

Turbulent Times: Report of Preliminary Findings from Year 1 of the Evaluation of the Care Services Improvement Partnership

May 2007

Michelle Cornes

Sherrill Evans

Peter Huxley

Jill Manthorpe

Martin Stevens

Paul Waddington

Correspondence to:

Dr Michelle Cornes,

SCWRU,

King's College London,

Franklin Wilkins Building,

150 Stamford Street

London,

SE1 9NN

Tel 01768 486462

Email: michellecornes@aol.com

KING'S
College
LONDON

University of London

Contents

Executive Summary

1: Introduction

1:1 Overview of report	7
1:2 The Care Services Improvement Partnership (CSIP)	10
1:3 Service improvement agencies	13
1:4 Towards a single delivery vehicle	18

2: Evaluation Methodology

2:1 Introduction	22
2:2 Documentary analysis and interviews	22
2:3 Survey of programme staff	23
2:4 Case studies	24
2:5 Re-analysis of existing data	25
2:6 Learning sets	26
2:7 Current situation	26

3: Views on the Early Development of CSIP

3:1 Introduction	27
3:2 Outer context	28
3:3 Inner context	29

4: Conclusion

4:1 Does CSIP work as a concept?	39
4:2 Recommendations and thoughts for Phase Two	42

References

Appendices

The research team would like to thank CSIP staff and the Evaluation Advisory Group for their contributions. Thank You.

Executive Summary

1: Aims and Objectives

1:1 This report presents preliminary findings from Phase One of the evaluation of the Care Services Improvement Partnership (CSIP). CSIP became operational in April 2005 and brought together eight previously independent Improvement Programmes (National Support Service for Child and Adolescent Mental Health Services (CAMHS); Integrated Care Network; Integrating Community Equipment Support Team; National Institute for Mental Health in England (NIHME); Health and Social Care Change Agent Team; Valuing People Support Team; Change for Children; Health in Criminal Justice).

1:2 The evaluation was commissioned by the Care Services Directorate (CSD) of the Department of Health shortly after the launch of CSIP in April 2005. The evaluation was designed as a three year project but revised to constitute two phases at the end of year one owing to uncertainty around the future of CSIP. Phase Two is currently under discussion. This report will help inform its direction.

1:3 The primary purpose of this study was the evaluation of CSIP itself, in terms of its achievement of its Business Plan, its influence on policy and strategy, and the extent to which consistent and effective programme activity developed at national, regional and local level. The second was the evaluation of its direct or indirect impact on service improvements in local communities. Because the study was affected by extraneous developments, this report concentrates on the first of these objectives.

2: Method

2:1 The evaluation was carried out against a backdrop of turbulence and high level political interest. This has challenged the study at every turn leading to a decision to divide the study into two distinct phases. This report is written at the close of Phase One of the study. As will be evident, most significantly, the aims and objectives of CSIP have evolved to such an extent that they rendered the original community based case study design outdated in some respects. CSIP's primary purpose was to bring together a diverse range of programmes with the intention that they should work together on cross cutting themes escaping the traditional 'silos' structured around different client groups. This was integration at its most visionary yet the difficulty in identifying and initiating service development work in these areas has meant that there was very little observable practice to evaluate in the early stages. Much activity has taken place under the banner of CSIP but this has been at a national level or regionally based within the confines

of the individual programmes (documented in over 70 Headline Management Plans) and therefore outside of the remit of what was intended as an overarching evaluation.

2:2 As the evaluation sought keep apace of these changes a partial and largely unanticipated ethnography emerges of the process of organisational uncertainty and metamorphosis. We use the term partial to reflect that it was not possible to execute our proposed methodology in full. Our work on Phase One was restricted to one year of study and included: a documentary analysis of business plans and corporate documents; observations and participation in a number of meetings; a pilot survey; and in-depth qualitative interviews with managers working at director level within CSIP (n=21). The data was analysed using Greenhalgh *et al.*'s (2004) framework for understanding successful innovation and change in health care. This is an evidence based approach drawing in over 6000 literature abstracts, 1,200 full text articles and over 100 books.

3: Findings

3:1 CSIP's primary purpose was to bring together a diverse range of programmes with the intention that they should work together on cross cutting themes escaping the traditional 'silos' structured around the different client groups. In the accounts of CSIP's senior managers there was a great deal of uncertainty as to how to translate this strategy into everyday practice. Most managers assumed this to mean a concentration of work around specific cross cutting themes such as 'workforce', 'commissioning' and 'social exclusion' which had resonance for all the client groups. More importantly, there was also a sense of shifting the locus of expertise away from that gained through working with a specific client group to a set of skills and competencies generic to all forms of service improvement work. In the rationale for CSIP, the assumption was that staff coming to CSIP from the previously independent programmes would necessarily be 'experts' in the field of generic change management and could easily move across to work in that area.

3:2 From the perspective of the senior managers, this was interpreted as quite a significant and not unproblematic change to job content. Some found *'it hard to put a finger on exactly what [this new generic] expertise is'* and some did not even want a career based along these lines. There was also the strongly felt view that it had taken a long time to establish the credibility of the old brands and that moves to a new corporate CSIP identity would damage that. This reflects that CSIP staff saw themselves as pioneers and innovators but that this expertise was rooted in their attachment to a particular client group. Most CSIP staff had never really thought of themselves as specifically 'change management gurus'. Furthermore, what the notion of working in silos did not capture was the sense in which each client group was also a social and political movement

(the older people's movement, the disabled people's movement and so forth) and the sense in which CSIP staff were not just change agents but '*champions*' of these movements.

3:3 A further problem was that the assumption of a common interest in generic service improvement overshadowed the extent of actual difference between the constituent teams. Indeed, cooperation and collaborative advantage were viewed almost solely as the opportunity to learn from one another. However, integration also created tensions and in the workplace itself a sense of separateness remained. For example, some programme leads saw service user involvement as central to CSIP while others saw it as peripheral given that they viewed their role as supporting professionals and service managers.

3:4 In negotiating a vision for CSIP, a further problem voiced by CSIP managers was the lack of evaluation of impact, and the different views about evaluation held through the organisation. This was an important theme in the accounts of the Senior Managers who were often frustrated not to be in a better position to prove the value of the work they had carried out under the auspices of the old constituent brands. This led to an element of subterfuge in which some managers '*talked the talk*' as regard the benefits of integrated working, but actively worked to maintain the integrity of the original 'brands'.

3:5 Ultimately, the lack of clarity and belief in the CSIP concept manifested itself as resistance to change with the consequence that the process of forming the Partnership had very little impact on the activities of the individual work programmes. These proliferated (CSIP Business Plan 06/07), while work on cross cutting themes and a corporate identity for CSIP were slow to materialise. In summary:

Factors facilitating CSIP's implementation:

- Well intentioned pragmatism and the drive and vision of individuals
- Belief in the value of learning and sharing with colleagues.

Factors inhibiting CSIP's implementation:

- Staff in the organisation strongly supported the previous ways of working and there was a great loyalty to the identity of the constituent teams. There was little appetite for change and the initial assessment of the implications of the innovation did not anticipate or seek to address these.
- There was a lack of devolved decision making and staff were not involved in developing a vision for CSIP, including potential changes to 'job content'
- Innovation-system fit was a problem – the differences between the constituent programmes were much greater than anticipated

- The CSIP concept was not evidenced based and there was lack of internal capacity to evaluate.

4:2 Recommendations and thoughts for Phase Two

4:1 During the writing of this report, the Department of Health announced that CSIP's future was under formal review and that 2007 would be a transition year for CSIP. This raises the issue as to the potential of this report to contribute to this debate. Again, we should like to begin by acknowledging the limitations of our own perspectives given the changes to the direction of our work.

4:2 The first point is how to avoid repeating the possible mistakes of CSIP. CSIP itself was founded for pragmatic reasons under the banner of 'partnership' and 'integration'. However, its senior managers consistently struggled to demonstrate the applicability of such concepts to the organisation and delivery of service improvement support. It will be critically important to assess then to what extent '*regionalisation*' (which is currently being championed by CSIP) is a genuine thought-through approach based on wide stakeholder involvement. Without establishing such a clear position then the problems of implementation and sustainability described above will resurface or a great deal of expertise will be lost to the DH and the wider health and social care communities if there is reluctance to 'retrain' as generic service improvement specialists.

4:3 Our final recommendation relates to the need to move swiftly with the Department of Health to an agreed purpose for the next phase of the evaluation and a revised protocol. What would seem most appropriate would be a dual focused analysis looking at the work of the regional offices as compared to the work of the (client based) individual programmes. We would seek the views of the Advisory Group, acting as wider stakeholders, on such a refocusing if this commands support with the funder. As well as giving strategic direction to the DH, this would help build the evidence base around improvement support delivery vehicles and could start to assess issues from a customer and quality perspective, for example, do users of improvement support prefer generic support or client specific support; do they prefer working through national networks or the hands on support provided by a change agents?

'[Discussing how CSIP is supporting a one star council to improve overall performance] Change agents are critical friends and what they do is reflect back to you where you are... It's enormously helpful to have someone who has this level of expertise and stature....'

CSIP Client Quoted in
Community Care 29th March – 4th April 2007

1: Introduction

1:1 Overview of report

This report presents preliminary findings from the first year of the evaluation of the Care Services Improvement Partnership (CSIP). The evaluation was commissioned by the Care Services Directorate (CSD) of the Department of Health shortly after the launch of CSIP in April 2005. The evaluation was designed as a three year project but revised to constitute two phases at the end of year one owing to changes in CSIP.

For the public and for users of services it is important to scrutinise the outcomes of investment in service improvement agencies such as CSIP which may have costs as well as benefits. The primary purpose of this study was the evaluation of CSIP itself, in terms of its achievement of its Business Plan, its influence on policy and strategy, and the extent to which consistent and effective programme activity developed at national, regional and local level. The second was the evaluation of its direct or indirect impact on service improvements in local communities. Because the study was affected by extraneous developments, this report concentrates on the first of these objectives. Figure 1 and 2 present a more detailed reference guide to the aims and objectives addressed in this report as compared to what was commissioned in the overall proposal.

The evaluation was carried out against a backdrop of turbulence and high level political interest. In Chapter 2 we describe how this has challenged the study at every turn leading to a decision to divide the study into two distinct phases. This report is written at the close of Phase One of the study. As will be evident, most significantly, the aims and objectives of CSIP have evolved to such an extent that they rendered the original community based case study design outdated in some respects. CSIP's primary purpose was to bring together a diverse range of programmes with the intention that they should work together on cross cutting themes escaping the traditional 'silos' structured around different client groups. This was integration at its most visionary yet the difficulty in identifying and initiating service development work in these areas has meant that there was very little observable practice to evaluate in the early stages. Much activity has taken place under the banner of CSIP but this has been at a national level or regionally based within the confines of the individual programmes (documented in over 70 Headline Management Plans) and therefore outside of the remit of what was intended as an overarching evaluation. As the evaluation sought keep pace of these changes a partial and largely unanticipated ethnography emerges of the process of organisational uncertainty and metamorphosis. We use the term partial to reflect that it was not possible to execute our proposed methodology in full and also because an ethnography would need much more intensive work

within CSIP programmes. Our work on Phase One was restricted to one year of study and included: a documentary analysis of business plans and corporate documents (see appendix for the list of documents); observations and participation in a number of meetings; a pilot survey; and in-depth qualitative interviews with managers working at director level within CSIP (n=21).

In Chapter 3, we explore the life and death of CSIP to tentatively draw out the key learning for the next generation of care service improvement agencies. We focus on the views of senior managers on: change management and the early development of CSIP; progress to engender a cross-cutting approach; and the unresolved tensions and uncertainties which have arguably weakened CSIP's position in the service improvement market place.

Figure 1: Study Aims and Questions - addressed in this report on the basis of data collected in Year 1

Study Aims Addressed:

1. To investigate progress in the development of CSIP and to identify the factors inhibiting or facilitating its implementation.
2. To assess the effect of CSIP development on the operation of the individual work programmes.

Research Questions Addressed:

- What impact does the process of forming the Care Services Improvement Partnership have on the activities of the individual work programmes? (Aims 1 & 2)
- What impact has the formation of CSIP had on individual programmes strategy and culture, work environment and job content? (Aim 2)
- Has the formation of the partnership facilitated cooperation between the programmes, in terms of cross cutting themes and other work? (Aim 1 & 2)
- What action, if any, is being taken to manage successfully the challenging aspects of the development of CSIP? (Aims 1 & 2)

Figure 2: Study Aims and Questions Not addressed in this Report - because data was planned for collection in Years 2 and 3

Study Aims Not Addressed:

3. To evaluate the impact of the CSIP in relation to its internal objectives and those of its organisational clients and their service users.
4. To assess the extent to which Care Services Directorate development funds have enabled the CSIP to make a sustainable difference to local services and the health and well-being of those using them.

Research Questions Not Addressed:

- What methods has the CSIP employed to support change across delivery agencies and how effective have these been? (Aims 3 & 4)
- Is there any evidence of a more integrated approach to planning and service delivery by NHS and Local Authorities, which addresses the diverse needs of individuals across the life course and which can be attributed to the activities of the CSIP? (Aims 3 & 4)
- What have been the key characteristics of any discernible changes and what evidence is there of their sustainability? (Aims 3 & 4)
- What are the key stakeholders' (policy officers; managers; practitioners; service users and carers) evaluations of the work delivered by the CSIP? (Aims 3 & 4)

****A more detailed statement of the work completed in Year 1 is shown in Appendix 1.***

1:2 The Care Services Improvement Partnership (CSIP).

CSIP's core purpose is service improvement. It was initially sponsored by the Care Services Directorate (CSD) at the Department of Health in April 2004, becoming operational in April 2005. The CSD held responsibilities across prisons, children and adults and oversaw eight Improvement Programmes:

- National Support Service for Child and Adolescent Mental Health Services (CAMHS);
- Integrated Care Network;
- Integrating Community Equipment Support Team
- National Institute for Mental Health in England (NIHME);
- Health and Social Care Change Agent Team;
- Valuing People Support Team;
- Change for Children
- Health in Criminal Justice.

The CSD recognised that the Programmes had made a valuable contribution to supporting policy implementation and service improvement and in doing so had developed specific infrastructures and areas of expertise. For historical reasons, however, each Programme had developed separately. As a result, the strengths of individual Programmes had not necessarily been reflected in the work of the others. While it was recognised that each of the programmes had a particular constituency of both consumers and services which it was established to support, experience had shown that there were many issues which they shared in common, for example, workforce recruitment & retention, or service redesign. It was asserted that, through a process of integration, the Programmes would be in a much stronger position to contribute across a wider spectrum of subjects - such as education, housing, employment and diversity – thereby delivering a 'whole life' approach, reflecting the cross-agency nature of people's use of services. The proposed solution was to move toward a single delivery vehicle or infrastructure to house all CSD sponsored improvement support. To this end, the eight Programmes came together as the Care Services Improvement Partnership (CSIP).¹ According to the original research brief published by the Department of Health (2005), the anticipated outcomes of the partnership were:

- increased influence and critical mass;

¹ Latterly, the Care Services Efficiency Delivery Team was also brought under the banner of CSIP reflecting that its work must demonstrate support to organisations to achieving public sector efficiency. A new 'Better Social Care Programme' was also incorporated to specifically support the implementation of the White Paper 'Our Health Our Care Our Say' (DH 2006).

- a clearly articulated commitment to support policy implementation and service improvement across health and social care communities;
- the ability to strengthen the work of individual Programmes through the pooling of expertise, increased impact and more effective work with local stakeholders;
- an increased ability to tackle cross-cutting issues such as education, housing, employment and ethnicity that affect diverse service user groups;
- a better use of resources through improved co-ordination;
- a stronger interface with key external organisations such as the Government Offices of the Regions, the Commission for Social Care Inspection, the Healthcare Commission and the Strategic Health Authorities;
- a more co-ordinated view, based on experience from the field, to inform policy development and heighten policy impact;
- contribution to a long term vision for national and local support to delivery programmes across all service user/carer groups.

CSIP's resources are delivered through eight regional development centres (Eastern; London; North East Yorkshire and Humber; North West; East Midlands; West Midlands; South East; and South West). The budget for 2005/6 was £39.45 million. This was divided between the constituent programmes as shown in Figure 3.

Figure 3: CSIP Income for 2005/2006 (in £ 000s)

Accommodation and Servicing	810
National Institute for Mental Health in England	24,191
Valuing People Support Team	2,800
Change Agent Team	2,541
Integrated Care Network	500
Change for Children	1,475
Integrated Community Equipment Support	600
The National CAMHS Support Service	1400
Health in Criminal Justice Team	5130
Total	39,447

In the original Business Plan for 2005/6 it was planned that CSIP's work would fall into three broad categories:

- i. 'CSIP national programmes' – where a consistent set of outcomes (and timescales) was required nationally. It was expected these would be relatively few in number. In the first year of operation these mirrored the interests of the former independent improvement programmes:
 - Children families and young people
 - Health and Social Care in Criminal Justice
 - Learning Disabilities
 - Mental Health
 - Networks (Integrated Care Network, Better Commissioning Network, Housing Learning and Information Network (LIN), Telecare LIN)
 - Older people and long term conditions
 - Adult social care
- ii. 'CSIP cross-cutting themes' – where all regional centres would work to achieve common outcomes but where the timescales and specific activities would be determined by the local situation in each of the regional centre patches. **Over time it was assumed that this would be the predominant mode of delivery in CSIP;**
- iii. 'Local priorities – where each regional centre would work on issues specific to their area (though such work would be consistent with the local achievement of national policy for care services);

Source: CSIP Business Plan 2005/6

Working collaboratively with a wide range of partner organisations, at government level (DH, DfES, GOs, Home Office, ODPM, DWP) and externally (CSCI, IDeA, SCIE, NHS Institute, NIHCE, and HCC)², it was envisaged that CSIP would contribute towards evidence-based policy and practice. CSIP set out to become an organisation in which learning from research and evaluation is actively disseminated and implemented. It was recognised in the Business Plan that the ultimate litmus test of CSIP's effectiveness would be whether people who use services perceived a difference as a result of its work. It was asserted that the views and aspirations of service users, patients, consumers, carers and citizens must be central to CSIP activities (Business Plan 2005/6 p3).

² See Appendix 2 for a Glossary of Terms

At a practice level, it was envisaged that CSIP would have a strong focus on delivering national policy priorities through the eight regional centres so that programmes could be tailored to local needs and circumstances. It was planned that CSIP staff would offer early support to organisations and services that were experiencing specific difficulties, based on a clear assessment of risk. Support was envisaged as comprising a range of methods subsequently published by CSIP as directory of improvement techniques (www.csip.org.uk/Serviceimporvementdirectory) (see Appendix 3). There was also a commitment to: building and supporting managed networks through which learning could take place; identification of positive practice; and the use of electronic and web-based approaches to capturing and sharing knowledge. In particular there was a commitment to focusing on 'high-impact changes' most likely to have a positive effect on services. In the first year of operation, however the key priority was that:

'Whilst it is essential that CSIP honours the existing commitments from the constituent teams that make up the new organisation, it is essential that future work is based on the inter-connections of needs and services... In practice this will mean that over time, existing programmes will change and become more cross-cutting and generic.'

CSIP Business Plan 2005/2006

1:3 Service improvement agencies

'Service improvement is about improving the quality of people's lives. At its heart, are the lives of people who use health and social care services and the people who support them although it can also improve the working lives of people who provide health and social care'.

www.csip.org.uk/serviceimprovementdirectory

Since its earliest days, the NHS has been characterised by almost constant structural change. Change of this kind has resolved some problems, at some times, but has left many other deep seated problems untouched (Iles and Sutherland 2001, p42). Interest in 'service improvement', 'innovation' and 'change management' is however fairly recent and stems from ambitious goals such as the achievement of the NHS Plan. Much time and public money has since been devoted to understanding and managing change in health services, first through the NHS Modernisation Agency and latterly through the NHS Institute for Innovation and Improvement (www.institutue.nhs.uk) and CSIP. In social care, the Social Care Institute of Excellence (www.scie.org.uk) was launched in 2001 and, in local government, the Improvement and Development Agency

(www.idea.gov.uk) was launched in 1999. A recent survey in Community Care (Unity Sale 2006) highlights that many front line social work practitioners are often confused by the range of support agencies some of which combine developmental support with inspection and regulatory activity (e.g. General Social Care Council (www.gsccl.org.uk), Commission for Social Care Inspection (www.csci.org.uk), Healthcare Commission (www.healthcarecommission.org.uk)).

Hartley (2005, p27) points to some of the conceptual uncertainties associated with the terms often linked to service improvement:

'Much of the innovation theory and literature has derived from new product development, where an innovation in technology can be observed and broadly agreed, even if the full implications or its impact are not initially known. By contrast innovations in governance and services are more ambiguous. Here innovation is usually not a physical artefact at all, but a change in the relationships between service providers and their users'.

Her synthesis of definitions of innovation include 'novelty in action' (Altschuler and Zegans, 1997) and 'new ideas that work' (Mulgan and Albury, 2003) while others differentiate between invention and innovation (Bessant, 2003). While innovation may be a term used to denote novelty, this can span a range of innovation, from large to small-scale, and rapid to incremental change. However, Hartley quotes Moore *et al.* as importantly focusing on practical impact, and the salience of this to service delivery in the public sectors:

'Those changes worth recognizing as innovation should be...new to the organization, be large enough, general enough and durable enough to appreciably affect the operations or character of the organization'

(Moore *et al.*, 1997, p276).

However, reinvention, reconfiguring or adaptation to another context, location or time period can also be a form of innovation. Rashman and Hartley (2002) argue that the diffusion of innovations (whether dissemination, or spread of good practice) to other organisations is particularly important for the public sector and its search to increase public value.

Hartley provides examples of a range of networks designed to disseminate innovation (for example, through cancer collaboratives, Beacons, peer review, pilots and demonstration projects). These have a longer history in health and social care services where regulatory mechanisms have often played their part in spearheading good practice as much as rooting out bad.

Hartley portrays the change in civil servants as one where 'mandarin officials' move to become 'efficiency maximizers', charged with seeking and spreading innovations to improve the quasi-market and the quality of service 'delivery'. Such personnel become:

'...Explorers commissioned by society to search for public value. In undertaking the search, managers are expected to use their initiative and imagination. But they are also expected to be responsive to more or less constant political guidance and feedback'

(Moore, 1995 p299).

More recently, Greer (2007) charts the rise of a managerial cadre within civil servants at the Department of Health and moves towards a 'decide and do' culture more in keeping with politicians' desire for fast and effective action.

According to Iles and Sutherland (2001) in their selective review of the evidence in the field of change management, systems require a source of energy if they are to shift and change. The energy, or impetus, for change can take many different forms, and can be generated from within an organisation or emanate from outside. There is however, a shortage of research that identifies the most effective sources of energy, as well as restraining forces. While leadership is recognised as key, a major problem in this field has been the dominance of gurus who prescribe courses of action without any basis in evidence.

In their systematic review of spread and sustainability of innovations in health service delivery and organisation, which includes an exploration of a range of themes linked to service improvement and change management, Greenhalgh *et al.* (2004) describe the theoretical complexity of the literature as a conceptual cartographer's nightmare. They identify over 6,000 abstracts 1,200 full text articles and over 100 books and discern eleven major research traditions that have independently of one another addressed the issue of diffusion and/or dissemination and/or sustainability of innovations in health service delivery and organisation. On the basis of the documentary analysis of CSIP's literature, the following research traditions would seem to have been particularly influential. Indeed, had the research continued into the field work stage as planned, the extent of coherency and compatibility between the different approaches would have been a key issue.

- ***Evidence-based medicine and guideline implementation:*** *in this tradition innovations are defined as health technologies and practices supported by good scientific evidence. Spread of innovation was initially couched of in terms of behaviour change in individual clinicians in line with evidence based guidelines. It is increasingly recognised in this research tradition that the implementation of most clinical guidelines requires changes to the*

organisation and delivery of services and hence organisational as well as individual change. Within this research tradition it has also been increasingly recognised that the evidence base for particular technologies and practices is often ambiguous or contested – and must be interpreted and reframed in the light of local context and priorities. As a result there has been a shift from a highly rationalist and linear perspective to a much more constructivist perspective in which the acquisition, dissemination, interpretation and application of evidence is seen as a ‘contact sport’ around the negotiation of meaning.

Promoting evidence based practice is a key objective of CSIP. In the NHS, responsibility for clinical and organisational improvement is split between agencies, with agencies such as the National Institute for Health and Clinical Excellence (www.nice.org.uk) leading on clinical matters and the NHS Institute for Innovation and Improvements and CSIP leading on organisational context in health and care services respectively. For CSIP a core service improvement objective is acting as the ‘bridge’ between government policy (as the embodiment of the evidence base) and the front line:

‘A social care change agent is appointed in each of the regional development centres.... They will establish a workplan which, in the context of a national framework, responds to the particular challenges of their local patch’.

CSIP Business Plan 06/07

- **Organisational studies:** *in this tradition innovation is seen as a product or process likely to make an organisation more profitable. Organisational innovativeness is seen as influenced by structural determinants (size, functional differentiation, slack resources, and so on); by elements of good leadership and management; and by inter-firm competition, collaboration and norm setting. This stream of research has many overlaps with the mainstream organisational development and change management literature.*

Within CSIP, ‘facilitating’ integration and collaboration between health and social care stakeholders is a key objective as is, improving the efficiency of services and offering general management support:

‘CSIP will host the continued delivery of the Care Services Efficiency Delivery Programme to support the implementation of the recommendations of the Gershon Report. The Programme will continue to work with local councils and service providers to develop and support initiatives to gain sustainable efficiency improvements in adult social care’.

CSIP Business Plan 06/07

- **Knowledge-based approaches to innovation in organisations:** *In this tradition innovation and diffusion are radically re-couched in terms of the construction and distribution of knowledge. A critical new concept is the 'absorptive capacity' of the organisation for new knowledge. Absorptive capacity is a complex construct incorporating the organisations existing knowledge base, 'learning organisation' values and goals (that is those that are explicitly directed towards capturing, sharing and creating new knowledge), technological infra structure, leadership and enablement of knowledge sharing, and effective boundary spanning roles with other organisations.*

In social care, the Social Care Institute for Excellence and non-government sponsored organisations Making Research Count (www.mrs.org.uk) and Research in Practice (www.rip.org.uk) work very much within this tradition. In July 2006, CSIP and SCIE entered into a partnership agreement:

'As new and developing organisations, SCIE and CSIP are developing internal and external knowledge management systems... The two organisations will ensure that their different knowledge management emphases (SCIE's focus on the identifying and building up of an accessible knowledge base for the wider social care community and CSIP's work in facilitating and equipping appropriate communities of practice) complement and reinforce each other'

Partnership Agreement Between CSIP and SCIE (2006)

- **Communication Studies:** *in this tradition innovation is generally new information (often 'news') and spread and conceptualised as the transmission of this information either by mass media or interpersonal communication. In this tradition, research has centred on measuring the speed and direction of transmission of news and improving key variables such as the style of message, the communication channel (spoken or written etc,) and the nature of the exposure of the intended adopter to the message.*

CSIP works through networks to identify and share what works to help people in services to work better to improve people's lives (CSIP Annual Report 2006).

One tradition which is important for understanding the position of CSIP, though not clearly articulated in its own literature, is complexity and general systems theory. A key concept in complexity theory is individual creativity and the importance of human interaction ('generative relationships') in developing new – usually unanticipated and unplanned – capabilities of the system (Greenhalgh *et al.* 2004 p.115). This views innovation as the emergent continuity and transformation of patterns of interaction,

understood as on-going, complex, responsive processes of human relating in local situations. Significantly, because complexity theory sees change as an organic and adaptive it questions the role and efficacy of external change agencies. While there is wealth of empirical research on change agents in general, the literature on the change agents' role in disseminating innovations in health service delivery and organisations is sparse (Hartley *et al.*, 1997, Greenhalgh *et al.*, 2004, p189). Furthermore, it is argued that innovation and the spread of new ideas are most likely to occur where the approach to change is exploratory, intuitive and responsive. While some exponents of soft systems methodology espouse the potential of outside facilitators (Iles and Sutherland 2001), the view is that this is generally at odds with the rational, planned and controlled ('managerial') approaches advocated in much conventional implementation advice:

'We recommend that the support and guidance of an experienced facilitator is always sought at the beginning of every service improvement journey. CSIP's Service Improvement Leaders are here to help... Do not be tempted to act on impulse... diagnosis of the areas for improvement is vital... (1) talk with and engage relevant others, (2) assess and plan for improvement, (3) make improvements and monitor regularly, (4) plan for sustainability and spread.'

www.csip.org.uk/serviceimprovementdirectory

In developing a vision for CSIP, Horn (2005) identifies inherent tensions. He states that to achieve its purpose CSIP would need to be a devolved organisation and that 'the centre should do what only the centre can do' (paragraph 16). In addition, he recognises that CSIP would need to manage the potentially competing goals of its role as both support for the implementation of national policy, and promoter of locally based improvements. Indeed, Newman (2001) anticipates the shift to more networked forms of governance, as a bridge between the state and the market, and also observes that this is not without inherent tensions between centralization and decentralization, and networks and hierarchies.

1:4 Towards a single delivery vehicle

In this section, we turn our attention to the literature underpinning our understanding of the development of CSIP as a single delivery vehicle for the Care Services Directorate's service improvement programmes. Promoting partnership and integrating services ('joined-up thinking') have been a driving force of policy developments over the lifetime of the Labour government (Powell and Dowling, 2006). However, there has been a dearth of good quality evaluation of the impact of such organisational developments (Dowling *et al.*, 2004). Das and Teng (2001, p253) claim that strategic alliances have significantly higher failure rates than individual

enterprises and according to Eden and Huxham (2001) many collaborative projects fail to live up to expectations. Fulop *et al.* (2002) identify negative consequences of mergers including a lack of management focus on service delivery and the long lasting barriers of different organisational cultures, although these effects may have been due to the process of merger itself. Again, Horn's (2005, p18 & p16) initial model for CSIP predicts some of these issues:

'In the volatile and fast changing environment that we work, the ability to nail down a small number of strategic goals for CSIP, and stick to them, will be key. In an environment where, for example, there have been 81 policy documents published in the five years to November 2004 that are relevant to mental health, establishing a clear direction of travel that is both decisive but with room for flexibility will be vital.'

Ferguson and Goddard (1997) argue that changes in the structure of organizations through merger, acquisition, consolidation, and redesign are often implemented in an effort to lower the costs. It is significant that CSIP's early development was intertwined with wider political turbulence which included reorganization within the Department of Health which meant a new departmental sponsor for CSIP, and the mass reorganisation of arm's length bodies which reduced their number by half, as well as 25% staff reduction and £500 million savings by 2008 (Greer 2007). Just as CSIP's second business plan was being finalised the Department of Health notified CSIP of a reduction in its budget. Social Care stood to lose £500k; Learning Disability £200k; and Older People 60K.

Inter-organizational projects are inherently risky because, according to Newell and Swan (2000, p. 1288), they 'are not governed by traditional hierarchical relationships [therefore] critical problems surround the development and maintenance of trust and the deployment of power amongst members'. Hardy and Phillips (1998) provide a framework of power in inter-organizational relationships, highlighting three aspects — formal authority, control of critical resources and 'discursive legitimacy'. Greater access to formal authority places some organisations in a position to administer formal/external controls, while others are more likely be the subject of these controls. Organisations with limited access to authority and resources can influence others through exercising discursive legitimacy but only if they are recognized as the authentic voice of those affected by the issue with which the collaboration is concerned. However, some actors are better positioned to pursue self-interest, so these risks are not evenly spread across the membership. Second, some actors can exercise greater control of the communications process, enabling them to manage agendas, or limit others' participation in key conversations and meetings. By these means, opportunities for more marginal organizations to exercise their discursive legitimacy may be restricted, privileging the interests of more powerful actors. The effect of these power differences is that certain

organizations come to occupy more central positions within a joint undertaking while others are rendered more peripheral. Given the unequal resource distribution between CSIP programmes highlighted in Figure 3 we were keen to explore to what extent this emerged as an issue within CSIP's development.

Vangen and Huxham (2003a: s61) report that 'recent years have seen a world-wide intensification in partnership working' in both the commercial sector and in social policy implementation. They claim that the benefits of partnership — including the combining of resources and expertise, the sharing of good practice and the spreading of costs and risks — are relevant in both contexts. These benefits constitute what Huxham (1996) terms 'collaborative advantage' — positive outcomes not achievable by organizations working independently.

Mandell and Steelman (2003) argue that cooperation among organizations within the private sector is supported primarily as a way to benefit the individual organisations involved, whereas partnership in the non-profit sector is championed, not so much as benefiting particular organizations, but as a means of tackling complex social problems. Such problems require a commitment to the 'building of inter-organisational capacity' among various organisations with a stake in the problem (Williams 2002: 105). In this research, we were particularly interested in the extent that the CSIP as a whole enables initiatives and outcomes that are greater than those achieved by the individual organizations prior to the creation of CSIP.

In the UK, partnerships are often advocated as a means of tackling cross-cutting issues and facilitating work across organizational boundaries (Powell and Dowling, 2006). Asthana et al. (2002) comment that 'for a concept so central to current public policy in the UK remarkably little is known about how to translate the rhetoric of partnership working into practical reality ... little substantive guidance is given about what is even meant by partnership'. Grimshaw et al. (2002) argue that conventional analyses of partnership underestimate the significance of power relations among the actors involved. Instead ideas such as working 'across organisational boundaries' in a 'holistic way' that is 'responsive to user needs' are presented as taken for granted 'good things', not as capable of generating competing interpretations with different implications for the distribution of resources and influence among the stakeholders involved. So, although the intentions of CSIP are expressed in the former terms, the evaluation was concerned to explore the latter.

Halliday et al (2005) note that official accounts contain little descriptive detail about the practice of partnership. These practices, along with the meanings that explain and justify them, have therefore to be produced locally, among actors with different interests and unequal access to power and resources. They suggest that a focus on how shared meanings may be constructed across differences suggests the following research questions:

How is the meaning of partnership constructed in the accounts of those involved in the implementation of partnership working? To what extent do these accounts depict partnership as more trust based or as more power based? How are the interests of different stakeholders represented and what are the implications of these representations for the enactment of partnership within the specific site of investigation? These formed some of the issues addressed in our interviews with CSIP Directors.

2: Evaluation Methodology

2:1 Introduction

The initial evaluation methodology was designed to be formative and to build up a continuous picture of CSIP's development over a three year period. However, owing to the pace of change and uncertainty around the future of CSIP, the research team is currently in discussion with the Department of Health as regard a revised research focus which is likely to require substantial changes to the proposed methodological protocol. The work that was completed in Year 1 included: a documentary analysis of business plans and corporate documents; observations and participation in a number of meetings; a pilot survey; and in-depth qualitative interviews with managers working at director level within CSIP (n=21). In this section we give more detail about this work and touch upon some of the challenges we faced in trying to execute our wider approach.

2:2 Documentary analysis and interviews with CSIP senior managers

In order to assess the impact of CSIP, it was agreed that time was needed for the organisation to gel and to progress its work programmes. In the early stages the research was kept up to date with developments via the Evaluation Steering Group. This brought together a range of stakeholders from CSIP, the Department of Health and external agencies (see Appendix 4).

Alongside traditional literature searching, emerging documentation was collected and analysed. This included CSIP business plans (Appendix 5), other corporate documents (leaflets and posters) and regular scrutiny of the CSIP web site (www.csip.org.uk).

Interviews were arranged with senior members of staff from each of the CSIP work programmes and national business support staff where relevant were interviewed. See Appendix 6 for the interview schedule. The covered:

- Progress with national work and cross cutting themes and work programmes
- Impact of CSIP development on programme activities
- Assessment of job content and work environment changes
- Self-assessment of programme impact.

Twenty-one CSIP senior managers were interviewed including the Chief Executive, thirteen National Programme leads and seven Regional Directors in April/May 2006. Most interviews were undertaken face to face

and were recorded and transcribed, with permission (two interviews were carried out over the telephone).

2:3 Survey of Programme staff

In order to investigate further the extent to which the CSIP was to emerge cohesively around emerging themes it was initially planned to send questionnaires to a random sample of 400 staff from the work programmes, made up of the Karasek Job Content questionnaire (Karasek, 1979), the Work Environment Scale (WES) (Moos, 1994) and the measure (Strategy and Culture) developed by Professor Janet Newman to assess cohesion and culture at the organisational level. This was to have been repeated in each of the three years of the evaluation to investigate changes in staff culture and climate as the organisation developed. One reason for choosing these measures was that we, and others, have used them extensively in the social care field, making comparisons possible. Standardised measures are useful to maintain a degree of independence between the researchers and the respondents, and avoid some of the disadvantages of specially constructed and unstandardised instruments.

It was agreed that an online survey was the best approach from a response, burden and cost perspective and plans were made to start setting up the survey. One major issue identified was that CSIP Diversity survey had just been planned. This presented a danger of duplication and staff burden, likely to result in low returns to both surveys. We also noted that in November there was to be a performance measurement consultation and an evaluation toolkit development, so we needed to try to arrange our staff survey before that date. On the 14th April we proposed the following draft programme:

- Finalise content of the on-line version (early May);
- CSIP web-manager puts the survey on-line (end May);
- Pre-test (end May);
- Pilot test with 50 staff (1st week June);
- Full survey (3rd week June);
- Data analysis and reporting (July-October).

This was subsequently revised, in the light of other developments, in May 2006: the revised plan is included in Appendix 7.

We reduced the number in the pilot to 30 after finding that the organisation did not employ as many people as we had first thought. Version 1 of the draft survey was completed by the 18th April, and sent to CSIP on the 21st. At the same time the Diversity survey and the staff directory were made available. Several double entries, missing entries, and out of date entries were identified and amended for sampling purposes. The on-line pilot survey took place in June and resulted in a 57% response. Of those directly

contacted by a member of the research team, 55% responded, and of those who had voicemail reminders left, 42% completed the survey. The main reason for non-completion was pressure of work, and not any disinclination to complete the survey, or any anxieties about confidentiality.

Concerns were raised at a series of meetings about the potential for overlap with the Diversity survey and a decision was taken to put the evaluation staff survey on hold in August 2006. A suggestion had been made to investigate whether the evaluation staff survey could be accommodated within the CSIP work. However, it became clear that the CSIP Diversity survey contained only two or three items comparable to the standard instruments and could not be substituted for the full standardised instruments; so the use of the Diversity survey as an alternative to the evaluation survey was not possible.

The software which was established to run the survey remains available at www.phpsurveyor.org/index.php and the pilot survey results with a completed n of 20 is available at www.surveys.csip.org.uk/admin/statistics.php?sid=7. They are anonymous and password protected.

2:4 Case studies

A key part of the evaluation was to understand how the different programmes were working together on the ground and the process and outcome of CSIP's work from the perspective of local stakeholders (service managers, practitioners, service users, carers and citizens). In order to examine this, the initial plan was to undertake four case studies each based in different geographical area (rural, urban, metropolitan, London). In each area it was anticipated that:

- CSIP should be working on an ongoing improvement project lasting between 12 – 18 months.
- This work should not predate April 2005 (the launch of CSIP).
- This work should capture the essence and rationale for CSIP as regards a cross cutting theme which requires in-put from more than one Programme.

In each of the sites, data was to be collected from key stakeholders:

- Chief Executives/ senior managers,
- practitioners,
- community leaders,
- service users and carers representative of the range of services covered by CSIP

In order to select the case study sites a special one day event was planned in January 2006 which aimed to bring together CSIP Senior Managers, staff and service users and carers. The event was cancelled by CSIP as it was felt too early to commence any case study research given that CSIP was still in an embryonic state. This necessitated a variation in contract. It was agreed with the DH that the case study interviews that were planned for Year 1 would be carried out in Years 2 and 3.

In addition, a small sample (25) of recent case files (from all the agencies in contact with the service user) in each of the four areas (N=100), were to be accessed. Data was to be extracted and analysed in order to track service careers. By October 2006, CSIP had decided this would not yield useful data and the Advisory Group agreed to an alternative approach. An extra tier of interviews was subsequently proposed as part of the variation in contact. Leaders/senior managers, drawn from national service user organisations and voluntary and community sector (e.g. Shaping Our Lives, Help the Aged, Mind) were to be recruited, as recommended by the Advisory Group. The purpose of these interviews was to allow for an 'external' perspective on the development and impact of CSIP nationally, to complement the 'internal' perspective drawn from the CSIP Senior Manager interviews.

2:5 Re-analysis of existing data

We envisaged reviewing and verifying the information contained in CSIP progress reports, for inclusion in the evaluation. In addition, it was planned to re-analyse raw data, depending on the types of information available, and the extent to which we could overcome issues of data quality and measurement differences. The following sources of data were to be included in this analysis:

- Programmes
 - Internal evaluations of individual initiatives
 - National research evaluations (e.g. the person-centred planning research)
 - Reports of performance etc to Department of Health, Department for Education and Skills, Home Office
- Case study sites
 - Performance data
 - Internal evaluations of projects involving work with CSIP partners
 - Any external research being undertaken/recently published concerning case study site agencies

Again, owing to the changes in implementation of the evaluation, this aspect was not undertaken.

2:6 Learning sets

Initially two types of learning sets were planned to meet at the end of each of the 3 phases of data collection, building on the action research approach developed by Hartley *et al* (2001) in their Learning Laboratories exploring the impact of management consultants in the public sector. The proposed function of each Learning Set was to consider the data collected in each year of the evaluation, through a process of reality checking but also as a way of identifying areas for specific focus. Two learning sets were planned for each year, made up as follows:

LS1: a nominated group of those working for CSIP who wish to consider their roles and the work of their peers.

LS2: volunteer groups of front-line practitioners working in services that are influenced/influenceable by CSIP in the local area; one in each of the 4 case study areas. Members of each group were to be drawn from a variety of agencies, professional roles and functions: what they were to have in common would be a 'front-line' relationship with service users and carers.

The first Learning Laboratory (LS1) was planned for 17th January 2007 and was cancelled early in January 2007 following advice to do so at the meeting with the DH on the 10th January 2007. At this meeting it was announced that the future of CSIP was under review and that the evaluation would be refocused.

2:7 Current situation

The current situation is that we await guidance from the Department of Health as to what should be the revised focus of the rest of the study.

There is growing evidence that our experience is not uncommon when it comes to evaluating complex policy initiatives. It may be that such evaluations are better commissioned as a portfolio of self-contained 'units' rather than a single approach delivered through a linear timeframe. Barnes *et al.* (2003) reach the same conclusion reflecting on the evaluation of another complex policy initiative (the Health Action Zones):

'Rather than understanding the passage of time as marking linear development of HAZs towards long term outcomes, there was a break in the progression [due to the intervention of short term political imperatives] and a sense of people being shaken off course...The complexity of such programmes cannot be captured within one overarching theory' (p268/272).

3: Views on the Early Development of CSIP

3:1 Introduction

In branding itself as a service improvement agency there was a certain expectation that CSIP would manage expertly its own integrative and change management process. Based on their extensive synthesis of the literature, Greenhalgh *et al.* (2004) propose a framework designed to reveal important lessons about how to manage innovation and change more successfully (see Appendix 8). This organises information in terms of an 'inner' and 'outer context' and emphasizes the linkages between different elements. The outer context encompasses the economic, political and legal and social contexts in which the organisation operates. The inner context refers to the medium within the organisation through which any innovation/proposed change must pass in order for it to be spread to be sustained; it also determines the rate and direction of adoption. This framework was used as the basis for our thematic analysis of data collected in Year 1 allowing us to generate evidence based insights into: (1) the early development of CSIP; (2) factors inhibiting or facilitating its implementation; and (3) the effect CSIP development was having on the operation of the individual work programmes.

In CSIP's first year of operation, most activity took place at a national level or regionally within the confines of the individual programmes. The activities of each of these programmes are documented in over 70 Headline Management Plans and the over 500 individual 'products' or 'deliverables' are recorded. Cross-cutting work was identified as follows:

- Workforce and Primary Care: One of the Regional Development Centre Directors took a lead to explore how activity being undertaken on that theme in each of the national programmes could be brought together.
- Work, across all client groups, to support health and social care organisations responding to the implementation of the Mental Capacity Act 2005 in 2007.
- Commencement of a scoping study on NHS and CSIP engagement with the 3rd sector to inform the development of a workstream to extend CSIP's work with the 3rd sector, emphasising particularly commissioning, developing and sustaining mature partnerships, and stimulation of social enterprise initiatives.
- Amalgamation of both NIMHE's and the Change Agent Team's work on older people's mental health.

CSIP Business Plan 06/07

3:2 Outer context

Twenty-one CSIP senior managers agreed to be interviewed for the evaluation including the Chief Executive, thirteen National Programme leads and seven Regional Directors. The first interviews took place in April-May 2006 (one year after CSIP's launch) and the plan was to repeat them again in 2007 and 2008. Feedback from the interviews was presented and discussed at a monthly meeting of the CSIP Directors. The preliminary nature of the findings were emphasised and it was highlighted that the primary purpose of the meeting was to generate discussion around the formative nature of the evaluation and how the research team could best collaborate with CSIP Directors to inform future development. However, the political context was such that the findings were received cautiously. Managers were fearful that they could be taken out of context and used against them. There was a sense of fighting for survival and little appetite for work intended to refine an approach which may not exist in the foreseeable future. It was already acknowledged in the second Business Plan (2006/7) that some aspects of the way CSIP is organised and delivers its work would change and senior managers were already focussing hard on the next '*innovation*' which was regionalisation:

'[Discussing CSIP's Second Business Plan] This document needs to be seen in the context of the considerable change that is taking place. Much of CSIP's service improvement work is already locally focused by way of being delivered through Regional Development Centres but, by participating in the processes by which a Memorandum of Understanding is to be agreed between the new Strategic Health Authorities and the regional Government Offices, we will do more to ensure that our work is targeted at each area's greatest challenges.'

CSIP Business Plan 06/07

In the words of the DH group responsible for commissioning this research project, there would be 'turbulence' within and around CSIP, and we should not expect all aspects of CSIP development and operational change to go smoothly. By the time of writing this report (April 2007) the Department of Health had announced that it would undertake a review of its service improvement capacity and that 2007 would be a transitional year for CSIP. This was accompanied by much media speculation:

'The Care Services Improvement Partnership may be split in two, separating its health and social care elements it has emerged... While [this] might clarify management responsibilities, as far as Department of Health strategic responsibilities are concerned it is a howler. It has been claimed on many occasions that the government does not practice what it preaches about partnership and integration.'

If CSIP is torn in two, no one should wonder why these things are said.'

Community Care Editorial 22nd-28th February 2007

3:3 Inner context

Tension for Change/Support & Advocacy: If staff in the organisation perceive that the present situation is intolerable, a potential innovation is more likely to be implemented successfully/If supporters of the innovation outnumber, and are more strategically placed, than opponents, it is more likely to be assimilated and successfully implemented (Greenhalgh et al., 2004).

A fundamental problem in the development of CSIP has been the loyalty and belief in the eight constituent 'brands' that came to make-up CSIP (Change Agent Team, Valuing People Support Team, and so on). There was, in effect, little appetite for change because the existing structure was perceived to be highly effective and very well regarded. In the first year of operation, a great deal of time and energy was thus devoted to protecting the original brands. In effect, this countered integration and change:

'Speaking on behalf of the [programme] I would say that we retain a very strong identity as a team we retain our brand name and the community knows us by our brand first and foremost... We have not tried to sell ourselves as CSIP but we have continued to sell ourselves as [name of programme] which is now part of CSIP... We have been ahead of the game in working out how to manage and keep this duality going... How you benefit from harnessing resources while retaining your identity for the community... There is a strong desire by members of the team to hang on to their identities so we have taken specific action to ensure that takes place'

CSIP Senior Manager

'What we have tried to do is carry on the [brand specific] work programme and contribute to CSIP and to continue to carry on doing what we think is good, but see what we can learn from the other programmes... So the approach we have tried to take is a pragmatic one and to try to say no we are not diluting our efforts, there is an opportunity here to link up with other programmes'

CSIP Senior Manager

'I think the challenge for CSIP is to take what ought to be the vision about how we can be more joined up about common implementation problems across the care groups... and I'm not sure we've fully got

there, because I think we've still got a situation where you've got the mental health programme, you've got our programme, you've got older people... some of the issues, workforce, recruitment, retention, care planning, user involvement, race and diversity, are common across them all actually. But we've still got it constructed in silos'

CSIP Senior Manager

'Although we're on the same floor as quite a few CSIP colleagues, I don't feel we are particularly integrated with them'

CSIP Senior Manager

Staff Involvement & Commitment/ Intra-organisational Networks: Early and widespread involvement of staff at all levels and, in particular, top management support and advocacy of the implementation process enhance the success of implementation... An explicitly narrative approach to intra-organisational networking - that is, the purposive construction of a shared and emergent organisational story - can serve as a powerful cue to action (Greenhalgh et al., 2004).

The majority of the senior managers interviewed did not feel that they had been fully engaged with as regards the initial development of CSIP.

'I think that people didn't necessarily feel involved... We just sat and watched it happen really.... [There were] daft things like consultation about the name and things... We all felt quite strong towards the silly name and yet it stayed.'

CSIP Senior Manager

As noted earlier, it is significant that CSIP's early development was intertwined with wider political turbulence which included reorganization within the Department of Health which meant a new departmental sponsor for CSIP, and the reorganization and reduction by half of arm's length bodies, as well as 25% staff reduction and £500 million savings by 2008 (Greer, 2007). Against this backdrop, it was openly acknowledged by CSIP Senior Managers that CSIP was the vision of a single individual based in the Department of Health and that there were highly pragmatic reasons for merging the individual service improvement programmes. These included the desire to have a vehicle which could capture resources for service improvement (which were under threat of being channeled elsewhere) and the issue of what to do with a number of programmes 'orphaned' following the closure of the Modernisation Agency. It was this story which underpinned CSIP rather than acceptance that integration of the Programmes was a better means of delivering service improvement

support. Furthermore, while working papers³ underpinning the development of CSIP asserted that the model being developed was 'evidence based'; the evidence base was not referenced or made explicit.

Innovation-system Fit/Capacity to Evaluate: An innovation that fits with the existing values, norms, strategies, goals, skill mix, supporting technologies and ways of working of the organisation is more likely to be assimilated and implemented successfully...If the organisation has tight systems and appropriate skills in place to monitor and evaluate the impact of the innovation, that innovation is more likely to be assimilated and sustained (Greenhalgh et al., 2004).

A further barrier to integration is that the extent of difference between the eight programmes seems to have been much greater than anticipated. These differences manifest themselves in three key debates:

- 1) Where does CSIP stand on the involvement of people using services?
- 2) Does expertise lie inside or outside of CSIP?
- 3) Is CSIP about evidence based practice or tacit understandings of what works?

Involvement of people using services

Opinions on the involvement of people using services were divided.. There were those who viewed this involvement as largely peripheral to CSIP's operations and those who saw not just involvement but '*citizenship*' as central to the whole ethos of what CSIP should be about:

'Our clients are not service users, our clients are organizations, agencies and that is a really important point to get over... People say surely we should be working with service users. No - our job is to help others do a better job for service users'

CSIP Senior Manager

"Nothing about us without us" should become a CSIP motto. That means employing people who use services... the second thing is that all the programmes should have strands of work that are about supporting and encouraging people who use services and their families to become articulate and empowered people in their local communities in their relationships with all the services and their relationships outside of services... enabling people out there to

³ See for example, 'NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (15 April 2004) LOCAL DELIVERY WITHIN A NATIONAL FRAMEWORK: THE NIMHE MODEL'.(pg 2)

assert their rights as a citizen. Your first job as a Government Funded Improvement Agency is to foster discontent with public services...we have got to get them to be the people who challenge rather than us going and telling them it is wrong'.

CSIP Senior Manager

Expertise

There were again two camps; those who see CSIP itself as a vessel of expertise and those who identify expertise as lying outside of CSIP:

'Service Improvement is about identifying the needs that services have outside of themselves to be able to deliver and know what their limitations are and how by providing them with additional resources which are not cash resources, but expert resources... And you need to be able to identify the gap between what they can do by themselves and what they can do with your help'.

CSIP Senior Manager

'The experts are out there let them get on with it... the risk is that we start to meddle through CSIP, I mean there may be good reasons why people attempt to, they're about giving commitments to ministers and all '.

CSIP Senior Manager

'Our job is to make sure that services work better to provide decent support for people so they can have better lives ... I struggle with the concept of service improvement because the implication is that there is something wrong and you're going to tell someone how to do it... I see my job as working with people to help them think about what's working and what's not working for them'.

CSIP Senior Manager

Evidence based practice versus tacit understandings of what works

In seeking to explain the method of working behind CSIP's approach to service improvement and better lives, two opposing paradigms were evident. One sits on the side of evidence based knowledge or practice and one which is more intuitive and tacit, being rooted in either the theories of management or empowerment:

'I see my job as making sure that everything CSIP does is based on best evidence'.

CSIP Senior Manager

'We have a wide range of tools and toolkits in terms of methodology to use to support change, and I think they are underpinning and fundamental to the way in which we deliver improvement'

CSIP Senior Manager

(Empowerment) 'I'm slightly skeptical of going and saying we're going to do process mapping today... that's not how I work personally in my job... I see my job as going in... facilitating conversations alongside people... about how things are working and then coming to a shared agreement about what needs to happen'

CSIP Senior Manager

*[Management] 'It doesn't really matter what theory of change you've got, its about getting people out there... [PCT's/local authorities] used to growl at each other... we had to choreograph them getting together, we had to give them policies they had to implement... it was getting them together to talk ... **It's just basic management** (researchers' emphasis) and partnership working and commitment to get on with it that gets us there... There's no substitute for getting people in a room and saying this the problem, here's the money, get it sorted and let them come up with it, rather than be too precious about theories of change and methods or whatever...'*

CSIP Senior manager

Because there were different understandings on operational aspects of service improvement, this led to disagreements about how CSIP's work should be assessed and evaluated:

'Well that's where I think we are weak. I don't think we do enough measurement, we shouldn't be doing anything we can't measure if we can't measure the outcome and improvement, and that's where I think we need to be sharper over the next year'

CSIP Senior manager

[Empowerment] 'A lot of what we do is softer and requires I think different methods more qualitative, more interpretive, less normative... what did the client think? Did the client get a good deal as well as did we make a difference and I think this is an area where in terms of evaluation we need to get more into...'

CSIP Senior manager

[Management] 'We'd performance manage that on the basis of outcomes...'

CSIP Senior manager

Assessment of Implications: If the implications of the innovation (including its knock-on effects) are fully assessed, anticipated and catered for, the innovation is more likely to be assimilated (Greenhalgh et al., 2004).

It was felt that the implications of the merger had not been fully assessed or thought through. Some senior managers saw the development of CSIP as paying homage to the NIMHE way of working:

'[CSIP reflects the] desire to develop the NIMHE model beyond mental health... Well I think NIMHE was the only sort of organisation that was regionally based and provided what I would describe as a bridge between government policy and local implementation of that policy. I think it stemmed from a desire around moving away from writing more policy to actually saying well shouldn't we be supporting people to actually implement this policy, see how we have done and get some results back'

CSIP Senior Manager

Others took a different view:

'The overwhelming [challenge] was that NIMHE was bigger than anything else and so was very dominant. And I think there was a lot of concern of the dominance of mental health and well weren't we just bringing in a few other people and badging things that had previously been NIMHE, badging them as CSIP... without going back to the drawing board and thinking them through.'

CSIP Senior Manager

The disproportionate size of one of the component organisations compared to others thus led to a number of issues and anxieties. Smaller organisations were felt at risk of marginalisation. The larger organisation feared the loss or draining away of its budget to the others. One respondent said that the quality of leadership in the constituent organisations was very variable.

Human Resources: In particular, job changes should be few and clear, appropriate training and support should be given... (Greenhalgh et al., 2004).

A further problem was that staff were not clear as to what the implications of CSIP were for their 'job content'. With a primary role in service improvement, CSIP was often understood as a bridge between the

Department of Health and the front line and also a bridge between different government departments:

'Our job is to support the implementation of national policy for local benefit, so we are the sense makers, the translators, the interpreters, whatever, but we are working on that bridge between local and central to try to make sense of things and trying to support implementation... What we provide for them [the centre] is a means of applying policy and applying it to practice or the phase I would use, implementing national policy for local benefit... You could argue it's not so much local /national, it's local/ regional and national'

CSIP Senior Manager

'We don't write policy, we help develop it, we advise'

CSIP Senior Manager

Some of those interviewed reported that the actual relationship between CSIP staff and 'policy people' in government was 'difficult to characterise'. This relationship seemed to be critical, but poorly understood, or differently interpreted in different places. There were also uncertainties as to where CSIP's loyalties should lie:

'How do you achieve an effective balance between implementing national policy and supporting local needs? Some people find they have got pressure both ways so they still have national stuff to do but now they have been asked to be a part of this development centre and that's more stuff they want me to do... how much do you give local stakeholders, how much do you give the centre?'

CSIP Senior Manager

A further area of uncertainty was around work on cross cutting issues. This was frequently assumed to be synonymous with working on specific issues such as social inclusion, well being, workforce, ethnicity/diversity and commissioning:

'At the moment a lot of the issues we deal with are whole government issues, we have approached them mainly from the health perspective or social care perspective but when we look at issues like wellbeing and inclusion well shouldn't we be working with different departments... The big idea is to have a development function that spans government departments and concentrates on broad policy issues'

CSIP Senior Manager

'We are in a process of migration, migrating from a collection of not exactly stand alone but stand alone-ish programmes to programmes'

which now have clear high level common objectives... If you look at our cross cutting priorities – workforce, commissioning, diversity they are all very alive to the words inside the white paper

CSIP Senior Manager

Only one senior manager interpreted the rationale for CSIP explicitly at the level of changing job content – that is shifting the locus of competency and creating a more generic style of working around service improvement:

'People tend to see themselves as experts in the field of mental health, older people etc, whereas CSIP is asking that people see themselves in terms of a different expertise... but people are finding it hard to put a finger on exactly what that expertise is...'

CSIP Senior Manager

It was acknowledged that if a person sees him or herself as a 'mental health person' or a 'learning disabilities person' then they might want to continue to pursue that expertise rather than another. A particular concern for one interviewee was that this shift had not been supported by a clear strategy for developing together:

'At the moment [CSIP] is heavily reliant on people coming in with a bunch of skills... There are one or two exceptions to that but there is no clear strategy for developing staff within CSIP. [You would expect to see] staff who are training and developing together on the underlying skills, then you would start to see the formation of an organisation and the ability to cross cut... That has not happened ...I don't see any real attempt to develop a central development resource so I would therefore predict that you will see varied ability in delivery... Potentially this could be one of the major factors in CSIP's demise'.

CSIP Senior Manager

Organisational structure: Structures and processes that support devolved decision making in the organisation (for example, strategic decision making devolved to departments, operational decision making devolved to teams on the ground) will enhance the success of implementation and the chances of sustainability (Greenhalgh et al., 2004).

A significant tension was reported between the national programmes and administration and the local programmes and administration. It was considered that programme integration worked better at the local level. Local programmes seemed to be working well, whereas a number of respondents were not happy about the central direction and leadership, some feeling that there was a lack of vision and direction, and that an opportunity had been missed to make a bigger splash, so to speak. Central 'drive' has been missing according to some respondents, or as one person put it, 'the total is less than the sum of the parts'. The mission statement was described as more 'admirable than memorable' by another. This picture was summed up by one respondent as 'quiet disorganisation'.

Consequences: These may be intended or unanticipated, more or less desirable and may have knock-on effect in other parts of the system (Greenhalgh, *et al.* 2004).

Most interviewees were frustrated by the slow pace of CSIP's development but did feel that they had gained something positive in the process:

'You always get some sort of forming and storming and all that kind of stuff when you put organisations together but it just feels like its taking so long really to get over some that... There's palpable frustration... I've felt it over the last year and so have lots of regional directors.'

CSIP Senior Manager

'I think people have benefited... it's bit like some people have got access to some different languages such as French and Spanish but some people have just got English. So I can now say I am more effective by being able to speak more languages – I have got more methods. I have got more tools'

CSIP Senior Manager

However, because change was slow to happen and integration had not been fully achieved in the first year of operation, outcomes relating specifically to CSIP were difficult to locate and the impact outside of policy influence was not clear:

'Supporting the green paper consultation which was logistically challenging gave people a vehicle to start thinking what CSIP could

be... Our successes have been putting the development centres' structures in place so that we are actually CSIP, and not NIMHE with a CSIP overcoat... We are beginning to create a different value base and a different culture in as much as people are now looking at the development centres and CSIP being a result of a range of programmes rather than one programme being dominant'

CSIP Senior Manager

'I can't give you an example of where CSIP has brought the programmes together... It hasn't done anything significant that I can produce'

CSIP Senior Manager

'Few [achievements] on the ground... But we are maybe seeing more lateral movement of ideas and methods'

CSIP Senior Manager

4: Conclusion

This section of the report summarises findings from Phase One of the evaluation of the Care Services Improvement Partnership (CSIP). During the writing of this report, it was announced by the Department of Health that CSIP's future was under formal review and that 2007 would be a transition year for CSIP. This provides an opportunity for the findings of the evaluation and the present report to contribute to this process.

However, we should like to begin by acknowledging the limitations of our own perspective given the changes to the direction of our work. The evaluation was carried out against a backdrop of turbulence and high level political interest. This presented substantial challenges in implementing an evaluation of CSIP as a whole. The evaluation was designed as a three year project but revised to constitute two phases at the end of year one owing to uncertainty around the future of CSIP. Our work on Phase One was restricted to: a documentary analysis of business plans and corporate documents; observations and participation in a number of meetings; a pilot survey; and in-depth qualitative interviews with managers working at director level within CSIP (n=21). The data was analysed using Greenhalgh *et al.*'s (2004) framework for understanding successful innovation and change in health care. This is an evidence based approach drawing in over 6000 literature abstracts, 1,200 full text articles and over 100 books.

The primary purpose of the evaluation was (Aim 1) to investigate progress in the development of CSIP in terms of its achievement of its Business Plan and to identify the factors inhibiting or facilitating its implementation. There was also concern (Aim 2) to assess the effect of CSIP's development on the operation of the constituent work programmes (focusing on strategy, culture, work environment and job content). Key themes were the extent of cooperation between the programmes and the manifestation of this in terms of work which was 'cross cutting'. There was also interest in what action was being taken, if any, to manage successfully the challenging aspects of the development of CSIP.

4: 1 Does CSIP work as a concept?

CSIP's primary purpose was to bring together a diverse range of programmes with the intention that they should work together on cross cutting themes, escaping the traditional 'silos' structured around the different client groups. In the original business plan for 2005/6, it was recognised that CSIP should honour the existing commitments from the constituent teams but that in future work should be more generic and based on the inter-connections of needs and services. The implication was that

over time as CSIP developed its corporate identity then the old identities of the individual constituent teams would fade away. According to Greenhalgh et al., (2004, p21):

'The knowledge that underpins the adoption, dissemination and implementation of an innovation within an organisation is not objective or given. Rather it is socially constructed, frequently contested and must be continually negotiated between members of the organisation or system'

In the accounts of CSIP's senior managers there was a great deal of uncertainty as to how to translate this **strategy** into everyday practice and the lack of involvement in the initial development phase of CSIP was clearly a problem. Most managers assumed this to mean a concentration of work around specific cross cutting themes such as 'workforce', 'commissioning' and 'social exclusion' which had resonance for all the client groups. More importantly, there was also a sense of shifting the locus of expertise away from that gained through working with a specific client group to a set of skills and competencies generic to all forms of service improvement work. In the rationale for CSIP, the assumption was that staff coming to CSIP from the previously independent programmes would necessarily be 'experts' in the field of generic change management and could easily move across to work in that area.

From the perspective of the senior managers, this was interpreted as quite a significant and not unproblematic change to **job content**. Some found *'it hard to put a finger on exactly what [this new generic] expertise is'* and some did not even want a career based along these lines. There was also the strongly felt view that it had taken a long time to establish the credibility of the old brands and that moves to a new corporate CSIP identity would damage that. This reflects that CSIP staff saw themselves as pioneers and innovators but that this expertise was rooted in their attachment to a particular client group. Most CSIP staff had never really thought of themselves as specifically 'change management gurus'. Furthermore, what the notion of working in silos did not capture was the sense in which each client group was also a social and political movement (the older people's movement, the disabled people's movement and so forth) and the sense in which CSIP staff were not just change agents but *'champions'* of these movements (for example, NIMHE and CAT are currently *campaigning* to raise awareness about the exclusion of older people with mental health problems from intermediate care, www.cat.org.uk – accessed 3rd April 2007).

A further problem was that the assumption of a common interest in generic service improvement overshadowed the extent of actual difference between the constituent teams. Indeed, **cooperation** and **collaborative advantage** were viewed almost solely as the opportunity to learn from one another.

However, integration also created tensions and in the **workplace** itself a sense of separateness remained. For example, some programme leads saw service user involvement as central to CSIP others saw it as peripheral given that they viewed their role as supporting professionals/practitioners and service managers. In many respects, CSIP's official literature is an expression of these unresolved differences in that the service improvement support offered to local communities is an eclectic mix of many traditions ranging from evidence based practice to basic implementation advice drawn from management science.

In negotiating a vision for CSIP, a further problem was the lack of evaluation of impact, and the different views about evaluation held through the organisation. This was an important theme in the accounts of the Senior Managers who were often frustrated not to be in a better position to prove the value of the work they had carried out under the auspices of the old constituent brands. This led to subterfuge in which managers '*talked the talk*' as regard the benefits of integrated working, but actively worked to maintain the integrity of the original 'brands':

'We have not tried to sell ourselves as CSIP but we have continued to sell ourselves as [name of programme] which is now part of CSIP... There is a strong desire by members of the team to hang on to their identities so we have taken specific action to ensure that takes place'

CSIP Senior Manager

Ultimately, the lack of clarity and belief in the CSIP concept manifested itself as resistance to change with the consequence that the process of forming the Care Services Improvement Partnership had very little impact on the activities of the individual work programmes. These proliferated (CSIP Business Plan 06/07) while work on cross cutting themes and a corporate identity for CSIP were slow to materialise. Furthermore, the fact that CSIP was seen to have struggled to manage the **challenging aspects** of its own internal change management process was a further nail in the coffin leading to adverse media speculation (*'Little known body to split'*) and, the likelihood of the demise of the CSIP concept (brand) itself.

In summary,

Factors facilitating CSIP's implementation:

- Well intentioned pragmatism and the drive and vision of a single individual
- Belief in the value of learning and sharing with colleagues

Factors inhibiting CSIP's implementation:

- Staff in the organisation strongly supported the previous way of working and there was a great deal of loyalty to the identity of the constituent teams. There was little appetite for change and the initial assessment of the implications of the innovation did not anticipate or seek to address this.
- There was a lack of devolved decision making and staff were not involved in developing a vision for CSIP, including potential changes to 'job content'
- Innovation-system fit was a problem – the differences between the constituent programmes were much greater than anticipated
- The CSIP concept was not evidenced based and there was lack of internal capacity to evaluate

4:2 Recommendations and thoughts for Phase Two

According to CSIP Senior Managers, CSIP was founded for pragmatic reasons under the banner of 'partnership' and 'integration'. However, its senior managers consistently struggled to demonstrate the applicability of such concepts to the organisation and delivery of service improvement support. It will be critically important to assess then to what extent '*regionalisation*' (which is currently being championed by CSIP) is a genuine well thought through approach. Without establishing such a clear position then the problems of implementation and sustainability described above will resurface or a great deal of expertise will be lost to the DH if there is reluctance to 'retrain' as generic service improvement specialists. A key question would be is there a groundswell of opinion among stakeholders that regionalisation is the right way to proceed. Given the strength of feeling about and support for the 'local' that we found, it may be that there will be greater success in achieving this objective. It may be important though, for the process to involve more activity and planning at the local level, rather than being managed into existence by the former national CSIP staff.

Our final recommendation is as regard the need to move swiftly with the Department of Health to an agreed purpose for the next phase of the evaluation and a revised protocol. What would seem most appropriate would be a dual focused analysis looking at the work of the regional offices as compared to the work of the (client based) individual programmes. As well as giving strategic direction to the DH, this would go some way to building the evidence base around improvement support **delivery vehicles**

and could start to assess issues from a customer and quality perspective, for example, do users (broadly defined) of improvement support prefer generic support or client specific support; do they prefer working through national networks or the hands on support provided by a change agents?

There was some evidence, not from the managers' interviews but the network meetings attended by the researchers, that the benefits of coming together had had more impact on the professionals and practitioners themselves than on services or service users. Whether the 'good' that networks or change agents achieve are real ones, which types of network activity have most impact on services and do these really reach the consumers of services are research questions that ought to be addressed. There will, of course, be multiple perspectives at work here, but it is important to try to capture them. Whether one can ever demonstrate that a particular network or change agent is a better way of achieving your goals than another method, may be beyond our research resources, but nevertheless is an important question (of cost-effectiveness ultimately).

'[Discussing how CSIP is supporting a one star council to improve overall performance] Change agents are critical friends and what they do is reflect back to you where you are... It's enormously helpful to have someone who has this level of expertise and stature. CSIP is not there to judge.'

CSIP Client Quoted in
Community Care 29th March – 4th April 2007

References

- Asthana, S, S Richardson, and J Halliday (2002) 'Partnership working in public policy provision: A framework for evaluation'. *Social Policy and Administration* 36/7: 780–795.
- Altschuler, A. and Zegans, M. (1997) Innovation and public management: Notes from the state house and city hall. In Altchuler, A. and Behn, R. (eds) *Innovation in American Government*. Washington: Brookings Institute.
- Barnes, M., Matka, E. and Sullivan, H. (2003) Evidence, understanding and complexity: evaluation in non-linear systems. *Evaluation* 9:3 263-282
- Bessant, J. (2003) *High-Involvement Management: Building and Sustaining Competitive Advantage Through Continuous Change*. Chichester: Wiley.
- Care Services Improvement Partnership (2005) Business Plan 2005/6. London: CSIP (www.csip.org.uk - Accessed April 2005).
- Care Services Improvement Partnership (2006) Business Plan 2006/7. London: CSIP (www.csip.org.uk - Accessed May 2006).
- Care Services Improvement Partnership & Social Care Institute of Excellence (2006) Partnership Agreement (www.csip.org.uk – Accessed July 2006).
- Care Services Improvement Partnership (2006) Annual Report (www.csip.org.uk – Accessed Jan 2007).
- Community Care Editorial (2007) 'Little Known Body Splits' *Community Care* 22nd-28th February.
- Das, T. K., and Bing-Sheng T (2001) Trust, control and risk in strategic alliances: an integrated framework'. *Organization Studies* 22/2:251–283.
- Dowling, B., Powell, M. and Glendinning, C. (2004) 'Conceptualising successful partnerships', *Health and Social Care in the Community* 12(4), pp. 309–317.
- Department of Health (2005) 'An Evaluation of the Care Services Improvement Partnership Call for Proposals'. London: DH.
- Department of Health (2006) 'Our Health, Our Care, Our Say'. London: DH.

- Eden, C, and Huxham, C. (2001) 'The negotiation of purpose in multi-organizational collaborative groups'. *Journal of Management Studies* 38/3: 373–391.
- Ferguson, B. and Goddard, M. (1997) The case for and against mergers. In Ferguson B., Sheldon, T. and Posnett, J. (eds) *Concentration and Choice in Healthcare*. London: Royal Society of Medicine.
- Fulop, N., Protopsaltis, G., Hutchings, A., King, A., Allen, P. Normand, C. and Walters, R. (2002) 'Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis' *British Medical Journal*, 325 246-353.
- Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) *How to Spread Good Ideas: A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation*. London: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D. (Copies available from www.sdo.lshtm.ac.uk)
- Greer, S. (2007) Come back, bowler brigade, all is forgiven. *Health Service Journal*, 8th February 18-19.
- Grimshaw, D. Vincent, S. and Willmott, H. (2002) Going privately: partnership and outsourcing in UK public services *Public Administration* 80 (3), 475–502.
- Halliday J., Asthana, S. and Richardson, S. (2005) Evaluating Partnership *The Role of Formal Assessment Tools Evaluation* 10(3): 284–30
- Hardy, C., Phillips, N. and Lawrence, T. (1998) 'Distinguishing trust and power in interorganizational relations: Forms and façades of trust' in *Trust within and between Organizations*. C. Lane and R. Bachmann (eds), 64–87. Oxford: Oxford University Press.
- Hartley, J. (2005) Innovation in Governance and Public services: past and present. *Public Money and Management*, 225(1): 27-34.
- Horn, P. (2005) *Care Services Improvement Partnership Local Delivery within a National Framework: A Proposed Model for CSIP*. London: CSIP.
- Huxham, C. (1996) 'Collaboration and collaborative advantage' in *Creating collaborative advantage*. C. Huxham (ed.), 1–18. London: Sage.
- Iles, V. and Sutherland, K. (2001) *Organisational Change: a review for health care managers, professionals and researchers*. London: National

Co-ordinating Centre for NHS Service Delivery and Organisation R & D.
(Copies available from www.sdo.lshtm.ac.uk)

Karasek, R. (1979) 'Job demands, job decision latitude and mental strain. Implications for job Redesign'. *Administrative Quarterly*, 24, 285-308.

Moos, R.H. (1994) *Work Environment Scale Manual (2nd Edition)*. California: Consulting Psychologists Press.

Maguire, Steve, N. Phillips, and Hardy, C. (2001) 'When "silence = death", keep talking: Trust, control and the discursive construction of identity in the Canadian HIV/AIDS treatment domain'. *Organization Studies* 22/2: 285–310.

Mandell, M. P., and Steelman T. A. (2003) 'Understanding what can be accomplished through interorganizational innovations: The importance of typologies, context and management strategies'. *Public Management Review* 5/2: 197–224.

Moore, M.H. (1995) '*Creating Public Value: Strategic Management in Government*'. Cambridge: Harvard University Press.

Moore, M.H., Sparrow, M. and Spelman, W. (1997) Innovation in policing: From production line to job shops. In Alchuler, A. and Behn, R. (eds) *Innovation in American Government*. Washington: Brookings Institute.

Mulgan, G. and Albury, D. (2003) *Innovations in the Public Sector*. London: Cabinet Office.

Newell, S., and Swan J (2000) 'Trust and inter-organizational networking'. *Human Relations* 53/10: 1287–1328.

Newman, J. (2001) *Modernising Governance: New Labour, Policy and Society*. London: Sage.

Powell, M. and Dowling, B. (2006) '*New Labour's partnerships: comparing conceptual models with existing forms*'. Paper presented to the ESCRC Partnership Seminar Series. Stirling: University of Stirling

Rashman, L. and Hartley, J. (2002) Leading and learning? Knowledge transfer in the Beacon Council Scheme. *Public Administration*, 80: 523-542.

Unity Sale, A. (2006) Do you know your quangos? *Community Care*, 2-8th November, 30-31.

Vangen, S, and C Huxham (2003a) 'Enacting leadership for collaborative advantage: Dilemmas of ideology and pragmatism in the activities of partnership managers'. *British Journal of Management* 14: s61–76.

Vangen, Sand C Huxham (2003b) 'Nurturing collaborative relations: Building trust in interorganizational collaboration'. *Journal of Applied Behavioural Science* 39/1: 5–31.

Williams, P. (2002) 'The competent boundary spanner'. *Public Administration* 80/1: 103–124.

APPENDIX 1: STATEMENT OF PROGRESS FOR YEAR 1.

Stage 1: Project Initiation (Nov 2005 - Jan 2006)	Notes	✓×
Produce project management framework	<i>See below</i>	✓
Appoint Research Assistant		✓
Appoint Co-coordinator		✓
Secure Ethical Approvals		✓
Establish Advisory Group		✓
Office Set-up/purchase equipment		✓
Design Project Information Leaflet		✓
Contact Sheet for Research Team		✓
Stage 2: Documentary Analysis		
Literature Review	Ongoing: It was intended that the major SDO systematic reviews of change management (Iles and Sutherland, 2001) and service improvement (Greenhalgh et al. 2004) would be updated by re-running the original searches for the non-included periods (i.e. from point of publication to 2008)	
Information Management	Ongoing monitoring of web sites, corporate literature etc,	
Stage 3 Interviews with Senior CSIP Staff		
Design Interview Schedule		✓
20 Interviews scheduled	20 Interviews Completed	✓
First Stage Analysis	Complete	✓
Agree format for the Senior Managers' Learning Sets Hold three senior manager learning sets	Format agreed and invitations sent. Delegate list drawn-up. Learning sets cancelled at the request of the DH in late Dec 2006.	×
Stage 4: Survey	The software which was established to run the survey is available at www.phpsurveyor.org/index.php The pilot survey results with a completed n of 20 is available at www.surveys.csip.org.uk/admin/statistics.php?sid=7 and is anonymous and password protected.	✓
Stage 5. 4 Case Studies & 4 Local Learning Sets	Cancelled for Year 1 at the request of the DH	×
Stage 7: Data Analysis	Completed for first round of Senior Manager Interviews	✓
Stage 8: Report Writing &		

Evaluation of the Care Services Improvement Partnership

Dissemination		
Interim Report April 2006		✓
Interim Report August 2006		✓
Interim Report October 2006		✓
Feedback report based on Senior Manager Interviews	Report produced and presentation given to CSIP Directors November 2006	✓
Next Interim Report April 2007		

APPENDIX 2: LIST OF ABBREVIATIONS

ADSS	Association of Directors of Social Services
BME	Black and Minority Ethnic
CAMHs	Child and Adolescent Mental Health Services
CAT	Change Agent Team
CfC	Change for Children
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
DCA	Department for Constitutional Affairs
DfES	Department for Education and Skills
DH	Department of Health
DRC	Disability Rights Commission
DWP	Department for Work and Pensions
GO	Government Office
HASCAS	Health and Social Care Advisory Service
HCC	Healthcare Commission
HO	Home Office
HONOS	Health of the Nation Outcome Scales
ICES	Community Equipment Services
ICN	Integrated Care Network
IDeA	Improvement and Development Agency
MHIP	Mental Health Improvement Partnership
NIHCE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NPfIT	National Programme for IT
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister
PCT	Primary Care Trust
PSA	Public Service Agreement
SCIE	Social Care Institute for Excellence
VPST	Valuing People Support Team

Courtesy of CSIP

APPENDIX 3: METHODOLOGIES INCLUDED IN CSIP'S SERVICE IMPROVEMENT DIRECTORY

Action Learning
Appreciative Inquiry
Changing Workforce Programme
Collaborative Methodology
Effective Team Working and Leadership Programme
Human Dimensions of change (including valuing team diversity)
Ladder of Citizen Participation
Lean Thinking
Managing Capacity and Demand
Raid Programme
Root cause analysis
Service Improvement Support Tool Mental Health
Six sigma
Six thinking hats
Statistical process control
Working with Groups – Honey and Mumford learning styles
Various Exercise (e.g. SWOT)
Various Ice Breakers and Energisers
Networks

APPENDIX 5: DOCUMENTARY ANALYSIS OF CSIP BUSSINESS PLANS (CONTENTS)

Overarching Business Plans

Business Plan for 2005/6: Prospectus for Change

Supporting Delivery in Care Services: CSIP's Business Plan 2006/7

Headline Management Plans 06/07

(CCE)

Workstream: CSIP Central Business Team

Workstream: CSIP Corporate Development Team

Workstream: CSIP Communications and knowledge services team

Workstream: Research and development

Workstream: Having a voice – ensuring a person focused organisation

Workstream: CSIP Primary Care Programme

2006/07 Headline Management Plans (ASC)

Workstream: CARE SERVICES EFFICIENCY DELIVERY

Workstream: *Getting to grips with the money*

Workstream: INDIVIDUAL BUDGETS PILOT PROGRAMME

Workstream: Joint Improvement Partnership for Adult Social Care

Workstream: PROMOTING SOCIAL CARE

Workstream: SELF-DIRECTED SUPPORT

Workstream: White Paper Delivery - Individual Budgets and Direct payments

(CYPF)

Workstream: CAMH

Workstream: Maternity and Paediatrics Service Re-Design Workstream (WTD)

Workstream: NSF Implementation Priorities

Workstream: CSIP Children Young People and Families – Summary HMP

Workstream: Safeguarding

Workstream: Children, Young People and Families – Workforce Development

Workstream: Child and Adolescent Mental Health (CAMH)

Workstream: Children, Young People & Families: Overview HMP

Workstream: Maternity and Paediatrics Service Re-Design Workstream

Workstream: NSF Implementation

Workstream: Safeguarding

Workstream: Workforce

(CJU)

Workstream: HSCCJP Mental Health

Workstream: HSCCJP Public Health

Workstream: HSCCJP Primary, Social Care and Vulnerable groups

Workstream: HSCCJP Service Improvement

Workstream: HSCCJP Young People & Children

(MHE)

Workstream: NIMHE Acute Inpatient Headline Management Plan Specialist Care

Workstream: Choice & Access

Workstream: Community Teams

Workstream: NIMHE Dual Diagnosis - Valuing and Supporting People with mental health and substance misuse difficulties/ Specialist Care

Workstream DELIVERING RACE EQUALITY IN MENTAL HEALTHCARE: NIMHE BME PROGRAMME Equalities

Workstream: Early Intervention (joint Rethink project)

Workstream: GENDER EQUALITY AND WOMEN'S MENTAL HEALTH

Workstream: High Impact Changes

Workstream: International Work & Partnerships/Leadership

Workstream: System Change/Improvement Partnership

Workstream: Service User and Carer Involvement in NIMHE

Workstream: System Change/Outcomes

Workstream: NIMHE/ABPI Pharmaceutical Partnership Group

Workstream Psychological Therapies

Workstream: Choice & Access

Workstream: Service Improvement/System Change

Workstream: Mental Health Improvement

Workstream: MENTAL HEALTH TRUSTS COLLABORATION PILOT PROJECT

Workstream: Values

Workstream: NIMHE/DH Victims of Violence and Abuse Prevention Programme (VVAPP)

Workstream: National Workforce Programme

(OPE)

Workstream: Developing Community Hospitals (DCH)

Workstream: Housing & Telecare LINs

Workstream: Integrated Care Network - *National Networks*

Workstream: Improving health and well being – promoting preventative approaches for older people

Workstream: National Commissioning Programme

Workstream: National Framework for Continuing NHS Care

Workstream: National Older People's Programme

Workstream: Older and Disabled People National Programme.

Workstream: Physical Disability

Workstream: Partnerships for Older People Projects

Workstream: Extending reimbursement and promotion of good practice in discharge for non-acute and mental health services

(LDI)

Workstream: SELF-ADVOCATE AND FAMILY CARER LEADERSHIP

Workstream: SELF-DIRECTED SUPPORT (incorporating In Control, Direct Payments and Person Centred Planning)

Workstream: EMPLOYMENT

Workstream: HEALTH

Workstream: LOCAL SERVICES FOR LOCAL PEOPLE

APPENDIX 6: INTERVIEW SCHEDULE FOR CSIP SENIOR MANAGERS

1) Can you tell me about the background to the development of CSIP?

- How involved were you in the initial development phase?
- Why do you think the decision was taken to merge the different programmes? What were the assumed benefits and have they materialised as yet?
- Were there any challenging aspects?
- How were these managed /resolved?
- What is CSIP?

2) What has been the impact on [insert name of programme, NIME, CAT etc,]??*

- Strategy
- Culture
- Work environment
- Job content

**(This question is only relevant if the interviewee has had prior involvement with CSIP Programmes)*

3) What is CSIP aiming to achieve?

- What is the role of an improvement agency?
- How have the different work streams/programmes been brought together?

4) How will CSIP achieve its aims?

- partnerships
- integration
- theories of change
- methods

5) How will CSIP monitor/evaluate its progress?

- What is improvement?
- What evidence do you have of improvement?
- What have been the achievements to date?

Discussion around what to focus on in the case studies

Request for permission to keep in touch even if the person moves to a new post/Agree how this will be achieved.

APPENDIX 7: SURVEY PROJECT PLAN (2ND MAY 2006)

<i>Week</i>	Activity – what and who
W/c 8 May	<p>CSIP (JA/IS): approve survey content.</p> <p>CSIP (IS), KCL (PH) approve this survey project plan</p> <p>KCL (MB), CSIP (IS): Discuss use of CSIP website for survey. Need to decide whether work to be done internally by CSIP web design staff or commissioned externally and discuss contacts/access to web-site.</p> <p>CSIP (IS): discuss use of CSIP website with CSIP web manager and what kind of support web manager can provide. And feedback to MB</p> <p>KCL (MB): Discuss issues with CSIP web manager: access to website for programming/technologies and languages/databases used at CSIP/etc</p>
W/c 15 May	<p>KCL (MB) Draft specification of requirements for IT work to develop on-line survey.</p> <p>KCL (MB) pre-code the paper version of the survey instrument for use by web designer</p> <p>CSIP (IS + web manager) KCL (PH) give comments on draft spec.</p> <p>KCL (MB) finalise spec</p> <p>KCL (MB) If commissioning external provider – identify number of potential contractors and obtain quotes/proposal for the work.</p> <p>KCL (MB/PH) Sampling of participants for inclusion in the pilot & full survey.</p>
W/c 29 May	<p>KCL (MB) Commission web designer/ make arrangements with CSIP to do internally</p> <p>Web designer: design and setting up work begins.</p>
W/c 5 June	<p>Web designer: Design and setting up work ongoing.</p> <p>CSIP web manager: provides support to contractor on technical issues</p>

Evaluation of the Care Services Improvement Partnership

	<p>KCL (MB) Preparation of materials for mail out to CSIP staff</p> <p>KCL (MB) recruitment of opportunity sample for pre-test</p>
W/c 12 June	<p>KCL (MB) Pre-testing the survey. How long take, ensure it all works. MB writes brief report on issues arising for web designer</p>
W/c 19 June	<p>Web designer: Revisions to web-site if necessary</p> <p>KCL (MB) prepares materials for pilot mail out</p>
W/c 26 June	<p>KCL (MB) Pilot survey with random sample of 30 staff from the list of CSIP staff and write brief report on issues arising. What response rate, how are people responding to being asked if we can follow up next year.</p>
W/c 3 July	<p>Web designer: Revisions to web-site if necessary</p>
W/c 10 July	<p>KCL MB: Initial email to survey sample</p>
W/c 17 July	<p>Web designer or manager: Close of play Friday 21 July extraction of dataset from CSIP and sent electronically to KCL.</p>
W/c 24 July	<p>KCL (MB) produce list of non-respondents and prepare and send reminder email to those that have NOT responded</p>
W/c 7 August	<p>Survey ends</p> <p>Web designer or CSIP web manager: data extraction and database send electronically to KCL.</p> <p>KCL Analysis begins</p>
August/Sept	<p>KCL Analysis</p>
Oct	<p>KCL Writing report</p>
November	<p>KCL preliminary report</p>

APPENDIX 8: A FRAMEWORK FOR THE SPREAD AND SUSTAINABILITY OF INNOVATION IN SERVICE DELIVERY – INNER CONTEXT.

<i>SYSTEM ANTICEDENT & SYSTEM READINESS...</i>
Structure of the organisation; Capacity to absorb new knowledge; receptive context for change
<p>Tension for change If staff in the organisation perceive that the present situation is intolerable, a potential innovation is more likely to be implemented successfully.</p>
<p>Innovation-system fit An innovation that fits with the existing values, norms, strategies, goals, skill mix, supporting technologies and ways of working of the organisation is more likely to be assimilated and implemented successfully.</p>
<p>Assessment of implications If the implications of the innovation (including its knock-on effects) are fully assessed, anticipated and catered for, the innovation is more likely to be assimilated. In particular, job changes should be few and clear, appropriate training and support should be given, and relevant documentation and augmentation (such as a helpdesk) provided for technologies.</p>
<p>Support and advocacy If supporters of the innovation outnumber, and are more strategically placed, than opponents, it is more likely to be assimilated and successfully implemented (strong indirect and moderate direct evidence) - see also 'Champions', under 'Communication and influence', above.</p>
<p>Dedicated time and resources If the innovation has a 'budget line' and if resource allocation is both adequate and recurrent, it is more likely to be assimilated.</p>
<p>Capacity to evaluate the innovation If the organisation has tight systems and appropriate skills in place to monitor and evaluate the impact of the innovation, that innovation is more likely to be assimilated and sustained (strong indirect and moderate direct evidence). In particular, measures must be in place to capture and respond to the different consequences of the innovation:</p> <ul style="list-style-type: none"> - those that are intended and predicted - those that are unintended and predicted - those that are unintended and unpredicted ('knock-on'). <p>Rapid, tight feedback enhances the organisation's ability to respond to the impact of these consequences</p>
<i>IMPLEMENTATION & SUSTAINABILITY...</i>
<p>Staff involvement and commitment Early and widespread involvement of staff at all levels and, in particular, top management support and advocacy of the implementation process enhance the success of implementation (strong indirect and moderate direct evidence). See also 'Champions', under 'Communication and</p>

influence', above, for a description of the different types of organisational champions.
Human resources Successful implementation of an innovation in an organisation depends on the motivation, capacity and competence of individual practitioners (strong direct evidence). Appropriate training enhances the chance of effective implementation and of sustainability.
Organisational structure Structures and processes that support devolved decision making in the organisation (for example, strategic decision making devolved to departments, operational decision making devolved to teams on the ground) will enhance the success of implementation and the chances of sustainability.
Intra-organisational networks Effective communication across internal structural (for example, departmental) boundaries within the organisation enhances the success of implementation and the chances of sustainability (moderate direct evidence). An explicitly narrative approach to intra-organisational networking - that is, the purposive construction of a shared and emergent organisational story - can serve as a powerful cue to action (limited direct evidence).
Extra-organisational networks The greater the complexity of the implementation needed for a particular innovation, the greater the significance of the inter-organisational network to implementation success.
CONSEQUENCES... may be intended or unanticipated, more or less desirable and may have knock-on effect in other parts of the system

Greenhalgh et al. 2004