem solving (Schön, 1991: Roberts, 2002: McKay, 2009) and developing the craft of professional knowledge (Smith, 2001). The ability and opportunity to critically reflect upon practice is thought to enable an individual to make decisions about appropriate future action (Mezirow, 1990). Accordingly occupational therapists like other health care professionals are expected to participate in professional supervision in order to ensure the quality of practice (Department of Health 1998:

College of Occupational Therapists 2005). The setting of practice standards as a collaborative PD activity will be discussed next.

1.5.2.5 Use of practice standards

The development, use and audit of practice guidelines are regarded as strategies to improve standards and enhance professional development (Cusick and McCluskey, 2000). However, some authors raise concern about adhering rigidly to practice standards that offer a formula for interventions (Creek, 2003). For the PD in this research context practice standards were set by a collaborative process between lead practitioners and academics. These were then introduced to the workforce for critique, revision, implementation and audit. The practice standards formed the agreed baseline of assessment and intervention procedures for occupational therapy provision in the PD Trust. The MOHO was used as the conceptual guide to generate intervention goals with service users (Melton et al 2008).

This section has provided a general overview of the PD structure adopted by the PD Trust. It represents the PD intervention that will be appraised as part of the context of this research. The general ethos of the programme was introduced first and emphasised the collaborative nature of the PD culture. The section then went on to introduce the main PD interventions which were built into the PD programme. These included: facilitated use of MOHO theory; training in conducting MOHO assessments; 'Practise in practice'; reflective supervision; building practice standards. As an overview has now been provided of the research context the next section will offer an introduction to rest of the thesis. It will be structured incrementally through successive chapters to offer the reader an insight into the narrative which follow.

1.6 Thesis structure

This document is a report of a Realistic Evaluation (Pawson and Tilley, 1997) research process and it is structured to guide the reader about the stages undertaken to complete the investigation. The interplay of context, mechanisms and outcomes is important in Realistic Evaluation structures so the thesis has been

constructed to reflect these themes. The thesis is broadly about the development of practice so whilst Chapter One has set a contextual picture about PD in the specific research environment, Chapter Two explores and reviews the outcomes that are expected of programmes which are connected with the PD literature. The outcomes presented are a synthesis of the literature and fall into areas connected with improvements for clients, services and professions. Specifically Chapter Two will review PD outcomes of evidence based practice; client centred practice; development of quality and equity across services; improvement in the clinical reasoning ability of practitioners; the emancipation of professions and continued professional development. Chapter Two will also touch upon why outcomes of PD are a challenge to evaluate. The literature suggests multiple reasons for this including challenges of evaluation methodology, the impact of context, issues of objectivity, time and the variety of PD mechanisms that exist.

The literature review continues in Chapter Three and concentrates upon understanding and identifying mechanisms that support positive practice development. As such theories of change are explored and distilled into four broad areas. These include social, organisational, individual and dynamic theories of change. Chapter Three goes on to discover what causes resistance to change and this section looks at internal and external motivation for change, the impact of change in routine, the challenge of forced change and the reality that individual practitioners have different capacities and attributes to equip them to undertake change. Effective leadership is drawn out in Chapter Three as a pivotal feature of learning and developing cultures and the various roles that a leader needs to adopt are explained. Finally, Chapter Three introduces PD interventions that have been explained and evaluated in the literature. In particular it appraises both single and multifaceted PD programmes and concludes that multifaceted interventions are more likely to offer effective learning opportunities for individual practitioners. At the end of Chapter Three the research question relating to this thesis is presented.

The theoretical underpinnings of this research are outlined in Chapter Four. The philosophical standpoint of this thesis is derived from critical realism as a way of theorizing about interpretive understanding. This chapter explains how the methodological choice of Realistic Evaluation (RE) described by Pawson and Tilley (1997) was selected as the appropriate genre for this study. This methodology considers what works, for whom, in what circumstance by seeking to understand how contexts (C) connect with activating or inhibiting mechanisms (M) to produce an outcome (O). As such the C+M=O equation emerges. The chapter goes on to appraise key research studies that have been undertaken using these relatively contemporary ideas. Furthermore, the chapter explains and critiques the multi-strategy approach favoured in RE studies, discusses the contextual issues related to RE and considers the strengths and limitations of the genre. This study is an insider researcher study which has its own set methodological implications. For this reason the concept of reflexivity is introduced in this chapter. Forms of triangulation are considered next followed by issues of generalisability. Chapter Four concludes with the three hypotheses which emerged in connection with this work.

Chapter Five explains how the methodology of RE led to the choice of methods. Information is provided about the development of the research methods and associated tools which included a single question survey, a semi-structured interview schedule, an observation of practice schedule and an audit of documentation tool. Sampling and recruitment strategies are discussed. The strategy for the enquiry is described as is its completion in four stages. These stages are a period of preliminary work at the beginning of the study, a sample building process, a pilot study and the main study. Ethical and data protection issues are described. The survey results are also provided in this section as these data were used to inform the sampling process for the qualitative methods. This leads to an explanation about the approach to data analysis of the qualitative data which was considered using a causal approach to three levels of abstraction. These include:

- understanding the contexts, mechanisms and outcomes that emerged across the data sets
- understanding how these connect in the real world for each individual's CMO 'case' and then
- a deeper level analysis to generalise CMO patterns across cases.

An overall profile of the qualitative data collected together with some broad demographic data is presented toward the end of the chapter.

In Chapters Six, Seven and Eight the main body of research results are presented and include relevant discussion and examples of reflexive comment. These relate to the levels of data analysis and abstraction noted above. Chapter Six presents the contexts, mechanisms and outcomes which emerged across the data set. The context is presented in four distinct but interrelated areas of the 'English Health Service Context', the 'Organisational Trust Context', the 'Immediate Local Team Context' and the 'Individual Personal Capacities and Attitudes Context'. Six common causal mechanisms were identified through the data analysis and these are also presented in Chapter Six. Initially a description of each one is provided and these include 'Building Confidence', 'Finding Flow', 'Accumulating Reward', 'Conferring with Others', 'Constructing Knowledge Know-how' and 'Channelling Time'. Next the interrelationship between the mechanisms is discussed and the levels to which they could be activated. The chapter goes on to discuss the critical point that the activated mechanisms identified interact dynamically to support an individual's progress with implementing PD. Similarly where little or no activation of mechanisms was found progress with PD was inhibited. The final part of Chapter Six presents the general outcome patterns that emerge from the data. Attention is given to the four levels of outcomes which are described metaphorically in terms of aircraft flight. They include:

- Pre-exploration or Dismissal or 'In the Hanger'
- Exploration or 'On the Runway'
- Action or 'Take Off'
- Achievement or 'In the Air'

Each of these is described in turn with behavioural indicators and examples of data provided to illustrate key points. Attention is also given to how the outcome levels interrelate and differ from aspects of the literature. A synthesis of how mechanism activation is related to outcome and illustrative examples are provided of the large variation of outcome stages found in the sample group together with the general picture of mechanism activation found.

In the seventh chapter CMO vignettes of individuals are provided across each of the outcome levels. They illustrate specific contextual features which are of importance to each of those featured. They also compare briefly with other individuals in the same outcome set to illustrate the contextual differences. At the end of this chapter a summary of the main findings from the analysis of individuals' CMO configurations is presented. This sets the scene for the next chapter which reports the third level of data abstraction to propose a theory of individual PD.

Chapter Eight illustrates a synthesis of the findings and presents the Individual Practice Development Theory. It illustrates the connection between the broad outcome level, the types of personal context found which relate to the outcome levels, the priority mechanisms for activation and the PD interventions which could facilitate that activation.

Drawing the thesis together, Chapter Nine offers a reprise of the whole thesis and a discussion of the completed research in relation to the wider issues. This chapter reviews the findings of the study and their implications for practice and policy in relation to the study hypotheses. In addition the chapter considers the new information that is discovered about individual PD through this work. The notion of a PD skills escalator is proposed as a way forward for engaging and monitoring individuals engagement in PD. Study limitations are recognized and recommendations for further research are proposed. In this chapter it is argued that

the research has provided original and insightful knowledge about PD and in particular how individuals' engage varies following the same basic prompt.

1.7 Chapter summary

To set the scene for the thesis and to assist with locating the context of the research study an account has been provided of the particular circumstances of the research. The key areas discussed have included occupational therapy and its unique position on human change development. In addition, the use of conceptual theories to support practice has been introduced as has the specific conceptual model adopted as part of the PD for this study. The practice and academic organisations involved have both been profiled and the PD programme and interventions explained and debated. Notably the study was concerned with occupational therapists who worked within an NHS organisation which specialised in providing intervention for people experiencing mental ill-health and those with learning disabilities. This research aimed to understand how engagement in PD played out for *individual* practitioners from the same baseline PD prompt. As such the next chapter will appraise the relevant literature related to what PD is expected to achieve. In other words, Chapter Two will attend to what is meant by PD outcomes, the expectation of PD and the reality of implementation.

Chapter Two - Outcomes of Practice Development

2.1 Chapter overview

The practice development (PD) programme which frames this study was introduced in Chapter One together with a synopsis of the nature of occupational therapy and occupational therapists. This was done to provide an overview of the research *context.* Chapter Three will explore the literature relating to the theories and realities of change in practice. It will further the idea that change is challenging for individuals and note that many systems and structures have been built to act as *mechanisms* for changing and developing practice in health care. This chapter however concentrates on identifying the range of *outcomes* that might be expected when organisations invest in PD programmes. [1] It will be argued that evolutionary practice requires change and that PD programmes can for some people in some circumstances be a way of achieving positive change. As such it will explore what the literature says about why health care managers should be concerned with change and developing practice. It will be suggested that individual practitioners are important in gaining the required team or organisational outcomes of PD. This chapter will be structured into two main areas and include the focus of expected outcomes of PD and secondly it will provide some appraisal about what challenges might be experienced in gleaning robust PD outcome data. Given that this chapter and Chapter Three form the underpinning literature review of the thesis the first section will describe the literature search strategy undertaken.

2.2 Literature review

The literature search strategy was formed into temporal parts as the thesis developed. At the start of the study a search using data bases of CINHAL and Medline was undertaken for literature concerning 'evidence based practice' (EBP) and 'practice development'. The ZETOX feature was used to provide regular

[1] For the purpose of this thesis the term PD will be used to describe programmes of intervention which aim to develop practice. Chapter three gives further account of PD programmes and interventions.

updates of contemporary literature on EBP, 'change' in health and social care; 'realistic evaluation' and 'practice development' in these fields. Some citation searches were undertaken to update literature on the subject areas as the study progressed. Finally a full and structured literature search using the same computerized bibliographical databases for the keywords 'evidence based practice'; 'practice development', 'change' and 'realistic evaluation' was undertaken. This was for the time period 2000-2008. One of the areas of literature explored in depth was the expected outcome of PD programmes.

2.3 The expected outcomes of PD

Organisations are expected to support and monitor practitioners' use of research based evidence to guide and explain treatment decisions. This is important to ensure safe and effective decisions in health care practice (Department of Health, 1998). Proponents of the 'practice development' campaign reflect this vision and call for outcomes of PD to reflect improved quality of care, evidence based practice, enhanced effectiveness and skilfully reasoned practice (Manley and McCormack, 2004). The goal of client-centred practice also features in contemporary ideas about the purpose of PD (Dewing, 2008). Other similar initiatives, for example quality improvement (QI), have comparable outcome goals but have emerged primarily from medical practice (Oldham et al 2007). Not all involved in delivering health care evaluation are convinced of the value of the activity surrounding the investment made. Thompson et al (2008) for example suggest that PD is being conceptualised as a simple replacement for rigorous academic investigation. Similarly, Carr et al (2008) hold concerns about the mismatched expectations of researchers and practitioners who collaborate in PD projects. However, where public policy is requiring practice change but research output is unable to keep pace new ways to implement and evaluate perceived best practice need to be fostered (Ganju, 2006).

PD programmes have generally been conceptualised as structured, facilitated set of learning orientated interventions for a team of people in practice settings to engage

in (McSherry and Warr, 2008). It could be argued then to be a more relevant, realistic and accessible form of development for most practitioners than more academic and distant forms of learning opportunity (Garbett and McCormack, 2002a). Equally, there is an argument that the two styles need not be conceptualised as mutually exclusive and forms of scientific enquiry like Action Research (Pryor and Forbes 2007) and Realistic Evaluation (Lhussier et al 2008) are advocated as particularly relevant methodologies for engaging practitioners in PD programmes because they foster commitment to evaluation. The outcome of any PD programme is dependent on the resulting behaviours of each individual involved in the team (McSherry and Warr, 2008: Garbett and McCormack, 2002). Indeed, in order to continue to practice, members of some professions are required to provide individual performance measurement data (Oldham et al 2007). As such, it could be argued then that programmes of practice development need to consider both the general team outcomes and those for the individuals involved.

Practice development has frequently been linked with the concept of continued professional development and in many instances the terms are used interchangeably (McCormack et al 2004). McSherry and Kell, (2007) suggested that the concept of 'service improvement' can also be aligned to some extent with PD fostering a cultural, transformational shift in how practice is structured. They conclude however that PD is more about team development whilst service improvement ultimately has a corporate focus. It has been argued however that outcomes which benefit teams in turn should benefit the organisation in which they are carried out so the two context areas should not be conceptually divorced (Dopson and Fitzgerald, 2005b).

It appears then that PD programmes might have laudable outcome ambitions which ultimately aim to improve health care delivery. The list below of main outcome themes have been synthesised from the literature. Given the prevailing position of EBP as central plank of modern health care policy this subject will be

explored in greatest depth and will be synthesised into the other PD outcome themes which follow.

- Evidence Based Practice
- Client-centred Practice
- Improved Quality and Equity of Service
- Enhanced Clinical Reasoning, skilful practice and accurate decision making.
- Emancipation of Professions
- Continued Professional Development

2.3.1 Evidence based practice

Achieving the transfer of research findings into practice or evidence based practice **(**EBP) has dominated health care discussion in international literature since the 1990's (Culshaw, 1995: Sackett et al 1996: Turner and Whitfield, 1997: Eakin, 1997: Dubouloz et al 1999: Chard, 2005). Criticism of EBP is common (Straus and McAlister, 2000) but some argue that tackling the challenges will also achieve political and practice outcomes (Tanenbaum, 2003). It is also well documented that practitioners from various professional groups including therapists (McCluskey, 2003: Bennett et al 2003: Cameron et al 2005); medical practitioners (Bhandari et al 2004: Lam et al 2004: McKenna et al 2004) and nurses (McCleary and Brown 2003: Estabrooks et al 2003: Gosling et al 2004) continue to feel challenged to implement EBP. As such it could be argued that PD structures and systems offer a way of changing practice to achieve EBP. This involves practitioners being able to undertake research-verified intervention, at the optimum point in time to meet individuals' needs (Hammond and Klompenhourwer, 2005). In Sackett et al's (1996) seminal definition of evidence based *medicine* there is a more overt emphasis on a practitioner's role to determine the course of clinical action within the most contemporary empirical evidence:

> *'Evidence based medicine is the conscientious, explicit and judicious use of the current best available evidence to guide decision making about the care of individual patients'*
>
> (Sackett et al 1996 p:71).

Whilst Sackett et al's definition concentrates on the discipline of medicine the concepts could be argued to translate to the practice of other health care professions (Taylor 1997). Accordingly, the outcome of PD would need to include a sound ability to also foster the empowerment of practitioners to consider variance from a set pathway of care in order to take into account individual concerns (Olsson, 2007).

When first described in the terms of evidenced based *medicine*, the emphasis of the concept was based in the use of research findings as *the* underpinning of all clinical decisions (Donald, 1995). Despite the support for an EBP approach to health care there has also been confusion and debate about the types of research that are defined and recognised as evidence (Williams and Garner, 2002). It has been implied that randomised controlled trials (RCT) are the only or ultimate valued method of undertaking empirical enquiry that can be used as true 'evidence' (Straus and McAlister, 2000). Other commentators propose alternatives to the RCT method and advocate that investigations should be developed to answer particular research questions rather than be limited in scope to one type of research method which may not adequately address the area of inquiry (Forbes and Griffiths, 2002: Thompson, 2003: Sehon and Stanley, 2003). If systematic reviews and meta analysis continue to be regarded as the highest level of evidence but are not available or attainable for some interventions, generating evidence for much health care practice will continue to be a challenge (Pawson and Tilly, 1997: Pawson, 2006).

The habitual *use* of best researched evidence for practice decisions poses a great challenge for practitioners in many practice fields and in different countries of the

western world (Friedman and Farag, 1999: Gerrish and Clayton, 2004: Metcalf et al 2001: Dysart and Tomlin, 2002: Bennett et al 2003: Nutley and Davies, 2000: Nutley et al 2007). This position is cause for concern from ethical, professional (College of Occupational Therapists, 2005) and legal (Department of Health, 1998) perspectives. Engaging in EBP was a fairly radical move within Occupational Therapy because the profession had not developed along a tradition and culture of undertaking or utilizing research in the practice setting (Welch, 2006: Culshaw, 1995: Humphries et al 2000). Strong support for a shift towards EBP emerged (Eakin, 1997). However, there is a body of work that begins to look at the reality of whether and how EBP is to be achieved (NHS Centre for Reviews and Dissemination, 1999: Le May et al 1998: Fitgerald and Dopson, 2005).

The level of self perceived knowledge about using EBP across various therapy disciplines has been demonstrated in the past to be generally low (Upton, 1999). In a survey of Australian occupational therapists participants were asked for their opinion of what had informed their clinical decision making (Bennett et al 2003). The most influential activities were clinical experience (96.3%), information from continuing education (81%) and discussion with colleagues (79%). It appears then that strategies which have a direct practice application that involve learning in teams and minimal independent investment of time by the therapist are more likely to have a positive impact upon their practice. Another interesting result was that only approximately half of the sample (56.3%) reported accessing current research literature as part of their PD. In another study, UK occupational therapists' perceptions of EBP were surveyed (Curtin and Jarmazovic, 2001). Their study results described the many EBP activities that therapists report participating in but there seemed to be a mismatch between CPD activity and evidence based activity. Clinical activity; maintaining CPD diaries and reading journals were mentioned but synthesizing research results into practice was not listed. These discrepancies could be a result of the survey method used for the research which does not allow for further explanation of stated responses. What is highlighted consistently

though is the participants' aspiration for packages of evidence to be ready for implementation.

These research studies above could suggest that practitioners are seeking PD activity to support research results being packaged ready for their practice application (Bennett et al 2003: McCluskey, 2003: Gerrish and Clayton, 2004). Alternatively it could indicate that practitioners do not feel generally motivated, confident or competent to undertake EBP in addition to their other responsibilities (Dubouloz et al 1999). However, when only some therapists are reportedly discharging their responsibility to use research evidence within their practice there is cause for concern (Welch, 2002). This suggests that implementing a structured programme of PD within health care teams also offers support to implement EBP and achieve evidence based outcomes (Brown and Roger, 1999: Cooke et al 2004: Hammond and Klompenhouwer, 2005: Veeramah, 2004). There is a possibility then that practice-based-evidence could be the result of such PD which could further contribute to the outcome of achieving client-centred practice (Forsyth et al 2005b).

For the purpose of this thesis EBP is regarded as the practitioner's ability to integrate research findings into the most appropriate intervention for an individual client for their stage of recovery. This definition has an inherent client centred perspective and this potential outcome of PD will be discussed next.

2.3.2 Client-centred Practice

Enhancing health care gain for clients is a key part of **c**ontemporary public policy; it requires that patients' choice be at the heart of all health care interventions (Department of Health, 2005). Developments in practice including those which aim to foster EBP must be viewed alongside the goal of integrating the values and choices of the client into practice (Bannigan and Birleson, 2007: Dewing et al 2006). To many practitioners this position is welcome as it enhances a patient's opportunity to gain benefit from intervention (Tickle-Degnen, 1998: Lloyd Smith,

1997: Clarke, 2004). On the other hand choice of intervention may prove challenging for patients if informed decisions are compromised by lack of information or if their choice of treatment has not been commissioned due to a lack of evidence (Olsson, 2007).

To ensure health gain and prevent harm to their patients practitioners are required to consider carefully the impact of their intervention (College of Occupational Therapists, 2005). Practitioners then have a challenge to consider patients' choice in addition to the various types of evidence available to them when making intervention decisions (Sackett et al 2000: Sumsion, 1997). Practitioners must also develop fresh perspectives informed by empathy with the service user experience (Garbett, 2004: Taylor, 2008.) If practitioners are able to use knowledge and skills judiciously, the goal of dovetailing best available evidence with an individual's needs and choices needs to be achieved (McCormack and Titchen, 2001).

Health care practitioners with clinical responsibilities locate their priorities within direct client care (LeMay et al 1998). These responsibilities are often articulated within humanistic rather than clinical language emphasizing the narrative, qualitative approach often selected by practitioners within their work (Scott, 2001). Utilizing EBP can be conceptualized as detached from patients' needs (Petros, 2003) and useful as a bonus to core practice (Melton et al 2003). Research has demonstrated that in some services there is literature available but little reading and synthesis is occurring as the therapists choose or are expected to use their time for 'hands on' clinical contact with service users (Humphries et al 2000). Within this scenario however, the quality of provision of care to clients could be compromised as practitioners could miss key developments affecting what interventions are offered to service users. On the other hand, even when multi-site structured PD has been facilitated successful improvement in outcomes for service users has not been consistent across sites (Redfern and Christian, 2003).

Service users' views on care delivery are driving the contemporary policy in all areas of health care practice (Department of Health, 2005). The development of practice needs to embrace this influence and empower collaboration in PD so that client centred outcomes are achieved (Dewing and Pritchard, 2004). Indeed initial definitions of PD have been updated to include the relevant contribution that service users can make to the process and outcome of practice development in health care (Pryor and Forbes, 2007). By working collaboratively a real perspective on service quality improvement through PD can be understood.

2.3.3 Improved Quality and Equity of Service

Quality and equity of services are a key component of the modern health care service (Department of Health, 2008). Indeed, services have been reminded for some time of their responsibilities to have clear lines of responsibility and comprehensive PD programmes. This ensures that requirements of clinical governance are met (Swage, 2003: Bezzant, 2008). It is clear that in the western world public health care is having a positive impact on mortality as the population is living longer (World Health Organisation, 2000). Ultimately the list of interventions which can be provided within the funds available has reached a ceiling so policy dictates that clinicians need to provide evidence-based interventions within a set tariff (Department of Health, 2006). This is part of a policy drive to ensure that patients receive equal access to care regardless of where they live in the UK (Department of Health, 2005). Making best use of resources then to raise standards of care within the same financial resource makes sense and these outcomes form part of what PD and quality programmes claims to offer as outcomes (McCluskey and Cusick, 2002: Glickman, 2007: Dewing, 2008: Bezzant, 2008:)

In critiquing why consistency of care has not been achieved across the NHS to date, realists would argue that the inequity is due to competing sources of evidence for which intervention is 'best' (Pawson and Tilley, 1997). Critique continues about the underpinning methodologies used and the quality of research undertaken

to guide the development of contemporary health care systems and practice (Davies and Nutley, 2000). The challenge then is for clinical research evidence to emerge that is relevant for practice and for dissemination to be timely, engaging and accessible to practitioners (Camiah, 1997). PD structures using clinical evidence in addition to research evidence could be supportive of raising standards (Formoso et al 2003: Thompson, 2003: Edwards et al 2004).

One feature of importance in some PD initiatives is the development of evidence-based quality standards, or care pathways as ways of illustrating the baseline care activities expected (Duncan and Moody, 2003: Melton et al 2008: Hall, 2004). A regime which promotes a linear approach to a pathway of care for a particular health issue is seen by some as limiting the clinical freedom of practitioners and the choices of service users (Petros, 2003). The cost of compensating patients for the results of poor or inadequate practice is increasing rapidly and is of concern to health service commissioners (Department of Health, 2000a). However, where health care services have to be limited to available finances it is perhaps important that balanced decisions are made (Department of Health, 2006). Thus what is provided will have greatest benefit as well as acting as a support to practitioners who make often difficult clinical decisions.

Some studies have indicated that practitioners would value the development of accessible evidence based, practice guidelines and treatment manuals as a PD to enhance the quality of their services (Corrigan et al. 2001: Cusick and McCluskey, 2000). Whilst acknowledging the value of accessible tools of this nature, the financial cost of such resources in their purchase and time out of direct patient care to learn about their use must also be taken into account. It must also be noted that accessibility of clinical knowledge and materials does not necessarily mean that they will be used in practice (Chard, 2000). Neither is there evidence that enhanced quality through PD in one area of practice necessarily improves quality in other areas (Ganz et al 2007). Even with enhanced practice information and

tools it could be argued that sufficient reasoning ability is required to skilfully decide what works when faced with unique clinical challenges.

2.3.4 Enhanced Clinical Reasoning.

Caution has been expressed by some commentators that the rigid use of research evidence with no flexibility allowed in practice decision making could lead to prescriptive, impersonal and irresponsible treatment for individual patients (Greenhalgh, 1996). Some argue that good decision making is concerned with the individualized treatment of an individual patient thereby relegating EBP to only a small fraction of health care practice areas (Petros, 2003). Ilott (2004) suggests that EBP should be used to inform decisions rather than being a practice rule. An approach which considers the individual's narrative, the environmental context, the complexity of need and the expertise and tacit knowledge of the clinician could make best use of resources (Greenhalgh, 1999: Sackett et al 2000: Gerrish and Clayton, 2004: Bennett at al 2003). Indeed, a conceptual model to guide practitioners in reclaiming the artistry of their practice has developed though research although few clues were provided about how this should filter to practice application (Paterson et al 2005). Thus practitioners' judgments alongside and integrated with the use of the best available research evidence could be used to guide decision making in health care (Sackett et al 1996: Fineout-Overholy et al 2004). Conceptually, PD is suggested as a means to build the personal capacities of practitioners to deal with greater complexity of decision making in a structured way (Forbes and Griffiths, 2002).

Commentators argue that with a structured PD programme a practitioner can gain greater empowerment and skill to tailor treatment for different people in different circumstances (McSherry and Warr, 2008). However, it is possible that when new knowledge is learnt and synthesised into everyday habituated action the resultant tacit thought processes might not be attributed to the PD (Mattingly, 1991). It is also possible that the development of practitioners' reasoning and decision making ability will depend on the type of PD in place (Manley and McCormack, 2004). In addition, the outcomes of PD may be affected by the seniority of those involved as

those with greater expertise naturally experience more confidence and clarity in their reasoning ability (Mitchell and Unsworth, 2005). Being able to skilfully reason and make confident, well articulated, accurate decisions for practice could be why some professions have achieved a greater emancipation in society.

2.3.5 Emancipation of Professions

The idea that PD has, in part, evolved out of the emancipatory actions of nursing leaders will be introduced later in Chapter Three (Section 3.5.1). Achieving an outcome where society is able to consider a different perspective on health care that is not dominated by the medical model has held attraction (Pryor and Forbes, 2007). They go on to give examples from the 1960's where pioneers of the nursing discipline changed systems of patient management to deliver better recovery orientated outcomes for patients. They also describe the development of uni-professional units where specific environmental contexts (or nurse development units) were set up in the 1980's to improve patient outcomes, increase efficiency and improve job satisfaction for nurses. Some academics however, have critiqued the claim that PD has an emancipatory element particularly as an academic pursuit (Thompson et al 2008). Others speak of the value of working and learning in an inter-professional manner (Freeth et al 2005: Reeves et al 2002). This way all contributions to health care are valued and developed to suit patient need. Nevertheless, contemporary examples can still be found in the literature where individual professions gain a feeling of benefit from proving their worth (Boniface et al 2008) or developing their identity (Fielding et al 2007) through PD initiatives. This may be connected with confidence in their profession specific skills within a medically dominated culture.

Gerrish and Clayton (2004) assert that the confidence to make changes to practice ultimately remains a particular challenge for members of the caring professions. Though this study was undertaken with participants from a nursing background there is likelihood that this theme will form part of a trend in other disciplines. To illustrate this point for occupational therapy, a small but significant number have been noted to express that research is too complex to use in practice (Humphries et

al 2000) or that they lack personal interest in research for practice (Curtin and Jaramazovic 2001: Taylor and Mitchell, 1990) which may also be an indicator of their lack of confidence in the task. There is also evidence that workers who are stressed in their work or feel devalued are less likely to engage in developing their practice (Corrigan 1994: Donat and McKeegan 1997).

One of the concerns expressed by some professions is the perception of little published evaluation literature about their contribution (Mairs, 2003). Indeed this argument could be extended to positive media coverage which serves to support public awareness, understanding and therefore propagates requests for particular services (Knight, 2004). In a culture where evidence is highly valued, disciplines that do not have such data available might be perceived to be compromised (Pollard, 2002). A PD structure which enables practitioners to engage in critiquing, using and generating evidence for practice could build practice skills and greater confidence in their contribution (Welch, 2002). Such activity could inherently provide opportunities for and outcomes of continued professional development amongst the workforce and for individuals.

2.3.6 Continued Professional Development

The importance of supporting individuals responsibility to continually develop their practice was mentioned in Chapter One (Section 1.3.2.3) and this outcome is part of clinical governance requirements (Department of Health, 1998). PD structures that are well constructed could have a central role for individuals to achieve their continuing professional development (Bezzant, 2008). Knowles et al (2005) argue that adults need information before their involvement in active learning can be assured. With these points in mind, it has been argued that PD and its outcome should be of equal concern to the individual practitioner as the organisation sponsoring it (McSherry and Warr, 2008). Individuals need to continually develop their practice by rigorously and reflectively examining their own interventions (Gamble et al 2001). In order to achieve this, PD structures need to reflect opportunities for mentorship and practice supervision (Lyons, 1999:

Wright, 2001: Roberts 2002: Sweeney et al 2001c: Phillips et al 2002). Other sources of professional development might include practice itself.

The workplace provides significant opportunity for professional learning and growth (Ewing and Smith, 2001: Alsop and Lloyd, 2002). This potential has been identified and incorporated into public policy (Department of Health, 1998). Continued professional development (CPD) throughout an individual's career forms part of the requirements of continued registration (Health Professions Council, 2004). However, in addition to practice practitioners also need to engage in other learning activities in order to be exposed to emerging knowledge in the field (Warne, 2002). More disciplines are now undertaking degree-level undergraduate training (McCluskey, 2003) but this in itself does not appear to be a major catalyst for activating an evidence-informed practice habit (Isted and Millsteed, 2004). Facilitated use of evidence based knowledge has been conceptualized as a positive way of delivering CPD (Sackett et al 2000: Curtin and Jaramazovic, 2001: Walter et al 2005). Accordingly, for the outcome of an individual's CPD to include evidence based practice it is necessary that practitioners are willing, competent and supported by their employing organisation to engage with evidence informed PD opportunities (Sackett et al 2000: College of Occupational Therapists, 2005: Hammond and Klompenhouwer, 2005). Interventions such as post-registration training opportunities could offer opportunities for learning in these areas (Curtin and Jarmazovic, 2001).

Investment in didactic training courses and time out of practice to understand and embrace evidence for practice can be costly (Curtin and Jarmazovic, 2001: NHS Centre for Reviews and Dissemination, 1999). Lack of financial resource is a regular feature of an individual's rationale for not embracing EBP (Taylor and Mitchell, 1990: Humphries et al. 2000: Curtin and Jarmazovic, 2001). Other evidence demonstrates that even with significant investment of time and finances, only a proportion of therapists might adopt the use of new knowledge into practice even when provided with the same educational opportunity (Chard, 2006:

McCluskey and Lovarni, 2005). This suggests that the practice context and the therapist's own skills and attributes have a bearing on the transfer of knowledge into practice (Leberman et al 2006).

Lack of time has been consistently reported to be perceived as an important barrier to the transfer of knowledge into new action (Curtin and Jaramazovic 2001: McCluskey, 2003: Humphries et al 2000: Warne, 2002). This is with particular reference to access to and subsequent reading of research information rather than time to attend continued education (Dysart and Tomlin, 2002). Indeed, this is not peculiar to occupational therapy with the situation extending to other health care professionals (Loke and Derry, 2003: Straus and McAlister, 2000). It is very likely that reading time, despite its importance, is not prioritized within the routines of health care practitioners as it involves time away from direct clinical contact with patients (Humphries et al 2000). It has been suggested that PD programmes can structure time for CPD outcomes to be achieved by individuals (McCormack et al 2004).

This section has discussed the proposed outcomes for PD structures. It has considered six main areas of outcome including evidence based practice; client-centred practice; improved quality and equity of service; enhanced clinical reasoning, skilful practice and accurate decision making; emancipation of professions and continued professional development. Whilst these goals are commendable it is also important to consider whether PD can be effective in achieving them for organisations and with individual professionals. The next section will argue that general positive outcomes can be identified in well constructed PD programmes particularly from an organisational perspective but that there is a challenge to understand the outcomes of individuals who engage in a team PD programme.

2.4 Discovering the outcomes of PD Programmes

This section will briefly discuss the challenges of effectively evaluating PD programmes. It will include examples of reports which conclude that PD

programmes have had an impact on developing practice. Accordingly, it will touch upon the methodology generally favoured in evaluation studies although this will be considered in more detail in Chapter Four. Furthermore it will assert that because PD programmes are context dependent and vary in their objectives that they are difficult to compare. The challenge of evaluating PD over time, including sustaining the practice developments made into routine practice will also be explored. To start, the section will consider examples of PD programmes that have been demonstrated as changing practice behaviour.

2.4.1 The 'method of evaluation' challenge

Measuring outcome of performance has received increased attention in healthcare (Oldham et al 2008). Strongly held differences of opinion exist between an experimentation approach and a theory-led approach to evaluation (Davies et al 2000). However, experimentation and other research approaches which control variables continue to dominate the methodologies used to evaluate PD programmes (McCormack and Manley, 2004). Indeed by some they are regarded as the most robust choice of design particularly where results are to be generalised (Eccles et al 2005). This approach has a particular focus in quality improvement (QI) programmes (Grimshaw et al 2004). There can be practical difficulties in setting up and conducting such studies which might lead researchers to undertake the next best thing. An example of such a study is described by Cook et al (2007). They report a significant increase in therapists' use of outcome measures in practice following their participation in a bespoke 'workshop' intervention. However, the self report design with no control group and no independent triangulating evidence could merit a critique of their fidelity to an experimental approach. It should also be noted that when PD intervention outcomes are measured in this way the focus is usually upon to what extent the intervention affects change rather than for which practitioners and in what circumstances individuals are changing their practice (Wensing and Grol, 1994).

The use of alternative methodologies for example Action Research (Pryor and Forbes, 2007: Jinks and Marsden, 2007) and Realistic Evaluation (Lhussier et al

2008: Redfern et al 2003) have been heralded as a way forward. These methodologies support the use of mixed methods to gather data and are proposed to have utility in gaining a holistic evaluation of PD activity (Gulmans et al 2007). It is clear that contextual factors are important for a real understanding of PD outcomes.

2.4.2 The 'contextual' challenge.

Shifting practice within a healthcare setting is highly context dependent (Brown and Rodger 1999: NHS Centre for Reviews and Dissemination, 1999: Ferlie and Dopson, 2005: Boomer and McCormack, 2008). This position is supported by a survey based study to examine the factors which influence the achievement of practice development amongst nurses (Gerrish and Clayton, 2004). These authors concluded that the dynamic processes and culture of an organisational structure are pivotal to a successful outcome of change. On the other hand, Allery et al (1997) found wide ranging reasons why general practitioners had engaged in change. It is clear from their study that many of the influences had no direct connection with the outcome of practice development for patient gain although the study was not looking at a PD initiative common to all participants. Developing PD programmes is more than just the responsibility of individual practitioners. PD outcomes need to be designed and supported as part of an organisational approach and reported with description of how the contextual features interact in the evaluation process (Dopson and Fitzgerald, 2005b). Descriptive case studies may be required to illustrate the developments made.

2.4.3 The 'subjectivity' challenge.

The scientific world often criticizes the use of narrative to evaluate services (Wensing et al 2005). The reality is that commentaries of this nature can be found in the literature (Harwood et al 2007: Golden and Tee, 2004: Caldwell, 2004). It could be argued that narratives are helpful, particularly in guiding thinking, maintaining motivation and sharing examples of advancing clinical practice (Denshire and Ryan, 2001). However, where academics and practitioners have undertaken concurrent practical and academic evaluation differences in outcome

have been exposed. For example, in Carr et al's (2008) study there was a difference in understanding of the evaluation objectives which became problematic. Academics (or 'outsiders') were seeking to generate new and transferable knowledge and the practitioners (or 'insiders') were concerned to refine their own practice. The tension was reported by Carr et al because it was concluded that this dynamic had a bearing on the evaluation results.

An example of a descriptive account is provided by Harwood et al (2007) when they share a narrative of their PD activities at bespoke accommodation for people with physical disabilities. Whilst the paper is based upon one local, context specific development it also serves to illustrate, in an engaging way, the quality benefits for service users of such developments. It also uses a variety of mechanisms to develop practice including gathering service user and carer feedback, providing staff training and education, undertaking environmental adaptation and fostering attention to enhanced communication amongst team members. However, the paper reports progress over one point in time. Producing sustained positive outcomes of PD over a longitudinal timeframe will be discussed next.

2.4.4 'Temporal' challenges

Ideally, every health care context needs to be dynamic, changing and evolving over time whether or not a structured PD project is in place (Dopson and Fitzgerald, 2005a). However, even though PD programmes can improve healthcare in the short term little is known about how to sustain quality improvement efforts over time (Chin et al 2008). It is important though that PD programmes have realistic time-lines planned and that consideration is given to how the programme might evolve over time (McCormack and Manley 2004). In a context which does have an active programme of PD, its ability to continue to achieve positive outcomes over time is in part dependent on the PD leaders whose role is to encourage others to forge ahead with change (McSherry, 2007). PD leaders, like other health care staff, do change roles so it is possible that PD programmes will be affected by change in leadership (see Section 3.4). Equally, it could be argued

that organisations need to attend to leadership succession planning in order to guarantee that PD programmes continue over time (Ryan, 2008).

Providing financial incentive to practitioners and leaders to sustain PD effort has been suggested as one way of ensuring longevity of performance (Chin et al 2008). They also suggest the availability of routine time out of practice to undertake learning. This study was undertaken in the USA so has cultural differences. However, the notion of reward for demonstrating enhanced performance at work is relevant in many cultures (Eraut et al 2000a).

2.4.5 The 'eclectic mechanisms' challenge

Appraising the success of PD programmes which combine of PD mechanisms is potentially problematic because PD's generally lack a consistent approach to the mechanisms that are used (Bury, 1998). There is good reason for this (discussed further in Section 1.5.3) and is because PD programmes need to be responsive to the local context. In other words the mechanisms which are facilitated to act as catalysis of change could be distinct amongst different PD programmes which therefore pose a challenge to outcome evaluation particularly for cross project synthesis (Grimshaw et al 2004). This point is further explored by authors who have undertaken studies to reveal the limitations of simplistic approaches to PD (Dopson and Fitzgerald, 2005a).

This section has introduced the challenges that can present when aiming to understand the outcome of PD programmes and how they translate or generalise across contextual situations. Five areas of challenge have been suggested and these include the methods chosen to evaluate PD outcome, the contextual circumstances of the PD programmes, the objectivity achievable through the evaluation, the temporary challenges and finally the degree of variation in the mechanisms or PD interventions.

2.5 Chapter summary

This chapter introduced the range of *outcomes* that might be expected when organisations undertake PD programmes. It has been argued that evolutionary

practice requires a change outcome and that managers should be concerned with leading change that positively develops practice. It has also suggested that the PD outcomes made by individual practitioners are important in order for the whole team to progress with the required organisational outcomes of PD. The chapter studied two main areas including a focus of expected outcomes of PD and secondly it has provided appraisal about what challenges can be experienced to gain robust PD outcome data. It has concluded that without attending to what PD interventions work for which individuals, PD resources used in a generic manner could be wasted. An argument has been developed which puts the case for including the position of the individual in the definition of PD outcomes.

In order to achieve required PD outcomes it is important to have PD intervention mechanisms or structures to support practice change which work for both individual practitioners and the organisation. This will be explored in Chapter Three.

Chapter Three - Mechanisms to Develop Practice

3.1 Chapter overview

There are a plethora of mechanisms, structures and interventions suggested in the literature to support change and development of health care practice. They have evolved to include the key constructs of practice development and quality improvement (QI). However, in order to appraise the literature on mechanisms and systems to support the development of practice it is first necessary to consider how people change.

In this chapter the focus will be to understand what the literature says about the support that is required for individuals to undertake change and develop their practice. Synthesis of the literature suggests that many of the mechanisms to promote the development of practice in health care are conceptualised as external to the individual practitioner. It will conclude that although the literature tackles subjects connected with adult learning and theories of change there is a gap in knowledge about how *individual* health professionals can be most effectively engaged in developing their health care practice. To illustrate this point the PD and QI literature has been synthesised and revealed the following four key areas:

- Theories about how people change
- Understanding resistance to change
- Leadership: a catalyst for change
- Structuring mechanisms to develop practice

3.2 Theories about how people change

Many theories exist which aim to explain how people develop, change and evolve. They are often not distinct but overlap to differing extents (Grol et al 2005). It is important to consider the underpinning concepts of human change in order that any required change in practice can be facilitated and managed safely, efficiently

and to best effect (Callan, 1993). Not all commentators agree that theories of change offer solutions to developing workplace practice. Beer et al (1990) for example conclude that rather than investing in change management programmes organizations need to change the job roles and responsibilities of staff and 'force' new behaviours. A directive approach might be appropriate in circumstances of organisational crisis where firm directional leadership is required (Griffiths and Clark, 2004). However, such action can serve to demoralize people, foster poor relationships and cause humiliation (Miller and Rollnick, 2002). It could also limit the learning potential of the people affected (Knowles et al 2005). An alternative position is to build participatory programmes of PD which take into account social groups, the organization's needs and individuals' responses to change in the workplace (Griffiths and Clark, 2004). By taking a holistic approach the mechanisms for facilitating change for different individuals can be more accurately identified (Walter et al 2005). For the purpose of this section theories of change have been organized into four distinct groups:

- social theories of change;
- organisational theories of change;
- individual theories of change and
- dynamic theories of change.

These will be discussed consecutively although reference will be made to the areas where theories overlap or interchange. The first of these to be considered are social theories of change.

3.2.1 Social theories of change

This section will introduce social theories of change which argue the critical place of community culture on the progress and impact of a change initiative. It has been claimed that social theories of professional development underpin health care Grol et al (2005). Grol et al suggest that this is because society expects a unique

contribution of professions, loyalty of the individual to their professional group and the production of new knowledge via research. Certain change interventions then become expected within professional development requiring members of that group to undertake further training and development (Dopson and Fitgerald, 2005a). Indeed a person entering a profession is expected to move from novice to expert through their professional practice experiences and learning (Benner, 1984). As such they are part of a community of practice (Wenger, 1998) through which they gradually learn to create and recreate work practices. However, members of a professional group do not necessarily have homogenous abilities, motivation or indeed work practices (Gollop and Ketley, 2007). Practice change by virtue of professional affiliation is perhaps a vision rather than a reality (McCluskey and Lovarini, 2005). Nevertheless, professional teams bind eligible members into social groups which can produce widespread change.

Social theories of change rely on the social context having the capacity to reward and reinforce the effort of teams and individuals. Thus the full potential of the workforce can be realised and the transformation on practice occurs and is sustained (Price, 2008a). It could be argued then that social as well as individual processes need to happen for change to occur (Scott, 1998). Bandrua (1995) for example, describes three key factors which generate change momentum: a personal, behavioural and contextual aspect. This reinforces a link between the individual and the social environment in relation to change theory. Underpinning this is the notion that individuals learn to change their behaviour through building personal efficacy within their social world. Bandura proposes that whilst the experience of personal efficacy is connected with personal mastery experiences, vicarious experiences, social persuasion and psychological and emotional states it is also connected to the relationship with others in the social world.

Gladwell (2000) presents argument and insight into how ideas grow into socially embraced change epidemics. This includes the idea that the perceived need to change can become contagious and binding amongst a social group without any

structured change process being necessarily cognitively planned. It is clear though that not all change initiatives within health care can be described in this way. For example, in Chapter Two (Section 2.3.1) examples are provided of how EBP is challenging to cascade. Change that has certain outcome requirements within a social context like health care needs strategic structure in order that the direction of change is planned and monitored (Ilott, 2004). To that end there needs to be cultural shift towards locating learning mechanisms that are well structured and financed on an individual and team level in order to achieve success (Gopee, 2002). Facilitating learning can occur through realising the energy and skill of members of a health care team in a social process (Knowles et al 2005).

Social theories of change have been used to theoretically frame studies which consider how individuals engage in research utilization (Estabrooks et al 2003). Of the twenty-one studies appraised in Estabrooks' systematic review two thirds reported results that were not overtly underpinned with theory. However, the others mainly considered Rogers (1995) theories about how ideas are diffused within community networks through the significant influence of 'adopters'. Adopters, in a social model of change within a health care context might be regarded as, for example, 'opinion leaders' (O'Brien et al 2003) or practice developers (Garbett and McCormack, 2002: McQueen, 2008). In contrast there are social theories of change which support emancipation of both frontline staff (Stewart, 2007) and local communities (Fawcett et al 1995). These concepts suggest that the energy for driving change is located with communities of people (Willey, 1986). However, in a structure of this nature the accountability for achieving change may be more difficult to identify and monitor. Health care organizations could be regarded as communities and cultures with their own specific purpose within the social world. It is not surprising then that organizational theories of changes have developed their own body of literature and these will be considered next.

3.2.2 Organizational theories of change

In this section the literature relating to organisational theory will be considered. Health care organisations are social designs which are directed at and collectively responsible for patient-centred practice (Buchanan et al 2007). As such organizational theory would suggest that their communities are the key to the organizations competence, the evolution practice and quality assurance (Wenger, 1998). Wenger argues that learning is the vehicle for the development of practice. He also suggests that by interacting within an organized culture people learn through and within the situation. However, communities of individuals within a work practice need a shared endeavour to gain a source of identity, support and commitment to the transfer of common learning amongst team members (Leberman at al 2006). This position supports Jones' (2007a) notion that focused cooperation amongst workers builds an effective organizational culture and supports sustainable change behaviour.

Organisations, particularly those dealing with multifaceted areas of human concern like health care are complex in nature so sustaining change is challenging (Elcoat and Roberts, 2000). It has been suggested that complexity theory can go some way to understanding the vast variety of systems within health care where particular functions are adapted and interconnected with each other in an active way (Plesk and Greenhalgh, 2001). Dopson and Fitgerald's edited textbook (2005) draws on a large amount of research evidence from the health care field. In it they appraise how evidence-based knowledge is moved into practice action by members of health care organisations. Organisational change can be thwarted by the context as much enabled (Gollop and Ketley, 2007). This information may offer clues about how change can successfully be facilitated for individuals within organisations. Particular contextual messages include the fact that change strategies need to offer time, resources and sustained attention if the change goal is to succeed (Ferlie and Dopson, 2005b: Fitzgerald et al 2003). They also advise that people who are responsible for implementing any changes within an organization must have a sense of ownership of the change. Given that NHS health care provider

organizations are in recent times developing a business ethos (Department of Health, 2006), successful organizational evolution is of greater importance. Organisational theories of change and practice development could have a prominent role in a culture of this nature (Price, 2008a).

The culture of an organization is an important influence on the spread and sustainability of change (Jones et al 2007). It follows that the approach to change management can have an impact upon whether the change will be sustained. For example, rapid change implemented across an organization may not be supportive of long term change behaviour (Buchanan and Fitzgerald, 2007a). Buchanan and Fitzgerald propose that new ideas are more likely to be adopted successfully in organizations with an innovative culture, receptiveness to change and an absorptive capacity. Alongside this Grol et al (2005) discuss theories of organisational culture and imply that the culture of an organization needs to act as a lever to healthcare improvement. An alternative view could be that individuals successfully making positive changes need to be conceptualised as the levers for overall cultural change in an organization (Beer et al 1990). Taking a purely organizational or social approach to the transfer of learning could result in missing important opportunities for all individuals within a diverse team to benefit from a PD programme (Leberman et al 2006: Knowles et al 2005). This leads to the notion of individual theories of change which will be discussed next.

3.2.3 Individual theories of change

Social and organizational factors may be important in individual theories of change but only in the way that they are perceived by the individual (Grol et al 2005). For example, Sadovich (2005) examined the relationship between 'work excitement' and burnout in nursing roles implying a connection between personal motivation and the social environment. They conclude that an individual's perception of the work environment influences their experience of work satisfaction, job performance and learning opportunities. On the other hand, Estabrooks et al (2003) undertook a systematic review of individual determinants

of use of research in practice. Their results suggested that an individual's belief in their ability or self confidence is the major indicator. It could, of course be argued that the work environment has a major part to play in fostering an individuals belief in their ability to succeed in changing their behaviour (Kielhofner, 2008b). Workplace educators and leaders then have a responsibility to be agents of change rather simply disseminators of knowledge (Bouchard, 1998: Knowles et al 2005: Leberman et al 2006).

The focus of some individual theories of change is primarily around *stages* of change (Peruniak, 1998). It could be argued that these ideas are fundamentally underpinned by their connection with an individual's motivation toward change and that people need to make meaning from new information in order to motivate action (Mezirow, 1990). Individuals need to experience specific phases or reach specific competencies in order that change behaviour becomes embedded in routine and personal volition (Kielhofner, 2008b). Prochaska et al (1998) provide an example of an individual theory of change in their 'Transtheoretical model'. Influences on behavioural change are acknowledged in smoking cessation interventions and will be considered here as an illustration. Prochaska et al's model concentrates its theories on emotional, cognitive and behavioural aspects. The stages proposed relate to understanding the individuals cognitive concerns and internal motivation to change their routines around the behaviour of smoking. Five phases of change are described which allow appraisal of the stage of a person's behaviour towards the change goal:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance.

Prochaska's theory is not connected with the PD of health care practitioners per se and some aspects are deeply focused on physiological issues relating to cessation

of smoking. However, the principles could hold significance for understanding behaviour change in other domains of human activity. Walsh et al (2004) provide a practice evaluation of connecting the principles of motivational interviewing with PD. Their paper is not empirically based but does introduce the notion that practice developers are most effective when facilitating learners to gain positive motivational experiences. They suggest that expressing empathy, developing discrepancy, avoiding argument, rolling with resistance and supporting self efficacy should be the principles upon which to base PD with sceptical or demoralized individual clinicians. A positive atmosphere of encouragement and feedback is more likely to foster long-term internalisation of the change into everyday practice (Griffiths and Clark, 2004).

The later work of Rogers (2003) reminds us that there are stages of change within his '*diffusion of innovation'* model. He also describes a five phase journey toward change as the practitioner becomes exposed to the existence of the innovation. These stages include:

- **Knowing about** an innovation,
- **Forming a judgement** about the value of the innovation,
- **Deciding whether to adopt** the innovation in practice,
- Actually **putting the idea into practice** and
- **Evaluating the result** of this decision.

This description of change could be conceptualised as process-orientated and requires an individual to discover their learning through behaviour change (Knowles et al 2005). The model is supported by theories of expertise development in medicine (Schmidt and Boshuizen, 1993). A staged and linear approach to change is helpful if conceptualised as a guide to develop and evaluate PD programmes particularly in work settings where there is a high level of certainty (Redfern and Christian, 2003). These stages could be particularly relevant for updating technical information. However, health care practitioners' often face complexity in their work so such a straightforward approach to

habituated practice change may be thwarted; particularly for novice workers (Schmidt and Boshuizen, 1993: Benner, 1984).

Other theories of an individual's capacity for practice change could be connected with their personal attributes and styles (Knowles et al 2005). In a survey of general practitioners, Robinson (2002) found that learning style preferences are linked with a practitioner's risk taking behaviour. He purports that 'risk seekers' and 'accommodators' prefer feedback, interaction and learning in practice whilst individuals who describe themselves as 'risk averse' and 'assimilators' tend to prefer lectures, theoretical learning formats and less interactive learning. With the likelihood that those who are risk adverse will find learning within a social group and sharing feelings more challenging it is important to plan a range of PD interventions which will accommodate a variety of individuals within a team (Allery et al 1997).

Other theories of change or managed learning with individuals within a system might be more relevant. For example, in the classic work of Lewin (1948) the author moves away from the idea of 'planned change' and into the conceptualization of 'managed learning'. In this important theory three stages of change are proposed. Firstly an individual has to gain a state of readiness for change by 'unfreezing' learnt behaviours. Next there must be a 'transition' of steps of the journey toward change and finally the new behaviour is refrozen into a solid foundation for future action. To compliment this position information about what strategies or mechanisms support each step of the change journey for an individual are required (Jonassen and Grabowski, 1993).

Other theories conceptualize stages of change for individuals in similar ways. Even when the type of behaviour change is different (for example vocational behaviour rather than self care behaviour), the stages are reasonably similar. For example, Grol and Wensing (2004) refer to a five stage model for inducing change in professional behaviour which they then sub-divide into ten steps. They suggest

that change starts with an 'orientation' to the innovation to promote awareness and interest. The process then moves onto 'insight' where the aim is to understand the learner's skills, routines and motivations. Thirdly the stage of 'acceptance' requires a positive attitude and decision to change followed by the action oriented stage of 'change' itself including here a confirmation that change is valued. Finally the 'maintenance' stage integrates practice into new routines. These studies serve to suggest that change is not a straight forward process and that there are many potential dynamics involved in achieving change.

3.2.4 Dynamic systems theory

It has been argued that none of the theories relating to individual, social or organisational change are adequate to clarify the complexities of individuals needing to change practice as part of a social team within a particular organisational structure (Lewis, 2000). An alternative, emergent conceptualisation which takes a holistic approach rather than one-dimensional approach to change is Dynamic Systems Theory which is grounded in the principles of self-organization within a given environment (Smith and Thelan, 2003). This provides a single explanation for the multiple facets of human development and growth (Lewis, 2000). Kolb (1984), for example locates experiential learning as being a cyclical process and having no end which compliments this position. Where other learning theories tend to emphasise environmental causation (for example organisational theories of change see Section 3.2.2), dynamic systems theory acknowledges the interplay between the environment and the individual (Lewis, 2000). This point is taken further as Smith and Thelan (2003) describe human development as based upon intricate systems which are composed of many individual elements acting on and within a complex environment. This implies that human behaviour change is not a linear process or mechanistic process but holistic and interactive requiring individual participation and adaptation (Knowles et al 2005).

Where uncertainty is a characteristic of an organization, a linear theory of change is inadequate (Redfern, 2003). To achieve change (individual and organizational)

in a complex health care culture sophisticated teamwork is required between practitioners, managers and leaders to enable best use of resources, value for money and best intervention for clients (Dopson and Fitzgerald, 2005a). Partnership working amongst clinicians, managers and researchers is required to ensure all stages of the process are fulfilled (Hammond and Klompenhouwer, 2005). The cooperation and particular set of knowledge brought by service users is also required as part of this process so that appropriate pathways of care can develop (Mead and Bury, 1998).

Dynamic systems theory assumes that there are multiple causes of change behaviour and that there is no one element responsible for causal priority (Grol et al 2005). Essentially human beings have an innate need to engage in occupations and have abilities to learn to adapt to their environment (Kielhofner, 2008a). Smith and Thelen (2003) point out that in a dynamic system there is self-organisation as a solution to a challenge from the environment. By adopting the stance that dynamic systems theory has relevance in the development of practice for individuals a challenge is posed to all stakeholders of the practice development. Thus the organisation, society in general and the individual have roles and responsibilities to enable workplace learning to occur.

In this section many existing theories of change have been considered. It has been argued that when realistically considered the various theories are not necessarily mutually exclusive. However, it is clear that individuals need to be motivated towards change rather than forced into change. This can be problematic when an individual fails to become engaged in the required change behaviour. Several reasons why individuals might resist change will be outlined next.

3.3 Understanding resistance to change

Understanding why resistance to change occurs can help us to establish mechanisms to support change when it is required to develop practice. Human resistance to change is not uncommon (Miller and Rollnick, 2002). This is in part

because engagement in every day activity typically forms into habituated patterns which support the complex routines and roles that humans adopt (Kielhofner, 2008a). To this end habituated work routines could be argued to be strongly embedded and difficult to alter. On the other hand resistance to change may occur at different levels and the reasons may be multi-factorial (Gollop and Keatley, 2007). For example, Honey (1997) proposes four common reasons for resistance to personal development change: parochial self interest; misunderstanding; need interpretation and low tolerance of change. These have been synthesised into three critical components of change which Miller and Rollnick (2002) describe simply as being 'ready', 'willing' and 'able'. However, a further synthesis of the literature by the researcher will address five key areas about resistance to change including:

- Lack of internal motivation to change
- Inadequate external motivation
- Fixed routine
- Forced change
- Characteristics of the individual

3.3.1 Lack of internal motivation to change

Continuing with a familiar behaviour might be considered easier than risking doing something different (Beer et al 1990). This might be particularly prevalent where behaviours have been established over a length of time. There is evidence, for example, which suggests that resistance to applying nursing research to practice is higher amongst more senior nursing staff (Camiah, 1997). Some health care professionals may not see a need to change and so may not look for ways to develop their practice or that of others. Furthermore, some individuals might be simply disinterested in change (Miller and Rollnick, 2002). However, being a professional requires an individual to demonstrate self-determination and be internally motivated to continually develop professional practice (Ewing and Smith, 2001). As such a degree of 'self-management' and motivation is required (Isles, 2006).

Health care practitioners should be able to relate to the philosophy of 'life-long-learning' (College of Occupational Therapists, 2002). A large body of evidence was reviewed by Hackett (1995) and indicated that a person's sense of confidence plays a key role in work related behaviours. Hackett concluded that the higher the person's perceived efficacy at any one time the more likely they are to take interest in further developing their skill and role performance. This connects with personal causation or self-belief to effect change which has been demonstrated elsewhere to be of critical concern in engagement in change (Estabrooks et al 2003). It has also been identified that the degree of self-control that an individual can achieve is shown to rise with the development of self-confidence and to decrease with external constraints (Bénabou and Tirole, 2004). The importance of external sources of motivation will be considered next.

3.3.2 Inadequate external motivation

Both internal and external motivational sources can be helpful in moving an individual into change action (Amabile et al 1994). People who are highly interested in their work gain a deep level of intrinsic enjoyment in and are therefore intrinsically motivated for to undertake their work (Sadovich, (2005). For other individuals it appears that their motivation is driven from external sources like the reward of acknowledgement from others (Lepper, 1988). The practice context holds external sources of motivation for change which are likely to have an impact on an individual's self efficacy (Zimmerman, 1995). These factors include, for example, positive feedback (Ryan, 2008); availability of mentorship support (Welsh and Dawson, 2006), the camaraderie and common purpose experienced amongst a team of people (Archer and Cameron, 2009) and the complexity of the job task (Zimmerman, 1995). Other common influences of the external environment are connected with the limited opportunities that practitioners perceive (including their own time) for updating their knowledge (Pollock et al 2000, Gerrish et al 2006). Other studies cite disagreement and perceived threats to professional groups to as additional potential impediments to

engagement in PD change (The NHS Centre for Reviews and Dissemination, 1999: Michie et al 2004). Where limited motivation is evident it is unlikely that an individual will change their long held practice routines and these will be discussed next.

3.3.3 Fixed routine

Individuals and organisations fixed in particular routines can become caught up in particular ways of responding to requests for change. This means that not all involved in a development programme are likely to change practice (Bradley et al 2006). Covey (1989) advises in his popular text that individuals can choose and form effective personal routines and habits in their responses to personal situations in the work role. He illustrates how individuals can opt to take a 'principled' approach to learning and responding to their responsibilities in order to subsequently change behaviour when approaching challenges. Miller and Rollnick (2002) support the use of positive thinking to facilitate a change in routine. It could be proposed that this needs to be taken further into 'doing' new behaviours in order to support new behaviour patterns being embedded (Lewin, 1948: Knowles et al 2005). Changing habits is well known to be challenging to some people and an individual's propensity to taking risk rather than being cautious will have a bearing on them embedding a new behaviour into their routine (Jonassen and Gabowski, 1993: Taylor, 2006). It is clear from Bradley at al's work that facilitative leadership is a key element of supporting people to change routine (see Section 3.4 for further detail of the role of leadership). Whilst some service leaders might autocratically force new work routines onto their staff it is likely in a culture of health care to cause some people to resist change even further (Jones, 2007b). Forced change as a source of change resistance will be considered next.

3.3.4 Forced change

It has been argued that an individual needs to believe in the need for change if real participation in new behaviour is to be achieved (Kaner et al 2003). Whilst it is helpful to identify different change strategies it remains clear from Honey's (1997)

example of seatbelt use in cars that not all people comply with the change obligation despite many years of legal requirement. This 'forced change' idea where people of low tolerance or interest in change have the environment around them altered is supported by other authors (Beer et al 1990). This approach suggests that resistance to change must be surmounted and in life threatening situations this could be justifiable. Another way of thinking though is that resistance is necessary in order to create debate, energy and ownership of new practice amongst those who will be directly affected with the change (Gollop and Ketley, 2007). Successful change in health care services is more likely if those responsible for delivering care are part of the whole process of change (Kaner et al 2003: Archer and Cameron, 2009). Adult learning theory supports the notion individuals need to feel involved in the change or learning event in order to that in order to accept the need for change (Knowles et al 2005). However, in any group of individuals there are differences in the speed at which innovation is adopted which may be connected with the characteristics of the individuals involved.

3.3.5 Characteristics of the individual

Little research has been undertaken to date to examine the characteristics of therapists who are successful in implementing new information into their practice. Chard (2006) considers the matter in her phenomenological research where therapists were asked to describe their attempts to put a new evidence-based skill into practice. She concluded that the attributes of single-mindedness, tenacity and the ability to re-conceptualize new ways of working seem to be the most important personal characteristics for the diffusion of new knowledge into practice action. These attributes could counteract the potential stress involved in dealing with organizational change particularly where individuals are empowered in their workplace to adopt the role of change agent (Callan, 1993)

A further consideration could be the attitudes of the practitioners themselves towards engaging in a PD. Arons, (2004) developed an attitude scale in order to measure health care practitioners' responses to evidence based change. He aimed

to establish practitioners' perceived readiness for change in terms of its appeal, their response to its mandatory implementation, their openness to new types of professional action and their perception of how new knowledge will change their usual practice. The range of attitudes documented in the results of administering the scale to over 300 mental health care workers suggest that the attitudes of practitioners play an important part in the adoption of innovation. Understanding the particular set of attitudes held by individual therapists may then assist in making practice development programmes more effective (NHS Centre for Reviews and Dissemination, 1999).

Roger's seminal work (1962) about the diffusion of innovation proposes that in any innovation a normal distribution amongst a group of individuals engaged in practice change can be identified. The range from one end of the bell curve to the other supposes that there will be individuals who set the pace of change (innovators) and those who are not ready or idle in the change process (laggards). These types of behaviours will be seen at opposing ends of the spectrum with a range of early, mid and late majority implementers at the centre. Individuals make sense of situations in different ways (Weick, 1995) so it could be argued that investment in communicating the rationale, requirements and consequences for lack of change will be important where people are resisting change. A study undertaken more recently supports this view and calls for a realistic expectation of diffusion rates within a practice change initiative (Bradley et al 2006). People are more motivated to learn when they can address challenges that they have faced in their practice and make sense of the requests being asked of them (Jarvis et al 2003). However, even if individuals are ready to change they may not be able to adopt new change behaviours if the context is unsupportive.

This section has considered what circumstances could cause an individual to resist a change initiative in the workplace. In particular the section has embraced the idea that paucity of both internal and external sources of motivation cause individuals to resist change. In addition, patterns of well established behaviours

embedded in strong routines are also a challenge but that these are not always altered if a social context attempts to force change. Finally the section concluded that there will always be some people who resist change but that this should not prevent attempts to develop structures that will support the development of practice. What the literature tells us about the important features of leading practice development programmes will be considered next.

3.4 Leadership: a catalyst for change

Leadership forms a vehicle through which practice development mechanisms can be driven. An argument will be made in this section that practice development leadership roles are important as catalysts for change particularly where resistance to the required change amongst individuals is identified. The section has been organised to initially discuss the literature in relation to effective PD leadership. It will then go on to consider PD leadership in relation to seven key components that have been distilled by the researcher from the literature. The components include the responsibilities of professionals and leaders to: explore barriers to change; identify local priorities for change held: foster commitment and coalition; provide incentive to change; ensure effective communication; manage the change and to monitor change in practice.

3.4.1 Effective practice development leadership

The literature reinforces that effective leadership is a critical part of a successful PD context and that skilled, thoughtful and committed leadership is also an essential mechanism for developing progressive professional practice (Ryan, 2008). A Cochrane Review supports this position by concluding that local opinion leaders can influence improved practice (O'Brien et al 2003). Ross and Offerman (1997) identify two types of leader. A transactional leader provides support to achieve targets whilst the transformational leader is successful at changing culture and aspirations of the people in an organisation. For change to be effective organisations need both types of leadership to be in place to compliment each

other and shape the culture of the organisation (Currie et al 2007: Dewing, 2008: Harrison and Coppola, 2007). Leaders also need to be able to have the capacity to be flexible and consciously intentional in their approach in order to lead in different ways for different individuals within a team (Taylor, 2008).

It has been identified that PD programmes require inspirational and transformational leadership as an essential feature (Dewing, 2008: McSherry, 2007: Garbett and McCormack, 2002a). Arguably PD leaders also need to be collaborative and in order to be successful the qualities of empathy, patience, tenacity and honesty are important (Archer and Cameron, 2009). There are a growing number of specific 'practice development' roles which have emerged in contemporary practice (McQueen, 2008: Turnpenny, 2003). However, developing practice in order to improve the patients' experience of health care can be conceptualised as the everyday duty of *all* practitioners (McSherry, 2007). Every professional involved in health care is obliged to embrace a continuous commitment to practice improvement (McCormack et al 2004: Garbett, 2004). Some commentators have reflected that job descriptions should echo this (McSherry 2007: Forsyth et al 2005b). Though specific practice development roles to facilitate change are important, PD also needs to be culturally embedded throughout organisational structures and professional care (McCormack et al 2006). A PD programme then might be regarded as a community of practice where learning in practice becomes not only based on an individual's development process but is to be constructed in the broader process of professional socialization (Abrandt Dahlgren et al 2004: Wenger, 1998) in addition to service user involvement (Dewing et al 2006). Whilst there is a need for all professionals to take initiative in their own practice development there is also a role for specific PD leaders.

Specific leadership has been important in the development of PD as a concept (Pryor and Forbes, 2007). Regardless of the discipline concerned, leaders with knowledge of their subject area in addition to passion and skill to implement PD

programmes are identified as important in the success (or otherwise) of implementing a PD project (Stokes, 2004: Garbett and McCormack, 2002b: Dewing, 2008: Atsalos and Greenwood, 2001: Isted and Millsteed, 2004: Dopson and Fitgerald, 2005a: Chard, 2006). On one hand there is much rhetoric about the importance of leadership to shape practice and ensure best outcomes for patients (Department of Health, 2000b). There are also cautions about the impact of an intensive leadership role with a PD unit on the individuals undertaking these roles (Atsalos and Greenwood, 2001).

Over the last decade the NHS has invested in new types of leadership posts for nurses and allied health professionals which have specific PD responsibilities (Turnpenny, 2003). Turnpenny reported an audit of some of these 'consultant' posts within the UK and described only a handful of appointments to occupational therapists. No mention was made of the connections that these professionals have fostered with academic researchers although descriptive accounts suggest that some partnerships are developing (Melton, 2006: Humphries 1998). On the other hand, securing and maintaining PD leadership posts could be a challenge (McQueen, 2008). Some have suggested that financial constraints and restructuring within the NHS system have been a part of this challenge (McSherry, 2007). In addition other reasons have been documented including a lack of clarity about the leadership tasks which could result in a lack of focused effort (Garbett and McCormack 2002a: McCormack et al 2006). Furthermore it has been reported that some PD leaders have felt overwhelmed by the role, have unrealistic expectations of their role and feel disempowered to undertake their duties (Atsalos and Greenwood, 2001). Senior management support for PD leaders is critical in order that they maintain their confidence and motivation over time (Curtin and Jarmazovic, 2001: Gerrish and Clayton, 2004). It is evident though that this has not always been provided (Currie et al 2007). Without serious consideration to leadership any attempt at further development of PD in a workforce could be unsuccessful (Bradley et al 2006). Arguably this is strategically short sighted both economically and from a service governance perspective (McSherry, 2007). It

could be suggested then that individual PD leaders also need support to learn and consolidate the key components of their roles.

3.4.2 Key components of practice development leadership

Effective leaders know that people learn in different ways, to different levels and at different paces (Knowles et al 2005). Practitioners often find it difficult to recognize their own transitions and developments so leaders need to have sufficient empathy to understand what drives others and what causes them to respond in certain ways (Archer and Cameron, 2009). Empathetic leaders foster a reflective approach (Titchen and Higgs, 2001). It is also important to have multifaceted interventions set up through leadership in order to offer relevant learning opportunities to individuals (Gerrish and Clayton 2004: McCormack et al 2006: Dopson and Fitzgerald, 2005a: Walter et al 2005). The NHS Centre for Reviews and Dissemination (1999) offers key messages to guide leaders in the evolution of PD programmes. These themes will be used in the next sections to structure discussion about how development programmes can be led to best effect. The first three have a greater focus on the individual whilst the latter four have organizational implications.

- Explore barriers to change
- Foster commitment and coalition
- Provide incentive to change
- Identify local priorities for change held
- Ensure effective communication
- Manage the change
- Monitor change in practice

It could be argued that these are seven important facets of PD leadership activity so this point will be addressed in the text and consolidated at the end of the section. First to be discussed is how individuals perceive barriers to adopting PD.

3.4.2.1 Exploring barriers to change

Requiring people to engage in developing practice requires an understanding of the problems that they face (The NHS Centre for Reviews and Dissemination, 1999). There is much literature to suggest that practitioners of all professional backgrounds have found it challenging to integrate new knowledge and practices into their work routine. Included here are occupational therapists (Creek, 2003: McCluskey, 2003); a broader group of allied health professionals (Metcalf et al 2001), nurses (McCleary and Brown, 2003: Gerrish et al); and members of the medical profession (Lam et al 2004). This implies that in practice there are many barriers to individual change, that change is not straightforward to achieve and a subsequent 'implementation gap' between known best practice and actual practice may result (Dopson et al 2005: Welsh and Dawson, 2006). Without understanding and identifying these barriers for individuals within their local context PD programmes could be compromised (National Institute for Health and Clinical Excellence, 2007). For example, an attempt at a training workshop for occupational therapists illustrates the barriers of implementing research findings about joint protection programmes for people with rheumatoid arthritis (Hammond and Klompenhouwer, 2005). These researchers undertook a survey to understand whether the therapists implemented their new learning into practice. It transpired that only approximately 25% of those involved implemented the new knowledge into practice. This could suggest that leaders need further understanding of the barriers to change prior to intervention being undertaken.

One example of a PD which aimed to understand the development needs of practitioners is given by Morley (2007). A key part of this action research process was to build a local programme aimed at accelerating the skill development of new graduate occupational therapists into the workplace. Using focus group methods, Morley structured the data collection with representatives of several stakeholder groups. This report is of a first phase process of research and as such is limited in its evaluation of the PD programme's effect. However, it does hold merit in its thorough approach to considering a challenge of PD by seeking to understand the

perception of participants and including them in the development of the PD programme.

In summary, if barriers are not identified and overcome with each individual involved in a PD, the overall success of the programme could be jeopardised (NHS Centre for Reviews and Dissemination, 1999). Early identification of the perceived barriers can assist leaders to plan appropriate PD interventions which support change and foster commitment and coalition (Welch and Dawson, 2005).

3.4.2.2 Fostering commitment and coalition

PD is dependent on commitment from team members to value a shared vision. This requires encouragement, engagement and consultation with the whole team (Atter, 2008). Leading a strong coalition of personally committed key players taking part in a PD is helpful (The NHS Centre for Reviews and Dissemination, 1999: Lewin, 1948). In contemporary practice PD outcomes are most desirable where there is collaborative, multidisciplinary working (Stokes, 2004). Successful examples of this can be found where nurses and therapists have documented the results of joint clinical PD initiatives (Melton et al 2008: Harwood et al 2007). This trend has been echoed in the literature about effective inter-professional education at postgraduate (Freeth et al 2005) and undergraduate level (Reeves et al 2002: Mackenzie et al 2007). However, there is no evidence to suggest that multidisciplinary PD is superior to uni-disciplinary PD (McCormack et al 2006). The key issue is that decisions about PD programmes should reflect the focus of the development in question (McSherry and Warr, 2008). A balanced, mindful, theoretically underpinned and contextualised approach about PD structures and interventions is essential (Slotnick and Shershneva, 2002).

A considered approach to PD mechanisms is proposed by (Cooke et al 2004). This programme of nursing PD uses reflective, case-based discussion over a longitudinal period. They concluded that the programme was successful in building the confidence and skill of the participants in utilising research in their

practice. This was attributed to a collaborative ethos of dedicated leadership support. The example given by Cooke above illuminates another point of interest. In their study practitioner participation in the exercise was voluntary. This raises an important issue about whether PD interventions should be optional or an expected part of practitioners' job responsibilities (McSherry, 2007). Without participation from all staff it could be unclear whether those who did not engage might be the staff members who had the most challenge in developing their practice. In this case a gap could emerge in the competencies and practice of health care workers (Humphries et al 2000). On the other hand, interventions could be provided for a smaller group who are responsible for cascading information and generating participation across the broader team (Forsyth et al 2005c). It is important however to connect with all stakeholders including managers, academics, and service users in the PD interventions particularly at the stage requiring sign up to the development to ensure endorsement and support (McCormack et al 2006: The NHS Centre for Reviews and Dissemination, 1999: Hammond and Klompenhouwer, 2005). In and of itself this provides a momentum and incentive for change.

3.4.2.3 Providing incentive to change

PD interventions should have in-built strategies to reinforce desired behaviour (The NHS Centre for Reviews and Dissemination, 1999). The incentives can include financial reward, making practitioners lives easier, gaining professional satisfaction from offering a better service to clients, resource reallocation, education and training performance feedback and empowerment. The use of participatory action research could be one way of providing some of these rewards (Taylor et al 2006). It can also act as a way of implementing and evaluating PD ideas in health care and its use is gaining momentum (Kielhofner et al 2006: Jinks and Marsden, 2007). Its principles are founded upon engaging directly with stakeholders in being able to take, own and act upon development decisions collaboratively and therefore drive forward change (Hart and Bond, 1995: Meyer, 2000). These principles make it particularly suitable to involve service users as

key collaborators in development processes (Burk et al 2003). In this research approach to PD which overtly includes participants as part of the research design, development initiatives are formally and concurrently evaluated with participants to understand the effectiveness of the changes in action (Taylor et al 2006). Morley (2007) for example undertook an action research study with newly qualified occupational therapists. The participatory nature of the PD generated knowledge that was intended for use by the research participants. This encouraged ownership of and personal accountability for practice developments and led to a positive experience of transition from new graduate to registered occupational therapist. Part of the incentive was the participants' ownership of the change; without this imposed programmes can undermine enthusiasm and motivation (NHS Centre for Reviews and Dissemination, 1999). As such it is important to identify local priorities for change.

3.4.2.4 Identifying local priorities for change

PD interventions need to be tailored to the local contextual situation so that changes are relevant for the environment in which the PD is occurring (The NHS Centre for Reviews and Dissemination, 1999: Dopson and Fitzgerald, 2005b). However, there has been criticism of evaluations which are unable to generalise the results to other contexts (Jinks and Marsden, 2007: Meyer, 1993: Winter and Munn-Giddings, 2001). Others argue that these criteria are actually the strength of this type of approach as understanding the context where change is desired is of critical concern to effect change (Pawson, 2006: Fitzgerald et al 2005). McSherry and Warr (2008) argue that the primary priority for embarking on a PD programme needs to be framed in achieving excellence for service users. Other contextual features have also been identified as core influences (Fitzgerald et al 2005). Amongst these are included the structural characteristics of the location and the make up of the leadership team. It follows then that decisions about the method for identifying local priorities for PD will need to be undertaken in different ways for different contextual situations. In some situations project group activity will be favoured (Golden and Tee, 2004) and in others a more informal approach to

gathering information about local priorities is effective (Harwood et al 2007). There is also a place for understanding and linking the service development goals with the personal development plans of individuals (Currie et al 2007). A realistic assessment of baseline criteria relating to the local and wider context needs to be undertaken by leaders before embarking on PD (McSherry and Warr, 2008). This is important so that outcomes of the PD intervention can be measured (Grol et al 2005). Manley (2004) describes the components of transformational culture measured through cultural indicators. These include staff empowerment, patient-centred and quality services and the workplace context. A caveat to consider is that not every practitioner will be at the same point of development as the next (Rogers, 2003). Therefore, the interventions involved in the PD need to be considered carefully. The development of local, appropriate PD interventions could be most effective if an organisational context includes practice development leaders who have skills and qualities of empathy, motivation, vision, political awareness and sound communication, in addition to clinical experience and knowledge (Garbett et al 2002). In order to achieve this excellent and well connected communication would need to be an integrated feature of the PD.

3.4.2.5 Ensuring effective communication

The success of achieving PD goals is often dependent upon effective communication (NHS Centre for Reviews and Dissemination, 1999). This is because communication connected with PD is typically required across a range of people, geography and agencies. As such messages need to be shared in ways which that are relevant to the particular audience (Ferlie and Dopson, 2005). Multidirectional communication channels are needed during times of change to keep people informed and engaged (Thompson, 1993: McSherry and Warr, 2008). Effective communication is therefore an essential mechanism to the process of managing practice change. The service users' perspective needs to be the central source of feedback about how the effectiveness of patient care communication is perceived (Gulmans et al 2007).

Clinical leaders have a pivotal role to foster the partnership of managers and connect professional communities. An organisational culture which actively manages open communication is has been repeatedly suggested as essential to leading new knowledge into practice (McCluskey and Cusick, 2002: Gerrish and Clayton, 2004: Hammond and Klompenhouwer, 2005: Dopson and Fitgerald, 2005b).

3.4.2.6 Managing practice development change

Managing change may involve strategies such as piloting a PD in one local area before it is cascaded to the whole of the organisation (Dewing, 2008). Other management strategies can include promotion of the project via opinion leaders and taking account of the pressures that practitioners are faced with to tailor PD requests to local areas (The NHS Centre for Reviews and Dissemination, 1999). It is clear though that appropriate organisationally imposed mechanisms have a major impact on achieving some degree of development in practice (Redfern and Christian, 2003). Action research has once again been noted for its cyclical, structured project management qualities and has been associated with helpful processes of planning, acting and reflecting to advance practice development (Roth and Esdaile, 1999: Hampshire, 2000). Another example of PD management is offered by Forsyth et al (2005c). This training programme development within a health care service was one part of a PD. Description is provided of the approach was aimed to affect the use of evidence based assessments across one workforce of occupational therapists (Forsyth et al 2005b: Melton et al 2008). They do not however provide empirical evidence of the success of the initiative. Neither do they attempt to consider the effect upon each individual involved. They do hold encouraging anecdote about the success of a PD intervention that involved partnership working, building leadership skill, collaborating with practitioners, and utilising bespoke, structured education techniques. Arguably, any change achieved needs to be monitored in order to understand what mechanisms have been effective within a local situation.

3.4.2.7 Monitoring change in practice development

It is important then that the extent of change required for health care practice can be identified and monitored. However, there can be practical issues with capturing suitable data from PD interventions (The NHS Centre for Reviews and Dissemination, 1999). PD is often conceptualised as a continuous journey that is complex and multifaceted (McCormack et al 2004). McCormack et al's (2006) synthesis however concludes that little attention is generally given by investigators to the complexities of outcome measurement of PD. Some authors provide pragmatic exercises to undertake evaluation (Fraser, 2002). Wilson and McCormack (2006) however support idea of using realistic evaluation as a methodology for understanding the impact of PD activity particularly where there is an emancipatory goal. This notion is endorsed by the findings of Redfern and Christian (2003) who outline nine PD projects and discuss why some were successful and why others did not have the contextual conditions to facilitate change. This form of evaluation is helpful in establishing new ideas about how to support failing PD. Further discussion about understanding the outcome of PD was considered in Chapter Two.

This section has located leadership as an important element of structuring effective PD interventions. It has been argued that every health care practitioner has a responsibility to some degree for leading the development of practice. It has also argued that there are seven key elements of PD leadership which need to be attended to before embarking on PD processes. The seven areas included responsibilities to: explore barriers to change; foster commitment and coalition; provide incentive to change; identify local priorities for change held; monitor change in practice; ensure effective communication and to manage the change. By leaders being mindful of contextual features and required outcomes, the most appropriate PD interventions are more likely to be available for individuals and practice communities.

3.5 Structured interventions as mechanisms to develop practice

Chapter One (Section 1.5) introduced the idea that individual practitioners have a duty to engage with programmes which support the evolution of their professional skill and ability. The concepts of Practice Development (McSherry and Warr, 2008) and Quality Improvement (Nolte et al 2008) are emerging as important for structuring the development of health care practice. The literature implies that there are many important features of PD and QI which include collaboration, leadership and the organisational context and these will be explored further in the first part of this section. The literature is also clear that multiple interventions are more effective at developing practice than single interventions. Thus the choice of single or multiple interventions to achieve PD will be further critiqued towards the end of this section.

3.5.1 Practice Development and Quality Improvement:

It has been argued that providing a defined structure for clinical teams to develop their practice offers a positive change mechanism (Dewing, 2008: Stokes, 2004: Bezzant, 2008: Chin, 2003). Practice Development and Quality Improvement programmes are structures of this nature and these will be compared and contrasted in this section.

The evolution of PD as a concept has been relatively swift. Much of the published work available about the construct has emerged within the nursing literature (McCormack et al 2004: Pryor and Forbes, 2007: Garbett and McCormack, 2002: Cooke et al 2004: Dewing, 2008). However, there is some development of this thinking within the literature associated with allied health professionals and texts have emerged which target all health and social care disciplines (McSherry and Warr, 2008). Quality Improvement programmes, on the other hand, although having been located in general business culture for decades have recently been emerging in the development of medical practice and research (Nolte et al 2008). Such programmes have emerged primarily in the USA to support practitioners to provide care that is in harmony with knowledge about contemporary practice

(Institute of Medicine, 2001). Practice development programmes have had a similar goal but in addition have overtly fostered the purpose of emancipating the practice of non-medical health care professionals in order to improve effectiveness of the patient's complete experience (Garbett and McCormack, 2002a) (see Section 2.2.5).

It is clear that in some circumstances structured programmes to develop the quality of practice can be 'transformational' (Phillips et al 2002: Golden and Tee, 2004: Mezirow, 1990). Transformational PD aims to facilitate a context where in-depth, lived experiences of the PD result in significant, long-lasting, habituated and personally valued practice change (McCormack and Titchen, 2006). Commentators agree that an active and ongoing learning culture is required within an organisation for individual and collective practice epiphanies of this nature to occur (Manley, 2004: Currie, 2007: Bezzant, 2008: Dewing, 2008). Whilst much evaluation of PD activity has emerged from practice set in one physical environment, for example, hospital ward settings (Bezzant, 2008: Cooke et al 2004: Jinks and Marsden, 2007) there is evidence emerging that transformational PD can develop in 'virtual' clusters within professions (Fielding et al 2007). On the other hand it cannot be assumed that an effort to build practice in one area of an organisation will necessarily cascade to a different team (Ganz et al 2007). Thus the importance of attention to multifaceted contextual features is reinforced in order to ensure the success of a PD (Humphries, 1998: McCormack et al 2002: Gerrish and Clayton, 2004).

Despite the claim that structured programmes to develop practice can be transformational neither QI initiative nor PD programmes are overtly connected with *individually* motivated action (Pryor and Forbes, 2007). It has been argued that in any team a variety of individuals with different personalities, personal capacities, motivations, roles and relationships exist (Leberman et al 2006). Dictating areas of development could however constrain an individual's capacity to achieve their personal development goals (Jonassen and Grabowski, 1993:

Knowles et al 2005: Leberman et al 2006). For example, whilst audit activity as a tool for quality improvement has merit because of its goal to better practice (Berk and Callaly, 2003), some studies have revealed that this structure has not been consistently effective to develop practice (Jamtvedt et al 2003). It remains the case that there are no theories in the literature to illustrate how individual practice development and quality improvements can be achieved.

This section has argued that whilst PD and QI have evolved separately and do have some fundamental differences the goal to develop the quality of practice is common to both. Examples can be seen in the literature where the interventions utilised to develop practice are common to both PD and QI programmes. These will be considered next

3.5.2 Practice development interventions

The literature suggests that there are many and varied PD interventions to be appraised when aiming to introduce new or enhanced ways of working amongst a group of individuals. Walter et al (2005), for example systematically reviewed the effectiveness of different approaches for promoting the use of research findings. They studied literature from across different sectors with over half of the empirical articles being drawn from health care. Five key groups of interventions were identified as being deployed with the aim of developing research informed practice: dissemination, interaction, social influence facilitation and reinforcement. However, reflective practice interventions lack feature in this list which is puzzling as reflection has been suggested as a key way of equipping practitioners for the complex decision making required in practice (Girot, 1995). Higgs et al (2004) takes a different view of PD intervention and concentrate their text on the use of reflective practice interventions as the interventions for developing practice knowledge. They suggest that practice change requires individuals to develop a 'practical and discursive consciousness' as a way of shaping the development of practice in the professions of health care. Rather than extracting and defining categories of interventions there could be an argument for constructing a menu of

PD interventions for individuals to meet their learning needs and potential. In Chapter One (Section 1.5) the interventions used in the PD being evaluated in this thesis were introduced individually although they were administered as multiple set of PD interventions. Further brief discussion will be made next to consider the utility of introducing single or multi-strand interventions.

3.5.3 Single-strand practice development interventions

There are many examples in the literature where uni-dimensional PD interventions have been implemented and appraised (see for example Davis et al 1995: Walker, 2001: Jamtvedt et al 2003). Single-strand interventions which focus on group training, feedback or reminders are the PD interventions most commonly studied (Wensing and Grol, 1994).

Training and education for health care workers is often promoted as the key to raising standards Nolan et al 2008). Occupational therapists commonly discuss the benefits of attending training courses for specific new techniques (Curtin and Jaramazovic, 2001). Training could be provided by an organization but transfer of learning not necessarily supported within the specific clinical area (Chard, 2006) (see Chapter Two, Section 2.6.1).

It has been reported that practitioners expect to participate in didactic training as part of their lifelong learning and EBP development (Dysart and Tomlin, 2002: Bennett et al 2003: Taylor and Mitchell, 1990: Curtin and Jaramazovic, 2001). It does not necessarily follow though that this PD intervention activity always results in practice change (Davis et al 1995: Wensing and Grol, 1994). Research suggests that didactic education has not always been effective in practice change in health care (NHS Centre for Reviews and Dissemination, 1999). As an example from an occupational therapy perspective Chard (2000) investigated UK occupational therapists' response to attendance at postgraduate training focused on developing practice to include the administration of a specific, evidence based standardized assessment - the Assessment of Motor and Process Skills (AMPS). Her research

investigated whether and how therapists *used* these new skills in relation to their ongoing clinical practice. Her findings suggest that only 66% of occupational therapists in her study fully completed the course (completion required the therapist to be appraised in undertaking a number of the said assessments in practice) although 73% reported that they were using aspects of the new knowledge in their practice. The reasons why some individual practitioners find this process difficult was further investigated in a qualitative study (Chard, 2006). The conclusion is framed within the complexities of the diffusion process (Section 3.3.5). Chard suggests that even formal recommendations, delivered directly to clinicians, do not necessarily support them to change working methods. However, follow-up support provided from a trainer encourages reflection, practice application and further learning (D'Eon and AuYeung, 2001). An additional benefit is that therapists involved in setting up and delivering the training not only develop further knowledge but can also develop skills of teaching and facilitation (Forsyth et al 2005c). The introduction of a supported reflective opportunity as part of the learning process could facilitate further integration of new knowledge into practice (Lowe et al 2007).

Another way to access emerging information is through learning from others in the workplace (Eraut et al 2000b). Facilitated discussion with colleagues is an effective way of learning about practice theory (Keponen and Launiainen, 2008). This way a community of practitioners form to share expertise of using new knowledge and discuss its application in real practice. Confidence can be built and a culture of learning fostered through such structure (Lave and Wenger, 1991). However, the experience of facilitated discussion is not always positive (Sweeney et al 2001b). It has been suggested though that providing an opportunity to habitually reflect on practice can strengthen thinking particularly where a theoretical framework and common practice standards are used (Wimpenny et al, 2006). On the other hand, learning through 'doing' in practice also has merit. Kane (2007), for example, described a staged model for practice based learning. These include the acquisition of knowledge, interpreting findings from the application of

new knowledge, questioning assumptions about previous practice and constructing new knowledge through professional dialogue.

Time has been invested in some services to document uni-disciplinary pictorial and narrative care pathway standards that occupational therapists are expected to follow, where appropriate, in their practice (Duncan and Moody 2003: Melton et al 2008). These authors claim that setting practice standards support the therapist's responsibility for clinical reasoning with the information that they generate through assessment procedures. When undertaking clinical audit it is important to communicate with stakeholders to agree the standards which are to be measured (Mittman et al 1992). Without such an action orientated, collaborative approach audit results can be rendered unworkable (Berger, 1998). In other fields integrated audit has illustrated that positive change in practice can be achieved through setting protocols for practice audit (Charrier et al 2008).

The NHS Centre for Reviews and Dissemination (1999) suggest that some single interventions can be effective (for example, educational outreach, opinion leaders, patient-mediated interventions and reminders). In a literature review about implementing changes in primary care Wensing and Grol (1994) concur and also add individual instruction to the list of effective single strategies. However, even for what might be perceived as a simple message, for example implementing a clinical guideline (Prior et al 2008) several learning and development methods have been needed to make some changes in practice (Fitgerald et al 2005). If some practitioners are not subsequently able to integrate knowledge into practice, the prudence of investing service resources in single PD intervention delivered this way could be questioned (Fraser, 2001). However, services have to weigh this potentially less expensive option against the gains from the more expensive multi-strand initiatives through cost-benefit analysis (Price, 2008b). The review will now turn to the use of multi-strand PD interventions.

3.5.4 Multi-strand practice development interventions

The Advancing Research and Clinical Practice through Close Collaboration (ARCC) model (Fineout-Overholt et al 2004) is an example of a multi-activity approach to PD aiming to drive the implementation of new knowledge. They recommend that interventions for developing practice for health care services need to be multi-factorial. In Fineout-Overholt et al's study the PD interventions included; mentoring for advanced practitioners, partnerships between academics and practice settings, gaining research grants, dissemination events / meetings, on line dissemination methods, newsletter facility and educational programmes. Other studies lend strong support to a multi-activity PD position. For example the NHS Centre for Reviews and Dissemination (1999) aimed to summarize the literature to provide advice to those involved in practice change. Like Fineout-Overholt's findings they conclude that successful intervention strategies are likely to use a variety of learning methods to capture the attention and commitment of participants to engage. The integration of new knowledge into practice was also appraised in a Kings Fund study (Wye and McClenahan, 2000). It was concerned with 17 new multidisciplinary practices in a variety of hospital teams across the UK. This study also reflected an incomplete diffusion of new knowledge into practice. Although the PD interventions were not clear in this document they did suggest that resources to fund project interventions was critical and that sufficient time was required to see progress. Sufficient resource seems to be part of the mechanics that tip PD into action although cost-effectiveness studies are rare (Prior et al 2008). Resource plus the availability of multifaceted interventions which target different barriers to change are more likely to be effective than single interventions (NHS Centre for Reviews and Dissemination, 1999: Gerrish and Clayton, 2004: McCormack et al 2006: Dopson and Fitzgerald, 2005a: Walter et al 2005).

Some caution must be exercised though that even the use of multiple interventions does not always produce the desired outcome (Wensing and Grol, 1994). There is little attention to the impact of PD programmes on individuals currently available

in the literature. However more latterly, there does appear to be some consensus that tailoring interventions for potential users of the new knowledge is likely to be the most effective use of PD resources (Walter, 2005: Grol and Wensing, 2005: Tracey, 2007). This idea chimes with the key points made by learning theorists that different individuals will respond to different interventions depending upon their context and personal attributes (Jonassen and Grabowski, 1993: Knowles et al 2005: Leberman et al 2006. Fitgerald and Dopson (2005) agree with this position when they conclude that "multiple cues affect the processes of innovation utilization". In addition they touch on the notion that individuals respond in different ways to PD programs with the configuration of variables with the programme itself affecting engagement.

This section has noted the evolution of PD as a way of structuring and evaluating ways of causing change to occur in health care practice. It has identified that change requires a learning culture within an organisation in addition to individually motivated action. With regard to the construction of PD interventions the most appropriate package needs to be developed with consideration to the whole practice context, the learning area and the range of individuals involved in the process.

3.6 Chapter summary

This chapter has explored the mechanisms which cause PD amongst teams of individuals. Through consideration of the theories of change including social, organisational, individual and dynamic theories of change this chapter has argued that change is effected and affected by the interplay of the characteristics and social systems of an individual. It has introduced the common reasons for resistance to change in order to outline what emphasis needs to be placed on PD initiatives. The resistances are connected with lack of internal and / or external motivation, the challenge of changing routines, the trauma of change that is enforced and each individual personal attributes. All these have a bearing on the likelihood that a person will change their practice behaviour. Strong leadership has been proposed to have an impact on how people change and the tasks of leaders to

support, effect and manage change have also been located as a critical part of the system of a learning culture. With regard to PD interventions it has been argued through appraisal of both single and multiple intervention strategies that people and places are inherently different so differentiated mechanisms are required as catalysts for change amongst a team of individuals.

3.7 Summary of the literature chapters

There is much rhetoric in the literature about the need for health care practice to evolve in positive ways to meet the needs of service users, organisations and professional groups. There is also a plethora of literature available which defines the change theories, structures to support change in health care, examples of how these PD interventions can be evaluated and the challenges that have been met. Synthesis of the literature suggests that there is no standard PD format that works well in all circumstances. Therefore it can be deduced that different people respond to different stimuli and that the context also has an impact upon their engagement in PD programmes. However, the literature says very little about the differences in individual practitioner engagement from the same basic opportunities. Further investigation is needed to identify if individual differences, for example the impact of gender, culture or personality, play a part. A gap also remains in the literature as to how individuals' engagement in PD unfolds when they have the same basic set of prompts to change, update and develop their practice. This specific area is the focus of this thesis.

Chapter One gave an introduction to the *context* of this study. It provided information about occupational therapy, occupational therapists. It also introduced the conceptual theory underpinning the PD program and also the PD interventions adopted in this context. Chapter Two reviewed the literature connected with PD *outcomes* in order to understand what PD outcomes are expected through a structured PD programme. It was also concerned with briefly explaining the challenges that have been experienced in evaluating the outcomes of PD

programmes. This chapter has studied concepts of change and in particular what *mechanisms* in a PD programme support positive change to occur.

The researcher argues that different people will respond in different way to a change request. All responses are valid and in order to achieve the desired PD outcome, all need to be considered. As such broad argument will be presented about how individual*s* react to a package of PD intervention and illustrate that different mechanisms might be required to make the development of practice a reality for all individual professionals. A realist approach to thinking has been used to guide methodology and the methods chosen. These will be explained further in Chapters Four and Five respectively. Using Realistic Evaluation (Pawson and Tilley, 1997) this research aimed to provide insight in the form of 'middle range theories'. The underlying theoretical assumptions which underpinned this work will be discussed the next chapter. The study offers generalisable findings about how other similar programmes might be implemented successfully for different individuals.

3.8 Overarching Research Question

How does engagement in an evidence informed practice development programme play out for individual practitioners from the same basic prompt?

More specifically:

- What components of an individual's **context** support or inhibit activation of facilitating mechanisms?
- What are the PD **outcome** levels that can be expected from a range of individual practitioners' engagement in a PD programme?
- What are the **mechanisms** which best serve to support practice development for different individual practitioners?

Chapter Four -Theoretical Position and Methodology

4.1 Chapter overview

This study was a Realistic Evaluation (Pawson and Tilley, 1997) of how *individual* health care practitioners (in this case occupational therapists) responded to a particular PD programme. In other words the study aimed to understand how the engagement of different individuals in a PD programme played out from the same set of basic prompts.

This chapter will introduce the epistemological stance of the study, that of critical realism and more specifically the methodology of Realistic Evaluation (RE) which bases its position upon the interplay of a context, mechanism and outcome equation (see Section 4.3). Research studies which have used RE will be appraised as part of this chapter and the multi-strategy approach supported by RE will be explored further. In addition, the context of the study will be considered in terms of the theory and practice of reflexivity to argue the case for the methodological decision to adopt an insider researcher approach. Discussion about the specific methods used in this study will be explored in Chapter Five but this chapter will consider issues of insider research, reflexivity and power; triangulation; generalizability and trustworthiness.

4.2 Locating the theoretical perspective - Critical Realism

To locate the study within an appropriate philosophical stance time was taken to explore potential theoretical positions before the appropriate perspective emerged. The study aimed to *understand* how individuals engaged with PD so with this in mind the study was broadly structured within the interpretive paradigm (Crotty, 2003). Thus a context for grounding the principles and logic for the study become apparent.

Realists argue that there are many paths to the discovery of knowledge and truth (Maslow 1954). Critical realism which embraces this idea of plurality has been located as a crucial philosophy without which the emancipation of social sciences

is challenged (Bhaskar, 1989). As a way of viewing the world critical realism holds several interconnected theoretical positions which were relevant for the conceptualisation of this study. Firstly, critical realism maintains that the world can be understood from the real perspective of real people and real services (Porter, 2002). When considering that the study was concerned with the perspective of individuals within a particular context this theoretical position is relevant.

Critical realism also purports that understanding a situation involves different layers of reality so rather than positioning the research solely from the perspective of the individual or the organisation it takes a view that different perspectives draw the reality (Robson, 2002: Byng et al 2005). Finally critical realism claims that understanding the links between components of the layers of social reality processes is of concern (Pawson and Tilley, 1997). The implication of this position is that explanatory hypotheses can be generated and then subject to non-predictive but empirical test which will endeavour to explain reality (Bhaskar, 1989). Through realist research, this thesis supported the perspectives of individuals and their reality of engaging in PD. To illustrate this supporters of critical realism argue that the regularities seen in society are the result of the combination of influential forces causing social change (Byng et al 2005: Julnes and Mark, 1998). They go on to suggest that these forces or mechanisms which give rise to commonsense experience may be present even when not active and when actualized, may or may not be observable.

Whilst the position of critical realism has a particular distinction from the traditional view of interpretativism, there are principles in common with social science philosophy that can be upheld (Delanty, 1997). The particular complimentary notions here are that it is possible to achieve causal explanations and that social actors can and will interpret their social reality (Kincheloe and McLaren, 2000). However, this stance alone does not take into account the investigation of the underlying mechanisms that produce actions or the possibility that some actors may not have experienced a mechanism during an intervention

(Julnes and Mark, 1998). This study aimed to understand what mechanisms best serve to support practice development for different individual practitioners. Thus a broad perspective was required. Realists claim that reality exists in three domains: the 'empirical' (experiences or observable events), the 'actual' (events which may or may not be observed) and the 'real' (structures and process which make reality and produce change) (Proctor, 1998). In addition proponents of the genre of critical realism argue that the 'real' perspective has more relevance in evaluative studies than the post-modern approach to provide a descriptive account of practitioners' perceptions and feelings (Byng et al 2005).

When considering the perspective of critical realism it is important to mention the field of interpretativism as a whole and to note that within it there are different ways of theorizing about interpretive understanding (Schwandt, 2000). Considering the world from an interpretive perspective Schwandt implies that in order to locate meaning in an action, one must illuminate what research participants are doing in a particular way. Whilst critical realism sits within the family of interpretive perspective, it does have its own particular place in the descendants of interpretive thinking (Robson, 2002). This particularly relates to its views on 'real', 'truth' and particularly generalization (see Section 4.4.3). However, with a view of multi-causality an interpretive approach appears appropriate.

It can also be important to understand the research participants' real world in a temporal and environmental context (Brady, 2000). Critical realists acknowledge that social events are essentially meaningful and meanings cannot be simply mathematically calculated (Wilson and McCormack, 2006). Three distinct realms of critical realism have been described: the real, the actual and the empirical (Archer et al 1998: Proctor, 1998). These are conceptualized and contextualized neatly into PD research by Wilson and McCormack (2006). They describe the 'real' in terms of the mechanisms used to make an effect on a social circumstance, the 'actual' as describing the implementation of the PD mechanism and finally, the

'empirical' which allows an observation and description of what happens after the implementation of the mechanism.

The research connected with this thesis is concerned with individuals who are engaged in a variety of contextual situations. For example, the individuals work in different clinical areas within a single NHS trust, they have different roles within the organisation and different personal circumstances. It has been argued that the same interventions might produce different outcomes depending on the different contextual features present (Wilson and McCormack, 2006: Redfern, 1998: Leone, 2008: Pawson, 2006) which was anticipated to be the case in individuals' response to a programme of PD. The methodology of Realistic Evaluation (RE), underpinned by critical realism aims to offer this way of thinking.

This section has focused upon identifying the appropriate philosophical stance and theoretical position of the study. Broadly the study was located within the in the interpretive paradigm. The study aimed to *understand* how individuals engaged with PD so combining the interpretive philosophical stance with the methodological position of RE indicates the way in which this investigation was viewed.

4.3 The introduction of Realistic Evaluation

An introduction to Realistic Evaluation (Pawson and Tilley, 1997) and its general concerns are considered in this section. Several features will be presented including its focus on case based context; its consideration to evaluate programme outcomes and its support of a multi-strategy approach. Studies which use an RE approach will be appraised throughout and toward the latter end of this section the limitations of RE will be debated.

Evaluation within the field of social science is generally motivated towards social betterment (Mark et al 2000). The same authors go on to say that RE offers a view about how people go about making sense of the world. RE is a relatively new

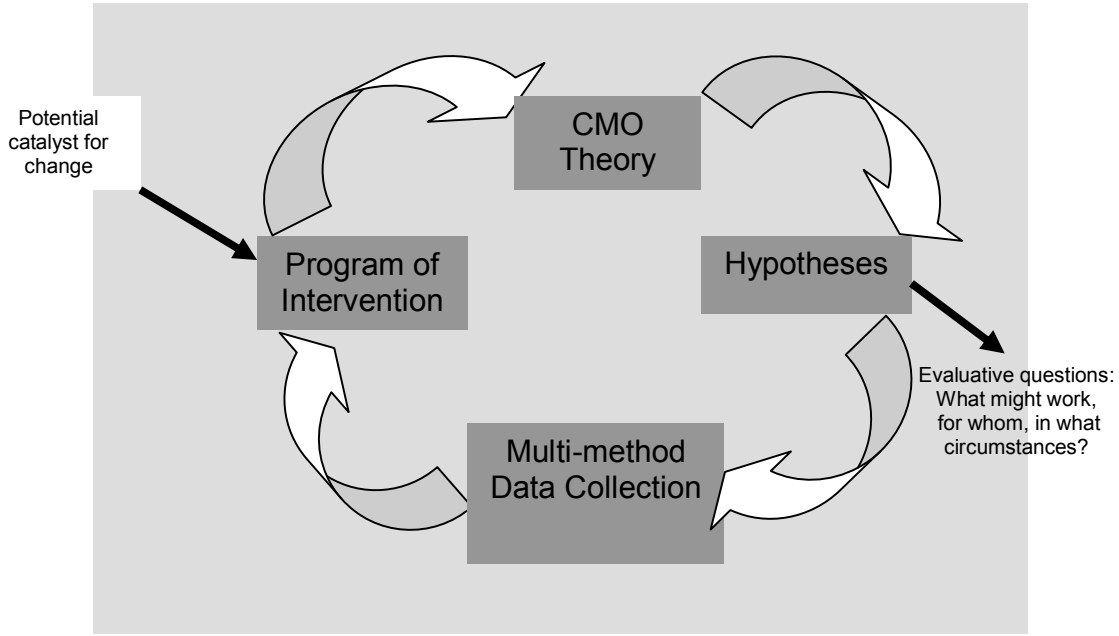
genre introduced by Pawson and Tilley (1997). It is considered as a theory-testing methodology (Pawson, 2003) and as a 'sense-making endeavour' (Julnes and Mark, 1998). The perspective of RE begins with a theory of "causal explanation based on generative principles" (Pawson and Tilley, 1997). In other words having theory-led strategies positions RE to consider which mechanisms are activated through an intervention, with what results even in multi-factorial circumstances (Dickinson, 2006). Thus, causal mechanisms are conceptualised as sensitive to contextual influences and their combination impacts upon the outcome within the social world (Mark et al 2000).

RE supposes that regularities in the patterning of social activities are brought about by the underlying *mechanisms* which are constituted by people's reasoning together with the resources that they are able to summon in a particular *context*. Realistic evaluation aims to expose, explain and therefore generate understanding of the internal workings of the mechanisms so that the new knowledge can be generalized to other situations if the context allows (Priest, 2006). Even though particular contexts cannot be divorced from consideration in an RE study the logic of the approach advocates that the power of a programme lies in its causal mechanisms (Leone, 2008). However, all of these elements, the context, the mechanisms and the outcomes, need to be considered as a whole as well as in relation to the various levels that they might be activated (Mark et al 2000). Pawson and Tilley's (1997) seminal work thus argues that the underlying mechanisms (M) triggered (or not) with particular contextual situations (C) influence the outcome (O) of an intervention effort. Establishing how contexts, mechanisms and outcomes relate to one another forms the basis of an explanatory and dynamic equation (the so-called C+M=O configuration) within an RE (Leone, 2008).

The research strategy of RE allowed the research to be considered as a cyclical process where the configurations CM+O theory leads to the development of

hypotheses in relation to individuals engaged in the programme. These were then investigated within the research process (see Figure 4.1).

Figure 4.1 The Realist Evaluation Cycle



Adapted from Pawson and Tilley, 1997 p: 85

The next subsections will use the CMO configuration to structure a discussion about the selection of RE for the contextual case of this study, the research outcomes achieved through other RE studies and consideration to the multiple methods that are supported within RE. In locating a methodological stance it is also important to consider the limitations of the genre and these will be explored in the final part of this section.

4.3.1 Selecting the contextual case for the Realistic Evaluation

Making sense out of a particular contextual or case study situation is particularly important in an RE study. Case study research is a means of establishing causal links in real life between an activity and its circumstances (Stake 2000: Edwards et al 2004). Situations which are too multifaceted for survey or experimental strategies can be explained through understanding the particular set of features

associated with a case (Dopson and Fitzgerald, 2005a). The focus on a particular case can also be valuable where the 'subjects' of research (in this case human participants) are complex (Scholz and Tietje, 2002). The same authors argue that the genre is useful where topics need to be holistically *explained* in relation to the contextual conditions. Research of this nature could also contribute to the wider context when it has utility within social policy (Pawson, 2006).

In realist research context is central for understanding human action and for understanding what counts as action from the actors' point of view (Locock et al 2005). Human beings live in a world that is constructed socially, physically and temporally. All social programmes rely on the interplay between institution and individual, the point being that real life does not reflect laboratory conditions. A strength of RE is its capacity to consider multifaceted programmes in multifaceted contexts (rather than only looking at one facet to reduce variables) and to consider the outcomes that are measures of quality of life (Forbes and Griffiths, 2002). At the same time criticism has been levelled at RE that 'contexts' are difficult to conceptualize and that they are sometimes difficult to differentiate from mechanisms (Dickinson, 2006). There is also the complexity of contextual hierarchy which may limit the recognition of CMO configurations (Ho, 1999). With this in mind it appears important that clarity of these terms and conceptual facets evolve to guide researchers who take an RE approach.

Research which involves the study of particular cases has been criticized for being subjective, sometimes anecdotal and too specific for findings to be used elsewhere (Wensing et al 2005). However where the importance of being specific overshadows the requirement of simplifying variables, case study research is an appropriate choice (Pawson and Tilley, 1997). Stake (1995), takes a pragmatic view and suggests that a case is studied when it is of very special interest and there is a need to understand activity within a particular circumstances. He argues that case study is "not a methodological choice but a choice of what is to be studied" (Stake, 2000). Realistic Evaluation has an overt focus and concern about

contextual influence so the study of cases as part of an RE investigation, such as the one described through this thesis is fundamental. In this research, the contextual 'case' can be described in layers. These are represented as the particular organisation which was committed to a particular PD programme with the goal of achieving particular outcomes by therapists.

4.3.2 Appraising the Outcome of Realistic Evaluation studies

The strengths of RE to evaluate the outcome of complex health care matters will be the focus here. RE is relatively new and as such there is not yet a multitude of studies of this nature to appraise although there are calls for its application in complex situations. Floyd et al 2004, for example note the potential of a RE framework to understand the complexities of what vocational rehabilitation works for which groups of individuals in which circumstances.

Whilst it had reportedly been a challenge to gain investment in studies of this nature (Redfern et al 2003) a growing number of investigations have, more latterly, been reported using this genre. For example RE has been used to evaluate new and emerging roles in health care (McCormack and Slater, 2006: Macduff and West, 2005). It has also underpinned studies concerned with health oriented intervention techniques (Leone 2008: Priest, 2006: Priest and Waters, 2007: Byng et al 2005) and assessment tools (Wilson, 2007). A study connected with work place context in health care has also been undertaken (Wilson et al 2005). The contribution made by some of these studies will be briefly considered next.

McCormack and Slater (2006) explained the utility of an RE framework in their study which aimed to clarify what difference was made to practice by the employment of clinical education facilitators. Here, mechanisms were conceptualized as those strategies employed by the clinical education facilitators to assist the learning experiences of nurses. They concluded that in the clinical context studied the dominant mechanism of 'classroom-based training and development' was ineffective in creating a culture of learning in clinical practice. Through research of this nature further CMO configurations could be hypothesized

to foster more effective and efficient use of the role. Macduff and West (2005) on the other hand adapt the wording of CMO to consider 'process' rather than mechanisms in their design. It is not clear from the account why the definition was changed but their results suggest fidelity to an RE study. Their analysis is synthesized to identify the typology of approaches to the new 'family health nurse' role and illustrates what processes successfully produce positive practice outcomes, in what circumstances. Like McCormack and Slater's study this also sets new hypotheses but takes a step further in locating these in a broader geographical framework.

Further examples of RE studies can also be found in health care literature where clinical intervention modes have been evaluated using CMO theories. Leone (2008) undertook a study to understand in what circumstance a set of interventions aimed at preventing recurrence of drug misuse by people found in possession of illicit drugs would work to modify behaviour of the recipients of the intervention. The sophistication of her study enabled a glance at the complexities involved and highlighted how contexts (for example the living location of a person) had a significant impact upon the uptake and success of interventions which had 'sanction-based' and 'treatment-based' mechanisms. The mixed method design utilized survey, individual interviews, focus groups and analysis of routine monitoring data as methods of collecting data about the participants engaged in the prevention programme. The study enabled recommendations to be made to policy makers about the various interventions that needed to be provided to work to best effect for the particular groups of people identified. The methodology also indicated where specific interventions did not work or the targeted outcomes of the intervention were not observed. In these cases either the change mechanisms were not activated or they were not observed (23% of the sample group did not engage in the research). In this case then, the RE approach for the methods used to gather data in this instance was limited in its ability to identify what would work to prevent all the different groups from reengaging in drug-misuse related behaviour.

Other authors illustrate how they have used what would be more traditionally described as positivist methods within their RE research design. In their ground-breaking study, Byng et al (2005) for example complimented a randomized controlled trail with a RE to appraise a practice intervention with people with long-term mental illness. The researchers were clear that though the RCT was helpful, it gave mixed results amongst the cases studied and did not provide any conclusions about the effectiveness or efficiency of the PD intervention. Whilst they acknowledge the methodological limitations of this combination they also note that the CMO configurations that were generated did help to explain what occurred in the intervention process. They conclude by outlining the reality of needing to identify the multiple contextual situations and multiple supporting mechanisms in order to evaluate the outcome of the mental health 'link' programme.

It is important to recognize mechanisms at the micro level at which they occur rather than being interpreted as grander programmes or theories of practice (Dickinson, 2006). For example, Priest (2006) reports a study using RE to outline the mechanisms that assisted Australian pre school children to develop skills. Priest suggests some causal mechanisms such as 'parents supporting their children more at home' which have a different nature from the mechanisms defined by Pawson and Tilley (1997). These mechanisms are not reactions of the individual to an aspect of the programme, they are arguably contextual variables. Whilst much of Priest's study has great utility some of the results would benefit from a greater level of critique, abstraction and synthesis of the emerging mechanisms.

In practical terms, RE has in recent times proved a useful genre for studies which aim to understand the impact of PD interventions within particular population groups, for example in special care nurseries (Wilson et al 2005: Priest, 2006); primary care (Secker et al 2005); substance misuse (Leone, 2008); mental health (Byng et al 2005) care of older people (Tolson, 1999). Wilson et al (2005) used RE as the underpinning methodology to gain an understanding of the workplace

culture of a special care nursery. Using mixed methods of survey, participant observation and interviews they reported on the core values and beliefs that were perceived as important by practitioners for practice. Whilst their description did not speak in depth of causal mechanisms of successful practice per se they did focus their results on the in-depth tensions within this micro-cultural context as a precursor to introducing a PD initiative into the environment.

Despite an extensive search of the literature, studies which specifically looked at the mechanisms which triggered PD in individuals change using RE was not located. It was decided that there was room for further studies of this nature.

Having considered the outcome and contribution to knowledge generation that RE studies can make a methodological question arises about whether RE is inherently multi-strategy in its approach or whether second level methodological decisions are being made. The next section will consider this further.

4.3.3 Realistic Evaluation as a multi-strategy approach

It is important to gain a real and broad perspective in a world where many realities exist (Pawson and Tilley, 1997). To achieve this pluralist thinking about research method selection needs to be adopted. The selection of multiple methods of data collection is relatively common in RE studies (McCormack and Slater, 2006: Macduff and West, 2005: Leone, 2008: Priest, 2006: Priest and Waters, 2007: Byng et al 2005: Wilson, 2007: Wilson et al 2005). Despite this questions have been raised in the past about the prudence of combining different methods within a single piece of research (Brannen, 1992). However, contemporary conceptualisation adopts a view that mixing methods can have a legitimate, practical utility (Creswell, 2002: Tashakkori and Teddlie, 1998) and contribute to the increased trustworthiness of a study (Conneeley, 2002).

By adopting a realist approach researchers can embark on studies which support the generation of critical segments of data (Proctor, 1998). RE concentrates on the theory of the desired changes so the collection of data relating to all the causal

factors of change are encouraged (Leone, 2008). Views have been expressed that assuming a one sided approach to data collection has limited use and carries some risk (Hammersley, 1992). Whilst this might imply an avoidance of a positive approach there is a view, that the notion of probability, albeit a realist form of probability, should be embraced when appropriate in RE studies (Williams and Dyer, 2004). This opens the way for quantitative methods to support the discovery of causal mechanisms and provide outcome data for some RE research.

Commentators have suggested that using a mixture of methods has utility and credibility when creating pathways to answering matters of research enquiry (Haverkamp et al 2005: Tashakkori and Teddlie, 1998). Furthermore, it is possible to enhance research findings by converging or conveying findings from different data sources (Creswell, 2003). Rather than being wed to a particular theoretical style and its most compatible method, researchers should combine methods encouraging integration and synthesis of knowledge and perspective. Consequently the use of a multi-strategy approach was a secondary methodological decision used within the research of this thesis. The theoretical utility and practical design of these are discussed in Chapter Five (Section 5.2).

4.3.4 The limits of Realistic Evaluation

A criticism and potential limiting factor of RE is its underpinning position that evaluation should be led by theory rather than laden with theory (Pawson and Tilley, 1997). This might lead to the view that theory does not take a large enough part in the research genre of RE or that the title itself removes it from being a philosophical position. Realism's key feature is its stress on the real mechanics of enquiry about the real world (Robson, 2002). Attempts to illustrate the utility of PD strategies will lead to a progressive body of scientific knowledge to support realistic clinical practice in health care (Wilson and McCormack, 2006). This is an important stance when consideration is given to the challenge of disentangling the complexities of social action. It is however essential that over time further evaluation and realist synthesis of results occurs (Redfern, 1998: Pawson, 2006).

Another critique of realism could be that it is unspectacular, simplistic and that commonsense tells us that there is a real world to discover. It could appear linear and might be difficult to utilise in complex situations. Though in many ways it sounds effortless the underpinning history and concepts are actually complex (Pawson and Tilley, 1997). Dickinson (2006) argues that the strength of the RE approach lies in the connection between the mechanism, context and outcome as it offers researchers the ability to undertake comprehensive evaluation research. Moreover, RE was designed with the purpose of trying to overcome some of the challenges posed with the measurement of social structures (Wilson and McCormack, 2006). However, if undertaken on a larger scale there could be issues of inter-evaluator reliability where CMO configurations could be conceptualized in different ways (Ho, 1999).

An additional perspective is that realism is 'positivism in disguise' (Mark et al, 2000). Henry et al (1998) have an alternative argument and suggest that discovering the meaningful patterns that make up reality is what will enhance empirical understanding of the world. A pragmatic perspective is that RE is better suited to some areas of evaluation than others (Ho, 1999). Whilst it is important that RE based research is able to recognize, express and examine inferred context-mechanism-outcome (CMO) configurations it is also important that it is framed as a response to an appropriate area of enquiry.

This section has introduced the genre of RE as a methodological stance for this research study. It has argued that the realist perspective of RE provides an appropriate position from which to answer the research and its ability to embrace a multi-method approach further confirms the selection. The next section will debate further the selection of RE for this study.

4.4 Realistic Evaluation and this study

The rationale for using the broad methodological position of RE has already been rehearsed in this chapter. Some methodological considerations particularly relating

to the research design and data handling will be explained further in Chapter Five. This section will attend to some additional important features of methodological concern particularly relating to the trustworthiness of the data which emerged. These include matters of:

- Insider Research, reflexivity and power
- Triangulation
- Generalizability

4.4.1 Insider research, reflexivity and power.

This section describes and discusses some of the issues that arose as a consequence of my duel role of researcher and lead practitioner. As such it is appropriate for the section to be written in the first person (Richardson, 2000). A central part of this study context was my status as an insider researcher, researching in the organisation which employed me as a senior practitioner and practice development leader. Swan (2008) identifies that the researcher's ability to interpret their own experience and its connection to power relations within a study can enable the discovery of new sense from old experiences. As such the researcher is acknowledged as part of and influential in the social and historic milieu or the research context (Kuper et al 2008).

In the research context I was studying with participants to whom at other times I provided practice leadership. Throughout the longevity of my career I had experience of a personal practice development journey much of which evolved from my own curiosity, motivation to learn and connection with academic scholars rather than participation in a formal PD structure. My experience spanned significant time as a senior practitioner, educator and leader in the fields of mental health and learning disability practice. I was also closely involved in the development and cascade of the PD programme being evaluated. Inevitably as the researcher I was an integral part of the study and had an impact upon the study findings.

There is potential for criticism of the ethics and trustworthiness of research where the researcher is an 'insider' in the context of the research (Conneeley, 2002). Darra (2008) suggested that in order for insider research to be ethically sound researchers need to be aware of the emotional impact of the research process on both participants and researcher and have strategies to ensure that no harm occurs to those involved. This is important to achieve as the interpretive paradigm supports insider research by asserting that researchers need to thoroughly immerse themselves in the phenomenon that they wish to interpret and understand in order that meaningful interpretation of human experience can be achieved (Denzin, 1989). Ferber (2006) agrees and suggests that by deconstructing the outsider/ insider debate it is evident that insiders do not consider themselves merely subjective. Thus, the insider researcher position can be viewed as a position of legitimate strength and rigor in research of this nature (Robson 2002). Reflexivity, both personal and methodological has been proposed as an essential element of every research investigation to consider the ethical issues that emerge (Finlay, 1998).

The concept of role change in the experience of clinicians who also have researcher responsibilities has been examined (Cusick, 2000). Like the practitioners in Cusick's study, I chose to openly adopt a different persona to the one usually assumed in the organisation, that of researcher rather than leader. I introduced myself in this way to all the participants who knew me in a different capacity and I dressed differently to my usual leadership role. Other strategies were incorporated including the offer to meet the participants in a place of their choice, at their convenience and ensuring very clear, explicit consent before joining them or approaching their clients. In order to generate objective information, the ambience facilitated during the interviews was genial and informal but not social.

Reflexivity is a process where subjective elements can be captured and analysed in order to provide deeper understanding (Finlay, 1998). It has been considered as an essential element of any study whether qualitative or quantitative as a way of demonstrating trustworthiness of findings and ensuring the human aspect of research participants is represented (Kingdon, 2005). An important criterion for good research is that data are not taken for granted by the researcher (Holliday, 2002). It is arguably not possible for the researcher to be consistently inside or outside the research so using a reflexive approach supports a more realistic science base (May, 2004). When using a reflexive approach rather than making futile attempts to eliminate my values or remove the impact of my own knowledge from the situation, I set about to understand them and use my presence as a catalyst to reveal data (Holliday, 2002). Furthermore, by using reflexivity, subjectivity in research can be transformed from dilemma to opportunity (Finlay and Gough, 2003).

Finlay (2003) has proposed five types of reflexivity which included:

- Personal reflexivity: introspection
- Meaning and reflexivity as inter-subjective reflection
- Mutual reflexivity: collaboration
- Reflexivity as social critique
- Reflexivity as ironic deconstruction

These will be considered in turn with regard to the issues of reflexivity connected with my research process and will draw on my insider researcher status and the power dynamics of the research context.

4.4.1.1 Personal reflexivity: introspection

Swan (2008) looked at the notion of introspective reflexivity which considers how researchers express their own thoughts, feelings, experiences and personal biases of the research topic and process. They go on to caution about a ‘confessional’

style but advocate that researchers speak *with* their experience rather than *about* their experience. My reflexive journal and research supervision supported my reflexivity here. It was important to challenge assumptions that I held about my objectivity and the values that I held about professional practice and my own development and motivation. I was also able to better spot the transference that occurred in my thinking when I was engaged in data collection with participants (See for example, Reflexive Quote in Section 7.2.4).

My position enabled me to undertake an overt filter of the information gathered through my particular knowledge and experience of the cultural context of the research setting. I had relevant clinical skills which enabled clinical data to be understood and interpreted so the data could be observed in a more detailed way. I brought an enquiring mind, the skills of being a good listener, general sensitivity which had been noted to be important attributes toward insider research (Robson, 2002). Using myself productively in the research enabled me to take a critical gaze at the emotional investment that I had in the study. This is described by Finlay and Gough (2003) as '*reflexivity as inter-subjective reflection'*. Avoiding a confessional stance was an important aspect of this reflexivity in order that my values did not overshadow those of the participant and a shift away from the phenomena being studied (Greenbank, 2003).

4.4.1.2 Meaning and reflexivity: inter-subjective reflection

In drawing together the themes of seeking meaning from participants it is clear that the perspectives of research participants and those of the researcher are critical to the methodological position (Kingdon, 2005: Ellis and Bochner, 2000). In this reality it is not only impossible for the researcher to remain neutral about the best way to study the social world but also undesirable (Greenbank, 2003). Some theorists argue that the researcher can never get outside the interpretative process (Denzin, 1989).

Exploring meanings which are involved in the research relationships forms the basis of this type of reflexivity. In order to do this I was conscientious to reflect and record my interactions with research participants to consider how the data gathering was influenced. Examples of this reflexivity can be seen in the results chapters (See for example, Reflexive Quote in 7.2.1) where reflexive quotes are provided to explain the nature of the relationship between researcher and participant.

4.4.1.3 Mutual reflexivity: collaboration

Mutual collaboration involves engaging participants in the understanding the data as part of the research process (Kingdon, 2005). Participants in this research were encouraged to feedback about the impact of my presence on their practice whilst data collection was underway and were also invited to read and comment upon research scripts. At a later stage participants were also invited where possible to comment upon the interpretations made through analysis of the data in a form of 'member checking' (Conneeley, 2002). These strategies added to the trustworthiness of the data and offered opportunity for reflexive account to be unpicked.

I was aware that my knowledge about people and the context did sometimes influence the interviews and observations. This was particularly relevant when I knew (or thought that I knew) the respondents from contact prior to the research. In order to counteract this and to foster collaborative reflexivity the interviews were constructed in a way that I encouraged challenge to any pre-conceptions held (Conneeley, 2002).

4.4.1.4 Reflexivity as social critique

Understanding the issue of authority in research through critique of the social construct of relationships is an essential element in insider research (Ferber, 2006).

It is important to give voice to the nature of the authority held by the researcher or by participants, in other words to understand and be overt about the potential power dynamics within the relationship (Conneeley, 2002). Again my reflexive journal was useful here to grapple with what authority I perceived and what impact I felt this was having. In addition, I was able to note what participants were expressing about this reality. (See for example, Reflexive Quote in 7.2.3).

4.4.1.5 Reflexivity as ironic deconstruction

Allowing all the voices within a study to be heard can be a challenge within insider research. The researcher needs to carefully consider the potential for her values to dominate and actively foster new views to be included through the data collection (Kingdon, 2005). In addition to notes in my reflexive journal I was able to consider matters of this nature with my research supervisors which added an 'outsider' perspective to the insider research (Robson, 2002). See for example, Reflexive Quote in 7.2.2

In order to address potential issues of my bias in the data or my potential blindness to new perspectives I structured my data gathering to reduce the impact of my own assumptions and beliefs (Conneeley, 2002). For example, I was careful not to become overtly reactive to the perspectives that participants shared or how they conducted their practice and would instead record my feelings about what I had heard and seen following data collection. This action allowed the participants expressions to be made whilst minimising my impact on their message.

Avoiding reflexive analysis and being invisible in the research process compromises the integrity and trustworthiness of the research (Kingdon, 2005). On the other hand it would be inaccurate to represent reflexivity as unproblematic and the use of this process has been described as a challenge in itself by proponents of its use (Finlay and Gough, 2003: Greenbank, 2003). This position is compounded

by the fact that the term reflexivity is used in many different senses which may propagate confusion rather than clarifying underlying issues (Holland, 1999). It requires significant researcher effort to identify and interrogate personal and professional courses of thinking and action (Ellis and Bochner, 2000). The interpretivists' view however that reflexivity is a natural process which adds richness to the data, illuminates potential power dynamics, undertaken well adds trustworthiness and enables the researcher to embrace and understand the data to best effect (Conneeley, 2002). Triangulation of data sources can also add to issues of trustworthiness of findings and will be discussed next.

4.4.2 Triangulation

Triangulation has been described in a variety of ways in the literature (Moran-Ellis et al, 2006). Triangulation is a widely used and valuable strategy (Robson, 2002). One type of triangulation involves the use of multiple research methods to enhance the rigor of the research (Bryman, 2006). For example, Cresswell (1998) concludes that data collected via multiple research methods is an effective way of checking pieces of information against other independent data sources to accurately 'measure' the phenomenon (see analysis Section 5.7). This action can increase confidence in the results supporting validity. Other commentators reject this as a superficial and potentially flawed way of considering the data (Walkerdine et al 2002). Walkerdine et al go on to consider triangulation as most useful to discover meaning and 'truth' from various perspectives and suggest that research that involves the integration of various types of data supports this outcome. Morgan-Ellis et al (2006) agree but focus their discussion on the process of integrating research results rather than only the outcome. They assert that it is a way of discovering more about a phenomenon than could have been achieved from a single method.

Another form of triangulation involves the combining quantitative and qualitative approaches (Robson, 2002). In Chapter Five (Section 5.2) detail is provided about

how mixed methods were incorporated into the research design for different reasons. Whilst some authors suggest that the use of mixed methods is a way of transcending research paradigms others might argue that when using a single methodological framework which celebrates plurality it acts to theoretically unite the different methods (Ellis-Morgan, 2006). Other authors suggest that using mixed methods affords the opportunity for triangulation in addition to other methodological benefits. For example, Bryman (2006) propose that allows 'complementarily' or further elaboration of results from the variety of data available. He also advises that results from one method can help the development of other results and that mixed methods can generate new perspectives from the paradoxes that may emerge. Finally, Bryman puts forward the opinion that mixed methods can also offer expansion to the results because of the different data components. This research has utilised triangulation to both enhance trustworthiness of the findings and support the generalizability of the results.

4.4.3 Generalizability

Issues of generalizability are discussed frequently within the qualitative research literature and criticism has been noted where research is context specific (Greenwood and Levin, 2000). The debate here is that the findings of research undertaken in specific situations can only be relevant in the context of the study. However, realists would argue that the commonalities and differences that occur within a given context can and should be analyzed and abstracted (Proctor, 1998). Indeed some realists reject the assumption that reality is too contextually complex to observe meaningful regularities (Mark et al 2000).

A critical realist view in an evaluation process allows results to be utilized successfully in differing contexts and is particularly helpful when considering what intervention works, for whom and in what circumstances (Byng et al 2005). This position is in contrast to constructivism where the limited reality or concentration on relativism would limit generalizability (Pawson, 2002). It also differs from a positivist approach where little or no attention is given to that which cannot be quantified (Forbes and Griffiths, 2002: Keat and Urry, 1982). With a

positivist approach the applicability of research results in the real and complex world is arguably reduced. Although discoveries can be made through this genre about the degree to which an intervention works for some people it does not give attention to the times and reasons why an intervention does not work (Pawson, 2006). There is a need then to ensure that research of qualitative nature is credible through the provision of sufficient detail in the research report for the process to be critically appraised (Robson, 2002).

In methodological terms of this research, the context of each of the participants engaged in the PD Trust is important. The evaluation is based around health care work with patients who experience the challenge of long term conditions. The project results in terms of generalizability may be located in, for example, mental health, older people's services and learning disabilities services. However, due to the level of abstraction the results may hold interest for practitioners in other fields, for example acute physical hospital care. The results may also have resonance for other disciplines in terms of their PD activities.

This section has considered important methodological aspects of this research design. It has been concluded that the insider researcher status was an important feature of the study and required robust and overt reflexivity to understand and display the issues of power which emerged. Triangulation of data has also been explored and emphasis has been provided about the utility of triangulating data. Furthermore issues of generalizability were outlined to further explain the trustworthiness of the research design.

4.5 Chapter summary and study hypotheses

Acknowledging the theoretical underpinnings and influencing factors of any study is important in order to locate the research focus and to highlight the supporting paradigm. Without this research can be charged with a lack of rigor (Wilson and McCormack, 2006). This chapter has located the study area within the qualitative interpretive paradigm, more specifically discussing the case for the underpinning views of critical realism and Realistic Evaluation.

The epistemological position of critical realism has been outlined as the lens through which this investigation was conceptualized. Though critical realism belongs to the interpretive family it differs from other family members in important ways. This particularly relates to its views on 'real', 'truth' and particularly generalization. Although it is not a member of the positivist family it does have the same concern to investigate 'what works' but its specific focus also addresses 'how' and 'why' an intervention works. This background led to a discussion about insider research, reflexivity, and power which has formed an important part of the methodological structure of this investigation and it has been argued that attention to these areas has strengthened the trustworthiness of the research process. In relation to searching for 'truth' through the research process the incorporation of triangulation of appropriate research methods is also incorporated. It is argued that this strengthens the ability of the research to answer the research questions (see Section 3.8) posed to a deep level. As such the level of abstraction achieved through the research design has enabled the research to have applicability or generalizability to other areas.

The next chapter will describe the research design which was constructed to consider the methods required to test each hypothesis underpinning this study. These study hypotheses are embedded in the CMO equation of RE methodology and include that:

1. The immediate environmental context and each person's own attributes have an influence upon their capacity to activate facilitating mechanisms.
2. The level of practice development outcome will vary for different individuals.
3 It is possible to identify the mechanisms which when activated are a catalyst for practice change.

Chapter Five -Research Design

5.1 Chapter overview

The fundamental methodological position of this research was located in the previous chapter. This section will introduce the design of the study which was structured into four phases. These phases will be described and considered in turn in the order that they were undertaken (see Figure 5.1). Firstly a description of the preliminary work associated with this study will be explained. Here, detail will be given about the rationale for choosing particular methods which was essentially to provide data to answer the research questions (see Chapter Four, Section 4.3.3). The research questions relate to understanding the contexts, mechanisms and outcomes of individuals' engagement in PD. In addition the methodological rationale and process of developing of the research tools will be described in the 'Preliminary work', Section 5.2. These included a survey, semi-structured interview schedules, an observation schedule and an audit tool. Phase One of the study design will be considered in the Section 5.3 of this chapter. It will outline the sampling processes for each phase of the study. Undertaking a pilot of the main study will be outlined in Section 5.4. This is followed by an account of the main study processes in addition to ethical and data protection issues. Discussion about these areas has been placed towards the end of the chapter. This is because it makes sense to describe what safeguards were undertaken after the reader has seen what data were collected and by what means. Information about how the data were analysed is provided and the chapter concludes with some basic demographic results. To begin with though, an account of the preliminary work undertaken will be given.

5.2 Preliminary work – Defining the issues

This section will introduce the preliminary work which was undertaken to define the issues for the evaluation and to further refine the study design (see Figure 5.1). Preliminary work was needed in this study for several reasons. Firstly, it was

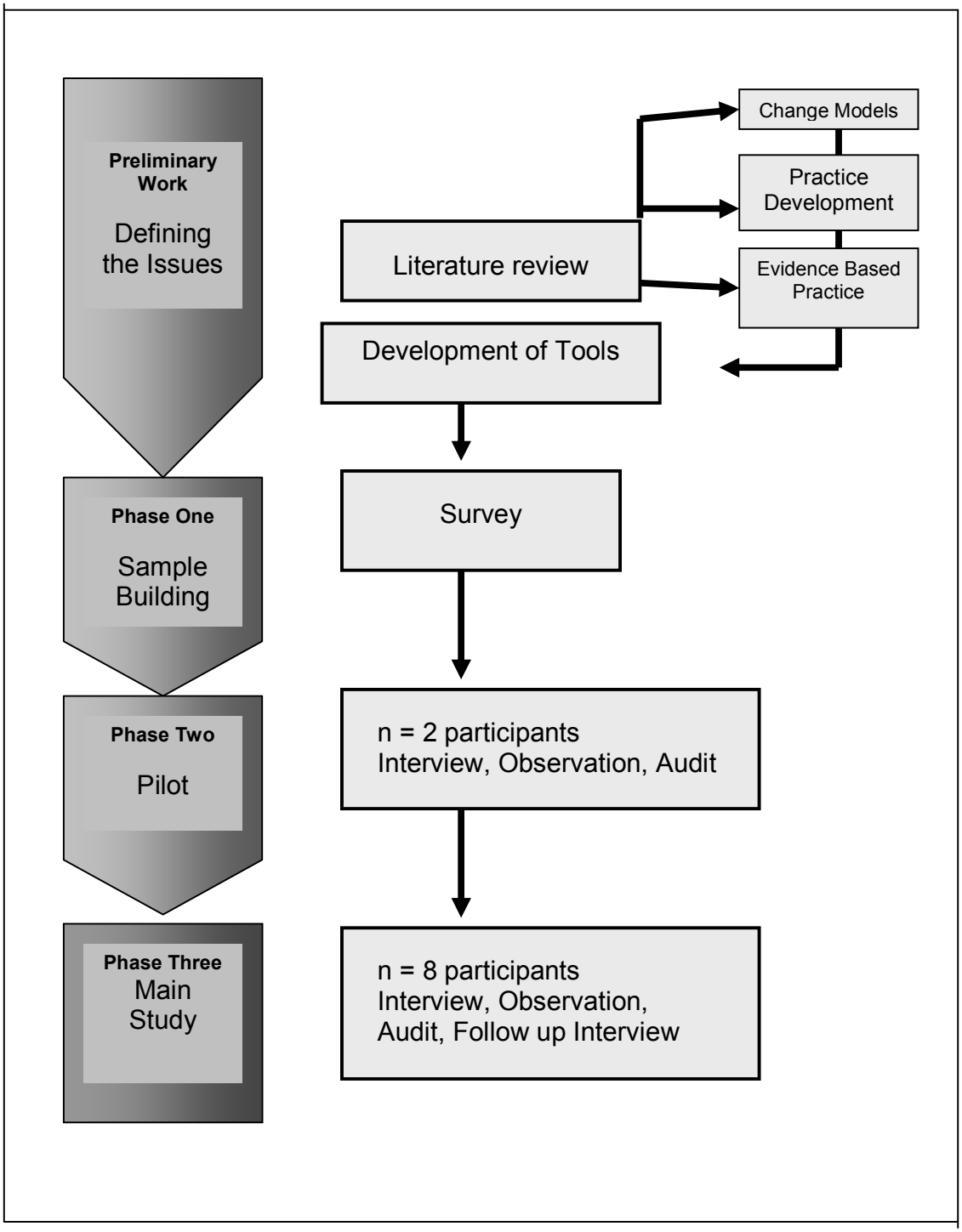
important to review the literature available which related to the topic of this study. This enabled the research question to be framed in relation to what was known and what needed to be understood further (Arbesman and Tsang, 2006). It also enabled the research design to emerge (Cronin et al 2008). Discussion about the reviewed literature is provided in Chapters Two and Three. This process emphasised the gap in the literature about how individuals engage in PD. Another important part of the preliminary work involved making decisions about theoretical perspectives and philosophical stance. This has been discussed in Chapter Four. The methodology of RE was used to underpin this study as it takes a perspective of understanding what the outcomes of PD are for individuals in relation to their own contexts. It is also interested in the causation of change through the activation of mechanisms. Neither of these areas of preliminary work will be rehearsed further at this point.

The preliminary work discussed in this chapter involved designing a three phased procedure over a 2 year period to gather the research data. In this section each method will be introduced sequentially. This section will also include the methodological rationale and the development process for the survey, semi-structured interview, observation schedule and audit tool.

For each of the methods developed the researcher's own practice knowledge was important in order that the instruments reflected the essence of the specific PD programme that was being implemented in the field (Conneeley, 2002). Conneeley goes on to say that as an insider-researcher the investigator is herself an instrument through which data are gathered (see Chapter Four, Section 4.4.1).

Realistic Evaluation inherently supports plurality in the selection of methods (see Chapter Four, Section 4.3.2). This encourages the understanding of realities from a variety of perspectives and enables the choice of method to be selected to answer the specific form of hypotheses developed (Pawson and Tilley, 1997). As such mixed methods of data collection were selected for this study, in part to bring together a more comprehensive account of the area of enquiry (Bryman, 2006).

Figure 5.1 The Data Collection Phases



Within the preliminary work phase, four types of research tools were developed. These included:

- **A Single Question Survey** (see Appendix 1).
- **Semi-structured Interview Schedules (**see Appendix 2a and 2b**).**
- **An Observation Schedule**(Appendix 3)
- **An Audit of Documentation protocol** (Appendix 4)

The Single Question Survey was essentially a process developed and undertaken to acquire an appropriate sample of participants for the main study. The development of the survey will be discussed in Section 5.2.1. The main study comprised the other data collection tools above and these were developed to gain a holistic view of each question which emerged from the research hypotheses. The combination of research methods can be helpful in taking into account as many aspects of a problem as possible (Flick, 2002). With regard to the study of therapy outcomes it has been suggested that mixed methods can offer a flexible yet rigorous approach to gathering data (Corcoran, 2006). The methods used for the main study were of a qualitative nature. These are well suited to realistic enquiry in practice situations where the real world is conceptualised as stratified into different layers (Robson, 2002).

A more detailed rationale for the use of each method in this study together with an account of the development of each associated research tool will be described in the four sections that follow.

5.2.1 Development of the Single Question Survey

The methodological decision to develop a single question survey tool was taken as a means of developing the study (Bryman, 2006). Survey is characterised by using structured questions to elicit self-report information from a sample of people (Forsyth and Kviz, 2006). The survey was primarily designed in order to produce a 'maximum variance sample' (Creswell, 1998) for using in sampling procedures for the pilot and main study. As such it was designed to be administered to all the occupational therapists in the PD organisation (n = 74). This allowed an

understanding of the range of engagement in an aspect of PD (i.e. using MOHO standardised assessment tools in practice). From this it was possible to form 'categories' of individuals at different self-assessed levels of engagement with this PD. A description of how the subsequent samples were made can be found in Section (5.3.2 and 5.3.3).

Of equal importance methodologically was that data from the single question survey could also be used to consider self-reported PD outcome at the point in time when the survey was administered. This information could be to corroborated or 'triangulated' with other data thus affording the study greater trustworthiness (Bryman, 2006). Whilst some bias has been identified in self-report methods (Adams et al 1999) this research uses self report as one of several means of gathering data in order that the findings be ultimately blended together into a coherent account (Moran-Ellis et al 2006). From a realist perspective it could be argued that data from self report enables this layer of social reality to be available in the evaluation of the intervention (Byng et al 2005).

From a practical perspective a decision was taken to make the survey deliberately brief in order to engage busy practitioners and to minimise the potential for respondents to be unable to recall information accurately (Forsyth and Kviz, 2006). As such, only one question was asked which was related to the practice standards (see in Appendix 1). Participants were asked to plot graphically across a one line continuum of engagement their current practice in using the PD standardised assessments in their practice. The questionnaire was designed to be returned by post to the researcher. The participants could be identified through an allocated study number and they were also invited to write their name on the survey. Confidentiality of information was assured. The ability to identify participants at the survey stage enabled reissue of the questionnaire to non-respondents and / or to invite participants to engage in the next stage of the research process.

In the host organisation all occupational therapists were invited to participate in the PD programme (Forsyth et al 2005a). As such *all* occupational therapists (n = 74) were invited to take part in the survey. The Single Question Survey was issued together with an explanatory letter (Appendix 1a) directly to the sample population via the organisation's internal postage system. Two follow up letters (Appendix 1b and 1c) were processed at two week intervals and only to those who had not returned their questionnaire. An administrative assistant undertook this task.

5.2.2 Development of Semi Structured Interview schedules

For the main study semi–structured interviews were one of three methodological choices made for method selection. Interview data formed the foundation and a main data source for understanding the therapists' reality (Fontana and Frey, 2000). Interview as a method has been criticized as 'slippery, unstable and ambiguous' between people, contexts and the temporal dimension (Scheurich, 1997). However, in realist terms these properties are celebrated as part of understanding the reality of particular circumstances (Pawson, 2006). By designing interview questions which enable exploration of a participant's thinking and affect, a thick description of each individual's cognitive explanation of their actions is offered for clarification (Pawson and Tilley, 1997) and identification with the research process (Kuper et al 2008).

An interview schedule was developed to illuminate inductively the *mechanisms* that assisted or prevented the therapists' engagement in PD within their own *context* and to provide data about the participants' perceived reality of the *outcome* of their efforts to engage in PD. The objectives were to ask about, listen to an interpret each therapist's perception of the rationales they created for the way in which they engaged with the PD, how they wanted to work in ideal circumstances, the constraints that they felt and how they felt it had affected their clinical practice (Mason, 2002). In order to gain longitudinal data about developments within therapists practice an interview schedule was designed to be used twice with each participant during the data collection, at initial interview and after a six month time

period (Appendix 2a). This method was also used immediately after the practice observation method (Section 4.2.3) although a different, more open set of questions was developed in order to ask the therapists to explain what had occurred in the observed practice (Appendix 2b).

The questions were semi-standardised with theory-driven content to draw out the participant's perspective about their engagement in PD (Flick, 2002). By making the questions broad in content and open in style the semi-structured interview allowed the researcher to collect information that is broad, holistic, in-depth and an integrative view of a participant's situation (Taylor and Kielhofner, 2006). The questions in the semi-structured interview instruments were developed from dissecting the main research questions (Chapter Three, Section 3.8). Areas included in the interview schedule included the therapist's current practice experience and their perception of the utility of the PD programme. The questions were structured into a reference guide for the researcher to use flexibly within the interview settings (Appendix 2a and 2b). By encouraging interviewees to speak openly and to discuss barriers to PD as well as the supporting factors it was possible to elicit mechanisms and contexts (Byng et al 2005). In addition prompt questions were used to encourage participants to expand on areas for more in-depth data to emerge (Lysack et al 2000). See Sections 5.5.1., 5.5.3. and 5.5.4. for details about how the interviews were undertaken.

Whilst the interview data had properties of gaining the participants perception other methods were designed to bring their own strengths to compliment the semi-structured interview (Adams et al 1999: Lysack, 2000). Examples of theses are the observation schedule and the audit tool. They will be introduced in the next two sections.

5.2.3 Development of Observation of Practice Schedule

The observation of individuals' practice as a method to gain insight to their day-to-day work was a methodological decision because understanding what individuals did with their practice development learning was part of the evaluative process.

Smith (2002) describes what people 'do' in the work environment as occurring in time, in local settings within the capacity of the individual involved. From a realist perspective the main contribution of observation as a method of evaluation is to help to understand a programme and how it is working (Robson, 2000). Observation enables the researcher to take a look at the interaction between structure and the actions which follow (Gerson and Horowitz, 2002). Gerson and Horowitz go on to suggest that observation is a way of understanding how people construct, interpret and make meaning out of their experiences. They conclude that where there is a methodological conundrum to see how people 'order' information into their real lives, observation can support the discovery of insights.

Observation can take many forms including participant or non-participant and variations within these categories (Flick, 2002). Naturalist observation or observation which is conducted in the natural setting is prevalent throughout the literature as a fundamental research method for gathering information about the field of study (Angrosino and Mays de Pérez, 2000). In this study a marginally-participant, observation structure was carried out. The researcher was a peripheral member of the clinical scenario but not an active participant in the therapeutic activities that took place in the home, clinic or community setting. This allowed the researcher to observe the actions of participants with minimal disruption to the intervention that was being undertaken. Robson (2000) suggests that this method of research could be defined as 'unobtrusive observation' in that the researcher is generally non-reactive and the process is natural and informal.

One of the main challenges of with this approach is defining the role of the researcher in the field, in particular how to observe without influencing the behaviour of those being observed (Flick 2002). The Hawthorne effect (Wickström and Bendix, 2000) suggests that people who are being observed might raise their game just because somebody is interested in them. On the other hand some individuals could lack insight or self-evaluation skills so observation can support understanding in this area (Taylor and Kielhofner, 2006). The insider

researcher has to be particularly aware of these possibilities where issues of power within the relationship may influence the actions of the participant (Conneeley 2002).

It could also be the case that the presence of the researcher disturbs the normal one-to-one therapist-client interaction just because a third person is present in what might be a fairly confined space. It is usual for ethnographers to observe for long periods of time which has the advantage that participants become used to the presence of the researcher (Chambers, 2000). Observation over a longitudinal period was not possible in this study so it was necessary to monitor how participants reacted to the researcher and how the researcher attempted to mitigate the effect of her presence. The following example from the researcher's reflective field notes is an example of such reflexivity.

Reflexivity Quote

As we walked through the hospital, the therapist spoke with the patient, enquiring about his family (his father had minor surgery that morning). Walking through doors, the patient waited for both the researcher and therapist to go through first. This made the dynamic very much inclusive of the researcher into the body of the session. I felt that not engaging in the conversation would have been intimidating and unnatural for the patient. I was also very mindful of the impact of taking notes when in a position where the patient could see. My notes were therefore brief and only jotted at appropriate times.

Researcher Observation notes Re: Eithwen

In designing the observation process the researcher was mindful to include an opportunity for the therapist participant to introduce the researcher to those involved directly in the therapeutic session (Creswell, 1998). Explaining the researcher's role to all those involved in the observation prior to the observation being undertaken was designed into the study process so that clarity about the unobtrusive aim of the observation was clear. This explanation was undertaken immediately before therapy was undertaken.

With regard to the practical development of the observation schedule, the researcher used her 'insider' knowledge (Conneeley, 2002) and the evidence base from the literature on the Model of Human Occupation (Kielhofner, 2002) to develop the observation schedule (see Appendix 3). Broad, pre-defined observational categories were constructed and a schedule was produced to record the observed behaviours of therapist participants in the field and reflexive accounts of the researcher's experiences, hunches and learning (Creswell 1998). The observer's behaviour was designed to be as unobtrusive as possible within the field and though visible to the participants there was to be as little active engagement during the therapy session as possible. For face validity the tool was checked out by experts in the field including the author of the theoretical constructs of MOHO which underpinned the PD (Kielhofner, 2002, 2008a). This added validity to the instrument.

5.2.4 Development of the Audit of Documentation tool

Collecting data from sources of already existing information like records made in health care documents can be a useful research method (Creswell, 2003). Silverman (2006) advises that the richness and relevance offered by textual data should not be ignored. He goes on to point out that textual data are naturally occurring sources of data that are usually readily available. It was anticipated that healthcare records of occupational therapy intervention made by participants would offer contextual information about the use of PD in practice (Bryman, 2006). This method can also be used as a supplementary method to corroborate and complement other data sources and thus add rigor to a study design by triangulation of data sources (Lysack et al 2006). Creswell describes the method as having practical advantages including time saving on transcription and that access to documents can be made at a convenient time. Another advantage is that the naturalistic language of the participants to be seen which may impart different information from that which is seen through observation or heard in interview (Hodder, 2000). The analysis of documents also has the advantage that they, like observation, are unobtrusive and non-reactive (Rogers 2002). On the other hand, Creswell notes that if documents are incomplete or inaccurate this could be

problematic. Another disadvantage of this method if used in isolation is that it is difficult to make meaning from the data without reference to the authors (Lysack et al 2006: Creswell, 2003: Hodder, 2000).

Clinical audit through the appraisal of notes made by professionals is recognized universally as a useful tool in evaluating the quality of care provided in health services (Berk and Callaly 2003). Health care professionals are familiar with routine audit of their health care records as an attempt to improve quality of practice (Berk et al 2003). There could be an assumption made that health care professionals are conscious that their notes will be audited which might raise the accuracy of their documentation. In addition, occupational therapists have a professional responsibility to routinely record their interactions, reasoning and observations of their practice with individual service users (College of Occupational Therapists, 2005).

An 'Audit of Documentation' schedule (see Appendix 4) to retrospectively appraise of the clinical notes made by the participating occupational therapist was designed. All occupational therapists in the PD Trust had been made aware of the audit process as setting and using practice standards was part of the PD process (see Chapter One, Section 1.5.2.5). The standards (Appendix 5) were then used to develop the audit tool (Appendix 4). As such a schedule was designed to collect data from notes made by the occupational therapist participants about the clients they saw during the research observation. The schedule was also checked out by experts in the field for face validity. It is possible that the records made by occupational therapists were positively affected by knowledge that the researcher would be appraising the notes. For this reason the notes audit was designed to have retrospective and prospective components (i.e. records were included of notes written in the whole episode of the clients care). This included before and after the time when the practice observation was made.

Throughout the last section the reader has been introduced to the rationale for the research methods and methodological implications for and of these choices. In addition a description of the development of the tools has been provided. In the next section describing Phase One of the research process an explanation of the sampling and temporal aspects of the data collection will be provided.

5.3 Phase One – Sample Building

This section will provide an overview of how a sample of participants was drawn for each phase of the research process. The sampling process should be guided by the specific research question in order to capture sufficient facets of the area of evaluation (Kuper et al 2008). Key to the sampling process was the administration, analysis and results of the survey which was used to understand the range self-perceived involvement in an aspect of the PD and these will be presented in this section. This is in order to provide clarity about the sampling process of the main study. In addition sampling issues about each of the different methods employed in the main study will be clarified in this section. The contribution of the survey to sample building will be considered.

5.3.1 Administration, analysis, results and initial discussion of survey

In Section 5.2.1 the development of a single question survey (see Appendix 1) was outlined. This aimed to provide basic self report information about participants' perceptions of their use of standardised MOHO assessments in practice. Inclusion criteria were that occupational therapists worked in the host organisation. Exclusion criteria were participants who were aware that they would not be able to be interviewed six months after the observational aspect of the research, for example, if notice had been given to move away from Trust employment or those close to retirement.

Of the 74 occupational therapists surveyed seventy one (96%) responded (see Figure 5.2). This high response rate could be explained through the use of a one question survey which required minimum time investment from participants. The

analysis took the form of calculating the numbers of people who had marked the line in similar places and calculating percentages of respondents within those categories (see Section 5.2.1).

The high level of surveys returned meant that the results represented self-reported engagement levels from participants with clinical responsibilities across the population served by the host organisation. This included the specialties of adult mental health, older people's mental health and adults with learning disabilities.

The results (see Figure 5.2) indicated that of those who responded, 18 (26%) of participants stated that they were administering standard assessments routinely (RU), 34 (48%) were administering standard assessments with intermittent use or more frequently (IU+) and ten (14%) were approaching the use of the assessments intermittently in their practice (IU-). Four (6%) respondents were about to start to use the assessments (AS+), one (1%) was not quite about to start to use the assessments (AS-), three (4%) were planning to use the assessments in 6-12 months and one therapist (1%) stated that they would never use the assessments. Thus 12% of participants reported that they had not yet used the assessments in practice and 88% self reported using the PD assessment material to some degree in their practice.

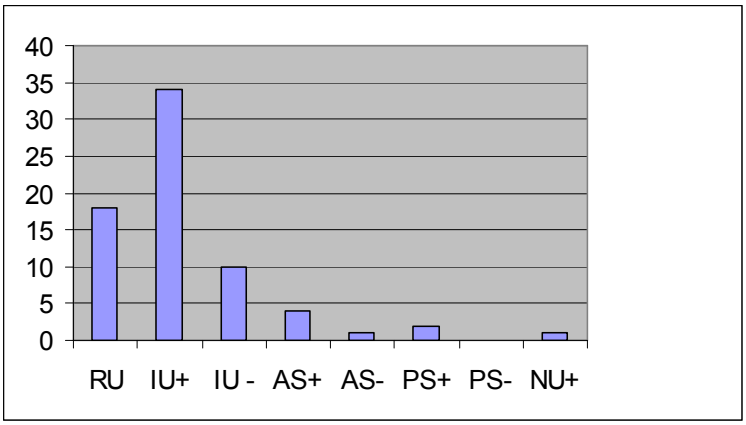
The inferential Kruskal-Wallis test was used to determine whether there was any difference between those participants who required prompting to respond to the survey request (i.e. after the first or second prompt letter) and those who did not. No significant difference was found so the early and later sets of responses were simply pooled as a single data set. Thus data was available from which to draw a sample for the pilot and the main study.

Figure 5.2 Results of Phase One – Survey

Single Question Survey Result

Therapists' perception of their use of Standardised MOHO Assessments within their practice

Total number in sample population = 74
Total number of returns = 71 (96%).



KEY:

Horizontal Axis:

* RU = Routine Use
* IU = Intermittent Use
* AS = About to Start
* PS = Planning to Start in 6-12 months
* NU = Never use

Vertical Axis = Number of Respondents

5.3.2 Sampling process for pilot

The aim of the sampling process for the pilot study (Phase Two) was to identify two participants who had self-rated with different outcomes of PD involvement through the survey (Phase Two, see Section 5.4). This was to test out the main study design and methods across outcome levels. For the purpose of the pilot sample, the survey results were sorted into three groups. For the pilot study data collection was planned with two people. These were to be sampled from different parts of the spectrum illustrated in Figure 5.2.

Participants were randomly selected with one pilot participant from the upper quartile and one from the lower quartile. The process was undertaken for each quartile by writing participants identity numbers on equal size pieces of paper, folding each three times, placing in a bowl and selecting at random. The outcome of the sampling process was that in group one (the upper quartile), the first person drawn was approached by telephone for permission to be approached by letter to seek engagement. This person agreed to participate in the study. In group two (the lower quartile), four people were drawn. The first had recently stated a new post so felt unable to participate, the second had left the PD Trust and the third explained that although keen they did not have the time capacity to participate. The forth person drawn from the sample agreed to participate. The sample process for the main study was slightly different and this will be described next.

5.3.3 Sample process for main study

A purposive, randomised, stratified sample (Silverman, 2005) was selected for this phase of the study. The aim was to include participants from across the spectrum displayed in Fig 5.2 (Kuper et al 2008). The sample process for the main study (Phase Three) aimed to achieve a maximum variation sample of registered occupational therapists who were involved in the PD programme, who were not likely to be retire in the six months following their initial participation.

5.3.3.1 Sample of occupational therapists

The marks made by participants onto the survey sheets (Appendix 1) were appraised by the researcher and have been outlined in Section 5.3.1. Where responses on the survey sheets fell above or below the categories set on the survey sheet ('Routine Use'; 'Intermittent Use'; 'About to Start'; 'Planning to Start in six-twelve months'; 'Planning to Start in 12-18 month' and 'Will Never Use') a ruler was used to sort the responses to the nearest category marker.

For each group participants' identity numbers were written on equal size pieces of paper, folding each three times and placing in a bowl. All papers were drawn from

each group and the corresponding numbers tabulated in order that participants could be sequentially invited to participate in the main study as required.

Strauss and Corbin (1998: 281) suggest that a sample of 10 can provide the skeleton of a theoretical structure in qualitative research. This was the number achieved within this research design. The goal here was to achieve conceptual power rather than population representativeness (Byng et al 2005).

Of the 71 respondents to the survey only 56 were eligible to participate in the main study by the time the sample was being drawn. The reduced number was due to people leaving the service of the PD Trust. Over the course of the main study 15 people were approached by letter inviting their participation. Eight of these agreed and subsequently took part in the study. The data from participants who took part in the pilot procedures were included (see Section 5.4) in the main sample and a multiple variation sample was achieved of ten participants (see Table 5.2).

5.3.3.2 Observation time sample.

Consideration was given to how observation times would be set. In order to add a structure to the process the researcher allocated a 'research observation day'. Following the initial interview, participants were provided with the date of the next research day available to the researcher. Participants provided the names and details of clients who would be seen on that day by the therapist. The researcher then arranged for information letters about the research to be sent informing the service user that they *may* be asked to participate in the study (see Appendix 6). The clients who were actively seen on the day of observation were provided with a more detailed letter (Appendix 7), an information sheet (Appendix 8) and a consent form (Appendix 9).

5.3.3.3 Documentation sample.

The notes made by participants about clients seen in the observation sessions were drawn for audit purpose. The researcher also sampled retrospective data from the

same notes, where available, to provide further data of the therapists' note writing behaviour prior to their participation in the research (see Section 5.2.3 re: Hawthorn effect).

5.4 Phase Two - Pilot

A pilot study was designed to test out the main study design and research tools (i.e. the semi-structured interview; practice observation schedule, post-observation interview and documentation audit). This pilot excluded the 'Follow-up Interview' for two reasons. The first was that the interview schedule was essentially the same as the first interview so would already be tested in principle. Secondly, the time frame of six months later for the second pilot interview would be prohibitive in the timescale available for the research.

Each participant selected for the pilot undertook an initial semi-structured interview; observation, post-observation interview and a notes audit was carried out. No significant changes were made to the study design or instruments following the pilot other than a decision to subsequently collect demographic information from participants. Therefore it was possible to include the pilot data in the main study and the two pilot participants completed follow-up interviews at the appropriate time.

5.5 Phase Three – Main Study

This phase formed the main section of the research data collection. The methodological decisions and the process of development of the research tools were introduced in Section 5.2. This section will report the process of collecting these data for the semi-structured interview, the observation and the documentation audit. Using the sampling technique described in Section 5.3 participants were sent a letter, provided with information about the study and asked for their consent to participate in the research by letter (see Appendices 10, 11 and 12). Data collection continued until no new trends and themes were being identified (Kuper et al 2008). As such saturation of mechanisms and outcomes was reached (see Chapter Six, Section 6.3.1).

Requests made to therapists to seek their participation in the main study were staged over time so that they did not have to wait for long periods to engage with the research process after agreeing to participate. Participants whose names were drawn were sequentially approached by letter (Appendix 10). An information sheet and consent to participate sheet was also sent to them (Appendices 11 and 12). If the therapist did not agree to consider participating in the research or a response was not given within two weeks, a further name was drawn from that category and the process repeated until the sample required was reached.

5.5.1 Initial Interview

Participants were offered a choice of venue for the initial, semi-structured interview in order that they felt comfortable with the research environment. In most cases the researcher travelled to the participant's work base. A quiet space where minimum interruption would be likely was arranged by the researcher. Interviews were scheduled to be a maximum of one hour in length. The interview data collected was audio taped and transcribed later into verbatim text by the researcher. Field notes were also made by the researcher following each interview. Throughout the data collection period, the researcher made field-notes of observations and interpretations to ensure capture of all related data including her own reflexive considerations.

5.5.2 Observation

As soon as possible after the initial interview, each participant was scheduled to participate in the observation strand of the research. Each participant was observed for one half day of their practice. Timings were negotiated with each participant in order that the observation was appropriate to their practice responsibilities and connected with the agreement of the client in therapy (see Section 5.6.1 and 5.6.2 on Ethical Issues). Depending on the participants context the observations spanned consultations or treatment episodes with one or two clients in a natural setting (for example, the ward setting, the occupational therapy department setting, the client's home, shop or café environment, case review meetings).

Free text notes were made during the observations in order that the researcher could capture a detailed description whilst maintaining minimal disruption to the natural flow of the session. The data was then transferred to the observation schedule soon after the observation session. This was to minimize the concern about the extent to which the researcher affects the situation under observation (Robson, 2002).

5.5.3 Post-observation debrief interview

Directly following (within the same day) each observation of clinical actions a post observation, semi-structured post-observation interview took place with the participating occupational therapist. This acted as a debrief interview.

5.5.4 Follow up interview

A follow up interview approximately six months later was arranged. Participants were contacted by the researcher via telephone. A mutually convenient date and venue were arranged and the procedure was the same as the initial interview.

5.5.5 Audit of Documentation

The case note documentation could only be accessed when they were not required by the team of clinicians involved in the care of the client. As such access to the documents was undertaken via the health records department of the PD organisation. The audit process was undertaken at convenient points following the practice observation. Collecting data for this method was structured with the audit tool (Appendix 4). The documents were trawled manually and appropriate data translated electronically directly to the audit tool.

5.5.6 Post data collection

At the end of each participant's involvement in providing data for the research a letter of thanks from the researcher was sent. Participants were also contacted following the data collection to consider (or 'member check') the transcripts and analysis as part of ensuring the trustworthiness of the data (Conneeley, 2002)

5.6 Ethical issues

Ethical conduct in research must involve behaviour that is underpinned with integrity and awareness of research ethics (Workman and Kielhofner, 2006). In this section the potential ethical concerns that were identified for occupational therapist participants and service user participants are raised. The processes undertaken to ensure that these ethical issues were addressed will be outlined and a report of the general ethical governance actions that were undertaken will also be provided.

5.6.1 Ethics and the occupational therapist participants

There were particular ethical implications for occupational therapist participants with regard to the maintenance of confidentiality, gaining their informed consent to participate and being sensitive to the pressure of their everyday workload. The researcher was employed as a leader within the PD Trust. Ethical difficulties could have arisen if occupational therapists felt pressurized to be involved in the study against their will, perceived that they might be criticized for their work or felt that refusing to take part would compromise their position (Robson, 2002). Potential participants were reassured through the information sheet, in the consent form and in any subsequent correspondence with the researcher of the confidentiality of the process and their right to withdraw from the study at any point without recrimination (see Appendices 10 and 11). These issues also relate to the researcher's reflexivity which has been discussed in Section 4.4.1.

5.6.2 Ethics and the service-user participants

Where vulnerable people are involved in research the ethical issues escalate (Conneely, 2002: Workman and Kielhofner, 2006). Service users who by definition were experiencing mental ill-health or learning disability were potential participants in having their treatment observed and their health care records audited by the researcher. As such, the informed consent of service user participants was required in advance of their involvement in the observation and documentation audit data collection. Those who were likely to be seen by the occupational therapist on the 'research day' were approached by the researcher, by letter at least two weeks in advance, informing them of the likelihood that they would be asked to participate (Appendix 6). The researcher, immediately in advance of the occupational therapy session to be observed, asked for the service user's agreement to have the researcher observe their therapist during their intervention session. They were also asked at this point for consent for the researcher to access their health care records (Appendix 9). If consent was not gained, service users from the researcher's next available 'research' day were approached in the same way. If the service users who were due to be seen on the 'research day' were assessed by the therapist as lacking capacity to provide informed consent to participate in the research, the client's main carer was approached by the researcher for their assent (Appendices 13 a, 13b and 13c).

5.6.3 General ethical governance

All measures possible were taken to eliminate any conflict of interest that emerged. The research proposal was presented to the PD Trust's Research Board, the PD Trust Data Protection Officer and the Local Research Ethics Committee (LREC) to request approval for the study. This enabled compliance with the Research Governance Framework (Department of Health, 2001). Potential members of the sample population were given information about the study and its confidentiality. Their prior informed consent to participate was actively sought. Participants were advised of their right to withdraw from the study had they wished.

The Local Research Ethics Committee (LREC) was approached on two occasions, firstly to gain favourable ethical opinion to commence Phases One and Two (LREC reference 03/81G) and secondly to gain favourable ethical opinion to commence Phase Three (LREC reference 04/Q2005/75). An additional requirement was to take responsible action with the data acquired. As such the following data protection design was included.

5.6.4 Data Protection

Conscientious data management has been argued to be an ethical responsibility (Workman and Kielhofner 2006). As such the research design ensured that all raw data, for example returned survey sheets and consent forms, were kept in a locked drawer in the researcher's office for the duration of the study. These data were accessible only to the researcher and the researcher took overt responsibility for confidential destruction of the data following completion of the analysis (approximately three years). The line manager of the researcher was informed of the data storage arrangements so that they could be destroyed should the researcher be incapacitated. Coding anonymised any data stored on personal computer.

This section has considered the ethical issues which were raised through the study design and outlined the measures taken. As a result of data collection a large volume of ethically sourced, rigorous data of thick description were available from the main part of the study. These data then required appropriate analysis and this will be discussed next.

5.7 Data Analysis

In this section the approach to the main study data analysis will be described. Key considerations about the approach the analysis of qualitative data sources will be discussed. This will be followed by an account of the three incremental stages

undertaken to systematically analyze the main sources of data (interview, observation and notes audit) in this study.

Researchers interested in narrative enquiry are seeking to make meaning, social significance and purpose from the analysis of qualitative data (Clandinin and Connelly, 2000). However, it is critical that social science is credible through the use of appropriate method, rigor, critique and objectivity of analysis (Silverman, 2006).

Illustrating qualitative research analysis as a systematic process is challenging because there is no smooth transition from gathering data and their analysis (Clandinin and Connelly, 2000). However, undertaking and illustrating a systematic approach enables research findings to achieve greater trustworthiness as the deficiencies and biases of the data analyst are minimised (Robson, 2002). In this research the data analysis commenced and continued from the beginning of the data collection process which is expected best research practice (Silverman, 2005). Accordingly, identification of emerging themes and data saturation was facilitated (Kuper et al 2008). In line with the methodological approach of RE (see Chapter Four) the analysis of interview data in particular took a 'causal approach' (Mark et al 2000) searching for themes which described catalysts and causes of engagement or challenges in PD involvement. The observation and audit data were supportive of gaining understanding of the outcome of PD in particular. The data analysis processes involved will be described in the next sections.

5.7.1 First level of analysis: Understanding themes across data set

This stage of the inquiry involved generating ideas about which contextual factors were likely to be important, to discover what the potential triggering mechanisms were and to illuminate data which gave evidence of positive, negative or status quo outcome for participants engaged in the PD. This stage of analysis was designed to discover the regularities in the data (Robson 2002, Tesch 1990) by systematically considering the interview, observation and free text audit data. Data were themed

initially into the areas of context, mechanism and outcomes. This relates to the underpinning methodology of Realistic Evaluation (see Chapter Four, Section 4). The codes served as 'bins' within the data analysis process and further categories and codes were identified through systematic analysis.

The analysis continued incrementally by considering the whole data set for what was *common* about the participants' responses. This was undertaken as each piece of data was gathered rather than waiting until the whole set was available. Through typing up transcripts and reading the scripts the researcher gained an overall perspective about the emerging reality (Robson, 2002).

Computer software is becoming increasingly useful in qualitative research as studies often generate a large amount of raw data (Rogers, 2002). Whilst it has been noted that computer software is particularly useful for undertaking content analysis (Silverman, 2005), it can also be helpful to sort, store and retrieve large volumes of rich narrative data. A computer program NVivo (QSR, 2002) was used to fracture each element of the data (that is the interview, observation and the audit data) and to store it in categories relating to themes of context, mechanism and outcome. As the analysis continued associated sub-categories for CMO emerged. Memos were written throughout the coding process to record the conceptual links and other observations about the data. As contexts, mechanisms and outcomes were identified, subcategories also emerged through analysis (see Figure 6.1; Table 6.1; Table 6.2). The first stage results are reported in Chapter Six, 'Context, Mechanism and Outcome Patterns' and formed the foundation upon which the second level analysis was undertaken.

5.7.2 Second level analysis: development of individual CMO cases

Using the criteria established through the first level analysis, all the data for each individual participant was analysed systematically. The emphasis in this level of data abstraction was to gain an understanding of the meaning of the text (interviews) and action (observation and audit) data (Robson, 2002). Once again

the Nvivo computer system (QSR, 2002) was utilised to sort the themes that were evident for each individual from the interview, observation and free text audit data. The categorised audit data was counted and collated and stages of outcome adoption again applied. Where possible these patterns were presented to participants as 'member checking' to test out their perception.

At the second stage of analysis it was possible to compare and draw together through conceptual synthesis connections which emerged between the CMOs. These are presented in Chapter Seven. At the end of this phase of data analysis the data for each individual were reassembled to provide prototype CMO case vignettes of individual practitioners whose CMO configurations had common patterns. Reports of selected individual CMO configurations are provided in Chapter Seven in order to illustrate what the research aimed to understand (see research questions Chapter Three, Section 3.8).

5.7.3 Third level analysis: generalisation across cases.

The next stage aimed to generalize from the specifics of individual cases to develop a range of testable propositions or theories. Using a systematic reflective approach conjectured CMO configurations were developed and represented a shift from the specifics (of individual cases) to more abstract or 'cumulative' theory (Pawson and Tilley, 1997).

The process undertaken was as follows. The data was considered for areas of contextual challenge that emerged across the data set. These phenomena were coded to represent general contextual challenges which may be experienced by an individual involved in a PD programme. To facilitate the analysis the reduced coded data in the individuals CMO configurations were utilised to theorise about the primary mechanisms which need to be activated to facilitate incremental progression along outcome levels. These theories were then tested against the study of positive and negative cases present in the detailed case studies, raw data

and the researcher's memos. Where conjectured configurations could not be developed beyond the prototype idea they were not included in the results. These conjectured theories provide results of a more general nature and form information which is likely to be of interest to others beyond this PD environment (Byng et al 2005). Primarily these theories are presented in Chapter Eight which outlines 'The IPD Theory'.

5.8 Profile of data

The profile of participants that were part of this study is important to locate in order to structure the context. It is presented in this chapter for convenience and will serve as a useful platform on which to understand and interpret the rest of the data presented in later chapters.

5.8.1 Data collection for individuals

In the main study (including the pilot participants) data was collected over a 30 month period (Phases Two and Three). Table 5.1 provides a summary of the types of data collected for each participant. Survey data were available for nine of the ten people sampled. No observation, post-observation interview or notes audit data were available for Hannah due to this participant's absence from the workplace during the data collection period. The notes audit for Isobel was not undertaken as the notes were unavailable during the data collection period. In the table that follows, the names of participants have been changed to preserve anonymity. The allocated names have been provided alphabetically to coincide with the chronological sequence of their participation in the study. As such, Ann was the first participant studied, Jackie the last.

Table 5.1 Data collected for each individual participant.

May 2004

Dec 2004

Dec 2006

Participant (Synonym)	Survey	1st Interview	Observation	Post-observation Interview	Final Interview	Notes Audit
Ann (pilot)	N	Y	Y	Y	Y	Y
Bev (pilot)	Y	Y	Y	Y	Y	Y
Caroline	Y	Y	Y	Y	Y	Y
Delyth	Y	Y	Y	Y	Y	Y
Eithwen	Y	Y	Y	Y	Y	Y
Fiona	Y	Y	Y	Y	Y	Y
Gillian	Y	Y	Y	Y	Y	Y
Hannah	Y	Y	N	N	Y	N
Isobel	Y	Y	Y	Y	Y	N
Jackie	Y	Y	Y	Y	Y	Y

Key

N = Not collected

Y = Collected

5.8.2 Demographic information

In this section an account is provided of the demographic profile of the participants in the study. In total, 17 therapists were invited to participate in Phase Two or Three. Of these, eleven therapists agreed to participate. One therapist withdrew prior to collection of data due to resignation from her post.

Ten participants took part in Phases Two or Three. Table 5.2 provides basic demographic information about the participants. With regard to seniority of the participants, two were junior therapists with up to two years post graduate experience; four were senior therapists with over two years experience and working at a senior clinical level and four had occupational therapy leadership responsibilities in addition to their clinical responsibilities. A similar spread is noted for specialist work areas: two participants worked with older people, three

with people with learning disabilities and five with adults of working age experiencing mental ill-health (two in-patients, three in the community). Of the group four had been qualified, practising occupational therapists for fifteen or more years, four had been qualified, practising occupational therapists between five and ten years and two had been qualified and practising for two years or less. Nine of the ten participants had worked for the employing organization for two years or more. All participants were female.

Table 5.2 Basic demographic information

Years Qualified	Years worked	Two years or more in organisation?	Grade	Gender	Specialty area
≤2	≤2	No	Junior	Female	Mental Health Older People
5-10	5-10	Yes	Lead	Female	Mental Health Older People
≤2	≤2	No	Junior	Female	Mental Health Working Age Adults – Community
5-10	5-10	Yes	Senior	Female	Mental Health Working Age Adults – Inpatient
5 -10	5 -10	Yes	Senior	Female	Mental Health Working Age Adults – Inpatient
≥15	≥15	Yes	Senior	Female	Mental Health Working Age Adults – Community
≥15	≥15	Yes	Lead	Female	Mental Health Working Age Adults – Community
5-10	5-10	Yes	Senior	Female	Learning Disabilities
≥15	≥15	Yes	Lead	Female	Learning Disabilities
≥15	≥15	Yes	Lead	Female	Learning Disabilities

Key

Pink = Therapists working with Older People with Mental Health needs
Blue = Therapists working with Working Age Adults with Mental Health needs
Green = Therapists working with people with Learning Disabilities

5.9 Chapter summary

The four phased study design was explained and explored incrementally in this chapter. Figure 5.1 provided a visual representation of the design. Initially the preliminary work involved in the study was described and included the rationale for choosing the particular and mixed methods of survey, semi-structured interview, non-participant observation and documentation audit.

The main body of research results will be provided in Chapters Six, Seven and Eight. The first of these will illustrate the result of the first level analysis of the data generated which provided results of important *contextual* factors, triggering *mechanisms* and subsequent general *outcome* for an individual's engagement in PD. Chapter Seven reports the second level analysis detailing the connections of individuals CMO patterns. In Chapter Eight a third level abstraction of the data is reported providing a theory of Individual Practice Development.

Chapter Six – Context, Mechanism and Outcome Patterns

6.1 Chapter overview

In order to present the data relating to how engagement in a practice development (PD) program plays out for individuals from the same basic prompts this chapter will provide an overview of the results from the first level analysis (see Chapter Five, Section 5.7.1). The research is a Realistic Evaluation (RE) (see Chapter Four, Section 4.3) so the initial results will be introduced in relation to the commonalities and differences in *contextual* arrangements, *mechanism* activation and *outcome* data.

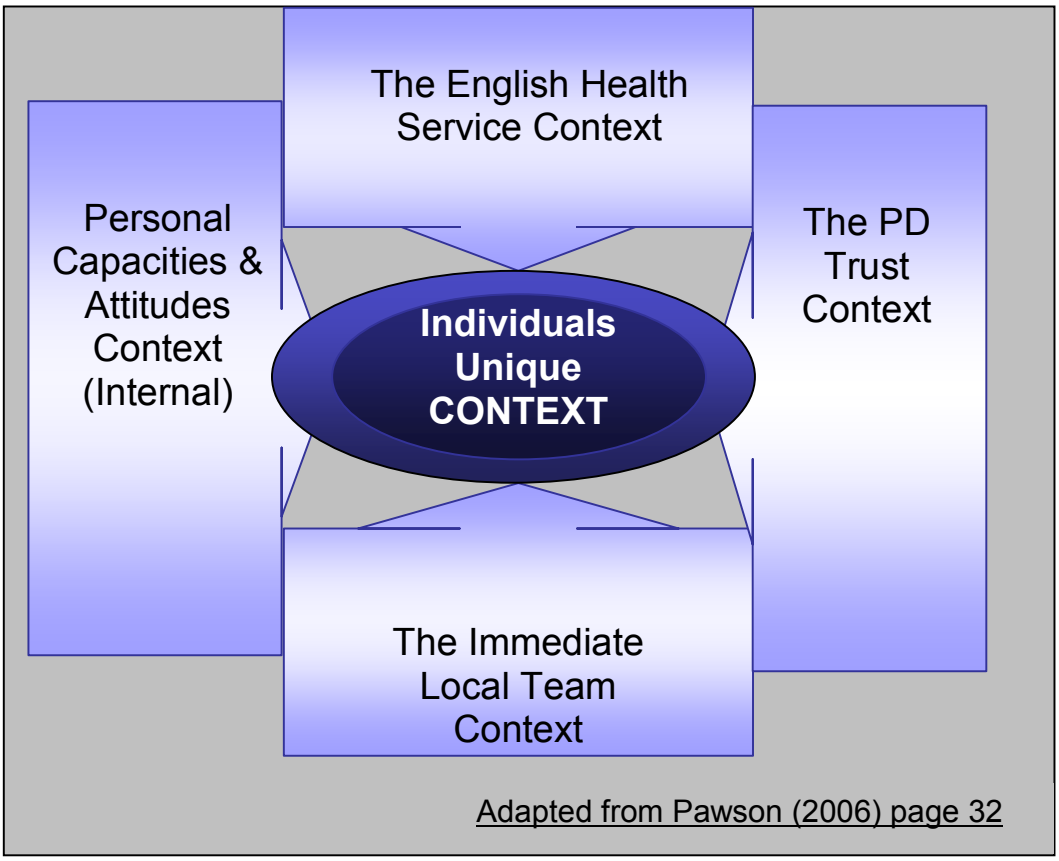
Context, mechanism and outcome theories (CMO) have been tested and the results will reflect the relationships of these key areas. Small illustrative sections of data will be provided as examples of supporting evidence. It should also be noted that pseudonyms have been allocated to individual participants in order to preserve anonymity (see Chapter Five, Section 5.8.1 and Table 5.1). Readers might also find it helpful to make reference to Appendix 14 where terms associated with the research data are explained. Some discussion of the results is also presented in this and other results chapters in order to locate the information within a wider framework and create a platform for further discussion in Chapter Nine. The three sets of interview data collected for each participant were the potent and primary source of data for understanding and illustrating the results of the contexts, mechanisms and outcomes at this initial level and other levels of data abstraction. The interview data were collected over time with the initial interview collected first, the debrief interview undertaken on the same day as the observation and that the final interview was six months later (see Chapter Five, Section 5.5). The audit and observation data were equally important and provided data with particular regard to outcome of PD. These data were also important for aspects of trustworthiness in testing the theories and assumptions built.

The key similarities and differences with regard to contextual situations between the individuals studied will be presented in this chapter. This will be followed by a description of the common mechanisms and the *levels* to which they were activated. In addition the outcome impact of the PD will be described by categorizing the extent the goals of the PD intervention had been achieved overall. This is important because even though all the individuals studied had the opportunity to engage in the same PD interventions there were differences in the extent to which the PD intervention had changed their clinical practice. This chapter will conclude with a synthesis of the four main outcome levels and the general level of mechanism activation within these outcome levels.

6.2 Context

Pawson's (2006) conceptualization of context was divided into four main areas (see Chapter Four). In essence the same four areas were also revealed in this study to frame the overall contexts of the individuals involved. To locate the contextual themes in relation to the data of this study the descriptive titles vary from those of Pawson. The key themes which emerged were: 'The English NHS Context', 'The PD Organisational Context', 'The Immediate Team Context' and 'Personal Capacities and Attitudes'. These results are summarized in Figure 6.1. This diagram represents the individual's unique contextual package as the central area of concern and illustrates how the four areas of context feed into each individual's contextual circumstance to make their experience of PD unique. Each area of context is described in greater detail in the text below together with excerpts of data.

Figure 6.1 Components of an Individual's Unique Context



6.2.1 The English Health Service Context

The first contextual area is concerned with the whole framework of public health care services in England, which is the political context of the NHS. The point in time covered by this research is significant as during the early parts of the millennium the NHS was strategically driving provider services to be more clinically accountable for their work (Department of Health, 1998) and to ensure that lessons were learnt from the increase in litigation (Department of Health, 2000a). In addition service providers, including occupational therapists were expected to engage in research activity and evidence based practice (Department of Health, 2000b) and professional bodies moved swiftly to develop a response to this (Ilott and White, 2001). Alongside specific developments to inform NHS clinical practice development policy also formed part of the English NHS context

at this time. Of particular significance to the NHS were the frameworks for public health issued via the Department of Health for: Mental Health (1999); Older People (2001b) and for people with learning disabilities (2001c). Furthermore the ideals of Recovery (Torrey et al 2005) and Social Inclusion (Care Services Improvement Partnerships, 2008) were emerging.

The data suggested that there were tensions for some participants with the overall policy context. In the main this was not overtly described, however, interpretation of the data implied that some policies supported the delivery of occupational therapy as a discrete discipline whereas others fostered the development of core mental health practitioner roles which changed the contribution of occupational therapists particularly in community practice. This had a bearing upon whether PD about occupational therapy intervention was seen culturally as a priority by each individual OT in the data set. This did impact upon some individual's ability to engage in the PD.

> *[The PD] helps to stem against the generic tide because, OTs are very flexible and people can do lots of different things. They [the OT] can still have a productive and a fulfilling role in a team [even if] not doing OT.*
>
> **Jackie: Final Interview**

Also expressed was a shared context of the profession of occupational therapy in the UK with its own unique characteristics and set of professional standards set within the professional body. It is clear that occupational therapists in mental health settings often work in very small occupational therapy teams spread thinly across large multidisciplinary teams (MDT's) with pressure to undertake generic rather than profession specific roles (Lloyd et al 2004). In these situations occupational therapists need to be able to explain occupational therapy to sceptical or less informed members of MDTs in order that service users can access the intervention and that the skills to deliver occupational therapy are not lost (Cook and Birrell, 2007). The implication from these contextual data is that this national

situation is reflected in a local context. As such, the data provide further argument for organisations to have well structured professional leadership to drive and monitor the delivery of profession specific practice (Boniface et al 2009: Forsyth et al 2005a).

6.2.2 The Organisational Trust Context

Each participant worked for the same organization (the PD Trust). The PD Trust hosted services that were in a variety of geographical locations, urban and rural, spanning in-patient and community sites and working with people of different ages and with different sets of needs. The participants were generally involved in only one small aspect of this service delivery (see Table 5.2). Overall, the PD Trust through its executive team, professional leadership structures and policy framework was perceived to support the PD initiative for occupational therapy practice development. This support at both policy and practical level was acknowledged as a critical aspect of successful engagement in PD by the participants.

> *I think that we are very lucky here in [the PD Trust] that we have got the [OT] Research and Development Strategy and we're in collaboration with [academic partners]. We've got an awful lot of access to standardised assessments in the Model of Human Occupation which gives us a really good foundation I think for where to go and where to start working.*
>
> **Eithwen: Initial Interview**

Participants placed value upon the high level leadership available to support the PD both from external sources (indicated in the above quote) and for the leadership capacity and support within the organization.

> *None of this [PD] could happen if there weren't people [leaders] making the space for it to happen and changing the thinking of the other professions around us and decision makers in the Trust to allow it to happen. So people*

out there have bought us time, facilities, resources, support to be able to do this and I think that we're incredibly lucky.

Isobel: Final Interview

Much has been written in the literature which relates to leadership as a key component to drive practice development (Atter, 2008: Chin et al, 2008: Harrison and Coppola, 2007). This was highlighted in Chapter Three (Section 3.4) and will also be discussed further in Chapter Nine (Section 9.4.2.2). It can be concluded then that each of these two areas of context (Sections 6.2.1 and 6.2.2) are important in scaffolding the participants' engagement in PD. It was evident that the participants were overtly aware that these elements were important contextually. However, the data did not suggest that these aspects of context were the significant catalyst for change. Rather, that they supported a change intent. On the other hand, the immediate, local team context did have a critical and direct role.

6.2.3 The Immediate Local Team Context

It has been noted that all practitioners in this study had the same 'NHS' and 'Organisational' context at the time that data were collected. Both these aspects of context held some challenges and supports for therapists' engagement in the PD. However, it is at the next level of 'Immediate Local Team' context that differences began to emerge. Examples from the data where the participants have acknowledged the importance of their team context are provided in this section.

In contrast to the previous two areas of context none of the study participants had the same immediate team context. Each clinical area in which each participant was practising had differences in terms of the fundamental support available for engagement in the PD, the expected role of the therapist, the PD expertise immediately available through mentorship and supervision and time pressures of clinical work. Each therapist had a different manager, a different geographical area, a different set of colleagues to work with and they worked across a range of different clinical specialty (see Table 5.2). They also had different personal

circumstances and attributes. These differences in contexts affected the therapists' experiences of engagement in this PD in both positive and negative ways. Thus, for the 'Immediate Local Team' aspect of context the data revealed that certain contextual features were important for setting an environmental framework to support the therapists to activate mechanisms to engage in PD. These specific elements which emerged from the data included the:

- Local team management support for PD engagement
- Contact with other occupational therapists in day-to-day practice
- Having the delivery of occupational therapy as an expected role of the participant therapist within the team
- Having PD expertise /peer support immediately available through mentorship and supervision
- Protected time allocated or authorised through managers to engage in PD initiatives

Whilst the aspects of context featured above did impact upon the participant's engagement in PD there were other aspects of context which did not. Participants working in the same clinical speciality (although in different teams) were identified as having different outcome results. For example, Isobel and Gillian worked in the Learning Disabilities services but their PD outcomes were different. Similarly, participants with the same lengths of experience had different outcome results. For example, Eithwen and Hannah had similar work history but different outcome results. This suggests that some aspects of context have relevance to determine the activation of mechanisms which support the individual's engagement in PD. In order to illustrate the points given in the list (above) examples of data will be provided to explain how the PD was supported or challenged by the immediate local team context. The senior OT in the example below had support from MDT colleagues and managers to progress the implementation of the PD in addition to her own interest which fuelled her

motivation. Furthermore, she had access to the resources that she required for participation in the new learning.

> *Having the opportunity to discuss it [PD] within [occupational therapy] supervision, at any time [helps]. That's formally and informally. The training opportunities as well, that [helps] for the enhancement of [my] practice. Aside from that it's just the general, informal peers, like team members that help enhance my practice as well. Using evidence base stuff and to read. There's lots of articles upstairs that we have in the files that I have access to which is really useful and I, you know, dip in and out of that.*
>
> **Bev: Initial Interview**

Some therapists expressed how the team expected them to undertake a variety of roles which because of the extended scope of the practice had little direct bearing upon their engagement in the PD. Contextual tension was a result for some where the therapists engagement in the occupational therapy specific PD may have been perceived as less of a priority by the team.

> *There are loads of barriers and challenges everywhere within, you know, a team within which you work. [The team] has views about how you work and you have different roles within that team as well, you know as Care Coordinator and that does affect the way in which you work with certain clients. You will be a care coordinator, an OT care coordinator and you will care coordinate as that profession but that's still not specific to your professional skills and you won't be doing maybe pure OT, you'll be doing maybe some generic tasks that another profession could do.*
>
> **Delyth: Initial Interview**

6.2.4 Personal Capacities and Attitudes Context (Internal)

This last aspect of context drew out the individual capacities and attitudes of the therapists' to form the last contextual layer. Included here were the very individual

sets of attributes held by each therapist, which had shaped their ability to engage in activating the PD mechanisms. These included:

- Therapist's health and well being
- Therapist's feelings about practice change
- Therapist's capacity for managing competing demands
- Therapist's capacity for negotiating time
- Therapist's interest in the PD
- Therapist's ambition and drive

Some comparison can be made here with the key characteristics, qualities and skills that others have proposed are important for those engaged in PD (McGurk 2008). The area missing from McGurk's list though is general well being. Hannah for example described the health challenges that she had experienced between the start and end of data collection. She noted how the illness experience had reduced her ability to manage the demands of her work role and her home life. This made engagement in the PD of a lesser priority to her.

> *I've been incredibly ill so I had huge chunks of time out. Being ill, that's hard enough but also little times when there's a day or two days off and I find that being in and out of work [that] it is very hard to keep a flow, both regarding your work within the team but also with your patients obviously. Within that year [the PD is] very, very bad timing.*
>
> **Hannah: Final Interview**

The therapists own feelings about implementing PD had an impact upon whether they were able to initiate engagement in a practical way. In particular there was some evidence that some therapists felt fearful of failing to implement the PD well enough with their clients.

> *I'm too scared to try an assessment in case I get stuck half way through and you're with a client and you're not sure what your supposed to be doing or if*

problems come up and you're not sure how to deal with those [or] maybe questions that arise from them [the assessment].

Ann – Initial Interview

Gillian struggled with the relevance of some aspects of the PD to her work. In particular she questioned the language used to describe the concepts expressed within the PD. This may have had an impact upon her interest in and commitment to engaging overall with the PD.

I'm not comfortable with the [MOHO] language, so I tend not to use it which doesn't really help me embrace the concepts I guess.

Gillian: Initial Interview

The data holds examples where personal capacities and attitudes overtly support engagement in PD. Fiona, the therapist in the next example described how she had no direct supervision available but had used her own interest in the PD together with her ambition, drive and capacity for negotiating time to override the challenges within her immediate team context. Fiona explained how she had built support systems for her engagement in PD and found alternative ways to construct her PD supports by becoming part of a new team (for some of her time) and undertaking a PD leadership role which located her within a leadership development group. She concluded by saying:

I've had the privilege of being part of the [OT PD] steering group from very early on really so, yes, I've had access to discussions at a different level I suppose.

Fiona: Final Interview

This section has illustrated how the data revealed that individuals' contextual situations were significant to their engagement in PD. It is also clear from the data that each contextual category should not be seen in isolation. A change in one

aspect of context can impact upon another in both supportive and inhibiting ways. This finding is also true for mechanisms which will be presented next.

6.3 Mechanisms

Mechanisms are a key feature of Realistic Evaluation (Pawson and Tilley, 1997) and these are described in Chapter Four (Section 4.3). In this study several mechanisms were identified and these will be defined and explained in this section. Furthermore it was also identified that the mechanisms to support an individual's engagement in PD, when activated, need to work dynamically amongst themselves and with the contextual features to support the outcome goal of practice development. These interrelationships will be introduced at the end of this chapter and further discussed in Chapter Eight. For the time being the *common* causal mechanisms which emerged from the data will be presented.

6.3.1 Common causal mechanisms

Causal mechanisms are the triggering processes which initiate change (Pawson and Tilley, 1997). In this instance a description of the causal mechanisms which the study found to be common across participants is presented. Causal mechanisms were developed inductively through in-depth analysis of primarily the interview data (see Chapter Five Section 5.7). The researcher then referred again to the literature which although using different language supports the findings.

The common causal mechanisms presented will be grouped together to introduce the whole set of mechanisms. These are perceived as being collectively important to scaffold individuals' engagement in any PD intervention. The data sample of individuals was drawn from ten participants and data saturation with regard to the mechanisms has been achieved. No new mechanisms emerged after data of five participants had been analyzed. The six common causal mechanisms which emerged are listed below. The first two are critical mechanisms to support development whilst the latter four support further activation:

- Building Confidence
- Finding Flow
- Accumulating Reward
- Conferring with Others
- Constructing Knowledge Know-how
- Channelling Time

Further conceptualization of the relationship between the six causal mechanisms will be provided in Section 6.3.3 together with an in-depth description using some quotations from the semi-structured interviews to provide illustration of the points made. Firstly though a synopsis will be given about why and how each mechanism was awarded different 'levels of activation' and also their variation in potency for effecting outcome.

6.3.2 Layers and intensity of mechanism activation

The data suggests that the activation of each mechanism is not a binary occurrence. That is the mechanisms do not switch simply 'on' or 'off' but have levels of potency of activation (see Table 6.1). These levels were revealed through the systematic data analysis described in Chapter Five and were also used to inform more in-depth data analysis of individual CMO patterns (see Chapter Eight). These levels are important as together with the pattern of individual contexts, the outcome of the PD for each individual appears to be effected by the intensity of this mechanistic activation. This is important because, as will be illustrated later (see Section 6.7), the level of mechanism activation achieved relates to the outcome success of participation in PD. An illustrated example of a simple lever system is provided here to consider the level of mechanistic activation to enable the movement of an object through leverage. If the levering process is not initiated there would be no activation of the mechanism. On the other hand, if the lever is pushed but without sufficient strength for the outcome to be achieved then the mechanism is activated but only partially, thus the object might only be

partially repositioned. If the lever is pushed and the outcome is achieved then the lever mechanism can be considered as being fully activated.

Four different levels of mechanisms activation were identified. These were drawn up inductively to reflect the stages of 'full' activation, 'partial' activation, 'embryonic' activation and 'no' activation (see Table 6.1). It should also be noted that in Table 6.1 'traffic light' colours are used to further illustrate the degree of mechanistic activation. Dark green represents full activation; light green represents partial activation; amber represents embryonic activation whilst red indicates no activation of the mechanism was present.

Through this analysis it also emerged that some of the common causal mechanisms had fundamental potency. The interrelationships of the mechanisms will be discussed later (see Section 6.4 and Figure 6.2) but at this stage it is worth noting that 'Building Confidence' and 'Finding Flow' are of primary and key concern.

Table 6.1 Levels of Mechanism Activation

Degree or intensity of mechanism *activation*	Explanation of data criteria
	Building Confidence
Full ***activation***	○ Evidence of therapist experiencing mastery with the use of this PD in practice
Partial ***activation***	○ Evidence of therapist experiencing some confidence to use this PD in practice
Embryonic ***activation***	○ Evidence of therapist gaining emerging confidence in using this PD in practice
No ***activation***	○ No evidence available to suggest that therapist has belief in her ability / self efficacy with this PD in practice
	Finding Flow
Full ***activation***	○ Evidence that therapist has developed valued structures and routines of engaging in using MOHO and the standardised assessments.
Partial ***activation***	○ Evidence that therapist has some routine of engaging in using MOHO and the standardised assessments.
Embryonic ***activation***	○ Evidence that therapist has begun to use MOHO and the standardised assessments but no routine established.
No ***activation***	○ No evidence that therapist has started using MOHO and the standardised assessments or evidence that available routines have been dismissed by therapist.

Accumulating Reward	
Full ***activation***	○ Evidence that therapist is experiencing high degree of positive reward for effort at implementing MOHO and the standardised assessments.
Partial ***activation***	○ Evidence that therapist experiencing some degree of positive reward for effort at implementing MOHO and the standardised assessments.
Embryonic ***activation***	○ Evidence that therapist is experiencing hope of / emerging feeling of positive reward for effort at implementing MOHO and the standardised assessments.
No ***activation***	○ No evidence that therapist is experiencing positive reward for effort at implementing or evidence that therapists believe that engaging in MOHO and the standardised assessments would not bring reward.

Conferring with Others	
Full ***activation***	○ Evidence that therapist engages in *several* available opportunities of discussing the use of MOHO and the standardised assessments in practice
Partial ***activation***	○ Evidence that therapist engages in *some* opportunities of discussing the use of MOHO and the standardised assessments with others
Embryonic ***activation***	○ Evidence that therapist engages *minimally in* opportunity to discuss the use of MOHO and the standardised assessments.
No ***activation***	○ No evidence that therapist engages in opportunities to discuss the use of MOHO and the standardised assessments *or* evidence that opportunities are dismissed.

Constructing Knowledge Know-how

Full ***activation***	○ Evidence that therapist has developed solid building blocks of learning MOHO and the standardised assessments' concepts and skills
Partial ***activation***	○ Evidence that therapist has developed some building blocks of learning MOHO and the standardised assessments' concepts and skills
Embryonic ***activation***	○ Evidence that therapist has foundation blocks in place to learn MOHO and the standardised assessments' concepts
No ***activation***	○ No evidence that therapist has a foundation of understanding MOHO and the standardised assessments' concepts or evidence that new knowledge has been dismissed.

Channelling Time

Full ***activation***	○ Evidence that therapist is engaged in protecting learning time for MOHO and the standardised assessments.
Partial ***activation***	○ Evidence that therapist is experiencing tension with protecting learning time for MOHO and the standardised assessments.
Embryonic ***activation***	○ Evidence that therapist has little protected time available for learning about MOHO and the standardised assessments.
No ***activation***	○ Evidence that no time has been available/ protected / used by therapist for learning MOHO and the standardised assessments.

6.3.3 'Building Confidence' Mechanism

'Building Confidence' appeared to be a pivotal mechanism to the individual's engagement in this PD. For example, confidence in the value of the PD approach for their practice; confidence in their own ability to learn a new way of thinking; confidence in putting the new knowledge into practice; confidence to share information with others. This mechanism is set in motion where individuals have an activated a sense of confidence in their own ability to use the PD principles to affect their work.

The literature supports the notion that the development of confidence is critical to learning and engaging in new work behaviours (Eraut et al 2000a). As an individual's confidence grows it can transform the person's life through their emancipatory action (Mezirow, 1990). Both intrinsic and extrinsic motivational factors can have a bearing upon a person's ability to build confidence in the workplace (Amabile et al 1994). An example of internal motivation could be the level of a person's fundamental interest in the subject matter to be learnt (Lepper, 1988). With regard to external motivation an example could be the style of the facilitator (Noels et al 1999). If individuals are unfamiliar with the content of new information it is important that facilitators are able to process and package what needs to be learnt in order for confidence to be built (Jonassen and Grabowski, 1993). This position is supported in studies where paucity of confidence has been seen as a factor in negatively affecting nurses' ability to change practice (Gerrish and Clayton, 2004; Gerrish et al 2006).

Many theories exist as to why and how people develop self efficacy in the things that they need and want to achieve in their lives. Bandura (1995) discusses these in depth and locates the purpose of self efficacy as the human need to strive for control over life circumstances. Bandura argues that the ability to affect outcome enables those outcomes to be predicable. In these circumstances an individual can feel increasingly assured that their efforts will

be likely to result in positive achievement thus supporting a situation which moves an individual from their knowledge acquisition into more skilled action (Benner 1984, National Institute for Health and Clinical Excellence, 2007). Behavioural indicators in this situation would be that the more capable a person feels the more challenges that they seek (de las Heras et al 2003a). Conversely, the reverse is true: feeling unable to exert influence over things that adversely affect one's life breeds apprehension, apathy and despair (Bandura, 1995). In this circumstance the less capable an individual feels the more likely they are to put less effort into the task or to avoid it altogether.

It was clear that some therapists had engaged with the PD interventions which led to further confidence about their ability in addition to their developing belief in the value of the PD initiative itself. There are examples in the data which illustrate that therapists were making positive choices to use some PD interventions to support their feeling of confidence in their clinical reasoning. The PD theory for these participants was conceptualized as a road map for rigorous thinking and the in-house assessment based training had a general impact upon the feelings of confidence that therapists' had achieved.

> *I'm feeling more confident using them [the assessments]. I suppose six months ago I was using them but often not 100% sure on where I was going or what the sort of treatment planning was from it. I'm by no means there yet but I'm feeling more comfortable having a go and trying them out and talking to patients about it as well.*
>
> **Eithwen: Final Interview**

There were also examples where the 'Building Confidence' mechanism was not yet activated which affected the practice undertaken. At this stage Ann had not undertaken in-house training in the assessment that she needed for her practice. Whilst this statement implies that the training might resolve everything, it also might not. The important aspect here is Ann's perception

that she needed the support of a facilitated training programme before gaining sufficient self-efficacy in the task to try the assessment out in practice.

> *I've only actually heard the name [of the assessments]. I don't actually know what they're about so I have to actually spend a lot of time reading them. But, I personally take things on board a lot better if I do it practically and see it done practically..... I want to do an OSA on someone but I've not quite conjured up enough courage to do it with them really..... I'm going on the VQ training; hopefully I'll see and learn a bit more.*
>
> **Ann: Initial Interview**

6.3.4 'Finding Flow' Mechanism

The activation of a mechanism of 'Finding Flow' was crucial to lead to outcome achievement. This was also perceived as a pivotal mechanism. 'Finding Flow' had two particular components. The first was where participants felt that they were connecting with an existing slip stream of PD interventions or tasks their 'Finding Flow' mechanism became activated. In addition the results suggest that 'Finding Flow' was also activated where therapists perceived the creation of a well used route to PD. Activation of this mechanism lead to the circumstance where the individual felt involved in a valued routine of PD activity. This is connected with an individual feeling part of a pre-determined tide of activity within their context and thus selecting experiences to move them along with the PD current. Lave and Wenger (1991) describe something similar in their seminal text concerned with situated learning where the properties of relevance and relatedness are conceptualized dynamically in the participation in learning. They propose that individual development is basically a social process and that learning is generated from the social environment. Thus in order for 'Finding Flow' to be activated the PD environment or context needs to be structured accordingly. Lave and Wenger also make it clear that some type of learning takes place in a context

no matter what educational structure is available. The results revealed that when 'Finding Flow' was activated in this research individuals were enabled to accept the PD and formulate their habituated routine (National Institute for Health and Clinical Excellence, 2007) and thus channel their learning.

> *When the [PD] initiative came along…. it just really excited me because I could actually see that we would be assessing people wholly and occupationally…. So I just embraced that really, very quickly, with relief!*
>
> **Fiona: Initial Interview**

The therapists who had the 'Finding Flow' mechanism fully activated had a vision of the direction of PD travel. They engaged with opportunities that presented in order to find their way through the complexities of learning the PD way of working. By activation of 'Finding Flow' mechanism, therapists had cognitively discovered the relevance of the PD to them through experiential learning (Jarvis at al 2003). Thus these therapists were demonstrating their own ability to micro lead initiatives by forming their own pathway to the overall change process.

Where therapists did not have the 'Finding Flow' mechanism activated the course of PD was inhibited or stalled. The next example illustrates that the therapist, despite offering some reflection on the advantages of engaging in PD interventions had not felt able to activate the mechanism 'Finding Flow' in her practice. This example also illustrates the importance of local context and individual context toward mechanisms activation.

> *At the moment, for me, I can spend the whole week and it's gone in seconds. I've been getting patients down [to the OT department] and I'm all over the place. Then I suddenly think well, if I'd done a MOHOST at the beginning when I started working with them on the first day and now, near discharge we do it again, you can see the difference, which I totally*

agree is very useful, but in reality its proving difficult to get used to that. I think as with everything once it's part of our daily functioning and how we do things then it'll become automatic but at the moment we're having to remind ourselves.

Hannah: Initial Interview

6.3.5 'Accumulating Reward' Mechanism

In order to successfully engage in PD the therapists outlined their need to feel that they were accruing an incentive of some nature from the effort. Where no 'Accumulating Reward' was activated the therapist's engagement in PD was less evident. Some authors suggest that reward implies the provision of incentive from an external source (Arkes 1978). However, the mechanism of 'Accumulating Reward' presented here is connected with the extrinsic *and* intrinsic motivational factors (Amabile et al 1994) such as the external recognition of performance in addition to the feelings of self-determination, competence, enjoyment and interest that may be experienced through engaging in a PD activity. Consistent interaction with skilled leaders could provide external reinforcement (Archer and Cameron, 2009). It is interesting to note that some research implies that learning with the incentive of financial or other external rewards is not necessarily supportive of sustained effort (Noels et al 1999). The same research suggests that where there is more personal choice of engaging in the learning material the subsequent learning is greater. This finding is supported by Knowles et al (2005) who advise that for adult learning to be successful the individual needs to perceive there to be an intrinsic value and personal payoff for their effort.

The rewards gained by therapists cited in this research varied and included the development of positive outcomes with service users; the maintained motivation of therapists toward PD activity; developed work status, mastery experiences and being validated by others for the therapist's professional contribution. The activation of "Accumulating Reward" mechanism can be

compared with the idea that where the person receives positive information about their engagement in PD the mechanism is activated to a greater level (Chowdhury et al 2002). Occupational therapists and other health care practitioners with clinical responsibilities generally locate their priorities within direct client care (LeMay et al. 1998, Metcalf et al. 2001). PD which has a relevance to this goal is intrinsically rewarding generally to therapists particularly where there is a perception that it sits with their underlying belief of why they chose this vocational pathway. This is illustrated in the example below.

> *Using it [MOHO theory] to define your practice I think is a very useful and positive experience for us as a profession as well as other people. It gives you a way of explaining things and I think a lot of people struggle with that. I think that we are a lot clearer on explaining because of that strong model and because of that strong, very strong professional identity. It gives you that strength and identity that means that you are more able to explain and justify what you are doing and why you are doing it.*
>
> **Delyth: Initial interview**

In the next example the participant was speaking of a previous work role (out with the PD Trust) where she did not feel that she was advancing her development as an occupational therapist thus activation of 'Accumulating Reward' was not evident at this point.

> *Being an OT you almost kind of lost skills and you just end up doing groups and making cups of tea and you say 'what's the point of doing three years at college just for the sake of doing this?'. Because anyone off the street could do that*.
>
> **Ann: Initial Interview**.

The participants commonly discussed the benefits of attending in-service local opportunities to learn specific new practice techniques. Despite some PD tools

being designed for therapists to teach themselves from the manuals, therapists spoke of the organization's internal training structure to implement standardized assessments as being an important catalyst for the structured use of assessments in practice which in itself was rewarding.

Mechanism activation is not mutually exclusive as is evidenced in the quote from Hannah in 6.3.4. Hannah had not activated 'Finding a Flow' and thus the experience of 'Accumulating Reward' was anticipated but not felt. The anticipation of 'Accumulating Reward' was not sufficient in this case to tip 'Finding a Flow'. Another example of this is featured in the quote below. Here the therapist describes how the opportunity to confer with others about and within PD interventions activates the reward mechanism for her.

> *"You'd have lots to take back [from conferring with others at the PD training events] and the very next day some part of it was useful and you could see the change that it had made to your practice"*
>
> **Eithwen: Initial Interview**

6.3.6 'Conferring with Others' Mechanism

The mechanism of 'Conferring with Others' whether in, for example, a one-to-one supervision session or a peer group debate can lead to enhancement of practice (Sweeney et al. 2001c; Wimpenny et al. 2006). Indeed, practice based on the idea of 'reflection on action'(Schön, 1991) as an individual undertaking or as part of a dialogue with others has been argued for some time to be an underpinning mechanism of professional problem solving (Roberts, 2002). Considered another way, Wenger (1998) discusses how a community of practice sustains the practitioner's ability to do their work by enabling learning through the development of meaning and identity. This is supported by Eraut and colleagues' (2000b) study who found that learning from contact with other people was a form of learning important to nearly all of their respondents. The results suggest that making meaning through 'Conferring with Others' involved sorting out misconceptions about the PD and seeking affirmation that

the engagement made was appropriate (thus feeding into 'Building Confidence'). On the other hand there is also evidence that 'Conferring with Others' is a product of the activation of 'Building Confidence' and 'Finding Flow' where some participants had taken a key part in sharing their developments by making presentations to their peers. It is clear then that this is not a linear process and that each pattern of activation has an individual fingerprint. Wenger argues that learning is a social process through which people learn to negotiate a pattern of practice which holds meaning. Other authors support this view and propose that '*social learning'* in a socially constructed learning environment can activate the formation of individual practice identity and professional development (Jarvis et al 2003). It is no surprise then that therapists in the study found this mechanism helpful to support their engagement in this practice development.

> *You can only do so much yourself. You can sort of 'down load your head' but then it's only your view on things and then I think it's important to have the opportunity to talk through things. It [supervision] often clarifies things a lot more than just thinking it through by yourself.*
>
> **Caroline: Final Interview**

Participants' were frustrated when the environmental context to support a type of conferring opportunity (e.g. PD supervision) was not available to them or not to the depth that they needed. It appeared then that for some people the lack of activation of this particular mechanism can be identified as potentially inhibiting their PD progress and was very dependent on their immediate context. The therapist in the example below implied that the she would have benefited from discussion with an immediate supervisor (or her community of practice) who was familiar with the PD knowledge. This she felt was not directly available.

> *It would have been lovely to have had a clinical supervisor who'd had some sort of handle on what it [PD] was all about really. I mean, I felt*

very much on my own with implementing it, doing the training and relying on my own understanding of that. A one to one forum where I could have mulled over how it all fitted into the service would have been wonderful. I've not had that.

Fiona: Final Interview

6.3.7 'Constructing Knowledge and Know-how'

The results suggested that PD knowledge appeared to be accumulated in parts. This process of knowledge assembly that occurs over time is itself a mechanism for change because as knowledge is gathered and synthesized successfully and with relevance into practice the therapist's confidence grew and they developed a flow in their use of the PD routinely. This is somewhat connected with the development of new knowledge through discovered information and requires professionals to engage in continued learning opportunities (Smith, 2001). The success of the activation of this mechanism is dependent upon a variety of learning opportunities being available to the therapists because different approaches will be effective for different people in different situations (National Institute for Health and Clinical Excellence, 2007). Eraut and colleagues (2000b) found that workers build knowledge incrementally and were sometimes challenged to identify what they have learnt and how it had occurred despite knowing that their practice had evolved. It is possible then that several different learning opportunities had shifted their behaviour in practice. Particularly relevant for novice therapists, this mechanism is initially important in order that practitioners can build the foundation on which robust and ethical practice decisions are constructed for future reference (Benner, 1984: White, 2001).

When I did the VQ training I thought 'that looks like an ideal kind of assessment to use'. So I started doing that and then used the Re-motivation theory of adding bits in at a time so it's a similar thing but I'm using the manual now as a reference and a back up to my thinking.

Bev: Initial Interview

Therapists reported that the PD interventions of practise in practice, supervision and formal education in theory were important in activating the mechanism of 'Constructing Knowledge and Know-how' thus facilitating their ability to piece together information into meaningful, relevant chunks and make sense of knowledge. Being able to make sense of practice knowledge systematically is in itself satisfying and conviction building so it also impacts upon the activation of the 'Accumulating Reward' (6.3.5) and 'Building Confidence' (6.3.3) mechanisms.

> *I think that there is just a continuing, developing awareness of when it's appropriate to use which [assessment] ..... Having been involved in developing the ICP and with the further teaching on case formulation and treatment goal planning, you start to move on. Whereas the focus probably six months ago was very firmly in assessment, we're now looking through, beyond that as to where we're going with case formulation and treatment planning.*
>
> **Fiona: Final Interview**

On the other hand being unable to activate the 'Constructing Knowledge and Know-how' mechanism is a source of frustration for therapists which can ultimately inhibit PD outcomes.

> *You get to the point where we can't take on new things, there's only so much new things and so much change that you can take on at once and if it means that some things have to be put on hold then I think that's the right thing to do otherwise people feel overwhelmed and overloaded and actually get to the point where they feel they can't be learning new things any more so that's something to keep an eye on.*
>
> **Hannah: Final Interview**

For participants in a more senior post this mechanism was also important. By learning concepts and skills that were relevant to practice therapists acknowledged that their practice know-how was being honed even when they had significant practice experience. Key to this process is working directly with clients or practise in practice.

A phased approach to learning implemented over time was an overt part of the PD initiative (see Chapter One). Therapists appreciated the PD information being provided in incremental pieces as a positive support for their engagement in and practical use of the available knowledge. Participants described how they had been able to fill the gaps in their knowledge through structured incremental learning.

> *Just adding a bit here and there of the process of going forward and not giant inspirational leaps, well much fewer of those than I would probably have expected but just little bits adding together and just forming a path forward and the dry patches between the marshy bits getting dryer and more solid as time's gone on really.*
>
> **Isobel: Final Interview**

6.3.8 'Channelling Time' Mechanism

Allocating time to development activities has been mentioned as a barrier to participation in many disciplines (Metcalf et al 2001: Dysart and Tomlin, 2002: McCluskey, 2003, Bennett et al 2003: Parahoo, 2000: Lam, 2004). However it has been argued that apportioning time to such activity should be part of a professional practitioner's responsibility (College of Occupational Therapists, 2005). Once again, activation of this mechanism is connected with a person's contextual situation as having a culture which positively supports investment of time in PD interventions will encourage individuals to use time for PD interventions (Mulhall et al 1998: Humphris et al 2000). It has been argued as helpful to have leaders design PD activity in order that practitioners

can have focused and co-ordinated PD experiences to maximize the time investment (McQueen, 2008).

Where participants in this study were conceptually able to allocate time to take part in PD activity of some nature they had activated the 'Channelling Time' mechanism to some level. Significantly, they were not generally reporting that PD interventions required time out of practice for external, didactic formal training courses to be provided. They expressed that their needs in relation to this PD could be met *within* the organization with a mixture of different learning opportunities available and strategically designed. Specifically, therapists felt that the activation of the 'Channelling Time' mechanisms included having short periods of time out of clinical work to concentrate on learning in a small group. Having a set time to implement before reporting back upon their new practice learning was also favoured. Thus the important point about this mechanism is that the therapist had a belief that using time for this PD was part of practice, an essential part of the mixture not just the icing on the top. Activation of the 'Channelling Time' mechanism included structuring time and having goal deadlines for learning parts of the PD which was of equal importance across levels of seniority.

> *[If given time to develop practice further] I would try to manage my time better so that I could set some time aside to really get to grips with spending some more time just on my own learning MOHO and getting really familiar with it, just on my own. Certainly here we've been trying to set aside some time for all the OT's to brainstorm and bring in case studies together so that we can all learn together. It's just time that's an issue, the normal pressures and crisis.*
>
> **Bev: Initial Interview**

Several participants were aware of pressures experienced by themselves or colleagues that the learning and practice change expected was bordering on overwhelming in terms of the time commitment for competing PD

interventions. This was particularly where individuals were engaged in additional PD programs or had extra work responsibilities for example for leading or managing a service.

There were also perceptions that the timing of PD interventions for some individuals proved a challenge and restricted the activation of the 'Channelling Time' mechanisms. This was particularly evident where participants worked less than full time hours and had challenges in their personal circumstances outside their work role.

> *Because I know that as that [practice development] was being introduced, I then went off on maternity leave and I can remember feeling quite envious as well and thinking 'there's some really good things happening and I'm going off to do other things' and that felt, you know, it was hard but it soon changed after having the baby (smiles)*
>
> **Delyth: Initial Interview**

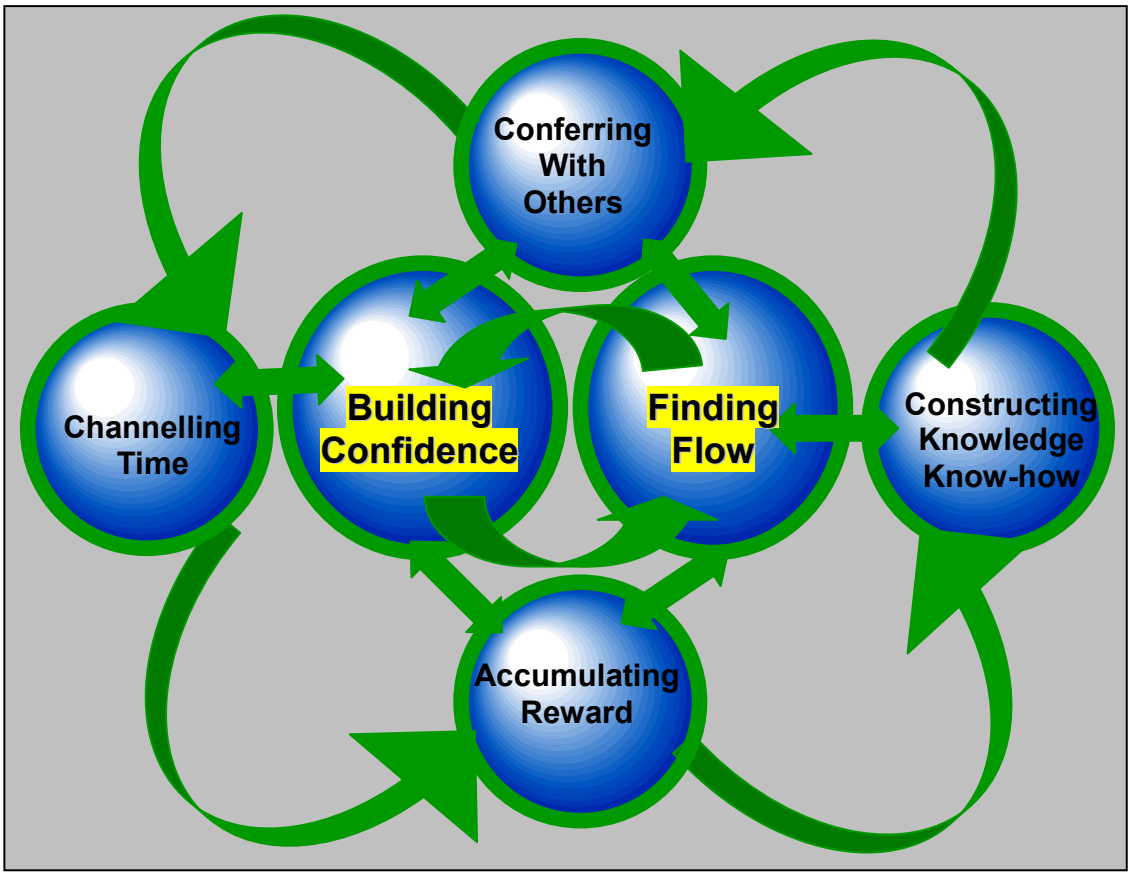
On deeper analysis it was evident that the mechanisms had a strong interrelationship in supporting individuals' PD. An over view of these relationships will be introduced next by considering a general theory of how the mechanisms associate with each other and evidencing further connections with quotes from the data .

6.4 Interface between mechanisms

Figure 6.2 is an illustration of a general pattern of interconnected relationships between the mechanisms. The diagram illustrates that the mechanisms are *not* discrete switches that are activated to produce isolated pieces of outcome. They are in fact interconnected with the core, central and symbiotic mechanisms being the 'Building Confidence' and 'Finding Flow'. The former is conceptualized as one which is deeply personal and of primary importance to the individual's motivation to engage in PD, the latter is crucial to the momentum that an individual needs to experience in order to direct energy into the PD experience. The other four mechanisms are supportive and can be

catalytic to the two central mechanisms. An activation of all of these to some degree is important for a high level of outcome. These common causal mechanisms will be discussed further at the end of the thesis (see Chapter Ten, Section 10.3.2). In addition the Chapter Nine will consider the mechanisms further in relation to Dynamic Systems Theory (Lewis, 2000).

Figure 6.2 Interface between Common Causal Mechanisms



Key to Figure 6.2

The blue spheres represent each individual mechanism. The green arrows and capsule around each sphere represent full activation of the mechanism. The mechanisms represented in the centre of the figure by the larger spheres and highlighted in yellow that is 'Building Confidence' and 'Finding Flow' symbolizes the key and pivotal

mechanisms which need to be activated in order to move toward a positive outcome.

The results suggest that none of the mechanisms successfully activate in isolation to produce significant PD outcome. Each seems to rely on the other to build the person's overall capacity to achieve robust practice development outcomes within the context. Figure 6.2 is presented to give a flavour of the inter-connections between the mechanisms. The data suggests that each mechanism can generate a spark of activation which has the potential to act as an ignition to another depending upon the strength of the contextual 'fuel'.

For example, one participant spoke of the confidence that she had developed to implement her PD knowledge to a particular level and then about the reward that she had gained personally 'Accumulating Reward' through engaging in a further piece of PD opportunity. Thus further self-belief was gained (activating 'Building Confidence') to return to practice activity and to piece together practice knowledge 'Constructing Knowledge Know-how'. The same therapist also implied that 'Conferring with Others' was important in this scenario as she had checked out through discussion with her peers the validity of what was being learnt at the PD event. The 'Channelling Time' mechanism had also been activated where the therapist had responded to the environmental opportunity and invested time in this PD opportunity by making a conscious priority of this time in her working role. As with many other examples in the data this example illustrates that participants need to have the 'Finding Flow' mechanism activated so that they are in a slip stream of activities focused toward the PD goal. Together then, 'Finding Flow' and the 'Building Confidence' work as the central mechanisms and have a role in activating or 'firing up' the other mechanisms to support the whole system to develop momentum.

You trundle along with your case load and you're doing the best that you can and you're implementing MOHO as much as you think that you can do and then you go to [in-service] training and it kind of just starts it up again, it fires it up and it's quite nice being in the same room as everyone else is feeling the same and it just feeds into your motivation and you go away and feel all excited again.

Bev: Initial Interview

Another way of conceptualizing this is that each of the mechanisms carries 'weight'. The heavier the relative mechanistic 'tip' for the individual (influenced by the context), the more engagement in PD is possible. With this data, it may not be possible to accurately measure the relative weight of the mechanistic 'tip' but some patterns may be postulated for further consideration. These will be addressed within the individual examples which follow in Chapter Seven.

6.5 Outcome levels

This section will present the four outcome levels that were identified through the first stage analysis of the data. These are presented in tabular format (see Table 6.2) and described in the associated subsection. In addition the notes audit results will be provided for clarity.

Analysis of the whole data set revealed that there were differences in the extent to which individuals engaged in the PD. These are conceptualized as different outcome levels. These outcomes for individuals have been broadly categorized as follows and to some extent mirror the terms described by Kielhofner 2008b. Table 6.2 summarizes the outcome levels which were conceptualized inductively from the data analysis. The outcome levels have been compared functionally with the process of aircraft flight to explain the concepts. The use of metaphor has been described as experiencing one thing in terms of another and is commonplace in social science writing (Richardson, 2000). The metaphor of air travel was chosen as it illustrates the stages of

movement to progress from a stationary position to one where the objective of the task is achieved.

It should also be noted that corresponding 'traffic light' colours are used to illustrate the level of outcome achieved by these individuals. The degree of outcome is represented by a corresponding traffic light colour. Two shades of green are used to illustrate the degree of intensity of the 'flight' achieved with the PD.

The four outcome levels included:

- **Pre-exploration or Dismissal** or **'In the Hanger' (**Red**)**
- **Exploration** or **'On the Runway' (**Amber**)**
- **Action** or **'Take Off' (**Light green**)**
- **Achievement** or **'In the Air' (**Dark green**)**

6.5.1 Pre-exploration or Dismissal Outcome level – 'In the Hanger'

When participants gained the outcome level of 'Pre-exploration or Dismissal' the data revealed that the individual did not implement the expected PD outcomes. The outcome is observed to be static, not having moved from their original practice behaviour or if there is movement it has not made a significant shift from the security of their metaphoric aircraft shelter. For example the individual may not have attempted to use MOHO to reason or formulate their work in practice, they may not have had the opportunity to undertake training in MOHO concepts or they could have been using assessment tools without training or adequate knowledge. Whilst there may have been some attempts made at using the PD language these therapists did not use the concepts or the assessments and expressed a paucity of confidence in using the PD. Also, the OT may have considered using or tried using MOHO theory in practice but decided that the concepts were not relevant or useful thus dismissing the PD as unnecessary for their practice. Where positive engagement was suggested the action was tentative, not routine, and generally cursory .When considering the metaphor of aircraft movement to this level of

outcome the participants were ‘In the Hanger’ as they had made no significant travel to use the PD in their practice and thus their behaviour remained parked in practice that would have been expected prior to the PD intervention.

> *That’s the point I’m at because I’m not even reading information. I’m not going to Link Forums [PD discussion groups] and I’m just plodding along. My reasoning hasn’t changed. I still understand what we do and why we do it through the model. So for the last year I don’t think that has changed much but I don’t think that I’ve developed any further in the last year.*
>
> **Hannah–Final Interview**.

6.5.2 Exploration Outcome level or ‘On the Runway’

Participants who had started to implement the PD within their practice fell into the ‘Exploration’ outcome level. Whilst there are limitations to the actual change noted they are gearing up to explore new options for practice. They have moved from sheltering in the hanger of pre-development thinking and are gaining speed toward taking off with change to their routine thinking and practice action. Thus, they may appear tentative or concerned about the journey ahead which will launch them into a different situation with their practice. Individuals who achieved this outcome level were trying to reason and formulate their thinking about their practice with MOHO. They were beginning an education process and starting to synthesise PD learning into their work. Though they were using the concepts there was evidence of struggle to embed the new knowledge into their daily routine. In terms of the flight metaphor the participants categorized into this outcome level had started to move on their journey toward integrating new knowledge into practice but had not yet progressed to getting off the ground with their practice. As such this outcome level is described as ‘On the Runway’.

Only in some note entries does the OT refer to the concepts in MOHO based theory. Her hand written note entries were mainly descriptive of things said and observation of client in conversation or activity. Typed report made is structured into MOHO based headings. That said, the report does not really articulate how these concepts interact 'dynamically' to describe the person's total occupational performance potential. It is geared towards a child protection report. Also, performance capacity is mixed with motor and process skills.

Jackie - Notes Audit

6.5.3 Action Outcome level or 'Take Off'.

The outcome level of 'Take Off' emerged where participants had partially implemented the expected PD outcomes by undertaking dedicated and specific training and there was evidence that they at least intermittently utilised MOHO to undertake assessment and clinical reasoning about clients' challenges. Typically these therapists had reached a point where they were beginning to conceptualise and articulate their work through the PD concepts. As such they had reached a 'Take Off' point and had started to take flight with their routine use of MOHO.

Now when I see someone, I'm thinking all the time about 'where is this person in terms of their volition, habituation, their performance capacity and their environment?' I mean, that's just how I think now and that really does inform my clinical reasoning a lot.

Caroline: Initial Interview

6.5.4 Achievement Outcome level or 'In the Air'

Therapists whose outcome level was defined as 'In the Air' confidently displayed their ability to soar metaphorically with the PD concepts. Typically they were routinely implementing the expected PD outcomes by articulating their clients' situations using the MOHO. In addition they were skilfully

selecting and utilising assessments in practice and making interpretations of results using MOHO theory. These participants had embedded enough of the development to be able to sustain 'flight' or implementation to adopt change into their practice. The pace of their practice development had propulsion. This was strong enough to maintain sufficient power for continued involvement in PD application. They had achieved travel through exploration to action and in some cases a higher level of achievement in the PD principles.

> *[It] was an overt dawning on me that I have absorbed this theory because I was [now] going in [to clinical situations], not looking at whether [the client] could get her legs over the side of the bath but how important was this to her, was it part of her routine that she would normally conduct her day, what was her will to carry on doing this and that was how my assessment was framed. Rather than saying 'oh, well there's a bath board in site, she's alright getting her legs over that, she's fine, 'cause clearly she wasn't fine because it wasn't meeting, it wasn't satisfying her as a person so. Something had shifted!*
>
> **Fiona – Initial Interview**

6.5.5 The correlation of Notes Audit results

The notes audit results were used together with other data to reveal the outcome levels presented above. Here a tabulated presentation of the notes audit raw data is provided for clarity. Table 6.3 provides, in tabular form, the results and some comment about the notes audit. These data are presented to illustrate the synthesis of the whole audit data set in relation to each individual's outcome to each audit standard. These data particularly relate to the 'categories' of data that were considered and collected as part of the notes audit data collection tool. These are coded into 'traffic light' colours to represent that audit standard categories (see Appendix 5). These were either met (green), partially met (amber) or not met (red). It is clear from the data that individuals differ in their use of the PD information in their

documentation of practice. It should also be noted that audit data was collected at one point in time and further data was collected from each individual using semi structured interview at least six months after the notes audit.

6.6 Outcome levels and the literature

When considering the outcome levels that emerged through this research it is useful to return to the literature to consider comparisons and differences in theory. Prochaska et al (1998) outline clinically orientated stages of change which allow appraisal of the *stage* of a person's behaviour towards the change goal. These were discussed in Section 3.2.3 and are described in five stages as pre-contemplation, contemplation, preparation, action and maintenance. The terms are action orientated and similar to the levels of outcome described here although they have more emphasis on the description of lead up to change rather than the level of change.

Another comparison with the literature on change would be with the description of the three developmental areas described in a conceptual model for therapeutic rehabilitation (Kielhofner 2008b). In this theory three areas related to 'human motivation for doing' are described as being connected incrementally. In Kiehofner's description the 'exploration' level is where the person tries new things and consequently learns about their own capacities, preferences and values. Secondly, a 'competency' level is described where the person begins to solidify new ways of doing that have been discovered through action or exploration. Finally there is an 'achievement' level where there is sufficient skill, habit and volition to allow a person to engage fully and maintain change over time. These levels of change assume that a person has some sort of engagement in activity. Whilst Kielhofner's levels of change would not be sensitive enough in this circumstance to report outcome levels in PD they are very similar. The 'Pre-exploration' stage in particular is helpful. Further discussion about comparison of outcome levels is provided in the discussion chapter (9.3.3).

Table 6.2 Practice Development Outcome Levels

Behavioural indicator (Interview, audit, observation evidence) **(1). Thinking / articulation with MOHO Theory**	**STAGE** (of outcome adoption)	**Behavioural indicator** (Interview, audit, observation evidence) **(2). Selecting MOHO Assessments in practice**
OT has not: ○ Attempted to use MOHO to reason / case formulate in practice ○ Had the opportunity to undertake training in MOHO concepts. ○ Using tools without back up or adequate knowledge OR ○ OT considered and / or tried using MOHO theory in practice but decided that the concepts were not relevant or useful. Not referenced in notes, practice and dismissively / not at all in interview.	**PRE-EXPLORATION** **'In the Hanger'**	OT has: ○ Not tried using MOHO assessments in practice ○ Tried using the MOHO assessments but is not adequately trained ○ Not had the opportunity to train in their use ○ Not read the MOHO manuals. OR ○ OT considered and / or tried using MOHO assessments in practice but decided that they were not relevant or useful.
OT is: ○ Trying to reason case formulate with MOHO ○ In process of training / reading material. ○ Not using to report opinion and reasoning for / with clients as yet.	**EXPLORATION** **'On the Runway'**	OT is ○ In process of training / reading manuals. ○ Trying out assessments with colleagues ○ Not using with clients constructively as yet
OT has: ○ Undertaken training in MOHO ○ Started using MOHO to reason / case formulate about client's challenges in practice intermittently.	**ACTION** **'Take Off'**	OT has: ○ Undertaken training in assessments ○ Has started using with clients in practice intermittently
OT is: ○ Able to articulate clients situation using MOHO concepts ○ Is using routinely in practice to reason / case formulate.	**ACHIEVEMENT** **'In the Air'**	OT is: ○ Using assessment(s) routinely in practice. ○ Synthesising knowledge of MOHO concepts to interpret assessment results

Table 6.3 Notes audit: categorical results and comment

KEY – GREEN X = outcome met (evidence each or most entries)
AMBER X = outcome partially met (evidence in some entries)
RED X = outcome not met (no evidence in notes)

	Q1 Clinical decisions recorded	Q2 Rationale for decisions	Q3 Sense in whole episode	Q4 Ref to MOHO	Q5 MOHO assessments	Q6 Past/future connection	Q7 Rational for assessments	Q8 Assessments use to formulate intervention	Comment
Ann	X	X	X	X	OSA Role checklist Interest Checklist	NO	NO	NO	Though assessments mentioned there was no evidence of raw data in file or interpretation / application of results.
Bev(a)	X	X	X	X	MOHOST VQ	YES	YES	YES	Appears quite habituated into documenting these areas.
Bev(b)	X	X	X	X	OSA	YES	YES	YES	Appears quite habituated into documenting these areas.
Caroline	X	X	X	X	NONE	N/A	NO	NO	Less evidence in notes than came through in interview and observation.
Delyth (a)	X	X	X	X	NONE	YES	NO	YES	Practice orientated around CPA
Delyth (b)	X	X	X	X	NONE	NO	NO	NO	Less evidence in notes than came through in interview and observation.
Eithwen	X	X	X	X	OSA AMPS	NO	NO	NO	Going through the motions with assessments but not really documenting what is being gathered.
Fiona	X	X	X	X	MOHOST AMPS	YES	YES	YES	Notes thorough and incremental and researcher able to follow patients narrative
Gillian	X	X	X	X	NONE	N/A	NO	YES	Little mention of MOHO or occupational performance of person. Very orientated to postural management and sensory capacity
Hannah									No audit undertaken
Isobel									Notes unavailable
Jackie	X	X	X	X	AMPS	YES	NO	YES	Less evidence in notes than came through in interview and observation.

6.7 Connection between Outcome and Mechanism activation levels

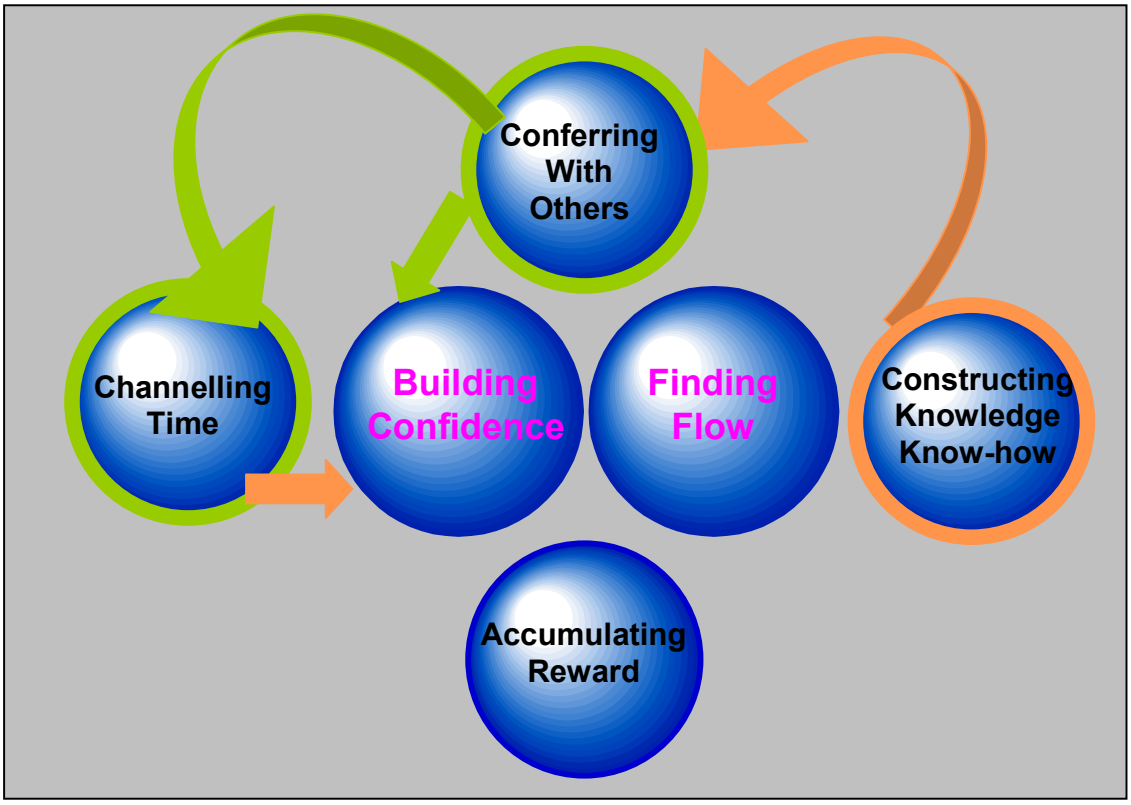
Presented in this section are the results from the analysis of the data which reveal the general commonalities and connections between *mechanisms* and *outcomes.* These are helpfully described in order to undertake further analysis and construct CMO patterns for individuals involved.

6.7.1 Pattern of Mechanism Activation: 'In the Hanger'

For participants falling into this grouping only some mechanisms are activated. It is not the case that no PD mechanisms are activated but it is also important to note that those mechanisms which emerged as being the strongest and most pivotal (those of 'Finding Flow' and 'Building Confidence' which are conceptualized as fuelling engagement in PD) were significantly deactivated. For example Ann expressed motivation to engage in the PD and had been able to activate the 'Channelling Time' mechanism to attempt to learn the PD concepts through attendance at structured discussion and local training events. This had an activating effect upon the mechanism of 'Conferring with Others' and 'Constructing Knowledge Know-how' at an embryonic level. However the mechanistic tip had not moved her to the point of gaining a sense of reward intrinsically or extrinsically or fostered her belief in her ability enough to engage. As such the mechanisms of 'Finding Flow' and 'Building Confidence' remained deactivated.

Figure 6.3 gives an illustrated example of how 'In the Hanger' participants were challenged to activate any PD mechanisms. These therapists did engage in some PD opportunities both formal and informal, for example by having discussions with others about the PD concepts. This indicated an activation of the 'Conferring with Others' mechanism in particular but the activation of the mechanisms was not strong enough to propel them into significant PD movement. This may have been in connection with inhibiting factors within the context (see Section 6.2.3 and 6.2.4).

Figure 6.3 Pattern of MECHANISM activation: 'In the Hanger'



Metaphorically then, these participants remained stationary in the hanger or if there was movement they were only taxiing around the hanger. Though some intent is expressed by these participants to achieve progress the reality appears to be that their practice had not developed enough for any significant movement to be noted and thus they made very little PD advancement.

In summary, the individuals whose outcome level is describes as 'In the Hanger' had a common experience of context. They each reported a challenge with personal context which prevented them from effectively engaging in the PD. Whilst the reasons for this were different, the solutions to firing the appropriate mechanisms to activate engagement in PD may be similar (see Chapter Seven, Section 7.2).

I need a lot of time to take on new ideas and to think how I'm going to put it into my own practice. I think that the constraint that I probably have is that it's very nice to go to all these clinical forums but actually bringing it to your own practice is a lot different I think….. I think for me, the constraints are that I've only had snippets of it so I've only actually heard the name. I don't actually know what they're about [the PD assessments].

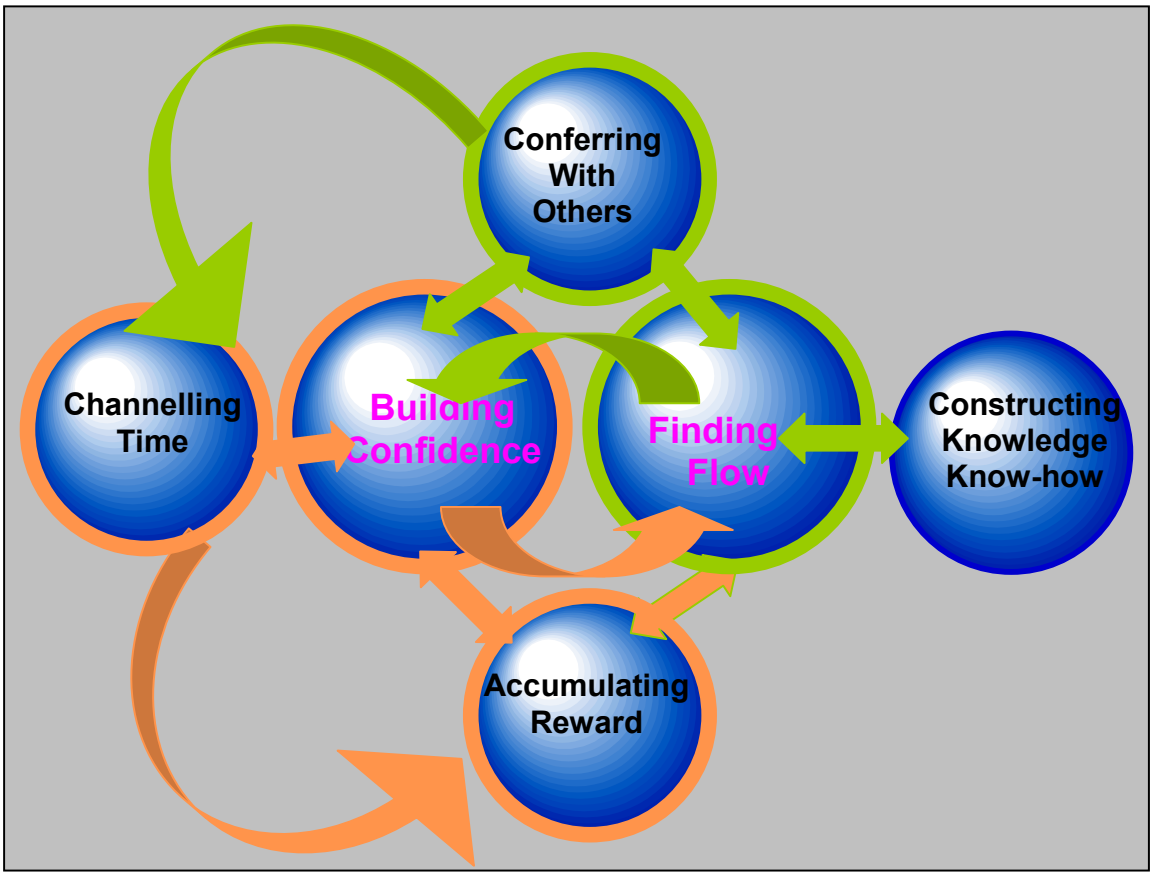
Ann: Initial Interview

6.7.2 Pattern of Mechanism Activation: 'On the Runway'

With regard to the outcomes noted for this grouping of participants, all had found a pathway and energy toward integration of the new knowledge. However, actual engagement into more routine practice action had not yet been achieved. In order to understand this further the next section considers the activation of mechanisms for this set of individuals.

When an individual was 'On the Runway' all mechanisms were activated to some different degree for each participant. The strongest and the most pivotal mechanisms, those of 'Finding Flow' and 'Building Confidence', were significantly set in motion. There is some connection between all the mechanisms even if indirectly which served to form the important foundation for the journey of using PD in practice. If one of the mechanisms became deactivated because of a contextual challenge then the outcome would also be negatively affected.

Figure 6.4 Pattern of MECHANISM activation: 'On the Runway'



All participants in this group reported being challenged by significant role demands which they noted had an impact upon the outcome of their engagement in this occupational therapy PD. For example, Delyth had responsibilities for core mental health tasks which are extended roles beyond occupational therapy practice. Jackie had a variety of work roles beyond clinical practice in her set of responsibilities and Gillian was required to engage in several PD processes (in addition to the one described in this research) so that she could fulfil the variety of referrals received. Despite the fact that all in this group worked in a part time clinical capacity they had all made efforts to engage in the PD process (see example in 7.2). This could

suggest that for these individuals the PD simply took proportionally longer to activate.

> *I'd like to be able to spend more time on clinical work because that's where I'd probably say its not me working like I'd want to work. I'm fitting it into a much bigger role. So, whilst I've tried to carve out a certain time of the week that doesn't work, that never works….. that's not the way that I would like to work. I'd like to have a lot more time to put to it [the PD] really.*
>
> **Jackie: Final Interview**

In summary individuals whose outcome level is described as 'On the Runway' seemed to have a common challenge with balancing a variety of knowledge necessary for their various extended roles. Thus their ability to engage with PD beyond a rudimentary level was thwarted at the point of data collection. With this group it is possible that without addressing the nature of their role challenge within their individual contextual situation that their full engagement in PD will never be reached (see example in Section 7.2).

6.7.3 Pattern of Mechanism Activation: 'Take Off'

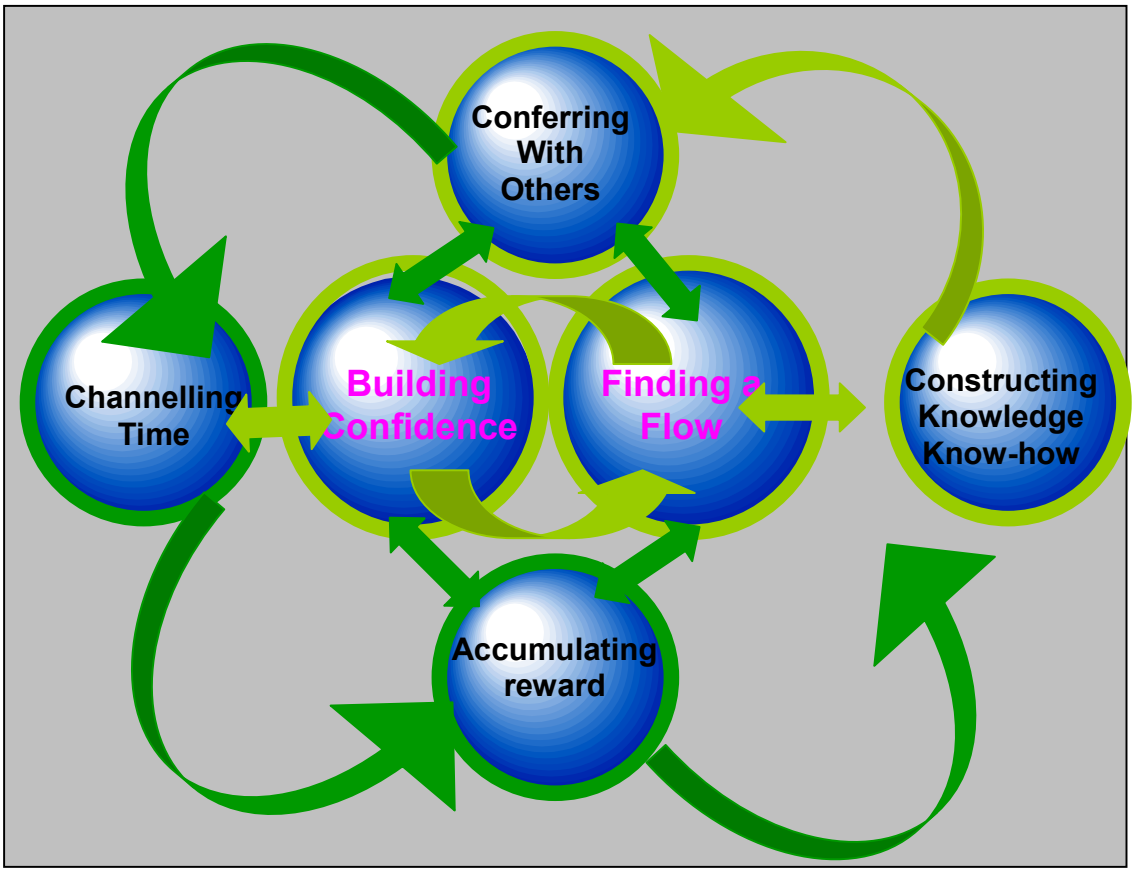
Participants described in 'Take Off' had all mechanisms activated within the 'action' level. The activation of the mechanisms was strong enough to fuel a significantly higher momentum of PD outcome. A change in contextual circumstances could be identified as part of the reason for engagement for some individuals.

For example, it is clear from the quote below that Eithwen perceived that a change in her practice had occurred although she was not able to describe a reason for the change. Whilst the outcomes were positive it is interesting that her clinical context had changed through securing a different job within the PD Trust.

But it's strange how its worked because six months ago I wanted to be using assessments more and I was feeling 'oh my gosh' and it felt like more of a chore 'cause I was thinking' I've got six MOHOST's to do' and now I've come to this new job, they're getting done. And `I don't know what it is but it just feels like things have changed.

Eithwen: Final Interview

Figure 6.5 Pattern of MECHANISM activation: 'Take Off'



In summary of the individuals whose outcome level is describes as 'Take Off' the challenge is to stay focused to continue their progress with engaging in the PD. Whilst the reasons for this are different the solution to continue firing the

appropriate mechanisms to maximize engagement in PD may be similar (see example in Section 7.2)

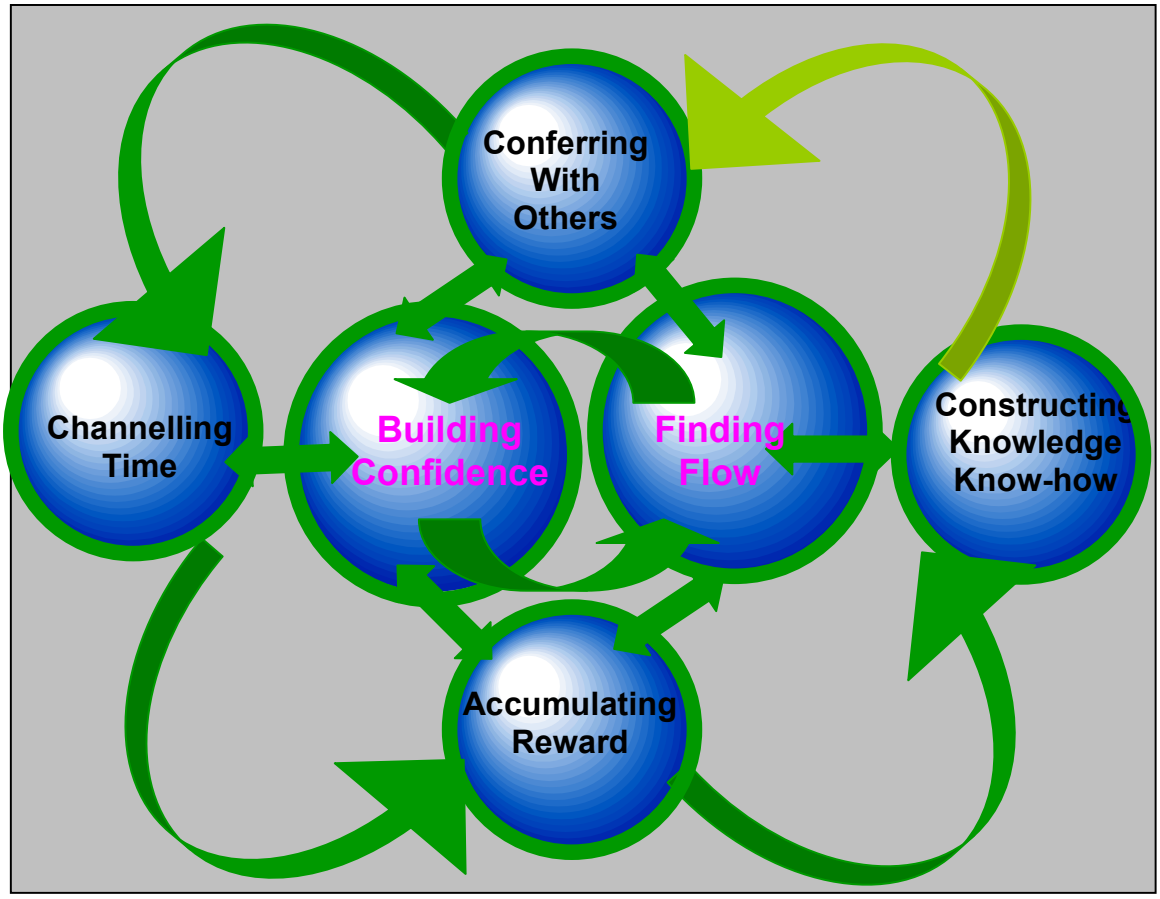
6.7.4 Pattern of Mechanism Activation: 'In the Air'

As with the previous outcome set, in the 'Practice Achievement' set all mechanisms were activated with the difference being that all were activated to more or less a full degree of intensity. The metaphor of 'In the Air' is given to illustrate that energy goes into PD activity but flight (or practice) looks less effortful as all the contexts and mechanisms have worked together to produce the desired outcome. For example, Bev, as a junior therapist had both a supportive learning context and sufficient individual capacities to gain activation of each learning mechanism. Interestingly, this was her first job and so culturally she was steeped in the organisations' expectation that her practice should always have PD action and goals.

> *What helps my clinical practice is using a framework, a model, which I've always had the opportunity to use since I've been in this Trust, so that's all the time I've been here. But also having the opportunity to discuss it within supervision, at any time. That's formally and informally. And the training opportunities as well, for that enhancement of practice. Aside from that it's just the general, informal peers, like team members that help enhance my practice as well. Using evidence base stuff and to read.*
>
> **Bev: Initial Interview**

It is likely to be advantageous to invest in the continued education of new graduates and Bev's situation highlights the importance of having senior and skilled support, of the same discipline, as part of the same team. This is very different from the experience of Ann (see Chapter Seven, Section 7.2.1) who as a relatively new graduate was isolated from senior colleagues of the same discipline.

Figure 6.6 Pattern of MECHANISM activation: 'In the Air'



In summary of the individuals whose outcome level is described as 'In the Air' their challenge is to maintain the momentum to deliver practice underpinned by the PD. Whilst the reasons for this are different the solutions to maintaining activation of the appropriate mechanisms to ensure engagement in PD may be similar. This will be discussed in Chapter Seven.

6.8 Chapter Summary

This chapter initially focused upon reporting the results of the common areas of context in which therapists are undertaking engagement in PD. The first level analysis, general introduction to the results in Chapters Six has presented a preliminary understanding about the common causal mechanisms which when activated support the development of positive practice development outcome

within particular contextual situations. In relation to the hypotheses described in Chapter Four, the results reported here support each of the hypotheses. These are that the immediate environmental context and each person's own attributes do have an influence upon their capacity to activate facilitating mechanisms. These results also indicate that it is possible to identify the mechanisms which when activated are a catalyst for practice change. In addition the results suggest that the levels of practice development outcome vary for different individuals.

In the next chapter the range of outcomes emerging from the *individuals* sampled will be described to illustrate the context, mechanism activation and outcome for an individual from each of the outcome set.

Chapter Seven – Individuals and Practice Development

7.1 Chapter overview

The previous chapter described the themes and levels of the context, mechanisms and outcomes of PD activity from the first level data analysis. This process was described in Chapter Five (Section 5.7). The regularities discovered in the data enabled presentation of overall and general themes. These provided a framework with which to consider the data relating to individuals to greater depth. In this chapter reference is made to the individual context, mechanism and outcome equations which emerge from the second level data analysis. The development of a theory to guide the implementation of PD in relation to individuals will be described in Chapter Eight.

Understanding the meaning of data for the individual participants was the goal of the second level of analysis. These results will be the focus of this chapter. This was important because even though all participants had the opportunity to engage in the same PD interventions there were differences in the extent to which the PD had changed their clinical practice. The connection between mechanism activation and outcome levels has already been noted in Chapter Six (Section 6.7). The results also indicate that there are connections between each individual's contextual situation, the mechanisms to activate PD and the resulting outcome, which in this case is the PD behaviour of an individual.

The chapter is structured to provide a summary of the main findings of individuals' engagement in the PD. However, a significant volume of detailed information was generated for each individual and is too large to present in totality here. In order to manage the narrative of this thesis an illustrative example of one individual from each outcome grouping will be provided in each section of this chapter. In addition brief reference will be made to each of the other individuals within the outcome groups. Throughout this chapter the researcher's voice will be presented in the form of reflexive quotes (Chapter Four, Section 4.4.1).

7.2 Emergent outcome 'sets' representing levels of individuals' engagement

These results will be presented in the same four sequential sections identified in Chapter Six. Continuing with the metaphor, reference will be made to the example of aircraft activity with the goal of flight in order to illustrate the outcome level stages in the following way:

Ann	**Pre-exploration** or 'In the Hanger'
Gillian	**Exploration** or 'On the Runway'
Eithwen	**Action** or 'Take Off'
Bev	**Achievement** or 'In the Air'

It should also be noted that corresponding 'traffic light' colours are used to illustrate the degree of mechanistic activation and the stage of outcome for these individuals (see Chapter Six, Section 6.7)

7.2.1 Ann

Ann was a helpful, caring therapist with just a few years post graduate experience. At the time of the first interview Ann had been an employee of the PD Trust for only a few weeks and spoke of settling into her new role. As a relatively junior grade therapist in a new post, Ann expressed interest in and an expectation that she would be led into a new way of practising. She acknowledged that she was drawn to seeking employment in the PD Trust because of the positive reputation that the PD initiative had generated.

> *I very much feel now that I've chosen this field I want to get much more knowledge so I think that my practice will be very different in a year or two years time or even six months!*
>
> **Ann - Initial interview**

Despite her initial enthusiasm Ann appeared to avoid a structured, proactive attempt to use the PD in her practice. Her attitude towards the use of PD was relaxed but at the same time she expressed frustration about the limits of her practice. At first interview, during observation and at follow up interview, Ann

was ‘on the brink’ of using the PD in her practice actions and indeed was observed to attempt this during the observation.

> *I’m on the brink of using more standardised assessments….. I’m on the brink of looking at MOHOST as well because I think that will be good with our client group….. I know what I’d like to do it’s a matter of doing it.*
>
> **Ann – Initial Interview**

However, Ann’s attempts at using the PD were rudimentary and unsophisticated and she expressed a lack of support to develop further implementation. Ann’s practice context was relatively isolated from other OT’s. She did not experience direct PD supervision from an OT nor did she demonstrate the personal drive to override her immediate formal sources of support and seek effective alternatives. She did not routinely engage with colleagues who could provide her with reassurance and teach her new skills which would build her use of the PD in practice. As such the pivotal mechanisms of ‘Building Confidence’ and ‘Finding Flow’ were not activated. Whilst being enthusiastic about the PD, there was little data to suggest that Ann was able to engage through her practice or in her note keeping. She was able to quote some of the PD concepts but did not demonstrate that this thinking was used to reason and case formulate in her practice. Similarly, Ann was not using the PD standardized assessment tools appropriately in her work at the point of data collection (also see quote in Chapter Six, Section 6.3.3).

> *The researcher mentioned the utility of the VQ and Re-motivation principles for her client group. Ann had not considered this possibility. Ann expressed that she felt as though she had been ‘left’ to discover her own priorities with no strategic guidance. This she felt inhibited her ability to engage in PD.*
>
> **Ann – Researcher’s Reflection Notes**

Ann was able to give some articulation to the PD concepts but her practice was generally conceptualized around tasks that she had learnt previously that were

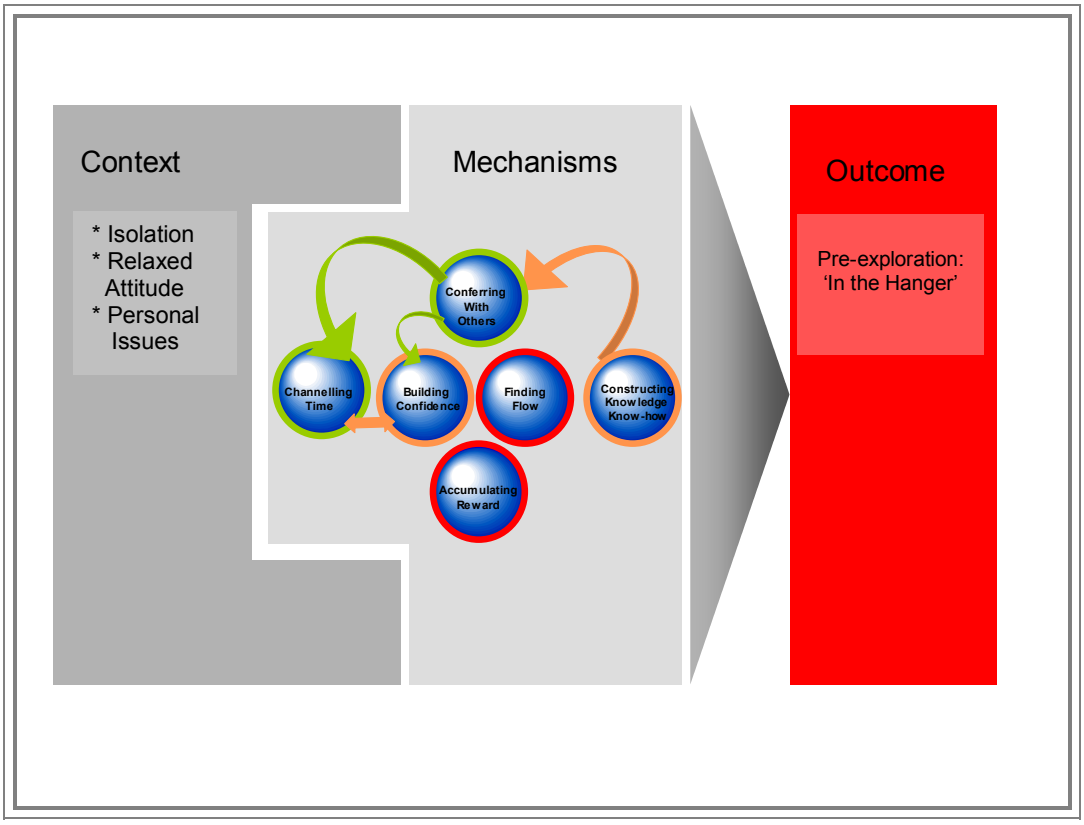
'prescribed' by other disciplines in her team. Her perception of her position with the PD programme was one of lagging behind others. This could initially be explained by Ann being new to the PD Trust. However, this position did not change over the course of the data collection period (approximately six months). Ann described her background in custom and practice, prescriptively orientated intervention rather than 'theoretically driven' intervention.

> *[With a 'screwed up' face and mumbled voice] I couldn't say off hand [what sort of theoretical assumptions have informed my choices and decisions]. It's a rehabilitative kind of approach. There's an educational approach as well. She's aware [the client] of what the anxiety is and what physical symptoms there are so and monitoring their seriousness and what helps her to control them.*
>
> **Ann - Observation Debrief Interview**

Reflexivity Quote – I had to make real efforts in the collection of this data to overcome my desire to want to launch into solving the challenges for this individual. This involved being overtly reflexive acknowledging the impact that what I was hearing and seeing was having on me.

Figure 7.1 summarizes Ann's CMO pattern. Ann's contextual challenges of isolation from other OT's in her immediate team context together with her own relaxed approach toward the PD inhibited the activation of supportive mechanisms to lead to positive PD outcomes (outcome level featured in red and is 'Pre-exploration'). Whilst some mechanisms were activated to an embryonic level, for example 'Conferring with Others' and 'Channelling Time', through her attendance at formal training sessions, this was not sufficient to make a real difference to her PD outcome achievement.

Figure 7.1 Ann: Context + Mechanism = Outcome equation



Comment on other individuals at this outcome level

Hannah's CMO pattern also fell into this set. Whilst the outcomes were similar there were elements of context for Hannah which varied. Hannah's post was a senior grade and she worked within a hospital OT department with a team of peers. Though availability of direct supervision and support from a more senior OT was high, Hannah also appeared overwhelmed by the requirements to make practice changes. Of critical importance was that Hannah had missed much time at work due to sickness. As such she had also missed the influence of the PD progression with her peers. Whilst Hannah suggested that her practice did not need to evolve she also had little practice knowledge of the development in reality. Hannah did not demonstrate the personal capacity to override her context and activate the mechanisms to progress toward practice change. Whilst agreeing that the organizational context supported practitioners to engage in the PD, neither Ann nor

Hannah was able to engage meaningfully in the PD at this point in time.

7.2.2 Gillian

Gillian was at a stage where she was moving from a junior to a more senior role over the course of the data collection. There were several other OT's in her team and she also had direct access to a more senior OT on site. This therapist had an underpinning sense of responsibility to her work which was fundamentally driven by the immediate needs of her clients and shaped by the culture of her multidisciplinary colleagues. Gillian agreed with the general idea of the PD although she was faced with a requirement to simultaneously implement several different practice development programmes beyond the one at the centre of this study. In addition Gillian worked part time hours which posed her an extra temporal pressure.

The data revealed that Gillian had achieved some momentum in her engagement in the PD. Gillian was at 'Exploration level' and had gained pace over time toward the 'Take Off' in her practice development thinking. However, the data suggested that she continued to be 'On the Runway' with the use of the PD in her practice. Given that in Gillian's practice context several different PD initiatives were being implemented at the same time this practitioner appeared to struggle to engage with each one fully. Gillian had to spend time being involved in competing PD's so she needed to make overt decisions about the focus of priorities within her limited time.

At first interview Gillian appeared dismissive of the PD suggesting that its use acted as a barrier between her and her clients. Her position with this shifted over the course of the study when she concluded that the PD could support her to offer better quality intervention.

The theory that I've learnt has also helped me to be more selective [about] the questions that I ask as well. The information that I'm looking for is different… the theory that I've gained has changed what I ask and what I look for, if that makes sense.

Gillian Final Interview

The activation of 'Finding Flow' mechanism had been problematic for Gillian. This was due to the competing demands of her context including the significant variation in the needs of her service users and the related requirement to engage in several, parallel PD initiatives.

Another tension for Gillian was her source of discomfort with the way in which the PD concepts were articulated. Gillian suggested that she avoided considering the PD theory on occasions as she felt the language was unobtainable, lofty and difficult for her to explain to her clients. Gillian appeared to have difficulty in translating the PD concepts into language that she was comfortable using. This perception inhibited her activation of the 'Constructing Knowledge Know-how as her belief in her argument is strong.

I have a real problem (smiles) with understanding concepts like volition and … can't think of the other one, so I find that difficult to take on the new language. If I really applied myself then, yes I'm sure that I could. I try not to use my client group as an excuse, but when I'm talking to my clients I will use simple language so I wouldn't use a term like volition with them so I'm not putting it into practice in that way. I'm not comfortable with the language so I tend not to use it which doesn't really help me embrace the concepts I guess.

Gillian Initial Interview.

With regard to 'Conferring with Others', this had been activated in Gillian in part and contributed to the activation of the 'Building Confidence' mechanism although

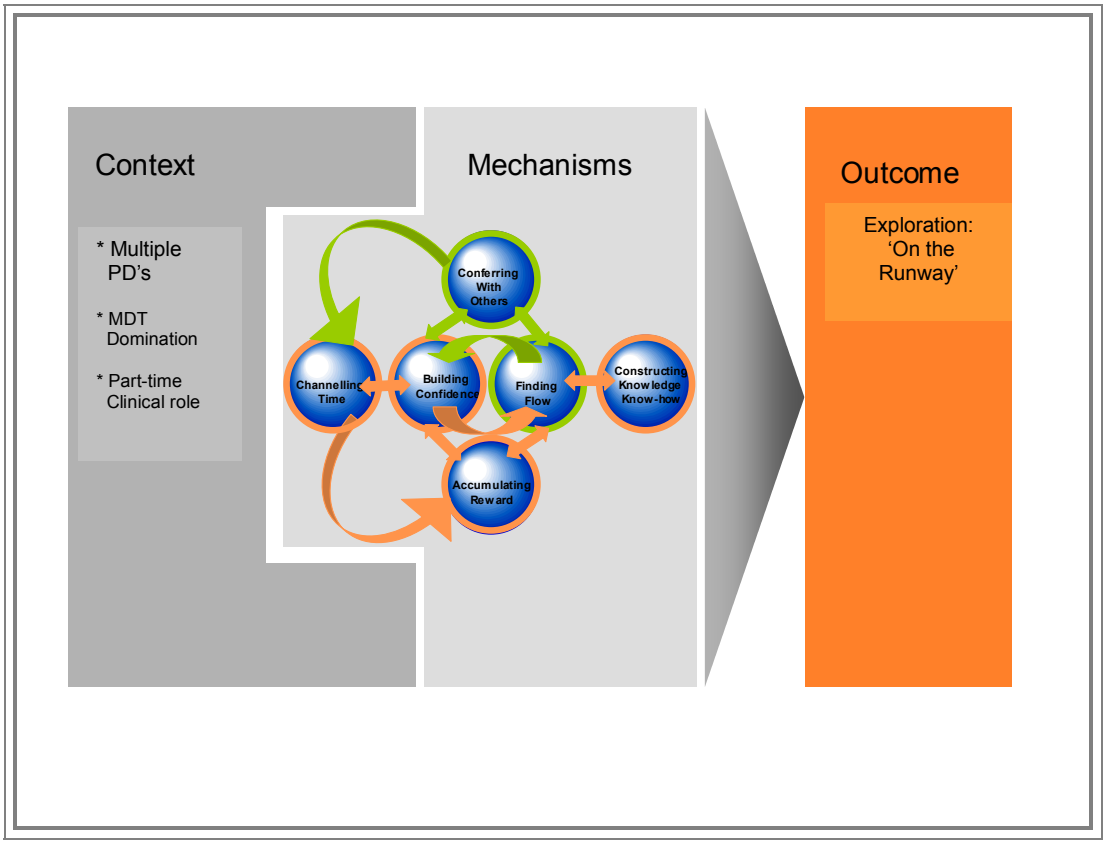
the pressures of her context led only to embryonic activation of the other mechanisms.

Gillian perceived that a vast amount of varying knowledge for the development of practice was required. Participants sometimes questioned their ability to weave the PD activities into their practice successfully with other parallel PD activities given breadth of different bodies of knowledge. They also questioned the potential time gap between learning information and the subsequent need to use particular knowledge with particular service users. Thus, with the confusion about where the activation of 'Finding Flow' should start, her activation of the 'Constructing Knowledge Know-how' mechanism and the 'Accumulating Reward' mechanism is only partial.

> *In many ways I still feel a novice, [but] when I look back at where I was a few years ago then I feel an expert! Because it's like 'waw', I've had so much training now and I can do so many things that I couldn't three years ago but where I am now, the more knowledge that I get the more I think I need to know!*
>
> **Gillian Final Interview**

Reflexivity Quote – During the collection of these data I found myself metaphorically biting my lip! I wanted to debate with Gillian about some of the rationales that she had for her arguments particularly about MOHO language. They were ones that I had adopted previously in my thinking but had since formed different opinions. This was a really tricky situation and difficult to manage! I managed to keep smiling, listening and encouraging her to speak!

Figure 7.2 Gillian: Context + Mechanism = Outcome equation



In conclusion, the main inhibiting factors presented in Gillian's environment were the culture of her MDT but perhaps most importantly the expectation that she engaged in many types of PD and apply them to practice within the same timeframe (Figure 7.2). This coupled with her still relatively junior position limited the level of intensity of mechanisms activation particularly evident in the two central, pivotal areas. Subsequently, PD outcomes for Gillian were at an 'Exploration' stage or 'On the Runway'. She was moving in the right direction but was challenged to lift herself into metaphoric flight with this PD.

Comment on others individuals at this outcome level

Jackie and Delyth both gained outcomes in this 'Exploration' outcome set. Their contextual situations varied from Gillian. For example, Jackie revealed that despite motivation toward the PD she had limited belief in her ability to use the assessment

tools precisely. This may be connected with her personal contextual attributes in terms of her high interest in new innovation but limited time capacity to adopt change into her personal practice action. Jackie's mechanism activation was also different in that though 'Accumulating Reward' was fully activated all other mechanisms were activated only to embryonic stage. By way of common contexts to all three participants in this outcome level, they worked in clinical roles on a part time basis and had significant demands to undertake extended scope tasks within their practice which was beyond undertaking pure occupational therapy.

7.2.3 Eithwen

Eithwen was a cheerful therapist who presented herself as outgoing, nonchalant, contemporary, inquisitive and friendly. She had achieved a senior position at a relatively fast pace. Eithwen's data suggested that she was struggling with her contextual situation at the point of first interview. Interestingly her pattern of outcome changed significantly when she changed jobs [between interviews]. It appeared that her changed work context had a catalytic effect upon mechanism activation. It was evident in her final interview data that mechanisms had been activated which supported her successful PD outcomes. Eithwen reflected upon how these were challenging in her previous role which she perceived as more isolated. The new context appeared to be of significance to fully activate the majority of the mechanisms to support her status as 'Take off' or 'Action' with her engagement in PD.

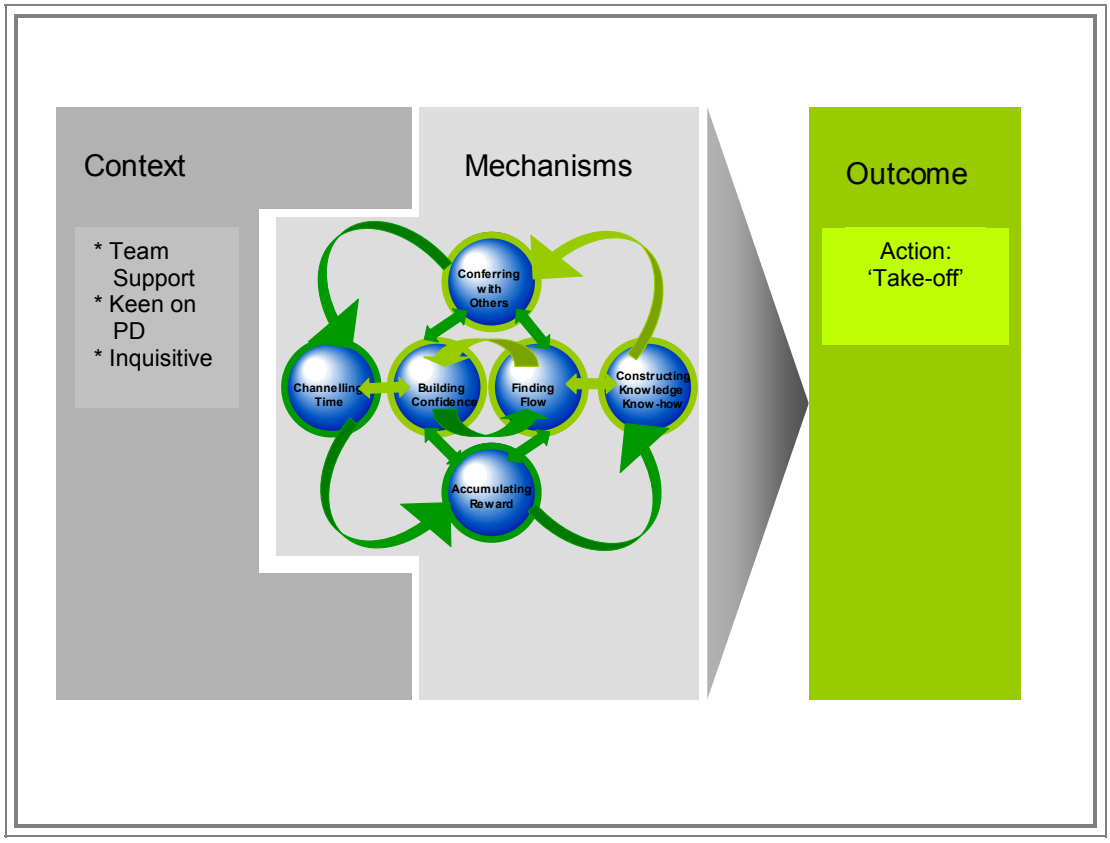
> *I think that I was probably feeling a lot more overwhelmed [in the first job] with the whole setting up of a service that had never had OT before……. I think [the new job] is a really nice environment to work in. Before, the OT team were really supportive but we were all working on our own individual wards with dedicated caseloads. Whereas now, we've all got designated patients to work with but we're still working more as a team with everyone else's patients.*
>
> **Eithwen – Final Interview**

Given that Eithwen's role at the point of final interview was relatively new it would be possible that her engagement in PD would metaphorically 'crash' should her ability to sustain the contextual support fail. However, there was evidence in the data of her developed confidence in the PD and a development of routine activity using the PD concepts. It seemed that Eithwen needed structure and support in her immediate team context to facilitate her engagement which was achieved through her change of job. For example, Eithwen said:

> *I've been using [the assessments] and I've had specific training from the Trust to carry them out and that's been really, really useful, to be able to share experience with other therapists using the assessments. I'm feeling more confident using them. I suppose 6 months ago I was using them but often not 100% sure on where I was going or what the sort treatment planning was from it, whereas now, I'm by no means there yet, but I'm feeling more comfortable having a go and trying them out and to sort of talk to patients about it as well.*
>
> **Eithwen – Final Interview**

Reflexivity Quote – I was aware of Eithwen's change in job role from in my leadership responsibilities but I had not appreciated how much the subtle difference in context would impact on Eithwen's ability to engage more fully in the PD. Through this process I learnt a lot about my own understanding of the choices that colleagues make and the fact that the rationales for some decisions might remain generally hidden from those in authority.

Figure 7.3 Eithwen: Context + Mechanism = Outcome equation



In conclusion, the data suggested that Eithwen's personal attributes had supported her in her initial job to take part in the PD albeit at an 'Exploratory' level. However, when her team context changed to support her interest in and value of the PD she achieved sufficient momentum to take off and begin 'flying'. The challenge for Eithwen was to sustain this position in order to continue with her progress rather than crash land or even glide to a halt.

Comment on other individuals at this outcome level

Caroline's context was different to Eithwen's in relation to her personal attributes, experience and local team context. Caroline was a pragmatic, clear thinking, energetic therapist who presented herself with humility but also quiet confidence. She had been practising as an occupational therapist for over fifteen years and more latterly had an associated leadership role. She had a sharp ability to learn and adopt

new information quickly within her practice. Despite the juggle of occupational therapy practice , generic roles an management tasks that Caroline needed to make in her everyday work she still managed to achieve 'Take-off' in her journey towards practice development. For Caroline then, rather than the team context being critical, her own personal attributes carried her (and others) toward PD achievement. This empowerment was sustained by believing that she would be supported in her actions by the organisation wide context.

7.2.4 Bev

Bev was a junior therapist who displayed an enthusiasm for the PD and was courageous and willing to try out new thinking in her work. Bev had the support of a more senior therapist in her team who was also very skilled in the PD concepts. As such the contextual conditions for Bev to engage in the PD were optimal although there were still the challenges of generic working to contend with as part of her work. The data revealed that for Bev all the PD mechanisms were triggered and most to full activation. Whist her activation of 'Building Confidence' had the least strength she had the support of the other mechanisms in full flow to support an incremental building of confidence. Bev spoke about the mechanism of 'Constructing Knowledge Know-how' and her temporal journey with piecing together new slices of knowledge over time. Her perseverance to work away at activating this mechanism was supported by her immediate team context.

> *It's like riding a bike, you learn it. It takes ages to learn it, like it's taken me ages to learn the Worker Role Interview. Oh and sometimes I just think 'I'm never going to get there' (laughs) but I think now I am, you know after using it about, what, six times and discussing it with [name of colleagues]. I think that I'm getting there now so. But I remember thinking that I was never going to get it with the OSA, never (laughs) but finally, yes, you know I am using it and I don't even think about it now. Its quite, it's just a nice feeling to think, 'yes, I can'.*
>
> **Bev - Final Interview**.

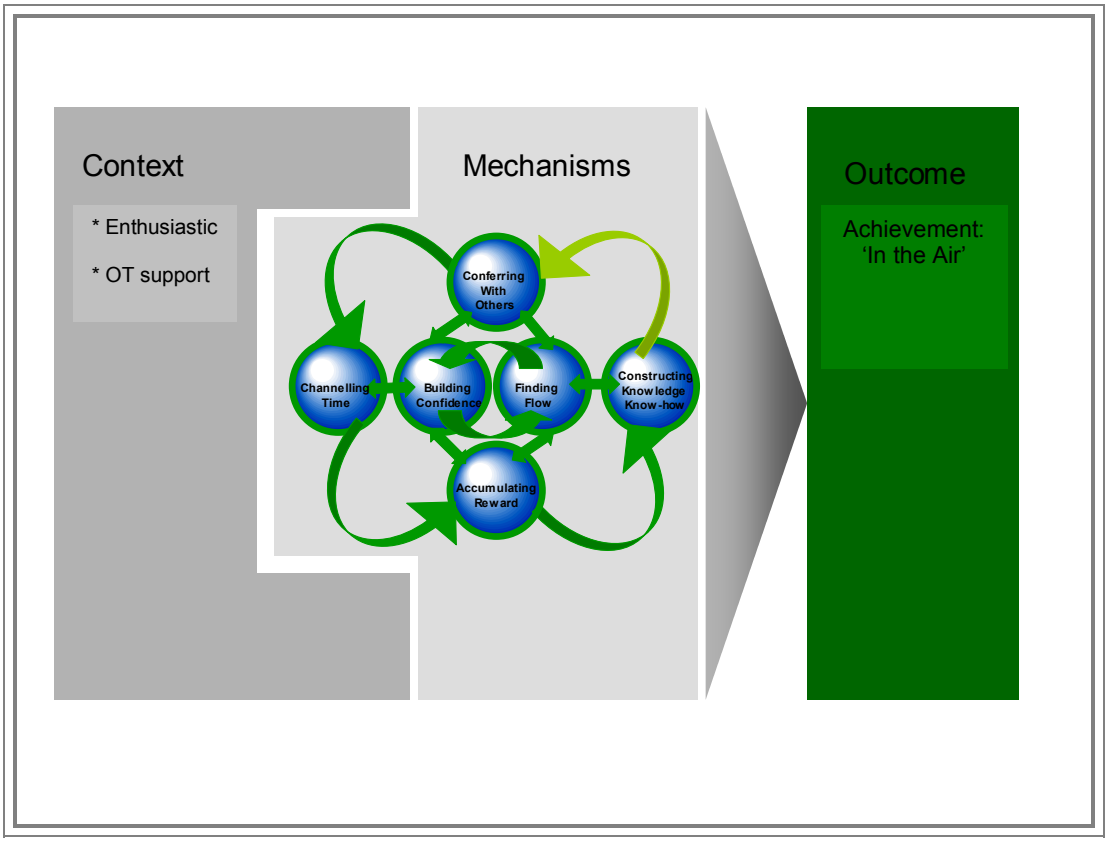
This successful implementation of the PD principles and practice into her work was evident through the observations of her practice. Bev had activated the 'Finding Flow' mechanism to full activation so that within her work she habitually considered her work with clients using the underpinning theory and selecting from the assessment tools available to her. In addition Bev was able to articulate this both verbally and within her note writing.

> *"We chose leisure because that was the only thing that he smiled at, that was the only indicator that he was willing to participate in some form of [occupational] engagement. We started off with very minimal input from me with doing reading out of a book and simply just sat very quietly and we've just added bits into that. When I did the VQ training I thought that looks like an ideal kind of assessment to use. So I started doing that and then used the Re-motivation theory of adding bits in at a time so it's a similar thing.*
>
> **Bev – Debrief Interview**

Reflexivity Quote – After a short time during the first interview I could feel myself willing Bev to illustrate what she had achieved. She reminded me of myself as a junior therapist hungry to do the best for the clients and eager to learn as much as possible quickly. In the data analysis I was careful to avoid over-interpreting Bev's data by being aware of my identification with her situation.

In summarizing the CMO for Bev it appeared that her contextual situation throughout the data collection period supported her ability to fully activate the mechanisms which together supported a high level of PD outcome.

Figure 7.4 Bev: Context + Mechanism = Outcome equation



Comment on others individuals at this outcome level

The seniority of Bev, Isabel and Fiona ranged through junior, senior and leadership levels but it appears that seniority did not relate necessarily to the altitude of the practice development that they achieved. It emerged that the PD outcomes of Isobel, Bev and Fiona fell into this outcome set. Whilst the outcomes were similar in that they were 'In the Air' they could also be conceptualized as being metaphorically to be at different heights and speeds in the air. These slight differences in their outcome stages related to the variation in their contextual situations and are reflected to a small degree the level of activation of the mechanisms. However each of these therapists was a high achiever in the PD despite the differences in their seniority and their clinical specialty areas. For each participant in this group there was one mechanism which was not fully activated. However, the type of mechanism varied for each individual.

7.3 Chapter summary

This chapter reported the results of the second level analysis of the data. These results have been constructed into four outcome 'sets' which represent the levels of individual's engagement in PD. The CMO patterns have been provided for some of the participants in the study to illustrate their engagement in the PD. The results of this level analysis are summarised into the following areas:

- Individual participants had many variables in their contextual situations. Whist the broader context of policy support from a cultural and organisation perspective was in essence common to all, there were significant differences in how a participant's local team (or immediate practice learning environment) and their own personal attributes or circumstances were constructed.
- The combination of individuals' different contexts together with the level of activation of mechanisms for each participant illustrated that a variety of different degrees of PD outcomes were achieved.
- In general therapists whose personal attributes and contextual situation were supportive of PD and stable achieved a higher level of outcome.
- Some therapists had made efforts to change their team context over the data collection period and this had an impact upon their successful PD outcome.
- Data analysis revealed differences in the pattern and intensity of activation of each mechanism for different individuals.

Chapter Eight -The Individual Practice Development Theory

8.1 Chapter overview

In the last chapter the second level data analysis led to the presentation of CMO configurations which related to all individuals in this study. This chapter will build on the findings to present results from the third level of data abstraction. As such a theory to guide the implementation of PD initiatives for individuals will be outlined.

8.2 The Individual Practice Development theory

Realistic evaluation enables the generation of theory which describe understanding of real social forces (Pawson and Tilley, 1997). Through this research a theory has emerged to guide the implementation of PD initiatives across disciplines, organisations and temporal and individual contexts (see Figure 8.1). This now need to be tested in other research studies. This theory describes which mechanisms need to be further activated for which contextual groups (and thus PD interventions offered) in order to help individual practitioners move to a more progressive outcome through a PD programme. The theory developed proposes that different types of PD interventions can be more effective for different individuals with their own contextually orientated learning strengths and challenges. The contextual groups presented in this section (see Figure 8.1) are drawn from the high level analysis of the data (explained in Chapter Five, Section 5.7). It should be noted that each emergent group is linked with the outcome levels and framed within participants' responses at a particular temporal point of the implementation of the PD.

The high-level analysis revealed four contextually-orientated codes which reflected the challenges that were experienced by participants. The codes are: 'Personal Context' challenge, 'Role Context' challenge, 'Staying Focused' challenge' and 'Maintaining Momentum' challenge. This Individual Practice Development **(**IPD) Theory is pictorially represented in Figure 8.1. Each of these will be explained in

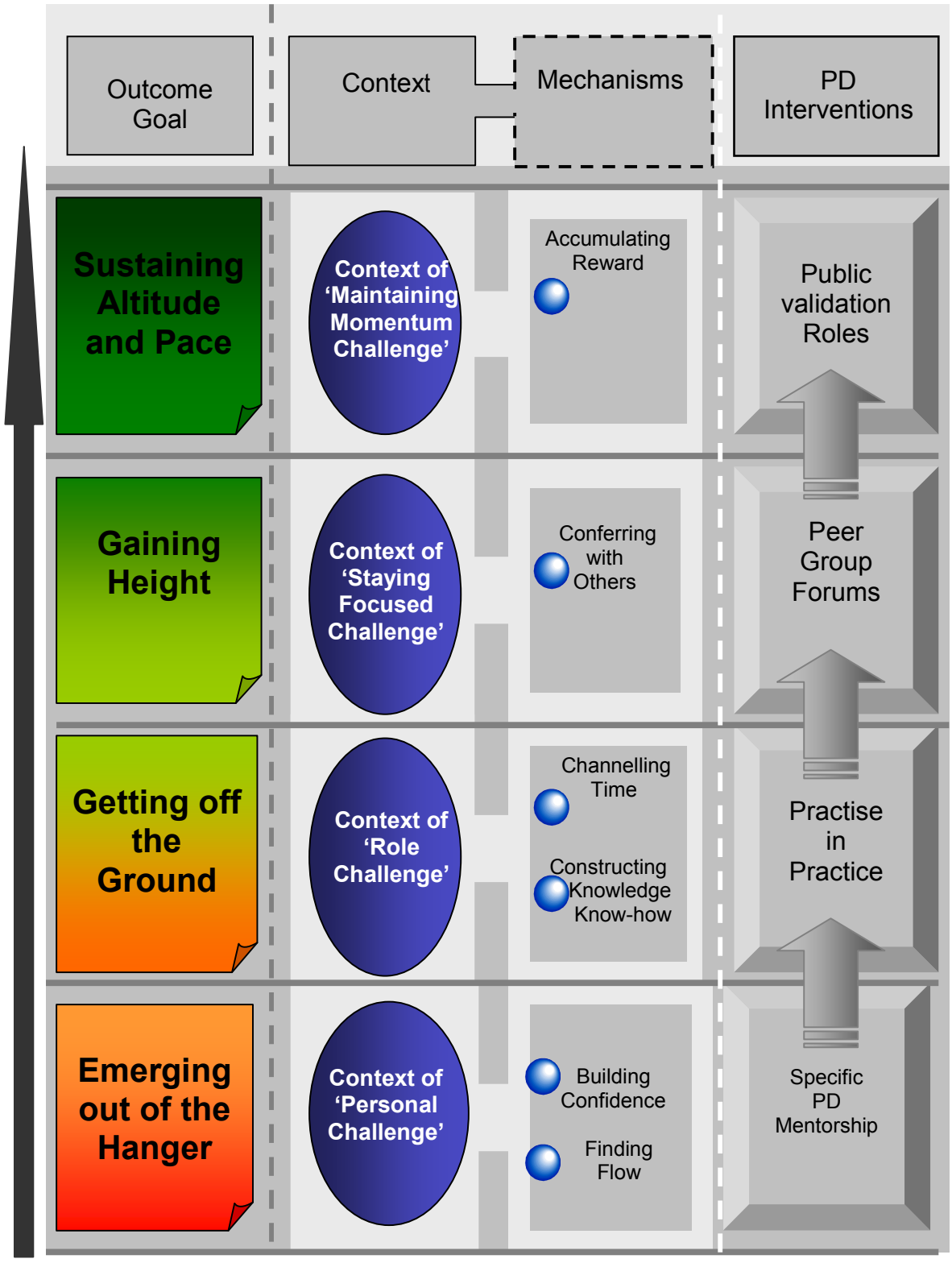
the sections which follow starting at the context of 'Personal Challenge' where the outcome goal is to 'Emerge out of the Hanger'.

8.2.1 'Personal Context' challenge

Both of the therapists with outcomes 'In the Hanger' had significant challenges which were related to their own capacities for learning at the time of data collection. Ann was new to the organization and had limited knowledge of the PD principles and the extent of support available. On the other hand Hannah reported having had significant experiences of personal illness, time away from her work base and limited capacity for or interest in new experiences at this time of personal trauma. Theoretically then, in order to progress with the PD practitioners experiencing this 'Personal Context' challenge need to activate the mechanisms of 'Finding Flow' and 'Building Confidence' in the first instance (Figure 8.1). Interventions such as specific PD mentorship, PD supervision & the setting of appraisal goals could assist practitioners to reach the PD expectations. That is not to say that the other PD interventions will not have a part to play at this point but the hypothesis is that they will be less effective if the core interventions are not available.

> *On top of that [there are my] health issues. I haven't been around [at work] for months and when I am around, I'm not necessarily particularly well, not necessarily concentrating particularly well and I'm being careful about who [patients] I am or not working with. Both of those things have had a huge impact. If those two issues [being ill and having few staff] hadn't been around I'm absolutely confident that I would be completing all the MOHO paperwork and following through the process effectively. Because I know that in past jobs that I've been able to do that.*
>
> **Hannah: Final Interview**.

Figure 8.1 The Individual Practice Development (IPD) Theory



8.2.2 'Role Context' challenge

There are role challenges which impact upon the outcome of PD specifically for those who were 'On the Runway' (Figure 8.1). All in this group worked part time, had significant other roles and / or had blocks of time away from work for personal reasons. Delyth, Gillian and Jackie worked in settings where the job role required their engagement in other PD programmes alongside the one investigated in this research. Other responsibilities which take a practitioner away from the specific practice to be developed alter an individual's core role and prevent significant activation of some important PD mechanisms. There is a need for these individuals to have an opportunity to activate the 'Constructing Knowledge Know-how' and 'Channelling Time' mechanisms in order to make further progress. PD interventions such as engaging in practice are required. [see also Delyth quote in Section 6.2.3 and Gillian quote in Section 7.2.2]

> *I tend to do spasmodic, it sounds dreadful doesn't it, times when I have the time to take on a series of clinical bits and then when they end, I usually need to stop for a while because there's been a backlog of other things and I have to go and do something else and then I can come back again so that's probably been a pattern for me for a few years.*
>
> **Jackie: Initial Interview**

8.2.3 'Staying Focused Context' Challenge

For those who are easily bored or have competing demands on their time the 'Staying Focused' challenge is important for progress to be made with PD outcomes. Where 'Take Off' has been achieved with the PD, individuals might be tempted to divert route once some knowledge has been gained. However, with social learning described by Lave and Wenger (1991) the 'Conferring with Others' mechanism can support continuation of learning a particular PD through communities of practice. Thus engaging such practitioners in attending and facilitating peer education, debate forums and facilitated reflective opportunities should be a priority (Figure 8.1).

I could read articles and I could obviously go and do stuff but what I'd probably like to do, what I'd like to do more that anything really is have a good old discussion and confab with people about ideas. I like to throw ideas around to discuss them and debate them and so probably some debates with clinicians about relevant clinical topics. I do like to throw ideas around 'cause I find that when you can express what's going through your mind it can help you sort of put things in order.

Caroline: Initial Interview

Since the last time we met I've been on a few other specific training courses, specific to the assessments. I'm going to the Volitional Questionnaire training in a couple of week's time. I've some, some more with the AMPS, I've been reviewing that. The Model of Human Occupation Screening Tool, I've been using and I've had specific training from the Trust to carry them out. That's been really, really useful, to be able to share experience with other therapists using the assessments.

Eithwen: Final Interview

8.2.4 'Maintaining Momentum Context' Challenge

Whilst contextual situations remain supportive and PD mechanisms are activated the data suggests that PD interventions need to be supported further by fully activating the 'Accumulating Reward' mechanism (Figure 8.1). This will 'stoke up' an individuals motivation to participate in delivering positive engagement with the PD interventions for the purpose of delivering best care to service users and also to evidence a person's continued professional development. Participants spoke about gaining extrinsic reward for their engagement in PD. Some had reached a point where they enjoyed using the standardized assessments because they structured their work well and supported best practice with clients. This also fuelled the person's sense of ambition, drive and responsibility to the PD which was seen as a motivational source for others involved in the PD.

I've been very conscious of allegedly being the leader of a very small group of OT's. [I have] needed to retain my credibility around them in terms of lots of issues to do with lots of positive and negative feelings I guess but that's what processes of change bring up. They're not all comfy, all glowing. But also, it's been hugely motivating to see, when I step outside [The PD Trust] and I see how people are working and the state of OT I am deeply thankful that I am here 'cause there's a hell of a lot of OT's out there that seem to be very lost, in some very dark places, where I would really rather not want to be! I've been to some similar places but, professionally I'm rather pleased to be here!

Isobel: Final Interview

Participants also spoke of the intrinsic rewards that they felt through participation such as feelings of satisfaction, achievement and validation for their effort. These feelings were rewarding.

I hate being left behind in anything. As the eldest of 'n' kids, I learnt a long time ago, you have to work bloody hard to stay out in front sometimes. Frequently I get that sense, or I put myself into that position of wanting to be somewhere near the front and not always able to deliver that. So, it's been exciting, it's been nerve-racking….. Wanting to be good at my job is a rather more personal one [motivation].

Isobel: Final Interview

All of the PD interventions will allow the individuals to gain some feedback. However, those who are habituated with the PD goals may be encouraged and supported to engage in presentation and publication of their PD work. As such their commitment is publicly rewarded and their perception of their own abilities developed.

When we were having the Link Forums and stuff I used to always go away and even if it was something that maybe I wouldn't use in practice I would always go away thinking 'oh, that was really interesting' and I'd come away and I'd think, 'oh yes, I'll speak at an away day now'.

Bev: Final Interview

It is perhaps relatively easy in practice to identify what outcomes or progress individuals are making with any PD initiative. However, identifying what individuals' unique contextual positions are is more challenging. This will be further discussed in Chapter Nine (see Section 9.4.2).

8.3 Chapter summary

This chapter has presented a synthesis of the third level data analysis and illustrated the development of a theory to support individuals to achieve higher levels of PD outcome. The IPD Theory has emerged and although it will need further testing to guide the implementation of PD initiatives across other practice areas it may have resonance in and offer insights to the development of PD structures elsewhere. This IPD Theory has described four broad contextual groups. These include the: 'Personal Context' challenge, 'Role Context' challenge, 'Staying Focused' challenge' and 'Maintaining Momentum' challenge. The theory developed proposes that different types of PD interventions can be more effective for different individuals with their own contextually orientated learning strengths and challenges. In describing the IPD theory, the mechanisms which need to be further activated for which contextual groups have been highlighted. It is expected that this will help individual practitioners develop more progressive outcome through a PD programme.

Chapter Nine – Discussion

9.1 Chapter overview

The overarching aim of this research was to understand how individual practitioners engage in an evidence informed practice development (PD) programme when the same basic prompts were available. Literature can be found which defines PD and offers evaluation of various PD interventions. However, in relation to how *individuals* respond to PD a gap was noted. This chapter will present a discussion about what has been discovered through undertaking a study using the methodology of Realistic Evaluation (see Chapter Four, Section 4.3).

It is proposed that PD leaders need to tailor learning interventions for individuals in order to achieve best uptake of the PD investment. The conclusion of this thesis is that differentiated PD needs to occur in order to maximise practice change across people, places and time.

9.2 Reprise of the investigative journey

Practitioners within an organisation hold a unique perspective about the context of their practice environments (Higgs et al 2001: Kielhofner et al 2006). Using reflective practice the insider researcher (see Chapter Four, Section 4.4.1) in this study noted that significant financial and emotional investment occurred to promote engagement in a particular PD. Chapter One of this thesis provided an introduction to the contextual position of the research and included a critique of the PD itself. The set of PD interventions used (Forsyth et al 2005a) aimed to develop the practice of occupational therapists with the goal of using theory and standardised assessments to inform clinical care. They included: facilitated use of MOHO theory; training in conducting MOHO assessments; 'Practise in Practice'; Reflective Supervision and Building Practice Standards (see Section 1.5.3). The PD interventions developed were considered to be contextually sensitive to the practice of therapists who worked in an NHS organisation to support people experiencing mental illness and people with learning disabilities. However, the

researcher's reflections suggested a variation in the level to which individuals adopted the PD in practice. Thus a literature search to consider the current context of PD in health care was indicated as the first phase of investigation of the thesis.

A search based on literature relating to the outcomes of PD revealed a key outcome theme of evidence based practice (see Chapter Two). However a paucity of information was revealed about how *individuals* achieve EBP although practice development and quality improvement structures are conceptualised as a way to make progress amongst teams. Other outcomes of PD were raised in this literature review including client centred practice; improved quality and equity of services; enhanced decision making skills; emancipation of professional groups and continued professional development. Chapter Two concludes that practice development structures have reported much positive outcome but that challenges still remain. Without understanding what PD activities work, for which individuals, and under what circumstances, valuable PD resources could be wasted. As such Chapter Three reviewed the literature relating to change theories and also the mechanisms that are reported to support PD. Effective leadership is regarded in the literature as a key and critical component of successful PD. Chapter Three concluded that many single and multiple PD intervention strategies exist but because people and places are inherently different, differentiated mechanisms are required as catalysts for change amongst a team of individuals. There is a case then for including the position of the individual in the ultimate definition and drive toward the development of practice.

In particular the importance of optimal contextual conditions is highlighted as a critical factor to the success of a PD (Dobson and Fitzgerald, 2005: Gerrish and Clayton, 2004: McCormack et al 2002). However, this literature concentrates primarily on the description, development and overall evaluation of PD programmes. Little attention is given in the literature to processes and individuals. Only a little more literature which attended to the relationship between individual context and the resultant processes and outcomes was available. The literature on

concepts of change presented in Chapter Three offers insight into theories of change from an organisational, individual and evidence based perspective. Despite this the field has not yet specifically synthesised PD, theories of change and evidence based practice with regard to the individual practitioner's engagement. This thesis therefore offers a unique contribution through an empirical study of how individual practitioners engage in PD activity. It has particularly concentrated upon the discovery of mechanisms which tip individuals to engage in PD. It also aims to understand the optimal contextual conditions for individuals to reach desired PD outcomes.

The detailed intention of the research was to gain an in-depth understanding and detailed description in three main areas. Theses included the *mechanisms* which best serve to support practice development for individuals; the components of the individual's *context* which support or inhibit activation of the facilitating mechanisms and the *outcome* levels that could be expected from a range of practitioners engagement in a PD programme (Chapter Three; Section 3.8). As such a Realistic Evaluation study (Pawson and Tilley, 1997) was undertaken (see Chapter Four) with occupational therapist participants using multiple methods of data collection (see Chapter Five). This methodology enabled the analysis of data to consider the mechanisms which were catalytic in the development and use of new knowledge in practice. Together with specific contextual and outcome data the causal mechanisms identified are presented in Chapter Six. In terms of this PD, developed practice (outcome) was defined as occupational therapists' ability to underpin their practice with MOHO theory and to utilize MOHO assessments in their practice (Forsyth et al 2005a) (see Chapter One, Section 1.4). General levels of outcome discovered through the data analysis are presented in Chapter Six. In Chapter Seven, the second level of analysis allowed presentation of vignettes of individuals describing context, mechanisms and outcome. Results of the third and final level of data analysis and abstraction are featured in Chapter Eight where the Individual Practice Development theory (IPD) is presented. The IPD is an original contribution to knowledge and provides the theoretical basis for structuring PD

activity with and for individuals in order to make best use of resource and motivation for engagement.

9.3 The study hypotheses

This section will reprise the study hypotheses presented in Chapter Four (Section 4.5). As such it will provide a general discussion about the theory associated with this research.

The genre of RE enabled three interrelated propositions to be investigated. This research has illustrated the accuracy of the initial hypotheses which were that:

1. The immediate environmental *context* and each person's own attributes have an influence upon their capacity to activate facilitating mechanisms.
2. It is possible to identify *mechanisms* which when activated are a catalyst for practice change
3 The level of practice development *outcome* will vary for different individuals.

In addition to confirming the accuracy of these hypotheses this research also discovered new knowledge and this will be discussed in Section 9.4. This research has enabled deepened understanding about how the context, mechanisms and outcomes work. The next three sections will consider each hypothesis in turn but will also summarise the interplay between contexts, mechanisms and outcomes. The first of these is the hypothesis that the immediate environmental context and each person's own attributes do influence their capacity to activate facilitating mechanisms.

9.3.1 Contextual situations activate mechanisms

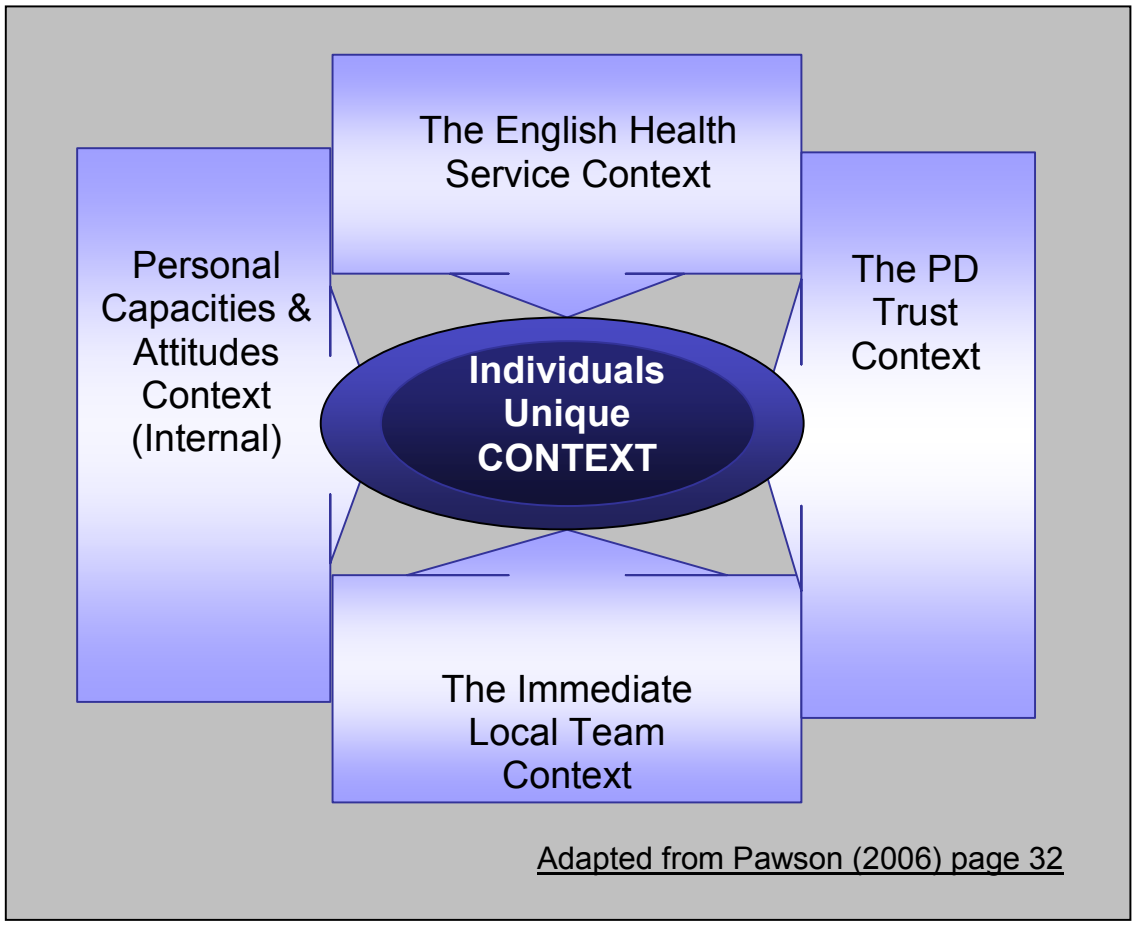
The study results revealed that the immediate environmental context and each person's attributes influence their capacity to activate facilitating mechanisms. The literature synthesised in Chapters Two and Three fundamentally supports the important role of context in achieving successful practice change (Dopson and Fitzgerald, 2005b: Manley, 2004: McNichol, 2004: Fineout-Overhold et al 2004:

NHS Centre for Reviews, 1999: Rycroft-Malone, 2002). However, these authors almost exclusively attend to the broader organisational context rather than the specific team context or the context defining the attributes of individuals. Figure 9.1 illustrates all the broad contextual domains relating to PD that were drawn from the study data (see Chapter Six, Section 6.2). The visual representation of the contexts is similar to Pawson's work (2006, page 32) but the concepts have been slightly adapted. Pawson represents the contexts as being layered whilst these data suggest more independent (although not mutually exclusive) contribution and influence from each area of context. Two of the contextual domains have relatively fixed and common attributes for individuals whilst the others are more changeable. For example, in relation to the study data collection period the 'English Health Service' and the 'PD Trust' contexts were regarded as relatively fixed attributes which were common to *all* participants' (Chapter Six, Sections 6.2.1 and 6.2.2). The main focus point for this study however was on contexts which *varied* between participants. These features of context are described as the 'Immediate Local Team' and the 'Personal Attitudes and Capacities' (Chapter Six, Sections 6.2.3 and 6.2.4).

The findings empirically and uniquely illustrate that there were optimal conditions within the 'Immediate Local Team' and the 'Personal Attitudes and Capacities' domains of context which were fundamental to an individual's successful engagement in PD. In addition the data reveal that these aspects of context varied for each individual involved in the PD (Chapter Six) providing evidence where individuals are challenged to engage in their PD because of these contextual features. For example, the data revealed that Gillian (see 7.2.2) struggled to engage fully in the PD activity due to the competing demands of her local team context. On the other hand the data relating to Hannah (see 7.2.1 and 8.2.1) illustrated how at the time of data collection, Hannah who was overwhelmed with her own personal circumstance, had little capacity for change in her context which had a negative impact upon her engagement.

It is possible to conclude then that the 'Immediate Local Team context' and each individual's 'Personal Capacities and Attitudes context' influenced their capacity to activate facilitating mechanisms leading to an engagement in PD. It could also be argued that **t**here is further investigative work to be undertaken to establish practical ways of understanding each individual practitioner's progress with a PD programme. This could include identifying their unique contextual situations in addition to their perception of their engagement. The development of a context based questionnaire to be used as a focus for face to face discussion between individual practitioners and supervisors could be a useful way of encouraging reflection and planning for an individual's engagement in PD. Through this, leaders could be assisted to understand the capacities and styles of individual practitioners and the variation in the workforce.

Figure 9.1 Components of an Individual's Unique Context

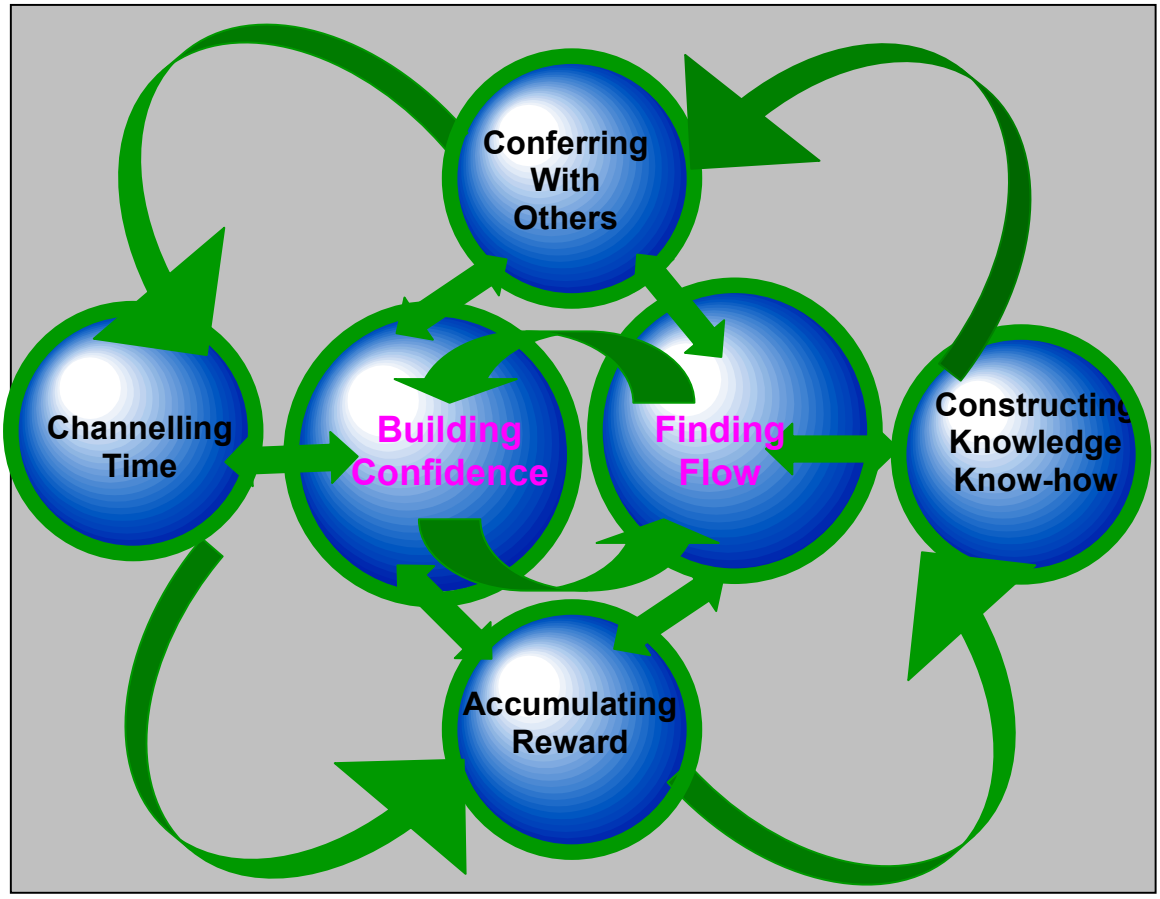


9.3.2 Identifying change mechanisms

The second hypothesis was supported by the study data to show that it is possible to identify the mechanisms which when activated are a catalyst for individuals to change their practice. One of the unique features of RE is its emphasis on identifying the mechanisms or triggers within social programmes (Pawson and Tilley, 1997). Chapter Four critiques the methodology of RE and considers other studies which have looked at causal mechanisms (Section 4.3.2). There is however a gap in knowledge about the identity of the catalytic mechanisms which trigger practice change. This research has identified six causal mechanisms which work dynamically to support the development of PD (see Figure 9.2). Two pivotal

mechanisms are described as ‘Building Confidence’ and ‘Finding Flow’. Without any activation of these mechanisms the PD outcome is compromised. The other mechanisms described as ‘Accumulating Reward’, ‘Conferring with Others’ ‘Constructing Knowledge Know-how’ and ‘Channelling Time’, work symbiotically and dynamically with the pivotal mechanisms to support steps toward practice change (see Chapter Six). Even though two mechanisms are described as pivotal, all mechanisms are important and form a heterarchical rather than a hierarchical system. In this data all the mechanisms are activated to different levels by different individuals (Chapter Six) but in order to provide a *general* illustration Figure 9.2 presents an image of *full* activation of each mechanism. A more comprehensive presentation of these mechanisms was presented in Chapter Six (Section 6.3) but a brief summary of their characteristics will be made here to support their unique place in the literature.

Figure 9.2 Interface between Common Causal Mechanisms



9.3.2.1 Pivotal mechanism – 'Building Confidence'

Activation of the 'Building Confidence' mechanism sparked the development of volitional steps to support the individual to believe in their own ability. In order to have sufficient confidence to undertake the tasks involved in PD (for example learn a new way of thinking, put new knowledge into practice, foster trust in the PD approach or provide self assurance to share PD information with others) an individual needs to perceive that they are able to do so (Miller and Rollnick, 2002). The 'Building Confidence' mechanism is activated when individuals construct a sense of confidence in their own ability to use the PD principles to affect their work with service users. Without activation of the 'Building Confidence' mechanisms PD action can be thwarted and thus the quality of practice outcomes

compromised. This is illustrated by Ann (in Section 6.3.3) where she describes her lack of courage to implement the change. On the other hand, when this mechanism is fully activated individuals report embracing change with a feeling of security (for example Bev in Section 6.4).

It is known that the development of confidence is critical to learning and engaging in new work behaviours (Eraut et al 2000b). Understanding what will trigger the building of confidence as part of an individual's development is therefore important (Chowdhury, 2002). Building confidence can evolve internally from personal drive, experience and interests (Bandura, 1995). The 'Building Confidence' mechanism supports this notion. It also appears that 'Building Confidence' can be triggered from external sources in the workplace for example through the encouragement and leadership felt or the opportunities which arise for an individual. Amabile et al (1994) also suggest that this is important and propose that evaluations of intrinsic and extrinsic motivations can be helpful in this process. Overtly planning to trigger 'Building Confidence' with individual staff could ensure that practitioners benefit from a collaborative leadership culture (Archer and Cameron, 2009). Thus the confidence of practitioners to undertake new tasks is conscientiously addressed by both professionals and leaders of PD.

Miller and Rollnick (2002) advise that confidence and interest in change are different concepts but that they go hand in hand. However, if an individual has low interest in change they suggest that facilitators need to work on enhancing the perceived importance of change as a priority. Amongst the group studied for this research the importance of change was not in question. However, it must be recognised that this research sampled from a population of individuals whose participation was voluntary. Those who were disinterested may not have engaged. On the other hand, there was a significant engagement with the initial survey undertaken with most people expressing an interest in using the PD assessment tools in practice (see Chapter Five, Section 5.3.1). Bandura (1995) locates self efficacy as the human need to strive for control over life circumstances. This

position has been suggested as being particularly important in the work environment (Hackett, 1995). 'Building Confidence' however, as a specific and pivotal mechanistic trigger offers a focus of attention in relation to PD within the work environment. This mechanism has been further described in Section 6.3.3.

9.3.2.2 Pivotal mechanism – 'Finding Flow'

The results suggest that 'Finding Flow' is activated where therapists perceive and create a personal current or route to PD. The 'Finding Flow' mechanism was fully activated when the habits connected with PD behaviour were driving performance and thus the behaviour was automated into a flow or routine of PD practice. This mechanism was influenced both by the external context (the environment) where it supported the development of PD practice (for example Eithwen in 6.2.2). This mechanism was also activated by the individuals' personal attributes of, for example, enthusiasm to do the best job (as is seen in Fiona 6.3.4), understanding (as Delyth 6.3.5), and the ability to visualise an end result (as seen in Isobel 6.3.7). An example where this mechanism is restricted from activation can be seen in the example of Hannah in 6.3.4. Hannah had personal capacity issues which reduced her ability to find a routine in the application of the new practice. 'Finding Flow' might be compared with Covey's (1989) work where the habits of highly effective people fall into both 'private' (internally conceptualised goals) and also those which can be understood from a 'public' perspective. 'Finding Flow' is similar in that the activation of new habits so that the individual can continue with the PD journey and prevent regression to previous well established behaviours. Like Covey's concepts, 'Finding Flow' sees the development of personal vision, discipline and behaviours towards the goal in addition to cooperating with what is to be developed as part of a social team. Other authors recognise the importance of practising new habits as part of the process of managing and maintaining change behaviour (Lewin, 1948: Prochaska et al 1998). It could be argued then that the 'Finding Flow' mechanism can be managed through the social situation of a work environment by critically appraising a PD environment to ensure that it facilitates and monitors 'situated learning' (Lave and Wenger, 1991). The 'Finding Flow' mechanism is further described in Section 6.3.4.

'Building Confidence' and 'Finding Flow' have major influential 'tip' when activated to generate greater change readiness and promote further energy for engagement. Their further activation is supported by the supporting mechanisms which are presented in turn next.

9.3.2.3 Supporting mechanism – 'Accumulating Reward'

The 'Accumulating Reward' mechanism is concerned with the individual's feeling of recognition for their effort and achievement toward behaviour change. When activated 'Accumulating Reward' bolsters the individual's rationale for their effort in engaging in a change process. It supports the effortful activity of behaving in a new way. As such 'the activation of 'Accumulating Reward' is connected with both extrinsic *and* intrinsic motivational factors (Noels et al 1999). Eithwen (in Section 6.3.5) is an example where engagement in a PD activity provides her with a sense of reward for her own benefit and that of her clients. Thus the activation of the 'Accumulating Reward' mechanism breeds further engagement with the PD. On the other hand, without the activation of significant 'Accumulating Reward' the outcome can be overt apathy or disengagement from the PD. An example of this is provided by Ann in 6.2.4 where her fear of trying out the PD has inhibited any activation of 'Accumulating Reward' that may be fired through her effort. This example also serves to reinforce how this then negatively affects the other activating mechanisms for example 'Building Confidence' and 'Finding Flow'. The activation of "Accumulating Reward" mechanism can be compared with the position that positive information received about engagement in PD activates the mechanism to a greater level (Chowdhury et al 2002). Further discussion about 'Accumulating Reward' is provided in Section 6.3.5.

9.3.2.4 Supporting mechanism – 'Conferring with Others'

'Conferring with Others' is the mechanism activated where an individual senses that they are making meaning about the PD through collaboration with others. Thus it involves speaking and listening to others about the PD, it's application to practice, sharing critique and success and future goals. Therapists created movement toward the outcome goal by generating a shared experience of discourse

and making meaning about the topic. Caroline (Section 6.3.6) can be cited here as an example. Caroline recognizes the progress that she has made through her structured collaboration about the PD with colleagues. Caroline also has awareness that further opportunities of this sort will further enhance her learning and maintain her momentum to engage in the PD (Section 8.3.3). Many authors conceptualise learning as a social process (Wenger, 1998: Jarvis et al 2003: Berger and Luckman, 1966). The 'Conferring with Others' mechanism is essentially the use of effective social exchange as part of a catalyst to learning. The data suggests that this is one mechanism for individual's engagement in PD to be activated but participation in a social milieu did not necessarily shift practice in and of itself. However, for some individuals, engagement in, for example group or one-to-one supervision debate or reflective opportunities, proved in part to be a catalyst for change. The mechanism itself is further described in Section 6.3.6.

9.3.2.5 Supporting mechanism – 'Constructing Knowledge Know-how'

This mechanistic process of 'Construction of Knowledge know-how' assembles knowledge within the therapists' cognition incrementally over time. It is thus a trigger for emerging change as with the newly located knowledge therapists become more confident and develop a routine for using the information in a practical way. As knowledge is gathered and synthesized successfully through the activation of the 'Construction of Knowledge Know-how' mechanism the articulation and demonstration of skill and practice ability grows. Isobel in Section 6.3.7 illustrates this point with clarity as she describes the growth in her practice based knowledge. On the other hand, when 'Constructing Knowledge Know-how' is inadequately activated a different outcome result can be expected. Jackie for example (Section 8.3.2) despite her effort was distracted from her knowledge construction by other role responsibilities. Knowles et al (2005) describe how adults orientate and achieve learning when it is relevant in their real life situations. If therapists have not sufficient opportunity to experience putting new knowledge into practice or feel torn between a variety of learning priorities then the 'Construction of Knowledge Know-how' could remain inactivated. Smith (2001) argues that when professionals engage in continued learning opportunities the

development of new knowledge is achieved. However, the success of the activation of this mechanism (further described in Section 6.3.7) is dependent upon a variety of learning opportunities being available (National Institute for Health and Clinical Excellence, 2007).

9.3.2.6 Supporting mechanism – Channelling Time

The 'Channelling Time' mechanism affords individuals the time required to learn and implement their PD. Without the activation of this mechanism an individual's engagement was superficial and incomplete. An important point about this mechanism is that the individuals who were able to trigger it effectively had a belief that using time for this PD was part of practice; metaphorically PD was conceptualized as an essential part of the mixture not just the icing on the top. However, there were many reasons why this mechanism was challenging to activate including the personal circumstances described by Delyth in Section 6.3.8. Investment of time in the PD was also seen as unwelcome by some who considered the interventions overwhelming or a distraction from 'real' work (see Hannah 6.3.7). Activation of the 'Channelling Time' mechanism included structuring time and having goal deadlines for learning parts of the PD. The literature approaches time for PD in a general and practical manner. For example, the College of Occupational Therapists (2005) and others (McQueen, 2008) recommend that time needs to be available for professional development activity. However, they do not describe what this should look like nor do they recommend strategies to alleviate the situation when people find it too difficult to channel time. The successful activation of this mechanism is connected with a person's immediate contextual situation. Without a culture to positively support investment of time in PD interventions individuals' activation of this mechanism is compromised. This mechanism is further described in Section 6.3.8.

9.3.2.7 The catalytic and symbiotic nature of mechanism activation

The data suggested that activation of individual mechanisms can (if triggered sufficiently in a facilitative context) act as a catalyst to trigger other mechanisms. This could be compared to a clock mechanism, where each successfully activated

stimulus affects the running of a different but related mechanism. The activated mechanisms work symbiotically drawing on the emerging strength of one to further develop another. Bev, for example in Section 6.4 is an example where many mechanisms fired in succession as she participated in a PD activity. Through conferring with others in a PD discussion forum session Bev spoke of having her confidence 'fired up', her knowledge enhanced and her flow with the PD implementation in practice further activated. She clearly expressed a sense of reward through her participation. This suggests that the mechanisms are inextricably linked, act dynamically and that none of the mechanisms activated in isolation is so effective. This is a dynamic system as illustrated by Lewis (2000). Positive outcomes emerge as mechanisms become successfully activated collectively (see Fig 9.2). This position coincides with Evans and Kersh (2004) who assert that skill development is not linear but is influenced by many factors. A question could be raised here about whether all six mechanisms have to remain activated to maintain PD outcome. Whilst this proposition would need further testing it remains clear that each of the mechanisms is important to influence positive PD outcome.

9.3.2.8 The impact of inadequate mechanism activation

Examples of the impact of inadequate mechanism activation can be seen in the research data. Activation of mechanisms to engage in this PD was weaker for example, where individuals were overwhelmed by being required to participate in several PD's at one time (see Section 7.2.2 Gillian), where individuals were required to undertake extended scope roles (see Section 7.2.2 Delyth) or where illness had an influenced a person's usual performance (see Section 7.2.1 Hannah). In Chapter Six, further illustration of how an individual's context can compromise mechanism activation is provided.

This section has illustrated that it is possible to identify the mechanisms which can be activated to change practice. The data revealed six mechanisms which have been described and discussed. It has also been established that mechanisms work together in a dynamic way to support change. It is important then that any PD

programme pays attention to the ability to activate mechanisms. This will enable each individual to achieve optimum level of PD outcome.

9.3.3 Levels of practice development outcome

The data suggests that the level of practice development outcome varies for different individuals. The explicit purpose of PD programmes is to improve the outcome of service provision, build expertise amongst staff and to attain the best value for investment (Bierema and Eraut, 2004). However, this study has illustrated that even with a structured approach to PD there remain differences in the practice behaviour change of different people. The literature hints at the variation in responses that individuals make to PD interventions (Chard, 2006: Davies et al 1995: Wensing and Grol, 1994: Wye and McClenahan, 2000). This message was supported in this research. It has also established new insights and extra understanding about the levels of PD outcome that can be experienced by individuals. It concludes that not only is there a variation in outcome for individuals involved in PD but that individual outcome can be achieved to different levels (see Chapter Six, Table 6.2).

In Chapter Five (Section 5.3) the results of the initial self rating survey are provided. These data suggest that the therapists' outcomes did vary. At the point in time when the survey was undertaken, few therapists (12%) reported that they had not started to change their practice by using the PD assessments. This survey was able to helpfully form the basis of a maximum variation sample for the main part of the study. The survey data further supported the theory that outcome levels of engagement in the PD vary. In fact, further variation was found in the therapists' outcome of PD through the main study than might have been expected from the survey results. This could be because of a time lapse between the survey and main study. Alternatively it could be that the self report encourages overestimation of PD involvement (Adams et al 1999).

Chapter Seven (Section 7.2) illustrates that of the ten volunteers, two participants were not implementing new knowledge in a significant way. It would have been

interesting to repeat the initial survey at the end of the data collection period to establish the spread of self-rated engagement at a different point in time or after significant changes to workplace culture for example service redesign.

In this research the outcomes were conceptualized through the metaphor of aircraft flight. The outcomes included 'In the Hanger', 'On the Runway', 'Take Off' and 'In the Air' with the latter category being applied to those participants where the greatest amount of engagement in the PD was achieved. Chapter Six provides an in-depth account of the outcome levels. Hannah, for example was in the pre-exploration stage 'In the Hanger' and did not use the standardized assessments and underpinning model of professional practice which had been the desired outcome of the PD initiative (Section 7.2.1). Jackie was at the exploration stage 'On the Runway' and had started tentative moves towards new behaviours (Section 7.2.2). Caroline (Section 7.2.3) intermittently used PD practice and was achieving action at 'Take Off'. Fiona had gained achievement in full and was metaphorically 'In the Air' with her integration of the PD into her practice (Section 7.2.4).

The comparison between stages of change and outcome of change is interesting. For example Prochaska et al 1998 outline the five stages in their 'Transtheoretical model of change'. Prochaska et al's model focuses on *processes*. This research is however about *outcome* (and the relationship with mechanisms and contexts) but similarities can be seen in the two theories. As is illustrated in Table 9.1, PD 'outcome' falls into four categories. When an individual is in a process of 'Pre-contemplation' and 'Contemplation' about change the outcome is the same. With other stages of change a different outcome can be noted. The similarities in the stages of change and outcome categories of change are illustrated in Table 9.1.

Table 9.1 Comparison of stages of change and outcomes.

Stages of Change Prochaska et al (1998)	Outcome categories of this research
Pre-contemplation	In the Hanger
Contemplation	In the Hanger
Preparation	On the Runway
Action	Take Off
Maintenance	In the Air

There are however differences when direct comparison of the *meaning* of categories is made. For example, the stage that Prochaska et al label 'contemplation' implies that there is cognitive reasoning occurring which may lead to a decision to change even if no attempt is made to undertake the new behaviour. They define this stage as an intention to take action within six months. A difference can be noted here from those in this study who were 'In the Hanger'. Both Ann and Hannah (Section 7.2.1) took some action in that they had spent time in some of the PD interventions. They also expressed belief in the PD as the credible way to undertake practice for the future. However, despite this their practice action was not sufficient for change in their behaviour to be acknowledged. It is possible then that despite some action through PD interventions their capacity to reflect-in action (Schön 1991) was hindered by their personal circumstances (Section 7.2.1 discusses this further).

In summary it has been established that individual's PD change can be identified and described in terms of their level of outcome thus supporting the original hypotheses.

9.3.4 Drawing the threads together

There were three hypotheses in this study. Confirmation has been provided that:

(1) The immediate environmental *context* and each person's own attributes have an influence upon their capacity to activate facilitating mechanisms.

(2) It is possible to identify the *mechanisms* which when activated are a catalyst for practice change.
(3) The level of practice development *outcome* will vary for different individuals.

Additional knowledge gained through the study which moved beyond the original hypotheses will now be discussed and represent fresh insights about maximising individual engagement in PD.

9.4 Moving beyond the original hypotheses.

This section aims to move the discussion from hypotheses into practice. As such the new insights revealed through this research will be considered. The material falls into three main themes. The first is about supporting individuals to progress with PD outcome goals. In this discussion the IPD theory will be introduced (see Figure 9.3) and will go on to explain each of the four sections which support the activation of particular mechanisms for individuals in different contextual situations. The second part of the discussion offers an IPD skills escalator which is introduced as a structure for individual occupational therapists and leaders / managers to use to support achievement of PD competencies. The final part of this discussion raises the point that even though occupational therapists might know about change from their professional training it does not necessarily mean that change is any easier for them.

Given the reality of the variation in engagement it is important to seek to understand what will support individuals to maximize their engagement. The new knowledge developed through this research to support individuals to progress with PD outcomes will be discussed next.

9.4.1 Supporting individuals to progress with PD outcome goals

It is now established that some individuals have challenges to engage in a PD structure and achieve PD outcome goals. It follows then that it is important to look at ways in which the challenges can be overcome. Chapter Seven illustrates how

different outcomes of individuals can be linked with context. The results of this research identified four broad categories of contexts that affect engagement (see Chapter Eight). These are arranged in a hierarchy according to their successful outcome status and include 'personal challenge' context; 'role challenge' context; 'staying focused' challenge and the 'maintaining momentum' challenge. If people are at different stages of change it is prudent to assess their progress and to tailor PD opportunities according to individual need. A theory of individual engagement in PD is proposed as a way forward (see Fig 9.3).

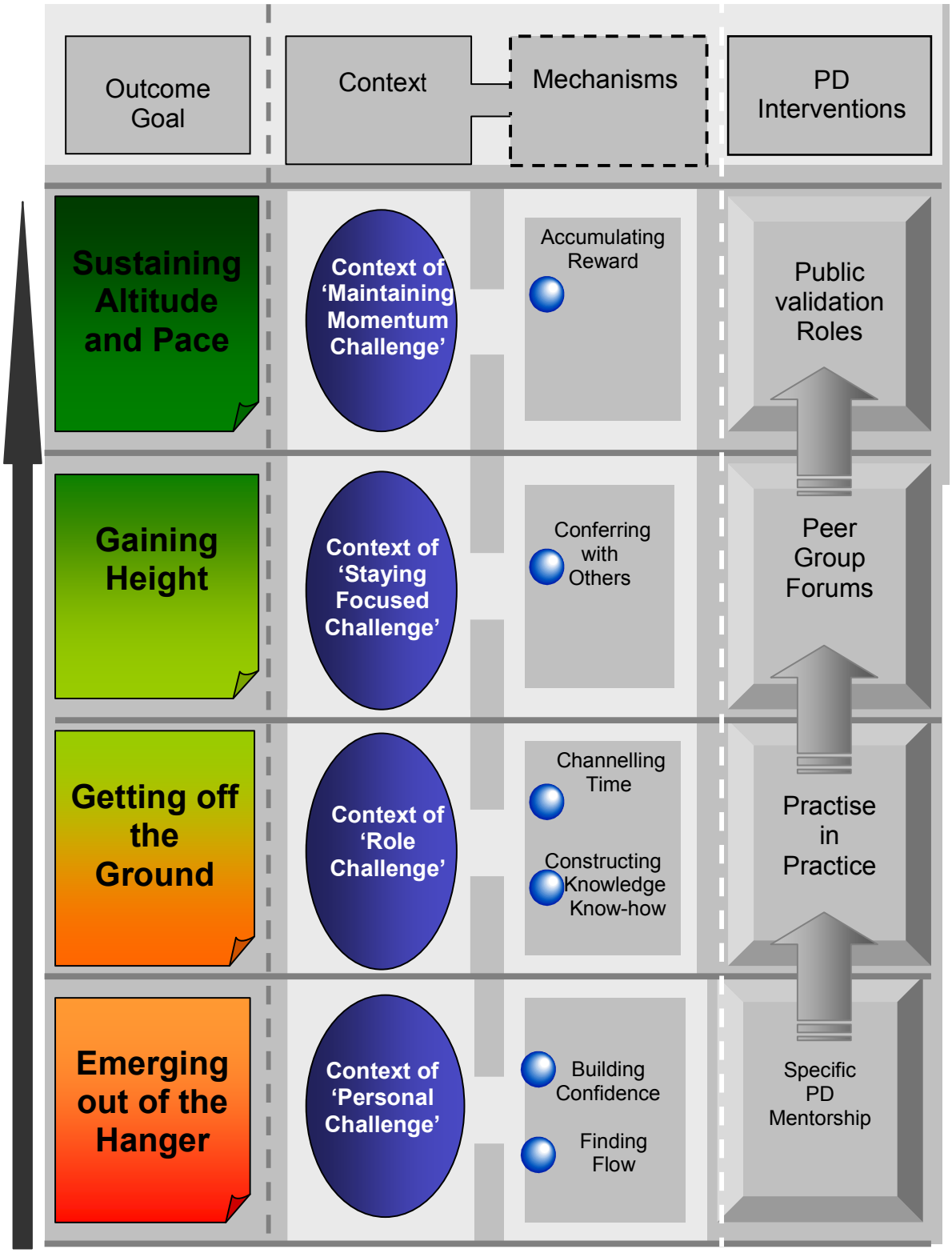
The Individual Practice Development Theory (IPD) introduced in Chapter Eight (see also Figure 8.1) provides an incremental approach and guide for individuals to develop practice. It recommends the PD interventions which should be of primary importance for individuals who present with particular outcome levels and contextual challenges. Figure 9.3 should be read from the bottom and in horizontal slices starting with the recommendations for those needing to 'Emerge out of the Hanger'. In this circumstance where the individual has personal context challenges the priority mechanisms for activation are 'Building Confidence' and 'Finding Flow'. The data suggests that specific PD mentorship should be established as the first activity to activate mechanisms in this contextual situation. Through this priority mechanisms can be activated in order to forward an individual's progress in the PD. However, PD interventions found in the higher level outcomes would not be recommended as the *primary* source of PD activity for those 'In the Hanger' as these could overwhelm the individual.

In order to illustrate further the recommended supports for individuals at each outcome level the next four sections will be formed around the horizontal slices of the IPD Theory. The PD outcome goals might include:

- Emerging out of the Hanger
- Getting Off the Ground
- Gaining Height
- Sustaining Altitude and Pace

Each of these areas will be illustrated and discussed in turn in the sections which follow. The emerging PD interventions associated with each slice of the IPD theory will also be discussed through this section.

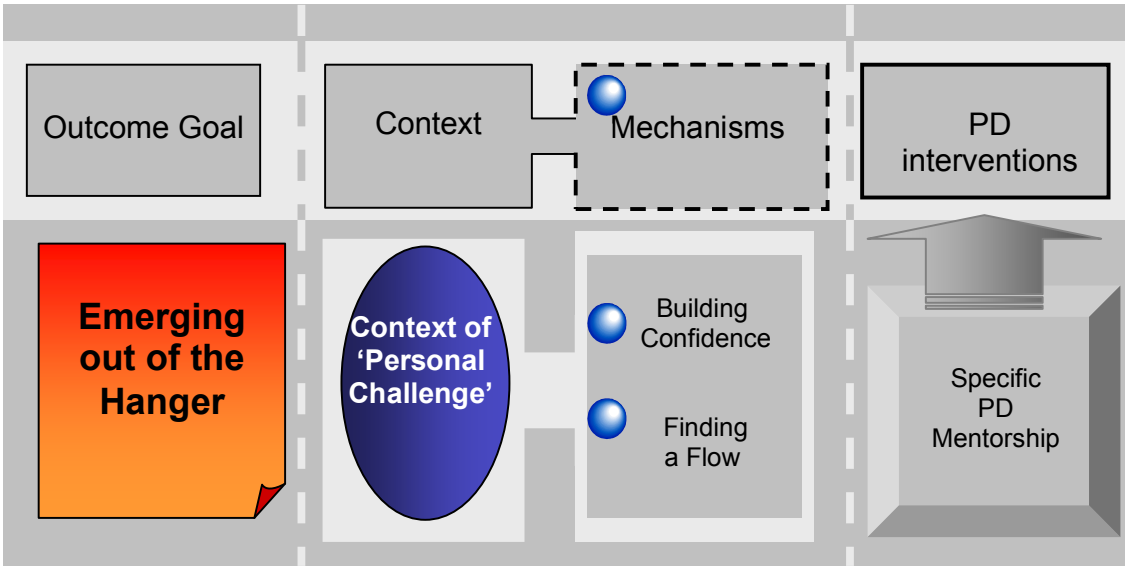
Figure 9.3 The Individual Practice Development Theory (IPD)



9.4.1.1 Emerging out of the hanger

Specific PD Mentorship is identified as the priority PD intervention to foster the activation of pivotal mechanisms for individuals who need to 'Emerge out of the Hanger' with their PD application. Figure 9.4 illustrates this. Reading the diagram from left to right the message is as follows. Where an individual has an outcome goal to 'Emerge out of the Hanger' the data suggests that personal context challenges could be the reason. In this case PD progress will occur if the mechanisms of 'Building Confidence' and 'Finding Flow' are activated as priority. The activity of Specific PD Mentorship is the recommended intervention at this stage.

Figure 9.4 Emerging out of the hanger



'Specific PD Mentorship' provides an individual with an opportunity to reflect on their practice in collaboration with a PD leader or mentor. This should include an opportunity to debrief, gain reassurance and further insight through reflective discussion with a skilled mentor. Reflection whilst undertaking practice action can prevent action (Schön, 1991). Therefore any PD interventions undertaken should be followed by collaborative reflexive appraisal (Van der Hem-Stokroos et al

2003). In effect this is a special case of 'Conferring with Others' which will act as an intervention to fuel the activation of the two pivotal mechanisms.
It is likely then that most individual professionals who are 'In the Hanger' because of challenges in their personal context will still have some aspiration to emerge out and build up their PD achievements. This was certainly the case for Ann and Hannah in this study (7.2.1). The IPD theory proposes that the intervention of 'Specific PD Mentorship' including the setting of individually orientated development goals needs to be the first line PD support offered to practitioners who have this contextual challenge.

Where practitioners have their own personal challenge, self efficacy can be compromised (Jerusalem and Mittag, 1995). Motivation to engage rises with the degree of self-confidence felt by an individual (Bénabou and Tirole, 2004) so it is important to have interventions available which enable PD participants to confer with others who validate their effort and enthuse with ideas. This recommendation does not exclude engagement in other PD interventions. However, the core investment in PD activity for these individuals needs to be in interventions which support building a foundation of self-confidence and an accounted-for routine in PD activity in practice. People improve their self-efficacy when they receive realistic encouragements (Chowdhury et al 2002). In addition the development of critical cognitive thinking is essential for learners to learn new information, matching this to the individual's unique needs and secure a sense of responsibility to do so (Kuiper and Pesut, 2004).

Skilful mentorship offers a safe and supported way for practitioners to explore their learning needs in relation to their contextual situations (Roberts, 2002) particularly where personal challenges are evident. Mentorship is important in health care practice particularly for junior or inexperienced staff (Sweeney et al 2001c). However, this research suggests that individuals with personal context challenges are not necessarily junior therapists so creative ways of supporting the development of more senior staff is vital. The mentorship requirement might be

more difficult to identify as more senior staff may feel the need to hide their inability to engage. Sensitive attention then needs to be given to the way the mentor interacts with the individual in order to gain most progress from the collaboration (Phillips et al 2002). The use of motivational techniques for example to promote engagement could be indicated in this scenario (Walsh et al 2004). It follows then that identification of mentors and mentorship training will need to occur for this approach to reach optimal effect. Another consideration might be that for people struggling with some personal context challenges (for example persistent illness) their ability to undertake their general routine responsibilities, never mind the practice development might be of concern. In these cases the line manager would be responsible for carefully monitoring an individual's performance. Careful consideration would need to occur about the appropriateness of the manager as mentor or collaboration between manager, mentor and the individual. Careful matching of individuals to achieve strong supportive mentor relationships is crucial (Wilding and Marais-Strydon, 2002). It could be proposed that mentor roles might be best placed with those who demonstrate their ability to adopt PD outcomes in their practice.

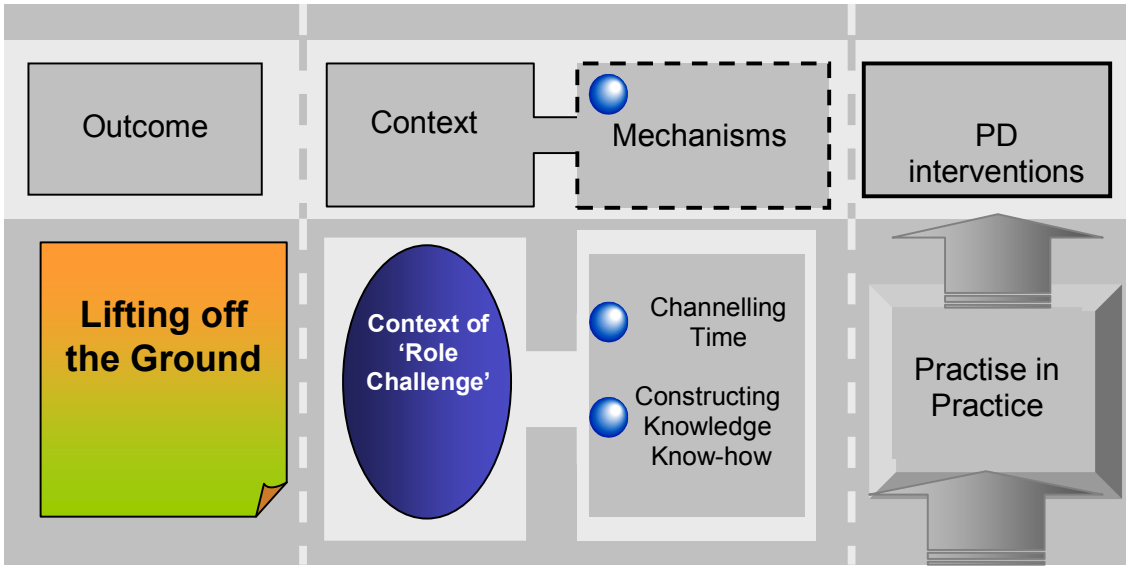
Whilst 'Specific PD Mentorship' is a key activity for individuals needing to 'Emerge out of the Hanger' it should be noted that it is an important activity at all outcome levels. However, for individuals whose engagement in PD is challenged by the complexities of their practice role a further PD intervention will be prominent. This will be discussed next.

9.4.1.2 Lifting Off the Ground

'Practise in Practice' is identified as the priority PD intervention to foster the activation of the supporting mechanisms for individuals who need to 'Lift off the Ground' with their PD application (See Figure 9.5) Once again, reading the diagram from left to right the message is as follows. Where an individual has an outcome goal to metaphorically 'Lift off the Ground' the data suggests that role challenge context could be the reason. In this case PD progress will occur if the

mechanisms of 'Channelling Time' and 'Constructing Knowledge Know-how' are activated as priority. The intervention of Practise in Practice' is the recommended intervention at this stage.

Figure 9.5 Lifting Off the Ground



When undertaking the PD intervention of 'Practise in Practice' the individual is expected to put new knowledge into action in the workplace. 'Practise in Practice' requires individuals to rehearse what is learnt through their basic PD training sessions or reading of PD manuals into everyday practice activity using this as the learning experience (see Section 1.5.2.3). As such individuals PD learning is integrated into rather than detached from practice. It should be coupled with PD mentorship (as can be seen in Figure 9.3) so that goals are set with PD learning, actual practice has sound governance and new learning applied to practice can be monitored and reflected upon. This type of intervention is a form of experiential learning whereby learning is brought into consciousness and located cognitively as self-evaluated, practice choice (Kolb and Fry, 1975). The 'Practise in Practice' PD activity is one way of enhancing the perceived importance of change because of its real clinical application (Miller and Rollnick, 2002).

Through ‘Practise in Practice’ the mechanism of ‘Channelling Time’ is activated as learning is combined with ‘real’ work. Similarly the mechanisms of ‘Constructing Knowledge and Know-how’ is activated as new routines and epiphanies of practice behaviour are discovered and used more routinely by the practitioner (Henaghen, 2009). Thus time is spent on testing and integrating routinely and practical knowledge is formed through doing. There is some evidence to imply that an individual’s work based knowledge is generally acquired through experiences that are independent of formal PD activity (Bierema and Eraut, 2004). Jarvis et al (2003) propose that experience, which can be a direct encounter or mediated, is caught up in the flow of time. However, this research suggests that ‘Practise in Practice’ is one of several PD interventions that need to be available to develop practice. ‘Practise in Practice’ can be supported and be most effective through the collaboration of practitioner, mentor and manager. For example, if managers are able to differentiate the allocation of cases at the point of referral or review, specific intervention based on the new PD information can be offered to the client. In this way the practitioner also gains a ‘Practice in Practice’ intervention experience. However, the research also asserts that there are extended scope responsibilities that some practitioners need to learn and undertake so they may not have the time to practice their new, profession specific skills.

Where it was the case that individuals were expected to undertake extended roles outside the scope of profession specific PD they were found to be more challenged to engage in the PD. Increasingly practitioners require a range of different types of knowledge and skill beyond that which is professionally bounded (Care Service Improvement Partnerships / National Institute of Mental Health England, 2008). In order to maintain the necessary skills for contemporary practice, practitioners will need to continually engage in PD interventions. Some of the literature on PD might lead to the assumption that only one PD programme occurs within a service at any one time (Atsalos and Greenwoon, 2001: Harwood et al 2007: Bezzant, 2008). It was clear from the data in this study that some practitioners were expected to

engage in multiple PD initiatives at the same time. It was also evident that those with significant extended scope practice responsibilities were challenged to remain focused on the PD initiative at the centre of this research study. The data also revealed that some participants actively avoided other PD opportunities (even though they were expected to participate) in order to self manage their learning effectively.

> *I struggle with [being expected to participate in several PD's]. Like being made to do [name of other PD] stuff. But……this afternoon it's actually a [name of other PD] study afternoon and [I felt that] this [research interview] was more important which my respective bosses accepted. So, I got dispensation to come and do this instead!*
>
> **Isobel – Initial Interview**

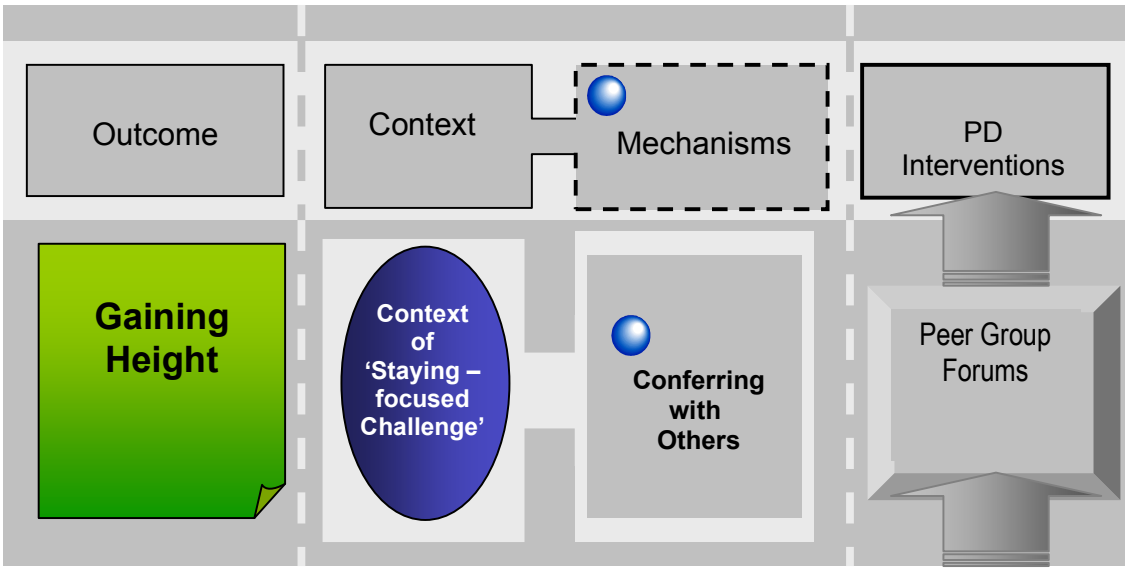
PD leaders need to be strategically mindful about the roles that are required of practitioners. Careful critique, rationalisation and co-ordination needs to occur of PD initiatives within an organisation. This will enable best use of resources; reduce pressure on staff and the finesse of a more facilitative context for the uptake of PD in practice. 'Practise in Practice' then is an essential intervention for grounding skill and activating PD mechanisms for real development. Without this gaining further height with the PD goal will be a greater challenge.

9.4.1.3 Gaining Height

Continuing with the flight metaphor, it is well known that 'Take Off' is one part of the journey that holds particular risks because once started many variables have to be managed in order to get the plane safely into the cruising position. Peer Group Forums for discussion have been identified as the specific PD activity to facilitate the activation of the support mechanism for individuals who need to gain extra height in their PD application. Figure 9.6 illustrates the IPD theory's approach to facilitate individuals where 'Peer Group Forum' activity is used to counteract an individual's challenge to stay focused on their PD goals. Reading the diagram from left to right the individual who has an outcome goal to 'Gain Height' in their PD

engagement the data suggests that staying focused could be their challenges. In this case PD progress will occur if the mechanism of 'Conferring with Others' is activated as priority. As has been mentioned PD intervention of the active involvement in 'Peer Group Forums' is recommended. Once again, this is an incremental approach and should be used in conjunction with other PD interventions of 'Specific Mentorship' and 'Practise in Practice'.

Figure 9.6 Gaining Height



Peer Group Forums need to be organised to be supportive of change behaviour by debating the pathway to innovation success (Fitzgerald and Dopson, 2005). In order for this community culture to develop PD leaders need to be informative and facilitative to support the intrinsic motivation of the learner (Noels et al 1999). In other words the agenda should be focused around the PD, its challenges and constructive solutions to its implementation. Sharing of positive practice can generate enthusiasm and ideas (Sleep et al 2002). Peer Group Forums however are not conceptualised as traditional, didactic training courses. Despite the fact that occupational therapists commonly discuss the benefits of attending training courses (Curtin & Jaramazovic, 2001) they can be a costly process and not all knowledge gained in attending courses is necessarily applied to the practice setting (Chard, 2006). Peer Group Forums on the other hand are opportunities to share experiences

of what has worked in practice to support practice at, for example, lunchtime participatory seminar sessions or local formal learning sets. The opportunity needs to be routine and participants need to take responsibility for sharing practice and learning. It is possible that not all ideas addressed in a peer group will be transferred to practice either. However, by keeping focus, encouraging active participation from members of the group and maintaining a local context, Peer Group Forums can be an important intervention. This might be particularly true where practitioners work in relative isolation from their peers. The likely success of this approach may be related to the fact that it can be repeated more often than formal training; this gives more opportunity to rehearse practice and make incremental development progress. In this way the 'Conferring with Others' mechanism is activated.

The benefits of activating the 'Conferring with Others' mechanism are many. These include opportunities for personal understanding (Mezirow, 1990), validation of effort (Amabile et al 1994), a prompt for reflexive thinking and presentation of ideas (Taylor, 2003) and to discover knowledge from experience (Lyons, 1999). Indeed discussion forums can also be an effective way of sourcing new information and inspiration (Melton et al 2008). Building and sharing practice based knowledge assists the organization to have an identity and culture of a community of practice (Wenger, 1998). Through this individuals are more likely to start to 'freeze' (Lewin, 1948) new practice behaviour into routine action. This could be because of the validation for efforts that occur through a problem solving approach in addition to the development of camaraderie amongst a group with common resolve.

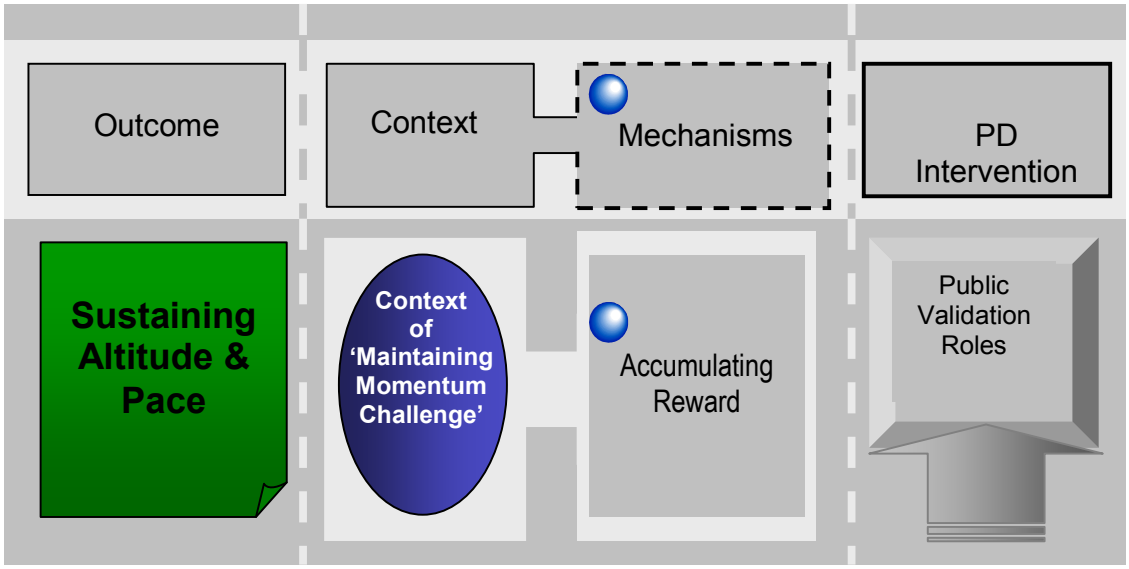
A reflective approach to PD Peer Group Forums is also required and this can have a transformational impact upon an individual's learning (Phillips et al 2002). In itself this experience can be a rewarding for the practitioner. The importance of reward based development of an individual's responsibilities will be discussed next.

9.4.1.4 Sustaining altitude and pace

'Public Validation Roles' have been identified as the priority pursuit to foster the continued activation of supporting mechanisms for individuals who need to sustain their engagement in PD. Figure 9.7 illustrates this. At appropriate altitude and in optimum conditions aeroplanes can use their autopilot feature to continue the journey. However, there are times when the context brings unexpected turbulence and requires attention from the pilot. There is also the need for refuelling after a time spent travelling so it could be argued that even when individuals are cruising with their PD application they are likely to require updates to sustain and improve their action. In effect, even when competency has been achieved it is likely that an individual would still benefit from engaging in one or all of the interventions at fixed intervals, for example through mentorship review. Practice development needs ongoing attention if it is to stay relevant and useful to the therapist in the longer term (McNichol, 2004). This is because the context of individuals and their teams can fluctuate so continued engagement in PD is not necessarily a one-way journey.

On the left hand side of the Figure 9.7 the relationship between the outcome of 'Sustaining Altitude and Pace' and the context of maintaining momentum challenge is clear. It is proposed that it is necessary to consciously stimulate the 'accumulating Reward' mechanism in this case. This is not to say that participants in the PD should not have experienced reward for their effort prior to this stage. Rather that activities which further reward their effort (and act as motivators for others) become opportunities with them. Thus the use of 'Public Validation Role' interventions in this circumstance is recommended.

Figure 9.7 Sustaining Altitude and Pace



Individuals who find themselves within the 'Maintaining Momentum' context are likely to have a personal attributes of being highly motivated, with a sophisticated degree of problem solving ability and a belief in the PD programme (Rogers, 1995). They may also become bored once they have developed some new knowledge or feel devalued if their expertise is not recognised. It is particularly important then that the knowledge and expertise of these therapists is acknowledged and their skills and enthusiasm channelled and utilised to best effect by the organisation. Therapists are likely to experience some intrinsic reward as their confidence in practice grows and they are better able to articulate a rationale for their professional opinion and decisions. By offering PD opportunities which offer extrinsic motivation as well, PD progress is enhanced.

Overt recognition of an individual's skills and abilities is a way of ensuring that the therapist stays focused on the PD (Evans and Kersh, 2004). Encouraging the up take of PD leadership responsibilities could be part of this strategy. However, this should be with the caveat of reducing other responsibilities and supporting a person in a new role. Leadership roles might include for example, training others in clinical procedures (Forsyth et al 2005c), offering practice supervision (Sweeney et al 2001c), taking a lead in peer group forum facilitation and contributing to work-

based projects (Ryan, 2008). Undertaking such roles can be a source of reward through influence and positive feedback. This feeling of reward can be an addictive experience which may further promote the continuation of PD activity (Willey, 1986) and also increase the individual's probability of promotion.

One of the questions that emerged from this thesis is how do individuals who are known to be metaphorically 'In the Hanger' or 'On the Runway' have facilitative mechanisms further activated. Arguably it is not cost effective to have every PD activity available for every individual particularly with the evidence from this research which suggests that even when people utilise the PD interventions the outcomes are not equal in impact on practice change. Graded exposure to PD interventions might be the answer. However, using IPD theory a way of identifying those who would benefit from which PD intervention at a particular point in time would need to be assessed. This is discussed next.

9.4.2 The IPD application in practice

This section introduces the argument for taking a structured approach with individuals towards their PD goals and utilising the available PD interventions. It will present the IPD as a skills escalator where individual competencies to deliver PD can be appraised in order to invest in the appropriate PD interventions for and with an individual. Furthermore discussion will consider how this would be beneficial for individuals and their managers or leaders.

The capacity for self assessment of PD outcomes is questioned. In this study there were discrepancies between the self-assessments (survey) and the researchers synthesis (based on interview, direct observation and audit of notes data sources). It has been noted that those who are moving through a novice stage into a more accomplished phase of competence often do not recognize their progress (Benner, 1984). Understanding individual therapists' attitudes to a PD may assist in making PD outcomes for individuals more effective (NHS Centre for Reviews and Dissemination, 1999).There are however few tools available which will plot

readiness for engaging in PD specifically. The scale developed by Arons (2004) could go some way to measuring health care practitioners' responses (see Section 3.3.5).

On the other hand, a more qualitative reflective approach might be helpful so that an individual is facilitated to gain insight into their own strengths, weaknesses and areas for knowledge development (McSherry and Warr, 2008). This concurs with contemporary recommendations about adult education and human resource development. Knowles et al (2005) for example, support the idea of making change happen by releasing the energy of those involved and to work with individuals to identify their own strengths and resistances to PD. A further advancement on readiness is to understand whether participants are ready, willing and able for change (Miller and Rollnick, 2002). This point raises the debate for the individual to be mindful of the importance of the change, confident and skilled in the change requirement and ready to take the initiative to prioritise change as part of personal activity. Developing techniques to understand resistances and readiness for PD could be an area for further development. The scaffolding mechanisms which emerged through this research could form the basis of a screening tool.

It is argued in this thesis that differentiating PD interventions for different individuals is important. One way of achieving this is to start the PD with a small range of baseline PD interventions available to all and then tailoring packages to various individuals involved. This could be a way of providing and monitoring appropriate bespoke packages of learning. Two potential challenges to a theory of this nature might be anticipated. Firstly, bespoke packages could be perceived as a very costly approach. However, it could be argued that a cost benefit analysis might indicate that an individual approach would be a good investment of resources compared to systems which are not always successful in delivering PD progress and perhaps wasteful of training resources. An example was the training investment made in the practice area studied by Hammond and Klompenhouwer's

(2005) where only 25% of those involved in the PD implemented the new knowledge into practice.

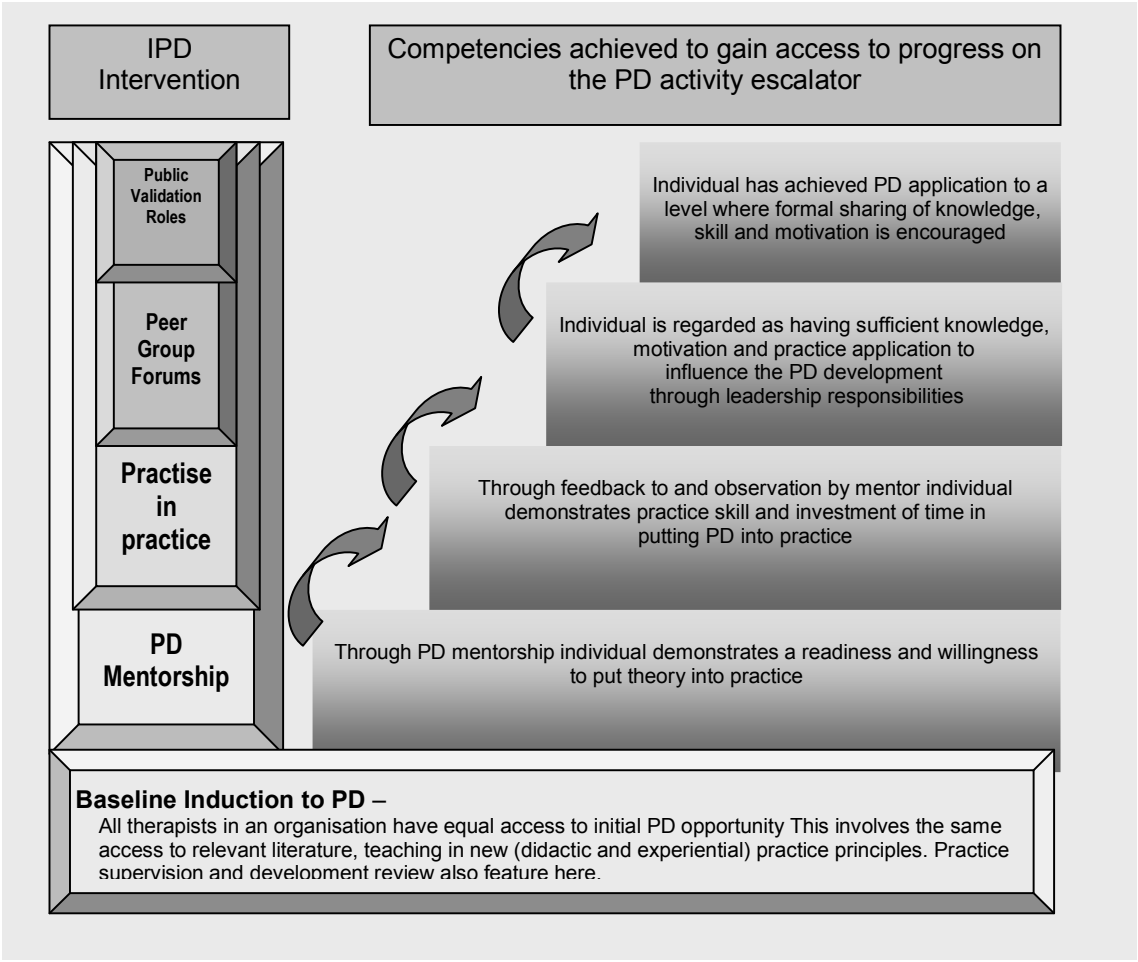
A second potential challenge could be a perception of unequal opportunities in the workplace. An alternative way of looking at this is that all individuals have equal opportunity to undertake learning even if different interventions are recommended for different contextual situations. This way learning is more successful and resources are used to better effect.

An individual PD 'skills escalator' is proposed to structure an overt, differentiated process of opportunity to engage in PD interventions (see Figure 9.8). Where a structured approach is desirable this stepped approach could act as a tool to outline the individual's achievements, needs and learning plan.

Reading Figure 9.8 from the bottom up it illustrates how all those expected to be involved in PD are provided with baseline induction opportunities for learning. This gives access to immersion in the new and required practice principles. As individuals become familiar with the new information then they need to demonstrate practice competencies (featured on the right hand side) in order to access investment in the learning interventions. Kane (2007) concluded that different educational intervention steps are required to facilitate implementation of innovation. This thesis goes further and argues that different interventions will be required at different temporal points. This is because people will learn at different rates and the context will be different within different practice areas.

Through this structured approach to individual PD learning points and aspects of relevance of the IPD skills escalator model emerge for individuals and their PD leaders and managers. As such the IPD skills escalator will be considered for these two groups in the next sections commencing with individual practitioners.

Figure 9.8 Individual Practice Development Skills Escalator



9.4.2.1 The IPD skills escalator and individual practitioners

There are several challenges for occupational therapists to engage in PD to the point of changed practice. The challenges which emerged from the literature have been outlined in Chapter Three (Section 3.3) and include a lack of internal motivation to change, inadequate external motivation, fixed routine, being forced to change and the impact of an individual's personal characteristics. Individual practitioners have a range of roles, experience, knowledge and skills (Riding and Rayner, 1998). It is proposed that the IPD skills escalator, used with individuals, could enhance engagement in PD by fostering greater understanding of the PD, identifying individual PD challenges and goals and empowering practitioners to

take responsibility for their own learning progression as applied to their own roles, experience, knowledge and skills. Health professionals generally want to achieve continued competency within their role (Higgs and Titchen, 2001; Chard, 2006). However, all humans have the potential to resist change (Honey, 1997). It is proposed that the IPD skills escalator is a tool to guide learning activity for junior and more experienced occupational therapists to support practice change.

It is possible though that not every individual practitioner will need to go through all levels of PD support implied in the IPD skills escalator. Some individual's will essentially 'teach themselves to fly' or they may have joined the organization with the required skill set already developed (Knowles at al 2005). It is important to acknowledge that individual practitioner approaching a PD start from different points and experience different professional and personal circumstances. It follows then that they could need different pathways to make PD progress. Whilst it is important to have a system to identify an individual's starting point it could also be argued that the extent or intensity of personal distractions might not be the best predictor to whether the individual will ultimately change practice or not. For example, an individual might find work activity a good distracter from personal issues or equally for some people work developments could be unachievable during a personal crisis. The important area of note is that whilst an organisation cannot necessarily influence the personal circumstances of an individual the organisation can make reasonable adjustments to workplace pressures.

In Chapter One (Section 1.2.2) it was argued that the concept of change for occupational therapists is central to their knowledge base and their expertise is concerned with helping others to change and develop. However, the results of this research suggest that knowing about change is not the same as undertaking personal change. Individuals involved in this research were generally able to identify that the PD programme offered them many opportunities to engage in changing their practice (Chapter Six, Section 3). This research also exposed different levels of consciousness amongst participants about the specific

mechanisms that would support their own PD change. The mechanisms of change would perhaps theoretically be familiar to an occupational therapist schooled in this subject and their knowledge of change might exceed the knowledge of others generally. However, this knowledge may be implicit and therefore not consciously considered particularly when related to the self rather than others (Evans and Kersh, 2004). Cognitive education regarding the concept of change does not necessarily prepare an individual for their own behaviour change (Eraut, 2000). This observation is worthy of further testing with the IPD skills escalator as other health care workers also aim to support change in others.

With regard to junior therapists preceptorship programmes, particularly for the first year of practice, have been highlighted as important for consolidating knowledge and skill in the practice role (Morely et al 2007). The IPD skills escalator model could support occupational therapists and other disciplines with learning strategies to consolidate their professional specific skills in a staged and supported approach (Riding and Rayner, 1998). Learning within the parameters of a particular discipline could be compromised when there is no immediate role model or mentor to share ideas (see Ann 6.3.5). This situation might call into question the wisdom of expecting new graduates to undertake extended scope or generic positions (Culverhouse and Bibby, 2008) particularly if no profession specific support is available.

Senior practitioners can be equally vulnerable when a new PD is introduced as they spend less time in practice and have fewer peers to confer with (Knowles et al 2005). Senior occupational therapists could benefit from advance exposure to the PD and advance notice about their role in the PD in order that they can manage others (Forsyth et al 2005c). Where possible, however, those in senior positions need to engage in the PD in order to preserve their perceived authority and competency to practise (Garbett and McCormack, 2002b). The organisation also needs to be sensitive to this and not undermine the position of leaders through the PD implementation (Currie et al 2007). In this circumstance both the organisation

and the more senior individuals have a responsibility to 'fast track' to PD competency in a timely manner. In addition a sensitive approach to the division of leadership roles needs to be undertaken in order to ensure that positive workplace dynamics are upheld. Whilst each registrant does have a responsibility for their own CPD an organisation also has a responsibility to ensure that systems of support are in place, are active and monitored (Bannister, 2001).

The IPD skills escalator offers a structure to support PD for occupational therapist practitioners. The organisation must also ensure that the extent of PD demand is realistic, facilitative and not overwhelming for the individual. This might be achieved by the adoption of the IPD skills escalator by professional leaders and managers within an organisation.

9.4.2.2 The IPD skills escalator and the leaders / managers

This research suggests that leaders and managers have to pay attention to supporting the individual learning needs of team members in order that holistic PD is achieved. The leadership role has been championed for supporting professional developments (McQueen, 2008) (also see Chapter Three, Section 3.4). As such, the IPD skills escalator could be used by leaders and managers to structure the assessment of PD competencies with an individual in order to gain their maximum engagement in PD. For example, Ann required more attention to her learning needs from immediate managers and leaders but did not independently seek the required support (see 7.2.1). It is likely that Ann would have benefited from dedicated and routine 'PD Mentorship' following her participation in 'Baseline Induction' activities (see Figure 9.8). It could be argued that if leaders had been able to apply the IPD skills escalator at an early stage of the PD implementation that situations like that of Ann's may have been avoided.

Organizations are increasing expected to undertake 'top down' PD and to facilitate developments that are focused, achievable and concerned with the well being of service users (Clarke, 2008). To be effective across an organisation, authorisation

to adopt new operational models like the IPD skills escalator need to be taken at a broader strategic level but within a climate of receptiveness to change and a culture of innovation (Buchanan and Fitzgerald, 2007b). As with any PD the suggestion is that a judicious choice should be made by the organisation following an analysis of the costs and benefits to establish the benefits for and challenges to the organisation, the staff and the users of the service (McCormack et al, 2004).

The authorization for practitioners to invest time and energy in any PD intervention is ultimately made at local team manager level. Understanding, sign-up and ownership of the PD from immediate line managers is critical (Chard, 2006: McCluskey and Cusick, 2002: Bradley et al 2006). Research has shown that occupational therapists who do not adopt profession specific PD are more likely to be managed by non-occupational therapy managers (Chard, 2006). Using the IPD skills escalator in collaboration with occupational therapy leaders who have a responsibility to deliver the PD outcomes could be beneficial. Professional leaders have a responsibility to further explain their position in order to demystify what can be provided and to skilfully lead and evaluate change (McCormack et al 2002).

An example from the literature where the IPD theory could have utility for leadership of PD is where services have development post schemes for junior staff (Siddons and Rouse, 2006). The PD leader might use the IPD skills escalator with individuals in association with team managers so that consistency of staff development is achieved. This could have an additional benefit of fostering collaborative leadership amongst colleagues (Archer and Cameron, 2009). Another concern in the literature is that mental health practitioners have been pressurised to work generically which may have had an effect upon their capacity to action referrals for specialist intervention like occupational therapy (Harries and Gilhooly, 2003). This situation may compromise the delivery of the required standard of practice for service users (Mittman et al 1992). Another outcome of generic working is that practitioners may not even attempt to use new profession specific knowledge in practice because of poor links between their professional

communities (Fitzgerald and Dopson, 2005). A case for structured attention to the professional development needs of individuals can be made through the need for efficiency and effectiveness of the specialist NHS workforce (Department of Health, 2008). The IPD skills escalator could assist practice leaders to achieve this.

Improved leadership has been associated with enhanced consumer satisfaction and quality of life (Corrigan et al 2001). Organisations then must attend to having sufficient, profession-specific, leadership capacity in order to initiate, steer and evaluate specific PD activity (Manley, 2004). This is also important in order to build up the understanding, relevance and ownership of the PD locally (Atter, 2008). There is also an argument for the integration of learning amongst different professional groups, depending on the relevance of the PD subject matter to their collective practice (Freeth et al 2006). Whilst there are potential complexities to this approach there are also service user benefits as professionals, including managers understand the broader health care perspective as a team. The relevance of the IPD skills escalator in multidisciplinary PD interventions is however likely.

This section has moved the discussion from hypotheses into practice. Of the three main areas considered, supporting individuals to progress with PD outcome goals was one. As such the IPD theory was presented (see Figure 9.1) as was each of the four sections which support the activation of particular mechanisms for individuals in different contextual situations were outlined. It concluded that graded exposure to PD interventions might support individuals to progress with PD. It was then recognised that in order to structure a graded exposure to PD individual occupational therapist's competencies would need to be appraised and that learning opportunities would need to be structured. As such the IPD 'skills escalator' model (see Figure 9.8) was introduced as a PD facilitation tool. It has been proposed the IPD skills escalator could support practitioners, leaders and managers in the advancement of PD goals and competencies.

9.5 Appraising the research

This section will introduce an appraisal of the methodology and methods used in this research. The discussion will be structured to consider a critique of the methodology of Realistic Evaluation (RE); the PD programme; the sample group drawn; methods, trustworthiness, insider research and applicability.

9.5.1 The methodology of Realistic Evaluation

Realistic Evaluation (Pawson and Tilley, 1997) was selected as the methodology for the study (see Chapter Four). This methodological decision was made because the genre accounts for the central role of three key elements of concern which include the contexts, mechanisms and outcomes of the PD. Understanding was sought about what intervention works (the outcome), how success occurs (the mechanisms) and in what circumstance (the context). As a result the main findings relate to how contextual features combine with activating mechanisms to produce a range of outcomes of developed practice amongst a group of individual practitioners. Using this methodology has served to further the body of knowledge about PD and the contextual features required to foster an individual's engagement in a PD programme. Furthermore, the RE approach has identified activating mechanisms together with principle PD interventions to support positive PD uptake. With regard to the transferability of the findings to other settings it is proposed that the mechanisms discovered (see Chapter Six, Section 6.3) are likely to generalise in other settings although this proposition would need to be tested in subsequent studies. It is proposed that other research methodologies would not have achieved the perspective that has been illuminated through the methodology of RE. Other facets have also been revealed through this methodology including insights about the specific PD undertaken. These will be discussed next.

9.5.2 The specific Practice Development programme

Detail about the specific PD programme was provided in Chapter One (Section 1.5). Through synthesis of the results, consideration has to be given to whether there were PD interventions missing from the PD programme that was being

utilized in this study. The data did not indicate that there were specific PD interventions missing. However, the PD itself was in relatively early days of implementation so it is possible that the capacity for PD leadership roles was limited. This would have had an impact upon the availability of specific PD mentorship and ultimately affected the outcome results for some individuals.

The data also revealed that some individuals found the new language within the PD concepts lofty and therefore challenging to use (see Gillian 6.2.4). The limitations to the use of the same theory to develop practice were explored in a survey in the United States of America (Lee et al 2008). Though the translation of the MOHO theory into lay language was not explored directly there was a suggestion made by some respondents that the concepts were too complex to explain to some service users. Forsyth and Kielhofner (2006) on the other hand propose that the words selected to describe therapy are important in order to convey accurately the specific issues faced by an individual. However, while practitioners still have this perception there will continue to be a contextual challenge to its use in practice which might be exaggerated where there are personal challenges for the individual. On the other hand, the high response rate (96% of potential respondents) to the initial survey (Chapter Five, Figure 5.2) coupled with the results that 88% self reported using the PD assessment material to some degree in their practice (Chapter Five, Section 5.3.1) does suggest that this population in general, valued the PD initiative. The next section will consider the sample group of those individuals who participated in this research further.

9.5.3 Sample group

Ten participants took part in Phase Three, the main study (see Figure 5.1). Though further data collection could have occurred the researcher considered that saturation of mechanism identification had been achieved with this sample size. No further mechanisms were identified after the analysis of five participants' data.

This position does not preclude the identification of further mechanisms when the study design is replicated in further investigations.

There was a methodological decision taken for individuals to self select on invitation to participate in the study. This was in order to preserve participants right to evaluate their capacity to participate in a research study. Undertaking ethical research practice is of a key concern in order to facilitate robust data gathering (Department of Health 2001a). Sampling across the spectrum of self assessed engagement in the PD was purposive (Chapter Five, Section 5.3.3) and it was known from the survey results (Section 5.3.1) that there were several potential participants available in order to ensure the availability of the sample required (Silverman, 2005).

The results revealed that a number of individuals in the main study sample were engaged to some degree in the PD. One explanation could be connected with the Hawthorne effect (Wickström and Bendix, 2000) where the perceived interest in the PD of the researcher was identified by the participants and acted as a factor in maintaining their interest. However, it is importance to emphasise that of those who chose to participate there was a still a range of engagement levels in the PD. This is interesting because it could have been postulated that those who engaged in the study knowing that they would be volunteering to have their engagement in PD observed and questioned might be at a higher level of participation in PD. This result could suggest that some individuals have less awareness of their own level of participation. Another interpretation could be that they were stimulated to express their position with the PD or that they were motivated to have direct access to a senior practitioner. Despite the range of participation achieved through this sample several potential participants declined the opportunity to take part in the research and this will be discussed next.

Nearly half of those invited to participate in the qualitative methods declined to contribute to this part of the study. The results may have been different had these

individuals chosen to engage although the individuals who declined were equally spread across the spectrum of self rated responses. However, nothing can be known about the reasons lying behind the decisions to decline participation in the study due to the consensus on ethical practice in research which stresses that potential participants should not be asked about their reasons for declining to participate.

Another point to note about the sample is that all the participants were women. The profession of occupational therapy has far fewer male registrants so this result is not unexpected. The literature suggests however that there are differences between women and men learners (Jarvis, 2004). Whilst it is not possible to predict what, if any, actual impact this may have on the results it is possible that for women one or more of the mechanisms might be more important that for a male population. Alternatively particular contextual features may be more important for one gender than the other. This is an area for further research.

A similar discussion might be made about the ethnicity of the sample group which had limited ethnic diversity. This may be an issue with regard to the uptake of PD. However, the impact can not be known without further investigation with further consideration to the sampling procedures and methods of data collection.

9.5.4 Methods

The methods for this study were specifically selected to achieve plurality in the means of data collection. RE encourages the understanding of realities from a variety of perspectives and enables the choice of method to be selected to answer the specific form of hypotheses developed (Pawson and Tilley, 1997) (see Chapter Four, Section 4.3.1). This methodological decision brought together a comprehensive account of the area of enquiry. Many reasons for using a mixed methods approach have been discussed in the literature (Bryman, 2006). In this study mixed methods were used primarily as complimentary methods to support the generation of explanation, illustration and enhancement about the context, mechanisms and outcomes of the individual's engagement in PD. They were also used as a sampling process and to enhance credibility of the findings. Individually

however, questions could be raised about the methods. For example, the self rating of engagement could be challenged as a reliable indicator of real engagement in the PD (Adams et al 1999). However, this method served the purpose for which it was primarily designed. It assisted to create a maximum variation sample for the next stages of the research.

It has been argued that novice researchers require practise and should utilise reflexivity (Chapter Four, Section 4.4.1) in order to achieve credible interview technique (Whiting, 2008). Though the researcher in this research was on a journey of learning, the best practice interview techniques suggested by Whiting of building rapport, putting participants at ease, encouraging in-depth description, appropriate participation and concluding the interview were familiar and part of a tacit knowledge skill set arising from professional practice as an occupational therapist and service manger (see Chapter Five, Section 5.2.2).

With regard to observation as a research method, Robson (2002) critiques it as providing only a brief snapshot of activity which may not be reflective of non-observed behaviour. However, the method was used as part of a whole process to reflect the reality of PD engagement. The observation method was initially conceptualised to be marginally-participant, unobtrusive and generally non-reactive (Chapter Five, Section 5.2.3). However, during some observations there was a greater degree of engagement with the researcher noted. This required intervention from the researcher albeit socially constructed. The researcher reflected however that this was unlikely to have significantly affected the results as the researcher was able to use her practice skills to refocus the interaction.

Reflexivity Quote

Throughout the session I was conscious of Eithwen's decision to use me overtly as part of the therapeutic environment. Whilst the client knew and had agreed to my presence as a researcher, the conversation during the session was facilitated by the therapist to be three way. She explained afterwards that she was pleased that the client invited me to be at the session as 'socialising with others' was part of their agreed OT treatment goals and a well articulated challenge for the individual. This seemed a natural use of my involvement and I don't believe adversely affected the results of the research.

Eithwen – Researcher Observation notes

The triangulation and integration of interview and observation data by reviewing, comparing and testing findings throughout the analysis enabled results to reflect the reality for the individual concerned (Siverman, 2005). When undertaking the audit aspect of the data collection some tentative theories about the data were already known.

It has been established elsewhere that what is undertaken in practice might not always accurately documented in health care records (Creswell, 2003). Notes audit was used as part of a whole process to reflect the reality of PD engagement and was particularly useful for understanding PD outcome. The audit data enabled greater understanding about how participants were able to use the new PD concepts and theories and articulate this through synthesis in their writing. It also highlighted their sense of responsibility and commitment to evidencing PD theories and assessments in their documentation. It was helpful to triangulate data particularly from the observation data to achieve this. It could be noted in Bev's notes, for example, that effort had been made to report her assessment findings using PD concepts. No such evidence could be found in the notes of Ann. Whilst Delyth had made effort in her thinking and learning with the PD the following researcher note is evidence of the challenges that she faced in integrating the PD into her practice context.

> Delyth's notes really reflected the gathering of clinical information for the Care Programme Approach narrative assessment. Her focus in her case notes was really on risk management rather than specific focus on specialist occupation focused intervention.
>
> **Delyth – Researcher note at Note Audit**

This leads to the point that the data sets linked together and influenced the synthesis made through analysis of the whole data set. In particular, the interview, observation and audit data formed part of a sequence of data collection for each individual and the collective data formed an integrated whole (Lingard et al 2008).

9.5.5 Trustworthiness

Trustworthiness or validity is another word for truth (Silverman, 2005). Porter (2007) describes a realist approach to validity and suggests that the reader rather than the researcher must judge the validity of the research. Several strategies were used to increase the trustworthiness of the results of this study. These included contact with the participants over a longitudinal period, the multiple methods employed to answer the research question and the varied experiences of the insider researcher (see Chapter Five). In addition a degree of member checking occurred via invitation to participants to check transcripts and initial analysis. However, little feedback was provided but this could be explained because each participant was a busy professional. Presentation of the results was made to members of the profession locally and nationally which provided feedback and questions about the data for further consideration. Research supervision has provided the majority of member checking.

9.5.6 Insider Research

In Chapter Four, the efforts made to avoid the challenges presented from conducting insider research (Finlay and Gough, 2003: Greenbank, 2003) are explained. Significant effort was required by the researcher to identify and interrogate personal and professional courses of thinking and action (Ellis and Bochner, 2000). Examples of such reflexivity are given throughout this thesis (see for example Chapter Seven). This enabled the researcher to draw out and deal positively with feelings which arose through the research process. Without such

attention to reflexivity there could have been an impact upon the findings or indeed the continuation of practice (Darra, 2008).

9.5.7 Applicability

This research was purposefully undertaken within a particular context and with a sample of participants from a particular professional group (Chapter One, Section 1.4). However, given that the nature of practice development is a means of improving quality of care, of driving evidence based practice, of enhancing effectiveness and of skilfully reasoned practice (Manley and McCormack, 2004) the principles of the findings could apply across disciplines. This would need further testing and is an area for further research. In particular the testing of this theory could transcend other organisational contexts and other disciplines. It could also be tested within multi-disciplinary PD structures with RE being the methodology to offer comparison of results.

This section has appraised the methodology and methods used in this research. The discussion was structured to consider a critique of the methodology of Realistic Evaluation; the PD programme; the sample group; the methods of interview, observation and notes audit; trustworthiness, insider research and the applicability of the research in other contexts and across other professional groups. It has concluded that the research methodology and methods were in general suited to the research undertaken and the process has offered helpful research results and synthesis in relation to understanding individual's engagement in practice development. The theory generated needs to be further tested for occupational therapists and other professional groups across varying contextual situations.

9.6 Summary of the chapter

This research set out to understand how individuals in different contextual situations engaged in a practice development programme. Literature can be found which defines PD and offers evaluation of various PD interventions. However, in relation to how *individuals* respond to PD a gap was noted. This research uniquely

concludes that that differentiated PD needs to occur in order to maximise practice change across people and places. This will be summarised in the concluding Chapter Ten.

Chapter Ten – Conclusion

10.1 Chapter overview

This research set out to understand how individuals in different contextual situations engaged in a practice development programme. In order to provide a conclusion of the results of this research this chapter will begin with a summary of the study findings. It will go on to précis the contribution that the investigation makes to the field of practice development and will also make recommendations about the application of the results in practice.

10.2 Summary of the study findings

The major and overarching conclusion of the research is that:

> **A differentiated approach to practice development needs to occur in order that each individual practitioner involved can maximise their practice change within their local practice environment.**

The following list provides a brief summary of further and more detailed findings of this study. They are presented in the sequence of 'strength' that they have, based on the evidence from the study.

1. Practice development is as relevant on an individual level as it is at an organisational level.
2. Skilled leadership capacity over a longitudinal period is essential for engaging a broad range of individuals in PD.
3. It is important to have a variety of PD interventions available which can be accessed to activate mechanisms for individual PD and are relevant to a person's learning style, personal attributes and individual practice context.
4. Management endorsement is required particularly at team and organisational levels for PD to be supported to best effect.

5. Making an assessment about the place that each individual is starting their PD learning can help with ensuring appropriate resource allocation is made.
6. The seniority of an individual's practice role does not necessarily equate to an increased engagement or expertise in PD.
7. Strategies to monitor whether PD mechanisms are being activated in individuals require reflection and skilful mentorship.
8. The introduction of several PD initiatives to the same individuals at any one time can impede engagement.
9. The PD introduced should correlate with the expectation of the individual's practice.
10. Illness or other changes to a person's usual personal or environmental context can have an impact upon the individual's capacity to engage in PD.

10.3 Contribution to the field of practice development

This section will outline four specific areas of contribution that this study makes to the field of 'practice development'. These include the view that individuals do not respond to PD as a homogenous group; that differentiated PD is likely to deliver better outcomes and that mechanisms supporting PD can be identified. Finally the section will highlight that individuals belonging to professions like occupational therapy, whose expertise is framed in knowing about how to support change, do not necessarily hold an implicit ability to apply that knowledge to independently changing their own practice.

10.3.1 Individuals do not respond as a homogenous group

The development of workplace-focused knowledge can be examined from a social and an individual perspective (Bierema and Eraut, 2004). However, the existing literature about PD does not adequately take into account the different responses that individual practitioners have to programmes of PD. The literature deals with people and places largely as if they are a homogenous group. But they are not. This thesis has reported an investigation into this unique area in order to understand how

individuals respond to a PD initiative. Its contribution is to illustrate that different PD outcomes amongst individuals are evident. It has illustrated that that different individuals in different contextual situations will accomplish different rates and depth of engagement in a PD programme.

10.3.2 Differentiated PD will deliver better PD outcomes

Practice development structures reported in the literature tend to be constructed to facilitate learning to a team in order to achieve good standards of local practice (McSherry and Warr, 2008). This thesis argues that PD which takes a differentiated rather than a whole team approach to PD learning opportunities is more likely to deliver better PD outcomes. As such PD needs amongst teams should be tailored for individual members of the team in order to make progress in gaining desired practice change across different individuals in a variety of contextual situations. Through the RE design the various PD outcomes can be explained from the basis of the contextual situations. In addition the mechanisms that need to be activated to achieve outcome progress have been identified. The central argument is that by understanding what these mechanisms are, PD leaders can ensure the best use of PD resources and tailor interventions to achieve maximum PD uptake.

10.3.3 Identification of mechanisms

The mechanisms which spark, propel and maintain engagement in PD amongst individuals are not adequately defined or evaluated within the literature. This thesis however has uniquely contributed to the PD literature by identifying the important mechanisms which, when activated, support an individual's engagement in PD. These include 'Building Confidence'; 'Finding Flow'; 'Accumulating Reward'; 'Conferring with Others'; 'Constructing Knowledge Know-how' and 'Channelling Time'. By identifying these mechanisms and understanding how they work dynamically and can be activated to varying levels individuals can be better supported to engage with a PD within their own context. This understanding could enable services to enhance their PD outcomes, use resources more effectively and efficiently and boost staff morale.

10.3.4 Knowledge of change does not equate to change behaviour.

The final overarching contribution to the PD literature is connected with knowledge about the change process. This thesis has illustrated that whilst professionals like occupational therapists might know about change in an academic sense from their professional training and practice experience it does not necessarily mean that change is any easier for them to personally undertake. This contribution to the understanding of PD programmes in health care supports the need for structuring PD activity with individuals in professional groups. In order to do this it is important to understand what stage of the metaphoric flight path of PD that a person has achieved at the start and throughout the PD journey. This thesis has offered a structure to understand this further through the application of the Individual Practice Development skills escalator with individuals.

10.4 Recommendations for practice

Featured here are 'top tips' for the application of the research results to practice. They are developed from a synthesis of the points raised throughout this thesis and offer brief summary of recommendations for practice organisations that are undertaking PD.

Table 10.1 Recommendations for practice

Recommendation No.1	Practice development should be conceptualised by services as a process for developing quality services through the development of the skills of individuals *and* teams.
Recommendation No.2	Services must ensure that there is skilled leadership capacity over a longitudinal period in order to successfully engage a broad range of individuals in PD.

Recommendation No.3	PD leaders need to be carefully selected for their ability and motivation to learn and to inspire and facilitate others to learn.
Recommendation No.4	Management endorsement is required particularly at team and organisational levels for PD to be supported to best effect.
Recommendation No.5	Services need to make a variety of PD interventions available in order that individuals are able to activate mechanisms to support their unique learning needs and practical application
Recommendation No.6	Services need to have strategies and supports in place to assess and monitor individuals progress with their engagement in PD
Recommendation No.7	Services should pay attention to the structures and systems in place which support individuals to *reflect* on their practice and their PD activity.
Recommendation No.8	Services should appraise PD options and introduce new programmes with care so that individuals have the best chance to engage in PD's which are most relevant to their clinical work.
Recommendation No.9	The impact of contextual changes should not be underestimated. Managers need to be sensitive to alterations in a person's personal or environmental conditions and make appropriate adjustments to their PD goals, activities and supports.

Setting a realistic goals with individuals about their engagement in and outcomes of PD is sensible and pragmatic. Tailoring interventions for potential users of the new knowledge is likely to offer insights to guide the most effective use of PD resources. The expectation of a hundred per cent uptake of a new development might be unrealistic especially where a specialist health care intervention requires an individually tailored approach rather than a prescriptive intervention. However, organisations and individuals have a responsibility to make best use of PD resources and opportunities.

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Appendix 1 Single Question Questionnaire

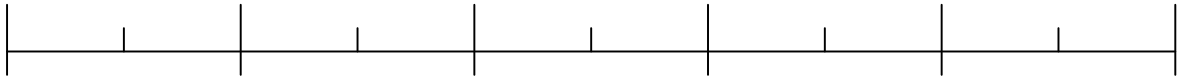
Study no.

City University London

St Bartholomew School of Nursing & Midwifery

NAME: _____

Please mark 'x' at a point on the line which best describes **your current practice in using standard MOHO assessments in your clinical practice.**



Will never use	**Planning to start in 12-18 months**	**Planning to start in 6-12 months**	Just about to start	Intermittent use	***Routine use with consecutive clients***

Please return this form to:

Thank You

Version 1 (Sept 04)

Appendix 1(a) Survey invitation letter

City University London

St Bartholomew School of Nursing & Midwifery

e-mail:

[PD Trust Address]

Dear ……(persons first name),

All occupational therapist working in [name] NHS Trust are being invited to complete the enclosed questionnaire. The research aims to understand occupational therapists' current involvement in the use of standard assessments in their clinical practice.

This research is part of my MPhil / PhD research degree at City University and is linked with the work we are undertaking with the [name of academic partner][2]. It is part of the process to continually develop the quality of our interventions for our clients through Scholarship of Practice. Participation is voluntary. It will take 2 minutes approximately to complete the questionnaire.

The data that you provide will be kept in strict confidence. It will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years). The results will be published although no data that could identify you will be shared and your contribution will remain confidential. All data kept on a computer database will be anonymous and your identity will remain undisclosed.

If you do not wish to participate your legal and / or employment rights will not be affected. If you do wish to participate, please could you return the completed questionnaire in the SAE within 2 weeks?

In order to obtain the most accurate information from this survey your help is fundamental. Please do not hesitate to contact me on [tel no] at [address], if you require further information or clarification. Thank you for considering this request.

Yours sincerely
Jane Melton
Research Student, City University.

[2] The academic partnership was independent of City University.

Appendix 1(b) 1st Follow-up, Survey Invitation Letter

e-mail:

Dear ……(persons first name),

A few weeks ago I wrote to ask if you would participate in a survey to help me gain an understanding occupational therapists' current use of standard assessments their clinical practice. The purpose of this letter is to offer a gentle reminder to anyone who intends to complete the questionnaire. If you decide to participate your contribution is voluntary and will be much appreciated.

This survey is confidential. The data that you provide will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years). The results will be published although no data that could identify you will be shared. All data kept on a computer database will be anonymous. If you do not wish to participate your legal and / or employment rights will not be affected.

In order to obtain the most accurate information from this survey your help is fundamental. Please do not hesitate to contact me on [telephone no] [address], if you require further information or clarification. Thank you for considering this request.

Please could you return your completed questionnaire by…… If you have mislaid your copy, another is enclosed.

If you have already completed and returned the questionnaire thank you and apologies for having troubled you with this letter.

Yours sincerely

Jane Melton

Research Student, City University.

Appendix 1(c) Second Follow-up, Survey Invitation Letter

[PD Trust Address]

Date
Dear ……(persons first name),

A few weeks ago I wrote to ask if you would participate in a survey to help me gain an understanding occupational therapists' current use of standard assessments their clinical practice. The purpose of this letter is to offer a last opportunity to anyone who intends to complete the questionnaire. If you decide to participate your contribution is voluntary and will be much appreciated.

This survey is confidential. The data that you provide will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years). The results will be published although no data that could identify you will be shared. All data kept on a computer database will be anonymous. If you do not wish to participate your legal and / or employment rights will not be affected.

In order to obtain the most accurate information from this survey your help is fundamental. Please do not hesitate to contact me on [tel no] at [address], if you require further information or clarification. Thank you for considering this request

Please could you return your completed questionnaire by…… in the SAE provided. If you have mislaid your copy another copy is enclosed.

If you have already completed and returned the questionnaire thank you and apologies for having troubled you with this letter.

Yours sincerely

Jane Melton
Research student, City University

Appendix 2(a) Semi-structured interview schedule

** Schedule for Initial Interview and Follow-up Interview (6 months) **

INTRODUCTION AND INFORMATION

- Thank you for your participation
- Reassurance of Confidentiality
- Introduction to the research question and process
- Interview format and timing
- Inform participant about their right to withdraw without consequences at any time

INTERVIEW QUESTION AREAS

- When you work with clients you are making clinical decisions all the time. Can you say something about **what influences or guides** those clinical decisions? What else?
- OK so we have talked a bit about what influences clinical decisions, lets move on to the feedback loop - what things enable you to tell whether those decisions have been **effective or well received**?
- **Why is it important** to work in the way that you do?
- Can you always practice in the way that **you would like** to with clients?
- How **would you change the way** that you work if given the opportunity?
- What **constraints** are there for using evidence to inform your practice / workplace?
- If, hypothetically, you were given a period of time to **further develop** how would you use this time?
- What would you like to **do that is different** from what you currently do?
- Can you think of a time in your career when there has been a **turning point** in your thinking? What happened?
- How does **GPT support / hinder** you to implement Evidence Based Practice?
- How does **Scholarship of Practice** affect your clinical practice?
- What **assessments** do you use with your clients? How do they assist with your work?

CONCLUDING COMMENTS AND OPORTUNITIES

Thanks for participation
Anything further to add?
Overview of next stages of research
Transcript check opportunity

Appendix 2(b) Semi-structured Interview Schedule

** Schedule for Post-Observation Debrief Interview **

INTRODUCTIONS AND INFORMATION

Thank you for agreeing to session being observed
Format of this aspect of research

INTERVIEW QUESTION AREAS

I was able to see the session and the way that you interacted with the client (s). It was not possible, however to observe your thinking. Could you give me an overview of the decisions that you made and how you made them?

- Perceptions of key decision points, dilemmas, surprises
- Talk directly about their rational, theoretical assumptions in making particular choices and decisions

Mattingly and Flemming (1994)

CONCLUDING COMMENTS AND OPORTUNITIES

Have you anything further to add?

Provide description of next stage of research

Provide participant with thanks again

Version 1 (Sept 04)

Appendix 3 Observation data structuring tool

Demographic Information

Participant ID	Session Code	Date	Time	Venue

Observation notes might include a description of the observed :-

Institution	(The way the setting operates in terms of regulations, tacit rules, rituals)
Event	(Piece of behaviour, defined either by the people in the setting or by the researcher)
Behaviour	(What people are seen or heard doing or saying)
Appearance	(What the setting or people in it look like)
Talk	(What people are head saying)

Holliday (2002)

Chronological description of what happened during the session:

[Blank for text]

Use of Theory: In the session, is the therapist observed to consider the clients:

			Description
Thoughts and Feelings (by asking)			
Choices (by offering)			
Sense of Control (by facilitating client choice)			
Consider the persons view of their own ability to succeed (personal causation)			

Interests (clients likes / dislikes considered)			
Values (sense of ‘meaning’ of occupation)			
Routines (clients usual schedule)			
Habits (behaviours customary to client)			
Performance Capacity (Cognitive, sensory, physical)			
Skill (responding to independent action / danger)			
Occupational Performance (occ. forms done in the session)			
Occupational Participation (occ. forms done outside of the session)			
Occupational Competence (degree to which a person sustains a pattern of occupational participation)			
Occupational Identity (persons subjective account of their occupational life)			
Occupational Adaptation (construction of identity and compentence within the environment)			
Physical Environment			
Social Environment			

Use of Standard Tools: In the session, is the therapist observed to use:			
			Description
Standard assessment(s) of overall performance			
Specialist aspect assessment(s) of performance			
Unstructured method(s) of data gathering			

Therapeutic Strategy – In the session, is the therapist observed to:			
			Description
Be honest and direct with the client			
Assure client of best interest in mind			
Validate ‘findings’ with client			
Show empathy for clients experience			
Demonstrate a genuine interest in the person			
Facilitate the use of an activity / occupational form as therapy			
Facilitate client choices/decisions			
Facilitate client commitment			

Facilitate client insight into themselves			
Negotiate with client during therapy			
Provide practice opportunities			
Encourage client to reflect upon achievements			
Encourage client to sustain effort in therapy			
Validate clients experiences			
Give feedback			
Offer advice			
Offer structure			
Coach the client			
Provide physical support			

Appendix 4 Audit of Documentation Tool

Subject ID	Session Code	Date

Brief vignette of client:

Stated occupational therapy aims:

Period covered by current episode of occupational therapy treatment:

Number of sessions recorded during this time:

Recording of Clinical Intervention by Occupational Therapists

1 Are clinical decisions made by occupational therapists being recorded in health care records?

Each entry	☐	Examples:
Most entries	☐	
Some entries	☐	
Never	☐	

2 Are occupational therapists recording their rational for their decisions?

Each entry ☐ Examples:

Most entries ☐

Some entries ☐

Never ☐

3 Do the clinical decisions make sense within the whole episode of care?

Each entry ☐ Example:

Most entries ☐

Some entries ☐

Never ☐

3 Of the occupational therapy records, how often does the occupational therapist refer to the concepts in MOHO based theory (influences of the social environment, physical environment, choices, control, personal causation, values, interests, roles, habits, performance capacity, occupational skills)?

Each entry ☐ Example:

Most entries ☐

Some entries ☐

Never ☐

3 Which assessment tools are used within the episode of care? -

OSA ☐

OCAIRS ☐

OPHI II ☐

MOHOST ☐

VQ ☐

WRI ☐

ACIS ☐

AMPS ☐

WEIS ☐

Role Checklist ☐

Interest Checklist ☐

Other (please list):

……
……
……

4 Was there a connection with assessments used in the past or those proposed for the future?

Yes ☐

No ☐

Comment……
……
……
……

Examples:

5 Was there evidence of the therapists rational for choosing an assessment within the notes?

Yes ☐ Examples:

No ☐

Comment:
……
……
……

6 Is there evidence in the notes that the assessments used informed the formulation of intervention?

Yes ☐ Example:

No ☐

Comment……
……
……

[PD Trust] name
AUDIT STRUCTCURE

SERVICE: Occupational therapy – [PD Trust name]

AUDIT TOPIC: To improve the quality of occupational therapists recording of clinical interventions.

NO. OF PATIENTS/CLIENTS:

TIMESCALE:
OBJECTIVE:
To establish from clinical notes the extent that occupational therapists record:

- The theory underpinning their clinical decisions
- Their use of evidence based practice
- Their discussions with clients about intervention choices

To understand whether clinical experience / grade has an impact on this

ASPECT OF CARE	% COMPLIANCE	EXCEPTIONS	DEFINITIONS AND INSTRUCTIONS
Clinical interventions recorded by occupational therapists in the Health Care Records indicate how clinical decisions were made.	100%	None	Health Care records (max)50 records even sample over team bases in [PD Trust](where OT) Timeframe – notes from start of OT episode of care
Occupational Therapy intervention recorded in the Health Care Record provide evidence of the occupational therapist underpinning thinking and practice within the concepts of the Model of Human Occupation	100%	None	Health Care records (max)50 records even sample over team bases in [PD Trust] (where OT) Timeframe – notes from start of OT episode of care
Assessment tools used within an episode of care include choices from the battery available within the Model of Human Occupation.	100%	None	Health Care records (max) 50 records even sample over team bases in PD Trust] (where OT) Timeframe – notes from start of OT episode of care

Appendix 6 Initial Information Letters to Service Users.

Dear ……(persons first name),

I am undertaking a research project to understand the effect of a new way of working that occupational therapists in the [name of organization] are developing. As you are currently involved in receiving treatment from an occupational therapist you are likely to be asked to consider participating in my research study.

This research is part of my MPhil/PhD research degree at City University. Occupational therapists are linking with an academic department at [name] to aim for the most up to date clinical assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. This research will aim to understand whether occupational therapists are choosing, with clients, to use the new information and ideas. It is part of the process to continually develop the quality of our work.

You are not being asked to make a decision now. If I am conducting research work with your occupational therapist on any day that you have an appointment you will be informed. I will discuss the implications with you and you will have time before your occupational therapy appointment to make your decision. If you decide to take part, I would need to observe one of the routine sessions that you have with your occupational therapist, [insert name]. **I would be observing the occupational therapist rather than yourself**.

This research is confidential. If you do not wish to participate neither your treatment nor legal rights will be affected. Please do not hesitate to contact me on [telephone number and base], if you require further information or clarification. Thank you for considering this idea.

Yours sincerely

Jane Melton
Research Student, City University.

Version 2 3rd November 2004

Appendix 7 Detailed letter to Service User

City University London

St Bartholomew School of Nursing & Midwifery

[Research contact details]

Date

Dear ……(persons first name),

Thank you for considering participating in my research study. I have attached, more detailed information about what would be involved so that you are able to consider the idea.

This research is part of my MPhil / PhD research degree at City University. The purpose of the study is to understand the effect of a new way of working that occupational therapists in the [name of PD Trust] are developing. Occupational therapists are linking with an academic department at [name of Academic Unit] to aim for the most up to date clinical assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. This research will aim to understand whether occupational therapists are choosing, with clients, to use the new information and ideas. It is part of the process to continually develop the quality of our work.

If you decide to take part, I would need to observe one of the routine sessions that you have with your occupational therapist, [insert name]. I would be observing the occupational therapist rather than yourself. (please see detail in information sheet). The research would also involve an audit of the notes that the occupational therapist has made about your occupational therapy treatment. This is to understand how therapists document their discussions with service users. The researcher will not extract any other information from your health records.

This research is confidential. The data collected will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years). The results will be published although no data that could identify you will be shared. All data kept on a computer database will be anonymous and kept undisclosed. If you do not wish to participate your legal and / or employment rights will not be affected.

If you do not wish to participate neither your treatment nor legal rights will be affected. If you do wish to participate, please could you complete and return the enclosed consent form in the SAE within 2 weeks?

Please do not hesitate to contact me on [telephone number and address], if you require further information or clarification. Thank you for considering this request.

Yours sincerely

Jane Melton
Research Student, City University.

Appendix 8 Information Sheet for Service Users

St Bartholomew School of Nursing & Midwifery

Date: 3rd November 2004
Version: 3

Information sheet: Service Users

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

This research is part of my MPhil / PhD research degree at City University. The purpose of the study is to understand the effect of a new way of working that occupational therapists in the [name of PD Trust] are developing. Occupational therapists are linking with an academic department at [location of Academic Unit] to aim for the most up to date assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. This research will aim to understand whether occupational therapists are choosing, with clients, to use the new information and ideas. [name] Ethics Committee has given a favourable ethical opinion for this study to be undertaken.

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given the attached information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your treatment in any way.

If you decide to take part, the researcher, Jane Melton will need to observe one of the routine sessions that you have with your occupational therapist [insert name]. The researcher will be observing the occupational therapist rather than yourself.

The research will also involve a review of the notes that the occupational therapist has made about your treatment. This is to understand how therapists document their discussions with service users.

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that leaves the clinical environment will not have your name or address attached to it so that you cannot be recognized from it. The data that is collected will be stored in a locked drawer and will be only accessible by the researcher. All data kept on a computer database will be anonymous. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years).

If you do not wish to participate neither your treatment nor legal rights will be affected. There are no disadvantages or risks of taking part in this research study. It is hoped that the information will be helpful to support occupational therapists develop their service, their clinical practice skill and their ability to make informed decisions thus enhancing the quality of their work with service users.

In the unlikely event you are harmed taking part in this study there are no special compensation arrangements. If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study the normal National Health Service complaints mechanisms should be available to you.

The results of this research study will be written up in academic documents such as my PhD theses and occupational therapy journals. You will not be identified in any way in any of these publications. You will be able to obtain a summary of the results from me at the address below.

If you require any further information about this study please contact me:

Jane Melton
[address and telephone number]

Email:

Thank you

Appendix 9 Consent Form for Service Users

City University London

St Bartholomew School of Nursing & Midwifery

Tel: [number inserted]

Participant Information Number for this study:

CONSENT FORM - Participants

Title of Study: **"Evidence Based Practice - Occupational Therapists Actions"**

Name of Researcher: Jane Melton, Occupational Therapy Department, Place + telephone number

Please **initial** box

1. I confirm that I have read and understand the information sheet dated xx/xx/xx (version one) for the above study. ☐
2. I understand that my participation is voluntary and I am free to withdraw at any time, without having to give a reason and without my legal rights or access to NHS treatment being affected. ☐
3. I agree to one of my occupational therapy treatment sessions being observed by the researcher, Jane Melton, who will take handwritten notes. If I decide to withdraw I will be able to ask for this data to be destroyed. ☐
4. I am willing to allow access only to those parts of my Health Records that are relevant to this study by the researcher Jane Melton and understand that strict confidentiality will be maintained. If I decide to withdraw, I will be able to ask for this data to be confidentially destroyed. I understand that nothing will be reported in a manner that would identify me. ☐
5. I agree to take part in the study ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Please return to: Jane Melton, [address]

cc. 1 for patient; 1 for researcher; 1 to be kept with hospital notes

Version 3 3rd November 2004

Appendix 10 Letter to Potential Participants

St Bartholomew School of Nursing & Midwifery

[Contact details of researcher]

Date
Dear ……(persons first name),

I would like to invite you to participate in a research study being carried out in [name] NHS Trust. This research is part of my MPhil / PhD research degree at City University London. I have attached more detailed information about what would be involved so that you are able to consider the idea.

The purpose of the study is to understand the effect of a new way of working that occupational therapists in the [name] NHS Trust are developing. Occupational therapists are linking with an academic department at [name of academic unit[3]] to aim for the most up to date clinical assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. This research will aim to understand whether occupational therapists are choosing, with clients, to use the new information and ideas. It is part of the process to continually develop the quality of the work of occupational therapists.

If you decide to take part, it would involve participating in two interviews with the researcher. These would each last approximately 1 – 11/2 hours and would have a six- month interval between them. The researcher would also need to observe one of the routine sessions that you have with a client / group of clients. Immediately following this observation, there would be an opportunity to debrief and share your thoughts about the session with the researcher (please see detail in information sheet). The research would also involve an audit of the notes that the occupational therapist has made about the treatment. This is to understand how therapists document their discussions with service users. Separate, informed consent would be sought from service users.

Your participation in the research is confidential. The data that you provide will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 4 years). The results will be

[3] Academic unit not City University

published although no data that could identify you will be shared. All data kept on a computer database will be anonymous.

If you do not wish to participate neither your employment nor legal rights will be affected. If you do wish to participate, please could you complete and return the enclosed consent form in the SAE within 2 weeks?

Please do not hesitate to contact me on [Tel no] at [address], if you require further information or clarification. Thank you for considering this request.

Yours sincerely

Jane Melton,
Research Student, City University.

Appendix 11 Information Sheet for Occupational Therapists

St Bartholomew School of Nursing & Midwifery

Date: 3rd November 2004.
Version: 3

Information Sheet : Occupational Therapists

Title of Study: "Evidence Based Practice - Occupational Therapists Actions"

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

This research is part of my MPhil / PhD research degree at City University. The purpose of the study is to understand the effect of implementing a programme of practice development on the clinical practice actions of occupational therapists within an NHS service. It will form an illuminative case study of a particular change initiative, in a particular context (i.e. within [PD organisation]). The study will be of descriptive value to the occupational therapy profession and will help to generate new knowledge to extend the forefront of the discipline. [name] Research Ethics Committee has given a favourable ethical opinion for this study to be undertaken.

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your collaboration with the School of Occupational Therapy. It will also not impact on your access to continuing professional development training through your Trust.

If you decide to take part, you may need to attend two interviews over the course of the next year. Each interview will last for approximately 1-1½ hours and will be tape-recorded. During the interview you will be asked, through a short series of set questions, about your perspectives and views on how specific occupational therapy assessments impact upon your

clinical practice. Following the interview, the tape will be written up for analysis and you will be asked your opinion as to whether you think it is an accurate record of the interview. You *will not* be required to prepare yourself in advance for the interview.

You will also need to have one of your routine intervention sessions with a client / group of clients observed by the researcher. There would be an opportunity following this observation for you and the researcher to debrief about your clinical decision making within the session. Finally, an audit of your note-taking with regard to the client(s) care would be undertaken by the researcher using pre-agreed standards of note-taking as a measure. Separate, informed consent would be sought from the client(s) prior to the research being undertaken.

This research process is confidential. The data that you provide will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 3 years). All data kept on a computer database will be anonymous. If you do not wish to participate your legal and / or employment rights will not be affected.

There are no disadvantages or risks of taking part in this research study. It is hoped that the information will be helpful to support occupational therapists develop their service delivery and clinical and therapeutic reasoning skills.

In the unlikely event you are harmed taking part in this study there are no special compensation arrangements. If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study the normal National Health Service complaints mechanisms should be available to you.

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that leaves the clinical environment will not have your name or address attached to it so that you cannot be recognised from it. It is important to note, however, that the researcher also has an ethical and professional responsibility to inform you and your employing organisation should malpractice be identified during the research process.

The results of this research study will be written up in academic documents such as my PhD thesis and occupational therapy journals. You will not be identified in any way in any of these publications. You will be able to obtain a summary of the results from me at the address below.

If you require any further information about this study please contact me:
Jane Melton [address and Email:]

Appendix 12 Consent Form for Occupational Therapists

City University London

St Bartholomew School of Nursing & Midwifery

Participant Information Number for this study:

CONSENT FORM – Occupational Therapists

Title of Study: "Evidence Based Practice - Occupational Therapists Actions"

Name of Researcher:

Jane Melton, Occupational Therapy Department,
Address + Tel number

Please **initial** box

1. I confirm that I have read and understand the information sheet dated xx/xx/xx (version one) for the above study ..... ☐

2. I understand that my participation is voluntary and I am free to withdraw at any time, without providing an explanation and without my employment or legal rights being affected ☐

3. I agree to being interviewed and the interview being tape recorded and transcribed. If I decide to withdraw, I will be able to ask for my data to be destroyed ☐

4(a) I agree that the researcher, Jane Melton, can observe one half day of treatment sessions with a client(s). If I decide to withdraw I will be able to ask for this data to be destroyed. ☐

4(b) I agree that following the observed treatment session, I will participate in a debrief interview session that will be recorded and transcribed. ☐

5. I agree to a follow-up interview, 6 months after the initial interview the interview being tape recorded and transcribed. If I decide to withdraw, I will be able to ask for this data to be destroyed ☐

6. I agree to take part in the study ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Please return to: Jane Melton, [address]

Appendix 13(a) Service User Assent – Information Sheet

City University London

St Bartholomew School of Nursing & Midwifery

Title of Study :

"Evidence Based Practice - Occupational Therapists Actions"

You are being invited to give your permission for the person in your care to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you are willing to give your permission for the person that you care for to take part.

I am a practicing, senior and experienced occupational therapist. This research is part of a part-time MPhil / PhD research degree that I am undertaking at City University. The purpose of the study is to understand the effect of a new way of working that occupational therapists in the [name of PD Trust] are developing. Occupational therapists are linking with an academic department at [name of Academic Unit] to aim for the most up to date assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. **This research will aim to understand whether *occupational therapists* are choosing, with clients, to use the new information and ideas**. [Name] Research Ethics Committee has given a favourable ethical opinion for this study to be undertaken.

It is up to you to decide whether or not the person that you care for takes part. If you do decide to give permission, you will be given the attached information sheet to keep and be asked to sign an assent form. If you decide to give permission, you are still free to withdraw your permission at any time and without giving a reason. A decision to withdraw permission at any time, or a decision not to give permission, will not affect the treatment of the person that you care for in any way.

If you decide to take part, the researcher, Jane Melton will need to observe some of the routine sessions that the person you care for has with their occupational therapist. She will be observing the occupational therapist rather than the person you care for.

The research will also involve a review of the notes that the occupational therapist has made about the treatment. This is to understand how therapists document their discussions with service users. All information that is collected about the person you care for during the course of the research will be kept strictly confidential. Any information about the person you care for that leaves the clinical environment will not have names or addresses attached to it so that the person you care for cannot be recognised from it. The data that is collected will be stored in a locked drawer and will be only accessible by the researcher. All data kept on a computer database will be anonymous. Following the completion of the study, the researcher will confidentially destroy all data (approximately 4 years).

If you do not wish the person you care for to participate, their treatment and legal rights will not be affected. It is hoped that the information will be helpful to support occupational therapists develop their service delivery and clinical and therapeutic reasoning skills thus enhancing the quality of their work with service users.

I will be very sensitive to the reaction of the research participants to having an observer within the session and will terminate the observation, leaving the session if required. In the very unlikely event that the person you care for is harmed taking part in this study there are no special compensation arrangements. If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study the normal National Health Service complaints mechanisms should be available to you.

The results of this research study will be written up in academic documents such as my PhD theses and occupational therapy journals. The person that you care for will not be identified in any way in any of these publications. You will be able to obtain a summary of the results from me at the address below.

If you require any further information about this study please contact me:

Jane Melton
[address, email, telephone number]

Thank You

Appendix 13(b) Service User Assent – Invitation Letter

St Bartholomew School of Nursing & Midwifery

Dear …….

Thank you for considering giving your assent for [insert name of individual client] to participate in my research study. I have attached more detailed information about what would be involved so that you are able to consider the idea.

This research is part of my MPhil PhD research degree at City University. The purpose of the study is to understand the effect of a new way of working that occupational therapists in the [PD Trust] are developing. Occupational therapists are linking with an academic department at [name of academic unit] to aim for the most up to date clinical assessments and treatments to be available to the users of the service. This involves a process of change in the way that occupational therapists carry out their work with clients. This research will aim to understand whether occupational therapists are choosing, with clients, to use the new information and ideas. It is part of the process to continually develop the quality of our work.

If you decide to give your permission for [name] to take part, I would need to observe one of the routine sessions that [name] has with their occupational therapist. I would be observing the occupational therapist rather than [name] (please see detail in information sheet). The research would also involve an audit of the notes that the occupational therapist has made about the occupational therapy treatment. This is to understand how therapists document their discussions with service users. The researcher will not extract any other information from the health records.

This research is confidential. The data collected will be stored in a locked drawer and will be only accessible by the researcher. Following the completion of the study, the researcher will confidentially destroy all data (approximately 4 years). The results will be published although no data that could identify [name of service user] will be shared. All data kept on a computer database will be anonymous and kept undisclosed

If you do not wish give permission for [name of service user] to participate neither their treatment nor legal rights will be affected. If you do wish to give your permission, please could you complete the enclosed assent form?

Please do not hesitate to contact me on [telephone number] at [address], if you require further information or clarification. Thank you for considering this request.

Yours sincerely
Jane Melton, Research Student, City University.

Appendix 13(c) Service User Assent –Carer Form

St Bartholomew School of Nursing & Midwifery

Participant Information Number for this study:

ASSENT FORM – Where clients do not have capacity to consent to participate in the research

Title of Study: Evidence based Practice – Occupational Therapists' actions

Name of Researcher: Jane Melton, [address, telephone number]

Please **initial** box

1 I confirm that I have read and understand the information sheet dated / / (version one) for the above study. ☐

2 I understand that [name of service user] participation is voluntary and I am free to withdraw assent at any time, without having to give a reason and without their or my legal rights or access to NHS treatment being affected. ☐

3 I agree to [name of service user] occupational therapy treatment sessions being observed by the researcher, Jane Melton, who will take handwritten notes. If I decide to withdraw permission I will be able to ask for this data to be destroyed. ☐

4 I am willing to allow access only to those parts of [name of service user] Health Records that are relevant to this study by the researcher Jane Melton and understand that strict confidentiality will be maintained. If I decide to withdraw permission, I will be able to ask for this data to be confidentially destroyed. I understand that nothing will be reported in a manner that would identify [name of service user] or me. ☐

5 I assent for …… to take part in the study ☐

Name of participant (client)	Date	Signature
Name of person providing assent for participant (if client lacks capacity to consent)	Date	Signature
Researcher	Date	Signature

Please return to: Jane Melton, [address]

Appendix 14 List of Terms which appear in the Research Data extracts

Abbreviation	Title	Brief description
AMPS	Assessment of Motor and Process Skills	Observational standardized assessment enabling simultaneous evaluation of motor skills and process skills and their effect on the person's ability to perform domestic or personal daily life activities (Fisher 2003).
Care Co-ordinator	Care Co-ordinator	A general mental health worker role with responsibilities to offer assessment, care planning and monitoring of a persons mental illness, risk and recovery in line with CPA (see below). The role is not discipline specific and is often undertaken by occupational therapists in contemporary community mental health practice (Culverhouse and Bibby, 2008).
CPA	Care Programme Approach	An approach to mental health care introduced by the NHS to ensure that people with mental illness living in the community receive support to be safe and supported in their recovery (Department of Health, 1999).
Habituation	Habituation	The semiautonomous pattern of behaviour which supports a person to act in consistent patterned ways to achieve day-to-day occupations (Kielhofner, 2008a).
ICP	Integrated Care Pathway	A structured approach to setting standards of care which outlines pathway options for individuals. Pathways should be collaboratively designed and understood across disciplines (Hall, 2004)

Link Forum	Link Forum	Discussion groups held routinely by the PD Trust. All occupational therapy staff were invited to attend. The focus was on using MOHO and its associated assessment tools in practice.
MOHO	Model of Human Occupation	Conceptual model describing occupational therapy concepts. It seeks to explain how human occupation is motivated, patterned and performed. It aims to assist occupational therapists to understand their client's ability to perform their occupations within their own temporal, physical and socio-cultural environment (Kielhofner, 2008a).
MOHOST	Model of Human Occupation Screening Tool	Primarily an assessment based on observation. The therapist can also utilize information gained from other sources to inform the ratings. It aims to provide a broad measure of an individual's occupational participation (Parkinson et al 2006).
OSA	Occupational Self Assessment	A self-report standardized assessment. It is designed to capture the clients' perception of their occupational competence and values. The impact and importance of the environment is also assessed (Baron et al 2006).
OT	Occupational Therapist Occupational Therapy	A registered practitioner. Therapeutic intervention designed with a client by a registered practitioner to enhance engagement in everyday activities.
Performance capacity	Performance capacity	A persons status of underlying objective physical and mental components and corresponding subjective experience which provides the ability to do everyday things (Kielhofner, 2008a).

Re-motivation Principles	Re-motivation Principles	An intervention package designed to support people to support a person to re-engage in their occupational life and environment (de las Heras et al 2003a).
Volition	Volition	The feeling of an intense and pervasive need to act which motivates an individual to undertake their day-to-day occupations (Kielhofner, 2008a)
VQ	Volitional Questionnaire	An observational assessment used to evaluate the individual's motivation for engaging in occupations in various environmental contexts (de las Heras, 2003b).
WRI	Worker Role Interview	A semi-structured interview assessment designed to gather clinical data from a person with a disability whose impairment is interfering with work (Braveman et al 2005).

Isobel – Worked Example of Analysis

A narrative explanation of the worked processes for analysing the data for Isobel is given below. This is a summary of the process which occurred over a longitudinal period with much time scrutinising the data. It is presented as first and second level analysis as described in the main thesis in Chapter Five, Section 7. The third level analysis is not presented here as a worked example as this involved the use of the whole data set to inform the theory development and is described in Chapter Five, Section 7.3.

The example is written in the first person as the researcher grappled with understanding the various data for Isobel.

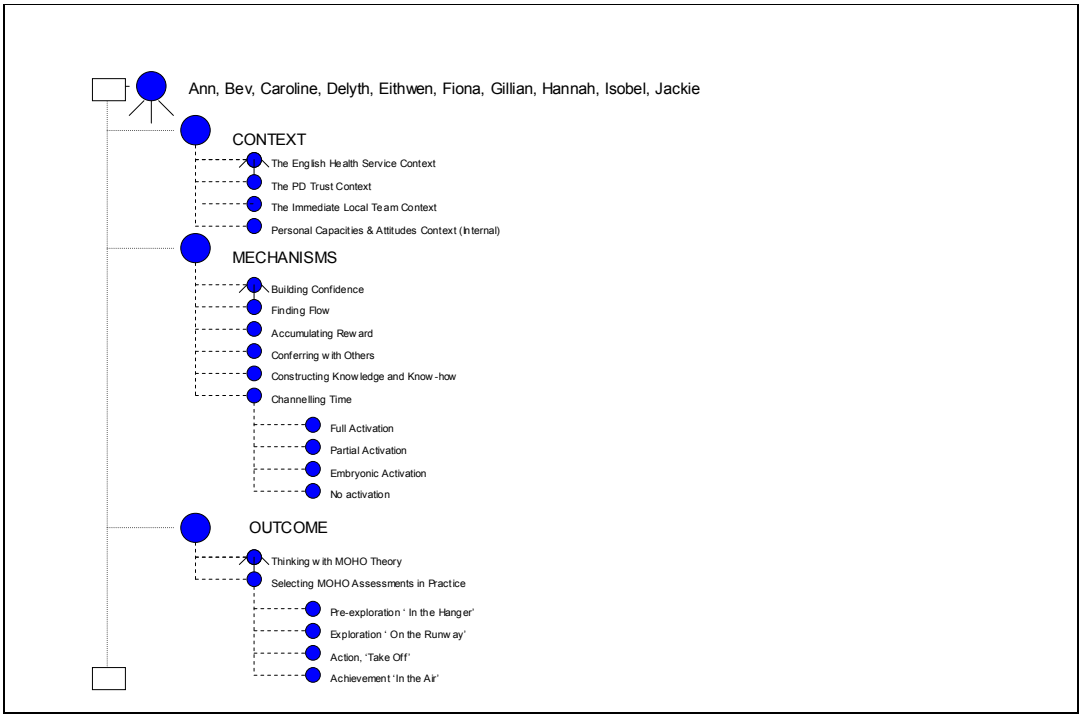
1. Isobel - First level of analysis: Understanding themes across data set

My first task was to get a sense of the overall regularities in the data about Isobel's engagement in practice development (PD). This involved a broad look at the data to gain a perspective of their overall richness. I transcribed the data myself which offered me an additional opportunity to immerse myself in the data. The initial general themes, sets of ideas or features which emerged from Isabel's data set (interviews, observation and notes audit) and her engagement in PD included:

- Keen and Competitive
- Very competent but expresses some doubt about her ability
- Passionate about her job
- Driven to achieve the best standard of work
- Reflective and aware of her own learning style preference
- Acts as an advocate
- Can be easily bored
- Juggling many roles and responsibilities and other PDs
- Very experienced
- Active in academic pursuits
- Considers it important to 'Think with Theory'
- Wants PD to be relevant to clients
- Expressing increased confidence in job role through PD
- Leadership responsibility and teaching role

Each data set was then systematically trawled and 'chunked' into the themed groups of Context, Mechanisms and Outcome. The NVivo software was used to draw the data into these data sets. The diagram below illustrates the 'tree' of codes used for this purpose.

Illustration of the NVivo screen which was used to chunk data into codes relating to Context, Mechanisms and Outcome.



Following this process of data reduction, I then considered and fractured the data relating to Isobel further in their individual sections relating to Context (C), Mechanisms (M) and Outcome (O). Some examples of the initial exploratory analysis and supporting pieces of data are given below. The themes that emerged were connected with those already discovered through exploratory analysis of earlier participants' data. The reader should refer to Chapter 5, Section 7 in the main thesis for more detailed information about process.

1.1 Isobel - Context

C1 Therapist's Personal Capacity and Attitude Context

It was evident that Isobel was a conscientious therapist who held a leadership position and was keen to maintain the perception that she was ahead of the field with PD. It was also clear that Isobel questioned herself frequently about her own ability to achieve this. However, her overriding ambition and belief in the programme counteracted her expressed negative beliefs about her own capacity. Her obvious enthusiasm, commitment and hunger to be recognised as a leader had strengthened her position to develop her own practice and to be an advocate and driver for the organisation's PD programme.

> It's incredibly exciting (pause). I've gone through phases of thinking 'Oh, my God, am I actually going to be able to do this, am I going to be one of the old ones that needs to be got rid of because they can't take the pace', and I hate being left behind in anything. Frequently I get that sense, or I put myself into that position of wanting to be somewhere near the front and not always able to deliver that. So, it's been exciting, it's been nerve-racking
>
> Isobel - Final interview

In addition to leading with PD programs within the organisation, Isobel had been inspired by postgraduate, academically accredited study. This had enabled her to gain skill to further critique developments rather than follow without question. Her baseline of value for the PD program was that it validated her role as an Occupational Therapist and her contribution to the well being of her clients. Isobel expressed a perception that she continued to learn and develop but admitted that she had a tendency to become bored with initiatives if they were not high profile or being acknowledged publicly as progressive.

> The combination of doing a master's [degree] and work that I've been involved in locally has been the equivalent of retraining and I am so glad that I've had the opportunity to do both of those. Either would have been good but to do both at the same time, I think has been spectacular…. I can argue my corner at university about MOHO… I know the pros and the cons as well. I'm not somebody who blindly worships it [MOHO] but can see that their can be downsides for people but in terms of OT's doing their very best for clients which is the reason why we're here, then I see it as being extremely helpful. So I am part way through my journey, I can see my progress.
>
> Isobel - Final interview

> Wanting to do proper OT has been a big one. Wanting to be good at my job is a rather more personal one. Wanting to be, well I said the thing about knowing that I qualified a long time ago, wanting to show that just because I've around a long time doesn't mean that I'm insisting on doing OT the way that I did it 20 years ago or what have you. I like new interesting stuff, I get bored quickly, I like to be able to achieve and I like to be able to show other people (pause) that there is something that I can contribute for this person so I like the fact that it can be seen by others.
>
> Isobel - Final interview

C2 The Immediate Local Team Context

Isobel acknowledged the importance for her to have freedom to act within her work responsibilities as being a pivotal part of the work environment that is important to her engagement in a PD policy. This had been possible in her local team context.

> In my case probably by leaving me alone and letting me get on with it within a framework of being able to access knowledge [helped me to learn and use MOHO]. [Also], talking to other therapists who are also striving for the same thing and having the people who have the leadership and the vision to be able to drive this process. And the management and structure, that is relatively laissé faire if that's the right term, and is not breathing down the back of my neck.
>
> Isobel – Initial Interview

C3 The PD Trust Context

In Isobel's world of practice she saw that the organisation offered a solid foundation on which she can develop her skills. Her perception was that leaders in the field hold a pivotal role to foster a facilitative environment.

> Is it [the organisation] being supportive? Yes it is. But none of this could happen if there weren't people, making the space for it to happen and changing thinking of the other professions around us and decision makers in the trust to allow it to happen. So people out there have bought us time, facilities, resources, support to be able to do this and I think that we're incredibly lucky watching the, watching the treadmill of other OT's in other places, they are doing OT and they have no chance to change what's going on 'cause there's nobody there driving the process. So we're incredibly lucky
>
> Isobel – Initial Interview

Whilst appreciating being supported to use her practice development knowledge, Isobel was aware of the difference in the development of her thinking as compared to therapists from other organisations. She had a pride in her position and a concern about therapy offered in other less theoretically-driven organisations.

> But also, it's been hugely motivating to see, when I step outside [the name of area] and I see how people are working and the state of OT I am deeply thankful that I am here. Because there's a hell of a lot of OT's out there that seem to be very lost, in some very dark places, where I would really rather not want to be, I've been to some similar places but, professionally, but, I'm rather pleased to be here.
>
> Isobel - Final interview

1.2 Isobel - Mechanisms

The change factor levels or mechanisms which triggered a reaction from Isobel towards engagement in PD were located through attention to the data. Six common causal mechanisms were identified at this first level of analysis and the activation level of them is worked through here for Isobel using the codes ascribed to the NVivo 'tree'. It would not be possible to illustrate all the quotes which support the level of mechanism activation that were attributed to Isobel through the analysis because of space limitation. However, the following data are presented as illustrative examples.

M1 Building Confidence – Full Activation

Isobel noticed that her thinking had been affected by the PD programme to the extent that she was contemplating her work in a whole new language and synthesis of ideas. This she described as supporting her practice action by making it gel into a coherence that gave her confidence as a therapist.

The fact that the PD programme was orientated to Isobel's specific professional role assisted in motivating her to be engaged despite the fact that the programme was challenging to implement. She was concerned to ensure that service users access occupation as therapy and that the paradigm of OT didn't get lost within a generic philosophy.

> Having been trained twenty something odd years ago, this whole process of picking up a conceptual model and using the tools has really helped to ground my thinking about what my practice is. I mean, when I trained, I couldn't have told you what an OT was. I can now, but I couldn't then. I think I spent quite a long time in that rather uncomfortable place (pause) So yes, framing the parameters of what is my role as an occupational therapist and what it is that I may be able to affect through our form of therapy.
>
> Isobel - Final interview

M2 Finding Flow – Full Activation

Isobel was aware that by using the surrounding PD context, the opportunities that were available to her that her routine in using the theory might develop inductively. In other words, Isobel didn't fight the change that was happening in her practice. Moreover, she took every opportunity to embed the new way of working into her routine.

> It's about becoming slicker with all of this, as it becomes familiar. I suppose what I've learnt is to stop panicking about it, to stop trying too hard because it's just happening. The more I'm around it, I'm just absorbing it, I'm being marinated, steeped in it. It's in my thinking all the time.
>
> Isobel - Final interview

M3 **Accumulating Reward** – Full Activation

Isobel was striving to offer the clinical supervision support to the colleagues within her area of responsibility and gained reward from the learning of others through this process.

> I'm not just a therapist working with clients, I'm a clinical supervisor, I would like to become much more skilled at that so I'm actually developing and supporting other therapists better and being able to challenge and support them through their growth more effectively.
>
> Isobel - Initial interview

> Getting involved in the practice development, well, the most obvious thing has been around the adoption of MOHO across the trust. I have really, really enjoyed that.
>
> Isobel - Final interview

M4 **Conferring with Others** – Full Activation

The structured opportunities to discuss and debate issues related to practice development were recognised by Isobel as being useful for moving her use of PD incrementally into action in the field.

> Being part of the steering group was really, really interesting and really helped to drive home [the information about MOHO]. Listening to other people who were working (pause), who were probably as motivated as me, I was going to say working at the same level as me, I don't know if that was true 'cause I don't know what levels we were all working at but, just listening to the struggles that they had was hugely helpful, in terms of their job, in terms of going to the group, in dragging, leading their care groups to wherever we were going and their own personal bits.
>
> Isobel - Final interview

It was clear that Isobel used discussion based forums to debate proposals and generate rigorous discussion. The data suggested that Isobel perceived that colleagues were at different stages of practice development at any given time and consensus was not always gained at each session.

> I had some huge battles with people about the fact that 'no it's performance capacity'. And there are still some people now who do not accept that and are not happy with that (said in animated tone) but tough, that's their problem! They're not right (laughs).
>
> Isobel - Final interview

Isobel also considered teaching others part of her learning and part of her responsibility to cascade PD learning. The pressure to explain concepts to others formed an incentive for Isobel to learn.

> Probably the most learning I've had is when I've actually had to go and talk to people about what I did so when I have to talk to people that learning is burnt into my brain and makes it much easier to apply, so as a strategy for me that makes a huge difference….. Oh, I ought to include students in there too, a student caught me out on performance capacity, I forgot the subjective element and she was able to tell me about it. Me feeling slightly silly, but never mind I've remembered it now (laughs).
>
> Isobel - Final interview

M5 **Constructing Knowledge and Know-how** - Full Activation

The phased approach to learning implemented over a longitudinal time line is an overt part of the PD initiative). Isobel views this as a positive support for her engagement in and bedding down of the knowledge that she's acquired. This has also enabled her to conceptually sort out and locate the place for the learning about various theories and techniques that she has been exposed to and expected to critique and utilise appropriately in practice.

> I needed to know how all those bits fitted together and how OT fitted with the rest of the world, a bit like trying to explain the pin man [a PowerPoint tool built for leaders to use in explaining theoretical concepts]. …. So I had to be able to explain that to myself to be able to explain that to other people, and if I could do that it meant that, again with a small 'v', a validity. I could see where it fitted….
>
> Isobel - Final interview

> I am part way through my journey, I can see my progress, I can talk my way through the 'pin man' in my sleep.
>
> Isobel - Final interview

M6 Channelling Time – Full Activation

Whilst on one level appreciating that building knowledge had a temporal dimension Isobel was also impatient to achieve expertise and service change. She expressed how her goal would be to enable a quicker timeline for adopting the PD and how everyday practice needs to reflect PD activity in situ.

> To speed up the whole process of bringing together all the stuff [MOHO assessments] that we've been trying to use
>
> Isobel – Initial interview

> So that, for me fits with what Scholarship of Practice is about, continuing [with] the scholarship, you know…… it continues all the time, every day.
>
> Isobel - Final interview

1.3 Isobel – Outcomes

PD outcomes were generally conceptualised in two ways (See Table 6.2). The first outcome was that the therapist would be able to think with MOHO theory, and the second that MOHO assessments would be selected and used by the therapist appropriately in the practice setting. The data presented for Isobel is mainly from the audit, observation and debrief interview data sets. This illustrates how the analysis concluded that Isobel had developed her practice to an Achievement level (See Chapter 6, Section 5).

O1 Thinking with MOHO Theory - practice achievement

It is evident that Isobel is using MOHO and other practice based theories routinely to inform her practice at many levels of client care.
For example, Isobel reported her use of research based information within the interpretation of her practice.

> In a broad way yes [the PD has affected my practice with this client]. If I contrast with how I would have approached this 'x' number of years ago compared to now, having a conceptual framework, a way of understanding what may or may not be influencing somebody it has been extremely useful in terms of giving a consistent way of articulating things to people about what things I'm looking at and the sorts of factors that I'm interested in. That has been very good. With people who don't do a great deal and where their quality of being becomes really, really important like somebody like [name of client].
>
> Isobel – Debrief interview

The use of professional language to define complex occupational concepts has been so well adopted that Isobel was able to reflect back on previous practice and redefine her past thinking within her newly found conceptual thinking and translate that into language that is understood by others. Whilst her treatment decisions

may not necessarily have changed, the way that she articulated them held more clarity and sophistication.

> When I was talking about the guy and his benefit books I guess now I would be talking about his volition and his personal causation and well, his interests and values. Because he didn't value it, he wasn't interested in it and therefore, whether or not he thought he could do it was irrelevant because he didn't even get to that point. So I'd have a different language to talk about that now, but I'd still be saying 'no' [to a particular request from carers]. I wasn't going to be working with him to get him to write his name whatever language I was using (laughs).
>
> Isobel – Initial interview

The next set of boxes give data example drawn from notes of the practice observation where Isobel was observed to consider her clients needs using MOHO theory. The client was unable to speak for himself so Isobel was working through his mother and some members of the care team in the observed session.

Attending to the person's activity **Choices**

Isobel
Is there a reason why he only has squash here?
MOTHER
He's stopped drinking squash at home. He only has tea.
Isobel
Could start by offering him choices at home?
NURSE
They have tried orange and mango at the respite home
Isobel
Is tea complicated at the centre? We could ask the speech therapist to advise.

Attending to the person's **Sense of Control (by facilitating client choice and explaining behaviour with theory)**

Isobel
[Speaking about sensory discrimination] *Well, there's different types of 'contact', there's very 'light touch', I think that's actually very painful for* [name of client]. *There's also 'deep touch', he'll be getting a lot of this*.

Isobel went on to advise that the touch that mother gives, light or deep is predictable to client so he is able to tolerate the situation better. Isobel postulates that client will be anxious around people whom he doesn't know as their touch is unpredictable.
MOTHER
I think that happens at the respite unit. There are two different staff who get very different reactions from my son.

Isobel
We have to celebrate the fact that client does react to people differently he's expressing his feelings and individuality. When [name of client] *is sitting on the floor here we can see it as him saying 'well no, I'm not comfortable doing that / in that situation'.* [Name of client] *does not hit out but many people who are tactile defensive like [client] will hit out.*

Explaining the person's **Performance Capacity (Cognitive, sensory, physical)**

Isobel
I also think that it's important to look at clients sensory processing.

Isobel then gave explanation about the 7 senses that humans have, the five that we all know about plus proprioception, where our body is in space and vestibular which is to do with balance.

We know that on some days [name of client] is more needy for sensory input than others. I think that people need to be very mindful about how people approach him. I would like to talk to the staff group at the [name of day centre] and the respite care home about this. Because he is sensory defensive, we can expect an extreme reaction if we are trying to get him to touch something. There is also a thing called 'shutdown' in sensory terms where he may look like he's going to sleep.

This thing about when he wraps his feet around his body, we know that his posture gives a calming effect for all people. He is trying to make himself feel better. There are ways that we can help him get this input without him having to wring his hands etc. These are a little trial and error. There are different ways of for example getting he proprioceptive input, for example weighted blankets / stoles. It gives a little extra pressure into the shoulders.

Attending to the **Physical Environment**
Isobel
The car harness, is this OK? (checking out current status of adaptive equipment.
(general nods of agreement)

Commenting about the **Social Environment**
Isobel
Reinforced that client has been observed to respond very differently to verbal and physical prompting on different days.

Therapeutic Strategies

Isobel was also observed to consider the following therapeutic Strategies with her client in this session:

Showing empathy for clients experience
Isobel demonstrate a genuine interest in the person. This extract is from an interaction after the larger group gathering between Isobel and the client's mother
Isobel
You OK? (Addressed to mum)
MOTHER
Why do I look a bit..?
Isobel
I could see that you were working hard to get your message across

Facilitating the use of an activity / occupational form as therapy Isobel

I would also recommend activities like trampolining which give linear movement helpful to [client].
Car journey's and horse riding are also useful. People who like cars and horse riding seem

to like the rhythmic nature of that. We know also that [client] likes to be outside.

Giving feedback
(Sitting with hand on chin listening to these stories) Isobel suggested that this 'hyper' behaviour might be explained in terms of sensory integration, that if the client had been highly stimulated he may have gone past the stage of being able to organise himself.

Explains her hunch that client does have auditory issues. She goes on to say that additional problems occur as the client filters our sounds also. This filtering process may block everything.

Offering advice
Isobel points out that this is likely to be different from the cause of [clients] need. She notes the advantages of administering this 'deep touch pressure' proposing that he client will find it easier to take a drink, get changed etc.

Offering structure
Isobel offers the support of an OT assistant to set up individual sessions with [client]. The aim was to gain greater understanding of activities that the client enjoyed.

O2 Structuring MOHO Assessments in Practice - practice achievement

Isobel was able to critique the available assessments based on their relevance for the client and their sensitivity to measure change. She was able to demonstrate her considered use of the tools even if the choice was to not use the 'measures'.

> There's no point in doing a repeat MOHOST because he would score so low across the bottom of MOHOST anyway, you know I wouldn't be expecting any of those factors to change.
>
> Isobel – Debrief interview

> The one that I use the most is AMPS, followed by MOHOST, followed by the sensory processing stuff (pause) within reserve (laughs). I suppose the next most likely would be the ACIS (pause) [and also] the VQ.
>
> Isobel – Initial interview

2. Second level analysis: Development of individual CMO cases

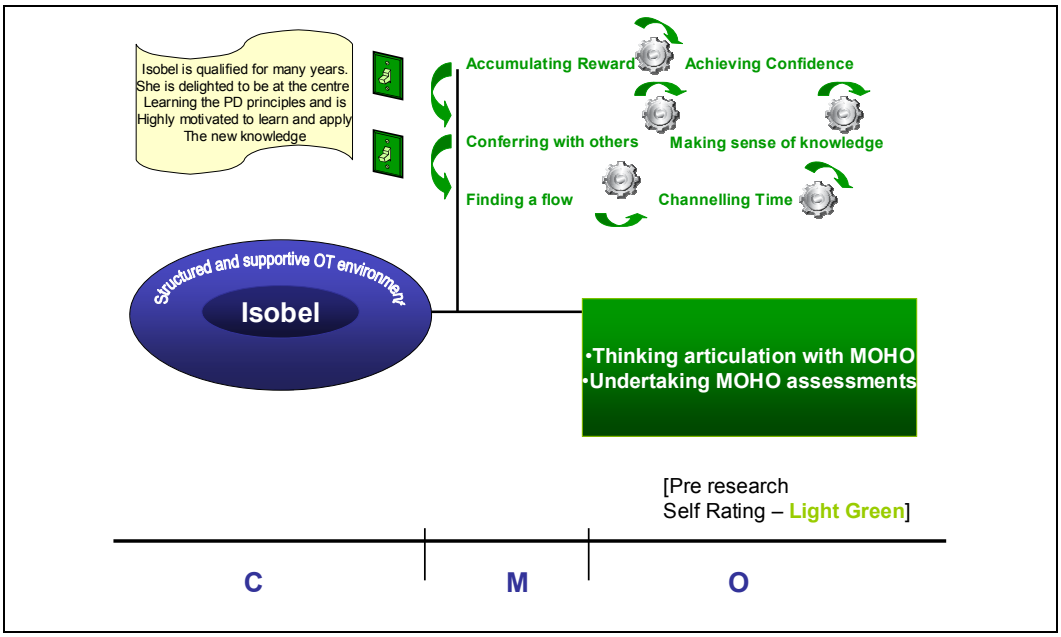
At this stage of data abstraction I was able to use the 'chunked' data relating to Isobel from the first level analysis and compare and illustrate it as a whole system of CMO synthesis. This allowed the individual pattern of CMO to emerge from the data for Isobel.

Narrative illustration of CMO for Isobel

	Context	Mechanisms discovered (use traffic light shade)	Outcome (use traffic light shade)
Isobel	**Individual Capacities** Over 20 years as an OT. High level of responsibility for clinical outcomes. Working as part of a small OT team at base. Studying for higher degree. High level of personal drive and commitment to role. Conscientious, hungry for recognition, feisty. Array of responsibilities. **Interpersonal environment -** Available OT support and leadership support for PD.	Achieving Confidence Finding Flow Constructing Knowledge & Know-how Conferring with Others Accumulating Reward Channelling Time	GREEN for both using MOHO theory and assessments appropriately in practice

The data for Isobel (and others) revealed that there was a pattern of interaction between the context, mechanisms and outcomes. Initially I illustrated this in the format shown below where the context is represented by two ovals, the inner is Isobel's personal attributes and the outer is the immediate team context. The switches represent the general mechanistic activation and being green represent that for Isobel the mechanisms represented here as 'cogs' are activated (like the traffic light metaphor). Similarly, the outcome goals are green to represent the level of outcome achievement in using PD by Isobel.

Initial Illustration of CMO pattern for Isobel



On closer analysis the data revealed a greater dynamic interaction between the mechanisms in addition to the aspects of contexts in order to reveal the subsequent outcome of PD achievement. A different way to illustrate this interaction was conceptualized (below). This illustrates a broad pattern for those participants, like Isobel who were conceptualized as metaphorically 'In the Air' with practice development. This was ultimately the way that the second level analysis was presented in the thesis.

Final illustration of CMO pattern for Isobel and others in this outcome group