**ANGLIA RUSKIN UNIVERSITY**

**FACULTY OF HEALTH, EDUCATION, MEDICINE AND SOCIAL CARE**

# THE POTENTIAL OF NEW KNOWLEDGE FOR PUBLIC MENTAL HEALTHCARE ORGANISATIONS: THE CASE OF ABSORPTIVE CAPACITY IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

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For the last four years I have endeavoured to develop a body of work that could make a contribution to research, and would enrich my own knowledge. The PhD became an opportunity to study, listen and learn, not only from books and journals, but also from individuals around me. Advancing one's knowledge, however, does not only mean increasing knowledge quantitatively, but also being able to renegotiate who one is, restructure one's values and understand more dimensions of the social world. Four years is only a tiny amount of time to explore existing knowledge. Yet, this period became an opportunity for me to make a start in learning and to discover more about myself. Part of the journey was the people I met in my academic and personal environment.

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**ANGLIA RUSKIN UNIVERSITY**

**ABSTRACT**

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**DOCTOR OF PHILOSOPHY**

# THE POTENTIAL OF NEW KNOWLEDGE FOR PUBLIC MENTAL HEALTHCARE ORGANISATIONS: THE CASE OF ABSORPTIVE CAPACITY IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

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The purpose of this study is to investigate the potential of absorptive capacity in Child and Adolescent Mental Health Services (CAMHS). Absorptive capacity is an organisation's ability to identify new external knowledge, assimilate it and use it for improving its performance. The construct has recently been studied in the public sector and findings showed that it can offer useful insights for advancing service provision; yet, evidence remains limited. CAMHS are called to respond to different knowledge areas in order to improve service quality and tackle service fragmentation, while they are among the most challenged health services due to low funding. Improving CAMHS can increase the chances for a healthier adult life, as most mental health conditions begin to develop at young ages. Studying the absorptive capacity of CAMHS could contribute to cultivating their responsiveness to new knowledge and, thus, the quality of provided services. A case study design was developed involving one NHS mental health organisation. Data collected from semi-structured interviews and organisational documents were analysed to identify processes of knowledge identification, assimilation and exploitation. Interviews were also conducted with staff members of local organisations involved in CAMH service provision to understand the role of the external environment in shaping the absorptive capacity of the CAMHS department.

The findings demonstrated that knowledge sourced by certain public organisations, such as NHS management and regulatory bodies, is often prioritised within the CAMHS department due to the commitment of the case study organisation to utilise knowledge from such organisations. Those dependency relationships limit the ability of the department to identify and utilise new knowledge from other sources, such as knowledge from the local external environment, which is valuable for improving service provision. The heterogeneous character of the local environment appeared to further restrain the identification of valuable knowledge, as well as knowledge exchange for the development of joint services. Finally, findings stressed the role of individuals in shaping the department's absorptive capacity. Absorptive capacity could be as a useful organisational construct which could assist CAMHS in improving their responsiveness to new and diverse knowledge – an ability that is valuable to transforming the mental health services provided to children and young people.

**Key words:** *Absorptive Capacity, Child and Adolescent Mental Health Services (CAMHS), Public (Mental) Healthcare Organisation; Mental Health Trust, Healthcare Organisation*

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## Introduction

The knowledge existing in the external environment has been singled out as valuable for private and public organisations, as it can contribute to improving an organisation's outcomes (Rashman et al., 2009; Van Wijk et al, 2011). The need to cultivate an organisation's skills so that it can acquire and utilise new external knowledge has led to the development of absorptive capacity (Van Den Bosch et al., 2003). Absorptive capacity is defined as an organisation's ability to identify, assimilate and exploit new valuable knowledge with the aim to improve its performance (Cohen and Levinthal, 1990). The construct suggests that the utilisation of new knowledge can advance a firm's organisational processes, products and services (Zahra and George, 2002; Lane et al., 2006). Absorptive capacity has been extensively researched in the private sector, due to its potential to improve the performance and competitive advantage of firms (Lane et al., 2006). The positive impact which absorptive capacity can have on an organisation's performance has recently led scholars to explore the transferability and usefulness of absorptive capacity theories to the public sector (Harvey et al., 2010b; Ferlie et al., 2015).

Studying absorptive capacity in public organisations could be attributed to the wider shift within the public sector to adopt management practices that can improve the effectiveness and quality of public services (Hyndman and Lapsley, 2016). Evidence showed that absorptive capacity can be a useful approach, as it can increase insight into the learning abilities of public organisations (Spencer et al., 2007). Yet, scholars argued that adopting private sector theories in public sector research should not happen uncritically (Easterby-Smith et al., 2008a; Rashman et al., 2009). The public sector presented characteristics that can be distinctly different from the private sector, e.g. the role of professional groups or the relationships with the external environment. Future studies should take into consideration attributes of the public sector and the impact which such characteristics may have on transferring new theories to public sector management (Easterby-Smith et al., 2008a; Rashman et al., 2009).

In health service research, the relationship between knowledge and service provision has been extensively examined and assessed, primarily due to the "second research gap", i.e. the transfer of research evidence to clinical practice (Ferlie et al., 2012). A number of knowledge mobilisation approaches have been developed, influenced by management theories of the private sector, such as

knowledge transfer, knowledge translation or knowledge brokering (Crilly et al., 2010; Burgess and Currie 2013; Davies et al., 2015). In spite of the rich research evidence regarding the potential of utilising new knowledge in healthcare settings at a micro-level, scholars argue that more research should be conducted at an organisational and network level (Ferlie et al., 2015). Scholars suggest that absorptive capacity can offer new and useful insights into the learning competences of healthcare organisations and the ways organisations can embed new knowledge into their practices (Oborn et al., 2012). Nonetheless, additional research is necessary to understand the organisational processes that make up absorptive capacity, as well as the factors that may have an impact on the development of the construct in public healthcare environments (Harvey et al., 2010a).

The central goal of this thesis is to contribute to the understanding of the potential of absorptive capacity for public mental healthcare organisations. To address this goal, the study focused on Child and Adolescent Mental Health Services (CAMHS). Selecting those services as the main focus of this thesis was based on the significance of mental health support for children and young people. Evidence demonstrated that approximately 75% of mental health conditions appear for the first time by the age of 25, while around 25% will have already shown first signs by 12 years of age (McGorry, 2013). Hence, ensuring access to quality and effective mental healthcare care allows CAMHS to address mental health challenges in a timely manner and increases the chances of children and young people being able to have a healthier adulthood (McGorry et al., 2013; Fonagy and Pugh, 2017). Despite the broad acknowledgement of the importance of young people's mental health, services continue to face major challenges in the UK, such as fragmentation among service providers, long waiting lists, difficulties in accessing appropriate therapies and scarcity of financial resources (Children's Commissioner, 2018).

Healthcare policies have emphasised the need to improve CAMHS and published directions with the aim of improving the effectiveness and quality of provided services. Successive governments have increased pressure on mental healthcare organisations to intensify the use of evidence-based practices in service provision, enable timely access, upskill the CAMHS workforce, and utilise service data in order to increase understanding of users' needs (NHS England, 2015b; National Health Service, 2019). Additionally, the mental health and wellbeing of children and young people has been increasingly recognised as a shared responsibility among physical, mental and social care and education. To address existing service demand, CAMHS are expected to collaborate with local organisations and develop joint models of care

that provide services tailored to the needs of young users (NHS England, 2015a; Wolpert et al., 2016). Although many of those areas of improvement are acknowledged as valuable recommendations for advancing the quality of service provision, implementation has proved to be challenging for CAMHS due to the limited funding allocated by the government (Frith, 2016). Overall, CAMHS are called to respond to different knowledge areas and develop sustainable relationships with other organisations, but their capacity is limited. Studying the absorptive capacity of CAMHS can contribute to understanding the ways in which services can systemise the use of valuable knowledge from their external environment.

The thesis is organised into six chapters. Chapter 1 focuses on reviewing literature around absorptive capacity and specifically the main components and key antecedents that drive its development (for examples see Cohen and Levinthal, 1990; Zahra and George, 2002). Additionally, transferring absorptive capacity to the public sector led to briefly reviewing the potential of new knowledge for public organisations, as well as characteristics that could possibly influence the conceptual transfer of the construct to public sector environments (Willem and Buelens, 2007). Finally, approaches around the mobilisation of knowledge are also presented in a nutshell, with the aim of providing insight into the utilisation of new knowledge in healthcare (Crilly et al., 2010; Davies et al., 2015). The purpose of this Chapter 1 is to build a theoretical foundation that assists in exploring the absorptive capacity of CAMHS.

Existing studies suggested that absorptive capacity can be affected by the organisational context (Van Den Bosch et al., 2003; Martinkenaite and Breunig, 2016). Chapter 2 examines the organisational context and inter-organisational environment of CAMHS with the aim of understanding the structure of the services and the factors that may have influenced their development across time. The chapter draws together healthcare and mental healthcare policies that have had an impact on the development of CAMHS until today and summarises the challenges that services still encounter (Parkin et al., 2019). The aim of said chapter is to provide context-specific knowledge and contribute to understanding whether CAMHS could benefit from investing in their absorptive capacity.

To address the main goal of the thesis, the study was developed based on two main research questions. The first research question focused on exploring the ways in which CAMHS identify, assimilate and exploit new external knowledge. The second

research question addressed the role of the inter-organisational environment in shaping the ability of CAMHS to identify, assimilate and exploit new valuable knowledge. Chapter 3 presents the methodology followed to investigate the research questions. An embedded case study research design was developed to explore the phenomenon of absorptive capacity in a new organisational setting (Thomas, 2011; Yin, 2013). The case study organisation was a NHS Mental Health Trust, with a specific focus on the CAMHS department. Document analysis and semi-structured interviews were used to collect data with regard to absorptive capacity. Content analysis was employed to identify textual meanings from organisational documents (Elo and Kyngäs, 2007). Thematic analysis of semi-structured interviews was conducted with the aim of developing meaningful themes in relation to absorptive capacity (Braun and Clarke, 2006). Weak social constructionism was used to inform the researcher's epistemological and ontological viewpoint on data analysis and interpretation (Searle, 1995).

Data findings are presented in two chapters based on the research questions. Chapter 4 presents the study's outcomes in relation to the role of the inter-organisational environment in shaping the absorptive capacity of the CAMHS department, by synthesising data from the two groups of staff members (case study organisation and local environment), as well as data from document analysis. Study outcomes contributed to interpreting the relationship between CAMHS and the national and local inter-organisational environment. Chapter 5 presents the main themes that were generated with regard to the absorptive capacity of the CAMHS department. Study outcomes in this chapter focused on factors that appear to influence each of the main components of absorptive capacity, as well as factors that can have an impact on the department's overall absorptive capacity. Finally, Chapter 6 discusses the study outcomes from the data analysis and explains how the two research questions have been answered.

My decision to study the absorptive capacity of child and adolescent mental health services was influenced by my professional experience, as well as by personal circumstances that helped me to understand the importance of improving mental healthcare. Specifically, my working experience in organisations focusing on human rights, mental health and humanitarian aid gave me the opportunity to understand how public and non-profit organisations operate, as well as the challenges that they may encounter. Through this experience, I also noticed that although such organisations are often staffed with specialised professionals in subject matter issues, fewer resources are invested in management that could enable meeting

organisational goals, such as introducing new and effective work practices, improve quality of service outcomes or investing in developing sustainable partnerships. As a result, I gradually became interested in understanding the ways public and non-profit organisations can invest in organisational learning and, consequently, improve their services.

My professional interest in mental health developed through my experience in a Dutch mental health organisations where I worked on projects focusing on mental health, including the psychosexual development of young people with autism, young people's transition to adulthood or the home support of young people with severe mental conditions. This experience increased my insight on the importance of mental health, particularly for young people. During the same time period, social and economic circumstances further increased my interest in mental health. The European financial crisis was deepening, leading several European governments to introduce austerity measures that had a major impact on the people's quality of life. My home country, Greece, was one of the countries that was most affected, with rapid increases in unemployment having a negative impact on individuals' mental health (Drydakis, 2015). The impact of the financial crisis became also evident in my own social environment, increasing anxiety and uncertainty about the future, particularly in younger people. Together with my professional experience, this further increased my interest in mental health and the importance of effective service provision and led to the development of the topic of present thesis.

I have reflected on the choices made throughout the development of this thesis and also considered possible biases. Reflexivity assisted in understanding the role of the researcher as part of the study and identifying any potential biases (Patnaik, 2013. Probst, 2015). Specifically, I considered the contribution of Chapters 1 and 2 in data analysis and discussion. The first two chapters focused on reviewing existing literature on absorptive capacity, the policies that contributed to the formulation of CAMHS to the present day and the main challenges services still encounter. Although the two chapters aimed to define the theoretical framework of the thesis, I kept in mind that knowledge obtained throughout the development of those chapters should not exclusively drive data analysis and collection, but should allow the identification of new findings that could contribute to theory development. For example, the role of individuals in an organisation's absorptive capacity has not been extensively studied. Yet, individuals' absorptive capacity was identified in the analysis as a factor that influences absorptive capacity at an organisational level. Similarly, recent reports around CAMHS provision presented in Chapter 2 highlight

key challenges around service quality and accessibility of CAMHS. Next to existing challenges, findings of the present thesis also identified existing good and effective practices that CAMHS have in place to enable the provision of quality services. Therefore, the theoretical background presented in Chapters 1 and 2 guided the development of the study, whilst it did not obstruct the generation of new and unexpected findings that contributed to developing theory around absorptive capacity in public healthcare organisations.

Reflexivity also helped me to understand the role of the researcher during the process of data collection. During the recruiting process, I used my local professional network to liaise with local service providers, which evolved when I participated in a research project run by a local charity. This helped me to approach potential study participants and connect with other local charities. I also searched online to see which local organisations were providing mental health support to children and young people locally, to ensure I approached organisations that are relevant to my study. During the interview process, I considered that participants may be self-conscious about sharing their views and experiences, due to confidentiality and the importance of the organisation's public image. This might have limited study participants' willingness to share their views. To address this barrier, I was able to demonstrate my interest in participants' experience, and avoided a critical approach or giving the impression I was testing their knowledge. Similarly, I realised that participants' reluctance to share their opinions could influence the way that I asked questions and could make me hesitate to ask about all the topics of interest. That was particularly the case with senior staff members who had a leading role in the case study organisation. The interview guide playing a significant role in navigating the interview and helped ensure that all topics were discussed.

Possible biases were also considered during the analysis of qualitative data. In relation to data from semi-structured interviews, I noticed that participants' views are articulated in both strong and subtle ways. Yet, useful findings can be identified in both implicit and explicit textual data in thematic analysis. I took this into account during the analysis process. Careful consideration of the meanings of textual data allowed me to minimise potential biases towards stronger statements and ensure that all the qualitative data received sufficient attention (please see Section 3.6.3 for more details). Possible biases were also considered in the analysis of organisational documents. Documents included in the analysis were mostly public documents. I also requested internal organisational documents, believing such documents could

potentially provide a greater level of detail in relation to internal processes associated with absorptive capacity. Yet, access was only given to one internal document. As a result, documents included in the analysis concerned a range of publically available policies and procedures, while a limited access was allowed to internal organisational documents. Given the nature of the public documents, I acknowledge that the processes identified as influential to the department's absorptive capacity represented mostly formal policies and documents provided limited insight about the degree to which processes where implemented in practice. I addressed this by combining findings from document analysis and findings from interviews to provide a greater level of detail and a richer picture around the implementation of policies and procedures in practice.

Overall, the main contribution of this thesis is to provide new evidence about the potential of absorptive capacity in CAMHS and the ways it can advance the learning abilities of those services. At a theoretical level, the findings of this study contribute to the absorptive capacity literature by adding new insights about its potential for the public healthcare sector – an area that remains under-researched. Moreover, findings explain the role of the inter-organisational environment, i.e. national or local organisations involved in service provision, which appeared to have a major influence on the absorptive capacity of a public mental healthcare organisation. My study also provides evidence about the knowledge which exists within CAMHS, as well as the role played by individuals in shaping organisational absorptive capacity.

Furthermore, the findings shed light on the ways in which the structure of the NHS system impacts the development of organisational learning skills, as well as the knowledge the case study organisation utilises in managing service provision. The study provides insight into the influence of organisational boundaries among local organisations on the development of integrated services, where CAMHS are key service providers. At a practice level, findings can be used to advise CAMHS and the case study Mental Health Trust with regard to their strategies for learning from the external environment. The study outcomes can be utilised to improve each component of absorptive capacity and contribute to the CAMHS' partnerships strategy with the local inter-organisational environment. Finally, the study provides a comprehensive description of the case study environment, which allows NHS managers from other mental healthcare organisations to consider the transferability of findings to more CAMHS settings.

The thesis sets the pillars for examining the potential of absorptive capacity in mental healthcare organisations. Considering the time framework for completing a PhD thesis, the project encountered several limitations. Research on absorptive capacity was combined with public organisations' literature and research on knowledge mobilisation in healthcare environments. Considering that all three theoretical fields have been widely studied, the current thesis reviewed only a small part of the existing literature, aiming to develop a comprehensive picture about the transfer of absorptive capacity in a public healthcare organisation. Furthermore, the study design included a representative number of local organisations, reflecting the diversity of the local environment. Yet, participation was also determined by the capacity of local organisations, as well as the time limitation of the thesis. Finally, the case study research design made it possible to construct a rich description of the selected organisation. Yet, organisational settings in different Mental Health Trusts can present variation, and this should be taken into consideration when transferring the findings of the present study to new environments. The study of the absorptive capacity in CAMHS was conducted by taking into consideration the identified limitations. The next chapter presents a literature review on absorptive capacity in public mental healthcare organisations.

## Chapter 1

## The potential of absorptive capacity for public mental healthcare organisations

Extensive research in the private sector has shown that the ability of an organisation to identify, assimilate and exploit new valuable knowledge from its external environment, i.e. its absorptive capacity, can improve the ability of a firm to meet its organisational goals (Cohen and Levinthal, 1990; Zahra and George, 2002). Investing in absorptive capacity can strengthen the receptiveness of an organisation to valuable new knowledge, which in turn can contribute to improving its competitive advantage and organisational performance (Cohen and Levinthal, 1990; Zahra and George, 2002). The possibilities which absorptive capacity offers in terms of improving an organisation's outcomes have led researchers to conduct studies in private, public and non-profit organisations, at local, national and international levels (for examples see Jung-Erceg et al., 2007; De Araújo Burcharth et al., 2015; Croft and Currie 2016; Martinkenaite and Breunig, 2016; Richards and Duxbury, 2014; Setti, 2016).

Public healthcare organisations are exposed to a wide spectrum of new knowledge areas, which they often struggle to incorporate into their practices (Harvey et al., 2010b; Croft and Currie, 2016). The performance of healthcare organisations is, in part, a function of an organisation's ability to learn and adjust to new knowledge (Harvey et al., 2010b). Additionally, the quality of provided services can be elevated when an organisation is able to learn and embed new knowledge in healthcare practice (Croft and Currie, 2016). Based on the idea that management theories can be valuable for improving public healthcare practice, scholars have recently introduced absorptive capacity to healthcare service research (Harvey et al., 2010b; Croft and Currie, 2016). Studies have found that absorptive capacity can suggest new insights into the exploitation of new knowledge at an organisational level in public healthcare organisations. Yet, it is proposed that further research is needed to identify the conceptual adjustments that may be necessary when transferring absorptive capacity theory to the public healthcare sector and identifying the ways in which absorptive capacity can enhance the ability of healthcare organisations to exploit new knowledge (Oborn et al., 2013; Ferlie et al., 2015; Harvey and Kitson, 2015).

This chapter puts forth a review of the literature regarding key conceptual and empirical studies that can contribute to investigating the absorptive capacity in public mental healthcare organisations. The literature review strategy was based on exploring studies from the following areas. Firstly, this chapter reviews seminal theories of absorptive capacity that originally introduced and analysed the main components of absorptive capacity, together with a number of works that studied the determinant factors of the construct. Secondly, the areas of organisational learning and organisational knowledge are also reviewed, providing further insight into understanding learning processes and the meaning of knowledge in an organisational context. Thirdly, since the idea of absorptive capacity has been introduced quite recently in the public healthcare sector, literature with regard to the characteristics of public organisations is included in the review, with the aim of adding insight into the nature of the public mental healthcare organisations and the ways particular organisational features may influence absorptive capacity. Finally, existing research on the use of new knowledge in healthcare organisations is also briefly reviewed.

The literature review was based on identifying academic publications in electronic databases. Relevant key worlds or combinations key words were utilised to conduct online searches for relevant academic literature in online databases (e.g. Science Direct or the online library search engine of Anglia Ruskin University). The Web of Science citation index was also used to identify academic papers relevant to absorptive capacity (please see Section 3.3 in Chapter 3 for details about the literature review strategy). Considering the large number of available academic works, literature included in the study was selected according to the objectives of the study (Jupp, 2006). To create a consistent body of literature and considering the diversity of existing literature, the review has certain limitations, which are summarised where relevant. Overall, the aim of the literature review was to create a theoretical basis that underpins this thesis and contributes to exploring the potential of absorptive capacity for Child and Adolescent Mental Health Services (CAMHS).

### 1.1. The model of Cohen and Levinthal and other contributions to absorptive capacity

Since the term “absorptive capacity” was initially proposed by Kedia and Bhagat (1988) and the first definition was published by Cohen and Levinthal (1990), the construct has been approached through numerous research lenses (Van Wijk et al., 2011). Studies conducted vary from exploring the learning ability of individuals to

investigating organisations' ability to innovate, and from improving the competitive advantage and performance of private firms to leveraging performance and improving service provision in public organisations (for examples see Deschesnes et al., 2003; Chen et al., 2009; Lev et al., 2009; Harvey et al., 2010b; Lau and Lo, 2015; Croft and Currie, 2016; Kotabe et al., 2017; Van Doorn et al., 2017). Absorptive capacity has been examined and employed by a wide range of disciplines, such as economics, strategic management, behavioural studies, organisational sociology and psychology (Cohen and Levinthal, 1990; Harvey et al., 2010a; Volberda et al., 2010; Van Wijk et al., 2011). Considering the wide research interest, Van Den Bosch and colleagues described absorptive capacity as "a potentially powerful multilevel and transdisciplinary construct" (Van Den Bosch et al., 2003, p.3).

Cohen and Levinthal (1990) gave the earliest definition of absorptive capacity and their work remains the most cited paper among studies on absorptive capacity (Van Wijk et al., 2011). Although the notion of searching and using new knowledge to improve the outcomes of an organisation existed prior to Cohen and Levinthal's influential paper, they were the first to publish a comprehensive description of absorptive capacity (Lane et al., 2006; Van Wijk et al., 2011). Their first work in 1989 was a forerunner for absorptive capacity and focused particularly on the functions of a firm's Research and Development (R&D) department. They argued that the ability of the R&D department to incorporate knowledge about technological advancements improves the overall ability of the firm to identify, absorb and exploit new knowledge (Cohen and Levinthal, 1989). Consequently, absorptive capacity does not only have a short term benefit for a firm, but also improves its long-term responsiveness to new knowledge, as well as its ability to make predictions regarding future technological developments that could be beneficial for the firm's outcomes (Cohen and Levinthal, 1994). Investing in the organisation's learning competence is cumulative in character and increases a firm's capability to evaluate external knowledge, upcoming changes and potential risks (Cohen and Levinthal, 1994; Lane et al., 2006; Harvey et al., 2010b).

In 1990, Cohen and Levinthal defined absorptive capacity as the ability of a firm to identify valuable new knowledge from external sources, assimilate it and use it to improve its "innovative performance" (Cohen and Levinthal, 1990, p.128). The ability to *identify* new knowledge, the first component of absorptive capacity, is an organisation's ability to distinguish knowledge that would be valuable for its organisational outcomes and import said knowledge into its units. Not all external

knowledge is useful for an organisation; hence, the identification of new knowledge is a critical component when it comes to filtering valuable knowledge (Todorova and Durisin, 2007). Pre-existing knowledge influences the directions towards where new knowledge will be sought – also called "path-dependence" (Cohen and Levinthal, 1990, p.135). Both the breadth and depth of existing internal knowledge can influence absorptive capacity. Specialised knowledge can facilitate communication and understanding among individuals, while diverse knowledge can create more opportunities for prior and new knowledge to be linked. Prior knowledge is largely based on individuals' absorptive capacity; for example, technical knowledge, decision-making and critical thinking about new knowledge can drive individuals' choices of said new knowledge (Cohen and Levinthal, 1990). Although absorptive capacity incorporates the capability of individuals to respond to new knowledge, the construct goes beyond the individual's level, as it includes processes that mainly take place at an organisational level (Cohen and Levinthal, 1990). Increasing an organisation's "openness" to new knowledge by establishing mechanisms for searching for new knowledge (e.g. searching for patents, conference participation, academic knowledge) and by developing collaborations with external organisations is an example of a process that can grow an organisation's ability to identify valuable knowledge (Caloghirou et al., 2004, p.29).

The identification of valuable external knowledge is followed by the *assimilation* of the newly acquired knowledge. Assimilation is the ability of an organisation to comprehend and interpret the new knowledge sourced from the external environment (Cohen and Levinthal, 1990; Lane and Lubatkin, 1998; Harvey et al., 2010b). Internal organisational processes can facilitate the assimilation of new knowledge, by sharing it within the organisation and connecting it with the existing knowledge base. Knowledge assimilation can be enabled by internal policies or the utilisation of a commonly-understood language among staff members (Cohen and Levinthal, 1990; Szulanski, 1996). Lewin and colleagues suggested examples of internal routines that can enable knowledge assimilation, such as learning from successful or unsuccessful examples of practice, encouraging informal interactions, utilising IT management systems, and knowledge sharing from central management towards the rest of the organisation (Lewin et al., 2010). The interaction among different professional functions and job rotation – also called an organisation's coordination capabilities, can also enable knowledge assimilation (Jansen et al., 2005). Such practices allow knowledge transfer among the organisation's units (Jansen et al., 2005; Szulanski, 1996; Todorova and Durisin, 2007). The knowledge

placed now within the organisation can be used to change existing processes and influence organisational outcomes (Lane and Lubatkin, 1998).

The final component of absorptive capacity in Cohen and Levinthal's model is the ability of an organisation to *exploit* new knowledge by modifying existing processes in accordance with the newly-assimilated knowledge (Cohen and Levinthal, 1990). New knowledge can be utilised to transform existing processes and improve organisational outcomes (Zahra and George, 2002; Flatten et al., Harvey et al., 2010b). An organisation might routinely exploit knowledge as part of its daily practices. However, absorptive capacity favours the development of systematic processes of knowledge exploitation (Zahra and George, 2002). For instance, formalisation capabilities (i.e. the tendency of an organisation to formalise internal processes that assist individuals in how to utilise new knowledge) or socialisation capabilities (i.e. the development of common values, principles and perceptions among individuals) can enable the exploitation of new knowledge (Jansen et al., 2005). Episodic power (i.e. individuals utilising their power) can also drive the exploitation of new knowledge (Easterby-Smith et al., 2008b). The outcomes of knowledge exploitation can contribute to the creation of new organisational processes or improve existing ones (Zahra and George, 2002; Lane et al., 2006).

As explained earlier, the key outcomes of absorptive capacity are identified in the improvement an organisation's performance and competitive advantage (Zahra and George, 2002; Lane et al., 2006). Studies also showed that absorptive capacity can contribute to adjusting an organisation's strategies to better address market needs, improve product and service development, increase innovation, enable the dissemination of best practice and increase an organisation's financial profitability (Szulanski, 1996; Tsai, 2001; Van Den Bosch et al., 2003). Finally, it is important to note that absorptive capacity can enable learning when an organisation invests proportionately in its main components. Unilateral attention on absorptive capacity could lead to investing heavily in acquiring new knowledge, which would not always allow sufficient time for knowledge to be exploited and would minimise opportunities to operationalise knowledge. Conversely, emphasis on knowledge exploitation does not automatically mean that an organisation is able to recognise valuable knowledge when those appear and can decrease the chances to benefit from new knowledge (Cohen and Levinthal, 1990; Zahra and George, 2002; Jansen et al., 2005). The complexity of absorptive capacity in managing new valuable knowledge makes its visual representation challenging. Diagram 1.1 demonstrates a simplified illustration

of absorptive capacity, showing an example of one-way movement of knowledge from the external environment towards organisational outcomes.

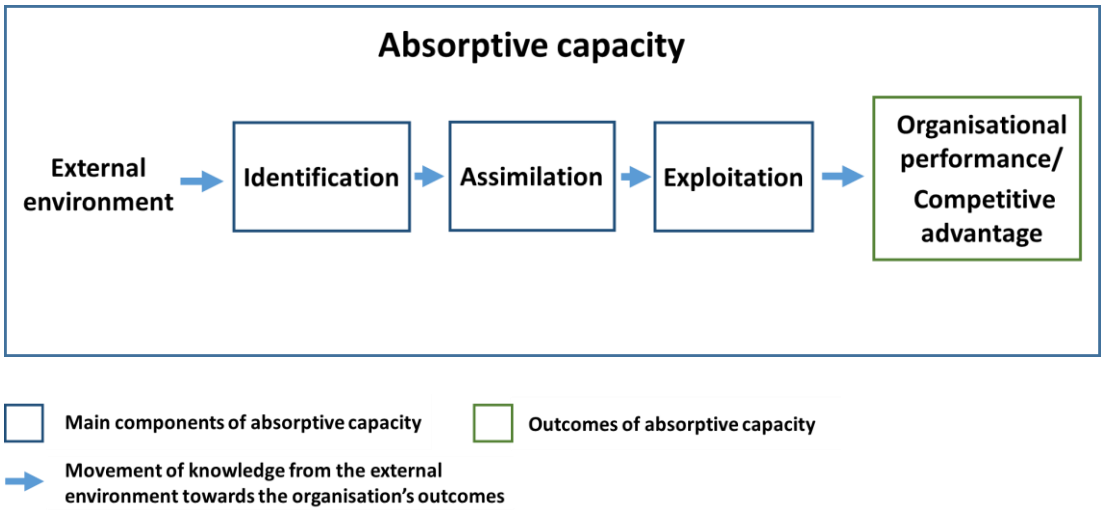



Diagram 1.1: Model of absorptive capacity (as adjusted by Cohen and Levinthal, 1990; Todorova and Durisin, 2007)

Overall, the three main components introduced by Cohen and Levinthal became the foundation for further exploration of absorptive capacity and influenced future research. The central notion of absorptive capacity to enhance the ability of a firm to identify and channel new knowledge yielded a large number of studies that examined its dimensions and the ways it can be implemented within organisational settings. The next section focuses on organisational elements that can influence an organisation's absorptive capacity. Discussion of antecedents is based on Cohen and Leventhal's work, while incorporating elements from subsequent works.

### 1.2 Antecedents influencing the development of absorptive capacity

Certain organisational conditions or individuals can influence an organisation's absorptive capacity, such as communication links with the external environment, gatekeepers, "appropriability" boundaries or external factors (Cohen and Levinthal, 1990, p.139). Solely the existence of new external knowledge is not sufficient to stimulate an organisation to search for new knowledge (Lane et al., 2006). Organisations assess external conditions and decide on the resources they intend to invest in exploiting external knowledge (Zahra and George, 2002). Thus, the ability of an organisation to invest in searching for new knowledge can be influenced by factors of the external environment, also called "industry conditions" (Lane et al., 2006, p.852). External industry conditions, such as competition, price changes or

market regulations, can accelerate or restrain the intensity which an organisation demonstrates in identifying new knowledge (Cohen and Levinthal, 1990; Lane et al., 2006). Firms may decrease their investment in absorptive capacity when they know that knowledge from competitive firms is publicly available, while other firms may decide to maintain their investment in absorptive capacity to be able to respond to new knowledge when that is accessible (Lane et al., 2006). Therefore, external conditions can have an impact on the degree to which an organisation invests in its absorptive capacity depending on the different industrial sectors.

The relationships which an organisation has with other organisations is a primary source of new useful knowledge (Cohen and Levinthal, 1990; Lane and Lubatkin, 1998; Knoppen et al., 2011). Knowledge coming from other organisations is mediated, however, by organisational boundaries, organisational culture, aims and internal mechanisms, which can influence the exploitation of new useful knowledge (Easterby-Smith et al., 2008a; Omidvar et al., 2017). Evidence has shown that similarities between the two organisations, particularly in their knowledge bases, organisational structure and payment processes, can enhance the absorptive capacity of the recipient organisation (Lane and Lubatkin, 1998). In other words, an organisation can be a better learner when it shares similarities with the source organisation (Lane and Lubatkin, 1998). Therefore, an organisation's awareness of its own knowledge base, learning capabilities and structure can guide it in identifying suitable partners that can that can serve as useful sources (Lane and Lubatkin, 1998; Knoppen et al., 2011). Studies on absorptive capacity and the external environment have examined inter-organisational learning via different pathways, such as the dual relationships between organisations (Knoppen et al., 2011), the organisation as part of a network of organisations, bringing together absorptive capacity and network theories (Peters and Johnston, 2009; Müller‐Seitz, 2012; Omidvar et al., 2017) or the potential of connective and desorptive capacity (Lichtenhaler and Lichtenhaler, 2009). Research outcomes demonstrated that the absorptive capacity of an organisation can be enhanced by dyadic or network relationships, as they give the opportunity to exploit new knowledge as a by-product of those relationships.

Gatekeepers and boundary-spanners can facilitate the mobilisation of new knowledge within the organisation's departments and create liaisons between an organisation and its external environment (Cohen and Levinthal, 1990; Jones, 2006). Gatekeepers' role is to identify useful external knowledge, decide on whether

it can potentially benefit the organisation's aims, and create associations with existing organisational knowledge to enable the diffusion and implementation of new knowledge (Allen et al., 1979; Huang et al., 2018). Studies on absorptive capacity have shown that gatekeepers which bring together new knowledge and assimilation processes can improve an organisation's innovative outcomes (Ter Wal et al., 2018). Boundary-spanners function as translators of new specialised knowledge and facilitate the liaison among different departments or with source organisations. Boundary-spanners emerged as a specialised role of gatekeeping and aim to address internal organisational limitations, which may restrain the exploitation of new knowledge, such as organisational objectives, language or targets (Tushman, 1977; Jones, 2006). The contribution of gatekeepers and boundary-spanners in absorptive capacity is most important when there is little overlap between new and prior knowledge, as they will create links to justify the association between prior and new knowledge. Their involvement is less needed when that overlap between new and existing knowledge is significant, as there is more understanding of the new knowledge and less effort is required for the implementation of said knowledge (Cohen and Levinthal, 1990). The effective assimilation and use of new knowledge of a group, however, lies also in the knowledge base of team members who act as recipients of knowledge – a factor as important as the role of the gatekeepers and boundary-spanners (Cohen and Levinthal, 1990).

Absorptive capacity is influenced by the appropriability processes that exist within a market environment. Appropriability refers to those regulations or mechanisms that an organisation has in place to control and protect its unique knowledge outcomes that ensure its survival and development (Cohen and Levinthal, 1990; Ceccagnoli, 2009). Examples of such protective processes are patents, secrecy agreements or criteria that define the degree of valuable knowledge that an organisation shares in the public domain and which allows organisations to retain their unique knowledge (Ceccagnoli, 2009). Considering that each organisation holds some unique knowledge, this becomes an incentive to invest in an organisation's absorptive capacity, as it can learn from competitions' knowledge (Cohen and Levinthal, 1990). An organisation that invests in absorptive capacity is able to learn and benefit even when knowledge is largely protected (Cenamor et al., 2017). At the same time, an organisation that is able to successfully combine absorptive capacity and appropriability can exploit knowledge from the external environment and produce innovative outcomes, while protecting its unique intellectual capital, especially within competitive environments where collaborators are also competitors (Ritala and

Hurmelinna-Laukkanen, 2013). Appropriability appears to be particularly relevant for studies that explore the competitive advantage of an organisation as an outcome of absorptive capacity.

Overall, the ability of absorptive capacity to systematically increase an organisation's performance has led to a large number of studies exploring the ways organisations can incorporate new knowledge into their practices (Volberda et al., 2010). Yet, little evidence exists regarding the potential of absorptive capacity in public healthcare organisations. Since research on absorptive capacity in public mental healthcare organisations is a new field, the adoption of a complex model with a multi-dimensional structure (for example, Lane et al., 2006) could be an early or limiting choice in exploring absorptive capacity in a public organisational environment (Harvey et al., 2010b). Instead, the present study adopted the main components of Cohen and Levinthal's work, i.e. the identification, assimilation and exploitation of new knowledge, as the underpinning theory to explore the absorptive capacity of CAMHS. The role of key antecedents, such as prior knowledge, intra- and inter-organisational learning processes, gatekeepers and external conditions suggested by Cohen and Levinthal was also considered as a factor that may influence the absorptive capacity of the case study organisation. The overall aim of the study was to explore key dimensions of absorptive capacity, while analyse and critically discuss new unexpected elements.

### 1.3 Additional research on absorptive capacity

Cohen and Levinthal's work became a foundation for future research that aimed to analyse, evaluate and expand absorptive capacity theory (Zahra and George, 2002; Lane et al., 2006; Todorova and Durisin; 2007; Volberda et al., 2010). Among the large pool of studies that followed, several works attempted to provide new and advanced explanations of Cohen and Levinthal's definition of absorptive capacity. One of the most prominent works was published by Zahra and George (2002), who proposed a "reconceptualisation" of the construct and contributed to the operationalisation of absorptive capacity (p.185). Their work introduced an additional dimension and defined absorptive capacity as the "acquisition, assimilation, transformation and exploitation" of new knowledge (p.189). Their model focused on the potential of absorptive capacity to advance and sustain the competitiveness of a firm (Zahra and George, 2002; Easterby-Smith et al., 2008a). They also suggested that internal processes, such as performance challenges or internal socialisation networks, could activate and strengthen different parts of absorptive capacity. Zahra

and George's reconceptualisation became a key approach and studies adopted it as their main model, especially through a dynamic capabilities perspective (for examples see Jung-Erceg et al., 2007; Easterby-Smith et al., 2008a; Lewin et al., 2011; Gebauer et al., 2012; Pittz and Intindola, 2015). Camisón and Forés named Zahra and George's model the "most far-reaching reconceptualisation" following Cohen and Levinthal's work (Camisón and Forés, 2010, p.708). Todorova and Durisin (2007) questioned the reconceptualisation suggested by Zahra and George (2002) by comparing their work with the definition of Cohen and Levinthal. They argued that it is necessary to maintain the dimension of value recognition, as it represents the critical ability of an organisation to distinguish valuable knowledge. They also suggested that the dimension of transformation, created by Zahra and George, is in fact an optional dimension which can assist in the assimilation of new knowledge, rather than being an integral part of absorptive capacity (Todorova and Durisin, 2007).

Focusing on the ability of absorptive capacity to enhance learning, Lane and colleagues (2006) suggested a definition that is composed of "exploratory learning, transformative learning and exploitative learning" (Lane et al., 2006, p.856). Based on the work of Cohen and Levinthal, Lane and colleagues elaborated on the conditions that influence absorptive capacity and suggested a distinction between internal factors, such as an organisation's structure and mechanisms, and external factors, e.g. environment conditions and the characteristics of new knowledge (for model see Lane et al., 2006, p.857). Furthermore, Cohen and Levinthal explained that individuals' absorptive capacity and the inter-organisational environment influence organisational absorptive capacity (Cohen and Levinthal, 1990). Based on this approach, Matusik and Heeley (2005) proposed a three-dimension model which was designed to determine the relationship among individual, organisational and inter-organisational levels. They elucidated that absorptive capacity is a synthesis of the interfaces that occur among the external environment, internal organisational processes, and the absorptive capacity of individuals (Matusik and Heeley, 2005).

Research on absorptive capacity increased knowledge of its main components, while contributing to further understanding the organisational antecedents that influence the development of absorptive capacity. Despite the diverse viewpoints of each new study, it appears that there is a consensus on the main components initially introduced by Cohen and Levinthal (1990). Most works recognised that absorptive capacity entails the identification of external knowledge that could be valuable for an organisation, the assimilation of this knowledge within an

organisation's units, and the incorporation of new knowledge into organisational practices with the aim of improving organisational outcomes (Saeedi, 2014). In other words, studies that followed Cohen and Levinthal's (1990) work made new suggestions taking into consideration and integrating the central components of Cohen and Levinthal's work in new models.

Apart from research that investigated the conceptual dimensions of absorptive capacity, a substantial body of empirical studies explored the implications of absorptive capacity in organisational settings. At an individual level, studies focused on the interface between the individual and the organisation (Hotho et al., 2012; Martinkenaite and Breunig, 2016) and on the role of key individuals in facilitating absorptive capacity (Jones, 2006). Research also examined the organisational antecedents that enable an organisation's absorptive capacity, such as the impact of combination capabilities (e.g. the interaction among different job holders), or socialisation capabilities (e.g. socialisation among staff members) (Van Den Bosch et al., 1999; Jansen et al., 2005). Scholars also studied the potential impact of human resource practices, mechanisms that enable investigation of new knowledge and the contribution of information systems (Lund Vinding, 2000; Knudsen and Roman, 2004; De Araújo Burcharth et al., 2015; Raymond et al., 2016). Furthermore, experts considered the role of the organisational structure (Ali et al., 2018), the impact of the inter-organisational environment (Jung-Erceg et al, 2007; Knoppen et al., 2011; Schleimer and Pedersen, 2014) and the effect of cross-sector relationships on an organisation's absorptive capacity (Pittz and Intindola, 2015). Research interest in understanding absorptive capacity also led to studying the ways in which it can be measured (Camisón and Forés, 2010; Flatten et al., 2011; Jiménez-Barrionuevo et al., 2011).

The aforementioned studies represent just a small sample of a large pool of research that aimed to identify the components and unravel the potential of absorptive capacity. Despite rich evidence, there are still under-researched areas. Features such as the character of knowledge or the sector-specific characteristics, can challenge existing models and add new parameters to be considered by the research community (Van Den Bosch et al., 2003). Scholars have identified research gaps that can be considered in future research development (Lane et al., 2006; Volberda et al., 2010; Van Wijk et al., 2011). Several of those areas of research directions are explained in the next section.

## 1.4 Areas of research development in absorptive capacity

Critics have argued that the increased attention paid to the empirical examination of absorptive capacity has led to the "reification" of the construct (Lane et al., 2006; p.833). Despite the vast interest of researchers in the operationalisation of absorptive capacity, there is limited research that has critically reflected on the theoretical development of the construct. Apart from a limited number of studies that have researched the essence of the main components of absorptive capacity (for examples see Zahra and George, 2002; Lane et al., 2006; Todorova and Durisin, 2007), most studies appear to have adopted an absorptive capacity model without necessarily critically evaluating its dimensions (Volberda et al., 2010). This has led research to produce little evidence about several key areas of absorptive capacity theory. For example, limited research has been conducted in exploring the nature of knowledge and the ways existing knowledge is combined with new external knowledge, as well as the role of individuals in an organisation's absorptive capacity (Lane et al., 2006; Volberda et al., 2010). A small number of studies have explored absorptive capacity in non-private organisations, the role of power or the role of regulators as an external condition that influences absorptive capacity (Lane et al., 2006; Todorova and Durisin, 2007; Harvey et al., 2010b; Setti, 2016). As a result, lack of rich evidence in the aforementioned areas may jeopardise the development of absorptive capacity. Scholars recommend that future studies should attempt to explore those gaps, few of which are discussed in this section.

As suggested by Cohen and Levinthal (1990), absorptive capacity is not simply the sum of individuals' absorptive capacity, but it also entails processes existing at an organisational level. Driven by this proposition, many absorptive capacity studies have focused on the organisational level absorptive capacity. Matusik and Heeley's proposition (2005) is one of the few studies to have suggested a distinction between organisational and individual absorptive capacity, highlighting the role of individuals in driving the new knowledge imported into the organisation and, in this way, influencing its organisational absorptive capacity. Szulanski also suggested that one of the important elements of effective "stickiness" of knowledge within the organisation is individuals' absorptive capacity (Szulanski, 1996). Although several studies have explored the relationship between individual and organisational absorptive capacity, there is an underlying assumption, that the organisation largely determines individuals' actions and, hence, their absorptive capacity (Martinkenaite and Breunig, 2016). As an outcome, there is limited evidence as to whether and how

individuals' absorptive capacity can influence absorptive capacity at an organisational level.

One of the areas with limited available evidence is the definition of knowledge in the context of absorptive capacity (Volberda et al., 2010; Wijk et al., 2011). Cohen and Levinthal initially argued that new knowledge of absorptive capacity is knowledge related to innovation – an approach that was later adopted by studies that focused on the contribution of absorptive capacity to the innovativeness of an organisation (Cohen and Levinthal, 1990; Vera et al., 2011). In several cases, studies suggested particular knowledge dimensions, such as domain specific, encoded and disciplinary knowledge (Lim, 2009), as well as the intra-industry, inter-industry and research knowledge dimensions (Schmidt, 2005), or selected particular knowledge areas, such as counter-knowledge created within an organisation or data-driven knowledge (for examples see Cegarra-Navarro et al., 2014; Wang and Byrd, 2017). However, most studies did not focus on a particular aspect of knowledge, instead they endeavoured to explore the overall ability of organisations to absorb any new useful knowledge that can improve their organisational outcomes (Zahra and George, 2002; Lane et al., 2006; Easterby-Smith et al., 2008a). As a result, although there is progress in exploring the nature of new knowledge further research could contribute to understand this concept (Volberda et al., 2010; Martinkenaite and Breunig, 2016).

Limited research has been conducted on the potential of absorptive capacity for public organisations. This is probably due to the supposedly little relevance of a construct that enhances the competitive advantage for the public sector (Harvey et al., 2010b). Yet, public sector organisations can face similar challenges to those encountered by private sector organisations, such as reduced organisational performance, operating within market environments that create competition or the purchaser-provider relationship, in the case of healthcare organisations (Harvey et al., 2010b; Croft and Currie, 2016). Research on the potential of new knowledge in the healthcare sector suggested that organisation theories developed in the private sector can make new recommendations and assist public organisations in addressing the aforementioned challenges (Harvey et al., 2010b; Ferlie et al., 2015). Yet, studies that focused on exploring the potential of new knowledge for public organisations emphasised that the attributes of the public sector can influence the transfer of theories from private to public organisations (Rashman et al., 2009). By taking into consideration public sector specific characteristics, absorptive capacity could suggest new insights for public healthcare organisations and further investment in empirical research is encouraged (Harvey, 2010b; Ferlie et al., 2015).

## 1.5 Absorptive capacity from an organisational learning perspective

Existing literature suggests that absorptive capacity shares similarities with the theoretical fields of organisational learning, knowledge management and dynamic capabilities (Van Den Bosch et al., 2003; Vera et al., 2011; Oborn et al., 2013; Apriliyanti and Alon, 2017). The origins of absorptive capacity can be primarily found in the organisational learning field (Van Den Bosch et al., 2003; Volberda et al., 2010; Martinkenaite and Breunig, 2016). Organisational learning aims to the optimisation of learning processes within an organisation (Daft and Weick, 1984; Fiol and Lyles, 1985; Argyris and Schön, 1996). The notion of organisational learning was initially developed by Cyert and March (1963), who suggested that organisational learning is the ability of an organisation to store knowledge and learn from it over a period of time (Easterby-Smith and Lyles, 2011). As an outcome, organisational learning can upskill an organisation with the ability to comprehend new knowledge, adjust its strategies accordingly, and meet its performance targets (Fiol and Lyles, 1985). The potential of organisational learning to enhance the learning skills of organisations has led to be established as a major contributor to organisation theory and it has led to the development of other major fields, such as theories of the learning organisation, inter-organisational learning or the role of the organisational context (Senge, 1994; Lane and Lubatkin, 1998; Argote, 2011).

Scholars of organisational learning acknowledged the existence of organisational level processes and introduced a stratification of individual, group and organisational levels of learning (Jones, 1995; Bapuji and Crossan, 2004; Easterby-Smith and Lyles, 2011). Specifically, organisational learning suggests that the learning ability of individuals contributes to the development of an organisation's learning ability (Tsang, 1997; Argote, 2011). Although learning is realised by individuals, organisational learning is not only the total sum of the individuals' learning (Fiol and Lyles, 1985; Argyris and Schön, 1996). It also includes organisational processes, structures, lessons learned or tacit forms of knowledge, which form part of the knowledge capital of the organisation and function as a guide for staff members to act (Argyris and Schön, 1996; Argote, 2011). Absorptive capacity has been associated with the ability on an organisation to learn in the seminal work of Cohen and Levinthal (1990) (Sun and Anderson, 2010). Similar to organisational learning, absorptive capacity entails the total of individual's absorptive capacities together with learning processes that exist primarily at an organisational level and enable absorptive capacity (Cohen and Levinthal, 1990). Additionally, organisational learning is influenced by prior knowledge that is progressively stored within the

organisation, as it operates as guidance for the organisation to orient the exploration and exploitation of new knowledge (Antal et al., 2001). The role of prior knowledge in driving the search for new knowledge has been also highlighted in absorptive capacity research (Zahra and George, 2002). As an outcome, an organisation that invests in recognising, understanding and incorporating new knowledge in organisational practice can also enhance its organisational learning skills (Apriliyanti and Alon, 2017).

Organisational learning cannot be achieved only by correcting an organisation's activities through incorporating learning from unexpected outcomes that occur in practice ("single-loop learning"). It also grows by incorporating those outcomes in organisational processes as lessons learned and by altering the organisation's values ("double-loop learning"), which then cultivate the organisation's ability to learn ("deutero-learning") (Argyris and Schön, 1996). One of the key attributes of absorptive capacity is that by identifying, assimilating and utilising new knowledge, an organisation develops its ability to learn in a specific field, while it also contributes to amplify the organisation's overall ability to learn (Cohen and Levinthal, 1989; Lane et al., 2006; Vera et al., 2011). Therefore, investing in an organisation's absorptive capacity could contribute to strengthening its double-loop learning skills (Sun and Anderson, 2010; Vera et al., 2011), and potentially its deutero-learning skills. Finally, intra- and inter-organisational relationships, as well as the role of the organisational context that are prevalent topics in organisational learning are also recognised as significant elements of an organisation's absorptive capacity (Lane and Lubatkin, 1998; Volberda et al., 2010). Given the similarities between the two fields, strengthening absorptive capacity is an investment in an organisation's ability to learn from the external environment and, thus, contribute to meeting its performance targets and improving the organisation's outcomes (Sun and Anderson, 2010).

### 1.6 Defining knowledge at an organisational level

Beyond individual knowledge, there is knowledge within an organisation, which exceeds the individual level and appears to be essential for meeting its organisational objectives (Cohen and Levinthal, 1990; Argyris and Schön, 1996). Research has referred to organisations' existing knowledge as "prior knowledge" or "knowledge base" to describe knowledge existing within an organisation (Cohen and Levinthal, 1990, p.128; Lane and Lubatkin, 1998, p.461). Yet, many studies in absorptive capacity appear to pay limited attention to the definition of knowledge in

organisational settings (Volberda et al., 2010). As explained in Section 1.5, following the work of Cohen and Levinthal (1990), which associated new knowledge with technological innovation, the majority of subsequent studies focused mostly on the processes that enhance organisational responsiveness and less on defining knowledge within an organisation (Volberda et al., 2010). The field of organisational knowledge could contribute to the interpretation of knowledge in absorptive capacity theory (Tsoukas and Vladimirou, 2001; Easterby-Smith and Lyles, 2011; Vera et al., 2011; Martinkenaite and Breunig, 2016). Although defining organisational knowledge is part of a complex debate, a brief review helped to understand knowledge as the subject of absorptive capacity.

Polanyi's influential work (1966) argued that knowledge appears in tacit and explicit forms within an organisation (Nonaka, 1994; Easterby-Smith and Prieto, 2008). The explicit form of knowledge concerns formalised and directly-transferrable knowledge, whereas the tacit form entails implicit, potentially unspoken and non-formalised forms of knowledge (Nonaka, 1994). Nonaka's work, which was based on Polanyi's approach, suggested that the two forms are in a continuous interaction through a "spiral of knowledge" and lead to knowledge creation, elevating individual knowledge to an organisational level (Nonaka, 1994, p.18). His work was underpinned by a positivist paradigm, where organisational knowledge is approached as having one true dimension waiting to be discovered. This research paradigm is prevalent in studies examining knowledge in organisational environments (Rashman et al., 2009; Vera et al., 2011). Scholars who adopt the constructivist paradigm argued that a positivist approach separates knowledge from human action and positivist scholars are inclined to primarily study explicit forms of knowledge, often neglecting tacit forms of knowledge (Cook and Brown, 1999, p.381). Such studies suggest that knowledge is not an organisational asset that is disassociated from individual agents, but a dynamic process that entails the interaction between knowledge and individuals. In other words, organisational knowledge entails the process of 'knowing', which is defined as the individual's ability to interpret and act upon knowledge (Cook and Brown, 1999, p.381; Tsoukas and Vladimirou, 2001; Vera et al., 2011).

An often-cited definition from Tsoukas and Vladimirou suggests that organisational knowledge is the ability of an organisation's members to make decisions about the suitability of new knowledge, influenced by the particular organisational context and their collective understanding of the organisation's regulations, processes or values (Tsoukas and Vladimirou, 2001; Crilly et al., 2010). Organisational knowledge is

influenced by the knowledge of individual members of the organisation, as each individual member processes new external knowledge in different ways. As a result, organisational knowledge is not a homogenous outcome of knowledge existing within the organisation, as it is also influenced by the diverse knowledge that each individual holds (Tsoukas and Vladimirou, 2001; Martinkenaite and Breunig, 2016). In other words, knowledge can be defined as organisational when it derives from decisions which individuals made according to their own knowledge and their understanding of the collective view of the organisation's routines (Tsoukas and Vladimirou, 2001; Rashman et al., 2009). The views of Tsoukas and Vladimirou assisted with understanding the nature of organisational knowledge, as well as the role individuals can have in determining its content.

Regarding suitable terminology, the terms "knowledge" and "information" are often used interchangeably in absorptive capacity literature, indicating that they are perceived as having a similar meaning (Martinkenaite and Breunig, 2016). Analysing Cohen and Levinthal's work, Richards and Duxbury (2014) suggested that an organisation can import new knowledge, which is the finalised form of information merged to serve a particular purpose, or new information, which still requires some processing, and both can be transformed to organisational knowledge (Richards and Duxbury, 2014). Van Den Bosch and colleagues used the term "knowledge" in the definition of absorptive capacity (Van Den Bosch et al., 2003). Similarly, the current thesis adopted the term "knowledge" to define absorptive capacity and to discuss the research findings. Together with the term "knowledge", the term "information" was also used in data collection to discuss processes of absorptive capacity with the study participants and to facilitate understanding of the interview questions (please see Section 3.6 for more details).

### 1.7 The transfer of absorptive capacity to the public sector

Public and private organisations often face similar challenges, such as the need to incorporate advancements into technology, to improve their performance, to invest in partnerships' development, and to respond to market environments. Such elements led public sector research to transfer organisation theories from the private to the public sector research (Rashman et al., 2009; Ferlie et al., 2015; Jarvie and Steward, 2018). The relationship between knowledge and improved organisational performance has also led researchers to explore the potential of knowledge for public organisations (Harvey et al., 2010b; Richards and Duxbury, 2014). Scientific interest intensified with the emergence of New Public Management (NPM). The

public sector was called to implement management practices developed in the private sector, with the aim of advancing organisational performance and improving the effectiveness and quality of public services (Boyne, 2002; Willem and Buelens, 2007; Richards and Duxbury, 2014). Yet, empirical studies that introduced organisational theories to public sector research often paid limited attention to the characteristics of public organisations – characteristics which may influence the adoption of such theories (Ferlie et al., 2003; Rashman et al., 2009; Harvey et al., 2010a). Certain characteristics are discussed in this section, to demonstrate why considering the public nature of organisations could add new insights into understanding how said organisations learn from the external environment.

The organisational context of public sector organisations can influence the development of learning pathways, as organisational processes can have an impact on the ability of individuals to learn (Kothari et al., 2011). A public organisation's values can differ from those of private organisations, as the former incorporates the notion of serving public needs (Boyne, 2012). Additionally, the bureaucratic nature of public organisations can limit these organisations' flexibility to introduce new knowledge and, as an outcome, advance organisational learning processes (Boyne, 2012). Studies showed that individual agents, such as managers, could affect the bureaucratic rigidness of public organisations and influence the development and sustainability of a culture of organisational responsiveness (Pablo et al., 2007). The existence of professional groups can facilitate the transfer of knowledge within those groups, while knowledge sharing can be jeopardised by boundaries among different professional groups (Bate and Robert, 2002; Currie and Suhomlinova, 2006; Rashman et al., 2009). Professional groups can have a significant impact on restraining organisational change, particularly in healthcare organisations (Ackroyd et al., 2007). Thus, organisational dynamics existing within a public organisational environment can influence the development of organisational learning processes.

Public organisations are considered "knowledge-intensive" environments, because their main operations involve the sharing and usage of knowledge, such as service provision and policy-making (Willem and Buelens, 2007, p.581; Lin et al., 2008; Yang and Maxwell, 2011). Knowledge in public sector organisations has been gradually understood as a public asset that can be shared either within or outside the organisation (Rashman et al., 2009; Yang and Maxwell, 2011; Henttonen et al., 2016). As opposed to private organisations, which often aim to safeguard unique knowledge that enhances their competitive advantage, public organisations have progressively familiarised themselves with sharing of knowledge to improve public

services (Rashman et al., 2009; Kothari et al., 2011; Yang and Maxwell, 2011). Developing a knowledge-sharing culture has been one of the central ideas of healthcare governmental policies in the UK. Healthcare policies encouraged public healthcare organisations to collaborate with other public and non-profit organisations, aiming to exchange best practices and understanding for improving the quality of care (NHS England, 2014; National Health Service, 2019). Although there is an increased recognition in literature about the strengths of sharing knowledge, less is known about the specific pathways through which knowledge creation, sharing and implementation take place within public sector organisations (Rashman et al., 2009).

Public organisations are considered to be less competitive in comparison with private sector organisations, which are in a continuous need to exploit valuable knowledge before their competitors (Richards and Duxbury, 2014). As an outcome, a low-intensity competitive environment may provide fewer incentives for public organisations to search for new valuable knowledge (Boyne, 2012; Richards and Duxbury, 2014). On the other side, lack of strong competition can lead public organisations to diminish organisational boundaries and enhance knowledge sharing. Broader NPM changes which aimed to increase the levels of competition have influenced the learning strategies of public organisations (Provan and Milward, 2002; Alonso et al., 2011). Policy changes that were based on NPM principles have directed public organisations to strengthen their culture of knowledge sharing, while increasing their ability to compete with other organisations (Richards and Duxbury, 2014).

The interface between a public organisation and its inter-organisational environment can differ from that of a private sector environment (Willem and Buelens, 2007; Rashman et al., 2009). Governmental bodies, other public or non-profit organisations, professional groups and citizen groups form part of a broader environment to which a public organisation is accountable and is required to demonstrate transparency in management and service delivery (Broner et al., 2001; Easterby-Smith at al., 2008a; Rashman et al., 2009). In the case of public healthcare organisations, their performance targets are directed by national and local stakeholders – a relationship that can influence the priorities which a public organisation sets (Kothari et al., 2011). Additionally, public healthcare organisations can often be incentivised to look for new knowledge due to policy directions, rather than meeting their own strategic goals (Bate and Robert, 2002). Additional research

is required, however, to explicate how the external environment influence organisational learning processes of public organisations (Rashman et al., 2009).

A small number of studies have explored the potential of absorptive capacity for public organisations, including healthcare organisations (for examples see Harvey et al., 2010b; Oborn et al., 2013). Scholars argued that the difficulty faced by public organisations in meeting performance targets could be associated with low levels of absorptive capacity. Research findings have shown that although public organisations can have learning processes in place that are related to different dimensions of absorptive capacity, they are largely used in a sporadic manner, rather than as a continuous process of responding to performance irregularity (Harvey et al., 2010b). Yet, it is the systematic responsiveness to new knowledge that can improve an organisation's absorptive capacity and, hence, its organisational outcomes (Zahra and George, 2002). Recent evidence suggested that absorptive capacity can assist in the reconfiguration of internal learning processes and mechanisms and, consequently, contribute to improving public service provision (Croft and Currie, 2016). Additional research is yet required to identify the ways in which absorptive capacity can be systemised in public organisations, as well as to clarify the variance that might exist among different public sector areas, such as education, health and other social services (Easterby-Smith et al., 2008a; Cooper and Levin, 2010; Harvey et al., 2010a; Biesma et al., 2012).

### 1.8 Mobilisation of new knowledge in healthcare organisations and the contribution of absorptive capacity

The need to improve the quality of healthcare services has led researchers to explore the ways in which new research knowledge can be implemented in healthcare settings (Davies et al., 2015). Within the field of knowledge mobilisation, studies increased insight into the processes through which knowledge can be embedded in clinical practice and contributed to advancing public healthcare services and the experience of service users (Crilly et al., 2010; Bauer et al., 2015; Davies et al., 2015). As part of this development, cross-sectoral approaches were developed, bringing together healthcare research and management and learning theories, such as organisational learning, knowledge management, resourced-based view theory, organisational development or information science (Crilly et al., 2010; Ferlie et al., 2012; Oborn et al., 2013). This advancement created new perspectives in healthcare research that focused on developing the learning skills of healthcare organisations (Crilly et al., 2010).

Bringing together organisation theories and healthcare service research led to the emergence of research sub-fields that address the gap between knowledge and healthcare practice. Various approaches or models in the areas of knowledge transfer, knowledge exchange, knowledge translation, knowledge brokering, communities of practice, diffusion of innovations, implementation science or evidence-based practices are key examples that aimed to improve knowledge mobilisation in healthcare practice (for examples see Greenhalgh et al., 2004; Graham et al., 2006; Proctor et al., 2009; Crilly et al., 2010; Ferlie et al., 2012; Grimshaw et al., 2012; Ward et al., 2012; Burgess and Currie, 2013; Kislov et al., 2014; Bayer et al., 2015; Davies et al., 2015; Ferlie, 2015). Such approaches have been grouped into three broad categories of linear, relationship and systems models (Best and Holmes, 2010). Linear models identify knowledge transfer as a one-way process, creating a separation between producers and users of knowledge (Best and Holmes, 2010; Davies et al., 2015). Relationship models, on the other hand, recognise the dynamic nature of knowledge utilisation and focus on users' involvement in processes of knowledge mobilisation, such as partnerships' development or knowledge sharing (Graham et al., 2006; Best and Holmes, 2010). Finally, systems models address the complexity of healthcare environments which emerged from the multiple interactions among individuals, structures, language and values (Best and Holmes, 2010; Crilly et al., 2010).

The aforementioned approaches set the foundations for exploring the learning mechanisms in healthcare organisations. Nonetheless, there are still gaps in understanding how organisations can strengthen their competence to exploit new knowledge and improve healthcare service provision (Proctor et al., 2009; Ferlie et al., 2012; Swan et al., 2016). Knowledge mobilisation scholars suggested extending the merging of management theories with health service studies and exploring theories that could offer an organisational level approach, while taking into consideration sector characteristics that may influence the transfer of such theories (Harvey et al., 2010b; Oborn et al., 2013; Ferlie et al., 2015). Absorptive capacity is identified as one of the key areas of future research. It is an organisational construct thoroughly researched in the private sector, which offers rich evidence related to improving the ability of organisations to exploit useful knowledge. Examining the potential of absorptive capacity can contribute to bring about novel insights into developing sustainable learning abilities for healthcare organisations (Ferlie et al., 2015).

## 1.9 Knowledge classification in healthcare environments

The initial interest in knowledge utilisation within healthcare primarily concerned the use of research evidence in clinical care. Soon scientific interest expanded to additional knowledge areas and how they could benefit service provision. Empirical studies selected particular areas of knowledge to study how it becomes embedded in practice, such as the implementation of clinical guidance (for examples see Prior et al., 2008; Grove et al., 2018), the potential of interpreting and using data in clinical practice (for examples see Freeman, 2002; Wang and Byrd, 2017), the alignment of IT systems between organisations for facilitating information exchange (for examples see Iroju et al., 2013), the evaluation of large-scale organisational changes (for examples see Pope et al., 2006) or the observation of individual actors' perspectives as to how they understand and value of new knowledge, such as professionals or patients (for examples see Staniszewska et al., 2010; Collins et al., 2017; Kalies et al., 2017; Barrett et al., 2018). Several studies also adopted a more critical perspective as to whether explicit forms of knowledge sufficiently encapsulate the knowledge capital of an organisation and whether tacit forms of knowledge are less prioritised (for examples see Currie et al., 2008).

Understanding the content of knowledge in healthcare environments has led to the creation of knowledge taxonomies, aiming to classify the spectrum of knowledge areas that influences health service provision (Davies et al., 2015). Examples of such taxonomies are the categorisation of evidence according to the areas of implementation, such as policy-making, problem-solving or politics (Weiss, 1979), classification of scientific evidence (Petticrew and Roberts, 2003), categorisation of individual and collective levels of knowledge use (Contandriopoulos et al., 2010), at theoretical, experiential and empirical levels of evidence (Harvey et al., 2011), the distinction between tacit and explicit forms of knowledge (Currie et al., 2008) or classification at micro, meso and macro levels of knowledge sources (Grove et al., 2018). Approaches of knowledge classification also recognised that there is a range of knowledge areas next to research knowledge, such as professional, technological or experiential knowledge, which individual agents may use in practice (Davies et al., 2015). Knowledge taxonomies have contributed to identifying the multiple dimensions of knowledge and assist in explaining the prioritisation of knowledge in healthcare practice.

The work of Grove and colleagues (2018) is particularly relevant to this thesis, as it suggested a classification that distinguishes the organisational and inter-

organisational levels. In particular, they developed a categorisation of knowledge and evidence used by orthopaedics based on the level approach developed by Pope and colleagues (Pope et al., 2006; Grove et al., 2018). Scholars explained that diverse sources of knowledge influence the decision-making of orthopaedics (Grove et al., 2018). Evidence showed that practitioners employ a wide spectrum of knowledge and evidence, including personal experience and expertise, policies and regulations to inform their decisions (Diagram 1.2; Grove et al., 2008). This categorisation was useful in understanding the external sources of knowledge, as well as whether internal sources of knowledge influence the absorptive capacity of the case study organisation. The three-level categorisation of Grove and colleagues was also advised to group knowledge sources used within the CAMHS of a mental healthcare organisation (as later seen in Chapter 4).

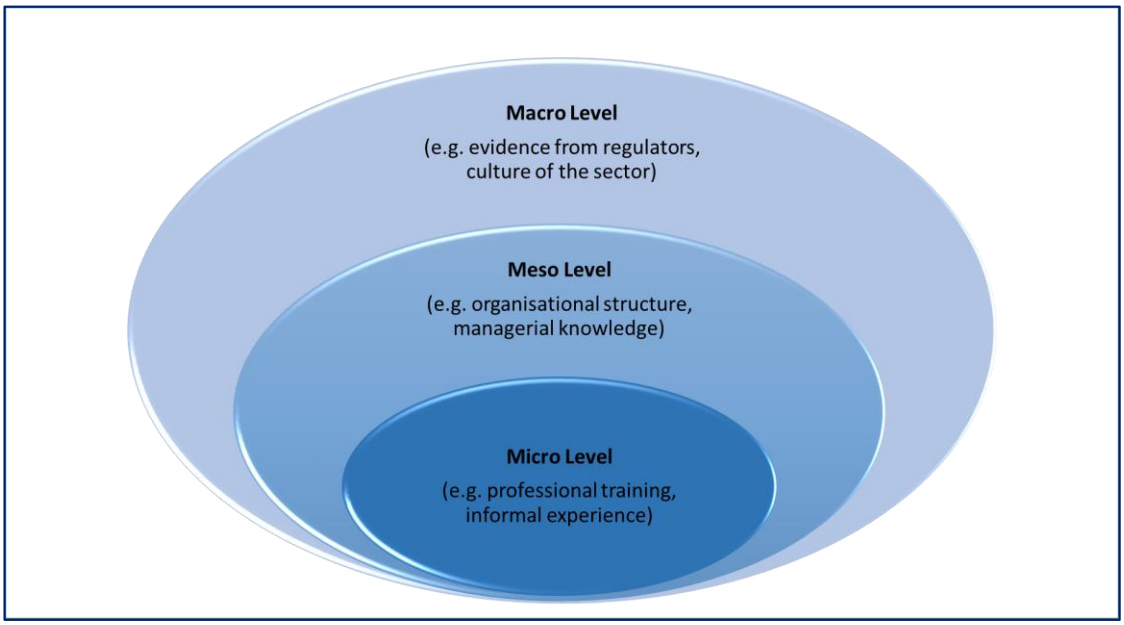



Diagram 1.2: The macro, meso and micro structural levels of knowledge (as adjusted by Grove et al., 2018)

Overall, studies on the exploitation of new knowledge in healthcare has expanded to researching the potential of management concepts in the healthcare sector and examining the contribution which different knowledge areas can make to the improvement of healthcare services (Ferlie et al., 2015). Absorptive capacity has been identified as a management approach that could be useful in strengthening the learning ability of a healthcare organisation at a strategic level (Oborn et al., 2013; Ferlie et al., 2015). Studying the absorptive capacity of a mental healthcare

organisation can contribute to understanding how public healthcare organisations respond to new knowledge and advance their ability to learn from their external environment, while also revealing new elements regarding the components of absorptive capacity (Oborn et al., 2013; Ferlie et al., 2015).

### 1.10 Summary

Absorptive capacity was identified as a significant construct in organisational research. Scientific interest in studying the operationalisation of absorptive capacity has grown due to its ability to improve the organisational performance and competitive advantage of an organisation. The vast majority of empirical studies have been conducted in private organisations, accumulating evidence about the processes through which absorptive capacity can be strengthened, as well as the organisational conditions that can favour or restrain the development of the construct. At the same time, studies in the public sector have increasingly adopted management theories to explore their potential contribution to addressing challenges for organisational performance and service quality, including theories of organisational learning or knowledge management. Transferring such theories to the public sector has offered interesting insights into the ways public sector organisations operate. Yet, scholars recommended that new studies should take into consideration public sector characteristics, such as the organisational context, the impact of the inter-organisational environment or the role of competition, as they can influence the examination of the potential of public sector organisations. Similarly, evidence from studies in the healthcare field has shown that the utilisation of new knowledge can offer new opportunities to improve healthcare service provision. Although studies initially focused on the implementation of medical research in clinical practice, soon scientific interest in other knowledge areas grew, such as innovation, technology, managerial approaches or network collaborations, and in exploring the ways in which these could assist healthcare organisations in improving their performance and service outcomes.

Although research on the absorptive capacity of public healthcare organisations is a novel field, recent studies demonstrated that it could provide new insights into managing and exploiting new knowledge. Scholars have recommended the study of absorptive capacity in different public sector organisations, including education and healthcare organisations. To contribute to filling this research gap, the current thesis adopted the main dimensions of absorptive capacity suggested by Cohen and Levinthal to investigate the potential of the construct for public mental healthcare

organisations and in particular for Child and Adolescent Mental Health Services (CAMHS). The study aimed to identify organisational processes and factors that can influence the absorptive capacity of the CAMHS department, while also examining the role of the inter-organisational environment of the department's absorptive capacity. Considering that absorptive capacity can be influenced by the organisational context, the next chapter focuses on the background and current structure of CAMHS. Specifically, it explains the importance of CAMHS for the health and wellbeing of children and young people, the policy changes that have shaped the services until today, and the challenges which services are currently facing. It also it reviews local strategies that drive the service transformation of CAMHS and presents a conceptual framework for this study.

## Chapter 2

## The organisational context of Child and Adolescent Mental Health Services (CAMHS) and the potential of absorptive capacity

The literature review in Chapter 1 suggested that the development of an organisation's absorptive capacity is influenced by external conditions, as they can create incentives or barriers for an organisation when it comes to searching for new valuable knowledge (Cohen and Levinthal, 1990; Lane et al., 2006). Existing evidence on absorptive capacity in the public sector, including healthcare organisations, proposed that future research should take into consideration organisational attributes and external factors, as they could influence the exploration of absorptive capacity (Ferlie 2015; Harvey et al., 2015). The thesis introduced the concept of absorptive capacity to a new organisational environment. Examining the background and organisational context of CAMHS contributes to understanding the potential impact of the external environment on the absorptive capacity of said services.

This thesis focuses on CAMHS due to the importance of children and young people's mental health for human life. Research evidence has shown that adolescence is the period during which most mental health difficulties appear for the first time, and thus investing in youth mental health increases the chances of having a healthier adulthood (Birchwood and Singh, 2013). Despite the recognition of youth mental health as a global priority, services continue to face significant challenges and national strategies are failing to address the mental health needs of the young population (Kieling et al., 2011; Dick and Ferguson, 2015). In the UK, services struggle to meet demand, due to long waiting lists, fragmentation of local service provision, lack of evidence-based approaches and use of data or limited funding (House of Commons, 2014; Children's Commissioner, 2018; Crenna-Jennings and Hutchinson, 2018). Healthcare policies published by successive governments have attempted to address service inconsistencies by reforming the organisational structure of CAMHS (Charman, 2004; Cottrell and Kraam, 2005).

The current structure of Child and Adolescent Mental Health Services (CAMHS) in the UK has been shaped over time by a number of transformations, mostly led by governmental policies. As part of the national healthcare system, CAMHS have also been influenced by wider health and mental health reforms, starting from the period of de-institutionalisation in the 1980s (Glasby and Tew, 2015). Among the numerous

policy publications that have been released since the founding of the NHS, several policy papers appear to have acted as key turning points in managing public healthcare and service delivery. Such policies did not only concern CAMHS in particular, such as the introduction of the “4-Tier” Model (1995) (Cottrell and Kraam, 2005), but also changed the overall governance of the NHS, e.g. the NHS and Community Care Act (1990), which proposed a role separation between purchasers and providers of healthcare services (Glasby and Tew, 2015). Issuing major healthcare policies has been driven by evidence that highlighted persistent problems, as well as by broader political conditions, including the emergence of New Public Management (NPM) and the austerity period (Alonso et al., 2011; Hyndman and Lapsley, 2016).

Reviewing key policies in this chapter increased insight into the wider changes that have shaped CAMHS over the past 30 years and provided understanding of the factors that lead current services to seek new knowledge. To provide a comprehensive description of the case study context, this chapter focuses on: a) explaining the importance of supporting young people’s mental health, b) reviewing policy changes that have affected health and mental healthcare provision in the UK and examining how those changes have influenced the ways CAMHS operate today, and c) summarising ongoing local strategies that guide organisational transformation in the case study CAMHS. The last section of the chapter presents the conceptual framework of the thesis and explains the potential contribution of absorptive capacity to CAMHS.

### 2.1 The importance of young people’s mental health

The increasing evidence regarding the prevalence of mental health conditions worldwide and their role in causing disability and death for millions of people has led to the acknowledgement of mental health as a global health priority (Prince et al., 2007; World Health Organisation, 2015). Evidence from mental health studies has influenced the definition of mental health, which has changed from being merely the prevention and treatment of mental health disorders, to the investment in the mental wellbeing of individuals (Prince et al., 2007; World Health Organisation, 2014b). Mental health is also a leading health challenge for children and young people (10-19 years old), as it is one of the primary causes of death, illness and disability for this age group (World Health Organisation, 2014a). Adolescence and young adulthood have gradually been brought to the forefront of public health discourse due to the importance of this time period for individuals’ development. Research findings have demonstrated that approximately 75% of young people who

experience a serious mental health disorder will present the first symptoms before the age of 25 (Kessler et al., 2007; Birchwood and Singh, 2013, McGorry, 2013). This evidence led to acknowledging children and young people's mental health as a priority area for new research and policy reforms. Nonetheless, further progress is required in order to make this health area an integral part of national policy agendas and to improve quality in service provision (Kieling et al., 2011; Kleinert, 2007; Dick and Ferguson, 2015).

Studies focusing on mental health prevalence in the United Kingdom showed that 1 in 8 children and young people experience a mental health disorder (5-19 years old) (NHS Digital, 2017). Comparison with previous studies demonstrates that prevalence in children and young people has seen a small increase (NHS Digital, 2017). Emotional disorders, including anxiety and depression, appear to be the most prevalent groups of disorders in this group (NHS Digital, 2017). The latest studies have shown that in the age group of 11-16 years old, 1 in 7 young people had a mental health disorder, while 1 in 4 of those who presented with a disorder had attempted suicide or self-harm. In the group of 17-19 years old, mental health disorders appeared in 1 in 6 young people. The majority of children and young people who face a mental health problem (66.4%) seek help from professional services (NHS Digital, 2017). Considering that the majority of young people use professional help, studies have highlighted the importance of providing accessible, timely and effective mental health support.

Research on young people's mental health has produced rich evidence about its importance for the overall health of individuals. Investment in research has increased in various scientific directions, such as the time periods when different mental health disorders emerge (for examples see Jones, 2013; Kessler et al., 2007; Mc Gorry et al., 2007; Jones, 2013; Erskine et al., 2015), the importance of data collection to evaluate the quality of services and the development of evidence-based national policies for service provision that specifically address young peoples' needs (for examples see Belfer, 2008; Hickie, 2011). Studies have also made suggestions about service transformation that can change the ways services are currently organised (McGorry, 2013; Malla et al., 2016). Overall, research on mental health and mental health service provision has provided evidence that can be incorporated into the national healthcare policy agenda and the Child and Adolescent Mental Health Services (CAMHS) to improve the services delivered to children and young people.

## 2.2 Early policies that influenced the structure of health and mental health services

Many healthcare policies have been published since the foundation of the NHS, resulting in frequent restructuring of the healthcare system (Ramon, 2008; Asthana, 2011). Policies aimed to gradually shift the NHS structure from a central, top-down management approach towards an approach that favoured de-centralisation and local competition, driven by the growth of New Public Management (NPM) in the UK (Ghobadian et al., 2009). Several policies introduced major re-organisations that influenced the NHS as a whole and had an impact on mental health services and CAMHS, while others focused particularly on improving child and adolescent mental health provision (Gilburt et al., 2014). The next sections present a review of key policies that appeared in literature as influential for healthcare in general and CAMHS in particular, with the aim of understanding the origins of the current structure of CAMHS and the challenges that CAMHS are currently facing.

A major reform of mental health services was introduced with the de-institutionalisation of mental health hospitals and the "Better Services for Mentally Ill" White Paper (1975) (Wall and Owen, 2002). This system re-organisation was based on the notion that mental health support and treatment can be provided outside a mental health institution. The reform focused on developing community care and enhancing the collaboration between health and local authority services (Glasby and Tew, 2015). Although de-institutionalisation became a milestone for the development of community services, the reform faced criticism about the conditions under which the transformation happened. New community settings had limited capacity to host patients and mental health patients could face unsafe conditions when having to move to general hospitals (Rogers and Pilgrim, 2001). Additionally, limited knowledge about treating patients within a community setting, the resistance of hospital culture to investing in community services, and the financial pressures of that period further delayed the transition to a community service system (Rogers and Pilgrim, 2001; Coffey and Hannigan, 2005; Ramon, 2008; Gilburt et al., 2014).

De-institutionalisation continued during the 1990s when it became the local authorities' responsibility to manage the process of closing down remaining mental health institutions and moving patients to new locations, limiting the involvement of the central government (Ramon, 2008). Following that period, mental healthcare gradually transformed into a system of service provision, supported by statutory, charitable and private service providers and a wide range of professionals with the

aim to deliver inpatient and community support (Hannigan and Coffey, 2011). Yet, policy-makers failed to allow the time and space necessary for the development of constructive partnerships across sectors involved in mental health service provision and to invest in the development of local solutions, which operated as persistent boundaries for the improvement of mental health service provision in the following years (Hannigan and Coffey, 2011). The next sections review key policies that influenced the structure of mental healthcare provision and particularly the structure of CAMHS.

One of the largest and most radical NHS reforms was introduced during the 1990s. The reform was an outcome of the intense financial pressures of that period, which were mostly attributed to the public service sector (Mays et al., 2011; Simonet, 2015). Through the "Working with Patients" White Paper (1989) and the NHS and Community Care Act (1990), the government introduced significant changes to the public healthcare sector, establishing a role separation between purchasers and providers of healthcare services. The new healthcare system aimed to create an internal NHS market and enhance competition (Glasby and Tew, 2015). The main impact of the NHS and Community Care Act was to increase the responsibilities of managing community care for local authorities, introduced a market structure into the public healthcare sector, and allowed the private and voluntary sector to be part of that market, with the aim of improving the performance of healthcare organisations and the quality of care (Ham, 1996; Glasby and Tew, 2015).

The Act created new opportunities for strengthening primary care services and enhanced the collaboration of primary and secondary care, as it led providers to develop services that were more responsive to the needs of patients (Ham, 1996). Additionally, there was some evidence to show that the efficiency and productivity of the system increased (Ham, 1996; Mays et al., 2011). The voluntary sector appeared to have a more visible relationship with the NHS under the new Act (Wall and Owen, 2002). Nevertheless, inadequate financial support to continue transferring services from hospitals to communities, the increased costs of managing the new contracting system, and the old-fashioned working attitudes in healthcare services, appeared to restrain the implementation of the new healthcare legislation. Despite the aim of the government to enhance joint working among service stakeholders, i.e. the NHS, private, voluntary and social services, collaborations and knowledge sharing were objectives that were not fully implemented in practice (Ham, 1996; Mays et al., 2011; Glasby & Tew, 2015).

The new NHS and Community Care Act (1990) was part of the government's plans to introduce and implement the private sector's market and management practices in the public sector (Hyndman and Lapsley, 2016). Policies that introduced New Public Management (NPM) principles, such as the NHS and Community Care Act, aimed to guide public organisations in adopting knowledge from the management practices of the private sector that could strengthen said organisations' performance, quality of services and financial inefficiencies. Examples of such practices were the creation of market structures, the adoption of performance measurements, the prioritisation of users' choices, resource management at a local level, or the "value for money" principle (Alonso et al., 2015; Callaghan et al., 2017). Yet, differences between private and public organisations in terms of organisational values, financial management and investment in competition raised serious concerns as to whether it is feasible and beneficial to embed private sector practices in public organisations (Simonet, 2015). Despite criticism, NPM strategies continued to form part of the health and mental healthcare policy-making of that period and subsequent governments continued including the NPM approach in healthcare policies (Simonet, 2015).

### 2.3 Organisational changes in Child and Adolescent Mental Health Services: the "4-Tier" Model in England

Child and Adolescent Mental Health Services (CAMHS) have probably received the least attention from policy-makers in comparison with other healthcare services (Jenkins et al., 2010). CAMHS structural changes have been primarily influenced by policies concerning mental healthcare or healthcare in general. Only a small number of healthcare policies focused specifically on the development of mental health services for children and young people. Following several service evaluation reports during the 1980s and 1990s that highlighted existing service inefficiencies, the implementation of a new service model for CAMHS was announced in the "Together We Stand" review (1995). The new "4-Tier" model introduced a service stratification based on the levels of severity of mental health conditions (Cottrell and Kraam, 2005; Jenkins et al., 2010). The four tiers facilitated service provision by categorising mental health needs into different levels of severity. Tier 1 included universal services provided by non-mental health specialists, such as school nurses or youth workers, who support prevention and early intervention. Tier 2 addressed the needs of young users who required mental health specialist services provided at a community level. Tier 3 focused on complex conditions, where service users were supported by multi-agency teams. Finally, Tier 4 offered services to young

individuals with severe conditions needing treatment and support in inpatient or daily units (Jerkins et al., 2010; The National Archives, 2010). The model has been maintained to the present day. Although the latest policies call for gradually replacing service stratification with service pathways that are based on users' needs (NHS England, 2015a), many of the NHS CAMHS are still based on the "4-Tier" structure.

The development of the tiered system was a response to the service inconsistencies that existed within the healthcare system at that time (Charman, 2004). The main purpose was to create a commonly accepted service structure that could be adopted throughout the country and facilitate the development of services that could address users' needs (The National Archives, 2010). By adopting a comprehensive service model, it was believed that local areas could bridge the gaps among the fragmented primary, secondary and specialised care via effective management, facilitate funding of services and enhance collaboration in services delivery (Appleton, 2000; Cottrell and Kraam, 2005; Salmond and Jim, 2007). Even though the new model drastically improved the structure of CAMHS, services addressing children and young people's mental health remained problematic. The lack of a specialised workforce, limited intention from staff to improve services, financial deficiency or even lack of communication among local organisations, retained fragmentation in service provision (Charman, 2004; Jenkins et al., 2010).

Following the introduction of the "4-Tier" model, growing evidence concerning the prevalence and the complexity of mental health problems of children and young people highlighted the need to continue investing in effective CAMHS policies, expert staff, stability in funding and multi-agency collaborations to effectively address mental health needs (Charman, 2004). Although new and improved policy papers were issued in an attempt to address these challenges, the "4-Tier" model remained one of the most influential policies, because it set milestones for effective coordination and management of CAMHS within the NHS. Most importantly, it helped to establish a structured system for CAMHS provision and to increase the overall understanding of the importance of mental health for children and young people (Charman, 2004; Cottrell and Kraam, 2005).

## 2.4 1997-2010: policy development in Child and Adolescent Mental Health Services (CAMHS)

Policy development in CAMHS between 1997 and 2000 took place in the context of the overall "modernisation" of healthcare (Hyndman and Lapsley, 2016, p.393). The then Labour government introduced a series of policy papers that influenced the structure of healthcare services, including "The New NHS: Modern, Dependable" (1997), "The NHS Plan" (2000) and the "National Service Framework for Mental Health" (1999) (for examples see Lester et al., 2004; Greener, 2008; Jenkins et al., 2010; Mays et al., 2011; Gilburt, 2014; Glasby and Tew, 2015; Callaghan et al., 2017). The key priorities of the modernisation policies were to enhance collaborative relationships between purchasers and providers for advancing the quality of care, create links between the health and the social sector, increase the utilisation of evidence based practices and patients' involvement, as well as establish the state's regulatory role in addressing social inequalities (Iliffe and Munro, 2000; Lewis and Gillam, 2003; Coffey and Hannigan, 2005; Mays et al., 2011; Glasby and Tew, 2015).

CAMHS improvement remained a low priority in comparison with other mental health service areas (Cottrell and Kraam, 2005; Jenkins et al, 2010). Although there was increasing understanding about the importance of improving the mental health of children and young people, data collected during that period demonstrated that CAMHS continued to struggle to provide sufficient services, due to poor funding allocation, low staff numbers, inadequate service development and inability to work collaboratively with other service providers (Jenkins et al., 2010). The "Children in Mind" Report (1999) highlighted that CAMHS were challenged due to lack of infrastructure and resources, as well as ineffective management (Charman, 2004). Nonetheless, guidance that specifically addressed the needs of CAMHS was gradually included in healthcare policies. For instance, the White Paper "Saving Lives: Our Healthier Nation" (1999) emphasised the need for early intervention investment and the "Bridging the Gap" consultation paper (1999) particularly addressed the needs of the 16-19 age group and suggested the recruitment of advisors for young people (Department of Education and Skills, 1999; Department of Health, 1999; Charman, 2004; Cottrell and Kraam, 2005). As a result, healthcare policy-makers demonstrated some progress in addressing the service challenges of CAMHS.

While the healthcare sector appeared to delay incorporating the improvement of CAMHS into policy-making, the social care and education sectors have taken steps to address service inefficiencies to support children and young people's mental health (Charman, 2004). Progress monitored in the aforementioned sectors enhanced the notion that mental health support for children and young people could be part of a broader network of service providers. It also led to the publication of joint policies, such as "Every Child Matters" (2004), issued by the Department of Health in collaboration with the Department of Education. The policy suggested the sharing of data between the departments of healthcare and education and the development of a collaborative action plan to ensure better opportunities for children (Cottrell and Kraam, 2005).

Finally, the "National Service Framework for Children, Young People and Maternity Services" (2004) contributed to defining the main targets for improving young people's mental health and wellbeing, taking into account evidence collected from previous years about service gaps (Jenkins et al., 2010). It placed emphasis on supporting the "mental health and psychological wellbeing" of children and young people throughout childhood and teenage life (Department of Health, as cited in Jenkins et al., 2010, p. 29). The new policy introduced an evidence-based framework that stressed the need to provide service descriptions and to increase the funding allocated to CAMHS, suggested monitoring of outcomes and strengthening service development (Charman, 2004; Salmond and Jim, 2007; Jenkins et al., 2010). The recommendations of the National Service Framework were also compatible with the "4-Tier" service model. Most importantly, the framework contributed to promoting child and adolescent mental health as an integral part of the mental health service system and the overall healthcare policy (Charman, 2004).

### 2.5 2010 onwards: recent health and mental health reforms

Policies published from 2010 onwards had a direct impact on the current structure of Child and Adolescent Mental Health Services (CAMHS) (Callaghan et al., 2017). Public sector policy changes introduced during this period have been influenced by the global financial crisis and the austerity period in the UK (Alonso et al., 2011; Simonet, 2015). In light of a wider public sector reform, major changes were also announced for healthcare. The new structure of the healthcare system introduced by the Health and Social Care Act (2012) aimed to increase the autonomy of local healthcare systems in decision-making and funding allocation, allow the further development of the internal market which would increase patients' choices, and

encourage local collaboration and integration of services (Department of Health and Social Care, 2012a; Frith, 2013; Ham et al., 2015). Clinical Commissioning Groups (CCG) were also established, which became the new local decision-making bodies (Department of Health and Social Care, 2012a).

The development of CCGs was soon evaluated and deemed to be insufficient to respond to system challenges. Critics stressed that the new commissioning system did not provide adequate knowledge and expertise for selecting and contracting services locally; there was little clarity as to how the new competitive environment would operate and the ways via which collaborative relationships could develop; there were also fears that such policies would lead to decreased public spending on healthcare (Nuffield Trust, 2010; Pollock and Price, 2011; Hunter and Williams, 2012; Ham et al., 2015). Additionally, the availability of different service options for patients increased service fragmentation, as there were different services available from which patients could choose, which would become a boundary for continuity among service systems (Weaver et al., 2017). This period of NHS transformation also influenced the CAMHS provision. Policy reforms promised to address the disconnected service provision, which still existed under the “4-Tier” service system, promised more funding and supported the integration of mental health services for young people into adult services (Callaghan et al., 2017). As a result of the aforementioned policies, commissioning groups would now also manage funding allocation and local decision-making for CAMHS.

Recognising the need for parity of esteem between physical and mental healthcare, the government published a series of policies focusing particularly on mental healthcare, such as “No Health without Mental Health” (2011) and “Closing the Gap: Priorities for Essential Change in Mental Health” (2014). Such policies aimed to addressing major challenges in mental health service provision, including the establishment of waiting time standards, investment in suicide prevention, access improvement and eliminating stigma on mental health conditions (Department of Health and Social Care, 2011; 2012b; 2014; 2015; Parkin, 2016). The “Five Year Forward View for Mental Health” (2016) policy introduced performance indicators that would be used to evaluate progress and created benchmarks for the quality of mental healthcare (NHS England, 2016a). Particularly for younger age groups, policy reforms aimed to increase access of children and young people to psychological therapies with the aim of improving the quality of care and timely service provision; these reforms also enhanced the role of schools in early support of children and young people’s mental health (NHS England, 2014; Parkin et al.,

2019). As an outcome, policies made more specific recommendations as to how mental healthcare organisations should improve the quality of care and set indicators to which organisations were expected to respond.

Regarding children and young people's mental health, the government introduced "Future in Mind" (2015) – a collaborative policy published by the Children and Young People's Mental Health and Wellbeing Taskforce. "Future in Mind" was a key milestone for CAMHS, because it focused on addressing the needs of children and young people and it set priorities for the next five years. Among the policy's key priorities were changes concerning the organisational culture and structure of CAMHS (NHS England, 2015a; Parkin, 2016). The policy emphasised the need to increase investment in prevention and early intervention, adopt evidence-based interventions, establishing single access points to improve access, upskill the CAMHS workforce and adopt the "Improving Access to Psychological therapies for Children and Young People" programme (CYP IAPT) (NHS England, 2015a, p.22). It was also intended that the "Future in Mind" objectives be incorporated into the new Local Transformation Plans (LTP). The LTP were plans that outlined the local strategies for the improvement of CAMHS provision, as part of the "Five Year Forward View" (NHS England, 2015b) policy. Therefore, "Future in Mind" set recommendations for improving CAMHS provision, which local CCGs were expected to incorporate into the planning of local mental health provision for children and young people.

Multi-agency collaboration was acknowledged as a key factor for tackling system inefficiencies in mental health. "Five Year Forward View" (2014) and "Five Year Forward View for Mental Health" (2016) policies aimed to stimulate the development of integrated systems of care by supporting the reduction of the organisational barriers existing in the three levels of physical and mental health services, social care and healthcare, and specialised and primary service provision (Maruthappu, 2015). These policies also recognised the contribution of organisations that are involved in mental healthcare provision, such as the third sector, and encouraged their active participation in strategic planning for improving service quality (Department of Health, 2015; Parkin, 2016). Particularly for CAMHS, collaboration among local service providers became a critical target for improving services. Policies highlighted that mental health support to children and young people required the involvement of all organisations that are part of their environment, including schools and local authorities (Callaghan et al., 2017; Parkin et al., 2019). "Future in Mind" underlined the need to bring together local service providers and

address mental health at all levels, starting from school up to acute care (NHS England, 2015a).The importance of involving local organisations, and particularly schools, remained one of the main targets of the latest "Long Term Plan" policy, aiming to emphasise the need for early support (National Health Service, 2019). As a result of the latest policies, there was now a clearer demonstration of the necessity of CAMHS working together with local stakeholders in order to develop joint service provision.

The gradual recognition of the need to achieve parity of esteem between mental and physical health led to an increase in the government's commitment to financial investment in mental healthcare (Parkin, 2016). In 2015, it was announced that £1.25 billion would be allocated in the next five years to strengthen mental health service provision. As part of this budget, £118 million was allocated to support the "Improving Access to Psychological Therapies for Children and Young People" programme, and would arrive by the end of 2019 (CYP IAPT), while £25 million would be also allotted to third-sector organisations that support children and young people's mental health (Parkin, 2016). Additional funding was also to be invested in supporting the local CCGs for the development of LTPs (Parkin et al., 2019). Despite governmental commitments, mental health service provision continued to face significant challenges, leading services to failing in providing quality and timely service support (Naylor, 2016; Parliamentary and Health Service Ombudsman, 2018). Policy analysts explain that, in reality, a small percentage of the financial investment promised for mental health would actually be invested in service development, with most of it being allocated to maintaining the system's existing needs (Naylor, 2016). By 2016, there were already doubts about how much of the announced funding has actually been translated to CAMH service provision (Parkin et al., 2019). As a result, on top of the traditionally small share of funding allocated to them, CAMHS were influenced by the wider financial deficiency (Callaghan et al., 2017). Insufficient funds created even more pressure on the ability of CAMHS to address the needs of the local population.

Policy reviews showed that there has been noteworthy progress in developing CAMHS-specific policies, setting targets for service improvement, increasing funding in specific areas, training mental healthcare specialists, adopting evidence-based interventions and decreasing waiting times (Fonagy and Pugh, 2017; Children's Commissioner, 2018). Despite that have been made in service delivery, CAMHS continue to struggle with providing quality services and meeting children and young people's needs. Recent service evaluation reports showed that the majority of CCGs

have not been able to meet the NHS benchmark goals for improving CAMHS performance, funding for local CAMHS remained inadequate to meet local demand, while there was only minor relief in workforce needs (Frith, 2016; House of Commons, 2019a). With regard to investing in collaborative relationships, formal cross-departmental collaborations at a governmental level were still limited, thus restricting the implementation of key "Future in Mind" targets (National Audit Office, 2018). Finally, it remained unclear how some policy directions, such as the "Future in Mind" objective for collaborative working and performance improvement, would be implemented locally (Firth, 2017; House of Commons, 2019a; Parkin et al., 2019). Ultimately, it lay within the CCGs' responsibility to decide how to integrate policy guidance into their local transformation plans (NHS England, 2015b). As a result, CAMHS continued facing challenges, among which the most major appeared to be service fragmentation, poor performance and insufficient funding. The next section looks into the latest evidence available on CAMHS quality and effectiveness, mainly based on policy and service evaluation reports (for examples see Children's Commissioner, 2018, Crenna-Jennings and Hutchinson, 2018).

### 2.6 The current status of children and young people's health services in England

As discussed above, several policy initiatives have been published since the adoption of the "4-Tier" model, with the aim of resolving service inconsistencies. Nonetheless, the most recent service evaluation reports showed that CAMHS continue to face significant challenges in providing quality services and timely access. The latest findings demonstrated that 1 in 5 children and young people was required to wait up to 6 months to access professional services, including physical, mental and educational support (NHS Digital, 2017). Of the total number of children and young people referred to mental healthcare specialists, approximately a third (5-17 years old) accessed public mental health services, while a third went onto a waiting list and a third were discharged (Children's Commissioner, 2018). Although waiting times varied vastly among different areas in England, the majority of CAMHS exceeded the recommended 4-week limit (Crenna-Jennings and Hutchinson, 2018). In several CAMHS, long waiting times have been identified by the Care Quality Commission (CQC) as a priority issue to be addressed (Care Quality Commission, 2017).

Lack of appropriate information monitoring strategies remains a key challenge that limits the ability of CAMHS to develop a concrete picture of service access, quality,

and mental health prevalence in local populations (House of Commons, 2014). CAMHS appeared to have only a small number of indicators in place against which service performance is monitored and evaluated (Children's Commissioner, 2017). Service users' data are not always consistently documented, leading to an unclear picture about the number of young users and the services they use within CAMHS (Care Quality Commission, 2018; Crenna-Jennings and Hutchinson, 2018). The recent "Five Year Forward View of Mental Health" (2016) policy introduced new indicators for monitoring performance – a development that contributes to improving information monitoring (Frith, 2016; Fonagy and Pugh, 2017). Yet, limited investment in recording and learning from service outcomes appeared to remain an obstacle for understanding local service needs. At a system level, scarcity of compatible data management systems also limits CAMHS to understand the pathways of services patients use. When young service users are discharged due to high levels of CAMHS eligibility criteria, they will seek help from other organisations that provide mental health support (Hagell et al., 2017; Care Quality Commission, 2018). Yet, CAMHS do not often have processes in place that facilitate signposting to other services and do not monitor where young people go when they do not reach the CAMHS thresholds (Hagell et al., 2017; Crenna-Jennings and Hutchinson, 2018). The Children's Commissioner emphasised their concern regarding the very limited knowledge which CAMHS have about the service pathways young people follow after being discharged. Such significant omissions leave a gap of knowledge regarding the percentage of young people who receive mental health support within the local service system (Children's Commissioner, 2018).

Financial deficiency still appears to be a major barrier to service improvement in CAMHS. Despite the government's promises to boost financial support, it remains difficult to have a clear picture as to whether funding has actually increased. On the contrary, evidence illustrates that funding in real terms was reduced during the period of 2010-2014 (Frith, 2016; Fonagy and Pugh, 2017). Following new national regulations, local authorities appeared to have recently increased budget allocation in CAMHS and are expected to continue increasing their mental health funding allocation under the "Mental Health Investment Standard" requirement (NHS England and NHS Improvement, 2018). Yet, the percentage dedicated to CAMHS remains proportionally smaller in comparison with funding allocated to adult mental health services (AMHS). Funding to community CAMHS represents only 1% of the funding dedicated to community mental health at a local level (Children's Commissioner, 2018). Apart from the increasing difficulty in accessing services,

scarce financial resources also led to significant gaps in staffing, increased workload for staff members and early retirement (Davies, 2014; House of Commons, 2019a). Although the recent rise in national spending made it possible to better address workforce needs, it yet remains inadequate to manage local capacity gaps, while there seems to be a great disparity of staff coverage among different areas in England (Care Quality Commission, 2018; Children's Commissioner, 2018).

Service evaluation reports showed that third-sector organisations, schools and social care are also struggling to help children and young people and provide effective early mental health support (Care Quality Commission, 2018). The need to address local demand has led those organisations to seek solutions from opportunities of joint working. Such examples are the collaboration between local schools and NHS CAMHS, the establishment of joint commissioning partnerships among local service providers or joint training of professional groups for delivering evidence-based practice (Fonagy and Pugh, 2017; Care Quality Commission, 2018). Yet, local service providers are also expected to compete for the same financial resources, thus creating a complex system of relationships among local service providers (Children's Commissioner, 2017; Care Quality Commission, 2018). As a result, even good examples of collaborative service solutions remain a partial solution for service inefficiency (Care Quality Commission, 2018). Recent policy reports suggested that an effective system re-organisation should embrace the reduction of boundaries that limit local organisations' ability to collaborate, such as funding or diverse organisational aims and should recognise the contribution of local organisations, i.e. the third sector, schools and social care, to the mental health and wellbeing of children and young people (NHS England, 2015a; Care Quality Commission, 2018).

Overall, policy reforms in CAMHS contributed to increasing awareness about the importance of child and adolescent mental health and helped to establish this health area as a national priority. Child and adolescent mental health has progressively become part of governmental agendas for improving children and young people's quality of life (Fonagy and Pugh, 2017). Nonetheless, services have confronted significant inefficiencies up until today. To address this problem, most recent policies emphasised, among other things, the need to incorporate evidence-based knowledge into clinical practice, use data for the advancement of service effectiveness, increase financial resources to shorten waiting lists and boost staff numbers. Additionally, policies gradually shifted their approach by recognising that the mental health of children and young people is a societal challenge which is not

only a responsibility that lies with CAMHS, but a health area that can be addressed by multiple sectors, including education, social care and the third sector. As a result, communication pathways and the development of a common language among local organisations would now be a prerequisite for enhancing joint working (Dubicka and Bollock, 2017).

### 2.7 The structure of the local healthcare system and the Local Transformation Plan

Although the primary responsibility for decision-making regarding healthcare funding lies with the central government, local Clinical Commissioning Groups (CCGs) are responsible for identifying healthcare priorities that should be addressed in each geographical area, determining local strategies and deciding upon local budget distribution to local service providers, i.e. NHS services, voluntary organisations and private organisations (Robertson et al., 2017). Other funders also support the provision of services, such as the local County Councils or the NHS directly (Robertson et al., 2017). Within the geographic area this study was conducted, the local CCG is responsible for planning the service provision and improving the healthcare of a total population of 900,000 people. Approximately 145,000 are children and young people up to 19 years old (National Health Service, 2014; Goose, 2018). The local health system has been identified as one of the 11 local health economies in England. Services struggle to meet local needs due to the growing percentage of ageing population, social determinants such as poverty and inequality, the rising demand for mental health services, and significant financial pressures (National Health Service, 2014; Cambridgeshire and Peterborough Clinical Commissioning Group, 2016). The local healthcare system includes four different Trusts operating as private and public entities, which increases the complexity in service provision. To address the aforementioned challenges, the CCG developed a local Sustainability and Transformation Plan (STP), which is a system-wide service reform that could improve access to services and care quality.

Through the STP, the local CCG aimed to respond to the financial problems the area encounters in healthcare provision and increase the autonomy of local communities in adopting new care models that fit best to the needs of the local population (NHS England, 2014). Local Trusts also participated in the development of the STP, formalising in this way their active involvement in implementing the new plan. As part of “Five Year Forward View”, local commissioners developed an additional plan that would particularly address the challenges of mental health

services for children and young people. The Local Transformation Plan (LTP) focused on reforming the local mental health provision for children and young people with the aim of simplifying access to services and improving commissioning processes (Miller and Goose, 2016). Specifically, it aimed to stimulate the active participation of local authorities as well as voluntary and public organisations, and moderate service demand for adult services (NHS England, 2015b; Miller and Goose, 2016). To meet the objectives of the LTP, the local CCG chose to adopt the THRIVE Framework (Wolpert et al., 2016).

The THRIVE Framework suggests the re-organisation of service provision based on young users' needs and the active participation of local service providers involved in the provision of emotional and mental services (Miller and Goose, 2016; Tavistock and Portman NHS Foundation Trust et al., 2017). The existing "4-Tier" CAMHS system has been increasingly recognised as a structure that restricts collaborations among local organisations, mainly due to the organisational boundaries and the differences in organisational culture that were maintained within the four tiers (NHS England, 2015a). At the same time, there is increasing recognition that mental health services for children and young people ought to enhance the implementation of new practices in service provision, including evidence-based interventions, personalised care or social prescribing and investment in prevention and early intervention (Wolpert et al., 2016). Aligned with the "Future in Mind" objectives, the THRIVE Framework is based on the notion of developing a system-wide approach that is driven by the needs of children, young people and their families (Wolpert et al., 2016; Tavistock and Portman NHS Foundation Trust et al., 2017). THRIVE was developed by the Anna Freud Centre, the Choice and Partnership Approach Programme (CAPA), the Child Outcomes Research Consortium (CORC) and the Tavistock and Portman NHS Foundation Trust.

Based on four main components that classify service response, THRIVE suggests a decision-making process that assists in guiding service provision for addressing mental health needs (Diagram 2.3). The framework aims to cultivate functional collaborations among local providers and encourage the development of a common language about mental health support and treatment that is understood among different groups of professionals and organisations (Wolpert et al., 2016). Joint working also aims to enhance local service providers' accountability for participating in the development of a service system where children, young people and their families are adequately informed and understand the importance of seeking help when needed (Wolpert et al., 2016). Considering those factors, the effective

incorporation of the THRIVE Framework into clinical practice appears to be dependent on the creation of sustainable links among local service providers that can enable the exchange of knowledge and develop patient-centred service pathways, as well as on the learning ability of service providers, including CAMHS, to incorporate new knowledge from THRIVE.

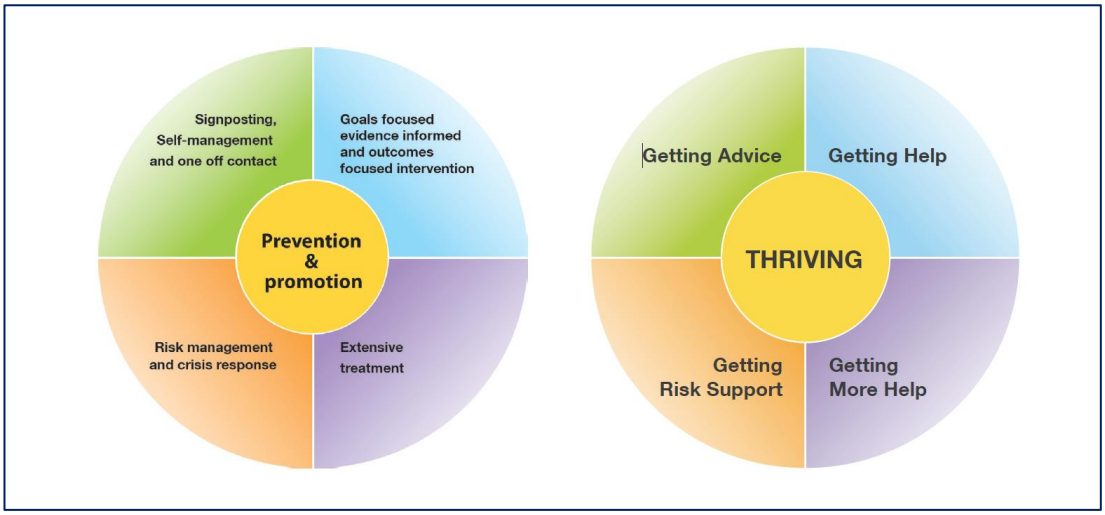



Diagram 2.3: The THRIVE Framework (as adopted by Wolpert et al., 2016)

The local CCG suggested a 5-year service transformation based on the THRIVE Framework (2015/2016-2020/2021) (Miller and Goose, 2016). The latest CCG review on CAMHS re-design demonstrated that part of the targets of the LTP published in 2015-2016 have been addressed. For example, strengthening service pathways for ADHD and Autistic Spectrum Disorders led to a reduction in waiting times. Transition from CAMHS to Adult Mental Health Services (AMHS) has been improved by the support of professionals who act as gatekeepers and assist with appropriate transition to AMHS (Goose, 2018). Emotional wellbeing needs were addressed by the development of Children Wellbeing Practitioners (CWP) who support children and young people with early to moderate mental health difficulties and contribute to information mobilisation among local organisations. Staff members of local service providers received training for “Improving Psychological Therapies for Children and Young People” (CYP IAPT). Moreover, service provision is supported by a new contractual agreement with counselling services to contribute to accessing evidence-based interventions (Miller and Goose, 2016). Therefore, local services, and mainly CAMHS, have responded, to a certain degree, to incorporating the THRIVE principles into practice according to the CCG. The next targets include,

among others, improve access to services supporting children and young people who are at risk due to complex life conditions, increase investment in suicide prevention and embody digital support in clinical practice (Goose, 2018).

Overall, the local CCG aims to transform services for children and young people by decreasing organisational boundaries among different service providers and improve the quality and effectiveness of services. Moving from a fragmented to a unified system of service provision could address current service problems, but it would require providers to develop and use sustainable communication pathways that could enable the systematic exchange of knowledge. THRIVE is not a framework that was adopted to focus solely on the transformation of NHS CAMHS, but also on improving the broader service provision system for children and young people. As the main provider of child and adolescent mental health services and largely funded by the local CCG, the local NHS CAMHS are called to align their strategies with the LTP and the THRIVE Framework, and to actively participate in the development of a holistic system of service provision. During the period of the current study, there was very limited evidence about the course of implementation, because service transformation was still in progress. Nonetheless, exploring the incorporation of knowledge about THRIVE within CAMHS and the local environment assisted in understanding more about the responsiveness of CAMHS to embed knowledge from THRIVE in their services.

## 2.8 Conceptual framework: the potential of absorptive capacity for CAMHS

CAMHS are required to transform their service according to the local strategic planning. As part of this, services are expected to incorporate new knowledge from multiple sources with the aim of reconfiguring existing organisational processes and improving service quality and efficiency. Evidence-based interventions, knowledge about digital transformation or practices of knowledge sharing with other service providers are examples of knowledge areas that local CAMHS are expected to embed in daily clinical practice. Developing these CAMHS' absorptive capacity has the potential to improve their responsiveness to new knowledge areas and, eventually, advance service quality. As discussed in Chapter 1, scholars argued that future research on absorptive capacity in the public sector should consider the role of the organisational context and the inter-organisational environment. A conceptual framework was developed to explain the investigation of absorptive capacity in a

mental healthcare organisation and CAMHS, and the position of the organisation within the wider healthcare system.

Developing a conceptual framework (Diagram 2.4) demonstrates the synthesis of the main theoretical concepts of this dissertation, i.e. absorptive capacity theory and the organisational context of CAMHS (Green, 2014). As defined by Miles and Huberman:

> *A conceptual framework explains […] the main things to be studied – the key factors, constructs or variables – and the presumed relationships among them […] can be rudimentary or elaborate, theory-driven or commonsensical, descriptive or causal* (Miles and Huberman, 1994, p.18).

The conceptual framework illustrates the study of absorptive capacity within the CAMHS environment. CAMHS are provided by one of the main departments of the case study organisation, which is a local mental health NHS Foundation Trust (further described in Chapter 3). Within the CAMHS department, the key components of identification, assimilation and exploitation of knowledge were studied (Cohen and Levinthal, 1990). According to absorptive capacity literature, absorptive capacity is associated with the improvement of organisational performance and service provision, which has driven the exploration of absorptive capacity within the CAMHS department (Croft and Currie, 2006; Harvey et al., 2010b). The CAMHS department is part of a wider organisation, an NHS Mental Health Trust, and is governed by the same regulations as the rest of the organisation. Beyond the Trust's boundaries, the CAMHS department operates within a wider environment. Various organisations contribute to the development of mental healthcare provision for children and young people, among which is also the CAMHS department as part of the case study organisation. The inter-organisational environment of CAMHS was distinguished at a national and a local level. At a national level, organisations' key contributions in service provision can be summarised in the development of regulations and guidelines for service quality, funding services, issuing of national policies or reports about service evaluation. National organisations appear to have primarily regulatory, advisory and supervisory responsibilities that direct the operations of the CAMHS department and the case study organisation, such as the NHS England, the Care Quality Commission (CQC) and the National Institute for Care Excellence (NICE). Locally, organisations mostly make a direct contribution to the mental health needs of the local population. Local service providers cover early stage mental health difficulties or address needs that

public CAMHS are struggling to meet. Local authorities focus primarily on funding allocation, service reforms and local decision-making.

Thus, the CAMHS department operates within a broader environment and, together with service providers and national organisations, aims to meet the mental health needs of young service users. Indicative boundaries in Diagram 2.4 outline the distinction between the CAMHS department and the case study organisation, as well as the national and local environments, although in reality such boundaries are less clear. This is because the objectives of the case study organisation can also influence the operations of the CAMHS department, while the operations of organisations in the external environment might expand to both national and local levels (for example, a local department of a national mental health organisation can offer services at a local level). Drawing together key dimensions of the construct of absorptive capacity and elements regarding the structure of the healthcare system, the following conceptual framework has been developed.

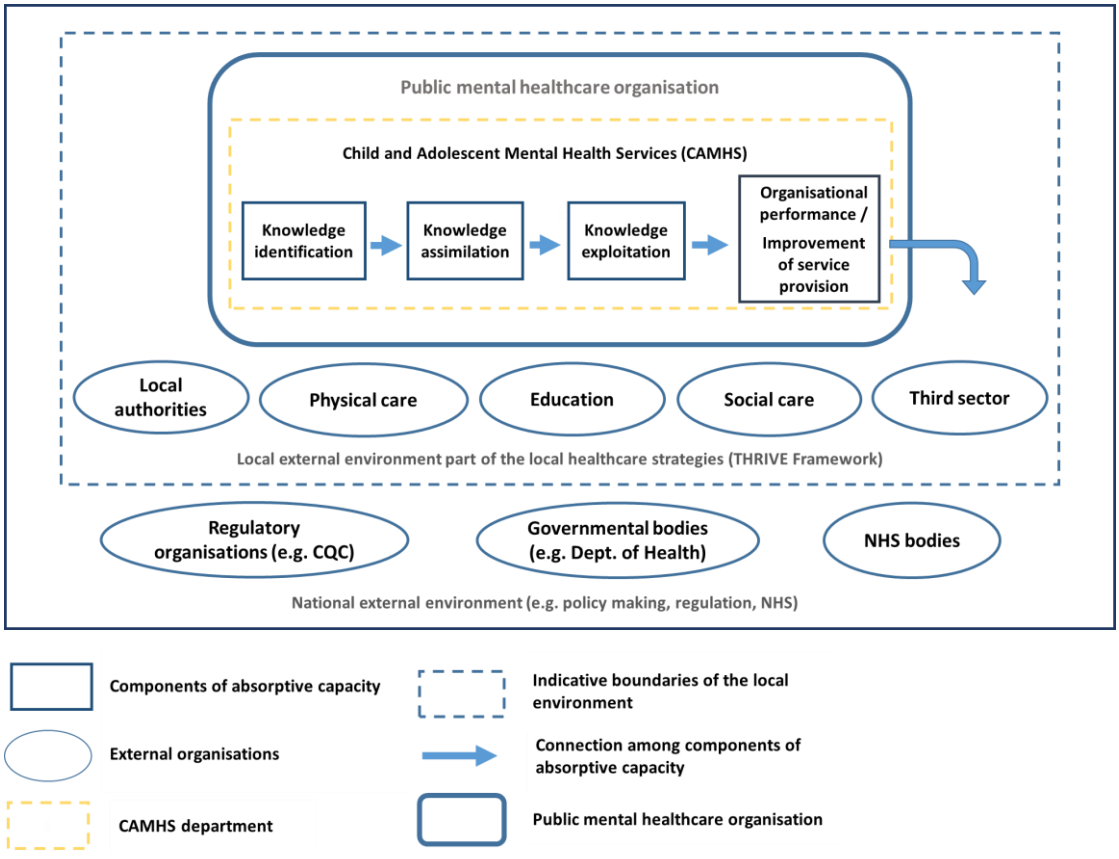



Diagram 2.4: A conceptual framework exploring the absorptive capacity of the CAMHS department, part of a mental health organisation

The conceptual framework is placed at the end of this chapter to demonstrate how absorptive capacity was explored in the public mental healthcare environment, to guide the development of the research design, and to operate as a point of reference for understanding the analysis of the thesis (Baxter and Jack, 2008). A revised framework is presented in the discussion section (Chapter 6), which incorporates how key findings of the study contributed to understanding the absorptive capacity in the selected case study organisation (Yin, 2013).

## 2.9 Summary

In order to gauge the influence of the organisational context on absorptive capacity, it was necessary to review the organisational background of CAMHS. This chapter briefly studied the structure of the NHS CAMHS, starting from the national policies in the 1990s until the recent development of local Sustainability and Transformation Plans. Several policies focused specifically on CAMHS: the “4-Tier” model, the “National Service Framework for Children, Young People and Maternity Services” and “Future in Mind” had an impact on shaped the services, aiming to address fragmentation and emphasise the need for evidence-based service provision. Most importantly, such policies contributed to bringing child and adolescent mental health into the policy spotlight, underscoring the need to strengthen early support; said policies also encouraged’ the development of collaborative work among service providers. Despite the steady improvement of CAMHS during the last three decades, more recent service evaluations demonstrated that service inconsistencies persevere. Services continue to confront major problems, among which are long waiting lists, decreased workforce and specialised staff, as well as difficulty in developing collaborations among service providers.

Reviewing the policy background illustrated that NHS CAMHS form part of an increasingly complex environment comprising national and local stakeholders. CAMHS are expected to meet governmental requirements regarding service efficiency, to develop partnerships, to increase the use of data and evidence-based knowledge, and to incorporate service users’ experiences into practice. Services are also required to comply with clinical guidance and regulation from NHS bodies (for instance NHS Improvement, NICE or the Care Quality Commission). At a local level, CAMHS are also committed to complying with the strategies of local CCG, such as in the case of the selected organisation, which includes participating in the adoption of the THRIVE Framework, together with other local organisations. As a result, CAMHS are expected to address a wide spectrum of improvement areas in order to

deal with existing challenges. Cultivating the learning ability of CAMHS at an organisational level can contribute to reconfiguring services in ways that improve provided services and address local needs. Based on the absorptive capacity theory reviewed in Chapter 1, the proposed conceptual framework suggests the exploration of the absorptive capacity of the CAMHS environment. Studying absorptive capacity can shed light on the current learning abilities of CAMHS and make propositions about how they can be improved. Contributing to advancing the quality of CAMHS is an investment in children and young people's mental health and increases the changes for a healthy adult life.

# Chapter 3

## Research Methodology

This chapter presents the research methodology selected to investigate the absorptive capacity in Child and Adolescent Mental Health Services (CAMHS). A public mental health organisation was chosen as the case study organisation, with a special focus on the CAMHS department (Yin, 2013). Considering that absorptive capacity can be influenced by the inter-organisational environment, local organisations were also included in the study with the aim of exploring their role in the CAMHS' absorptive capacity. Qualitative research methods were utilised in order to gain insight into the department's absorptive capacity by collecting staff members' own views and by analysing organisational documents. Existing studies in absorptive capacity have encouraged the adoption of qualitative methods, as they can provide an in-depth narrative about the dimensions that make up absorptive capacity and a more detailed explanation about the interface among those dimensions, while they can offer views in aspects where quantitative methodology might be limiting (Easterby-Smith et al., 2008b; Harvey et al., 2010b Müller‐Seitz, 2012).

The main objective of the study was investigated via two main research questions:

1. How do public Child and Adolescent Mental Health Services (CAMHS) identify, assimilate and exploit new external knowledge?
2. What is the role of the inter-organisational environment in shaping the ability of public CAMHS to identify, assimilate and exploit new external knowledge?

The next sections present the research paradigm underpinning the current study, the selected case study organisation, as well as the research methods chosen for the study. The process of data collection and analysis is also explained, together with the methods of triangulation selected for combining the data.

### 3.1 Research paradigm

A research paradigm explains the epistemological and ontological perspectives that advise the development of research methods and data interpretation. The research paradigms that have been formulated in organisation theory have been strongly influenced by social theory. Research paradigms that became "exemplars" for social research were eventually transferred to organisational science in around the 1970s

and became an opportunity for organisation theorists to discuss their philosophical angles beyond the prevalent paradigm of functionalism (Clegg and Hardy, 1999; Burell, 2002; Kuhn, 1970, as cited in Burrell, 2002, p.26; Tsoukas and Chia, 2011). Burrell and Morgan's work became a milestone in initiating a philosophical conversation about the development of research paradigms in the organisational science field "based upon different sets of metatheoretical assumptions about the nature of social science and the nature of society" (Burrell and Morgan, 1979, p.8). The four separate research paradigms which they suggested, i.e. functionalism, interpretivism, radical humanism and radical structuralism, were based on the debate between the objective and subjective dimensions of science and the regulatory and radical dimensions of society (Burrell and Morgan, 1979).

Burrell and Morgan's work provided a basis the development of more pluralistic approaches in organisational theory (Tsoukas and Chia, 2011). As the dialogue on research paradigms continued, additional research paradigms became part of the ontological/epistemological landscape, including the postmodernist approach and the critical realism approach (Burell, 2002; Newton et al., 2011; Hatch and Cunliffe, 2013). To address the differences between research paradigms, Gioia and Pitre suggested that new approaches should be able to combine dimensions from paradigms that appear to be contrasting, which could offer new perspectives in organisational research and address the unilateral approaches that have been introduced by traditional paradigms (Gioia and Pitre, 1990). Research studies could benefit from "a multi-paradigm approach to theory building [which] would help researchers achieve a more comprehensive understanding of organizational phenomena" (Vera et al., 2011, p.156).

Contemporary literature in organisation studies primarily discusses three key research paradigms: functionalism (also referred to as modernism), constructionism (also referred to as interpretivism) and postmodernist approaches (Hatch and Cunliffe, 2013). Critical realism is also prevalent in organisational studies, which emerged as a response to the debate between positivism and interpretivism (Tsang, 2014). According to functionalism, the world has one true dimension, which can be discovered in similar ways as the physical world (Burrell and Morgan, 1979). In contrast with the predominant functionalist paradigm, constructionism assigns a subjective view on social reality and aims to interpret the world through the meanings attributed by social beings (Reed, 2006). Postmodernism also rejects the objective view of the world and suggests that language is the means through which reality can be explained (Hatch and Cunliffe, 2013). Critical realism accepts the

existence of an external world, to which humans have access through their own understanding of reality. It suggests that social reality represents only a small part of that external reality and the real world exists beyond the social dimension of it (Fletcher, 2017).

Aiming to explore the absorptive capacity of the CAMHS department, the current thesis is informed by the research paradigm of weak social constructionism. Weak social constructionism suggests that social events are interpreted through the meanings individuals collectively assign to them within a certain context, and therefore knowledge is socially constructed. Yet, there is an objective reality beyond the social context (Searle, 1995). In contrast with strong social constructionism, weak social constructionism argues that there is an objective, real world outside its subjective interpretation (Sayer, 1997). Due to its realist ontology, weak social constructionism is placed close to critical realism on the continuum, as both research paradigms present similarities in suggesting an objective view of the world (Sayer, 1997). Weak social constructionism contributes to understanding a central debate in sociological theory between the social construction of reality suggested by constructionism and the objective existence of the world argued by realism (Somerville and Bengtsson, 2002; Rust, 2005). This approach can be useful for examining organisational phenomena, by bringing together the different perspectives of individuals to interpret those phenomena, while accepting the objective existence of reality.

Weak social constructionism accepts the socially constructed nature of organisations and knowledge, yet it argues that there is an objective reality (Lawson, 2002; Somerville and Bengtsson, 2002). Searle suggests a distinction between the objective ontology and the subjective-objective perception of epistemology. The world is composed of “brute facts” and “institutional facts” (Searle, 1995, p.2). Institutional facts emerge as an outcome of human interpretation within a specific context, such as the monetary system or the social institution of marriage. Brute facts exist beyond social interpretations and are independent of the human perception (Searle, 1995). More specifically, weak social constructionism suggests that there is an objective world that is composed of objective facts and which is independent of human interpretation – e.g. the existence of a mountain or a river. There is also the humanly constructed world which is made up of systems, meanings or beliefs. Yet, within this environment, there is a distinction between an objective and a subjective perception of knowledge in an “epistemic sense” (Searle, 1995, p.8). For example, the statement “Abraham Lincoln was the 16$^{th}$ President of

the United States" is objective in the sense that individuals' perceptions cannot alter this fact. It is ontologically constructed, because the American governance system is human made. The statement "Abraham Lincoln was a great president" is a subjective statement as it entails one's political belief and views. Therefore, a distinction is proposed between events of the social world that are largely independent of individual perceptions and events that are highly dependent on individual values, beliefs or attitudes. Searle explained that:

> *Whenever the function of X is to Y, X and Y are parts of a system where the system is in part defined by purposes, goals, and values generally. This is why there are functions of policemen and professors but no function for humans […]. Whenever the function of X is to Y, X is supposed to cause or otherwise result to Y. […] because X has the function Y-ing even in cases the function X fails to bring about Y* (Searle, 1995, p.19).

This means that a fact, X, can be interpreted by individuals in a certain way (i.e. Y) within a specific system or environment, to which certain functions have been assigned. X can result in Y within this environment and, thus, Y becomes an indication for X even in the case when X does not always cause Y. For example, the function of a pen is to write, and this remains a function of a pen even if the pen is broken. A Y event is useful to understand the world around us in the sense that it can assist in understanding more about X. Y events that emerge as an outcome of the individual's interpretation do not reduce the characteristics of X as part of a wider system; instead they present a version of it as this appears within a specific environment or organisational setting. In other words, individuals can state social events to interpret ontologically-subjective phenomena (e.g. election system), as well as ontologically-objective phenomena (e.g. gravity).

For Searle, social facts also entail "collective intentionality", i.e. a belief an individual has about something, as part of a group believing the same thing (Searle, 1995, p.23). Thus, an individual's intention to interpret a social event is mainly driven by the collective intentionality of the group to which the individual belongs. For instance, a person plays football as part of a team and acts as part of a group's intention to play and potentially win. Additionally, institutional facts exist within environments that are characterised by "constitutive rules", i.e. rules that do not only aim to regulate a specific environment, but also enable the realisation of an action (Searle, 1995, p.27). For example, the rules of football do not only regulate football, but also create the appropriate conditions for individuals to actually play. Overall,

these elements make up social reality within weak social constructionism. Individuals' ability to state institutional facts in order to give meanings to brute facts contributes to creating a representation of the real world. The interpretation of the real world via institutional facts is not separate from the real world, but a continuation of it. Weak social constructionism assisted in unfolding absorptive capacity within a new organisational context, interpreting individuals' role, and understanding the factors influencing its development.

### 3.2 Abductive research approach

An abductive approach was adopted to inform data analysis and the interpretation of the research findings. Abduction aims to understand and theorise social phenomena through the interpretation of concepts that were identified from collected data (Blaikie, 2007). It suggests a thinking process, a reasoning pathway, which aims to consolidate individuals' experience and transform it into concepts that can contribute to the construction or re-construction of a selected theory (Kapitan, 1992; Dubois and Gadde, 2002). It moves beyond solely portraying a representative image of the collected data, aiming to build a theory from the newly identified concepts (Blaikie, 2007). Ultimately, the aim of abduction is to suggest a new pathway of research development which is informed by the study outcomes and can expand existing research (Kapitan, 1992).

> *It is the process of moving from lay descriptions of social life, to technical descriptions of that social life that the notion of abduction is applied* (Blaikie, 2007, p.91).

Specifically, abduction can enable the development of new theoretical contributions in a case study research design (Dubois and Gadde, 2002). During the stage of data interpretation, the researcher describes the activities of study participants and it is expected that said description will remain close to the vocabulary used by the individuals. Following the initial interpretation, concepts that have been generated from data analysis can be further developed and associated with the adopted theory (Blaikie, 2007). An abductive approach makes it possible to create associations between data and theoretical concepts by "going back and forth between [the theoretical] framework, data sources and analysis" (Dubois and Gadde, 2002, p.556). Abduction enables the creation of new concepts outside the original theoretical framework (Meyer and Lunnay, 2013). It is primarily associated with the

constructionist research paradigm and it has also been adopted in studies influenced by a realist ontology, such as critical realism (Fletcher, 2017).

### 3.3 Literature review

The literature review conducted in Chapter 1 drew together scholarly work on the main subject of the current thesis, i.e. absorptive capacity in mental healthcare organisations, and presented the research gap that this study aims to address (Grant and Booth, 2009). Academic papers were selected based on their relevance to the theory of absorptive capacity, the use of knowledge in the public sector and the development of knowledge mobilisation concepts in public healthcare organisations. Absorptive capacity theory was the central focus of the literature review, while the other two scientific fields were used to inform the literature review. Academic works included in the literature review were selected based on the objectives of the study (Jupp, 2006). While suitable studies were included in the review, others were excluded for being less relevant or not directly contributing to the research objectives of the thesis.

A group of key words/phrases and combinations of key words/phrases was used to search for literature several times in electronic databases (Table 3.1). Published papers and books were identified via Science Direct, Google Scholar, PubMed and the Anglia Ruskin University Library online search engine. The database search was inclusive of different research methodologies and geographic areas (Webster and Watson, 2002). The reference lists of key papers were also reviewed to identify works relevant to the main areas of the literature review and provide further clarifications about existing research gaps.

| Key words for literature review | |
|---|---|
| **“Absorptive capacity”** | “Absorptive capacity” and “Healthcare” |
| **“Organisational learning”** | “Organisational learning” and “Absorptive capacity” |
| **“Organisational knowledge”** | “Organisational knowledge” and “Absorptive capacity” |
| **“Public sector”** | “Public sector” and “Knowledge” |
| **“Knowledge mobilisation”** | “Knowledge mobilisation” and “Healthcare” |
| **“Child and adolescent mental health services”** | “Child and adolescent mental health services” and “UK” or “England" |

Table 3.1: Key words utilised for the search of literature

Additionally, a search on the citation indexing website Web of Science was conducted, identifying approximately 8,000 academic works which included the term “absorptive capacity” in their title, abstract or authors’ key words. The vast majority of published works were in the fields of “Management”, “Business” and “Economics”, while only 66 papers were in the field of “Public Administration” and 35 in the field of “Health Policy Services” – categories that appeared to be most relevant to the present study. This search demonstrated that research on absorptive capacity in public organisations is limited, while only a small number of studies have been conducted to assess the absorptive capacity of public healthcare organisations.

The study also included grey literature that contributed to describing the organisational context of CAMHS. In Chapter 2, national policy papers from the Department of Health, inspection reports from the Care Quality Commission (CQC), reports from the House of Commons and service evaluation reports from national policy organisations and think tanks (e.g. Children’s Commissioner, the King’s Fund or the Nuffield Trust) were reviewed in order to understand the current structure of CAMHS, as well as to draw together most recent data about service quality and performance. Local service planning reports from the local Clinical Commissioning Group were used to describe the local service environment and the latest healthcare

plans for service transformation at a local level. Organisational documents, such as annual reports and organisational strategies, were employed to provide details about the case study organisation. Overall, grey literature assisted in understanding the CAMHS organisational context, the challenges that services face today, and the local environment where the study was conducted.

### 3.4 Case study research design

The current study utilised a case study research design to investigate the absorptive capacity of Child and Adolescent Mental Health Services (CAMHS). A case study allows for the in-depth exploration of a social phenomenon which takes place within a pre-defined environment (Stake, 1995; Thomas, 2011; Yin, 2013). Case study research designs have been used in different scientific disciplines, primarily within the social sciences field, such as sociology, anthropology, as well as in organisation studies (Hamel et al., 1993; Stablein, 2006; Stake, 2011). Case studies have been increasingly used in organisational research, including studies in healthcare, with the aim of developing a comprehensive image of organisational phenomena (Fulop et al., 2001; Baxter and Jack, 2008). It is a suitable research design when theory about a particular social phenomenon is still in the early stages, when the context can affect the phenomenon under examination, and when the boundaries of the two are not clearly distinguished (Hamel et al., 1993; Yin, 2013). Yin's case study propositions, an often-cited work for developing case studies, have been used to develop the research design of this thesis (Stablein, 2006; Yin, 2013). Considering the limited evidence available about the nature of absorptive capacity in healthcare settings, a case study research design contributed to understanding this phenomenon in the selected case study organisation.

A case study is suitable for seeking answers to "how" and "why" questions and investigating elements that make up a certain phenomenon (Yin, 2013, p.9). Different research methods can be combined in a case study, such as document analysis, interviews, observation and questionnaires, where data can be drawn together to interpret a social phenomenon (Hamel et al., 1993; Fulop et al., 2001; Stake, 2011; Gentles et al., 2015). The combination of different research methods can strengthen the study outcomes (Baxter and Jack, 2008). Particularly in organisation studies, research that adopts more than one method can provide a comprehensive understanding of the examined phenomenon (Jick, 1979). The current case study utilised two research methods: organisational documents and semi-structured interviews. The selected methods assisted in exploring the ability of

the CAMHS department to identify, assimilate and exploit new knowledge, as well as to interpret the department's relationship with the external environment. Information from the organisation's website was also reviewed to describe the case study organisation, as well as its aims, structure and size. The selected research methods are presented in detail in the next sections.

The case study research design developed for this study presents several limitations. Data collection may result in large, difficult-to-analyse textual data (Yin, 2013). Keeping the research objectives in mind can facilitate navigating through large qualitative datasets. Case studies allow for the investigation of a specific phenomenon only in a certain time period, limiting the insight which longitudinal data can offer (Yin, 2013). Yet, organisational phenomena may entail processes that take place over time, such as the examined phenomenon of absorptive capacity. Data collection from two research methods assists in collecting data from different sources and creating a comprehensive image of absorptive capacity in the CAMHS department. Due to the nature of this research approach, findings cannot be represented numerically and cannot be generalised in the same way that quantitative methods are (Hodkinson and Hodkinson, 2001). A detailed description of data collection and analysis can demonstrate rigorousness in a case study and support the trustworthiness of the study outcomes. The next section explains the strategies followed in the current thesis to show the trustworthiness of the case study design and outcomes.

### 3.4.1 Building a rigorous case study

The rationale of a case study research design is to collect evidence about a phenomenon within a particular environment that can contribute to its theoretical conceptualisation. Although the intention of the researcher collecting and analysing qualitative data is to remain as objective as possible throughout the study, it is impossible for said researcher to not involve their subjective perception (Stake et al., 1995). Providing explanations about the suitability of the selected case study organisation and its structure, the selection of participants and documents, the selection of other local organisations, as well as the data analysis processes that have been developed, can demonstrate the "trustworthiness" of qualitative research methods (Shenton, 2004, p.63).

Setting up a case study entails a series of decisions that demonstrate the rigorousness of the research design, such as selecting the case study environment,

defining its boundaries, choosing suitable research methods for data collection, and elucidating the data analysis. Such description allows other researchers to understand the new concepts that have been generated within the pre-defined context and identify similarities between different environments while considering the "transferability" of findings (Shenton, 2004, p.69). A detailed description of the case study, justification of selection and case study boundaries are provided in Section 3.4.3 and Section 3.4.4, which enables the comparison of the selected organisational setting with similar ones. The aim of transferability is not to generalise outcomes in the same way as in quantitative studies. Considering that every environment is composed of a unique combination of characteristics and conditions, transferability aims to facilitate understanding about the potential transfer of study findings in different environments and contribute to shaping a wider picture of the researched phenomenon (Shenton, 2004).

A case study research design also aims to show that the research outcomes are an actual representation of the organisational reality. "Credibility" can be demonstrated by selecting appropriate and reliable research methods and triangulating data, as well as by comprehending the nature of the selected organisation (Shenton, 2004, p.64; Baxter and Jack, 2008). The selected research methods, i.e. qualitative interviews and documents, are often used in case study research designs, especially in organisational settings case studies, including healthcare (Braun and Clarke, 2006; Yin, 2013; Buchanan, 2015). Data findings were triangulated to demonstrate complementary meanings (Denzin, 2009). Further details about document analysis are presented in Section 3.5, interviews analysis is described in Section 3.6, and triangulation is explained in Section 3.7. Understanding of the case study organisation was an amalgamation of knowledge from organisational documents, semi-structured interviews and information from the organisation's website.

An accurate and justified description of the research design and data analysis can also establish that research outcomes resulted from a rigorous research rationale and minimise the impact of the researcher's own perception – also called "confirmability" (Shenton, 2004, p.72). Additionally, adopting a detailed explanatory narrative throughout the study provides rich details about the study, permitting the research design to function as an exemplar for future works that investigate the same organisational phenomenon and potentially leading to similar results (Mays and Pope, 2000; Shenton, 2004). Such a description process can also increase transparency regarding the methods used in the study. Ultimately, a demonstration

of “dependability” can provide a framework according to which a similar research study can be repeated (Shenton, 2004, p.71).

Different approaches have been suggested regarding how qualitative analysis and reporting can become more rigorous, and these suggestions often involve specific criteria, actions or sequences of steps that can increase the validity of the research outcomes (May and Pope, 2000; Barbour, 2001; Baxter and Jack, 2008). Many of those measures can potentially contribute to enhancing the soundness of qualitative studies, although they may also lead to transitioning to a quantitative type of analysis (Barbour, 2001). The essence of rigorous qualitative analysis appears to lie primarily in developing a detailed, reflective narration of the study development and in demonstrating a systematic analysis of the collected data (Dingwall et al., 1998; May and Pope, 2000). As an outcome, the need to provide a structured explanation of the implementation of the study design and data collection and analysis is considered throughout this thesis.

### 3.4.2 Embedded single-case study research design

The purpose of the case study was mainly exploratory and aimed to make propositions about how the researched phenomenon can be further investigated in future studies (Yin, 2013). An embedded, single case study design was developed to explore the absorptive capacity of Child and Adolescent Mental Health Services (CAMHS). Considering that CAMHS form part of a larger public mental healthcare organisation (NHS Foundation Trust), an embedded case study design was most suitable, making it possible to focus on one unit rather than taking a holistic approach where the whole organisation would be the focus of the study design (Yin, 2013). The main unit of the study was the CAMHS department, while a small number of participants from two additional departments were included in the study to contribute to understanding the absorptive capacity of the department. The selected mental healthcare organisation was a common case study. Adopting a common case study assists in identifying daily events and elements, with the purpose of providing insight into the processes that make up an examined phenomenon (Yin, 2013). Next to the case study organisation, a number of local organisations involved in the provision of mental health services to children and young people were included in the study. Adding those organisations to the research design assisted in exploring the role of the inter-organisational environment of the absorptive capacity of the CAMHS department. This project study followed an adaptive design which allowed for the constructing of reasonable adjustments in the study design during

the course of the study – important when it comes to best answering the research questions (Yin, 2013).

More specifically, three departments were included in the initial study design (Diagram 3.4), while a number of local authorities, third-sector organisations and a private company were added to the study design as part of the local external environment. New elements that were identified during the early stages of the study required several adjustments to be made. Within the case study organisation, availability of staff members was different to that initially planned and new participants from different departments were invited to contribute to the research (please see Section 3.6.1 for more details on selection of study participants). Initial contact with local organisations showed that not all had the capacity to participate in the study (e.g. third-sector organisations), and thus new organisations were sought to participate in the study design (please see Section 3.4.4. for a description of local organisations). Interviews with study members of the case study organisation also revealed new organisations that were relevant to be included in the study due to their relationships with the CAMHS department, such as a local NHS organisation and a local social enterprise. Diagram 3.4 demonstrates the initial research design and Diagram 3.5 shows the final research design.

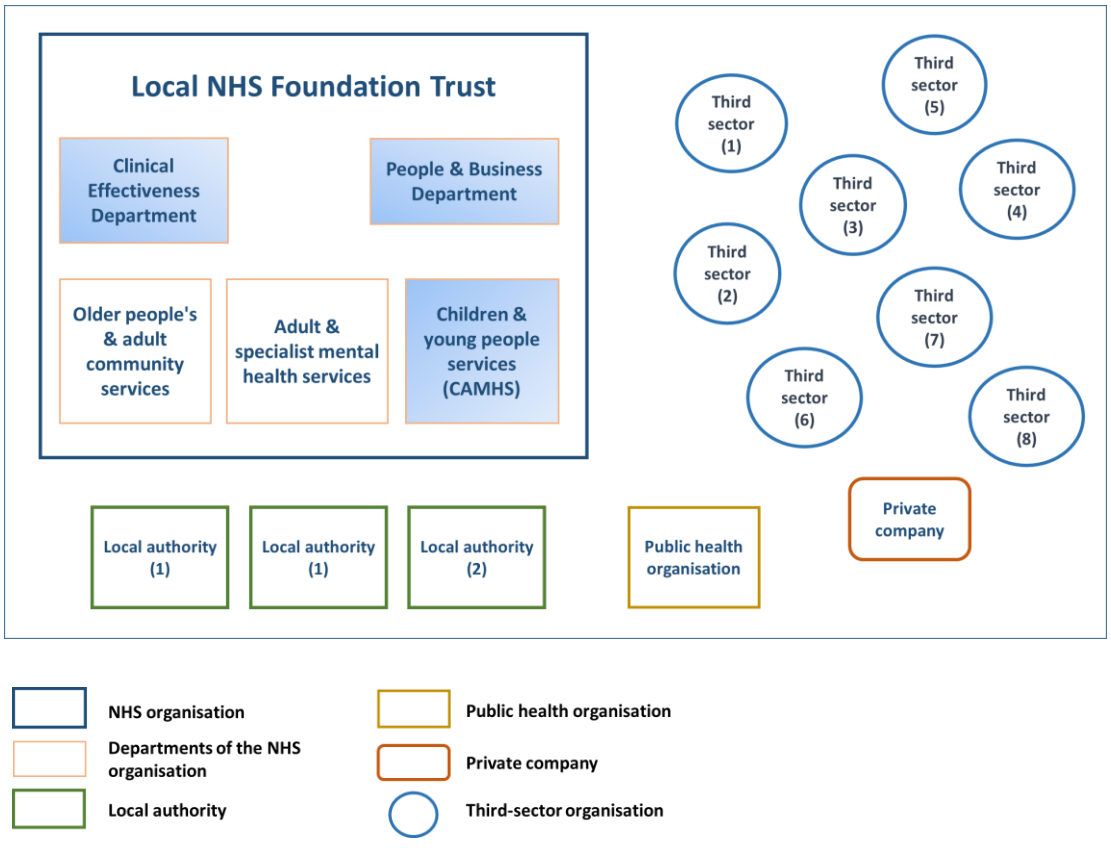



Diagram 3.4: Initial research design (case study and local organisations)

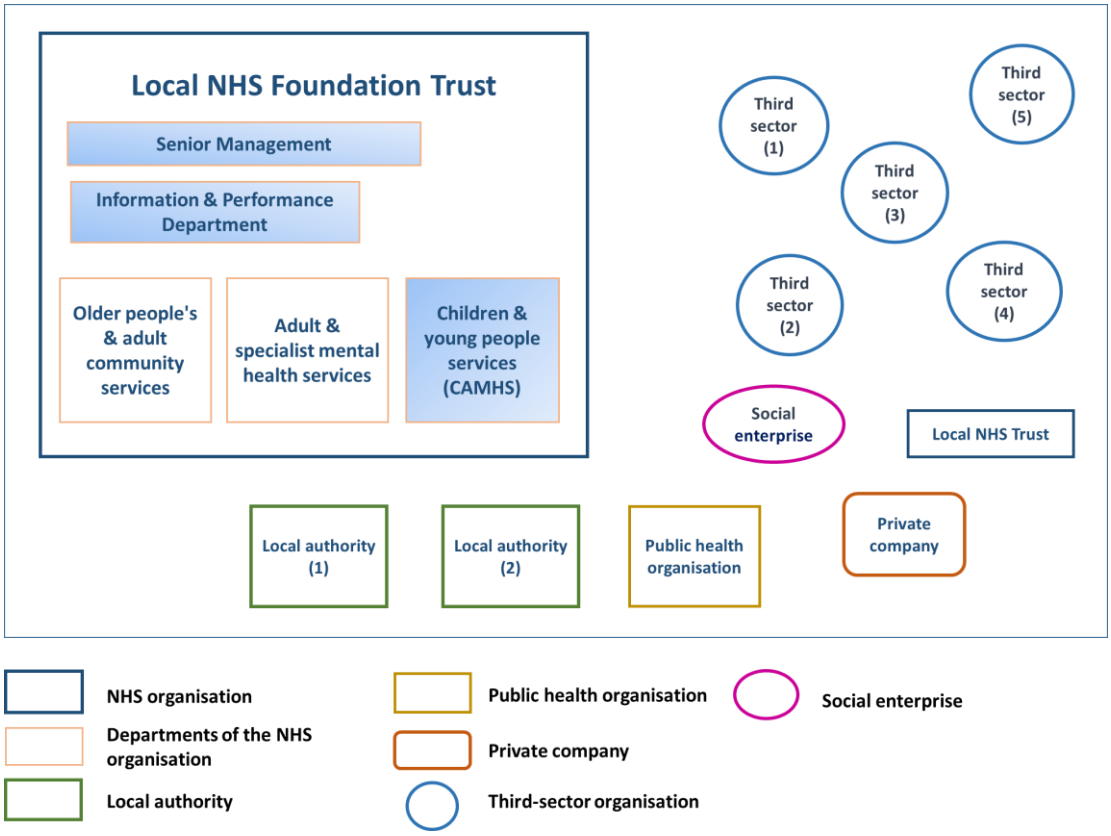



Diagram 3.5: Adjusted research design (case study and local organisations)

Including the case study organisation in the study and collecting data required contacting the research department of the organisation and requesting access. In particular, an initial contact was made with the R&D Department of the case study organisation, to discuss the process of gaining access to the organisation and collecting data. Collecting data within the main case study organisation required an ethics approval from the Health Research Authority (HRA) and an ethics approval from the University leading the present study. Specifically, a staff-only ethics request for conducting research within a NHS healthcare organisation was approved by the Health Research Authority (HRA) (IRAS Project ID: 230225) (please see appendix for ethics approval Letter 1). A participant information sheet, a consent form, the study's research protocol, an interview guide, and a description of activities were included in the application (please see appendix for the PIS and the CF). A second ethics request was approved by the Faculty Research Ethics Panel of Anglia Ruskin University (FREP number: FMSFREP/16/17 160) (please see Appendix for ethics approval Letter 2). Both approval processes were completed prior to the start of the study. During the course of the study, an additional NHS organisation was identified as relevant to be included in the study. An ethics amendment was made to be able

to access the organisation and recruit one participant in the study (please see Appendix for ethics approval Letter 3).

Following the approval of HRA ethics application, an internal approval was also required by the case study organisation to confirm that there is sufficient capacity to support the current research project. After approximately a month, the R&D Department approved the capacity requirements of the present study. Following the completion of the two ethics approvals and the capacity approval, a staff member with clinical and managerial responsibilities, as well as knowledge on research management, was appointed as Local Collaborator. As required by the HRA ethics process, a Local Collaborator acts as a liaison between the researcher and the organisation to enable data collection and any other study requirements. A series of meetings were organised between the local collaborator and the researcher to introduce the study and to identify potential study participants and organisational documents for the data collection. During their first meeting, the researcher explained the objectives and the timeline of the study and outlined the requirements of data collection, i.e. the identification of potential study participants and internal organisational documents (please see more details in Section 3.5.1 and Section 3.6.1). Furthermore, the local collaborator invited the researcher to a group research meeting taking place fortnightly, where junior and senior researchers present and discuss their projects. This was an opportunity to share knowledge with other researchers within the field of applied health services research.

### 3.4.3 Description of the selected case study organisation

A central element of a case study design in the organisational field is to define the organisation that is being researched (Rashman et al., 2009). The case study organisation used in the present study is the largest NHS Mental Health Foundation Trust in the selected county. The Trust employs approximately 3,600 staff and has around 90 locations in 3 local areas (Cambridgeshire and Peterborough Foundation Trust, 2016a). The organisation addresses the needs of approximately 900,000 residents and provides services to all age groups: children and young people, adults and older people. It receives most of its funding from the local Clinical Commissioning Group (CCG), NHS England (for inpatient services), and the NHS Transformation Fund (Cambridgeshire and Peterborough NHS Foundation Trust, 2016a).

The CAMHS department has 29 teams that offer a total of 22 services to young service users through 3 main service pathways: the Integrated Children's Health Services, the Community Child and Adolescent Mental Health Services (CAMHS), and the Specialist and Inpatient CAMHS (Cambridgeshire and Peterborough NHS Foundation Trust, 2016b). The first pathway provides integrated services to children and young people, including school nursing, health visiting, mental health support, and speech and language therapy (Cambridgeshire and Peterborough NHS Foundation Trust, 2018). Community Child and Adolescent Mental Health Services offer specialist treatment to young people, including psychotherapy, cognitive behavioural therapy (CBT) and family therapy. This service pathway also includes learning disability services, alcohol, substance misuse and court assessment services. Services are geographically spread within the county (North, Central and South Team). The Specialist and Inpatient CAMHS provide specialised services to children and young people with complex needs (Cambridgeshire and Peterborough NHS Foundation Trust, 2018). The organisational structure has been based on the "4-Tier" system (please see Chapter 2, p.38). During the period 2016-2017, the department reported approximately 108,000 contacts with young patients (Cambridgeshire and Peterborough NHS Foundation Trust, 2016b).

### 3.4.4 Description of local organisations

Apart from the services provided by the CAMHS department, local service provision is supported by a number of organisations that contribute to the development and improvement of the local mental health service system for children and young people. As explained in Chapter 2, governmental policies and local strategic plans, such as the "Future in Mind", the local Sustainability and Transformation Plans and the THRIVE Framework, suggest the collaboration of local service providers in order to offer a robust spectrum of service choices to young people and their families (National Health Service, 2015; NHS England, 2016a; Wolpert et al., 2016). As an outcome, the study included a number of local organisations, rather than national, with the aim of monitoring and evaluating the effect of the local inter-organisational environment on the absorptive capacity of the CAMHS department.

Reviewing the structure of the current service system in Chapter 2 assisted in understanding which kinds of organisations have a key role in service provision. As a result, the study included organisations that are: a) involved directly in service provision or b) have a decision-making and advisory roles in local service provision. The Local Sustainability and Transformation Plan (Miller and Goose, 2016) also

assisted in identifying local organisations which have a central role in service provision. An online search was also conducted to find local organisations and understand their role. A list of local service providers was prepared, including a total of 18 organisations. Identified organisations differed in their structure (public, non-profit or private), their role (service provision, funding, decision-making, advisory role), the range of services (supporting mild or moderate conditions), their funding processes (publicly-funded or self-funded) and the geographical focus (regional or local). Due to the unclear borders of the local inter-organisational boundaries, the time limitations of the study and the available capacity of local organisations participation was not exhaustive. The variation among local organisations selected aimed to include a representative sample of the local environment. A total number of 11 organisations were included in the study:

- *Two local public organisations (local authorities):* local authorities were included because of their commissioning role in the local area and their coordinating role in adopting the THRIVE Framework. Local authorities also have responsibilities in monitoring the development of funded service delivery, evaluating services, responding to users' feedback and contributing to the development of the local Sustainability and Transformation Plan. Social care service provision is also coordinated by local authorities, focusing primarily on early level support of the mental health needs of children and young people.
- *A public independent organisation*: the main aim of this organisation is to improve service provision by promoting service users' views to decision-makers in social and healthcare. Including this organisation in the study contributed to understanding the impact of the current service provision on young service users.
- *A NHS Trust*: this organisation focuses on providing physical care services to children and young people. It was particularly relevant to include this organisation in the study due to the service integration developed between this Trust and the case study organisation during the period of data collection.
- *Five third-sector organisations (charities)*: The charities included in the study are local service providers. Four charities are local charities providing mental health support to children and young people and one is a local branch of a national mental health charity. They offer early support to young service users who need help, but are unable to access services because of the

limited capacity of the CAMHS department. Services are often provided in school settings or other locations around the county. Of the total number of invited charities (12), 2 were not included, as participants did not provide consent for using their data, while 5 did not respond to the study invitation or denied participation due to limited capacity.

- *A social enterprise*: this organisation was selected because it was the second organisation receiving funding from the local CCG, next to the CAMHS department, to provide mental health services for the local young population. Services focused on children and young people with early or mild mental health conditions.
- *A private company*: a private company was included in the study due to the funding it provided to local third sector organisations and the role of the social corporate responsibility department to organise discussions about the improvement of mental healthcare services to children and young people.

Negotiating accessing to the aforementioned organisations was organised according to the information available to their public websites. The researcher approached each organisation either by contacting directly a suitable professional (e.g. the Director of a local charity) or by using the general contact email of the organisation to introduce the study and request to liaise with professionals that may be interested to participate in the study.

### 3.5 Document analysis

Document analysis was selected as one of the two research methods of the present thesis; this kind of analysis aims to interpret the content of organisational documents and collect evidence to provide answers to the research questions (Prior, 2003; Bowen, 2009). Analysed documents can be reports, policies, newspaper articles, organisational procedures, photographs or diaries (Bowen, 2009; Matthews and Ross, 2014). Document analysis is often adopted in studies which use a case study research design, as it can contribute to understanding complex phenomena (Thomas, 2011; Yin, 2013). Findings from document analysis are frequently combined with other research methods and can play a complementary role in answering the research questions of a study, such as interviews or meeting observations (Bryman, 2003; Bowen, 2009). The current analysis focused on organisational documents of internal policies.

Document analysis presents several advantages, which were taken into consideration when selecting it for this research. Different types of documents are often publicly available, especially those concerning the functions of public organisations, thus allowing access to relevant data and decreasing the chances of accessibility limitations (Matthews and Ross, 2014). This was particularly helpful for the current study, as a large number of organisational documents from NHS healthcare organisations are available in the public domain. Additionally, such documents have a predefined content, which does not change with time, and thus no changes can occur in the content of documents which could potentially affect the research process (Bowen, 2009). Analysis of documents can also reveal a variety of evidence, such as evidence about the broader environment of the examined topic, thus contributing to the development of a rich picture of the phenomenon under research (Bryman, 2003).

Document analysis also has several disadvantages that were taken into account. Useful documents can be protected due to confidential content, and permission may be required to use them, which brings about the risk of not being granted access (Matthews and Ross, 2014). In the current study, permission was sought for commercial documents to be included in the project. Despite their rich content, documents might provide limited information in relation to a specific research question (Bowen, 2009). There is limited consensus in literature about an optimal process for selecting and analysing documents. Published works give limited clarifications about the process followed for analysing documents, which makes the standardisation of document analysis difficult (Bowen, 2009). Scholars recommend that a detailed and rigorous procedure be followed for analysing documents, as this can increase the reliability of the analysis outcomes (Bowen, 2009). Content analysis was adopted to analyse the selected documents, which is described in the following sections.

### 3.5.1 Selection of organisational documents by the main case study organisation

Document analysis focused on documents that describe the internal policies and procedures of the selected case study organisation. Documents were selected from four groups of documents based on their relevance to absorptive capacity. The documents section of the official website of the case study organisation was reviewed to identify potential documents to be included in the analysis. The selection process was completed in two rounds. During the first round, documents

were selected according to their relevance to the first research question, i.e. the identification of processes of recognition, assimilation and exploitation of external knowledge. Specifically, documents that describe organisational processes which can facilitate the identification, assimilation and exploitation of new knowledge were sought. The review included the latest version of available documents, i.e. documents published in 2017, including the year 2017 (e.g. documents covering the period of 2016-2017) or the latest version of a document. Public documents were presented on the official website of the case study organisation as follows:

1. *Publications*: this section included 12 documents about news, annual reports, the Estate Strategy, Trust consultations and Trust responses (Cambridgeshire and Peterborough Foundation Trust, 2017a) (please see Table 1 in appendix for a full list of documents).
2. *Medicine Information*: this section included eight documents with information about mental health prescribed medicine (Cambridgeshire and Peterborough Foundation Trust, 2017b) (please see Table 2 in appendix for a full list of documents).
3. *Mental health leaflets*: this section included 12 documents containing information about self-help and other similar information (Cambridgeshire and Peterborough Foundation Trust, 2017c) (please see Table 3 in appendix for a full list of documents).
4. *Documents That Guide Practice*: this section included 225 documents related to various organisational and medical processes that aim to manage daily practice and improve service provision (Cambridgeshire and Peterborough Foundation Trust, 2017d) (please see Table 4 in appendix for a full list of documents).

Note: The structure and content of the documents' lists might have been subject to change, due to alterations in the organisation's website after the completion of data collection. Table 1, Table 2, Table 3 and Table 4 in the appendix provide full lists of the four sections and documents are highlighted with different colours to demonstrate the process of selecting documents in the first and the second round.

After reviewing the titles of the documents included in each of the four sections, 30 documents were identified in the first round. Documents selected in this round focused on defining operational standards, organisational strategies or internal procedures, and could potentially assist in understanding organisational processes of identification, assimilation and exploitation of new knowledge, e.g. the Workforce Strategy or the Organisational Change Policy & Procedure. Documents that were excluded in the first round were documents which focused primarily on providing

information to patients or other medical information (e.g. Insomnia: Practical Tips, Coping with Anxiety Leaflet, Administration of Medicines by Intramuscular Injection) or additional processes that could not directly contribute to understanding the absorptive capacity of CAMHS (e.g. NHS England UnitingCare Review for Adult and Older People's Care, Absent Without Leave Policy and Guidance, Appeals Procedure, Carers policy).

In the second round, the introductory sections of the first-round documents were read through to understand whether each document provided generic information or outlined specific processes of identification, assimilation or exploitation of knowledge. After completing this round, 18 documents were identified to be included in the document analysis. 12 documents were excluded due to the following reasons: a) documents provided generic content about the organisation's goals and future plans rather than content specific to the components of absorptive capacity (e.g. Operational Plan 2016-2017, Workforce Strategy 2016-2021) and b) documents were parts of other documents already selected for the analysis (e.g. Risk Assessment Policy, Access to Health Records Policy). Most organisational documents included in the analysis were internal policies and procedures that concern the case study organisation as a whole, including the CAMHS department. Next to public documents, access to corporate documents was negotiated with the local collaborator, such as an organisational chart, a business plan or implementation strategies of the THRIVE Framework. However, access was only provided to one corporate document. In total, 18 documents from the section "Documents That Guide Practice" were selected for the analysis and 1 corporate document was provided by the management team of the CAMHS department (Table 3.2). The total volume of qualitative data included in document analysis was 351 pages.

| Organisational documents included in content analysis |
|---|
| Information Governance Policy |
| Information Risk Policy |
| Information Security Policy |
| Intellectual Property Policy |
| Learning and Development Policy |
| Appraisal Policy |
| Mandatory Training Policy |
| NICE Guidance Implementation Policy |
| Nice Scoping Tool |
| Research Database Policy |
| Capability Policy |
| Shared Decision-Making Policy |
| Data Information Quality Policy |
| Freedom of Information Policy |
| Health and Safety Policy |
| Supervision Policy |
| Systems Access Policy |
| Policy for the Development and Management of Procedural Documents |
| Corporate document of the CAMHS department |

Table 3.2: List of organisational documents included in the document analysis

### 3.5.2 Content analysis

The selected organisational documents were analysed by using content analysis. Content analysis allows for the interpretation of the content of documents by developing meaningful categories and contributes to understanding the phenomenon under examination (Elo and Kyngäs, 2008; Julien, 2012). This type of analysis is increasingly used in research in the health sector (Hsieh and Shannon, 2005; Elo and Kyngäs, 2008). Said analysis focuses on evaluating textual content and the aim of each document, by identifying either direct or descriptive meanings within the text, also called “manifest content”, or implicit meanings, also known as “latent content” (Graneheim and Lundman, 2003, p.105). Content analysis can follow either a quantitative or a qualitative analysis approach (Graneheim and Lundman, 2004). Literature suggests different pathways for conducting a rigorous content analysis (Hsieh and Shannon, 2005; Bowen, 2009). Content analysis experts suggest that the detailed explanation of selecting documents, coding,

analysing and interpreting textual data can strengthen the validity of the research outcomes (Hsieh and Shannon, 2005).

The content analysis of the organisational documents followed a qualitative approach. A qualitative approach was considered to be more useful in identifying the richness of the document content, rather than a quantitative approach, where instances of words or phrases are counted. Qualitative content analysis focuses on the interpretation of textual data with the aim of identifying concepts that represent the examined phenomenon (Julien, 2012). Analysing data qualitatively can reveal information on which a quantitative analysis may provide a limited perspective (Drisko and Maschi, 2015). The qualitative content analysis proposed by Elo and Kyngäs (2008) was used to analyse the documents of the case study organisation and an “unconstrained matrix" was developed to assist with analysis (Elo and Kyngäs, 2008, p.111). The proposed matrix made it possible to define several initial categories of interest to the current study, i.e. processes related to absorptive capacity, while it also permitted the development of new categories that were not yet part of the matrix but could contribute to understanding the researched phenomenon (Elo and Kyngäs, 2008). Analysis followed the steps below:

- *Identification of units*: the first step before starting the analysis was to separate documents into units. Units can vary from a sentence or a paragraph to a whole document (Graneheim and Lundman, 2003; Elo and Kyngäs, 2008). In the current analysis, each document formed a separate unit. Full documents had a suitable size to maintain consistent meanings throughout the analysis (Elo and Kyngäs, 2008).
- *Familiarisation with the content of selected documents*: before proceeding to analyse the documents, familiarisation with the content of the documents helped to provide an initial understanding of the documents and to identify parts of the content that are relevant to the research questions (Bowen, 2009).
- *Summarising the original text*: each document was read through and short summaries were created on the sides of each PDF document. This helped to identify the key meanings of each document. Figure 3.1 presents an extract from the document “Information Governance Policy” and shows how the process was conducted.

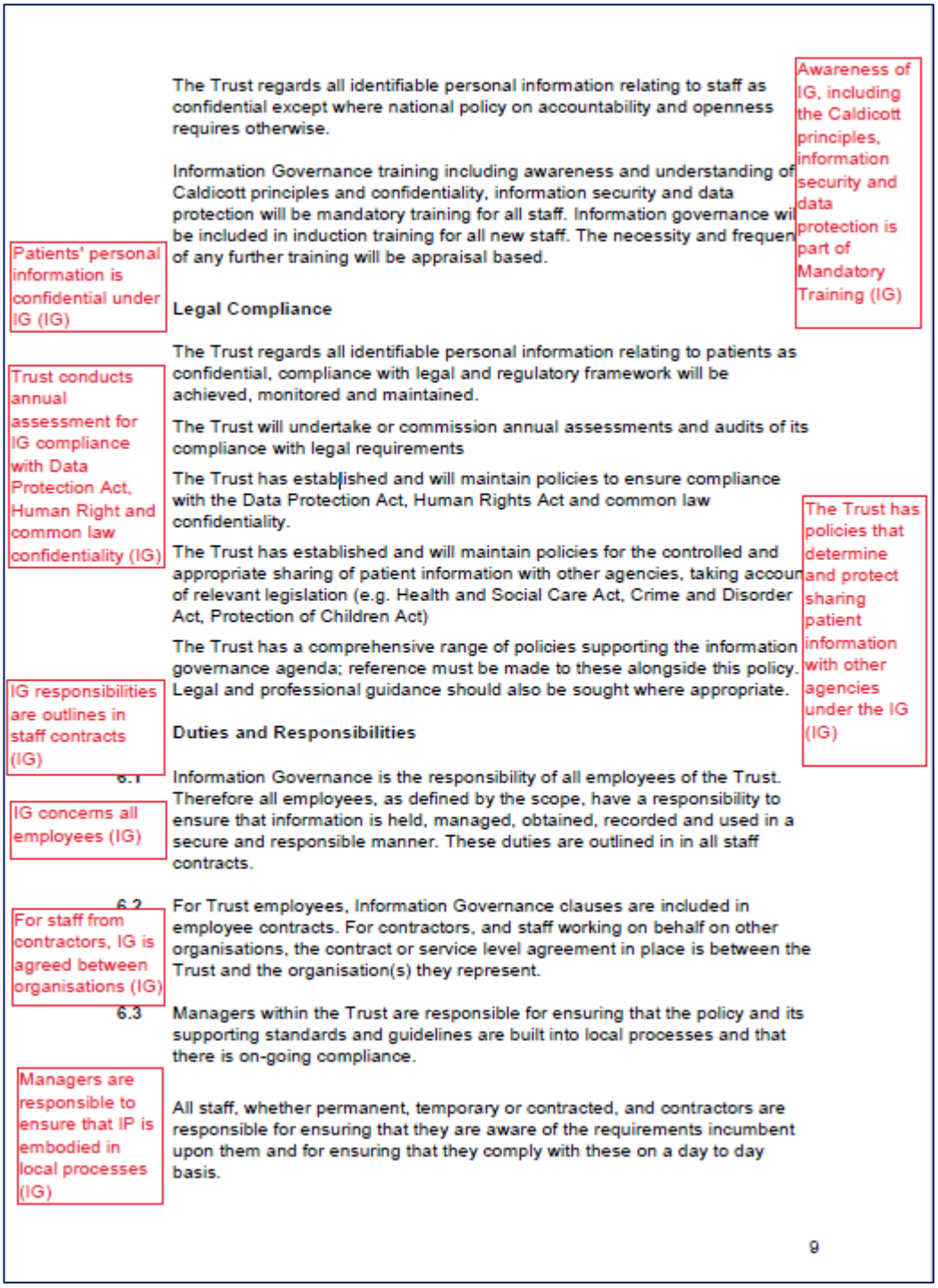



Figure 3.1: Analysis extract from the organisational document “Information Governance Policy”

- *Content analysis*: the textual summaries created in all documents were utilised for the content analysis. By using an excel document, summaries were allocated to pre-defined categories (Figure 3.2). Summaries that did not fit to any of the existing categories were grouped together and new

categories were gradually developed. Pre-defined and new categories all together developed an unconstrained matrix.

| New category: Processes of identification of mandatory knowledge | New category: Controlling knowledge exploitation | New category: Learning processes - Training | New category: Individuals (boundary-spanners and senior management) | Pre-defined category: Inter-organisational environment | New category: intra-organisational communication |
|---|---|---|---|---|---|
| Green: processes of identification of mandatory knowledge | light blue: control processes | yellow: mandatory training | light blue: boundary spanners | pink: control information with the external environment | blue: importance of internal dissemination for knowledge |
| Orange: responsibilities of all staff | | | dark blue: senior management responsibilities | | |
| There is a structured mandatory training needs analysis for mandatory training, that includes the list of topics, the staff member expected to attend each meetings, the frequency and the way each training is delivered (MT) | Failure to comply with mandatory training requirements may result in invoking the disciplinary or capability framework under the Trust's Disciplinary or Capability Policy (MT) | IG is included in the induction training of new staff (IG) | Line Managers are expected to promote the value of LD towards developing evidence based practice and reaching national, local and departmental goals (LD) | The Trust has policies about sharing patient information with other agencies under the IG (IG) | IG is significant to Clinical Governance, service planning and performance management (IG) |
| The need to develop a new document may appear as an outcome of a legal change, new guidance, new service/intervention, national requirements or other (DMPD) | Employees are expected to follow the HS mandatory practices (HS) | HS policy is included in mandatory training and supervision of staff (HS) | R&D Manager is expected to coordinated and review the development and exploitation of innovation with the Trust (IP) | Stakeholders and contractors are expected to comply with DIQ (DIQ) | Health and Safety implementation requires collaboration between clinical governance and risk management |
| Staff is responsible to ensure that they are updated with the latest relevant standards (NICE GI) | All staff is expected to report any information related to innovation being generated within the Trust (IP) | Awareness of IG, including the Caldicott principles, information security and data protection is part of Mandatory Training (IG) | The Board has the overall responsibility for the implementation of the HS policy (HS) | A process will be agreed among different organisations on how new service delivery affected by NICE guidance will be delivered (NICE GI) | Implementation of HS requires the collaboration of different departments/teams e.g. LD team or Infection Prevention and Control Modern Matron (HS) |

Figure 3.2: Sample of the excel sheet used to develop the unconstrained matrix of the document analysis

- *Developing an unconstrained matrix*: pre-defined and new categories composed a representative description of the phenomenon under examination in organisational documents (please see Table 3.3). The pre-defined categories included in the matrix were:
    - *Organisational processes facilitating absorptive capacity*: An organisational process was defined as a composition of activities which has been operationalised and contributes to meeting an organisation's objectives (Garvin, 1998). This category included processes that could be related to the main components of absorptive capacity (i.e. knowledge identification, assimilation and exploitation). Three sub-categories were created under this category: 'plans', 'frameworks' and 'other processes'. Descriptions provided in the analysed documents assisted in understanding the content of each process and on which components each organisational process focused most. Examples of such processes are "Mandatory Training Needs Analysis", "Competency Framework" or "Training Action Plan" (please see more details in Table 8 in appendix). As an outcome a diagram was developed which shows the investment of the

organisation in the components of absorptive capacity (please see diagram in Section 5.4.1).

- *Inter-organisational environment*: This category contributed to understanding the relationships which the organisation has with the external environment. For example, the “Information Governance Policy” document demonstrated that the Trust has policies in place which regulate relationships with the external environment with regard to information sharing and particularly in relation to confidential information.
- *Funding resources:* this category focused on the relationship between financial resources that may have an impact on absorptive capacity. It was not used in the data analysis as findings were very limited.

- Next to the pre-defined categories, five new categories were generated:
  - *Processes of identifying mandatory knowledge*: this category highlighted mostly organisational processes that focused on the organisation’s responsiveness to mandatory forms of knowledge. For example, there is a structured analysis available with the aim to identify the mandatory training staff is required to complete.
  - *Learning processes: assimilation via training*: this category showed the organisation’s intention to strengthen learning via different kinds of training. Most types of training appeared to focus on mandatory forms of knowledge, such as the Information Governance Training or the Health and Safety Training.
  - *Individuals as boundary-spanners*: although each document explains that all staff members are expected to have knowledge of the organisation’s policies and procedures, certain staff members have specific responsibilities in disseminating new knowledge within the organisation. For example, Line Managers are responsible for developing and maintaining a culture of knowledge sharing for both mandatory and non-mandatory knowledge areas.
  - *Controlling knowledge exploitation*: organisational documents emphasised the importance of implementing certain knowledge areas, such as NICE guidance, clinical governance, data quality or mandatory training and demonstrated the need to ensure implementation in practice.
  - *The role of intra-organisational collaboration*: this category showed that the organisation recognised the importance of sharing

knowledge across its departments. For instance, inter-departmental knowledge sharing is encouraged for the implementation of data regulations and clinical governance or the development of new internal policies.

- Two categories presented an additional sub-category focusing on the responsibilities of staff members (i.e. “processes of identifying new knowledge” and “boundary-spanners”), but were not used in the analysis as they did not contribute to the research questions.

| Unconstrained matrix | |
|---|---|
| **Pre-defined categories** | **New categories** |
| Organisational processes of absorptive capacity | Processes of identifying mandatory knowledge |
| Inter-organisational environment | Learning processes: assimilating new knowledge via training |
| Funding resources | Controlling knowledge exploitation |
| | Role of intra-organisational communication |
| | Individuals as boundary-spanners |

Table 3.3: Unconstrained matrix created by the analysis of organisational documents

- The outcomes of the document analysis were triangulated with the findings from the semi-structured interviews to develop a comprehensive narrative about the absorptive capacity of CAMHS (please see Section 3.7 for triangulation). The triangulation of the categories of document analysis with the interviews’ themes is presented in Chapter 4 and Chapter 5.
- Finally, content analysis showed that the organisational documents covered three main areas:
    - *Management of confidential or non-confidential information*: these organisational documents focused on guiding the management of new knowledge according to the confidential and non-confidential

character of information, e.g. Information Governance Policy, Freedom of Information Policy or the Intellectual Property Policy.

- *Quality in service provision*: these organisational documents focused on the improvement of service quality by incorporating new knowledge into clinical practice, such as the NICE Guidance Implementation Policy, the Shared Decision-Making Policy or Safety Policy.
- *Learning and development of staff members*: these documents focused on enriching knowledge that staff members use in clinical practice to provide safe and evidence-based services, e.g. the Learning and Development Policy, the Supervision Policy or the Mandatory Training Policy.

Finally, analysis showed that different terms were used to describe knowledge in organisational documents. Therefore, the terms 'knowledge', 'information' and 'data' were all included in the analysis as similar terms. All documents included guidance as to when they should be updated to ensure that latest knowledge is included in the internal policies.

### 3.6 Qualitative semi-structured Interviews

The purpose of qualitative interviewing is to collect interviewees' subjective opinions and contribute to interpreting the phenomenon under examination (Brinkmann and Kvale, 2015). Semi-structured interviews are conducted as an on open dialogue between the researcher and the interviewee, providing the space for the latter to express their own perspectives (Warren, 2011). A semi-structured interview is guided by a number of pre-selected themes, which can also be formed as questions. In the current study, participants were interviewed about their personal perspectives in relation to their work routines and processes related to the identification, assimilation and exploitation of knowledge from external sources (Bryman, 2012). Qualitative interviews have been adopted by different research fields in social sciences, including organisational research (Cassell, 2009; Alvesson and Ashcraft, 2012).

Similar to other social environments, interviews are utilised in organisation studies to collect data and develop rich explanations about the ways in which different events are taking place within organisational settings (King, 2004). The increasing use of qualitative interviews is based on the understanding that it is a research method that

can provide deeper comprehension of the dimensions of social reality within an organisation, where quantitative methods appear to be limiting (Cassell, 2009). The degree to which the researcher delves into the interpretation of interview data, the attention they pay to the context of the interview and the distance developed between the interviewee and the researcher, are factors that can affect the process of interviewing in organisational research (Alvesson and Ashcraft, 2012). Given the complexity of conducting qualitative interviews in organisational environments, a thorough reflective process can assist with analysing data and lead to theoretical contributions. The next sections present the processes followed for recruiting study participants, data collection and analysis.

### 3.6.1 Sampling and inclusion of study participants

The selection of study participants for the interview process was based on purposeful sampling. Purposeful sampling aims to identify and include participants who can provide rich evidence about the phenomenon under examination (Gentles, 2015; Palinkas et al., 2015). Patton (2002) explained that “information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling”. It has been a predominant method of sampling in qualitative studies (Coyne, 1997). To a certain degree, sampling in qualitative studies always entails a degree of purposefulness, especially in case study research designs, considering that the aim of the study is to find sources that can provide rich data (Coyne, 1997; Gentles, 2015). The purposeful nature of qualitative research is one of the elements that distinguishes it from quantitative research (Patton, 2002).

Sampling was based on identifying staff members with job responsibilities that are relevant to the processes of identification, assimilation and usage of new knowledge within the CAMHS department, as well as to the relationship between the CAMHS department and the external environment. Staff members who could contribute to the research objectives had job responsibilities related to managing knowledge mobilisation, staff members’ learning, service management or having contact with external organisations. Suitable staff members who meet the inclusion criteria were sought within the following three groups:

1. The CAMHS Department (Children and Young People Services)
2. The Performance and Finance Department
3. Senior Management

Potential participants within the case study organisation were identified with the help of the local collaborator. Before the start of the study the researcher discussed with the local collaborator, the structure of the organisation and a first group of participants was identified (sampling). The local collaborator made the initial contact with potential participants and the researcher followed up with more information about the study. The identification of suitable staff members was repeated two and three months after the beginning of the study to renew the list of potential participants, as several staff members did not respond to the initial study invitation (re-sampling) (Miles and Huberman, 1994). Examples of staff members who were invited to participate represent different levels of the organisational hierarchy, such as CAMHS Director, Chief Operation Officer, Service Manager or Team Leader. Considering that a key objective of the study was to identify organisational processes that are associated with absorptive capacity, individuals' with responsibilities around service re-design and management were included in the study. Considering that the inclusion criteria focused mostly on staff members with some managerial or coordinating responsibilities, it is acknowledged that this limited the inclusion of frontline workers in the study. This is a limitation for data collection as it led to minor representation of staff members that provide services to children and young people. Yet, 12 participants from the case study organisation had clinical experience or provide clinical services as part of their job.

Similar inclusion criteria were used for identifying potential study participants in the local external environment. Staff members from local organisations were selected based on their job description. Inclusion criteria aimed to identify staff members who had responsibilities related to utilising new knowledge, service management or liaising with local organisations. Examples are: Executive Director, Manager, and Director of Operations. Invited participants who met the inclusion criteria were identified by each organisation's website. One or two staff members from each organisation participated in the study.

The number of study participants was determined by the qualitative nature of the study, data saturation and the overall nature of the study. In a qualitative research project, sample sizes are smaller than what is traditionally included in quantitative studies, due to the purpose of qualitative research, i.e. to thoroughly examine textual data and seek meaningful associations (Crouch and McKenzie, 2006). Data saturation is a key indicator for the appropriate number of interviews in a study. Data are saturated when analysis of new data makes minimum or no contribution to the outcomes of the study (Gentles et al., 2015). The ideal number of interviews in

terms of saturation is reached when collected data are rich enough to provide evidence about the objective of a study, but not too rich so as to cause repetition of meanings (Mason, 2010). The number of interviews is also dependent on the nature of the study. Moreover, in the present research design, the number of interviews was dependent on the availability and the total number of staff members who met the inclusion criteria, rather than solely on the saturation of interview data (Marshall et al., 2013). A review of approximately 500 PhD studies showed that the average number of interviews was 32 (Mason, 2010). Scholars have suggested that 15 interviews could be a minimum number, while others have supported the notion that 20 or 25, and no more than 50 interviews, could be adequate for a qualitative study (Mason, 2010). Past studies which adopted a case study research design for investigating absorptive capacity included 20 participants (Jas and Skelcher, 2005) or 18, 31 and 23 participants per organisation (Easterby-Smith et al., 2008b). Considering data saturation, the number of interviews conducted in previous studies and the time limitation of a PhD study, a total of 29 interviews were conducted within the case study organisation and the local environment altogether.

### 3.6.2 Process of conducting semi-structured interviews

Following the identification of potential participants, staff members were contacted via email and received an e-version of the information package (invitation email, information sheet, consent form). After receiving a positive response, staff members were contacted and an appointment was arranged in a mutually convenient time and place. Consent forms were returned by participants either in person or by sending a scanned copy via email. If staff members did not respond within a two-week time period after receiving the information package, then an email reminder was sent. Participants who did not respond to the email reminder were not contacted again. The interviews usually took place during office hours in the participant's office or occasionally in meeting rooms at Anglia Ruskin University. Before the start of the interview, participants were reminded that the interview would be audio-recorded and they were asked whether they had any questions regarding the study. Staff members were reassured] that participation in the study was confidential and that the content of the interviews would be anonymised.

An interview guide was used to direct the interview and keep the discussion relevant to the areas of interest, while allowing participants to expand on new topics (Stuckey, 2013). The researcher designed the interview guide based on the key areas of the study (Brinkmann and Kvale, 2015). Specifically, the guide was

engineered based on the three main components of absorptive capacity, i.e. the identification, assimilation and exploitation of new valuable knowledge. The three main components were used as the core themes of the interview guide. Additionally, the interview included a section about the inter-organisational environment and the influence it may have on the department's absorptive capacity. Finally, study participants were asked about the THRIVE framework, as an example of knowledge that was being incorporated into service provision during the period of the current study (see Chapter 2 for more details). The semi- structured interview guide allowed participants to expand on their responses, something that may have changed the order of the themes discussed. Most interviewees appeared willing to talk about the topics included in the interview guide. Some interviewees preferred to expand on certain topics more than others, thus contributing to the richness of the data.

Each interview was scheduled for one hour. The duration of the interviews conducted varied from 26mins to 01h15mins. Specifically, 14 interviews lasted between 50mins to 1h7mins, 8 interviews lasted between 40mins to 49mins, 4 interviews lasted between 34mins to 39mins, 2 interviews lasted between 26mins to 30mins. One interviewee refused to be recorded, but note-taking was allowed during the interview. Notes were used later in thematic analysis. After the completion of the interviews, recordings were securely stored and the identity of each interviewee was hidden and replaced by a number. All interviews were transcribed verbatim. 11 recordings were transcribed by the researcher and 18 recordings were transcribed by a transcription service. The transcription of audio recordings lasted for a period of 7 months. The total volume of data collected from qualitative interviews was 21hs26mins, transcribed to 665 pages or 179,376 words. Following the completion of all interviews, a thematic analysis was conducted (Brinkmann and Kvale, 2015).

Before starting the interview process, the interview guide was also piloted with two volunteers. Staff members of Anglia Ruskin University with professional experience in the public healthcare sector provided feedback on the suitability of the topics developed. The volunteers found the interview guide suitable and suggested the use of the term 'information' instead of the term 'knowledge' to facilitate understanding (please see Table 5 in appendix for the interview guide). During the interviews, the words 'knowledge' and 'data' were also introduced by the interviewees. Furthermore, jargon words were avoided so as to make questions comprehensible to the study participants, such as absorptive capacity, knowledge assimilation or knowledge identification. Examples of questions include "What kind of information do you use in your daily work?'" and "How do you judge what information is

important?". Overall, approximately 40 staff members were contacted within the case study organisation, and 16 agreed to participate in the study. In total, 25 staff members of local organisations were invited and 13 of them agreed to have an interview (Table 3.4).

| Anonymised list of study participants | |
|---|---|
| **Case study organisations** | **Inter-organisational environment** |
| Member of Senior Management (1) | Trustee - Charity A |
| Member of Senior Management (2) | Executive Director - Charity A |
| CAMHS Senior Clinical Manager (1) | Manager - Public organisation A |
| CAMHS Senior Clinical Manager (2) | Executive Director - Charity B |
| CAMHS Consultant (1) | Manager - Charity E |
| CAMHS Consultant (2) | Executive Director Charity C |
| CAMHS Consultant (3) | Director of Operations Charity D |
| CAMHS Senior Clinician | Executive Director - Charity D |
| CAMHS Senior Manager | Manager - Public organisation B |
| Manager at Information and Performance Department | Manager - Public organisation C |
| CAMHS Manager (1) | Manager - Private Company |
| CAMHS Manager (2) | Consultant - Social Enterprise |
| CAMHS Manager (3) | Member of Senior Management - NHS organisation |
| CAMHS Manager (4) | |
| CAMHS Psychologist | |
| CAMHS Team Leader | |

Table 3.4: Anonymised list of study participants

### 3.6.3 Thematic analysis

Qualitative data collected from the semi-structured interviews were analysed following a thematic analysis. Thematic analysis is a research method used to analyse qualitative data by creating groups of meanings generated from textual

content (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006). The aim of thematic analysis is to collate and analyse participants' experiences and lead to meaningful patterns that explain the examined phenomenon (Braun and Clarke, 2006). Thematic analysis shares similarities with content analysis, as both have a qualitative and descriptive nature (Drisko and Maschi, 2015; Vaismoradi et al., 2015). Different approaches are suggested in the literature about classifying and analysing qualitative data in thematic analysis. The approach of Braun and Clarke (2006) is used to guide thematic analysis. They defined thematic analysis as an open, reflective approach of summarising and connecting data into patterns that manifest the key meanings of the data. The inductive approach underpinning thematic analysis allows data to create new, unexpected themes (Braun and Clarke, 2006). Clarifying the steps followed in thematic analysis contributes to the trustworthiness of the research outcomes. The analysis steps that were followed are:

- *Familiarising with qualitative content*: after completing the full transcription of the interview recordings, the transcripts were read though to develop a preliminary understanding of the content. Keeping notes helped with developing a first impression about the key meanings that could be generated from the transcripts. In the present thesis, the researcher was the person conducting the interviews, thus contributing to understanding the content (Braun and Clarke, 2006).
- *Using NViVo to create nodes and sub-nodes*: employing NViVo helped to create an initial organisation of the data. After reading through the qualitative dataset, interviews were imported into the data management program NViVo, which was used to develop groups of data and to organise the qualitative content into meaningful nodes (Silver and Lewis, 2014). Each part of the dataset was coded either under existing nodes or under new ones that were gradually generated (Douglas et al., 2009). On several occasions, text fit under more than one node. Text was double-coded only a few times to avoid repetition of meanings. All nodes were initially considered to be equally important, so as to allow the identification of new patterns (Braun and Clarke, 2006). In the current study, emphasis was placed on themes related to processes of absorptive capacity, as well as new components of absorptive capacity that could increase understanding about the development of absorptive capacity in mental healthcare settings. The table below is an example demonstrating the coding process from the original text to nodes

and from nodes to the themes of “Knowledge identification” and “Factors that influence absorptive capacity” presented in Chapter 5.

| Original Text | Nodes and Sub-nodes | Final themes |
|---|---|---|
| “I think, probably, the priority that I would give would be anything that comes from the government, Department of Health, any of the NICE guidance stuff, because those are generally must-dos, so we need to be fully briefed on those”. | *Node*: Value identification of new information<br>*Sub-node*: Mandatory knowledge | Knowledge identification |
| “And about the information we gather. We tend to be very focused on what we do as… What our profession is, as to the information we gather”. | *Node*: Value identification of new information<br>*Sub-node*: Job responsibilities | |
| “We have someone who works in the trust who is responsible for all the NICE guidance in terms of making sure that we know – the organisation knows – what our NICE guidance is”. | *Node*: Factors of absorptive capacity<br>*Sub-node*: The role of gatekeepers | Factors influencing the absorptive capacity of the CAMHS department |
| “We struggle to provide our own services, so we have lots of vacancies. Recruitment of mental health nurses is difficult. That’s a national picture. That’s not just CAMHS”. | *Node*: Factors that influence absorptive capacity<br>*Sub-node*: Funding | |

Table 3.5: Example of the development of the themes “Knowledge identification” and “Factors that influence the absorptive capacity of the CAMHS department”

- *Conducting two rounds of NViVo coding*: coding of the semi-structured interviews was completed in two rounds. During the first round, 16 interviews were coded from the case study organisation. 13 interviews with staff members from local organisations were coded in the second round. Table 6 and Table 7 in the appendix show the key nodes and sub-nodes that were used for addressing the research questions.
- *Reviewing and refining nodes and sub-nodes*: once analysis was completed and useful nodes were identified, a review process was conducted. Nodes

and sub-nodes were re-read one by one and refined to explore the different meanings that have been generated. This process was another opportunity for the researcher to rethink which nodes are supported by rich or thin evidence, which nodes might overlap and which appear to be more relevant to the research questions than others (Braun and Clarke, 2006). Adjusting and merging nodes and sub-nodes led: a) to the development of the main themes and the sub-themes of the absorptive capacity of the CAMHS department and b) to the themes and sub-themes that describe the relationship between the CAMHS department and the inter-organisational environment. It is important to note, however, that the development of themes and their sub-themes was an iterative process, developed throughout the analysis (Douglas et al., 2009). The researcher re-visited the themes at different times and made useful adjustments as relevant. That is an outcome of the inductive nature of thematic analysis and the gradual comprehension of the meanings emerging from the dataset (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006).

- *Reporting the findings of the thematic analysis*: each theme was described by providing an analytic explanation of the key findings it includes (Vaismoradi et al., 2013), as well as anonymised quotes. The overall narrative aimed to develop a coherent picture that wove together all themes and sub-themes that had been identified (Braun and Clarke, 2006). The detailed presentation of the themes and the connections existing among each of them contributed to understanding the transferability of the study design (Vaismoradi et al., 2013). A thematic map was also developed for addressing the first question and it is presented in Chapter 5, focusing on the absorptive capacity of the CAMHS department.

### 3.7 Triangulation

Triangulation is a method of creating combinations of data with the aim of strengthening the understanding of a certain phenomenon (Jick, 1979; Mays and Pope, 2000). It is often recommended in case study research as it gives the opportunity to bring together data from different sources and create a rich picture for the examined case study (Dubois and Gadde, 2002; Yin, 2013). Qualitative data collected using different research methods or data from different groups of participants were triangulated in this study, with the aim of increasing insight into specific areas of the study (Lambert and Loiselle, 2007). Findings from the analysis

of the interviews from the case study organisation, the interviews from the inter-organisational environment and documents were triangulated to identify the "convergence, complementarity or dissonance" of the data (Farmer et al., 2006, p.378). Triangulation in this study focused primarily on complementarity, where outcomes that contribute to the same or similar dimensions of the areas of interest were drawn together and compared (Mays and Pope, 2000; Farmer et al., 2006). Bringing data together assisted in adopting an enriched view of the examined organisational reality and, in this way, contributed to the trustworthiness of the research outcomes (Shenton, 2004). While triangulation originated from the positivist research paradigm, more recent studies have adopted triangulation from different theoretical perspectives, such as constructionism (Briller et al., 2008). Constructionists adopting triangulation do not aim to respond to the validity of qualitative outcomes, as positivists would aim to do. Instead, triangulation from a constructionist perspective aims to draw together different perspectives which were generated from collected data and provide a thorough understanding of the examined phenomenon (Hastings, 2010). Under this perspective, triangulation can also address the aim of a case study design, which is to bring together diverse collected data in order to create a comprehensive representation of the studied topic (Hastings, 2010; Yin, 2013).

Familiarity with the data findings (gained during the processes of content and thematic analysis) assisted in determining which areas of data would be most suitable to be triangulated (Farmer et al., 2006). Data triangulation and methodological triangulation were used to triangulate the data:

A) *Data triangulation*: findings from two different participants' groups collected by using the same methods, i.e. the findings from the interviews with staff members of the case study organisation and the findings from the interviews with staff members of local organisations, were combined to gain insight into the effect of the external environment on the absorptive capacity of the CAMHS department (Denzin, 2009). The views of the study participants about certain topics were brought together to examine different perspectives on the same issues. Data triangulation was conducted by identifying nodes with similar titles from the two participants' groups and combining the key meanings from those nodes. This type of triangulation allowed for the development of a richer narrative about certain elements of the analysis, such as the relationships between the main case study organisation and the local inter-organisational environment, as well as how the former is

perceived by other local organisations. Table 3.6 presents an example of the nodes that were combined to discuss the role of the inter-organisational environment in Chapter 4. Column A shows nodes that were identified from the analysis of interviews with staff members of the case study organisation and column B illustrates nodes from the analysis of interviews with staff members of local organisations.

| **A. Nodes generated from interviews with staff members of the case study organisation** | **B. Nodes generated from interviews with staff members of local organisations** |
|---|---|
| • Partnerships with formal bonds | • Formal collaborations among organisations<br>• Relationship between the case study organisation and other organisations |
| • Informal collaborations | • Informal relationships among organisations |
| • Challenges in partnerships | • Challenges between statutory bodies and other organisations<br>• Challenges in local network of services |
| • Commissioning – Competition | • Commissioning – Competition |
| • Impact of organisational boundaries | • Organisational boundaries within the local environment |

Table 3.6: Example of combining nodes from the two groups of study participants in interview analysis

B) *Methodological triangulation*: the findings from two different qualitative methods, i.e. document analysis and interviews with staff members of the case study organisation, were combined to explore the processes and the factors that influence the absorptive capacity of the CAMHS department (Denzin, 2009). In this triangulation type, the combination of document analysis and interview findings permitted the development of a multi-sided

perspective on several aspects of absorptive capacity, such as organisational processes that enhance knowledge assimilation and exploitation (Table 3.7). Triangulation was based on combining nodes from the thematic analysis of the interviews and categories from the content analysis of documents. Methodological triangulation was somewhat more difficult, as the combined data had different textual formats and sources addressed to different audiences. In table 3.7, column A shows nodes from the analysis of interviews with staff members of the case study organisation and column B illustrates categories from the document analysis.

| **A. Themes generated from interviews with staff members of the case study organisation** | **B. Categories from document analysis** |
|---|---|
| • Knowledge identification | • Processes of identifying mandatory knowledge |
| • Knowledge assimilation | • Intra-organisational communication<br>• Learning processes: Training |
| • Knowledge exploitation | • Controlling knowledge exploitation |
| • Factors that influence absorptive capacity | • Organisational processes of absorptive capacity<br>• Individuals as boundary-spanners |
| • The heterogeneous local environment (presented in Chapter 4) | • Inter-organisational environment (presented in Chapter 4) |

Table 3.7: Combination of themes generated from data analysis with categories from document analysis

Data triangulation is included in Chapter 4 and representative quotes from both participants' groups are presented to demonstrate complementarity. Methodological triangulation is put forth in both Chapter 4 and Chapter 5, where coding extracts

from the document analysis and participants' quotes are included to demonstrate the complementary meanings.

### 3.8 Summary

The research methodology presented in this chapter described the underpinning rationale and the research methods selected for addressing the main objectives of this thesis. The methodology was developed on the basis of collecting empirical evidence within an organisational setting. The research design of a case study was selected as a suitable research approach for gathering rich evidence about the absorptive capacity of the CAMHS department. Data collection was based on qualitative research methods, aiming to develop a rich narrative about the examined phenomenon and to set the foundations for further research from future studies. Document analysis and analysis of semi-structured interviews were chosen as appropriate research methods for exploring the phenomenon under examination in a new organisational environment. Abductive reasoning guided the interpretation of collected data and the development of theoretical propositions, which contributed to the adapting of the conceptual framework. The research paradigm of weak social constructionism was advised for the development of the research methodology and the analysis of collected data.

Overall, the study aimed to follow an exploratory research path and make theoretical recommendations about absorptive capacity in mental healthcare organisations. The next two chapters present the data findings based on the two research questions. The second research question is discussed in Chapter 4, where the analysis findings in relation to the effect of the external environment on the absorptive capacity of the CAMHS department are introduced. Presenting data about the external environment before discussing the department's absorptive capacity assisted with comprehending the structure of the wider environment around the CAMHS department and the case study organisation. Chapter 5 presents the analysis outcomes in relation to the first research question, i.e. the absorptive capacity of the CAMHS department. The last chapter discusses the findings from both chapters and explains how the research outcomes contribute to understanding the development of absorptive capacity in public mental healthcare organisations.

## Chapter 4

## Findings – The role of the inter-organisational environment in shaping the absorptive capacity of the CAMHS department

The literature review highlighted that the external environment can influence an organisation's absorptive capacity (Lane et al., 2006). This chapter presents findings related to the second research question "What is the role of the inter-organisational environment in shaping the ability of CAMHS to identify, assimilate and exploit new external knowledge?". The analysis of the collected data explored the relationships between the case study organisation and the inter-organisational environment, as well as the effect that the latter has on the CAMHS department's absorptive capacity. Findings from bringing together analysis outcomes from semi-structured interviews with staff members of the case study organisation and local organisations involved in CAMHS provision, as well as organisational documents. Interview data from the two participant groups have been triangulated with data triangulation. Data from interviews and organisational documents were combined following a methodological triangulation.

The first part of the chapter presents a classification of the knowledge sources which staff members of the CAMHS department identified as valuable. The second part focuses on the views of study participants about the relationship of the local inter-organisational environment with the CAMHS department. The third part presents findings about factors that staff members define as influential to knowledge sharing within the local network of organisations. The last part discusses findings about the THRIVE Framework – a document that was traced within the local healthcare system, and the ways the staff members from the CAMHS department and the local environment appear to respond to its implementation during the period of data collection. Exploring the role of the local inter-organisational environment was particularly relevant as local health systems have recently developed individual strategic plans for improving mental health service delivery for children and young people, following the "Five Year Forward View" and the "Future in Mind" policy papers (NHS England, 2014; 2015a; Cambridgeshire and Peterborough Clinical Commissioning Group, 2016).

### *4.1 Mapping the knowledge sources of the CAMHS department*

As part of exploring the department's absorptive capacity, staff members were asked to identify the information they use on a daily basis. These questions aimed:

a) to map the external environment and identify the landscape of knowledge sources, and b) to contribute to understanding what is defined as valuable knowledge by staff members. Staff members explained the areas of knowledge they use in daily practice, either by talking about the type of information or by referring to its source. Staff members used the terms ‘knowledge’, ‘information’ and ‘data’ to describe the information they use, thus demonstrating that those terms are thought to have a similar meaning. To map knowledge, the analysis advised the classification of macro, meso, and micro levels presented in Chapter 1, p.29 (Grove et al., 2018). This classification assisted in drawing together sources of knowledge that are defined as valuable by study participants and categorising them in relation to individuals, the organisation and the local and national external environment (Diagram 4.1). The four levels are presented in the next section, while further details about each level are discussed throughout Chapter 4 and Chapter 5.

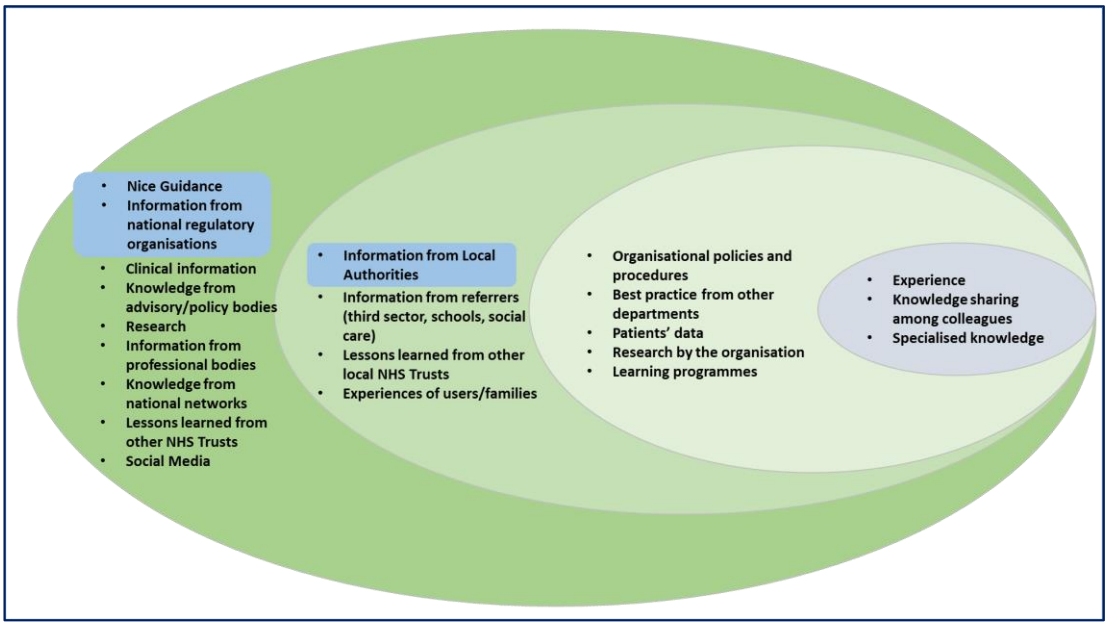



Diagram 4.1: Map of knowledge sources based on the macro-national, macro-local, meso and micro levels (adopted from Grove et al., 2018)

#### 4.1.1 Macro-national level

Knowledge from the external environment at a national level originates from NICE guidance, information from regulatory national organisations, knowledge from advisory and policy-making bodies and professional bodies, clinical information, knowledge from national networks, research, social media and other NHS Trusts. Participants defined NICE guidance and regulatory bodies as the most prevalent sources of new knowledge.

NICE guidance for clinical practice is used by staff members to inform clinical procedures and guide service provision. The implementation of said guidance is perceived to be mandatory and staff members clarified that they are expected to use it. A CAMHS Senior Manager explained that "*Yes, we do have to apply NICE guidance"*. The implementation of NICE guidance is decided and monitored by senior management.

> *And then we track NICE guidance in the delivery of care. So I would have people in the organisation, whose job it is to think about what the NICE guidance is in particular areas, and whether we're delivering care according to NICE guidance or to what extent we're not delivering care according to NICE guidance (*Member of senior management (2) – Case study organisation).

In addition, information sourced by regulatory bodies was also identified as a predominant source of knowledge for staff members. Such sources are national organisations including the Department of Health (DoH), the Care Quality Commission (CQC), Public Health England, NHS Improvement or NHS Digital. Staff members reported that they are again expected to respond to information coming from regulatory bodies concerning policy and regulation. Such information is shared within the organisation and towards the CAMHS department via senior management.

> *I suppose, if we're obliged to, it has a statutory place, so there's lots of information that comes from the government (*CAMHS Manager (1)).

> *[…] Public Health England, particularly around our health visiting, school nursing services, so they will get information that will come in there. That will come through to the main senior leadership team through the service*

*managers, because they'll tend to be working with it on a day-to-day basis.* (CAMHS Senior Manager).

Apart from knowledge areas that are identified as having a mandatory character, interviewees also referred to other types of knowledge as valuable. Such knowledge has an advisory role for them and can potentially inform practices of the case study organisation and the CAMHS department, such as information about the national CAMHS agenda or policy-making. A CAMHS Director explained that:

> *[The] Future in Mind [and] Five Year Forward documents would be another one [example]. I guess, these are all documents that synthesise the direction of travel for children's mental health. They influence me in terms of being aware of what the issues are across the nation and how that applies in our context, and the direction of travel that commissioners and the government would like the services to go in (*CAMHS Senior Clinical Manager (2)).

Staff members explained that they may sporadically consult additional sources that can help their daily work. They may use research to gain insight into evidence-based knowledge about mental health, healthcare management or young patients' experiences. Interviewees may also share new research knowledge within the organisation and in their teams. Furthermore, they periodically consult knowledge sources related to the staff members' professional background, such as sources about clinical information, and knowledge from national networks or professional bodies.

> *I went to a conference at the Royal Society of Psychiatrists last year about ADHD and things like that. The information that I would have got there I would have brought back to the team and shared it* (CAMHS Manager (1)).

> *We might seek information from clinicians internationally, or we might seek information from specialists based in the UK, that sort of thing* (CAMHS Manager (2)).

NHS Trusts and Foundation Trusts also function as knowledge sources for study participants. NHS organisations that provide services similar to those provided by the CAMHS department are considered a reliable and useful source when it comes to seeking knowledge related to best practice. Staff members would use their professional network to identify useful knowledge from colleagues in different geographic areas.

*So, I would have contact with colleagues who run similar services across England. So, if I were struggling with an issue or thinking about how some other service might tackle an issue, then I might use that network to give me some ideas or things like that* (CAMHS Senior Clinical Manager (2)).

#### 4.1.2 Macro-local level

The local environment also was identified as a valuable source of knowledge by staff members. Participants pointed out several knowledge sources: local authorities (Clinical Commissioning Group (CCG), County Council), referrers (third-sector organisations, social care, schools) or partners, such as the local Children's NHS Community Services. Similar to the macro-national level, knowledge which has a mandatory character was identified as a priority for study participants, such as knowledge that comes from local funders (i.e. the local CCG). Staff members also demonstrated that non-mandatory knowledge areas which are valuable are sourced by local organisations. Non-mandatory knowledge concern primarily two areas: knowledge about the local system of service provision to young people and information with regard to individual young patients.

*All of our patients are referred by a community team; that comes with some level of information – sometimes more detailed, sometimes less* (CAMHS Senior Clinical Manager (1)).

*Also I will be linking in with other agencies like the [local] County Council, the [other local] County Council, [local Children's] Community Services, trying to understand their current initiatives or strategies and trying to link that up with what we are doing* (CAMHS Consultant (3)).

Part of the knowledge which staff members use in their work, especially in relation to service provision, is sourced from service users and/or their families. Service users and families' experiences can provide insight into the young patients' mental health status, which can positively contribute to their therapy. Additionally, families often provide information about other local services they have accessed, aside from CAMHS. Finally, service users shared their experiences regarding service provision and possible ways of improvement. Knowledge coming from service users and their carers was identified as a source that appeared to be less frequently used by study participants in comparison with knowledge sourced by local organisations.

*We don't always [know] until actually you meet the family or speak to the family. It happened a few times with the CWP [Children's Wellbeing Practitioners] referrals when we started taking on cases. We were finding that we would ring the family and say "this is our service, we could offer you a new appointment, and if you would like to proceed with it", and then they would say "my daughter is already accessing the school nurse"* (CAMHS Team Leader).

*Yes. I think I mentioned how sometimes the parents are able to tell us about what's going on and keeping up to date with those things because we don't have the time* (CAMHS Psychologist).

#### 4.1.3 Meso level

The case study organisation was defined as a source of knowledge by the study participants. Staff members referred to knowledge related to management, such as updates of internal policies that govern daily practice (e.g. Information Governance), new strategic documents, data regarding performance, latest reporting on finance and service quality (such as the Integrated Performance Report) or best practice from other departments of the organisation. Several internal policies appeared to have a mandatory character for staff members, such as the Information Governance policy or mandatory training.

*So, a lot of it [information used on a daily level] is management, meaning a great deal of it is the policies and procedures of the [main case study organisation]* (CAMHS Manager (3)).

*Less detailed, but we're now getting more detailed, metrics about the quality of service; metrics that relate to the staff, and performance and happiness of staff* (Member of the organisation's senior management (2)).

A second knowledge source identified pertained to information related to patients (individual patients or datasets). Information about individual patients may be shared among team members who work with a specific patient (e.g. via case notes or supervision meetings), or can be anonymised information collected to monitor the effectiveness of services in improving the mental health of young people (such as Routine Outcome Measures or reports on patients' data), in accordance with the confidentiality regulations. Staff members described this latter source as less used in comparison with management knowledge.

*We're always looking at case notes, going back over what we've done before, information from schools. When we are doing assessments, information from paediatrics, so assessments that they've had before they come into the service* (CAMHS Psychologist).

*So we try to do [ROM] at each session obviously, […] we do try to gather that data as much as possible, which helps us determine whether our programme is suitable in working and whether the people are progressing* (CAMHS Team Leader).

Finally, two more forms of knowledge sources are training programmes (e.g. workshops or learning programmes) and research produced by the organisation. Training programmes that take place within the organisation are a source of knowledge. Research that is produced by the organisation to provide evidence which can improve clinical practice can also be a source of knowledge for staff members.

*We're very connected to CLAHRC, so sometimes there's research that comes out, and we try to help that to influence our services* (CAMHS Senior Manager).

#### 4.1.4 Micro level

Sources of knowledge are also identified at an individual level. Staff members referred to their own professional knowledge as a valuable source of knowledge for their daily work, which is often a result of accumulated years of professional experience. Additionally, individual staff members recognised the value in knowledge that is being shared within their direct work environment via colleagues. Knowledge sharing can take place in a one-to-one setting or within teams; for instance, when working with specific patients and staff members want to share views on the best options for patients' support.

*So at the moment because they are doing CAMHS Tier 3 cases, because of the issues with our referral system, I would advise the practitioners to talk to other Tier 3 practitioners if they are concerned. They can take them into a team meeting if they are concerned* (CAMHS Team Leader).

*There's the knowledge and experience you already have, I suppose, is one thing, because you have a store of information in your head, a knowledge of*

*how to do something, or processes, or a network of contacts you can have that all provide you with a level of information to know how to resolve an issue* (CAMHS Manager (2)).

Overall, four levels of knowledge were identified with the help of the macro, meso and micro analysis levels put forth by Grove and colleagues (2018), which assisted in understanding the knowledge sources which staff members use. At this point, three key elements were identified in the analysis. The first element is the mandatory character of new knowledge. Mandatory knowledge refers to the knowledge which staff members are expected to incorporate into their daily work due to the commitment of the CAMHS department and the case study organisation to the source organisation. Data analysis showed that mandatory knowledge is one of the knowledge types that staff members utilise. The mandatory character of knowledge was briefly discussed above and it is further discussed in Chapter 5. The second element is the role of the macro-local level. Staff members indicated the value of knowledge sources from local organisations, highlighting the importance of the macro-local level. The macro-local level is further discussed in the following sections of this chapter. The third element is that the knowledge map showed how the value of new knowledge is constructed by staff members. Diagram 4.1 presents four groups of knowledge areas that are defined as valuable for staff members. Participants demonstrated a diverse spectrum of sources that they recognise as valuable. The notion of valuable knowledge also appeared to be influenced by the mandatory character of knowledge. Although it is difficult to provide a concrete definition of what is considered valuable knowledge, the development of the four levels of knowledge sources provides a first understanding of what is considered as valuable knowledge by the staff members of the CAMHS department.

### *4.2 The heterogeneous local environment and its role in shaping the absorptive capacity of the CAMHS department*

As demonstrated in Chapter 2, an organisation's absorptive capacity is influenced by the external environment and the commonalities it shares with source organisations (Easterby-Smith et al., 2008a; Lane and Lubatkin, 1998). Data from interviews with staff members of local organisations were brought together with the views of the staff members of the CAMHS department to examine the effect of the local inter-organisational environment on the department's absorptive capacity.

Feedback from staff members of the case study organisation aided in shaping a map of the local external environment of the CAMHS department (Diagram 4.2), also defined as the macro-local level in the previous section. The CAMHS department's activity in working together with local organisations on a regular basis has been grouped into four broad areas: third-sector organisations and social care, local NHS organisations, schools and local authorities.

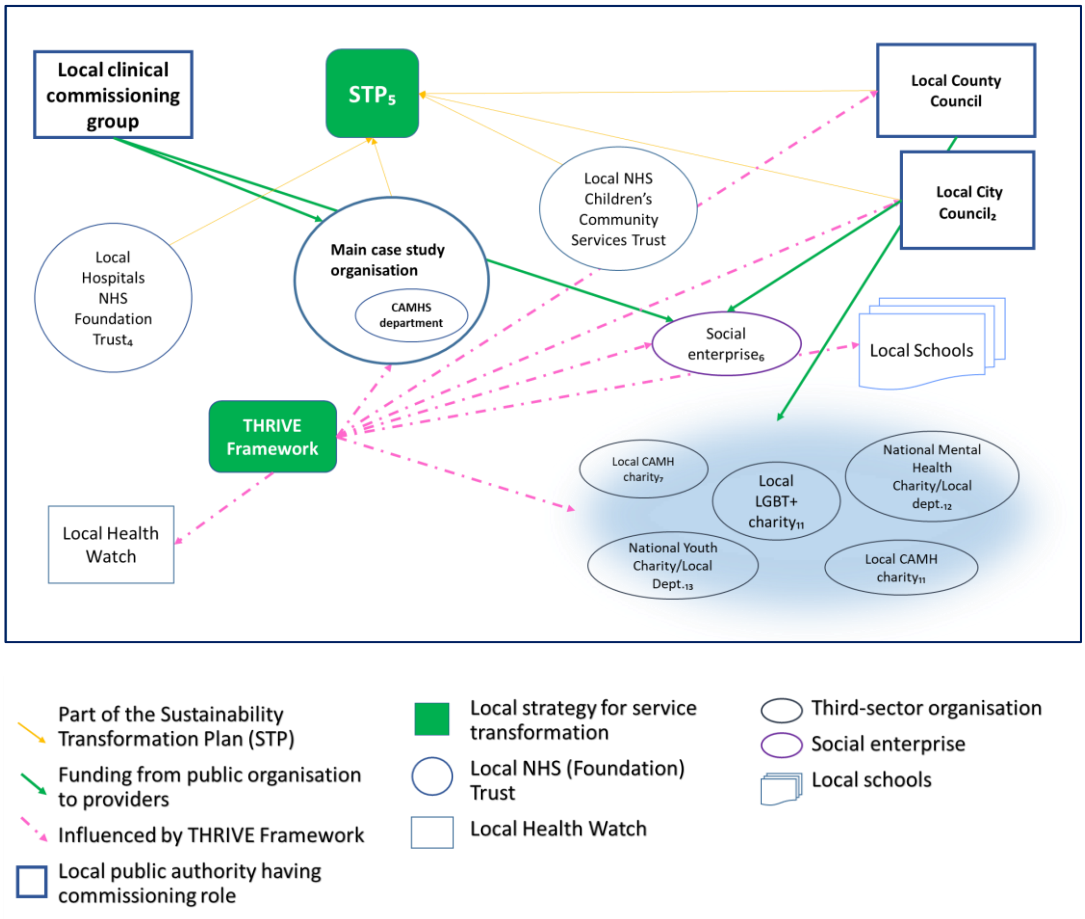



Diagram 4.2: The local inter-organisational environment of the CAMHS department as identified by study participants of the case study organisation

### 4.2.1 Informal relationships between the CAMHS department and local organisations

Study participants from the CAMHS department explained that social care services and third-sector organisations (also referred to as charities or voluntary organisations) that support the mental health of children and young people are a key group of organisations with which they interact for identifying new knowledge. Staff members explained that the identification of valuable knowledge from this group or

knowledge sharing primarily concerns the transfer of patients from one service to another when needed (signposting or referral) or cases where patients use more than one service. Staff members may receive patients' information or discuss patients' needs, consistent with confidentiality regulations (i.e. patient's consent), to find suitable services that are available and can address the needs of young users. Study participants explained that knowledge identification or sharing usually takes place via informal pathways and happens largely at a "per case" level. Communication appeared to be sporadic, i.e. sharing information for an individual patient when needed, rather than systematic. Identification of valuable knowledge may also concern more general information about service availability and development. Study participants argued that the absence of systematic organisational-level processes had become a major boundary for their work and for identifying useful information, specifically when that is confidential. Informal processes appeared to restrain the ability of staff members to benefit from knowledge sourced by local organisations with regard to the needs of young people in service provision.

> *If young people referred to us don't meet the threshold for community CAMHS or that'd be more community, then we would signpost them to voluntary sector providers* (CAMHS Manager (1)).

> *If you talk one-to-one with individual informatics people, they all say data sharing is going to help but we haven't really got a clear way through the requirements to see how we can do that yet. (*Manager- Information and Performance department-Case study organisation)

Staff members highlighted the lack of organised signposting of young patients and the need for sustainable collaborative relationships among service providers that can enable exchange of knowledge. Study participants from both the case study organisation and local organisations raised this issue and indicated the need to establish information systems that ensure the safe exchange of information with local organisations.

> *The part of the relationship that does not really work is the funding relationship or any sort of strategic relationship. So there is a book in front of them [case study organisation], there are all the services that are free, I will send them there* (Trustee – Charity A).

Local NHS Trusts and NHS Foundation Trusts are also a group of organisations identified as staff members having regular contact with regard to knowledge identification. Staff members from the CAMHS department often need to be in contact with services of physical health. Despite the linkage between physical and mental health needs and the needs to regularly exchange patient information, staff members did not identify many systematic pathways of information exchange between the CAMHS department and physical healthcare services.

> *[…] we should be able to put those children in the ADHD service which is run by [the case study organisation]. That passage needs to be easier. At the moment, they have to come through our referral process and, actually, then, if we want them to go to [the case study organisation], they have to go through the single point of access. Patients wait twice* (Member of Senior Management – NHS organisation).

A new partnership was under development between the CAMHS department and the local children's community services during the period of data collection, with the aim of addressing the challenges of knowledge exchange between the CAMHS department and other local public healthcare services. Participants explained that knowledge mobilisation among those organisations appeared to intensify during the period of partnership development. Therefore, the development of partnerships was seen as an enabler for the identification of valuable knowledge.

> *We've got lots of work streams where we are working much more closely with [local children's community services], who are the other main providers of health children's services, so that will be shared in that way. As I say, the example of [local children's community services] and us working is more aligned* (CAMHS Senior Manager).

Study participants from the CAMHS department also referred to schools as a group of organisations with which they have occasional interaction, primarily because schools act as a source of referrals. Several staff members might interface more frequently with school staff members due to their job responsibilities. Although developing communication links with local schools would be useful for the identification of new knowledge, it was seen as being even more difficult to establish than with other organisations. It would require a tailored approach due to the fact that schools are organised in trusts and each one is responsible of organising its

own mental health solutions. In this case, the structure of schools in academic trusts appeared to further restrain the development of systematic knowledge identification.

> *In my work with the cases team, the main organisations we that have a lot of interface with are schools. So a lot of our referrals will come from schools* (CAMHS Consultant (1)).

Lastly, staff members identified the local clinical commissioning group (CCG) as an organisation with which they were in contact for identifying and exchanging information. In contract with the aforementioned examples, interaction with the local CCG was primarily in the context of their funding relationship and it would usually take place via formal or informal pathways (e.g. meetings or reports). The relationships with this organisation appeared to differ from the previous examples, as it predominantly concerns reporting progress in meeting the needs of the local population and contract specifications. Reporting to funders also appeared to often becoming time consuming for staff members.

> *We have to report on a monthly basis to commissioners, how we're doing against that* (CAMHS Manager (2)).

> *I mean for the contracting, commissioning and the regulatory, there is very clearly set out contractual agreement about what we provide every month and setting the template and the format and how to do that.* (CAMHS Senior Clinician).

Overall, study participants jointly recognised local service providers as organisations from which they can identify or exchange useful knowledge, primarily about service provision and patients' information. While staff members acknowledged the need for using local knowledge and sharing their own knowledge in order to better formulate care, organisational processes of knowledge identification in the CAMHS department and knowledge sharing remain informal and sporadic. Lack of organisational processes was highlighted as a barrier for the systematic and safe identification of valuable knowledge, not only by staff members of the CAMHS department, but by staff members of local organisations, too. The informality of relationships among local organisations appeared to operate as a barrier, not only for facilitating the identification of new knowledge, but also sharing of new knowledge, particularly when this concerns confidential information.

### 4.2.2 Local organisations' role in knowledge sharing within the local environment

Staff members of local organisations shared their views on the ways knowledge is mobilised within the local environment. Study participants explained that they participate in different activities that enable the mobilisation of new knowledge, such as forums or local network meetings, as representatives of their organisation. Such activities demonstrate a degree of intention to develop connections with the local network. Resonating with the previous section, when relationships develop to formal collaborations, this seems to have a positive impact on the development of communication pathways among organisations and enable the circulation of knowledge. For instance, staff members explained that when they jointly deliver particular services to young people or delivering training together or to each other, these activities enable the establishment of formal links between organisations that facilitate knowledge exchange.

> *We do work very closely with the [Charity B] […] and we deliver very similar work to young people; we subcontract them for a part of our youth investment work we do with young people. So we have that really nice collaboration with [Charity B]* (Director of Operations – Charity D).

The study participants from local organisations reported a number of relationships that they considered as successful and sustainable. Analysis showed that positive experiences with previous collaborations in service delivery or of tender process can operate as an enabler for staff members to maintain and enhance collaborative relationships among local organisations.

> *For example, I worked with a school who have deaf children. […] That is really nice that you have worked on a project and you have that relationship. If there is another project, then maybe we could work again together […] I do try to keep those avenues open* (Manager – Public organisation B).

As a response to the need for providing a unified local model of services to young people, as required by the Local Transformation Plan, several organisations came together and formed a collaborative intitiative. Study participants explained that, through this new collaboration, their intention was to combine the capacity of several small local organisations and, in this way, efficiently address the lack of service provision, especially in the early stages of mental health problems.

> *Well we come together in various groups, to try to work out how to kind of provide a holistic offer and I think that this is an ongoing conversation. There is an initiative locally at the moment to try to pull all organisations together. There are challenges, because we work differently […]. But I think we do need to keep talking to make sure we are not overlapping or we are not distracting from each other* (Executive Director – Charity C).

Study participants explained that this initiative was also a result of the gradual develoment of local service providers. Staff members of local organisations argued the growing knowledge and experience local organisations have, contributed to shifting from having a reactive approach to external system changes to developing strategic collaborations that can improve the quality of service provision. Although activities regarding knowledge exchange have remained sporadic on several organisations' agendas for a long period of time, staff members explained that communication with the extenal environment has now become part of their organisational strategy.

> *[…] one of our strategic aims is to actually strategically move mental health players which shake the market and challenge decision-making, while in the past we would just sit back and say well, you know, the [case study organisation] is big, they are medical, they are NHS, of course they get the money* (Director of Operations – Charity D).

Staff members explained that local organisations, other than the CAMHS department, present a certain degree of connectedness. Successful past collaborations operated as positive experiences and increase the chances of new collaborations. The tendency to take initiative and intensify formal links is also seen as an outcome of local organisations' experience, as well as their need to become more visible to local funders and to develop a unified spectrum of services. Although data from the interviews with the staff members of local organisations did not provide further details about the type of relationship they have with each local provider, it contributed to the description of the local environment and understanding their role in knowledge mobilisation within the local service system.

#### 4.2.3 Information governance boundaries

Part of the information staff members share is regulated by the information governance regulations of each organisation. Part of that information is classified as confidential and there are restrictions in sharing it. Confidential information concerns

both organisational and patients' information, either individuals' data or anonymised data. Patients' data recorded by the CAMHS department are protected by the Information Governance Policy (included in document analysis) of the case study organisation.

Due to the involvement of more than one organisation in planning individual patients' care, staff members of the CAMHS department and other organisations explained that they may be required to share information with regard to young patients when young users need to transition from/to CAMHS. However, different information governance regulations can operate as a boundary. For example, patients' consent for data use might have been provided for one organisation and, therefore, data cannot be transferred to another due to lack of common regulations on information governance. Because of data restrictions, patients may also be asked to complete new assessments if they use the services of a new organisation, which can be overwhelming and time consuming. Although staff members of the CAMHS department demonstrate understanding of the importance of information governance, at the same time they explain their struggle and concern when regulations do not facilitate collaboration for better planning of service provision. New regulations also appear to create additional anxiety for staff members due to lack of clarity as to what data can be shared. As an outcome, individual staff members appeared to understand the usefulness of information governance regulations in enhancing data protection. Yet, they explained that said regulations can confine their flexibility to share and use relevant information that could facilitate planning of care. Increasing regulation in information governance was seen as an additional cause of worry rather than comfort for staff members and, thus, have a negative impact on joint working.

> *So, we wouldn't necessarily know, which sounds crazy in society now, but we don't have a system that knows if a- We rely on the patient, or the young person telling us who else is involved, and they might not always know* (CAMHS Manager (3)).

> *We would definitely talk about young people, so we will share cases sometimes or, you know, cases go between us and them and we need to talk about transfer of care. It is a tricky question because there is definitely corporate in all the organisations where there is consciousness about what information we share.* (CAMHS Consultant (3)).

Participants who talked about the need to increase flexibility in data sharing did not only refer to information related to individual cases, but also to anonymised and aggregated datasets, which can be shared among organisations and impact understanding about the overall needs of the local population. Study participants from both study groups highlighted that bringing together such information can significantly contribute to monitoring and interpreting the local mental health needs and, eventually, optimise the quality of services provided.

> *They've obviously got a well of information [GP Practices], we've got a well of information. I think together the sum of it would be greater than its parts but there's no mechanism as such for us to routinely do that* (Manager – Information and Performance department – Case study organisation).

Furthermore, study participants from both interviewee groups argued that the organised sharing of data among organisations also affects the potential of that data to be used in effectively monitoring progress and meeting the objectives of the local healthcare system against the local Sustainability Transformation Plan, which is a requirement for the organisations that form part of it. Adjusting regulations that can protect individuals' information, while increasing insight into the needs of the local system can also contribute to meeting the key targets of the "Five Year Forward View" (2014) policy.

> *It's quite difficult to do because we've got patient consent, we've got GDPR, general data protection regulations. There are lots of barriers to sharing data that I think would help clinicians and therefore our patients. […] The national picture's quite useful. […] The idea of the STP is wider than one provider so it makes it quite challenging in some respects to meet the information needs of the STP* (Manager – Information and Performance department – Case study organisation).

Overall, data protection governance was identified as an area that can create a conflict between regulation implementation and collaborative service provision and may cause worry among staff members as they are expected to be cautious about the information they share. Restrictions in sharing such knowledge appeared to decrease their ability to import and absorb valuable knowledge needed to provide services that best respond to young users' needs.

### 4.2.4 Internal policies: setting boundaries with the inter-organisational environment

One of the pre-defined categories of document analysis aimed to collect evidence with regard to the internal policies and procedures that exist within the case study organisation in relation to the external environment. Although staff members explained in previous sections that sustainable communication pathways are needed to enable the identification of valuable information, analysis of internal policies showed that organisational documents focus primarily on regulating existing relationships and there is limited evidence about strengthening connectedness with the external environment. Specifically, documents included in the analysis appeared to focus primarily on determining the boundaries of knowledge sharing between the case study organisation and partners or the public, and the kind of information the former's staff members are expected to protect. For example, internal policies determined how partner organisations are expected to comply with the organisation's policies that guide practice, such as the procedures and regulation regarding the Data Quality Information Policy or the Information Risk Policy. In the case of NICE guidance, only one process of communication with other organisations was identified (i.e. when a guidance should be implemented in collaboration with another organisation, e.g. physical care) (Figure 4.1).

| Pre-defined: Inter-organisational environment | | | | | | |
|---|---|---|---|---|---|---|
| Information security policy concerns the whole of the Trust and contracting organisations | Stakeholders and contractors are expected to comply with Data and Information Quality Policy | When staff is taking information outside the Trust must ensure that the Caldicott Principles are followed | The Trust protect sharing patient information under relevant regulations (e.g. Protection of Children Act) | A confirmatory assignment of Intellectual Property to the Trust is required for IP exploitation as evidence to potential investors | The Trust should not agree to contracts with partners that restricts disclosure of information (Fredom of Information) | Responsibilities will be agreed when new implementation of NICE guidance involve other organisations (e.g. physical care) |

Figure 4.1: Analysis extract of the pre-defined category "Inter-organisational environment" in document analysis

### 4.2.5 The role of organisations' aims, size and data management systems

Staff members from both study groups appeared to agree that local organisations share a common aim, namely improving children and young people's mental health. Nonetheless, differences among local organisations were often interpreted as a

restraining factor for collaborative attempts. Specifically, study participants from both groups explained that the differences among local organisations can restrain the development of communication streams at a local level. Consequently, this perception could have a negative impact on the CAMHS department's ability to identify useful knowledge from the local environment. Staff members from both the CAMHS department and local organisations gave several examples of how organisations can vary in their main objectives and structure.

For example, staff members of the CAMHS department explained that social and physical care services present differences in their approach to interventions and the optimal duration of an intervention from which a young person could benefit. Such difference can operate as a boundary to the services each organisation develops and the information each one collects.

> *They don't see that as being very effective if the family needs further intervention, whereas we don't view it that way. So there's a difference about what we see as being appropriate in terms of, A, the information we collect, or what we're trying to achieve might be slightly at odds. So that's important* (CAMHS Manager (2)).

Another example is that organisational aims may influence the commitment of organisations towards national policies. Representatives of third-sector organisations explained that organisations may be less engaged with governmental policies in comparison with public healthcare organisations. As a consequence, this seems to allow a greater degree of flexibility for service providers of the third sector to adjust their individual strategy in meeting children and young people's needs in comparison with the CAMHS department. For example, governmental policy initiatives can be based on a cost-saving rationale – something that does not always align with local charities' strategy. The Executive Director of Charity C explained that:

> *[…] one of the ways we think it works is long term and that does/doesn't necessarily align with a government policy. Government policy is for cost savings and therefore for very short-term work. Research shows that long-term work has more lasting benefits. So, to a certain extent we look at government policy but we don't necessarily go 'Ok, that is how we are going to work', because we don't necessarily think that that is the most effective*

*way, covering most in the cheapest way possible* (Executive Director – Charity C).

In addition, study participants from the CAMHS department explained that the size of an organisation can also influence their perception of the potential collaboration with another organisation. A small organisation with a limited number of staff members may be viewed with scepticism when developing collaborative work. As an outcome, an organisation's size can be an obstacle in developing collaborations among organisations.

*I'll give you an example [of partnership development]. We wanted to [collaborate with] a voluntary sector organisation. […] we can form productive relationships and share information appropriately and they do understand and we listen to their language and clarify what we are talking about. But it becomes a lot more difficult when you work with a much smaller, very local organisation* (CAMHS Senior Clinician).

Different data management systems and the use of different measurements to monitor information, primarily in relation to monitoring patients' details, was determined by staff members as a significant barrier to sharing knowledge among local service providers and to identifying and exploiting new useful knowledge for the CAMHS department. Study participants explained the impact which different systems of data management have in their daily work in two key technical ways: 1) it limits staff members' ability to bring information from patients together in cases of co-working between the CAMHS department and other organisations (e.g. one of the key functions of Children's Wellbeing Practitioners), and 2) it restricts the ability of partner organisations to combine datasets and look into the emerging patterns that can contribute to service development. Consequently**,** diverse data monitoring systems constitute barriers hindering the ability of staff members to jointly use data for development treatment plans or to benefit from larger databases. A staff member from the CAMHS department noted that having common IT systems can significantly contribute to developing a pro-active attitude and can enhance collaborative work.

*Because every organisation has a different database, most of the databases are not fit for purpose and they cannot actually hold routine outcome measures, analyse them and then report them in ways that allow us to improve our services. So what we should have is shared outcome measures*

> *so […] we can all present the outcomes of the interventions we offer and then together we can 'Look at these patterns. […] So we make a plan, we enact it and then we look to see how the outcomes change or don't change. We do that together'* (CAMHS Consultant (3)).

#### 4.2.6 Speaking different 'languages'

Different organisational aims may also affect the 'language' adopted by the staff members of each organisation. The term 'language' was used during the interviews to discuss potential differences among local organisations around service provision. Analysis showed that the term is interpreted by study participants in two main ways: a) to describe whether organisations use the same definitions around mental health (e.g. what a mental health problem is, what the thresholds for service provision are or how assessment is defined), and b) to discuss whether organisations have the same views regarding best practices in service provision. Analysis illustrated that 'language' differences between the CAMHS department and local organisations are seen as a barrier by staff members to develop communication links and enabling knowledge exchange.

Specifically, participants from both study groups reported that organisations adopt different definitions of terms related to mental health. Those differences can create confusion and miscommunication among staff members who attempt to collaborate and exchange useful knowledge. Having different definitions is not only spotted among different types of organisations, such as public and non-profit or different public organisations, but also among different providers within the NHS (e.g. acute providers and community providers).

> *An example of not speaking the same language is that they use ED for emergency department and we use ED for eating disorders. For quite a while there has been that kind of difference and getting muddled about what someone's talking about. […] There are lots of oddities in the languages that we use as a service* (CAMHS Psychologist).

'Language' variation might also lead to confusion about what is defined as a mental health problem within each organisation and which mental health problems are addressed by each of said organisations. As a consequence, the use of different definitions increases the difficulty of developing a collaborative system of service provision. Moreover, it can also be a misleading factor for the expectations which

the local environment receives from the CAMHS department with regard to the latter's role in local service provision.

> *I think there are difficulties around different perspectives on what constitutes illness in children, and at what level a child ought to be thought about by the mental health service. And when they are thought about by the mental health service, of what that thinking should consist. From the point of view within [case study organisation], what other people expect of us appears to be something of an incoherence to us* (Member of Senior Management (2) – Case study organisation).

Differences in 'language' was identified as a term which study participants also used to describe diversity in local organisations' approach to strategically planning and implementing improvements in service provision in the local environment. Specifically, the term 'language' was used to describe and interpret local organisations' mentality about best practices for mental health provision. Study participants interpreted different 'languages' mostly as a barrier to effective communication among local organisations.

> *When we meet with education and social care, we often don't have… No, we don't [speak the same language]. They have different thresholds and a different remit, different beliefs. That makes it more complicated* (CAMHS Senior Clinical Manager (1)).

Furthermore, study participants argued that often local organisations have the tendency to work in an isolated manner and make limited effort to develop collaborative relationships. This attitude was described using the words 'siloed' or 'in silo' to explain local organisations' trend to work in an isolated way and investing limited time and effort in developing relationships and sharing knowledge within their local environment. This is a characteristic that appeared in the case study organisation, as well as in other service providers in the area. 'In silo' work was determined by staff members to be a restrictive factor for developing a collaborative system of service provision and mobilising knowledge locally.

> *I've moaned about [case study organisation] being siloed internally. Actually, [case study organisation] and our acute providers and neighbours are probably siloed as well. Especially when you think about the STP, we've all got a day job to do in terms of our operating reporting, our statutory reporting and all the usual stuff for our own organisation. The proactive element of*

> *sharing data or discussing data with someone across the road at a neighbouring Trust doesn't really happen routinely, to be honest* (Manager at the Information and Performance department – Case study organisation).
>
> *In theory, yes [there is collaborative work]. I think there is a lot of silent working and there is a lot of luck of joint commissioning so...* (Director of Operations – Charity D).

Finally, study participants argued that the interests of senior management staff members of the case study organisation appeared to have a negative impact on developing sustainable relationships that can grow the mobilisation of knowledge. The creation of new partnerships can lead to one organisation taking more responsibilities in comparison with other organisations, thus creating conflicts among the organisations involved. These kinds of conflicting relationships among local organisations can have a negative impact on the ways partnerships are being developed. Therefore, power interests among senior management appeared to influence the development of collaborative relationships and, thus, the possibilities of knowledge exchange and knowledge identification for the CAMHS department.

> *I think some challenges are around power and ownership and is one organisation going to trump another and going to tell them what to do or is it an equal partnership and I think you have to actively work on partnerships. So some challenges at Board and Director level demonstrate the behaviour of collaboration to make this work and I am really committed to doing that* (Member of the Senior Management (1) – Case study organisation).

Overall, although all local organisations aim to contribute to the improvement of service quality, the difference between organisations' aims, size, data management systems, and 'languages' appeared to create a heterogeneous environment. Although the heterogeneous nature of local organisations aims to address the different levels of service provision, it is interpreted by staff members as a barrier and a factor that increases the difficulty in finding common points of reference and collaboration. The tendency of local organisations to work in an isolated way and the power interests of senior management further hinder the potential of collaborative relationships.

### *4.3 Local organisations' staff members' view of the case study organisation*

Study participants from the local inter-organisational environment were asked to discuss the relationship of their organisation with the CAMHS department and the case study organisation. Data analysis showed that their views often focused on the difficulties they have faced in developing relationships with the CAMHS department and the lack of adequate capacity the department has to address the local mental health needs of young people. Specifically, participants from local third-sector organisations explained that developing and maintaining communication links with the CAMHS department requires continuous effort from their side. As an outcome, the resources required by a small-size organisation to develop and maintain communication with the local NHS provider can discourage the former from investing in developing collaborative relationships. Additionally, staff members from local public organisations noted that a relationship with the case study organisation can take time to develop, due to the organisational changes that the latter is often required to implement. Consequently, the time and effort that has been required so far by staff members of local organisations to build relationships with the case study organisation has created the impression that it is a difficult and complex task to complete, and this has led staff members of local organisations to question the case study organisation's intention to develop relationships with local service providers.

> *One of the delaying factors was ideally placed to deliver that was our specialist mental health services because they've got the expertise in-house, but at the time they were also trying to improve their ADHD service, improve their crisis service, and start a whole new eating disorder service. Actually, their capacity as a provider to implement all of this innovation and still run an effective service, they just couldn't do everything all at once* (Manager – Public organisation C).

Several study participants also noted that staff members of the CAMHS department appear to have limited knowledge of the services available in the local environment. Lack of awareness regarding local service provision can operate as a barrier, especially for an organisation that signposts young patients to other local organisations, as it can be interpreted as lack of willingness to collaborate.

> *Yes, there is a kind of cross referral, but we certainly get young people coming to us and it is like 'we are done with them'. And actually, we are not*

> *clinical, we are not statutory, we are not therapists, we are a youth work organisation* (Executive Director – Charity B).

Furthermore, study participants reported that the present low capacity of the case study organisation has a significant impact on the level of severity of young people's conditions that other local service providers are called to address. Due to long waiting lists and decreased funding, children and young people who need specialised help often contact non-NHS organisations for support. That increases the service burden on those organisations, as they often do not have the capacity and/or knowledge to address more complex mental health problems.

> *Well there is only a certain capacity that we have, but what is affecting us is the nature of the difficulty, the children we see. So we are giving more training and support to practitioners in order to ensure that the needs are addressed. It is frustrating sometimes to see that cases that have not been taken at CAMHS would have been seen before. That has happened, and there are certain cuts as well* (Executive Director – Charity C).

Overall, the experience of study participants from local organisations with developing collaboration with the CAMHS department has been mostly discouraging. It would often require time and effort to understand the complexity of a large organisation, such as the case study organisation – something that local organisations could not always dedicate. In addition, staff members from local organisations saw limited willingness from staff members of the CAMHS department to create effective communication pathways both for referral of patients, as well as for a broader sharing of knowledge and expertise with regard to service provision in the area, which becomes further disheartening for developing productive relationships.

### *4.4 The role of gatekeepers*

Study participants from both interviewees' groups indicated that gatekeepers have a key role in the development of relationships among local organisations. Most study participants stated that the gatekeeping positions which their organisations have are positions that aim to maintain contact with the external environment. Staff members often saw gatekeeping activities primarily as developing personal relationships with individuals from other local organisations, with the aim of facilitating knowledge exchange with regard to service provision to young users.

*[…] if you know someone in an organisation you could go to the various queries… it is a lot better, yeah. If you build up a relationship with someone in an organisation you can approach them, if you have any challenges. I think that is probably a good way rather than not knowing where to go in the organisation, which may not be very practical* (Manager – Public organisation A).

*I suppose it's about developing trust with colleagues in other organisations, that they know why we say things and we know why they've said things. Then, when people leave, it often breaks down again.* (CAMHS Senior Clinical Manager (1)).

Study participants argued that the knowledge gatekeepers have about their local environment, does not always become embedded to the rest of their organisation. The risk that the study participants saw here is that in a case where gatekeeping is personalised, the relationships built are heavily influenced by the individual gatekeeper and often have to be recreated once those staff members leave or are replaced. The study participants from local organisations demonstrated that this is particularly the case with larger organisations, such as the case study organisation, and less so with smaller organisations, where mobilisation of new knowledge appears to be faster. Staff members from local organisations explained that maintaining relationships with gatekeepers from the CAMHS department was not always possible, either because the organisation is too large and complex or they do not know who is the right person to communicate with, or because an existing relationship is disrupted when a gatekeeper leaves their position.

*So you might get to know somebody and they get to know you, you build up a relationship. You don't start at base one all the time. And then they go and that happens, it has happened, it happens anyway. It has happened a lot in the health service in particular, slightly less so in the councils* (Trustee – Charity A).

*[…] you don't know to who to talk to and I keep saying we should have buddies. They [CAMHS department] should have a dedicated person in their team, because, at the moment, what we do is that we will send a referral to them, but instead of doing that we could have joint allocation meetings – a conversation about young people. A joint plan rather than keep passing them back and forth between services* (Director of Operations – Charity D).

To sum up, study participants associated gatekeepers with having a positive impact on the mobilisation of knowledge and recognised their contribution to the local environment. Nevertheless, the findings showed that the personalisation of the gatekeeper position and the limited impact their work may have within an organisation, including the case study organisation, restrained the development of systematic exchange of knowledge.

### *4.5 The funding system and its impact on the local inter-organisational environment*

The funding system appeared to be a determinant factor for the relationships among local organisations, as well as the capacity each organisations has available. Staff members explained that financial deficiency leads the local service system to face major challenges in providing adequate mental health support to young users. Next to this, imbalanced investment in the different service levels and the existing competition are also factors that influence the relationships of local organisations. The present section demonstrates how funding mechanisms and allocation affect knowledge exchange between the CAMHS department and the local environment.

#### 4.5.1 Imbalanced investment among services

Allocation of financial resources at different levels of services was reported by study participants from both study groups as imbalanced, where early intervention services are given only a limited share of the available funds. Although this may allow the majority of resources to be invested in specialist services, it leaves early stage services with less financial support. Additionally, children and young people's mental health services receive the smallest funding allocation in comparison to the adult and older people's mental health services and physical health services. Study participants argued that imbalanced investment in CAMHS, and particularly in early intervention services, increases pressure on service provision.

> *Someone's got to make a difficult decision and say, 'If we took some of that money and gave it at the start of life', when the children are well but it's actually about preventing it happening. This would be a better use* (Member of Senior Management – NHS organisation).

Study participants from the CAMHS department highlighted that when local organisations which provide early support fail to address existing needs, those cases will deteriorate until reaching the level of CAMHS support. As an outcome,

limited access to early support services will eventually lead to a significant increase in the service burden on specialist services, which are mostly provided by the CAMHS department.

> *Social care in this area is really struggling to provide the sort of care that is needed for families across the board, across all the age ranges. […] So their provision about supporting the community, and keeping everybody feeling calm and safe, isn't happening* (CAMHS Manager (2)).

As a consequence, inadequate funding allocated to CAMHS and other local service providers, such as Social Care, and insufficient financial investment in early help services has led to increasing the service demand for CAMHS and has become a major barrier to timely access to appropriate service support for children and young people.

#### 4.5.2 Commissioning process and the impact of competition

Pressure which organisations face due to limited available funding is accompanied by the competition that is created at a local level due to the commissioning process**.** Local organisations seek funding sources from various funders, but in some cases they may compete for the same funding, such as funding from the local commissioning group (CCG). The commissioning process appeared to create a degree of competition among local organisations that already collaborate or plan to collaborate in the future for service provision. Study participants from both groups explained that local competition creates an additional level of boundaries among organisations and can jeopardise opportunities to collaborate for providing a holistic approach to services. As an outcome, competition becomes a restricting factor for collaboration.

> *[…] for me the most unhelpful thing this government or that successive governments have done over the last 15-20 years is this, you know the internal market is a disaster, particularly in my field. It's particularly destructive trying to create collaborative care when half of the agencies around one of the young people I work with are possibly all going to bid for the same work. […] We have an implicit need for one team to fail because we want the work* (CAMHS Consultant (1)).

Furthermore, study participants explained that funding agreements create specific commitments to deliver services and separate contracts. As an outcome, every local

organisation that receives public funding is expected to deliver the requirements of its own contract. As an outcome, this invisible barrier enhances the mentality of organisations to work separately and contributes to maintaining discontinuity of services.

> *So, the dangerous conversation that then goes on, I've heard, within [the main cases study organisation], is, "Oh, they're commissioned to do that, they're commissioned to do that", so then you have, "Well, we're commissioned to do this, they're commissioned to do that. That's them, this is us", and you get the silo and you get that too, actually* (CAMHS Manager (3)).

> *But the current contracting arrangements and mindset are quite rigid, so I think that's a bit of a challenge when we were asked to do this* (Manager – Public organisation C).

Study participants from local service providers argued that the process of services commissioning does not operate in favour of the need to develop a joint system of service provision that would include organisations providing services at all different levels. Study participants explained that local funding allocation is influenced by a hierarchy that has been gradually established in the local system, as to which organisation should receive funding. As an outcome, commissioning practices appear to have maintained a unilateral investment that is often allocated to particular organisations, including the CAMHS department, and may exclude other local service providers from receiving public funding.

> *So I think the consultation is a good place to start that we come together as providers and say what we want to see locally, rather let the commissioners decide what should happen locally, because we have a grass root information, we have access to the people who need the help. Commissioners sit behind desks […].* (Director of Operations Charity D)

Barriers created by the funding system lead young service users and their carers to tackle a complex system where providers often operate isolated from other organisations, making the use of the services difficult and inefficient. A CAMHS Senior Clinical Manager explicated their concern that the discontinuity of services often leads parents to have to deal with different services and "they may be involved with three or four different health teams". A CAMHS manager also explained that:

*[…] what you don't want is to have to come into a service and out into another service and be bounced to somewhere else because you don't fit the bill – you should just be able to come and get some care* (CAMHS Manager (2)).

Overall, study participants argued that the internal market system leads organisations to work separately and maintains a fragmented service system. The imbalanced investment at different levels of services and the competition created among organisations do not support the development of collaborative relationships, where meaningful mobilisation of information can take place. Thus, the current healthcare funding system appeared to operate as a major limitation to the creation of collaborations that would allow for the establishing of communication pathways among local organisations and the exploitation of valuable knowledge of the CAMHS department from the local environment.

### *4.6 The responsiveness of the CAMHS department and the local inter-organisational environment to the THRIVE Framework*

Study participants from both groups were asked to share their views about the ongoing local transformation in children and young people's mental health services. During the early stages of implementation, THRIVE was introduced to both groups of participants via different pathways, such as workshops organised by the Anna Freud Centre (key developer of the THRIVE Framework), the CCG, the CAMHS department or via gatekeepers who shared their knowledge about the new framework. Interviews conducted for this study included questions about THRIVE, providing an opportunity to track an example of new knowledge that is relevant to local services and to capture staff members' perspectives on THRIVE, as well as on its assimilation and exploitation. Participants' views focused primarily on the assimilation and the utilisation of knowledge related to the framework, as well as the challenges that study participants faced regarding the ways the framework principles affect the re-design of the local services. Limited evidence was found in relation to the identification of new valuable knowledge of the framework, considering that the adoption of the framework has been decided by the local CCG.

#### 4.6.1 Assimilating the THRIVE Framework

Staff members from the CAMHS department explained that they understand the THRIVE Framework as an initiative that aims to change the current "4-Tier" service structure and develop a service provision system that is driven by the needs of

young users. They also interpreted the key objective of THRIVE as a framework that places emphasis on improving access to the different service levels by increasing investment in early intervention services rather than focusing primarily on specialist services.

> *I think what Thrive is trying to address is that very often we only have a very small number of kinds of help. They are often quite expensive and of a high level. But actually what apparently you're asking for is often something of a rather lower level. And because we don't have anything like that, we throw something that is more than they need or want* (CAMHS Consultant (1)).

Within the case study organisation, staff members demonstrated a good degree of awareness about the THRIVE Framework, also because the CAMHS department is expected to comply with it. The framework is included in the funding agreement between the case study organisation and the local CCG as the future direction for the service re-design of CAMHS delivery. As an outcome, the principles of THRIVE are expected to be assimilated and used in the service transformation plan agreed with CAMHS department.

> *We have to comply with what is defined in our contract. […] So it is referenced there as a future direction* (Member of Senior Management (1) – Case study organisation).

Within the local environment, most participants appeared to have an understanding about the main aim of THRIVE to create looser organisational boundaries and enhance collaborations that can address the fragmentation of mental health services in the area. Several participants' demonstrated awareness of the aims and components of THRIVE, either because they were involved in its adoption as part of local re-design, such as representatives from local authorities, or because their organisation has advised THRIVE in relation to service provision. Finally, a few staff members from local organisations appeared to have limited or no knowledge of the THRIVE Framework.

> *We needed to reduce [service] gaps, we needed to just think about things differently and Thrive in its way of thinking about needs, being needs-based, outcome-focused and about the young person, rather than being about the service, seemed to just resonate with us* (Manager – Public organisation C).

> *Just heard of it. Thrive model, yeah, just heard of it, I don't know* (Executive Director – Charity B).

Overall, findings from study participants demonstrated variation about the degree to which knowledge about THRIVE has been assimilated the local service environment. Staff members of the CAMHS department showed more coherent knowledge about THRIVE in comparison with staff members from the local environment.

#### 4.6.2 Using the THRIVE principles in practice

Staff members from the case study organisation gave examples that demonstrate the ways in which the THRIVE principles are being embedded in practice. They explained that they use the THRIVE principles in planning the re-design of service provision in the CAMHS department. Depending on the level of service provision, participants clarified that the THRIVE Framework is utilised within the services to different degrees. For instance, the framework was seen as being less relevant to inpatient services so far compared to community services. Additionally, staff members stated that they use the THRIVE language to manage services and to communicate with local organisations (schools, commissioners or other service providers). In some cases, participants explained that THRIVE is understood as a set of principles, rather than a directly implemented model. For this reason, it might not be at the forefront of someone's daily work, but will operate more as a guiding map in service re-organisation.

> *So if I'm writing anything, or if I'm thinking about, are we achieving this or are we not, if I'm developing anything… So all my strategic work has that in mind* (CAMHS Manager (2)).

> *So, a bit less here, more in outpatient work. I suppose, it's so acute the work here, in that people are really in crisis when they're admitted, and families are at their wits' end, that I see the Thrive as – I suppose, we're at one end of Thrive. So, I would see that as fitting more in the community, with how people can get help early and support early* (CAMHS Manager (1)).

At a local level, findings about implementation varied. Study participants from local service providers explained that the use of the THRIVE principles had a supportive rather than leading guidance in shaping their services. The practice which staff members mostly used to incorporate THRIVE was the adoption of the THRIVE language as a point of reference in decision-making and replace the "4-Tier" system narrative. THRIVE was also used to advice for the development of a local partnership among third-sector organisations (presented in Section 4.2.2). Finally, a

few participants appeared to have a good knowledge about THRIVE, primarily because their organisation received funding from the CCG. Overall, the degree to which local service providers engage with THRIVE is influenced by the relationship they have with local funders and particularly the CCG.

> *[…] we have internal debates of how much of the language we want to pick up, because it is quite big in the mental health field but it is not that big in the youth sector. [..] It makes logical sense to me, but in order to have a language that works well everyone should understand it. […] There is pressure from one area to do that and also pressure not to do that, but obviously we are not funded by the CCG and we receive funding from various resources* (Executive Director – Charity D).

> *So THRIVE is part of our mental health counselling re-shaping the service […], but it is kind of bigger than Thrive, it is the whole kind of language and the model of delivery […].* (Director of Operations – Charity D).

> *Because if that's what the policy-makers and commissioners are referring to in their thinking, then we have to try* (Executive Director – Charity A).

As a result, findings showed that participants associate the adoption of the THRIVE Framework with the degree to which it corresponds to each organisation's main aims and relationship with local funders.

#### 4.6.3 Challenges in implementing the THRIVE Principles

Study participants from both groups of interviewees explained that the utilisation of the THRIVE principles in service transformation faced several barriers. Participants from the case study organisation argued that the incorporation of THRIVE principles into the local environment is still in the early stages of implementation. Study participants from local organisations also explained that they see the implementation of THRIVE quadrants as still being at an early phase, while only a few differentiated themselves by saying that THRIVE is at a middle stage of implementation.

> *I would say we're sort of early stage and the reason I would say early stage is that I don't think that I hear, in the kind of workforce on the ground, a sort of awareness of where they would fit in a Thrive framework. It hasn't sort of permeated down to the sort of workers on the ground* (CAMHS Consultant (1)).

Critical voices appeared to see THRIVE as a new local policy initiative that does not necessarily facilitate the ongoing CAMHS transformation, either because it does not add anything principally novel to the already existing practices which local organisations use, or because it yet remains unclear how re-design of services can actually happen. Staff members from both study interviewees' groups doubted whether THRIVE could achieve an actual change for the local system. They also explained that the framework runs the risk of being seen as one more policy change that will be soon replaced by a new one.

> *Because the THRIVE framework is so embracing, and so all encompassing, it is not a guide on choosing. It doesn't say in tough times if you would do one thing, do this. It just says for a child, the very best would be, and then what anybody would say the very best for a child would be. So that's my concern about it* (Member of Senior Management (2) – Case study organisation).

> *It's something that I think some of those people get a bit change weary as well, because I know as a service they went through a massive restructure probably 18 months before we started all this. It was, like, "Okay, there is a change again"* (Manager – Public organisation C).

Additionally, participants explained that the 'culture' of individuals to work within their own organisation's boundaries and their habit to base their work on the '4-Tier' structure could also be a challenge for incorporating the new THRIVE principles into practice. Ultimately, service transformation based on the THRIVE quadrants is seen as bearing the risk of transferring the mentality of local organisations to work in an isolated manner under the new four quadrants of the THRIVE Framework. Finally, some participants argued that such a system transformation would require time until it would actually transform the structure of the local system of service provision.

> *I think it is the fact that it is just a new model. I think that the tiered system, […] it was kind of used in social care, it was used in CAMHS and I think it has been around for so long. I think people have understood that and whilst it is not a dramatic change, it is more about the flowing of cases to be able to kind of move through the different sections and the language. I just think that culture of individuals who have been around for a long time, I think it takes time to learn a new model [Thrive] and understand what it means. I think just time hopefully…* (CAMHS Team Leader).

*I think people are starting to understand but as you say, it's the big cultural change and people thinking about things differently, it takes time* (Manager – Public organisation C).

*So, you have the four quadrants, and the danger is they operate in four different silos and there's no threshold cross-over* (CAMHS Manager (3)).

Moreover, staff members explained that the incorporation of the THRIVE principles into the local healthcare system was negatively affected by the financial deficiency that the case study organisation and other local organisations were confronting, as this significantly limited the investment of existing human resources in developing collaborations for service re-organisation. Additionally, when staff members resigned, they could not always be replaced by new and equally skilled staff members, increasing considerably the difficulty in planning and implementing organisational changes. Hence, even when there is consensus among staff members about the usefulness of the THRIVE principles, it seemed that financial deficiency becomes again a substantial barrier to the incorporation of the new framework into practice, especially during the early stages of implementation.

*And then the other big threat to big scale changes like this is much more just, if you like, a sort of climate, that if you're faced with huge cuts and service kind of cutbacks or a staff group that feels increasingly kind of put upon and any kind of change is really difficult* (CAMHS Consultant (1)).

The data findings demonstrated that there is agreement among study participants from both groups regarding the necessity of actively engaging local organisations in reaching consensus as to how the THRIVE Framework principles will be implemented. Study participants argued that the implementation of THRIVE principles is not only dependent on the capacity and capability of the case study organisation to incorporate new knowledge and, thus, restructure service provision. It is also directly associated with the ability of other local organisations to commit and contribute to the incorporation of THRIVE guidance for the re-design of local children and young people's mental health services. Therefore, creating accountability and agreement as to how services will be shaped was identified as a pre-condition for the integration of services, as described by the THRIVE Framework.

*It's not consistently clear across all services as to what the provision can be from each service, and how we come together on that to be an accountable*

*care system. […] But the whole point in having an accountable care system is that everybody has to be in the game to do it, and we're only at this point – you're only working with one, two, three, or four people at any given time, so it's going to take a little while* (CAMHS Manager (2)).

*[…] how the i-THRIVE was being seen by the local authorities and how it was being seen by the health service. As a health service and a local authority, there was a mismatch between how we were focusing on i-THRIVE* (CAMHS Psychologist).

Overall, the THRIVE Framework was defined by study participants as a guide that directs the current local service transformation for children and young people's mental health services. Within the case study organisation, staff members appeared to have a good understanding of the THRIVE Framework, whereas there was more variance in understanding THRIVE in the inter-organisational environment. Study participants gave examples of how the THRIVE principles are being incorporated within their organisations, such as the adoption of the THRIVE language in practice or the use of THRIVE as a guide to form partnerships and advise organisations' strategy. Nonetheless, the utilisation of THRIVE in organisations' practices appeared to vary according to the commitment each organisation has to local funders. Regarding the potential of THRIVE to improve service provision, staff members expressed their concern about the actual change THRIVE can introduce, because it does not contain fundamentally new principles, it may be replaced by another policy in the near future or it is not influential enough to change individuals' working culture. Most importantly, both groups of participants recognised that the re-organisation of the local service system as directed by the THRIVE principles can only be successful if all local organisations are actively involved in the ongoing service transformation.

### *4.7 Summary*

The aim of this chapter was to analyse the environment around the case study organisation and they ways it could potentially influence the CAMHS department absorptive capacity. The purpose was twofold: 1) to understand and map valuable knowledge and the role of the external environment as a source of knowledge for the CAMHS department, and 2) to investigate the effect of the local inter-organisational environment on the absorptive capacity of the CAMHS department and on knowledge exchange among local organisations in a period of ongoing

transformation. As part of this, findings regarding the THRIVE Framework have been used as an example to explore how knowledge from the framework is being embedded in the local service environment.

Findings presented a rich map of knowledge that staff members identified as valuable and underlined the influential role of mandatory knowledge. Knowledge from the local environment was identified as useful for the CAMHS department, as it is primarily related to patients' information, knowledge about local services and local service development. Yet, analysis illustrated that relationships between the CAMHS department and local service providers remain informal and that operates as a barrier for staff members to effectively identify new useful knowledge. The findings demonstrated that there are very limited organisational processes in place that could facilitate the exchange of useful knowledge and create sustainable communication streams. The personalised role of gatekeepers, as well as the isolated manner that the CAMHS department often operate, are factors that were identified as further restraining the identification of new knowledge and the knowledge exchange with local service providers.

Local organisations that provide mental health services for children and young people, including the CAMHS department, share a common goal of contributing to the improvement of the young local populations' mental health. However, diversity among local organisations appeared to influence the development of communication pathways. The different aims of each organisation, their structure, the 'language' each organisation adopts or even the power interests' of senior staff members were identified as elements that have a determinant impact of the development of collaborative relationships among local organisations. The CAMHS department is, therefore, part of a heterogeneous environment, which it often interpreted by the staff members of the CAMHS department as a boundary for forming stable and long-term communication streams. Additionally, data findings showed that local organisations also face barriers when it comes to developing relationships with the case study organisation. The large size of the organisation and the limited intention staff members of the CAMHS department showed to engage with the local environment add to the complexity of the local environment. Furthermore, the relationships that are formed among organisations are also strongly influenced by the local funding system. The structure of the internal market based on which the funding system operates, creates competition among organisations that are otherwise expected to collaborate. The decreased funding allocated to the CAMHS

department and other local service providers appeared to put in jeopardy the potential of local organisations to develop sustainable relationships.

Analysis of data related to the THRIVE Framework reflected the complexity of the local environment described above. Staff members of the case study organisation demonstrated a good understanding of THRIVE, while awareness of THRIVE in the local environment varied. Although the framework has been adopted as a language that enables communication within the CAMHS department and among local organisations, the implementation of the THRIVE principles is still being seen as a policy initiative adopted by local funders, rather than a useful tool for service transformation. The degree to each organisation appeared to be engaged with THRIVE is influenced by the relationship of that organisation from local funders. Finally, study participants shared their concern regarding the potential of THRIVE and the actual transformation that it can deliver. Above all, there was a consensus among study participants that the effective implementation of THRIVE knowledge would require the collaborative work of local organisations, more than the individual contribution of each organisation.

## Chapter 5

## Findings: The absorptive capacity of the CAMHS department

This chapter presents the main findings from the thematic analysis of the semi-structured interviews with staff members of the CAMHS department and the content analysis of organisational documents. Data were brought together to provide answers for the first research question “How do public Child and Adolescent Mental Health Services (CAMHS) identify, assimilate and exploit new external knowledge?”. Findings presented in this chapter were generated from the analysis of interviews with 16 staff members of the case study organisation and the CAMHS department. Document analysis included 18 public organisational documents and one commercial document. Findings from the two qualitative methods were drawn together to explore the processes of absorptive capacity within the CAMHS department and the case study organisation.

The chapter presents findings in relation to the ways knowledge is identified, assimilated and used in the CAMHS department. Interviewees were asked to explain the ways in which they judge whether new external knowledge is valuable to be imported into the CAMHS department, how it is being processed and eventually implemented to reconfigure and improve services for children and young people. The findings were associated with each of the three main components of absorptive capacity, while a number of factors appeared to have a positive or negative impact on the overall absorptive capacity of the CAMHS department.

### *5.1 The ability of the CAMHS department to identify new valuable knowledge*

The ability of an organisation to identify valuable knowledge is one of the main components that can enhance its absorptive capacity (Cohen and Levinthal, 1990; Zahra and George, 2002). Prior knowledge which staff members of the CAMHS department hold and which is accumulated over time appeared to influence the value attributed to new external knowledge. The professional expertise of staff members forms part of the knowledge existing within the CAMHS department and influence the ability of staff members to identify valuable knowledge. Additionally, the public character of the external environment, also appeared to have an influential role in defining the value of new external knowledge. Thirdly, the objectives of the CAMHS department also guide staff members to decide on the value of new knowledge. Finally, outcomes demonstrated that existing formal

processes related to the identification of new knowledge tend to focus on mandatory knowledge areas (Diagram 5.1).

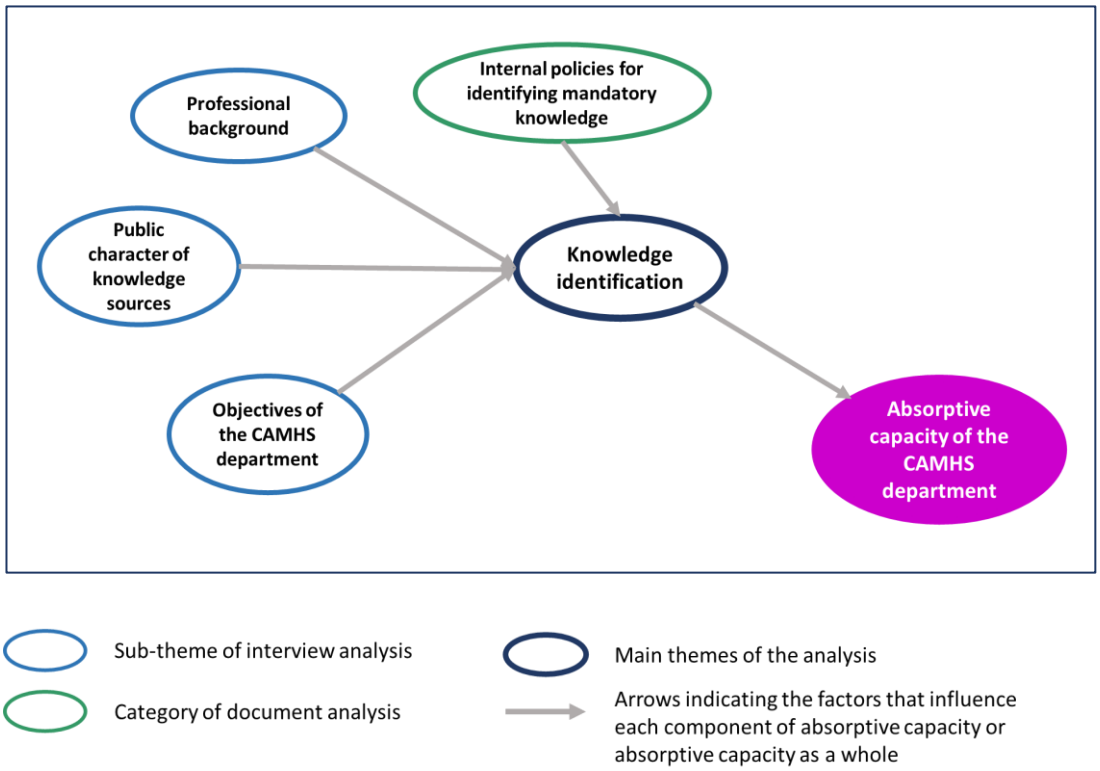



Diagram 5.1: Theme of "Knowledge identification" and sub-themes

### 5.1.1 The role of professional background

The professional background of staff members was identified as a determinant factor for identifying new knowledge. Considering that knowledge has a cumulative character, as explained on p.10, prior knowledge drives the search for new knowledge. Indeed, the data findings showed that the professional knowledge of staff members can influence their choices in selecting new knowledge and drive their judgment about the value of external knowledge. Several staff members highlighted that professional knowledge in their specific field of expertise strongly influences the choices they make in terms of what they would consider as valuable knowledge to import within the organisation.

> *[…] there is obviously cross-fertilisation. If something is in my head it informs everything I do, even if it may not be directly relevant to my day-to-day work* (CAMHS Consultant (3)).

*[…] as a doctor, I'm trained in analysing and selecting good quality reports from scientific literature* (CAMHS Senior Clinician).

In cases where staff members with various professional identities work together, professional diversity appeared to be both an enabling factor and a barrier to recognising the value of new knowledge. For instance, there are interdisciplinary groups where staff members collaborate to reach a consensus on the services provided to children and young people. Several staff members appeared to acknowledge the contribution new knowledge from other professionals can make to improving solutions provided in service provision.

*So, the family therapist I work with will have access to a range of information that I won't see, probably. The psychologist would be the same. Our teacher would, again... So, we all come to it from different slants and hopefully, in the middle of all that, you get a rich consensus of information about how different disciplines would consider a topic and what's relevant. So, that can be a whole load of informal conversations and it can come up through clinical discussions* (CAMHS Senior Clinical Manager (2)).

However, findings showed that diverse professional backgrounds appeared as a characteristic that can also become a barrier among staff members when it comes to recognising the value of new knowledge. This finding arose particularly between staff members working on management and service provision. Staff members explained that they may have different priorities due to their professional background and, therefore, different criteria for defining what knowledge is most valuable. In other words, the definition of valuable knowledge can vary among staff members as it is influenced by their professional background. Staff members explained that new knowledge can become a conflicting issue and have a negative impact on the identification of valuable knowledge. One of the interviewees with clinical responsibilities explained that:

*[…] I don't think it is an organisational issue. I think it is a people function issue. So where I connect is with the clinicians […] I think we speak a common language. […] it is around clinical care and best practice for patients and for the community. So this is where I think language is coherent, around the function of the person within the organisation. Sometimes I talk to one of the senior managers in one of the organisations […] I am hearing that*

*language, a certain language and I am thinking alright, it is not my language* (CAMHS Consultant (3)).

Another interviewee with managerial responsibilities shared the following:

*I think the sort of first line workers, frontline workers, to some extent, are psychologically drawn more to what [with clients], that's kind of why they're good at what they do, because they connect with that work. And so at the risk of overgeneralising, which I am about to do, they're probably just less interested in this kind of large-scale conceptual reorganising and theorising about the kinds of ways that we might develop helping services* (CAMHS Consultant (1)).

### 5.1.2 The public character of knowledge sources as a driver of knowledge identification

Staff members explained that the sources from which external knowledge originates is a factor that can influence their judgement of recognising value to new knowledge. The public character of new knowledge appeared to influence the definition of valuable knowledge and to affect the degree of value that staff members attribute to the latter. Regulatory, advisory and policy-making organisations in (mental) healthcare, as well as local authorities, are some of the examples that were see as sharing valuable knowledge because of their public character. This perception adds value to knowledge sourced by public organisations and, as an outcome, it is more likely to be imported into the CAMHS department by the staff members.

*[…] so the Prime Minister has brought together a number of these organisations […], the expert groups together, to look at the CQC inspection, and then produced lessons learned from the Care Quality Commission. […] So I would see that as a good quality report […]* (CAMHS Senior Clinician).

*When actually, sometimes, the information that, say, the local authority might hold, is really pertinent to the things that we do* (CAMHS Senior Manager).

Staff members identified public organisations as more trusted sources of knowledge in comparison with other organisations, primarily due to the clarity which such sources demonstrate in the production of new knowledge. Study participants referred to examples of public organisations linking knowledge reliability with their public structure. This characteristic appeared to be different for non-public

organisations, such as third-sector organisations, where quality of knowledge was questioned by staff members.

> *Obviously, if you've got something that's been produced by a statutory organisation, you would hope that it's been through a governance process and has been through a fairly rigorous checking mechanism, whereas if you have something from a source that might be non-statutory, you might not know what that source could be. […] Some of the organisations would be, for example, charities, which can be extremely helpful, but they might have a particular slant on what information they want professionals to be thinking about* (CAMHS Senior Clinical Manager (2)).

#### 5.1.3 The objectives of the CAMHS department

Staff members explained that their judgement on the value of external knowledge was also driven by what can best meet the current needs of young people and can provide value for money. For example, identifying interventions and/or therapies for children and young people that can improve their mental health operates as a driver for evaluating new knowledge. Additionally, staff members may also look for new knowledge that can assist with reaching a balance between mental health needs and expenditure.

> *So, if I'm looking at information and it really can demonstrate that it has improved outcomes, emotional health and wellbeing outcomes, for children and young people then I think it's worth us considering looking at, as to how it then fits into our delivery and our structure, or how we can change our services to improve outcomes all the time* (CAMHS Manager (3)).

> *And also to critically look at what we do – is it the best way to do it? Is it the most efficient way and if we only have a thousand pounds to spend, which service, which intervention, which model of care, provides the most value for us?* (CAMHS Senior Clinician).

#### 5.1.4 Internal policies for identifying new external knowledge: emphasis on mandatory knowledge areas

Analysis of the organisational documents demonstrated that internal policies which focus on the identification of valuable new knowledge were primarily associated with mandatory knowledge areas. The findings showed that the organisation has in

place various processes that aim to assess the need to import new knowledge. Yet, there is a tendency to focus primarily on mandatory forms of knowledge, which the organisation is required to implement, such as knowledge with regard to clinical practice, local regulations, strategic or legal amendments. The 'Mandatory Training Needs Analysis' is an example of a process used to evaluate the need for importing new mandatory knowledge. The analysed documents also provided some information about existing processes that contribute to identify new knowledge which is not mandatory (e.g. Personal Development Plan), but limited details were identified about how new knowledge is identified. Overall, the findings showed that the organisation invests in the identification of mandatory areas of knowledge, while there is limited reference to the identification of knowledge of non-mandatory knowledge areas (Figure 5.1).

| **New category: Processes of identification of new knowledge** | | | | | |
|---|---|---|---|---|---|
| **There is a process that identified a list of topics staff members are expected to attend (Mandatory Training Needs Analysis)** | **A training action plan aims to identify actions in a timeline to meet statutory and organisational requirements** | **The need to develop a new document may appear as an outcome of a legal change, new guidance, new service/ intervention or national requirements** | **NICE Scoping tool aims to monitor to which degree existing practice already meets the requirements of NICE and where there is still improvement** | **Individuals are required to self-assess their knowledge and engage with their line manager during the appraisal process to identify potential improvements** | **Learning and development needs are identified according to clinical necessity, national/ regional guidelines, legal duties, audit or research, strategic planning, supervision process, individuals' needs** |

Figure 5.1: Analysis extract of the new category "Processes of identification of new knowledge" in document analysis

Overall, the findings showed that the value of new knowledge that is imported into the organisation is influenced by the judgement of staff members, which is mostly influenced by certain criteria. The professional background of staff members plays an key role in their judgement of the value of new knowledge and can lead to disagreement among staff members as to what is identified as valuable knowledge. Additionally, the public character of the source from which new knowledge originates and the potential of new knowledge to meet the objectives of the CAMHS department in providing services for children and young people also appears to influence ability of staff members to identify new valuable knowledge. Internal policies that support the identification of new knowledge appeared to primarily focus

on mandatory areas of knowledge and fewer processes focus on enhancing the overall learning ability of staff members.

### *5.2 The ability of the CAMHS department to assimilate new valuable knowledge*

Assimilation of new knowledge is identified as the second main component of the absorptive capacity of an organisation (Cohen and Levinthal, 1990). Knowledge assimilation refers to the ways in which new knowledge is being understood, shared and processed following its identification (Lane and Lubatkin, 1998). Study participants identified a number of formal and informal processes, such as training, IT systems, emailing or supervision meetings that influence the assimilation of new knowledge in different ways. Additionally, several factors were also identified that appear to enable or restrain the assimilation of new knowledge. The need to reach consensus about new knowledge and the objectives of the CAMHS department appeared to enable knowledge assimilation. However, intra-organisational communication and the geographical distribution of the CAMHS department were identified as restraining factors. Diagram 5.2 shows the sub-themes that were generated under the theme “Knowledge assimilation”.

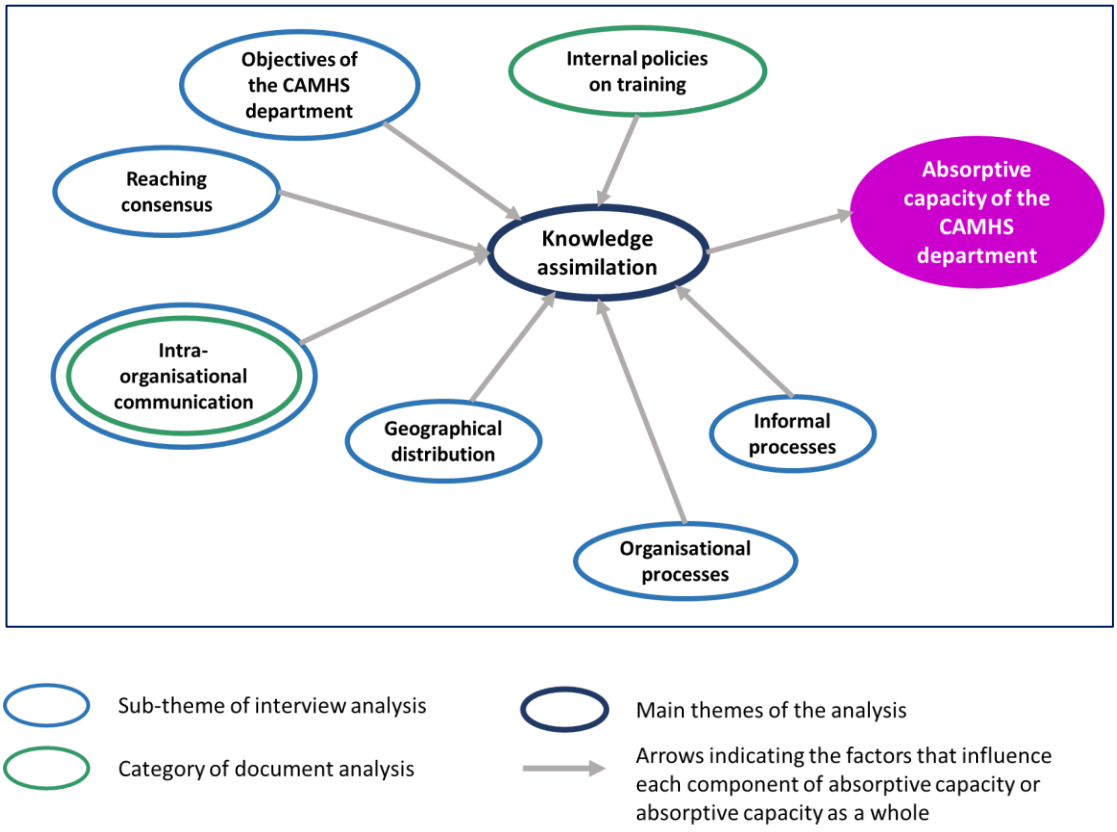



Diagram 5.2: Theme of “Knowledge assimilation” and sub-themes

### 5.2.1 The role of organisational processes in assimilating new valuable knowledge

Staff members named different organisational processes that they adopt to enable the assimilation of new knowledge within the CAMHS department and the rest of the organisation. Specifically, group meetings were described as one of the primary ways to share, discuss and process new knowledge. Staff members referred to examples of meetings that take place within the CAMHS department, as well as inter-departmental meetings in which CAMHS staff members participate. Different types of meetings (e.g. governance or business meetings) and at different levels (e.g. team meetings, senior management meetings of the CAMHS department, inter-departmental meetings or board meetings) were identified as examples of "formal ways" (CAMHS Senior Clinical Manager (2)), during which new valuable knowledge is shared and discussed and often used to re-design service implementation.

> *Then we have more formal ways of distributing information. So, we have a business meeting for our team, we have a senior management for our team, which has, kind of, got clinical governance aspects to it. We have a meeting with our colleagues who work in different inpatient units. So, we all meet together* (CAMHS Senior Clinical Manager (2)).

Additionally, staff members explained that internal data management systems are used to analyse and share information related to patients' data and the effectiveness of services. Staff members referred mostly to patients' data systems, such as "SystemOne", "RiO", and routine outcome measures (ROM), all of which are assessments used to monitor the effectiveness of service interventions or patients' safety systems, such as the system "Datix". Data management mechanisms facilitate the processing of data and appear to contribute to the assimilation of new valuable knowledge.

> *[…] I suppose I'm quite dependent on the systems we already have in place for information to come in […]* (CAMHS Senior Manager).

Lastly, staff members identified managerial and clinical supervision, professional training, internal reports and newsletters as examples of organisational processes that are associated with the assimilation of new valuable knowledge. Clinical and managerial supervision refers to a series of meetings, where supervisors and supervisees discuss and process matters about patients, particular therapies,

professional training, as well as operational issues. Professional training for specific staff groups or individual staff members also appeared to facilitate the assimilation of new knowledge (e.g. workshops for AMBIT approach, THRIVE Framework, Continuing Professional Development or professional development as part of professional specialisation, e.g. nurses, doctors). Finally, internal reports and newsletters focus mainly on internally disseminating information related to the organisation's strategy, outcomes or challenges.

> *So, I suppose, we gain a lot from learning about what's gone wrong in places and the recommendations that come out of those [daily internal] reports* (CAMHS Manager (1)).

#### 5.2.2 Internal policies: assimilating new knowledge via training

Document analysis contributed to identifying internal processes related to the assimilation of new knowledge and added to the findings from the interviews' analysis. One of the new categories in document analysis focused on learning via the different forms of training. Analysis showed that mandatory training is one of the most prevalent forms of learning in internal policies. Mandatory training can entail new clinical processes, patients' safety, new information management policies, maintenance of data quality or latest requirements from professional bodies. Figure 5.2 provides examples of mandatory training identified in internal policies. For instance, training on Information Governance is included in the induction training of all new staff. Some forms of mandatory training are planned specifically for managers, while others concern particular professional groups (e.g. doctors). Next to training, other recommended kinds of learning where also identified, such as mentoring or coaching, which did not appear having an obligatory nature, but no additional information was provided by the analysed documents.

| New category: Learning processes: assimilating new knowledge via training | | | | | | |
|---|---|---|---|---|---|---|
| Information Governance is included in the induction training of new staff | Health and Safety policy is included in mandatory training | Staff is provided with training and resources for Data Information Quality, including quality principals, latest policies or campaigns | Awareness of Information Governance, including the Caldicott principles, information security and data protection is part of Mandatory | Core Statutory and Mandatory training is required by statute or policy | Information Risk policy is included in induction and mandatory training | Learning and development trainings include mentoring, coaching or on-the job learning |

Figure 5.2: Analysis extract of the new category “Learning processes” in document analysis

### 5.2.3 The role of informal processes in assimilating new valuable knowledge

Staff members explained that they often prefer to share new knowledge through informal pathways in order to facilitate and accelerate the assimilation of valuable knowledge. Informal knowledge sharing can be for operational as well as for clinical knowledge. Sharing knowledge via emails was identified as the most common and fastest way of sharing knowledge. Informal gatherings or discussions may also take place to share and discuss information that can be relevant to a team. Informal processes appeared to be useful for staff members as they enable knowledge dissemination and may even be preferred to formal organisational processes presented in earlier sections.

> *If I want them all to know, and it’s something they really need to look at, then email with attachments, that sort of thing. We’re not very good at doing anything other than that* (CAMHS Manager (2)).

> *We have the weekly case discussions, which try to remind people about […]. We try to keep a culture of talking about it as an important thing* (CAMHS Senior Clinical Manager (1)).

### 5.2.4 The objectives of the CAMHS department

Similarly to the component of knowledge identification, staff members explained that the objectives of the CAMHS department constitute a key criterion which influences their decision as to whether they would share new external knowledge within the CAMHS department. The department’s main goals in relation to the ways services can be best provided appeared to function as a key driver for mobilising knowledge

within the department and discussing ways it could be implemented. One of the interviewees with clinical responsibilities explained that they would share knowledge that can benefit specific needs which patients have:

> *If I found out anything new that would change my perspective and makes sense and I think would benefit the client group then I would share that information* (CAMHS Psychologist).

#### 5.2.5 Reaching consensus on new knowledge

Sharing and discussing new valuable knowledge among colleagues (e.g. during group or one-to-one meetings) was identified as an activity that staff members prefer as a means to reach agreement on the ways new knowledge can be formed into actions for implementation. The interest staff members have in reaching a consensus and sharing accountability regarding the implementation of new valuable knowledge is a factor that appeared to enable the sharing and joint processing of new knowledge among colleagues. Staff members explained that their activity of sharing and processing new external knowledge among members creates the opportunity to discuss, define new actions and resolve issues that may arise regarding the ways new knowledge will be implemented. This element was identified among staff members with similar positions in the organisation's hierarchy (e.g. among Directors), but also among staff members with different levels of responsibilities (e.g. Service Managers and Team Managers).

> *I think it is about sharing consensus and sharing accountability, so no one person is taking something forward without colleagues agreeing to it. […]. So the best way forward, other way I think we, for the most part, are trying to get agreement with other people who are leading the teams* (CAMHS Consultant (3)).

> *[…] Sometimes it is because we need to take action together on something and I need them to have that information to show what that action is that needs to be taken. Sometimes it is because that information will give new insights and different perspectives and views on some of the challenges and risks that we are currently dealing with* (Member of the organisation's senior management (1)).

### 5.2.6 Intra-organisational communication

Absorptive capacity theory suggests that the assimilation of new knowledge is dependent on the communication among an organisation's units (Cohen and Levinthal, 1990; Jansen et el., 2005). The data findings demonstrated that intra-organisational communication is significant for the assimilation and implementation of new valuable knowledge by enabling sharing among individuals and departments. Yet, there are certain barriers may restrain the dissemination of knowledge within the case study organisation. More specifically, analysis of internal policies showed that there is recognition of the importance of communication links within the organisation's departments. The topic of "intra-organisational communication" was one of the new categories in document analysis. Findings demonstrated that the assimilation of new knowledge may concern more than one department. As shown in Figure 5.3, the internal dissemination of new knowledge on health and safety matters requires collaboration between Learning and Development and the Infection and Prevention service. New knowledge around information quality can improve operations and corporate governance within the different departments. Cross-departmental knowledge sharing is identified in internal policies appears to be a key factor for the effective assimilation of new knowledge (Figure 5.3).

| **New category: Intra-organisational communication** | | | | | |
|---|---|---|---|---|---|
| **Implementation of Health and Safety requires the collaboration of different departments/ teams e.g. the Learning and Development team or the Infection Prevention and Control Modern Matron** | **Information Governance is significant to Clinical Governance, service planning and performance management teams** | **Development of new internal policy documents should provide information about possible links or contradictions with existing internal policies and the Trust's objectives** | **Information Quality processes contribute to corporate and clinical governance, through the development of management processes** | **Health and Safety implementation requires collaboration between clinical governance and risk management** | **Information Quality contributes to having more efficient operational management and better quality in services** |

Figure 5.3: Analysis extract of the new category "Intra-organisational communication" in document analysis

While the document analysis indicated that intra-organisational communication is important for the assimilation of new knowledge, evidence generated from the interviews illustrated that the dissemination of new knowledge can be disrupted by several factors that can influence the ways in which new knowledge is disseminated. Staff members argued that new knowledge is often selectively shared with them so as to minimise overburdening of staff members and maintaining a balance between workload and time spent on assimilating new knowledge. This element was particularly present during the period in which the interviews were conducted. Staff members received excessive amounts of new information due to the ongoing service transformation, which could become overwhelming.

> *So, I don't always share it. The reason for that is… What's the reason for that? The team here have been in a lot of transition, and I think change can be difficult* (CAMHS Manager (3)).

Barriers to internal knowledge dissemination were also identified in relation to knowledge distributed by the senior management towards the CAMHS department. Staff members argued that knowledge disseminated from senior levels of management towards practitioners may be partially or poorly communicated. Limited understanding of the aims of new knowledge can significantly hinder staff members' ability to process new knowledge and make its exploitation meaningful, while they might feel left out from major organisational changes. Study participants with clinical responsibilities explained that they might receive partial or delayed information with regard to the organisation of services, which limits the potential of this information to be absorbed.

> *I think that information does happen to the service managers and things like that. I don't think it gets fed down, necessarily, to the clinicians yet. I'm sure there are things in progress with that. It will hopefully happen better. The communication there. […] Information isn't filtered through that well, whether that's external or internal* (CAMHS Psychologist).

> *So, I'm not always sure that these pieces of information are conveyed in a way that helps us to understand why we have to do them. […] I would say that's about the way that the information is conveyed. I suppose, if every day you're told you have to do a new thing, well, for me at least, I want to know, "Why am I doing that? What purpose does it serve?". So, "How has this*

*information come about in the first place? How is it applicable to this area?"* (CAMHS Manager (1)).

Another example of poor communication was identified in relation to the data management systems operating within the case study organisation. Data management systems process data and produce reports about service users of the CAMHS department. Study participants reported that IT systems do not always produce data which are directly relevant to the knowledge needed by the CAMHS department. Unfitting reports make the assimilation of new knowledge difficult as the information included in such reports does not directly match the need of the department. Additionally, combining patients' data from different IT systems is not always possible. This was identified as a significant obstacle for staff members as it makes it difficult to generate knowledge that is vital for their daily clinical practice, such as specific data on school referrals or the age of service users. Therefore, the limitations that IT systems present in generating tailored information and the compatibility among different IT systems that manage data was identified as key technical barriers in intra-organisational communication and in disseminating knowledge suitable to the needs of the CAMHS department.

*[…] we will collect information internally regarding referrals, say, coming in the door. […] but we don't have any software to pull out what schools have referred. We can tell you which schools the children belong to that have been referred, but we don't have a way of pulling out which school send the most referrals in, or which GP sends the most referrals in* (CAMHS Senior Manager (2)).

*We don't have the right data. We don't know who's in our services. We can't say for sure, without huge manual trawling, for example, I can't very easily identify […] what number of open cases, where those children and young people live […]* (CAMHS Manager (3)).

### 5.2.7 The role of geographical distribution

The CAMHS department is located in three geographical areas of the county. Study participants explained that new valuable knowledge is being shared among different locations in meetings with representatives from those locations. The aim of assimilating knowledge among various local teams is to synchronise service provision among the different locations. In cases where new knowledge is

successfully implemented in one location, it will then be shared with other locations as a good practice.

> *[…] we also don't want a totally different service in Cambridge than we have in Peterborough or we have in Central. So, I would liaise with, [coordinating members of different locations], talk to them about what the ideas are coming up […] and look at how we ensure that we can take some of this forward* (CAMHS Manager (3)).

Providing services in different locations, however, appeared to create several obstacles in terms of the mobility of staff members and in the development of common practice. Staff members explained that they may struggle with working across different locations. Additionally, different locations may also develop varied practices, resulting in differences regarding how services are provided. As a result, the geographic distribution of the department can hinder the assimilation of new useful knowledge.

> *[…] I suppose one of the main challenges that we… This ward, we work across multiple localities. Maybe half our patients are [based within the county]. We also have patients from [neighbour counties]. Those areas all might work differently to each other* (CAMHS Senior Clinical Manager (1)).

Overall, the analysis provided evidence as to how new knowledge is shared and assimilated within the CAMHS department and the case study organisation. New knowledge that has been recognised as being valuable is shared through a number of formal or informal processes. Different organisational processes facilitate the mobilisation of new knowledge within the organisation, while staff members also use informal pathways to disseminate information which they think is important. Staff members argued that the necessity of reaching a consensus before embedding new knowledge in practice is a key factor that enables the utilisation of processes that facilitate the assimilation of new knowledge. Interrupted intra-organisational communication may have a negative impact on the internal dissemination of new knowledge. Finally, the geographic distribution of the CAMHS department might function as an obstacle for the assimilation of new knowledge and, as an outcome, the harmonisation of service provision among the different locations of the department. The next section focuses on the ways knowledge is exploited within the CAMHS department.

### *5.3 The ability of the CAMHS department to exploit new valuable knowledge*

The ability of an organisation to apply new knowledge is an integral part of its absorptive capacity (Cohen and Levinthal, 1990; Zahra and George, 2002). Analysis of the semi-structured interviews helped to identify elements that contribute to the exploitation of new knowledge within the CAMHS department and to improve services for children and young people. A number of formal and informal processes, as well as the factor of trust towards staff members, were identified as elements that contribute to ensuring that new knowledge is incorporated into clinical practice (Diagram 5.3).

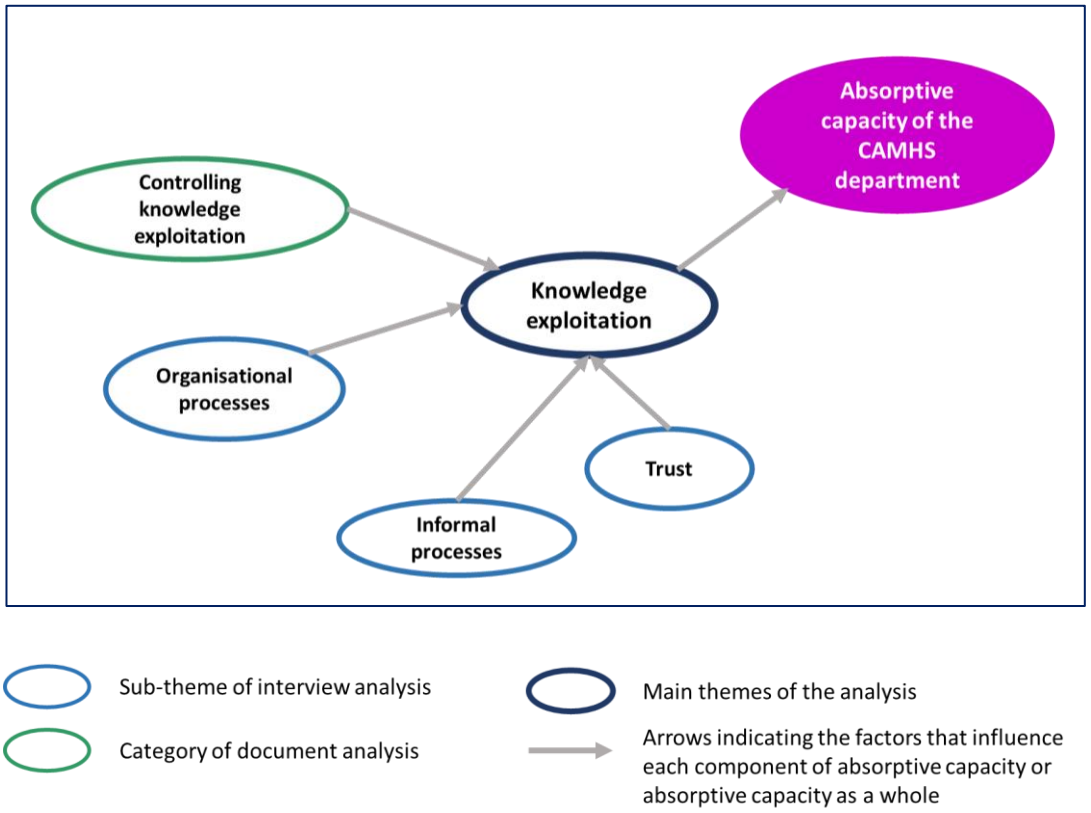



Diagram 5.3: Theme “Knowledge exploitation” and sub-themes

#### 5.3.1 <u>The role of organisational processes in the exploitation of new knowledge</u>

Staff members explained that there are a number of organisational processes that enable the implementation of new knowledge and the monitoring of progress in embedding knowledge in practice, among which the most prevalent are supervision, group meetings, internal reporting and planning processes. Several of those

processes were also identified in the previous section as processes that facilitate knowledge assimilation. This section focuses on their role in the implementation of new knowledge.

Supervision meetings (clinical and managerial) were identified as organisational processes that assist in monitoring the implementation of new knowledge. During supervision meetings, supervisors can review the ways in which useful knowledge that has been discussed in previous sessions is implemented in practice. Examples are knowledge about clinical practice, the use of Routine Outcome Measures (ROMs) by clinicians, feedback from children and young people with regard to the quality of services or completion of staff members' mandatory training. As a result, supervision meetings appeared to assist staff members in keeping track of whether new knowledge is being embedded in practice and the ways this is realised.

> *I think [clinical and managerial supervision] are the structures that are in place, that determine, that help us keep a tab on what we are practising – everything that is being discussed in terms of knowledge* (CAMHS Consultant (2)).

Group meetings were also identified as an organisational process that enhances the implementation of new valuable knowledge. Several types of meetings included monitoring of knowledge implementation as part of the organisations' agendas. Group meetings may take place either within the CAMHS department or inter-departmentally where staff members from the CAMHS department participate. Examples of such meetings are directorate level meetings (such as directorate management meetings or senior leadership meetings), quality and patient safety meetings or clinical governance meetings. Meetings are used to monitor whether new valuable knowledge is implemented not only in a top-down manner (i.e. to implement knowledge from senior management into practice), but also to inform about knowledge implementation in a bottom-up manner (i.e. to inform senior management). Examples include knowledge from NICE guidelines, service standards, new policies or practice, and operational practices or others.

> *Then in our clinical governance meetings, which happen once a month, again, they're, kind of, specific clinical areas which we need to review every month to check that we are meeting policy* (CAMHS Senior Manager).

> *As then it escalates up through the organisation for the executive, we have a monthly meeting with each directorate and one of the things we do in this*

> *meeting is go through the risks in that directorate, risk register on what they are doing around them* (Member of the Senior Management (1) – Case study organisation).

Internal reporting appeared as a formal process that is associated with knowledge exploitation. Study participants explained that internal reports are mostly used to circulate knowledge in a bottom-up manner, usually focusing on the implementation of new policies, guidelines, identified risks within the organisation or performance information. A member of the organisation's senior management explained that reporting is a way for them to continue overseeing the progress of implementing particular areas of knowledge that they see as essential for the organisation:

> *Sometimes I will ask for, particularly if it is something new, new policy or something that we need to address I will ask the, there is a report that comes through to our [senior management] so that we can see how that information has become seeded and what will change as a result of this information. […] A lot of the information will be about trans-risk, performance, so [this should be] reflected in the information that goes to [senior management] with the action plans which address what needs to be done as a result of the insight into learning from that information* (Member of the Senior Management (1) – Case study organisation).

Different forms of planning were also identified as a key formal way through which exploitation of new knowledge is monitored. Planning appeared to be used for setting actions and milestones that can be used as referral points for checking the progress of applying new knowledge. Staff members explained that different forms of planning are also utilised as a means to increase accountability among staff members as to which actions they are expected to complete. Examples of planning are action plans, business cases, development change plans or others.

> *So those conversations, while they are friendly, also have an element of what's called holding to account. Which is, "Tell me if this can't be done, cool. But if we've said it can be done, let's just check that it is being done"* (Member of Senior Management (2) – Case study organisation).

Analysis showed that organisational processes which exist within the CAMHS department and the case study organisation can facilitate knowledge assimilation as well as the utilisation of new valuable knowledge. Several organisational processes appeared in both the "assimilation" and "exploitation" themes, such as supervision

processes, group meetings or internal reporting. Staff members explained that such organisational processes can enable the processing and discussing of new knowledge, while help them to monitor exploitation of that knowledge, with the aim of embedding new knowledge in practice within a period of time.

### 5.3.2 Forms of controlling knowledge exploitation

Findings from internal policies demonstrated an additional element in relation to the exploitation of new knowledge. Analysis of organisational documents highlighted organisational processes that aim to increase the control on implementation of new knowledge in practice. The term 'control' was used in the title of this category to stress the emphasis given to those implementation processes, as there is often an explicit requirement for actions that must or must not be performed. Figure 5.4 shows examples from internal processes to control the exploitation of new knowledge. For example, failing to complete mandatory training may lead to disciplinary actions. Staff members who receive a new training/course supported by the case study organisation are expected to stay in the organisation for at least 2 years. As an outcome, internal policies showed the tendency of the organisation to ensure the implementation of particular areas of knowledge, usually focusing on legally-binding knowledge, mandatory training or other forms of professional learning.

| New category: Controlling knowledge exploitation | | | | | | |
|---|---|---|---|---|---|---|
| All staff is responsible to report any implementing information security processes or for any problems in the information systems | Failure to comply with mandatory training requirements may result in invoking the disciplinary or capability framework under the Trust's Disciplinary or Capability Policy | Employees are expected to follow the Health and Safety mandatory practices | Implementation of supervision policy is monitored by the HR Department | An employee is committed to stay in the organisation for at least 2 years after the completion of the professional qualification | The Trust owns any Intellectual Property that is generated from employees | NICE Guidance is reported quarterly and in the annual report |

Figure 5.4: Analysis extract of the new category "Controlling knowledge exploitation" in document analysis

### 5.3.3 The role of informal processes in the exploitation of knowledge

Although formal monitoring takes place primarily during different types of meetings and internal reporting, staff members explained that they will often use informal

ways as part of overseeing the implementation of new knowledge. For instance, staff members would engage in informal conversation asking the opinion of other staff members as to whether specific knowledge is being used in practice or whether a specific task has been completed.

> *Sometimes I would ask individual colleagues, lots of different colleagues "do you think people are using outcome measures? What do you think?"* (CAMHS Consultant (3)).

#### 5.3.4 Trust as a determinant factor for knowledge exploitation

Staff members explained that monitoring the exploitation of new knowledge is often embodied in organisational processes, giving the opportunity to evaluate the degree to which it is being used in management and in service provision. However, they recognised that it remains a difficult task to have a concrete picture as to whether knowledge is integrated into practice. Additionally, the amount of knowledge needed to be implemented is large and it could lead to overload of work if confirmation for using new knowledge was constantly required. As an outcome, staff members will often associate utilisation of new knowledge with trust towards other staff members. In other words, apart from monitoring the implementation of new knowledge, they also trust that other staff members will use that new knowledge in practice. Additionally, several study participants argued that staff members have an overall understanding that implementation of new knowledge is an integral part of their job responsibilities.

> *I mean that would cause overwhelm if I wanted feedback from everything. Often I trust people to consider themselves whether that information is necessary for the objectives that they need to achieve* (Member of the Senior Management (1) – Case study organisation).

Overall, data analysis demonstrated that the implementation of new useful knowledge is often being monitored by organisational processes, such as supervision, different types of group meetings, internal reporting or planning. Such processes may be similar to the ones adopted to enable knowledge assimilation. Knowledge exploitation was also informally observed through informal discussions among staff members. Despite the processes that are in place to oversee whether and how new knowledge is being used, the large volume of knowledge that reaches the CAMHS department does not make it possible to confirm whether all is applied in practice. Trust towards staff members appeared to be an element that contributes

in overseeing the implementation of new knowledge. In the following section, elements that affect absorptive capacity as a whole are presented.

### *5.4 Factors influencing the absorptive capacity of the CAMHS department*

Previous sections presented findings that focus mostly on the individual components of absorptive capacity. This section puts forth findings that appear to influence absorptive capacity as a whole. Firstly, data outcomes from document analysis indicated a tendency to invest in processes that enable the organisation's ability to assimilate and exploit new knowledge, while less evidence was found about investing in its ability to identify new knowledge. Secondly, analysis showed that the mandatory character of new knowledge (already introduced in Chapter 4) influences the prioritisation of new knowledge which staff members use in clinical practice. Thirdly, workload was identified as a major boundary for the evaluation and usage of new knowledge, as staff members are struggling to meet existing service demand. Increased workload is caused by staff shortage, lack of clarity about the support each local organisation can provide, increased managerial responsibilities for clinical staff, long waiting lists and decreased funding allocated to mental health services. Such factors are intertwined and significantly restrain the department's capacity to meet local mental health needs. Fourthly, gatekeepers and boundary-spanners appeared to play a key role in the department's absorptive capacity. Finally, individual absorptive capacity was identified as a key determinant for the department's absorptive capacity. All aforementioned factors are shown in Diagram 5.4.

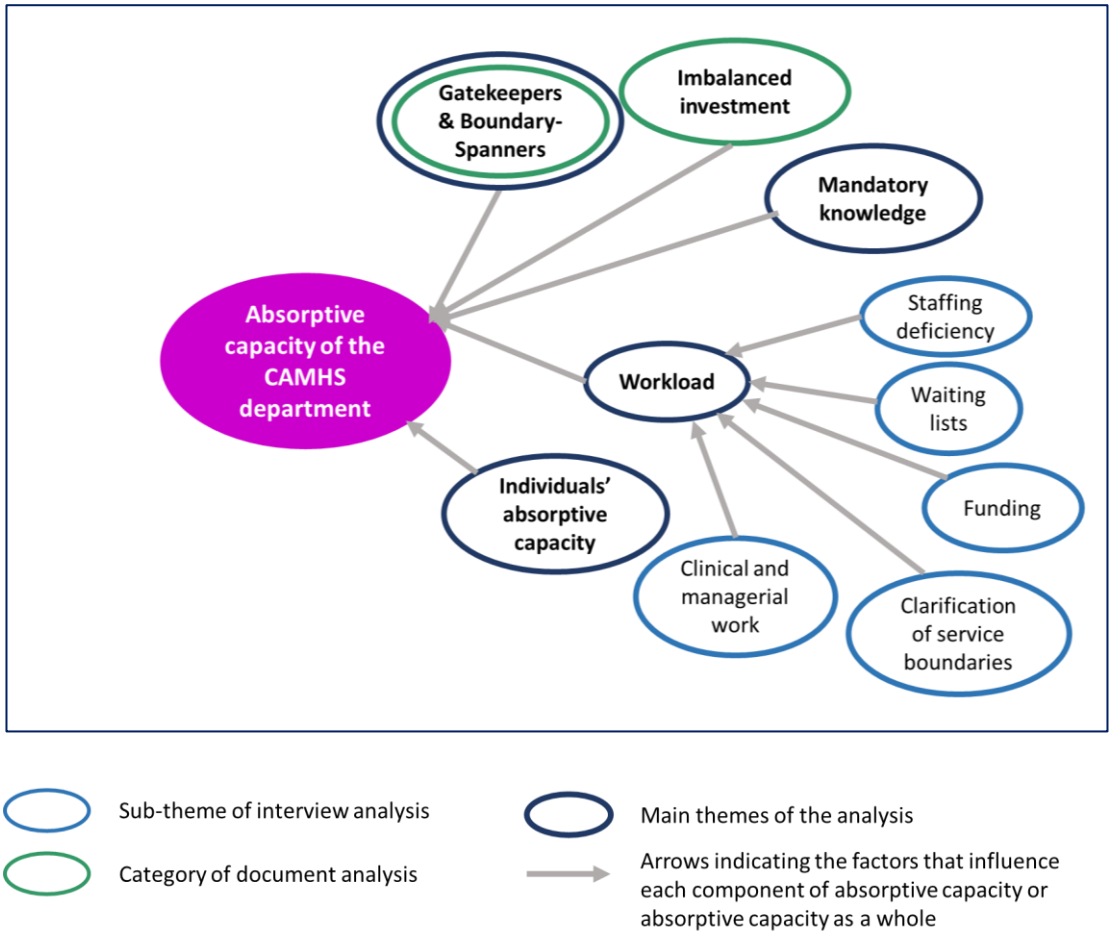



Diagram 5.4: Theme "Factors that affect absorptive capacity" and sub-themes

### 5.4.1 Imbalanced investment in the main components of absorptive capacity

Absorptive capacity literature has shown that an organisation should equally invest in the components of absorptive capacity to be able to improve its organisational outcomes (Cohen and Levinthal, 1990; Zahra and George, 2006). As discussed in previous sections, staff members utilise existing organisational processes that enable the "assimilation" and "exploitation" components of absorptive capacity; yet less evidence was identified about processes that facilitate the component of "identification". Document analysis contributed to bringing together organisational processes that are mentioned in internal policies, aiming to explore the degree to which the case study organisation tends to invest in the different parts of absorptive capacity (Diagram 5.5).

In particular, one of the pre-defined categories in the document analysis focused on identifying organisational processes in relation to absorptive capacity. Such

processes had a short title and would be accompanied by a short definition. For example, the Training Action Plan aims to monitor the progress of mandatory training and to ensure that staff members meet statutory and organisational requirements. Other types included consultation or internal dissemination of documents. Analysis identified three main groups of processes in this category: “plans”, “frameworks” and “other processes” (for more details please see Table 8 in appendix). The definition of each process assisted in positioning them in the diagram below, according to their relevance to each component. Each organisational process appeared to address one, two or three components. Processes were grouped in cycles with no outlines, considering the fluid boundaries among the absorptive capacity components. Although it is difficult to distinguish the boundaries of each component and each process, this diagram assisted in understanding the organisational processes that enable learning in the CAMHS department. Diagram 5.5 demonstrates that although there is a tendency to invest in processes that facilitate the “assimilation” and “exploitation” of new knowledge, limited findings were identified about the component of “knowledge identification”.

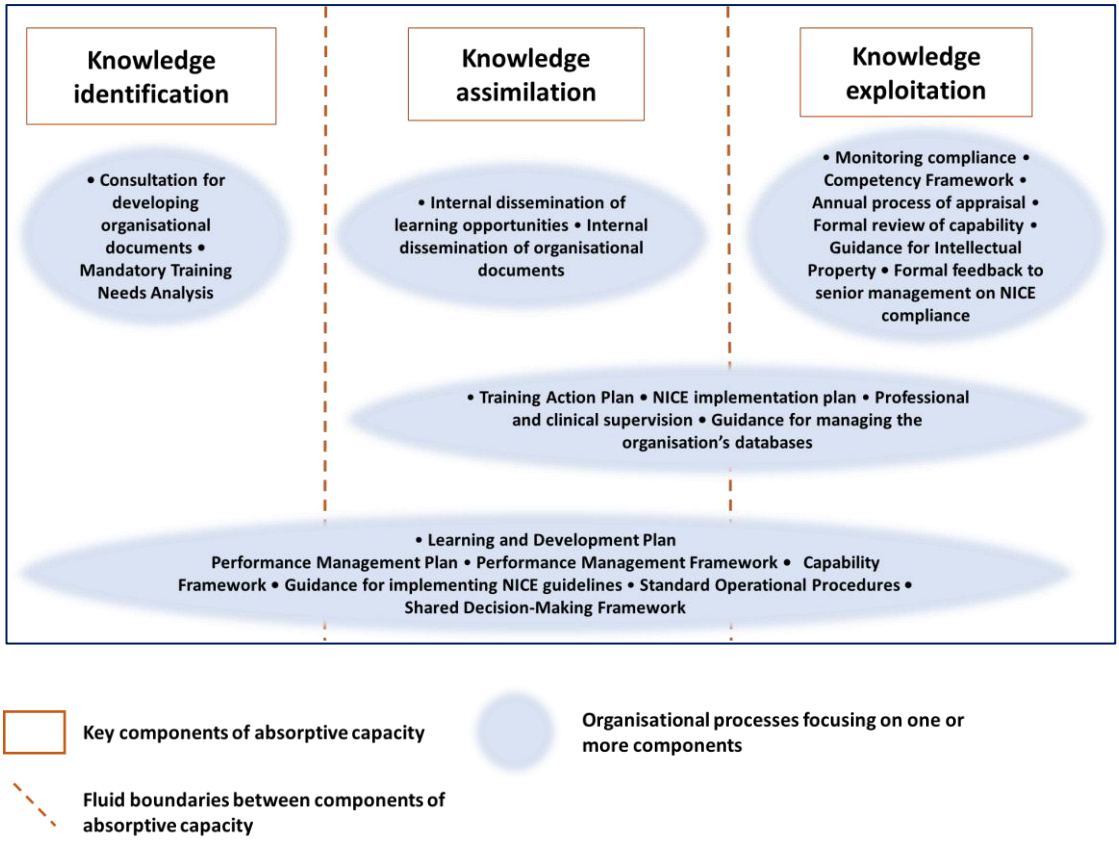



Diagram 5.5: Organisational processes identified in document analysis in relation to the key components of absorptive capacity, i.e. identification, assimilation and exploitation of new knowledge.

### 5.4.2 The role of mandatory knowledge

Staff members explained that knowledge flowing into the CAMHS department appears to exceed the capacity of the staff members to respond to it. Due to the large amount of knowledge which staff members come across, it becomes challenging to absorb all knowledge that can be useful to the CAMHS department. As an outcome, staff members are led to make choices as to which knowledge areas they will prioritise. One of the study participants argued that:

> *The emails that we get on a daily basis, we can't keep up with and they don't get looked at* (CAMHS Psychologist).

Staff members explained that their choices about which knowledge should be embedded in practice are highly influenced by the mandatory character of the different areas of knowledge. New knowledge that has a mandatory character would possibly become a priority in being assimilated and used in practice. As shown in Chapter 4, knowledge that comes from external bodies, such as the Department of Health, the National Institute Centre for Excellence (NICE) or the Care Quality Commission, and aims to regulate service delivery and/or organisational processes is expected to be prioritised by staff members. A CAMHS Senior Manager and a CAMHS Manager agreed that knowledge related to regulation becomes a priority in being implemented:

> *I think, probably, the priority that I would give would be anything that comes from the government, Department of Health, any of the NICE guidance stuff, because those are generally must-dos, so we need to be fully briefed on those* (CAMHS Senior Manager).

> *So, I suppose, there's so much information that we're obliged to use, we focus on what we have to use first, and there's a lot of it. So, that [information that we are obliged to use] I would expect to flow down through the organisation and into the directorates, and then from the directorates down into a team level* (CAMHS Manager (1)).

As a result, the mandatory character of new knowledge appears to become a criterion for staff members that drives which parts of new knowledge will be a priority in being implemented, while other knowledge areas may become secondary or optional. Staff members explained that prioritisation of mandatory knowledge could even switch their effort away from the implementation of knowledge that is

considered to have a direct impact on children and young people's services, such as knowledge about local service provision, reports of patients data or effective interventions.

> *[…] balancing of where we're at now with the NICE guidelines and CQC inspectorate feedback, balancing that off with what a really good children and young people's mental health service would actually look like in the future* (CAMHS Manager (3)).

Staff members also come across dilemmas concerning the ways mandatory knowledge can be used in practice. The CAMHS department's flexibility in implementing new knowledge can be affected by the regulatory relationship between the organisation that acts as a source of knowledge and the case study organisation. For instance, a policy or a research paper appears to have higher flexibility over the ways it is implemented than a new guideline. One of the CAMHS Senior Clinical Managers gave an example in this regard:

> *I think it's more helpful to be more flexible, but it's difficult when the people telling you don't see it as flexible, but see it as rigid. […] My view would be that we had the same piece of information, which is the change in the code of practice, but interpreted it differently. […] So the same external piece of information, interpreted differently by people who were coming in as – I suppose – experts in inspection but not experts, necessarily, in delivering the service. Us trying to think, "Well how does your interpretation affect what we do with the patient?" […] That's the guidance, but when you start looking into what that means in practice it starts to become quite difficult to implement* (CAMHS Senior Clinical Manager (1)).

> *How we then translate that [policy documents such as Future in Mind] into the work that we do is the bit that, as practitioners, we have to do* (CAMHS Senior Clinical Manager (2)).

Overall, staff members argued that the mandatory character of new external knowledge is as a key factor that drives the prioritisation and utilisation of new valuable knowledge. Mandatory knowledge is prioritised because it is sourced by certain public bodies that appear to have a dependency relationship with the case study organisation. Such knowledge may also allow limited flexibility for staff members to implement it, restraining its use in ways that can benefit service users. Subsequently, knowledge that is being prioritised is not always defined by the

CAMHS department, but can be directed by organisations with which the other organisations have a dependency relationship. This can also lead staff members to neglect new valuable knowledge which could also be useful for the CAMHS department in terms of service provision.

### 5.4.3 The influence of workload

Chapter 2 demonstrated that CAMHS face major barriers in meeting the needs of local populations, primarily due to low capacity and service fragmentation (Care Quality Commission, 2018; Hagell et al., 2017). Staff members explained that they often face increased workload, which affects the ways they identify, assimilate and use new knowledge. The main causes of increased workload are staff shortage, the boundaries among local services, existing waiting lists, the balance between clinical and managerial work, and the lack of funding. Specifically, staff members argued that spending time in identifying external valuable knowledge can often be restrained, as it is expected to be balanced with routine work, which is being demanded increasingly frequently. As a result, staff members appeared to spend most of their time delivering clinical practice and responding to mandatory forms of knowledge, which leaves little time to spend on seeking new valuable knowledge.

> *What I've found is that the biggest difficulty I will find is the time. So, in this job so far, I've realised that you just work all the time to stand still* (CAMHS Manager (3)).

Workload seemed to equally affect the dissemination of valuable knowledge among colleagues, having a negative impact on its assimilation. Staff members explained that they do not have sufficient time to spend on processing and discussing new knowledge that could be potentially useful for services.

> *[…] that sharing knowledge is something that, in the pressures of ordinary work, tends to be seen as very low on the hierarchy of needs* (CAMHS Consultant (1)).

Limited time due to workload was also identified as a factor that influences staff members' ability to exploit new knowledge. Knowledge that has been assimilated is not always being implemented due to lack of sufficient time. For example, the use of new knowledge with regard to the incorporation of the THRIVE Framework or evidence-based research in practice may be neglected due to daily work responsibilities.

> *But actually, on a day-to-day basis, we're trying to survive. Obviously, we try to emulate, where we can, all of that research-based evidence about what the provision should be. But it's very difficult to do* (CAMHS Manager (2)).

Staff members explained that significantly increased work is attributed to a combination of factors which have a negative impact on the workload which staff members confront. The most prevalent factors appeared to be the staff shortage within the CAMHS department, the lack of clarification of service boundaries between the CAMHS department and other providers of mental health support locally, long waiting lists, the limited balance between clinical and managerial work and the scarcity of funding that supports the services. All elements that contribute to creating increased workload are interlinked and affect each other, leaving staff members under significant work pressure and, hence, with limited time to invest in identifying, assimilating and applying new useful knowledge.

> *At the moment we're rushed off our feet. The waiting lists are huge. We're trying to do the best we can. Unless we're given more time, which can only be provided by more money and more clinical staff… I mean, there's always going to be a demand on our service but if we felt there was enough resources there, then perhaps we would be able to have the time to do that* (CAMHS Psychologist).

a) Staff shortage

Staffing deficiency leads staff members to struggle with existing service demand. Most study participants argued that decreased recruitment of new employees leads them to dedicate most of their working time to routine work and the increased need for service provision, leaving little or no time to invest in new knowledge.

> *So, a big issue around recruitment, so we've always got recruitment issues, so it's a matter of we've got much more demand than we have staff to be able to cope with the demand at the moment* (CAMHS Manager (3)).

Although poor recruitment is a significant organisational challenge faced by the whole organisation, the increased local need to respond to children and young people's mental health problems further augments the need for new staff specifically supporting CAMHS. For example, the need for crisis support for young people has been at its highest in recent years, increasing pressure to recruit new staff to support this patient group:

*The prevalence of crisis is so severe that results in hospitals attendance and admission have shifted massively in the last 15 years. So there is a kind of catch up with the shifting demand. There is also a workforce component, because crisis services for young people haven't traditionally been commissioned in the way they have for adults. It is a workforce to therefore create and generate* (Member of the Senior Management (1) – Case study organisation).

b) Clarification of service boundaries

Services provision by the CAMHS department and, thus, workload, is also affected by the lack of clear organisational boundaries existing between the CAMHS department and other local service providers. Study participants from the CAMHS department explained that there is limited understanding of the mental health conditions that each organisation can support, as well as the levels of conditions that can be addressed by the CAMHS department and by other organisations that provide early intervention help. As an outcome, unclear service boundaries can increase the service demand at CAMHS and lead to workload which staff members are unable to meet.

*I think it is trickier when you get up to the Getting More Help – Risk Help, coz it becomes more specialist and other professionals feel that we just need to leave CAMHS to do it because it is so complicated and that could be quite right. Professionals here, for example psychiatrists, they are specifically trained for mental health, so why a school would feel like, you know, they have a lot to offer, they feel fall out of their depth* (CAMHS Team Leader).

c) Waiting lists

Long waiting lists create and put pressure on staff members on a daily basis. Staff members unanimously agreed that local mental health services for children and young people are struggling to meet existing demand, including the CAMHS department and other local service providers. Increased waiting times are interdependent with the lack of staff and the unclear boundaries among local services discussed above. As a result, long waiting lists put the CAMHS department under stress to meet the needs of the local young population.

*I think when workload is high and waiting times are higher than what we would like them to be, staff and services do come under pressure and that*

*can make people entrench back to "we just need to do this" that bit and not see the whole picture* (Member of the Senior Management (1) – Case study organisation).

d) Clinical and managerial work

In addition to staff shortage, service boundaries and waiting lists, study participants explained that management responsibilities can also become a boundary to the time they are able to spend exploring and absorbing new knowledge. The majority of study participants were involved in both clinical and managerial work and they often referred to the lack of balance between the two aspects of their work. Demand on service provision constantly decreases the amount of time they can spend out of clinical practice. As an outcome, increased commitment to management activities can become an additional barrier to exploring the potential of new useful knowledge.

*But the problem is always the demands between frontline clinical work where you have to see children […] and also do other activities like reading various reports, be they audit reports, research reports, management reports, there's always a big, big big conflict with time management between the two* (CAMHS Senior Clinician).

*So, I worry that clinicians, particularly, are having to spend too much time doing that, rather than delivering clinical care, and I'm not sure we've got the balance of that right. Yes, I think those are the things that leap to my mind* (CAMHS Senior Clinical Manager (2)).

e) Funding

Insufficient funding has a negative impact on recruitment, waiting lists, work balance and, consequently, the workload to which staff members are expected to respond. Study participants explained that financial deficiency which brings services under pressure is not only an outcome of recent funding cuts, but also an outcome of prolonged funding reductions in the healthcare system. As a result, consequent funding reductions have led to increasing pressure on service provision today.

*Every year, we're asked to make cost improvement savings. At the same time as being told that our funding is increasing, we have to make savings, which is difficult to understand* (CAMHS Manager (1)).

Additionally, limited resources can lead to investing in services that focus only on some parts of the healthcare system and not supporting the system as a whole, such as allocating more money to specialised services instead of early intervention services. Additionally, low funding can increase pressure to discharge young people faster in an attempt to meet the needs of a larger number of young people.

> *I think one of the main challenges is, in terms of children's mental health, there is a very severe shortage of money to do something proportionate to the need. This biases intervention towards the more severe. It also prioritises intervention over prevention by the very nature of the fact that prevention is more expensive, notwithstanding that it is being sold cheaper* (Member of Senior Management (2) – Case study organisation).

> *Sometimes there are pressures on the service to see more people. The needs of the clients may indicate that they need more clinic time, but the service is wanting to push them through* (CAMHS Psychologist).

Additionally, study participants also argued that, despite the struggle of the case study organisation to meet local needs, senior management may still commit its funders to deliver services that require more capacity than is available, responding to pressure from funding bodies or politicians. As an outcome, lack of capacity and unrealistic commitment lead to an increase in unmet services demand at a local level.

> *An unwillingness on the part of the Trust to sort of, if you like, exploit the limits of its capacity, and then put that to the politicians. […] I think there's sort of, there's an organisational temptation to sort of […] Say that we can do more rather than say this is what we absolutely can do* (CAMHS Consultant (1)).

Overall, increased workload was identified as a key factor having a negative impact on the time staff members can invest in exploiting new knowledge. The factors discussed above can confine the learning ability of the CAMHS department and particularly limit its ability to identify knowledge that is beneficial to its own organisation aims. The next section looks into the effect of gatekeepers on the absorptive capacity of the CAMHS department.

### 5.4.4. The role of gatekeepers

Study participants explained that several staff members act as gatekeepers or boundary-spanners, because their job responsibilities entail duties that focus on recognising and sharing new valuable knowledge within the CAMHS department. Gatekeepers focus more on acting as a link with the external environment for importing new knowledge and disseminating it within an organisation. Boundary-spanners focus primarily on facilitating the mobilisation and sharing of knowledge within an organisation (Jones, 2006; Huang et al., 2018). Data analysis showed that gatekeepers and boundary-spanners can be involved in mobilising operational, clinical or research knowledge. In particular, staff members of the CAMHS department clarified that gatekeepers act as liaisons with external sources and facilitate the identification of knowledge that is valuable for the CAMHS department. Due to their responsibilities in identifying new knowledge, gatekeepers can often be seen as representatives of the case study organisation.

> *We have someone who works in the trust who is responsible for all the NICE guidance in terms of making sure that we know – the organisation knows – what our NICE guidance is. [The staff member] will have emailed that to me. I will look at it and see where there are ones that are relevant for children and young people* (CAMHS Senior Manager).

> *It's our managers and managers [of the local public children's services] that have to come together to look at how that works and how that makes that work, which is a really important thing to do* (CAMHS Senior Manager).

Gatekeepers who import new valuable knowledge often hold managerial positions and share information in a top-down manner. Frontline staff members, such as trainees, whose role entails identifying new knowledge related to clinical practice, can also operate as gatekeepers. However, study participants reported that new knowledge introduced by frontline workers is usually assimilated mainly at a local level, without always moving towards more senior levels of management.

> *[Trainees] will bring that information to supervision and I'll take that from them: especially the trainees who are learning at the moment and in some ways get taught new things all the time and are more up-to-date because they have more time* (CAMHS Psychologist).

An example of staff members who act as gatekeepers and facilitate the mobilisation of knowledge between the external environment and the CAMHS department was the position of Children's Wellbeing Practitioner (CWP). The responsibilities of CWPs include liaising with schools and providing interventions for mild and moderate mental health support, while contributing to sharing knowledge about the needs of the local population among partner organisations. Their role also includes signposting, i.e. making suggestions as to where and how children and young people can receive help (within CAMHS or other local service providers).

Study participants explained that CWPs were jointly developed by the CAMHS department and local NHS children's community services. As an outcome, CWPs are aware of both organisations' regulations and their work entails activities that aim to meet both organisations' objectives. Study participants explained that support from both partner organisations appeared to enhance the CWPs' ability to develop a perspective in their work that merges both organisations' aims, i.e. those of physical and mental health for children and young people. Yet, study participants said that the involvement of CWPs in two different NHS organisations may also encounter obstacles due to different organisational structures, such as diverse IT systems, mandatory training or information governance.

> *We are going to use those posts [children's wellbeing practitioners] to work more closely with the [local public children's organisation] emotional health and wellbeing team and that is great […] also it is a way we can work together with the [local public children's organisation] and try to integrate a bit more so that we use research more efficiently so that the kids don't get bounced between organisations* (CAMHS Consultant (3)).

> *At the moment we are not fully functioning in terms of taking on caseload and things in this new collaborative amalgamated service because of the funding that we have got, things like IT issues* (CAMHS Team Leader).

Analysis of internal policies also contributed to understanding the role of individuals in absorptive capacity. One of the new categories focused on the role of boundary-spanners. Findings illustrated that certain staff members can have responsibilities for ensuring that new knowledge is disseminated and exploited within the case study organisation. In particular, certain groups, such as managers and/or supervisors, act as boundary-spanners for disseminating new knowledge and ensuring that policies are implemented within the organisation. Figure 5.5 shows a

few examples of staff members who can act as boundary-spanners. For example, Line Managers are expected to create and maintain a culture that encourages staff members to engage in activities recommended by the Learning & Development Team. Line Managers also have a key role dissemination knowledge about the potential of Intellectual Property (IP) within the organisation. The role of boundary-spanners appeared to focus on ensuring that knowledge in relation to internal policies is assimilated and used in practice, and to report the implementation progress to senior levels of management. For instance, managers are responsible for monitoring the proper implementation of information governance or for supervision of employees. This category is represented together with the "gatekeepers" theme in Diagram 5.6, as the two groups appear to be overlapping.

| **New category: Individuals as boundary-spanners** | | | | | |
|---|---|---|---|---|---|
| Line Managers are expected to promote the value of Learning and Development towards developing evidence based practice and reaching national, local and departmental goals | Research and Development (R&D) Manager is expected to coordinate and review the development and exploitation of innovation with the Trust | Team/Service Managers and Line Managers should ensure that all new staff received Health and Safety training, information and supervision as part of their induction | Line Managers are expected to create and maintain an environment that knowledge sharing is enabled | Union Representatives aim to engage with staff members, offer information, advice and guidance | Managers are responsible to ensure that knowledge about Intellectual Properly is embodied in local processes |

Figure 5.5: Analysis extract from the new category "Individuals as boundary-spanners and controllers" in document analysis

Overall, staff members who act as gatekeepers and boundary-spanners can have a key role in the interface between the CAMHS department and the external environment, as well as in the internal dissemination of new knowledge. Their contribution influences the identification of new valuable knowledge which can be used to re-configure services and improve care quality.

### 5.4.5. Individuals' absorptive capacity

Literature has shown that individual absorptive capacity forms part of the organisational-level absorptive capacity (Cohen and Levinthal, 1990). Staff members talked about the responsiveness of individuals to new knowledge and argued that there is an association between individuals' learning skills and the improvement of service provision. Specifically, study participants explained that the identification, assimilation and use of new knowledge may be also disrupted by

individuals' responsiveness to new knowledge. Data showed that staff members could also display a degree of rigidness in several cases in incorporating new knowledge within the CAMHS department.

For example, internal patients' data reports produced by the case study organisation are generated with the aim of being used by staff members as part of their daily work. Data showed that accessing and processing internal data reports could be considered by staff members to be an optional task rather than an integral part of staff members' jobs. A Manager explained that the idea of using data reports is still to be embedded on staff members' work routine:

> *The idea being that if [staff members] need something, it's there, they can go and get it. […] it's not [the Information and Performance department's] data, it's [the staff members'] data and therefore they're responsible for it and if they need it, it's there […] not all departments do that. […] We're getting there and the data that my department uses is used a lot more than it ever has been, but it's just seen as a nice-to-have at the minute rather than core business* (Manager at the Information and Performance department – Case study organisation).

Study participants argued that staff members could display a degree of rigidness in introducing and incorporating changes within the CAMHS department, indicating a limited ability of staff members to learn. Resistance towards introducing changes seemed that it could be part of staff members' work attitude, either because they think that implementing new knowledge is not part of their existing work or because they think that the system around them is inflexible to organisational change.

> *I just think that the culture of individuals who have been around for a long time, I think it takes time to learn a new model and understand what it means* (CAMHS Team Leader).

> *I think the second challenge though is around shifting attitude and mind-set, which is about some individuals rather than in services in total that actually we can have a safe plural model of provision that includes third sector […] it is the harder thing!* (Member of the Senior Management (1) – Case study organisation).

As demonstrated in Section 5.4.4, gatekeepers' role can contribute to addressing this rigidness and create connections between new knowledge from the external

environment and existing knowledge of the CAMHS department. Nonetheless, study participants underscored that gatekeepers who create liaisons with new knowledge are often individual cases – something that is interpreted as being inadequate for developing sustainable relationships, if more staff members do not engage in learning. Certain study participants argued that single cases of effective connectivity with other organisations might put collaborations at risk when individual gatekeepers leave their post.

> *If we are reliant on individual people then we are not a resilient system. If we are reliant on one or two people as the key and critical people who can make things work and without them it doesn't work and we face barriers, then we are actually not operating, because it should be at every level and lot of people* (Member of the Senior Management (1) – Case study organisation).

Several study participants recognised that effective learning is dependent on enhancing the ability of all staff members to learn and critically evaluate new knowledge, rather than counting on a small number of individuals who act as gatekeepers. This could also improve the rigidness which some staff members demonstrate towards searching for importing and exploiting new knowledge. Advancing individuals' learning skills was identified as a factor that could improving the department's service provision.

> *The more people interrogate the information, the more likely they are to cleanse it of inaccuracies, because they'll say, "Hang on, that doesn't look right to me". And then they enquire or somebody says, "Yes, that bit of the dataset doesn't look so good". So that's really helpful. It's a self-improving process in terms of data quality. And it encourages mental flexibility* (Member of Senior Management (2) – Case study organisation).

Overall, individuals' absorptive capacity appeared to influence the department's absorptive capacity due to rigidness which it might demonstrate towards organisational change that can happen through the adoption of new knowledge. Educating staff members on critically evaluating new knowledge could improve the department's absorptive capacity.

Diagram 5.6 brings together the themes and sub-themes presented in Diagram 5.1, Diagram 5.2, Diagram 5.3 and Diagram 5.4, with the aim of demonstrating the components of the absorptive capacity of the CAMHS department. The map combines the themes that were generated from interviews' analysis, as well as the

categories developed in document analysis. The grey arrows show that sub-themes determining each of the themes and all themes together influence the absorptive capacity of the CAMHS department.

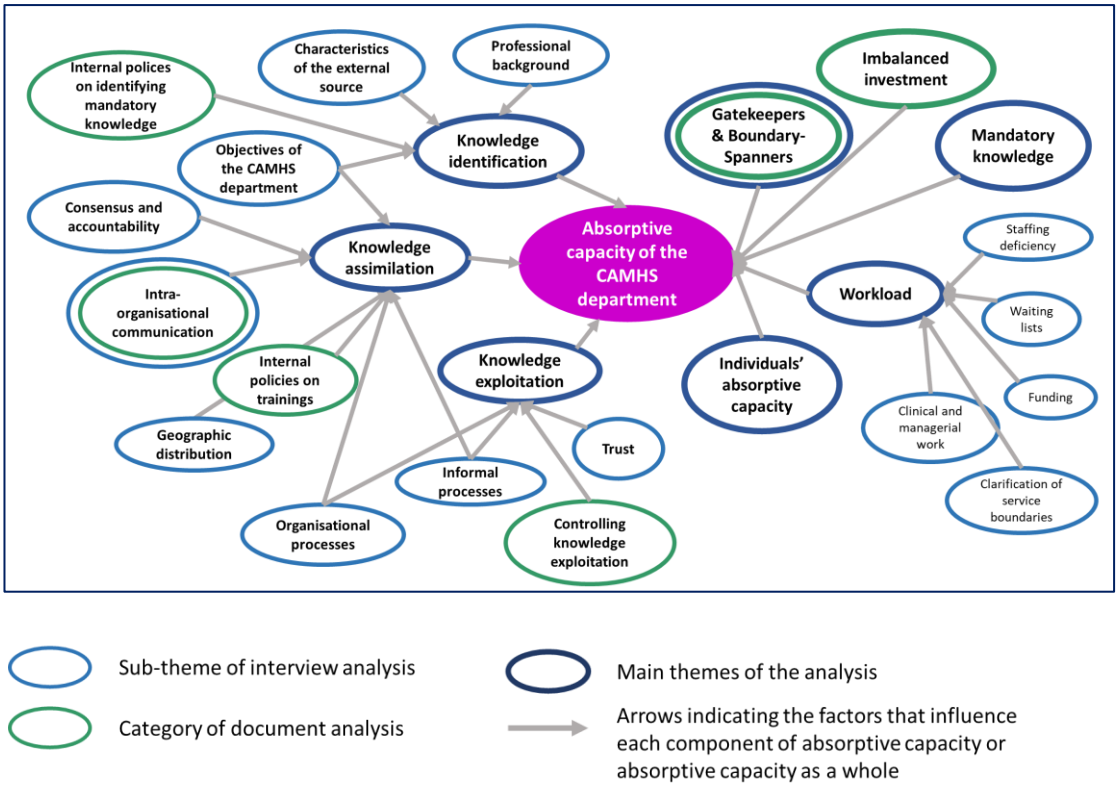



Diagram 5.6: Thematic map of the absorptive capacity of the CAMHS department

### *5.5. Summary*

Findings from interview and document analysis contributed to identifying factors that influence the absorptive capacity of the CAMHS department – either each component separately or its absorptive capacity as a whole. With regard to the component of knowledge identification, findings showed that the definition of valuable knowledge is not only indicated by the main goals of the case study organisation, but is also constructed by the individuals. Staff members' prior knowledge, and specifically knowledge related to professional expertise, has a significantly influences the value which staff members attiribute to new knowledge. Knowledge sourced by public organisations is also perceived as valuable to be imported within the CAMHS department. Processes that facilitate knowledge assimilation operate as a medium which staff members use to reach a consensus on the implementation of new knowledge and meet the objectives of the CAMHS department. Yet, staff members explained that several factors restrain the

dissemination of knowledge within the department and the organisation, such as incompatible IT systems or limited sharing of useful knowledge from senior management. Processes similar to those which facilitate knowledge assimilation are also adopted by staff members to monitor the progress of implementing new knowledge, thus demonstrating a relationship between the components of knowledge assimilation and exploitation. Considering the large amount of knowledge, implementation is also dependent on trust towards staff members and their professional commitment to improving services for children and young people.

Findings also highlighted factors that influence the total process of absorptive capacity. The findings highlighted the influence of mandatory knowledge on the knowledge which staff members prioritise in practice. The case study organisation appeared to have dependency relationships with public national organisations (NHS England, CQC, NICE). Knowledge that is disseminated by those organisations is often prioritised, while other knowledge areas, such as internal data or knowledge from research, can become secondary priorities. In addition to the mandatory character of new knowledge, analysis of internal policies demonstrated an imbalanced investment in the main components of absorptive capacity, where limited evidence was identified in relation to organisational processes that enable knowledge identification. Moreover, the department's absorptive capacity is also strongly influenced by the workload to which staff members are required to respond on a daily level. Staff shortage, long waiting lists, limited financial resources, unclear organisational boundaries with the external environment and additional managerial work appeared to create increasing workload, which further constrains staff members' flexibility in searching for, sharing and exploiting new useful knowledge.

Study participants underlined the effect of individuals on the department's absorptive capacity. Individuals who facilitate the transfer of knowledge from the external environment within the organisation (gatekeepers), as well as across the organisation's units (boundary-spanners) can have a positive impact on the department's absorptive capacity. Although gatekeepers appeared to facilitate absorptive capacity, staff members argued that the incorporation of new knowledge into practice is also dependent on each individual's learning skills. The rigidness which staff members can show towards new knowledge and their limited understanding of the benefits of diverse knowledge areas (e.g. data reports) could have a restraining impact on organisational-level absorptive capacity. Therefore, individuals' low learning ability can be a negative factor for organisational-level absorptive capacity.

## Chapter 6: Discussion

Existing studies have shown that absorptive capacity can be a useful approach for exploring ways of improving the performance of public healthcare organisations and, eventually, service provision; however, more research is required to unveil the potential of absorptive capacity for healthcare organisations (Harvey et al., 2010b; Croft and Currie, 2016). To contribute to addressing this research gap, the thesis examined the absorptive capacity of the Child and Adolescent Mental Health Services (CAMHS) department of a public mental health organisation. The main aim of the study was to collect evidence about the organisational processes of the CAMHS department of the case study organisation and the factors that strengthen or hinder the department's ability to recognise, assimilate and use new knowledge. The role of the inter-organisational environment was also studied to explore its potential influence on the absorptive capacity of the CAMHS department. Study participants' views and findings from document analysis have been analysed and brought together to explain the CAMHS department's absorptive capacity.

In this chapter, analysis of findings are discussed in relation to existing literature with the aim of demonstrating the contribution which absorptive capacity theory can make to improve the learning abilities of CAMHS. Aspects of the organisational context outlined in Chapter 2 are also included in the discussion, aiming to understand the effect of healthcare policies and the NHS structure on the absorptive capacity of CAMHS. The discussion is organised into three main sections: the first section discusses findings that were relevant to both research questions (i.e. the absorptive capacity of the CAMHS department and the role of the inter-organisational environment), while the following two sections focus on findings that contribute to answering the first and the second research questions respectively.

### *6.1 Factors influencing the absorptive capacity of CAMHS*

#### 6.1.1 The influential role of mandatory knowledge

Absorptive capacity theory illustrates that relationships between an organisation and external knowledge sources can influence the learning outcomes of the former, either in dyadic relationships or within networks (Lane et al., 1998; Apriliyanti and Alon, 2017; Omidvar et al., 2017). Reviewing the inter-organisational environment in Chapter 2 demonstrated that CAMHS are influenced by national and local policies that direct the development of mental health services provided to children and young people. Data findings of the present study showed that there is a dependency

relationship between the CAMHS department (as part of a larger mental health organisation) and several national and local organisations which influences the former's absorptive capacity. As shown in the map presented in Chapter 4 (p.96), certain external sources of knowledge were prioritised. Those were identified primarily at a macro-national level, such as NHS England, the National Institute Centre for Excellence (NICE) or the Care Quality Commission (CQC) and at a macro-local level, primarily by the Local Clinical Commissioning Group (CCG), creating a group of knowledge areas with mandatory character. Several knowledge areas might address the whole organisation (CCG contractual agreement), while others might be CAMHS-specific (e.g. NICE guidelines for CAMHS). Although mandatory knowledge can be valuable for service quality and effectiveness, its prioritisation can influence the effort and time which staff members allocate to knowledge that is not mandatory, yet beneficial to local services for children and young people. Examples of non-mandatory knowledge are identified at the macro-national, macro-local and meso levels, such as research evidence, knowledge from local service providers or patients' data reports. Similar findings were highlighted in a recent study on absorptive capacity in public healthcare, showing that the influence of mandatory knowledge is also evident in other healthcare settings (e.g. Clinical Commissioning Groups) (Croft and Currie, 2016). Capacity is often dedicated to responding to policy implementation, which limited the CCGs' ability to search for new knowledge (Croft and Currie, 2016). Outcomes of the present study showed that dependency relationships with the aforementioned public organisations is connected with the prioritisation of new knowledge in the CAMHS department.

The influential role of mandatory knowledge was also identified in the internal policies of the case study organisation. Analysing organisational documents was an opportunity to explore the organisation's investment in the components of absorptive capacity. Study outcomes showed that internal policies associated with knowledge identification appeared to focus primarily on mandatory knowledge, such as NICE guidance or professional s' clinical requirements. As explained on p.10, cultivating an organisation's ability to recognise the usefulness of external knowledge is a critical ability of an organisation's absorptive capacity (Caloghirou et al., 2004; Todorova and Durisin, 2007). Yet, limited evidence was found about organisational processes that facilitate the identification of new knowledge and encourage the search for diverse knowledge sources that could improve service provision. Internal policies also emphasised the need for training related to mandatory knowledge areas. Although training was identified as a coordination capability by Van den

Bosch and colleagues (1999) which can facilitate knowledge assimilation, internal policies focused primarily on training related to mandatory knowledge. Finally, organisational processes in relation to knowledge exploitation focused often on controlling the implementation of mandatory knowledge, aiming to ensure that mandatory knowledge areas are used in practice. As a result, internal organisational policies associated with absorptive capacity tend to address mandatory knowledge areas, rather than cultivating the overall department's ability to respond to new and diverse knowledge.

These findings indicate the impact of the NHS structure on the organisational learning abilities of CAMHS. Although the 2012 reforms aimed to enhance de-centralisation in healthcare and strengthen local decision-making, scholars have argued that dependency from central management remains present (Black and Mays, 2016; Checkland et al., 2018). Research has also shown that healthcare organisations are influenced by policies and governmental requirements as to the ways they can optimise performance or spending priorities (Rashman et al., 2009). In this study, the limited autonomy mental health Trusts have from local CCGs and national organisations is reflected on the influence this relationship can have on the absorptive capacity of the CAMHS department. Such dependency relationships, however, come in contrast with the objectives of most recent healthcare national policies focusing on exploiting new knowledge from the local external environment (NHS England, 2014; National Health Service, 2019). Findings about the influence of mandatory knowledge also contribute to understanding the effect of regulators on an organisation's absorptive capacity – an area that remains under-researched in the absorptive capacity field (Lane et al., 2006).

#### 6.1.2. Information governance and data management systems

Recent studies on absorptive capacity indicated that the boundaries of public healthcare organisations with the external environment can be more flexible due to the low-intensity competition, as well as the mobility of staff members, e.g. an individual working at a healthcare organisation and a university (Easterby-Smith et al., 2008b). As explained on p.24, public sector literature showed that public organisations have gradually grown a knowledge sharing culture – a characteristic that has also been embraced by the latest healthcare policies (Kothari et al., 2011; Yang and Maxwell, 2011; National Health Service, 2019). However, the findings of this study showed that boundaries between the case study organisation and the local external environment actually restrained the identification of new knowledge by

the CAMHS department. Several boundaries have been identified, which are discussed throughout this chapter. This section focuses specifically on the impact of incompatibility of different data management systems within the case study organisation and among local organisations and the information governance regulations among local organisations.

An organisation's IT capabilities, such as data management systems, can enable the assimilation of new valuable knowledge and its incorporation into practice (Van Den Bosch et a., 1999). Yet, findings showed that the combination and utilisation of useful service data within the CAMHS department could be jeopardised by the incompatibility of data management systems used within the case study organisation. This can have a negative impact on generating knowledge tailored to the needs of the CAMHS department. For example, incompatibility of the IT systems used within the case study organisation restrains the collation of information for developing patients' treatment plans or for generating reports that can answer questions about the provided services, such as the number of users referred by schools. Literature on absorptive capacity has highlighted the positive impact of using outcomes of IT systems on private organisations' performance (for examples see Roberts et al., 2012; Liu et al., 2013; Iyengar et al., 2015; Wang and Byrd, 2017). In the case of the CAMHS department, improving the compatibility of IT systems used within the case study organisation was identified as a key factor for utilising service data in routine practice. Addressing the boundary of IT systems' incompatibility could enhance the department's absorptive capacity, because it would make it possible to generate new knowledge that is suitable for the service needs of the department and can be directly used by staff members.

Additionally, organisational boundaries appeared to limit the linkage between data management systems of different organisations that provide services to young users. The findings of the study showed that staff members often struggle to have a good overview of the services which young users have accessed, while children and young people are required to be assessed again if they are using the services of a new organisation. Non-connected data management systems did not only restrain the collation of individuals' information, but also the linkage of large datasets that can offer insight into the healthcare conditions of the local population. Existing literature has highlighted the importance of data systems interoperability for healthcare organisations, i.e. data systems' technical ability to meaningfully merge data that can enable the generation of useful information which is valuable for daily clinical work (for examples see Iroju et al., 2013; Dixon et al., 2014). The

significance of developing sustainable and efficient IT systems within the NHS has been gradually recognised and addressed by policy-makers (Price et al., 2019). Yet, lack of interoperability remains a significant barrier, because it prevents CAMHS from having a comprehensive understanding of the support provided to young users at a local level (Hagell et al., 2017; Children's Commissioner, 2018). Thus, enabling the linkage of data management systems of CAMHS and other local providers can increase the understanding CAMHS staff members have about local service provision. The concept of interoperability has been implemented in the emergency services to enable their responsiveness to emergency demand (fire and rescue, policy and NHS emergency services) (Wankhade and Patnaik, 2019). Interoperability did not only refer to the compatibility of IT systems, but also to joint training, sharing knowledge about organisations' management, and optimising resource utilisation among services (Wankhade and Patnaik, 2019). This approach could potentially offer new insights for CAMHS and assist on bridging data systems incompatibility, as well as additional gaps with local service providers, such as the use of different 'languages', the influence of professional groups or the lack of adequate financial resources.

Separate information governance regulations also appeared to be an organisational boundary, which restrains the identification of useful knowledge in the CAMHS department, as well as knowledge exchange among local organisations. Lack of joint information governance regulations appeared to restrain professionals to collaborate and develop treatment plans for individual service users, as well as organisations to share information that could assist the development of services which are most suitable for service users' needs. On top of existing regulations, new information governance regulations, such as the General Data Protection Regulation (GDPR), appeared to cause additional concern for staff members in terms of what information can be shared. Adjusting information governance regulations and technological boundaries can facilitate learning from the local external environment and increase the department's skills to predict and strategically address local population needs.

#### 6.1.3 The role of gatekeepers

Gatekeepers have been identified in literature as a key facilitator of an organisation's absorptive capacity, because they contribute to bridging the gap between new and existing knowledge (Cohen and Levinthal, 1990; Jones et al., 2006; Ter Wal et al., 2017). Within the CAMHS department, the contribution of

gatekeepers in introducing new useful knowledge was acknowledged. Nonetheless, their contribution was often monopolised by identifying gaps in mandatory knowledge areas. As a result, focusing their job in particular knowledge areas could inhibit their contribution to the department's absorptive capacity. Similarly, internal policies illustrated that the role of boundary-spanners was also associated with the assimilation and implementation of mandatory knowledge in practice. Additionally, knowledge from gatekeepers was mostly shared by senior management with the department, while knowledge from frontline workers remained local, rather than being spread to the rest of the department and towards senior management as lessons learned from practice, as shown on pp.163-164. This demonstrated a top-down hierarchy that could hinder the utilisation of knowledge coming from frontline workers who appeared to gain valuable knowledge sourced by service users or research. As an outcome, the contribution of gatekeepers on identifying and dissemination valuable external knowledge may also be at risk due to the top-down culture of the case study organisation.

Knowledge identified and shared within an organisation by the gatekeepers can benefit an organisation when it is actually utilised by the rest of the team members (Jones, 2006). As explained on p.14, gatekeepers' input can be mostly useful and contribute to the meaningful assimilation and exploitation of new knowledge only with the active involvement of other staff members (Cohen and Levinthal, 1990). Nonetheless, analysis illustrated that the rest of the staff members were not always strongly engaged in an interactive relationship with gatekeepers. Additionally, gatekeeping positions often appeared to be personalised and once the individual were replaced, relationships with the external environment would often need to be re-built. This finding was highlighted in Section 4.4 by staff members of local organisations who often invested resources to build relationships with CAMHS, yet they struggled to maintain them. Considering the resources are needed to rebuild communication pathways, local organisations appeared to limit their efforts to connect with the CAMHS department. Overall, examining the effect of gatekeepers on the absorptive capacity of the CAMHS department and the knowledge exchange within local organisations showed that gatekeepers are useful for identifying valuable knowledge and developing relationships, but their potential could be restricted when the position is personalised and by the limited involvement of the rest of the staff members within CAMHS.

### 6.1.4 The influence of public funding

As presented in Chapter 1, the degree to which an organisation invests in its absorptive capacity is influenced by the conditions of the external environment, such as market dynamics or competition (Zahra and George, 2002; Lane et al., 2006). Service evaluation reports presented in Chapter 2 assisted in describing the conditions that influence the current status of CAMHS. Experts argued that a central factor that has an impact on mental healthcare is the inadequate funding, especially in recent years when service demand has increased (British Medical Association, 2017). The insufficient funding allocated to mental healthcare has put the quality and effectiveness of mental health services for children and young people at risk (Children's Commissioner, 2018; Crenna-Jennings and Hutchinson, 2018). Although local CCGs aim to gradually increase the percentage of local funding allocated to CAMHS, services continue to receive the smallest share of funding allocation in comparison with adult and older people's mental healthcare (Frith, 2016, Naylor, 2016; Parkin, 2016). Findings of this study showed that inadequate funding from the CCG can influence the allocation of resources within the CAMHS department. Additionally, as shown in p.162, the need of the case study organisation to meet funders and politicians' expectations can also lead the case study organisation to commit to the maximum of its capacity, while in reality the department struggles to cover the total service demand at a local level. As explained earlier in this chapter, the establishment of the CCGs aimed to increase local autonomy and support the development of service systems that can meet local needs (Checkland, 2018). However, findings from the study indicated that inadequate funding and the dependency from the local CCG could influence the allocation of resources in the CAMHS department, allowing little flexibility to invest resources in organisational learning activities.

Study participants argued that insufficient funding has an impact also on the broader local environment. Evidence from this study showed that that insufficient public financing leads to imbalanced funding allocation between physical care or adult mental healthcare and children and young people's mental healthcare, resulting in the latter receiving the smallest share, which is inadequate to cover the actual needs of the local young population. As a consequence of the inadequate financial support in the local public sector, the third sector receives a growing number of referrals. Although third-sector organisations have been recognised as key providers of health and social care (Gilburt and Ewbank, 2019), findings showed that local organisations do not often receive public recognition and funding

equivalent to the increasing support they offer locally. As a result, the study showed that local organisations are often led to make careful choices as to the organisational activities that will be allocated funding. This effect could decrease the number of opportunities for the CAMHS department to learn from the local environment, as local organisations may limit their investment in developing collaborative relationships.

## *6.2 The absorptive capacity of the Child and Adolescent Mental Health Services (CAMHS)*

### 6.2.1 The ability of the CAMHS department to identify new knowledge

An organisation's absorptive capacity is influenced by the prior knowledge existing within the organisation as the latter drives the identification of new knowledge (Cohen and Levinthal, 1990; Matusik and Heeley, 2005). Based on definition suggested by Tsoukas and Vladimirou (2001) discussed in Chapter 1 (p.22), organisational knowledge can entail an organisation's goals, objectives or values that exist within an organisation, interwoven with knowledge which individuals have as part of their role within the organisation. The macro-national, macro-local, meso and micro levels of the knowledge map presented in p.96 indicated areas that form part of knowledge individuals use in their work. The knowledge existing within the CAMHS department appears to be composed of commonly accepted organisational practices (e.g. internal policies), common objectives (e.g. the notion of mandatory knowledge or the objectives of the CAMHS department), amalgamated with the knowledge which individuals have as part of their job (e.g. professional expertise or clinical duties). As a result, organisational knowledge appeared to be heterogeneous – a characteristic that can be attributed to the different knowledge capital which each individual has. Although section 6.1 highlighted the determining role of external organisations in driving the knowledge used in the CAMHS department, exploring individual's knowledge contributed to understand the influence staff members could have on the knowledge identified and utilised within the department.

Two key elements were identified as influential in driving the ability of individuals to identify new external knowledge. Firstly, knowledge that is associated with the professional background of individuals could affect the value ascribed to external knowledge and can lead to disagreement among staff members about what can be considered valuable knowledge. Although findings provided examples where different professionals collaborate, e.g. within multi-agency professional teams,

evidence showed that diverse professional backgrounds can lead to disagreement among individuals as to what knowledge is perceived as valuable. As shown on pp.134-136, clinicians consider knowledge related to quality treatment as valuable, whereas managers referred mostly to knowledge related to re-design of service pathways or cost efficiency. Thus, professional experience could function as a barrier to the CAMHS department's ability to identify and eventually use new and diverse knowledge areas, as diversity of new knowledge could lead to disagreement about what knowledge is most valuable to be incorporated into service provision. Similar to the findings of this study, Croft and Currie's study on the absorptive capacity of CCGs (2016) demonstrated that professional groups, particularly clinicians and managers, can limit organisations' ability to acquire new diverse knowledge, indicating that this factor is also present in other types of settings within the healthcare system. Although existing literature has pointed out that that professional groups can inhibit the dissemination of valuable knowledge (Ferlie et al., 2005; Currie and Suhomlinova, 2006), only a few studies have examined the effect of these groups on a public organisation's absorptive capacity (for examples see Easterby-Smith et al., 2008b; Croft and Currie, 2016).

A second element that appeared to influence the identification of new knowledge is the perception of staff members of the CAMHS department that knowledge sourced by public sector organisations is valuable. As shown on pp.136-137, knowledge originating from public organisations appeared to be recognised as valuable and prioritised for use in clinical practice in comparison with knowledge from non-public organisations, such as third-sector organisations. Such a perception could be a barrier for the ability of the CAMHS to benefit from new valuable knowledge, as it can limit the diversity of new knowledge areas (Cohen and Levinthal, 1990; Harvey et al., 2010b). Considering the latest policies strongly encourage the utilisation of knowledge from difference sources (e.g. academia, third sector or technological environment), a limited perception of sources' reliability could inhibit the diversity of knowledge which the department is expected to embed in practice (NHS England, 2015a; Wolpert et al., 2016; National Health Service, 2019).

Overall, the impact of individuals' professional background and the perception that public organisations are more reliable knowledge sources in comparison with other sources are two characteristics associated with staff members that appear to drive the identification of knowledge and limit the diversity of new knowledge. Although existing studies on absorptive capacity have highlighted the importance of individuals' effect on organisational absorptive capacity (for examples see Matusik

and Heeley, 2005; Martinkenaite and Breunig, 2016), the role of individuals is often seen as mostly driven by the organisation's strategy. The findings of this study showed that individuals' knowledge could have an influential role in determining the value of new knowledge and its prioritisation. Hence, aside from the department's objectives, the identification of new knowledge is also driven by the way staff members construct the notion of valuable knowledge. Individuals' absorptive capacity is further discussed in section 6.2.4.

### 6.2.2 The ability of the CAMHS department to assimilate new knowledge

Absorptive capacity is also dependent on processing and communicating the newly identified knowledge within the organisation (Cohen and Levinthal, 1990). Existing evidence suggests that staff members may utilise formal and informal pathways to facilitate knowledge assimilation (Martinkenaite and Breunig, 2016). Indeed, findings presented in Section 5.2.1 identified various internal processes that influence the assimilation of new knowledge within the CAMHS department, such as data management systems, supervision processes, departmental and cross-departmental meetings or training, as well as informal processes, such as casual discussions with colleagues, reflecting on the department's objectives, and emailing. Such processes appeared to enable social integration – an element which can facilitate the exchange of knowledge and, thus, assist with the assimilation of new knowledge (Zahra and George, 2002). Knowledge assimilation has been characterised as probably the most difficult component to conceptualise in public healthcare organisations, indicating that organisations may not pay the necessary attention to the internal processing of new knowledge (Harvey et al., 2010b). The current study highlighted several enabling and restraining factors that have an impact on the assimilation of new knowledge within the CAMHS department.

Two key factors appeared to enable the assimilation of new knowledge: the need of staff members to reaching a consensus on new knowledge that will be incorporated into practice and meeting the objectives of the CAMHS department. Specifically, the findings presented in Section 5.2.5 illustrated that meetings (departmental or interdepartmental) are utilised by staff members as a medium to enable reaching consensus among staff members on the future implementation of new knowledge in clinical practice. Existing literature in public organisations suggested that heterogeneous organisational knowledge can become an obstacle in knowledge sharing at a group level (Richards and Duxbury, 2014). Evidence from the present study showed that knowledge sharing within group meetings could enable reaching

an agreement on the implementation of new external knowledge and potentially bridge areas of disagreement among staff members. Additionally, meeting the objectives of the CAMHS department was also identified as a factor that facilitated the assimilation of new knowledge. Similar to findings regarding the component of knowledge identification, the objectives of the CAMHS department appeared to drive the priorities of staff members in assimilating new knowledge. The two enablers strengthen cross-functional interface and collaboration within the CAMHS department, as well as across departments and, thus, enhance the department's coordination capabilities. This is relevant to the department's absorptive capacity, because enhancing coordination capabilities can stimulate an organisation's ability to incorporate new knowledge into organisational practices (Van Den Bosch, 1999).

Research has shown that the organisational context can influence the transfer of knowledge among the organisation's units and influence its learning ability (Szulanski, 1996). Data analysis demonstrated that the internal dissemination of new valuable knowledge, which is key to knowledge assimilation, appeared to be restrained by three main barriers. Firstly, communicating new knowledge to all levels of the organisation is often mediated by the top-down hierarchy of the organisation. Internal knowledge dissemination appeared to be disrupted, either due to delayed sharing or due to selective sharing of new knowledge by senior management with the rest of the staff of the CAMHS department. As shown on p.145, selective knowledge transfer about re-design of services could inhibit staff members' understanding of the purposes of organisational chances. As a result, the disrupted top-down distribution of knowledge could limit staff members' comprehension of the purpose of new knowledge – also called "causal ambiguity" by Szulanski (1996) – and restrain the assimilation of new valuable knowledge.

Secondly, although training has been identified in absorptive capacity studies as a means which enables knowledge assimilation (Van den Bosch, 1999; Lewin et al., 2011), document analysis indicated a tendency within the case study organisation to invest mostly in training related to mandatory knowledge (Section 5.2.2). This finding demonstrates that training supports primarily the assimilation of mandatory knowledge, although limited evidence was identified about for non-mandatory knowledge areas. Thirdly, geographical distribution of the services provided by the CAMHS department appeared to be a limiting factor. Various locations present differences in provided services, thus increasing the difficulty of assimilating and, eventually, using the same knowledge. The communication links between the organisation's units are a key antecedent of absorptive capacity, as they influence

the dissemination of new knowledge among an organisation's units (Cohen and Levinthal, 1990). Hence, disrupted communication within the CAMHS department's units and between the department and senior management could limit the department's responsiveness to new knowledge.

### 6.2.3 The ability of the CAMHS department to exploit new valuable knowledge

The last main component of absorptive capacity concerns the use of knowledge in practice and the reconfiguration of existing processes with the aim of improving an organisation's outcomes (Cohen and Levinthal, 1990; Zahra and George, 2002). Knowledge exploitation within the CAMHS department was identified through organisational and informal processes, similar to those discussed in relation to knowledge assimilation. In particular, organisational and informal processes identified to enable knowledge exploitation were supervision processes (clinical and managerial), group meetings, internal planning or informal discussions among staff members. Thus, exploitation of new knowledge appeared to be facilitated by the formalisation and routinisation of intra-organisational processes, as suggested by existing literature (Jansen et al., 2005). In addition, study participants explained that they use organisational processes, such as group meetings or internal reports, to share and discuss new knowledge, as well as to ensure that new knowledge has been implemented. As shown on p.150, staff members will first discuss new knowledge, then review the implementation of the same knowledge at a different time point and discuss again knowledge that has not been implemented yet. This finding demonstrated that knowledge assimilation and exploitation are interrelated and staff members may use processes that enable the two components inter-changeably to facilitate assimilation and ensure the implementation of new knowledge over time. Findings from the present study indicated a longitudinal characteristic of absorptive capacity based on an iterative process between assimilation and exploitation that can gradually lead to the incorporation of new knowledge into service practice.

Despite the existence of organisational processes that enable knowledge utilisation, monitoring the progress of knowledge exploitation appeared to remain a challenge. The large volume of new knowledge that staff members encounter makes it impossible to fully monitor the implementation of new external knowledge that is valuable for the services provided by the CAMHS department. As explained on p.152, the factor of trust has a determinant role on knowledge exploitation. Findings

demonstrated that trust is based on an underlying agreement among staff members that the new knowledge upon which staff members have agreed will eventually be implemented in practice. The value of trust appeared to function as a socialisation capability that facilitates knowledge exploitation and moderates the need for developing control processes (Jansen et al., 2005). The role of trust has been researched in intra-organisational learning in public organisations, where evidence showed that it can facilitate the development of connections among individuals and stimulate knowledge sharing (for examples see Yang and Maxwell, 2011; Hsu and Chang, 2014). In absorptive capacity, the notion of trust has been primarily studied at an inter-organisational level (for examples see Hurmelinna-Laukkanen and Blomqvist, 2007; Pittz and Intindola, 2015), while a very limited numbers of studies have explored the role of trust at an intra-organisational level (Qureshi and Evans, 2013). The present study suggests that when trust forms part of the shared beliefs that exist within an organisation and is embraced by staff members, as in the case of the CAMHS department, it could enable the utilisation of new knowledge.

### 6.2.4 Factors that influence the absorptive capacity of the CAMHS department

Three main factors were identified that influence the absorptive capacity of the CAMHS department as a whole. Firstly, findings illustrated that there is an emphasis within the organisation the case study organisation to investing on organisational processes that enable the components of knowledge assimilation and exploitation, while less evidence was identified about processes that can facilitate the identification of new and diverse valuable knowledge. Secondly, increased workload prevents staff members from allocating adequate capacity to the identification, processing and use of new knowledge. Thirdly, low levels of individual's absorptive capacity also appeared to have a negative impact on absorptive capacity at an organisational level.

Specifically, data findings illustrated a tendency of the organisation to invest in developing organisational processes that concern the assimilation and exploitation of new knowledge, such as the implementation of frameworks or guidance, while less evidence was found about organisational processes that strengthen the organisation's ability to identify new useful knowledge. This element was identified in findings from the analysis of internal policies (Diagram 5.5. in p.155) as well as from evidence presented in Section 5.1, Section 5.2 and Section 5.3. Key works on absorptive capacity highlighted that an organisation should equally invest in the

components of absorptive capacity to benefit from external valuable knowledge. An organisation mostly investing in knowledge identification does not automatically have the ability to embed new knowledge in practice. Similarly, an organisation that has developed knowledge exploitation abilities does not necessarily have the ability to recognise new knowledge (Cohen and Levinthal, 1990; Zahra and George, 2006). As an outcome, imbalanced investment in the later stages of absorptive capacity of the CAMHS department could limit its ability to systematically evaluate the potential contribution which new external knowledge can make to service provision. The unilateral investment in the CAMHS department's absorptive capacity could be linked to the degree of autonomy the case study organisation has from other organisations (e.g. NHS England, CQC, CCG) as part of the NHS system presented in Section 6.1.1. The long-term relationships with NHS bodies, regulators and funders as part of the NHS system have potentially grown the reliance of the case study organisation on organisations that act as sources of mandatory knowledge. As an outcome, dependency relationships could have an impact on the flexibility of the CAMHS department to further grow its ability to critically evaluate and benefit from a wider spectrum of external knowledge.

Gaps in the capacity of local CAMHS appears to create increasing workload for staff members and often lead to early retirement (Children's Commissioner, 2018; House of Commons, 2019a). Data analysis showed that increasing workload becomes a significant barrier to the absorptive capacity of the CAMHS department. Five aspects were associated with increased workload: workforce shortage, unclear boundaries among services providers, long waiting lists, lack of balance between clinical and managerial work and limited financial resources. In addition to the role of financial deficiency (presented in Section 6.1.4) in leading to long waiting lists and low numbers of staffing, the department appeared to confront increasing workload due to unclear boundaries with other service providers as to which organisation can best address different levels of severity, as well as due to lack of balance between clinical and managerial work which staff members are expected to deliver. As a result, workload leads the department's capacity to be dedicated mostly to clinical practice and implementation of mandatory knowledge and restrains the allocation of sufficient capacity and resources to learning from non-mandatory knowledge areas. As an outcome, study findings showed sporadic responsiveness towards new knowledge areas and limited ability to recognise and exploit opportunities that could enable service improvement.

Individuals' absorptive capacity was also identified as a factor that influences organisational absorptive capacity. The improvement of service provision appeared to be also associated with individuals' ability to critically evaluate new knowledge, assimilate it and use it in practice. Yet, data findings illustrated that there could be a degree of resistance from staff members towards recognising, critically evaluating and incorporating new knowledge into their daily work. As shown on pp.166-167, low responsiveness of staff members was associated with their overall work mind-set. For example, when the implementation of new knowledge was optional, such as internal data reports, research outputs or knowledge from local service providers, it was not always seen as an integral part of staff members' job responsibilities. Non-mandatory knowledge may also be understood as relevant only to specific professional groups, rather than an organisational asset that could be used in practice. Thus, in cases where individuals' absorptive capacity appeared to be low, it could negatively impact on organisational absorptive capacity and service improvement. Staff members' recommendations for improving individuals' absorptive capacity were to invest in training for advancing individuals' learning skills.

The impact of individuals on absorptive capacity was also discussed in previous sections as having as influential role on what knowledge is defined as valuable (Section 6.2.1) and on liaising with gatekeepers for enabling the embedding of new knowledge in practice (Section 6.1.3). Although the importance of individuals' absorptive capacity is often recognised in literature, studies on absorptive capacity often focus on researching organisational-level characteristics and, as a result, less is known about the role of individuals' absorptive capacity (Lane et al., 2016; Yildiz et al., 2019). Findings from the study contributed to further understanding the impact of individuals' absorptive capacity – a research gap in absorptive capacity theory (Volberda et al., 2010; Martinkenaite and Breunig, 2016).

### *6.3 The role of the inter-organisational environment in shaping the absorptive capacity of the CAMHS department*

The aim of the second research question was to understand the effect of the inter-organisational environment on the CAMHS department's absorptive capacity. The "relative" nature of absorptive capacity indicates the influential role of the external environment in an organisation's absorptive capacity (Lane and Lubatkin, 1998, p.461). Findings presented in Section 4.2 showed that knowledge from the local environment was identified as valuable, because it is associated with the mental

health needs of the local population and it can contribute to improving service quality and efficiency of the CAMHS department. Yet, five main barriers of the local environment were identified that restrain learning from local knowledge sources: the lack of sustainable communication pathways with local organisations, the tendency of the case study organisation to work in an isolated manner from the rest of the local organisations, the heterogeneous character of the local environment, individuals' power interests and the competition created among local organisations due to the NHS internal market. The first two characteristics are internal to the CAMHS department, while the last two are characteristics of the local environment.

Firstly, inadequate investment in organisational processes that enable systematic and safe knowledge exchange between the CAMHS department and the local environment can become a key barrier for the department's ability to identify new valuable knowledge. At the macro-local level, third-sector organisations and social care services, followed by local NHS organisations and schools, were identified as service providers which have a degree of communication with the CAMHS department (Diagram 4.1). Communication would mostly focus on patients' needs, such as referrals, signposting, young patients using more than one services or information about available local services. Data analysis revealed that although such processes are important operations for facilitating access to service support, most interactions between the CAMHS department and local service providers happen informally. Although the local external environment provides triggers that can initiate learning from the external environment (Zahra and George, 2002; Lane et al., 2006), the lack of communication pathways with the external environment restrains the systematic identification of valuable external knowledge. A recent study on absorptive capacity in the public healthcare sector showed that systems which enable the meaningful collection of information can enable the exploratory capability of a healthcare organisation (Spencer et al., 2007). Thus, investing in formalising pathways of knowledge identification from the local environment could strengthen the department's absorptive capacity and contribute to advancing the quality of provided services.

Secondly, the tendency of the case study organisation to often operate isolated from the local network of service providers appeared to limit the potential of the department to identify knowledge that is valuable for its service quality. Several interviewees from both the case study organisation and the local environment used the phrase "in silo" to describe the relationships between the CAMHS department and other local service providers. This form of isolationism was often described as

an organisational characteristic rather than a characteristic of individual staff members. The effectiveness of absorptive capacity is heavily based on the relationship which an organisation has with the external environment, considering that it is the primary source of knowledge (Lane et al., 2006; Omidvar et al., 2017). An organisation's ability to benefit from new knowledge and produce innovative solutions cannot be solely based on its own resources, but is also highly dependent on its ability to create liaisons with its external environment. As a result, "openness" to external knowledge sources is a critical factor for improving an organisation's outcomes (Caloghirou et al., 2004, p.29). In the case of CAMHS, establishing sustainable relationships with local organisations has been also identified as a priority in the latest policies and service evaluation reports, as it would enable service integration (NHS England, 2015a, Frith, 2016). Therefore, the tendency of the CAMHS department to work in an isolated manner could operate as a counter-factor to accessing valuable knowledge from the local external environment which is critical to its services and to developing relationships with local service providers.

Thirdly, the heterogeneous character of the local environment presented in Section 4.2 was identified as a barrier for the CAMHS department's ability to identify valuable knowledge and for the exchange of knowledge with local service providers. The heterogeneous character was mostly associated with the different strategic approaches among local organisations (also called 'language') and the different definitions organisations had around mental health. Existing research on absorptive capacity suggests that learning between organisations must entail a degree of common knowledge between a learner and a source organisation, which allows the former to identify and communicate with new valuable sources, as well as to include a degree of diversity, which creates an opportunity for the learner organisation to exploit new knowledge (Cohen and Levinthal, 1990; Lane and Lubatkin, 1998). Knowledge diversity, therefore, is a necessary component of learning from external sources in absorptive capacity (Cohen and Levinthal, 1990; Lane et al., 2006). Data analysis showed that diversity in the ways local organisations choose to support service provision locally was interpreted as a boundary for staff members of the CAMHS department. As a result, the heterogeneous character of the local environment appeared to operate as a limitation for the identification of new knowledge from local providers, rather than serving as a learning opportunity.

Previous studies on absorptive capacity have shown that an organisation's interaction with organisations that act as knowledge sources can be restricted by

formal organisational boundaries, such as regulations, as well as by boundaries related to the organisations' culture (Omidvar et al., 2017). Indeed, findings from the current study showed that although local organisations share a common goal, i.e. improving the mental health of young service users, the 'language' differences among local organisations could have a negative impact on the development of collaborative relationships. Studies in absorptive capacity showed that investing on embedding the notion of "goal interdependence" in partnerships can enable the acquisition of useful knowledge within cross-sectoral collaborations (Pittz and Intindola, 2014; p. 1176). In public service organisations, partnerships development is also associated with investing in a common goal and meeting targets that a single organisation cannot address (Wankhade and Patnaik, 2019). The differences existing among local organisations in the ways they contribute to service provision appeared to hinder the development of liaisons among local service providers and to limit the possibilities of the CAMHS department to identify new valuable knowledge from local organisations. Building relationships with local organisations based on a common goal could assist in overcoming the boundaries of the heterogeneous local environment and enable knowledge identification for the CAMHS department.

Fourthly, the development of sustainable collaborations among local organisations could be hindered by individuals' interests. The creation of new partnerships appeared to be negatively influenced by the senior members' interests, who aim to have a leading role in the local healthcare system. In the absorptive capacity model of Todorova and Durisin (2007), power relationships are identified as a factor that can explain why certain knowledge areas are absorbed instead of others. Interestingly, the effect of power on the development of absorptive capacity in public organisations has already been highlighted in the few studies on the absorptive capacity of public healthcare organisations, primarily as a factor that drives the knowledge areas that will be prioritised within the organisation (Easterby-Smith et al., 2008b; Croft and Currie, 2016). The findings of the present study showed that power interests mediated and potentially delayed the development of partnerships of the CAMHS department due to individuals' interests and, thus, could have a negative impact on the identification and exploitation of new useful knowledge. Together with the role of professional groups and individuals' absorptive capacity presented in previous sections, the influencing role of power contributed to further understanding the impact which individuals could have on the development of absorptive capacity.

Finally, findings presented in Section 4.5.2 showed that local organisations often compete for public funding, while they are also expected to collaborate for developing joint services. Competition is an integral characteristic of the NHS internal market system (Glasby and Tew, 2015). Outcomes of this study showed that competition among local providers can restrain the development of partnerships and hinder the fruitful exchange of valuable knowledge among local service providers for the development of joint services. Additionally, competition appeared to contribute to maintaining a mentality of isolated working and service fragmentation in the local environment. Furthermore, the rationale behind the internal market appeared to be in contrast with the expectations of the latest policies, mainly the "Five Year Forward View" and the "Future in Mind", where local organisations are guided to collaborate (NHS England, 2014; NHS England, 2015a; Miller and Goose, 2016). The limitations posed by the competitive structure of the NHS market on the service integration have recently become part of public policy debates focusing on legislative changes (House of Commons, 2019b). The findings of this study underscored the impact of the NHS market system on the ability of the CAMHS department to benefit from external valuable knowledge sourced by the local environment. Finally, in absorptive capacity literature, the association of absorptive capacity with an organisation's competitive advantage has led research in the public sector to focus primarily on the impact of the construct on public organisations' performance (Harvey et al., 2010b). Yet, the present study showed that exploring the role of competition within public healthcare environments can increase insight into its influence on public healthcare organisations' learning.

### 6.3.1 Development of local care models and the contribution to the absorptive capacity of the CAMHS department

Despite the barriers existing within the local environment hindering the development of collaborative relationships, a new care model between the CAMHS department and the local children's community services was developed with the aim of integrating physical and mental health services. Although it was still an ongoing process during the period of data collection, study participants explained that knowledge exchange intensified during the period of partnership development. This finding provided an example showing that the formalisation of relationships could accelerate mobilisation of knowledge between partners and, thus, increase learning opportunities for the CAMHS department. Improvement in communication between partner organisations was also evident in other care models in England (Naylor,

2017), indicating that care models could have a positive impact on the absorptive capacity of mental healthcare organisations.

Additionally, the creation of the new job position of Children Wellbeing Practitioners (CWPs) facilitated knowledge mobilisation, as shown on p.164. CWPs role was on supporting children and young people with mild and moderate needs, while they also had gatekeeping responsibilities. CWPs appeared to enable knowledge sharing among the two key partners and schools, with the aim of facilitating the referrals or signposting of individuals to appropriate services. The formalised relationship between the two partners allowed CWPs to have access to knowledge about the organisational structure, training or data management systems of both partners. As a result, the new care model facilitated knowledge exchange and established CWPs as a position with gatekeeping responsibilities. CWPs appeared to enhance connectivity among partner organisations and enabled the identification of new knowledge for the CAMHS department that is valuable to service provision.

Next to the partnership supported by the CAMHS department, a new collaboration was developed among local third-sector organisations, called “Fullscope”. The new partnership aimed to provide a spectrum of services that support children and young people with early mental health difficulties, particularly in school environments. The collaboration adopted the THRIVE Framework principles, demonstrating a degree of responsiveness of those organisations to new knowledge from THRIVE and to the Local Transformation Plan (Miller and Goose, 2016). Overall, the two examples indicate a degree of responsiveness of the local environment to the development of collaborations, which could set the basis for future and potentially larger collaborations that can improve the quality of care (Ham, 2018). In relation to the CAMHS department, collaborations for improving service provision within the wider service system could indirectly benefit the department, as they make it possible to free up part of its overloaded capacity. Additionally, such collaborations could indicate the ability of local organisations to collaborate and learn from each other, providing insight into the potential “learning relationships” which the CAMHS department can develop at a local level – a factor that can have a positive impact on organisation’s absorptive capacity (Lane et al., 2006, p.857).

### *6.4. The THRIVE Framework: an example of responsiveness to new knowledge*

The current study was conducted during the period of implementation of the Local Transformation Plan (LTP). For this reason, study participants were asked to discuss the responsiveness of the CAMHS department and the local service environment to the THRIVE Framework. The aim of this part of the interview was to gain additional insight into the CAMHS department's absorptive capacity by using the example of the THRIVE Framework. Findings about the key components of absorptive capacity focused mainly on the assimilation and utilisation of the framework in local service provision, considering that the CCG has already identified THRIVE as the framework to lead the local service transformation. Evidence from the present study showed that incorporating the THRIVE principles into service management was seen by study participants of both groups as still being at an early stage. These findings differ from timeline suggested by the LTP implementation plan, as the period of data collection (2017/2018) was planned to be the mid-stage of implementation of the THRIVE Principles (Miller and Goose, 2016). Unsurprisingly, financial deficiency appeared to delay the embedment of THRIVE in local service provision.

Data analysis showed that there is understanding within the CAMHS department about the proposed service re-organisation, indicating a degree of responsiveness to assimilating and using key knowledge about THRIVE. Findings illustrated that the framework has contributed so far to creating a common language and facilitating communication among colleagues and the local environment. The responsiveness of staff members of the CAMHS department to THRIVE was also driven by the commitment of the department to respond to the service transformation plan of the local CCG. Within the local environment, several local organisations appeared to have explored THRIVE mainly with the purpose to understand whether it harmonises with their own strategies or to advise the development of the "Fullscope" partnership (mentioned in the previous section), rather than being used as their main guide for service planning. The framework was adopted by a social enterprise - service provider as an outcome of their funding relationship the local CCG. As a result, findings indicated that the degree to which each organisation has assimilated and used the THRIVE Framework was often associated with the different relationships organisations had with the CCG. This study outcome is linked to the dependency relationships discussed in Section 6.1.1, which appears to drive the prioritisation of knowledge at a local level.

Study participants demonstrated scepticism about the potential of THRIVE to change services, as it remained unclear for them what are the novel elements the framework introduced to the existing practices. They also argued that the framework does not specify the particular re-organisation steps that should be followed locally for incorporating the THRIVE principles into service provision. This perception indicated a gap in study participant's knowledge, as it contrasts with the main aim of the framework to allow local organisations to decide upon the optimal way the THRIVE quadrants can be developed locally (Wolpert et al., 2016). Additionally, data analysis stressed the doubts of participants from both groups as to whether the THRIVE framework could address the "in silo" attitude that was part of the department's mentality, as well as the boundaries created within the local environment due to the commissioning system. Ultimately, the fundamental notion of THRIVE to create linkage among different service levels and invest in a multi-agency approach in service provision (Wolpert et al., 2016) appeared to come in contrast with the existing healthcare system, which is mostly based on organisational boundaries and commissioning that favours competition. Considering that the CAMHS department is committed to embed the THRIVE principles in provided services, the above-mentioned boundaries should be taken into consideration when planning service provision within the local environment, as they could possibly delay the development of communication pathways and limit learning from the local environment.

### *6.5 A critical review of the study findings*

Findings of this study allow us to identify several critical points which contribute to the development of absorptive capacity theory. Outcomes demonstrated that the case study organisation has organisational processes in place that enable the identification and implementation of new knowledge in service management and provision in the CAMHS department. Yet, the inter-organisational environment appeared having a significant impact on determining the knowledge that will utilised within the CAMHS department and the case study organisation. Study findings revealed the dependency relationships existing between national organisations and local funders and the case study organisation, which have an influential role on forming the latter's priorities in using new knowledge. While previous studies have extensively studied the outcomes of absorptive capacity, the measurement of the construct and its effectiveness on organisational performance, there has been less research interest in examining the components of absorptive capacity in greater detail and the power dynamics between the external environment and an

organisation's absorptive capacity (Zahra and George, 2002; Van Den Bosch, 2003; Todorova and Durisin, 2007). Studying the individual components of absorptive capacity in a public organisational setting added to the absorptive capacity literature by shedding light to organisational processes and factors that influence learning from the external environment. Simultaneously, it added to the recently developed literature of absorptive capacity in public healthcare organisations, which aims to understand the potential of absorptive capacity in strengthening knowledge mobilisation at an organisational level in healthcare organisations (Oborn et at., 2013; Ferlie et al, 2015).

The use of qualitative research methods allows questions to be asked about how the absorptive capacity of the CAMHS department is formed and the ways the external environment influences the development of the department's absorptive capacity, areas that have been identified as research gaps (Lane et al., 2006; Easterby-Smith et al., 2008b, Volberda et al., 2010). Particularly, data analysis generated evidence about facilitators that enable the department's absorptive capacity. Findings distinguished existing organisational processes that can assist the CAMHS department to learn from the external environment and good practices of absorptive capacity, such as clinical or managerial supervision, reaching consensus around new valuable knowledge, reporting systems or informal discussions among staff members. Those findings demonstrate that there is a degree of investment in the organisation's absorptive capacity which facilitates the implementation of new useful knowledge in service provision. The Trust invests in processes that enable parts of absorptive capacity, which appear to be a strength of its operational strategy and enable the utilisation of new useful knowledge.

Similarly, the study identified factors that can restrict the department's absorptive capacity, including the top-down hierarchy within the case study organisation, data management systems that do not always provide data useful to practice and the partial sharing of information from senior management to frontline staff. Such factors can hinder staff members' understanding about the usefulness of new knowledge and obstruct its assimilation (Szunanski, 1996). Most importantly, the study highlighted the imbalanced investment of the organisation in the three components of absorptive capacity, which can have a negative impact on an organisation's learning abilities (Cohen and Levinthal, 1990, Zahra and George, 2002). Findings identified processes that enable the components of knowledge assimilation and exploitation, while less evidence was generated about processes that enable knowledge identification. The weak ability of the CAMHS department to

identify new knowledge can be associated with the dependency relationships existing between the case study organisation and the external environment, such as regulatory organisations, NICE or the local CCG, who drive to a significant degree the knowledge prioritised in the case study organisation.

Organisations that act as knowledge sources appeared to largely determine the knowledge used within the case study organisation. Previous studies on absorptive capacity have explored the relationship between a learner organisation and an organisation that acts as a knowledge source (Lane and Lubatkin, 1998; Knoppen et al., 2011; Omidvar et al., 2017). Nonetheless, limited evidence has been generated about the power relationships that may existing between learner organisations and sources (Todorova and Durisin, 2007). Studying the role of regulators has also been until now a missed opportunity in evaluating the external factors that shape an organisation's absorptive capacity (Lane et al., 2006). Findings of this study underlined that the external environment and particularly regulatory organisations can actually drive to a significant degree the knowledge implemented in the case study organisation. This finding adds to outcomes from recent studies that explored absorptive capacity in public healthcare organisations and recognised the influential role of regulators (Easterby-Smith, 2008b; Croft and Currie, Harvey et al., 2010). The present study contributes to address this gap and adds to the literature of absorptive capacity in the public sector, as well as in the private sector, where the power influence of organisations that are knowledge sources has been until now understudied.

Exploring the role of the external environment also revealed the impact of the aforementioned dependency relationships on the ability of the case study organisation to respond to national healthcare policies. The relationships between the case study organisation and key organisations, e.g. regulatory organisations, NICE or local funders, appeared to limit the organisation's ability to adopt and implement new knowledge that would help meet priorities set by the latest policies. Prioritising knowledge sourced by the aforementioned organisations restricts the ability of the case study organisation to invest sufficient capacity in exploiting novel knowledge areas that can contribute to improving service quality and accessibility, as recommended by the most recent policies. For example, 'Future in Mind' recommends the development of partnerships between the NHS and local service providers that can enable the development of a joint system of service provision (NHS England, 2015a). Yet, the case study organisation appeared to have limited capacity available to invest on systematic communication and fruitful collaborations

with local service providers. As a result, studying absorptive capacity in NHS CAMHS and the case study Trust revealed a wider problem in the structure of the healthcare system in England, which concerns the divergence between the structure of the NHS healthcare system and the most recent healthcare policy directions. Although this gap lies beyond the responsibility of the case study organisation, it is the latter that is called to respond to both learning priorities set by regulatory organisations and the policy directives that lead the transformation of children and young people's mental health services. Ultimately, the structure of the NHS system influences to a large extent the priorities in implementing new knowledge and the growth of the absorptive capacity of the case study mental health Trust, due to power dynamics that have been established.

At a local level, the heterogeneous character of the local environment was identified as a key barrier that restricts knowledge exchange among service providers and, consequently, limits the possibilities of identifying and utilising knowledge that is useful for improving service provision in the CAMHS department. Local organisations can be useful knowledge sources for each other because they work towards a common goal, i.e. to improve the mental health of children and young people. Nevertheless, different organisational aims and preferred approaches on meeting service users' needs often restrict the formulation of sustainable collaborations and limit knowledge exchange around service provision. In line with existing literature, differences in organisational aims, structure and culture between source organisation and learning organisation can have a major impact on identifying new knowledge (Lane and Lubatkin, 1998, Omidvar et al., 2007). Thus, the improvement of communication among local service providers around organisational aims and strategic approaches to service provision can enable the effective identification of valuable knowledge from the CAMHS department.

The structure of the local funding system can further limit the creation of communication pathways that can enable the identification and exploitation of new useful knowledge. Based on the commissioning approach, funding resources are allocated via tenders that create competition among local service providers. Competition has been acknowledged in absorptive capacity literature as a factor that can accelerate the search for new knowledge and, hence, improve the quality of an organisation's outcomes (Cohen and Levinthal, 1990; Lane et al., 2006). However, evidence of the present study showed that competition can actually have a negative effect on the ability of the case study organisation to seek and use new

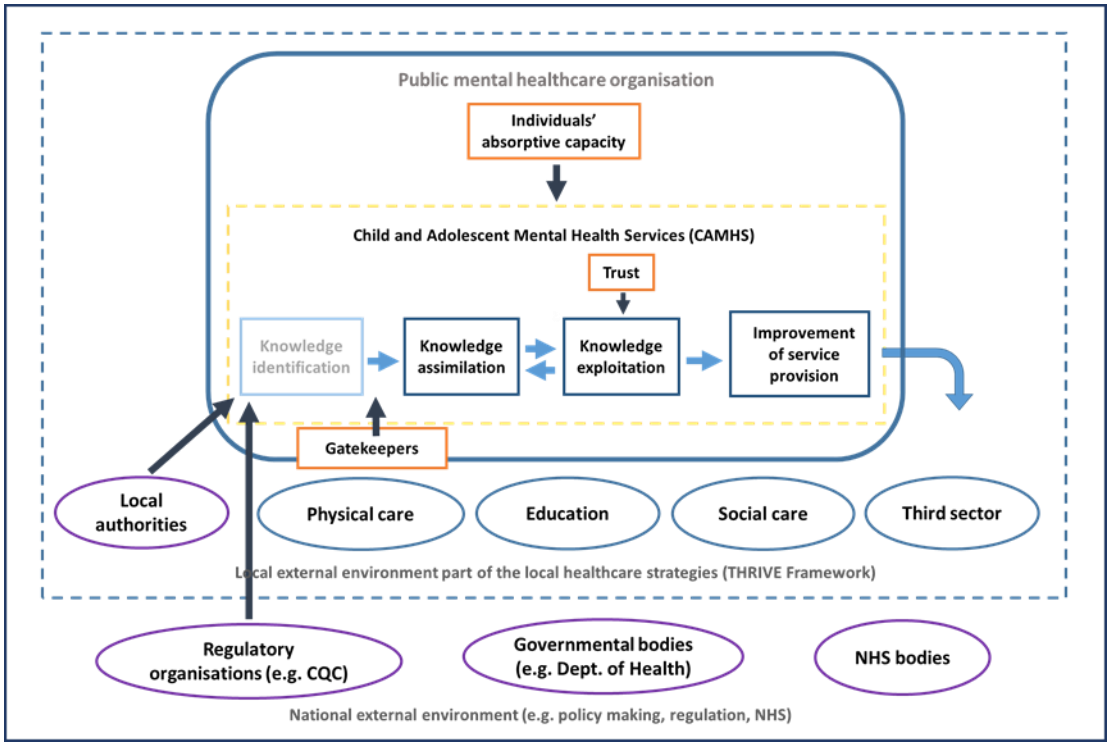
useful knowledge from local organisations. Competition appeared to enhance the tendency of local organisations to work in silos and have a negative impact on developing sustainable relationships. Hence, the NHS commissioning structure, in combination with the heterogeneous character of the local environment, appeared to maintain the fragmentation of service provision within the local system and to operate as a barrier for the CAMHS department to identify knowledge valuable to service provision. Investment in creating sustainable relationships within the local environment can contribute to addressing the boundaries existing within the heterogeneous local environment and, hence, enable the identification of new valuable knowledge ability valuable to the CAMHS services.

Finally, study outcomes demonstrated the impact of individuals on the development and effectiveness of organisational absorptive capacity in the CAMHS department. Existing literature has mostly focused on absorptive capacity at an organisational level, while the limited evidence around the role of individuals has been identified as an important omission (Volberda et al., 2010; Martinkenaite and Breunig, 2016). Interviewing staff members allowed to study their role in the learning abilities of the CAMHS department. Individuals' critical skills on evaluating new external and diverse knowledge appeared to be a key component of the department's absorptive capacity. Their professional background and perception about what consists a reliable knowledge source can affect the knowledge they recognise as valuable and will prioritise in using in practice. Thus, individuals did not have a role solely on implementing knowledge in CAMHS, but they participated on determining what knowledge is most valuable to be implemented within the department. This finding highlights the impact individuals' can have on the development of absorptive capacity within the case study Trust. Based on those findings, it is recommended to further explore the role of individuals to both the private and public sector. Future studies around absorptive capacity should study individuals' role as a key component of absorptive capacity and invest in exploring the contribution they can make in organisational absorptive capacity.

Overall, findings from the present case study showed that absorptive capacity can be a useful organisational approach for improving the ability of CAMHS to exploit new valuable knowledge. Recent service evaluation reports demonstrated that CAMHS are called to respond to different knowledge areas that can improve service quality and effectiveness, e.g. evidence-based practice, quality improvement approaches or knowledge that enables digital transformation (NHS England, 2015a). Absorptive capacity can enhance learning within the Mental

Health Trust at an organisational level and strengthen the ability of CAMHS to utilise knowledge that is valuable to service provision, such as the aforementioned areas. Cultivating absorptive capacity can also assist to identify areas of improvement in existing learning practices and to critically evaluate the role of the external environment in driving the knowledge incorporated in service provision. Finally, recent local strategies suggested that the improvement of local service provision should not be based on services provided individually by local organisations, but on the development of a system of care that embraces all providers (Goose, 2018). Strengthening the absorptive capacity of the CAMHS department can improve its ability to identify knowledge about the level of local needs and the care provided by other local services and, thus, transform its services on the basis of developing a connected system of service provision that can address the needs of the local young population.

Study outcomes assisted to adjusting the conceptual framework presented on p.53 and gave rise to a new proposition that reflects the findings around the absorptive capacity of the CAMHS department. Although not all findings could be represented in the diagram, key elements were included to demonstrate influential factors of the department's absorptive capacity. The impact of dependency relationships from national and local organisations on the CAMHS department were added to show their influence on prioritising new knowledge (black arrows). The component of knowledge identification was adjusted (represented now with a light grey colour) to demonstrate the weaker ability of the CAMHS department to identify new knowledge. The interchangeable relationship between knowledge assimilation and exploitation was also added (represented by two blue arrows) to show the connection between the two components. Finally, the role of gatekeepers, the role of trust and the role of individuals' absorptive capacity were added to show the influential position of the three factors.



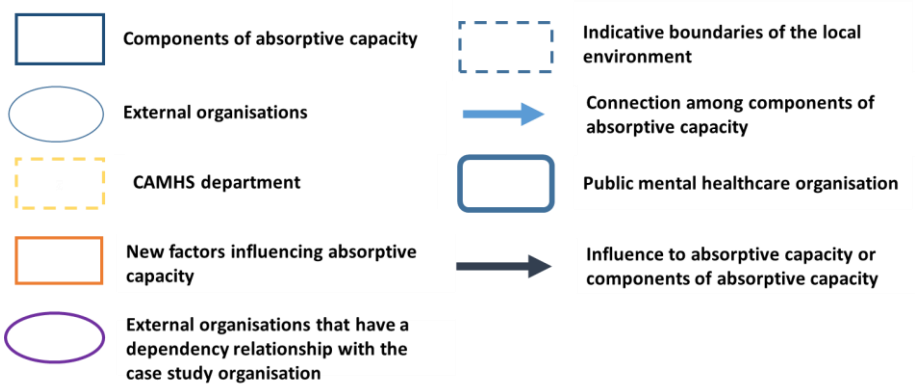




Diagram 6.7: Adjusted conceptual framework

### *6.5 Limitations*

The study outcomes present several limitations that should be taken into consideration. The findings discussed above highlighted characteristics of the case study organisation that are associated with its public character. Although such findings were identified as influential, an extensive comparison between public and private environments in relation to absorptive capacity would exceed the objectives of this study. Furthermore, data collected within the case study organisation from staff members and organisational documents represented a part of the overall structure of the case study organisation and it is anticipated that further

organisational processes exist which could be potentially relevant to the current study. Yet, data collection was dependent on the participation of staff members, on accessibility to public and private documents and on the time limitations of the thesis. Considering those limitations, the structure of the case study research design and the rigorous research process followed throughout the study assisted in synthesising data findings from different sources and viewpoints, thus increasing the trustworthiness of the study outcomes.

## Conclusion

The thesis examined the contribution which absorptive capacity can make to the service provision of public CAMHS. Exploring the construct of absorptive capacity provided insight into the ability of the CAMHS department to respond to new knowledge and increased understanding about the role of the external environment in shaping the department's absorptive capacity. The contributions of the study can be identified in four main areas. Firstly, the study showed that the absorptive capacity of the CAMHS department can be influenced by the role of the inter-organisational environment, due to the dependency relationships which the mental health Trust appeared to have with several public organisations within the healthcare system, e.g. NHS bodies and regulators. Secondly, the study demonstrated that there is limited investment within the case study organisation in organisational processes that could assist the department to identify new and diverse knowledge. Thirdly, outcomes highlighted the role of individuals' absorptive capacity, such as their responsiveness to new knowledge or their role in constructing the meaning of valuable knowledge, and the impact they could have on the knowledge that is absorbed within the department. Lastly, the study contributed to understanding the value of knowledge sourced by the local environment, as well as the barriers that may be created in learning from the local environment due to the diversity among local organisations. Investing in the department's absorptive capacity could grow its responsiveness to new knowledge and contribute to improving the services provided to children and young people. The study proposes the further exploration of the key components of absorptive capacity in NHS CAMHS and the factors that could influence the development of the construct. The key contributions of the present thesis can be identified at an inter-organisational, organisational and individual level.

At an inter-organisational level, the study highlighted that the CAMHS department's absorptive capacity is influenced by the dependency relationship between the case study organisation and public organisations which manage NHS and guide service provision, such as NHS England, NICE or the local CCG. Despite the directions of recent healthcare policies to decentralise healthcare in the last two decades, the study showed that the autonomy of the local Trust remains limited. As a consequence, the aforementioned organisations appeared to drive the knowledge areas that will be prioritised within the CAMHS department. Additionally, CAMHS confront significant funding deficiency, as they remain among the most underfunded services in mental healthcare. Given the financial pressures, the ability of the

CAMHS department to plan and strategically respond to new useful knowledge is undermined. As an outcome of prioritising mandatory knowledge while being underfunded, valuable non-mandatory knowledge areas become a secondary priority, such as knowledge about local service provision, patients' data reports or research knowledge. Ultimately, the dependency relationships existing within the structure of the NHS system appeared to restrain the ability of the CAMHS department to respond to non-mandatory knowledge that is valuable for meeting to the needs of the local population.

The study contributed to understanding the absorptive capacity of the CAMHS department, as well as the factors that may influence it. Knowledge identification was mostly associated with individuals' ability to identify new valuable knowledge and the need to meet the objectives of the CAMHS department. The component of assimilation appeared to be facilitated by the need of staff members to reach consensus for new knowledge, as well as meeting the department's objectives. Yet, knowledge assimilation was restrained by the impact of the top-down hierarchy on knowledge dissemination, incompatible data management systems and the different geographical locations of the department. Trust among staff members was identified as a shared value for ensuring the utilisation of new knowledge. Findings also revealed an inter-changeable utilisation of processes that enable knowledge assimilation and exploitation, with the aim of incorporating new knowledge into practice over time. Furthermore, outcomes highlighted the tendency of the case study organisation to invest in organisational processes that enable knowledge assimilation and exploitation, while less evidence was identified about knowledge identification – an element that appeared to be reflected within the CAMHS department. Overall, the study showed that the CAMHS department demonstrated a degree of absorptive capacity. Yet, the imbalanced investment among the key components, as well as internal boundaries could have an impact on the department's ability to benefit from new knowledge.

The thesis contributed to comprehending the role of individuals in the CAMHS department's absorptive capacity. Determining the meaning of valuable knowledge appeared to be mediated by staff members' professional background and their perception about which sources are most reliable to offer valuable knowledge. While gatekeepers appeared to play a key role in identifying new knowledge and linking it with existing knowledge, the active involvement of the rest of staff members was identified as a prerequisite for effectively embedding of new knowledge within an organisation. Findings indicated that the low responsiveness of staff members to

new knowledge is associated with individuals' learning skills and could hinder the incorporation of new valuable knowledge within the CAMHS department. Finally, individuals' power interests was identified as a determinant factor in the development of local partnerships. Overall, the role of individuals arose as a key element of the department's absorptive capacity. This finding contributed to the wider literature of absorptive capacity and underlined the influential role of individuals, an area that has been insufficiently researched.

Furthermore, the study shed light on the significance of the local environment as a knowledge source, as it can provide access to knowledge about the services offered to the local young population. Yet, knowledge identification appeared to happen mostly via informal pathways, particularly between the CAMHS department and service providers. The heterogeneous character of the local environment was identified as a factor that further increases the difficulty of the CAMHS department to identify new useful knowledge. The study showed that differences among local organisations in their structure, such as in information governance regulations and data management systems, as well as in the 'language' each organisation adopts, function as a boundary for the CAMHS department to identify new knowledge. The isolated manner of the CAMHS department to operate within the local environment appeared to further limit the identification of useful knowledge from local sources. Lastly, the commissioning system within which local collaborations are expected to compete maintains boundaries among local organisations. Therefore, establishing systematic and safe communication pathways that enable knowledge exchange could assist in overcoming the boundaries of the local environment and in improving the ability of the CAMHS department to identify valuable knowledge for the local environment.

Tracing the THRIVE Framework was an additional opportunity to observe the responsiveness of the CAMHS department and the local system to new valuable knowledge. The study showed that embedding the THRIVE quadrants in practice would require the negotiation of the aforementioned boundaries as THRIVE is based on the development of collaborative relationships and the mobilisation of knowledge among service providers. Most importantly, exploring THRIVE Framework demonstrated that the re-design of mental health services for children and young people that aims to bring together local organisations will probably continue facing such boundaries - often associated with the current structure of the NHS system. At a wider policy level, the study contributed to understanding the contradiction that exists between recent policies that aim to the development of

integrated service systems, which are tailored to the needs of local populations (e.g. care models or THRIVE Framework), and the NHS structure, which maintains a dependency status between NHS management and local Trusts.

At a practice level, the study contributed to understanding the CAMHS department's investment in the main components of absorptive capacity. It provided evidence related to the enablers of the key components, for instance the importance of reaching consensus, the usefulness of organisational processes that enable knowledge assimilation and exploitation, the role of gatekeepers (e.g. CWPs) or the role of trust among staff members. It also demonstrated potential areas of improvement, such as the impact of top-down hierarchy in knowledge dissemination, the boundaries created by incompatible data management systems, the limited learning skills of individuals or the role of professional background in determining the value of new knowledge. Additionally, the study stressed the importance of establishing sustainable communication pathways with the local environment that could enable the identification and utilisation of valuable knowledge for the CAMHS department. It also demonstrated that different information governance regulations, data management systems, as well as the different strategic goals of local organisations could restrain the CAMHS department' ability to absorb new knowledge.

More broadly, the contributions of the present study to practice could be potentially used to advise other CAMHS departments. The challenges of the healthcare system which were identified in this study as influencing absorptive capacity have also been outlined in service evaluation reports as having a national impact on the quality of service delivery, such as the financial deficiency of CAMHS, the fragmentation of services, the need to incorporate evidence-based practices or the lack of systems that facilitate information exchange with regard to the service pathways young people follow. Considering that NHS CAMHS around England possibly have similar dependency relationships within the NHS system as those identified in the case study organisation, findings from this study could be useful for other CAMHS departments confronting comparable challenges. The adjusted conceptual framework could be utilised to explore the potential of absorptive capacity for other CAMHS departments and public mental health organisations. Finally, findings of the present study could contribute to future studies that focus on the absorptive capacity of mental healthcare and healthcare organisations.

*Study recommendations*

This study recommends the further examination of the absorptive capacity in CAMHS and mental healthcare organisations by taking into consideration the organisational context, the role of the national and local inter-organisational environment, as well as the impact which staff members could have on the development of absorptive capacity. At an organisational level, future research can further explore organisational processes that enable absorptive capacity within a mental healthcare organisation and make recommendations as to how those could be optimised. Existing literature in health services that focuses on the implementation of interventions or service re-design could be brought together with absorptive capacity theory and contribute to developing solutions that can be adopted by mental healthcare organisations and improve their learning abilities at an organisational level. Exploring organisational ambidexterity theory could also shed light on the ability of an organisation to maintain a balance between importing new knowledge and developing routines that facilitate the implementation of new knowledge (Raisch and Birkinshaw, 2008). At an individual level, the study recommends researching the key components and determinant factors of individuals' absorptive capacity, with the aim to provide further insight to the overall literature of absorptive capacity about the impact of individuals in the absorptive capacity of organisations.

At an inter-organisational level, future studies could examine the potential of absorptive capacity for organisations that are part of new local models of care. Considering that organisations supporting children and young people' mental health are expected to create joint service pathways, examining the potential of absorptive capacity for new systems of joint services could offer new insights into how services could benefit from new knowledge. Additionally, future research could further investigate the dependency relationships between mental healthcare organisations and national organisations (e.g. regulators or NHS bodies) and the possibility of increasing the flexibility of mental healthcare organisations regarding the implementation of mandatory knowledge. Examining absorptive capacity in more health and mental health settings could enrich existing evidence about the potential of absorptive capacity for healthcare.

At a policy level, the outcomes of this study recommend the further examination of the relationships existing between local mental healthcare service provision and organisations that act as sources of mandatory knowledge, such as NHS

management or regulatory organisations. Considering that the recently developed STPs aimed to increase the liberty of local healthcare systems in service planning, local mental healthcare organisations could benefit from have the necessary space to develop service solutions that are tailored to the needs of local populations. Finally, increasing allocated funding could enable the development of the absorptive capacity of CAMHS and facilitate the creation of fruitful collaborations that can operate as knowledge sources. Overall, the study outcomes could be used to advise policy-makers and contribute to addressing boundaries that were identified as limiting for the absorptive capacity of CAMHS and public mental healthcare organisations.

At a practice level, the study recommends the adoption of absorptive capacity as an organisational approach that could contribute to improving the CAMHS department's responsiveness to new knowledge. Investing in staff members' learning skills could strengthen their confidence and critical skills on the benefits of new and diverse knowledge, e.g. academic knowledge, healthcare technology or knowledge from third-sector organisations. Additionally, the study recommends addressing internal boundaries that appeared to mediate the assimilation of new useful knowledge, e.g. increasing transparency in knowledge dissemination from senior management to the rest of the staff members or enabling the dissemination of knowledge from frontline workers within the department and the rest of the organisation, as lessons learnt from practice. Developing compatible data management systems within the case study organisation could also enable the generation of knowledge that is tailored to the needs of the CAMHS department.

At an inter-organisational level, the findings of the study recommend the development of collaborative relationships that are based on the common goals among local organisations. Providing appropriate support and tools to staff members of the CAMHS department for the development of partnerships could enable the identification of new knowledge, particularly from local organisations. Additionally, adopting a common language, such as the THRIVE Framework, could facilitate the communication among local providers. Findings also recommend the exploration of investing in joint information governance agreements and compatible data management systems with the aim to assist to the safe and systematic identification of new knowledge, particularly when it involves confidential information. Overall, cultivating the CAMHS department's absorptive capacity could improve the balance of prioritising between mandatory and non-mandatory knowledge areas and

advance the department's ability to identify, assimilate and utilise external knowledge that is valuable for service provision.

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## Appendix

### Letter 1: Health Research Authority (HRA) Approval Letter

NHS
Health Research Authority

Ms Lida Georgia Efstathopoulou
Anglia Ruskin University
Health Building; Young Street Campus
Cambridge
CB1 2LZ

Email: hra.approval@nhs.net

19 September 2017

Dear Ms Efstathopoulou

**Letter of HRA Approval**

| | |
|---|---|
| **Study title:** | **Improving the ability of public youth mental health services to use new knowledge: The case of absorptive capacity.** |
| **IRAS project ID:** | **230225** |
| **Protocol number:** | **N/A** |
| **Sponsor** | **Anglia Ruskin University** |

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

**Participation of NHS Organisations in England**

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details

and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

**Appendices**

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

**After HRA Approval**

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

**Scope**

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hso-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

**User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

**HRA Training**

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **230225**. Please quote this on all correspondence.

| IRAS project ID | 230225 |
|---|---|

Yours sincerely,

Natalie Wilson
Assessor

Email: hra.approval@nhs.net

*Copy to:* *Professor Selim Cellek, Anglia Ruskin University, Sponsor contact*
*Senior R&D Manager, Cambridgeshire & Peterborough NHS Foundation Trust, Lead NHS R&D contact*

| IRAS project ID | 230225 |
|---|---|

**Appendix A - List of Documents**

The final document set assessed and approved by HRA Approval is listed below.

| *Document* | *Version* | *Date* |
|---|---|---|
| Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Conditional Approval-Faculty Ethics Committee-Faculty of Medical Science-Anglia Ruskin University] | | 30 May 2017 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Letter-Anglia Ruskin University] | | 26 July 2017 |
| HRA Schedule of Events [HRA Schedule of Events for CPFT ] | 2 | 19 September 2017 |
| HRA Schedule of Events [HRA Schedule of Events for Cambridgeshire and Peterborough CCG] | 2 | 19 September 2017 |
| HRA Statement of Activities [Statement of Activities for CPFT] | 2 | 19 September 2017 |
| HRA Statement of Activities [Statement of Activities for Cambridgeshire and Peterborough CCG] | 2 | 19 September 2017 |
| Interview schedules or topic guides for participants [Interview schedule for CPFT staff members ] | V1 | 26 July 2017 |
| Interview schedules or topic guides for participants [Interview schedule for non-profit organisations and local authorities] | V1 | 26 July 2017 |
| IRAS Application Form [IRAS_Form_22082017] | | 22 August 2017 |
| IRAS Application Form XML file [IRAS_Form_22082017] | | 22 August 2017 |
| IRAS Checklist XML [Checklist_22082017] | | 22 August 2017 |
| Letters of invitation to participant | 2 | 13 September 2017 |
| Non-validated questionnaire [Delphi Questionnaire] | V1 | 26 July 2017 |
| Other [Certificate of Good Clinical Practice-Lida Efstathopoulou] | | 31 May 2017 |
| Participant consent form [Consent Form_The use of new knowledge in public youth mental health services ] | 2 | 13 September 2017 |
| Participant information sheet (PIS) [Participant Information Sheet for CPFT _The use of new knowledge in public youth mental health services ] | 2 | 13 September 2017 |
| Participant information sheet (PIS) [Participant Information Sheet for non-profit organisations and local authorities _The use of new knowledge ..] | 2 | 13 September 2017 |
| Research protocol or project proposal [Research Protocol] | V1 | 10 July 2017 |
| Summary CV for Chief Investigator (CI) [CV Lida Efstathopoulou] | | 06 July 2017 |
| Summary CV for student [CV Lida Efstathopoulou] | | 06 July 2017 |
| Summary CV for supervisor (student research) [CV Dr Paul Sanderson] | | 24 July 2017 |
| Summary CV for supervisor (student research) [CV Dr Hilary Bungay] | | 24 July 2017 |
| Summary CV for supervisor (student research) [CV Dr Fiona McMaster] | | 14 July 2017 |

| IRAS project ID | 230225 |
|---|---|

**Appendix B - Summary of HRA Assessment**

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.**

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Lida Georgia Efstathopoulou
Email: lida.efstathopoulou@pgr.anglia.ac.uk

**HRA assessment criteria**

| Section | HRA Assessment Criteria | Compliant with Standards | Comments |
|---|---|---|---|
| 1.1 | IRAS application completed correctly | Yes | No comments |
| | | | |
| 2.1 | Participant information/consent documents and consent process | Yes | No comments |
| | | | |
| 3.1 | Protocol assessment | Yes | No comments |
| | | | |
| 4.1 | Allocation of responsibilities and rights are agreed and documented | Yes | This is a non-commercial, multicentre study taking place in the NHS.<br><br>Two Statement of Activities documents have been submitted. They will act as the agreement between Sponsor and participating NHS organisations that are 'all site activities' and 'recruiting' site-types. No other agreements are expected. |
| 4.2 | Insurance/Indemnity | Yes | Where applicable, independent contractors (e.g. General Practitioners) |

| Section | HRA Assessment Criteria | Compliant with Standards | Comments |
|---|---|---|---|
| | arrangements assessed | | should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study |
| 4.3 | Financial arrangements assessed | Yes | Sponsor is not providing funding to participating NHS organisations. |
| | | | |
| 5.1 | Compliance with the Data Protection Act and data security issues assessed | Yes | No comments |
| 5.2 | CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed | Not Applicable | |
| 5.3 | Compliance with any applicable laws or regulations | Yes | No comments |
| | | | |
| 6.1 | NHS Research Ethics Committee favourable opinion received for applicable studies | Not Applicable | |
| 6.2 | CTIMPS – Clinical Trials Authorisation (CTA) letter received | Not Applicable | |
| 6.3 | Devices – MHRA notice of no objection received | Not Applicable | |
| 6.4 | Other regulatory approvals and authorisations received | Not Applicable | |

## Participating NHS Organisations in England

| *This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.* |
|---|
| This is a non-commercial, multicentre study. There are two site-types involved in the research.<br><br>Activities and procedures as detailed in the protocol will take place at participating NHS organisations performing 'all site activities'.<br><br>Activities at 'recruiting sites' will include emailing the information package to potential participants |

and staff interviews.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If Chief Investigators, sponsors or Principal Investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the Chief Investigator, sponsor or Principal Investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

## Confirmation of Capacity and Capability

*This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.*

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

## Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

A Local Collaborator (LC) is expected at participating NHS organisations performing 'all site activities'

The Chief Investigator (CI) is responsible for research activity occurring at 'recruiting sites'.

Sponsor does not expect research staff to undertake any specific or additional training for the study.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

| IRAS project ID | 230225 |
|---|---|

## HR Good Practice Resource Pack Expectations

| *This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken* |
|---|
| As this study is taking place in primary care establishments, we expect you contact the primary care management function to follow their local process. We would expect where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if occurring in clinical areas of participating NHS organisations. Letters of Access would not be expected if occurring in non-clinical/administrative buildings. |

## Other Information to Aid Study Set-up

| *This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.* |
|---|
| The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. |

## Participant Information Sheet

Anglia Ruskin University

**PARTICIPANT INFORMATION SHEET**

**Project Title:** *The use of new knowledge in public youth mental health services V2*

**IRAS ID: 230225**

**Brief summary of the project**

This project aims to investigate the ability of youth mental health services of the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) in using of new knowledge and its relationship with local organisations. For this, we would like to interview members of staff and discuss with them about their job, daily tasks, working together with other organisations, and to complete a questionnaire related to work routines. Your feedback will be vital for us to understand how the organisation relates and responds to new knowledge. Outcomes of the research project can be shared with you after the completion the study.

**Purpose of the project**

The aim of the study is to explore how new and useful knowledge from external sources could possible help the organisation improve its performance and, consequently the provision of services to young people. In order to achieve this, it focuses specifically on an organisational construct called 'Absorptive Capacity'. Evidence shows that the ability of an organisation to learn from external sources, i.e. its absorptive capacity, can help in improving its performance. Most evidence until today has emerged from research in the private sector. This study aims to examine the potential of this construct in public organisations that provide youth mental health services and offer a new framework that could be used to advise these organisations.

**Why have I been asked to participate?**

You are invited to participate in this study because you are a staff member of the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

**How many people will be asked to participate?**

30 staff members of the CPFT and 20 members of other organisations involved in the provision of youth mental health service have been invited to take part on this study.

**What are the likely benefits of taking part?**

By sharing your views on daily routines related to the use of new information and knowledge, you will help us to identify how such processes take place within your organisation. Research outcomes will be used to make recommendations about the potential of new knowledge for public mental health organisations. Findings will be also used to formulate a framework which will be shared with participating organisations and can feed back to practice.

**Can I refuse to take part?**

You can refuse to take part in the interview and the questionnaire process. You do not have to give a reason for not wanting to be part of this study.

**Has the study got ethical approval?**

This study has received an Ethical Approval from the Faculty Ethics Committee of the Faculty o' Medical Science in Anglia Ruskin University.

**What will happen to the results of the study?**

The researcher will write a report by summarising the main points from our data analysis. The report will be shared will participating organisations. Results will be also used to publish the outcomes of this study in academic journals, as well as to inform other departments of Anglia Ruskin University or relevant organisation and think tanks.

**Contact for further information**

Lida Efstathopoulou

## Your Participation in the Research Project

**What will I be asked to do?**

You will be asked to participate in an interview and to complete a questionnaire two times. During the interview, you will be asked a number of questions related to your daily work routines, how you use new information and other relevant questions. This interview will last approximately an hour and it will take place in a time and location that is convenient for you. In order to keep a good record of you views, the interview will be recorded. In addition to this, you will be asked to complete a one-page questionnaire twice (a third time might be required but this depends on the results of the second time).

**Will my participation in the study be kept confidential?**

Your participation will be kept confidential. Only the researcher will know about your participation. The content of the interviews will be anonymised. Outcomes of the questionnaires will be also anonymised after every round. The researcher will hide your name and will give a number to your interview and no other person will know to whom each interview belongs to, apart from the researcher. However, if any information emerges that is threatening for yourself or others, it will be shared will you line manager/senior member of your organisation.

Additionally, only the researcher will have access to the content of your interview and will know what you said. The content of your interview will be kept in secure files in the university's virtual working environment. After being anonymised, a senior research team member will also have access to parts of the content, in order to give advice for the data analysis process.

We would also like to record your interview. An audio recording device will be used for this. This will help the researcher to remember what you said and collect the opinions of all interviewees. Interviews will be transcribed. If you wish to have a copy of the transcript of your interviews, you can state that in the consent form (V1).

In the final report, small anonymised parts of the interviews will be used. For example, a phrase might be included in the report in order to explain findings from the interviews. Although these phrases will be anonymised, it is possible that someone might recognise that a phrase has been said by you.

**Are there any possible disadvantages or risks to taking part?**

Although the interview does not include questions that could cause feelings of anxiety, there is a small risk that the interview might make you feel stressed or anxious. If that happens, you can tell the researcher that you need a break or that you want to stop the interview. In addition to this, if you feel that there is a question that you don't want to answer, you can ask to skip this question, without explaining why.

The interview will last approximately 1 hour and this can make you feel tired. In order to reduce this feeling, the research team will arrange a meeting that is convenient for you. During the interview you can ask to take a break, if you feel that you are getting tired. Each round of the questionnaires will last approximately 20 minutes. By participating in this study, you maintain all your legal rights.

**Whether I can withdraw at any time, and how.**

You can withdraw from the study at any time and without giving a reason. You can state your withdrawal either in person or by sending an email to the contact person stated in the top of this form. In case you would like to withdraw, the contact person will ask you whether you agree or not that we used information that you have given so far. You can say yes or no to the use of this information. You can change your opinion on that until the end of the data collection (28 February 2018). After that time point, you will not be able to change your mind.

**What will happen to any information that are collected from you?**

The information you gave will be saved in a university remote desktop secured with a password. This information will be anonymised and it will be destroyed after the completion of the study. A hard copy of your consent forms will be also kept in a locked cupboard until the end of the project. Your data will be stored at Anglia University for 5 years after the completion of PhD study. After that time data will be deleted and any hard copies will be destroyed with the use of specialised software.

Once all interviews are completed, a report will be produced, which will include the most important findings. The researcher can send you a copy of the report, if you wish to have one. You can state that at the Consent Form (V1).

**Contact details for complaints.**

If you have any complaints about the study, you can speak to Lida Efstathopoulou in the first instance. You can also, contact the Anglia Ruskin University's complaints Office.
Email address: complaints@anglia.ac.uk
Postal address: Office of the Secretary and Clerk, Anglia Ruskin University, Bishop Hall Lane, Chelmsford, Essex, CM1 1SQ.

## Consent Form

Anglia Ruskin University

**PARTICIPANT CONSENT FORM**

**NAME OF PARTICIPANT: ____**

**Title of project:** ***The use of new knowledge in public youth mental health services V2***

**IRAS ID: 230225**

Main investigator:
Lida Efstathoooulou

Academic Supervisor
Dr. Hilary Bungay

1. I agree to take part in the above project. I have read the Participant Information Sheet (V1) of the study. I understand what my role will be in this study, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the study at any time, without giving a reason.

3. I am free to ask any questions at any time before and during the study.

4 I understand what will happen to the data collected from me about the project.

5. I have been provided with a copy of this form and the Participant Information Sheet (V1).

6. I understand that anonymised quotes from me will be used in the final report of the project.

7. I understand that the interview will be recorded.

8. I understand that my data will remain confidential. However, if any information occurs that is threatening for myself or others, it will be shared will my line manager/senior member of my team.

☐ Yes, I would like to receive a copy of my interview transcript

☐ Yes, I would like to receive a copy of the final report of this project

Data Protection: I agree to the University[1] processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me*

Name of participant (print).....Signed.....Date.....

(Signature of the researcher .....)

**Please return this form to:**
Lida Efstathopoulou (in person)

**Or email a scanned copy to:**

---

[1] "The University" includes Anglia Ruskin University and its Associate Colleges.

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**I WISH TO WITHDRAW FROM THIS STUDY.**

If you wish to withdraw from the study, please speak to the researcher or email them at lida.efstathopoulou@pgr.anglia.ac.uk stating the title of the research.

You do not have to give a reason for why you would like to withdraw.

Please let the researcher know whether you are/are not happy for them to use any data from you collected to date in the write up and dissemination of the research.

---

**Please return this form to:**

Lida Efstathopoulou (in person)

**Or email a scanned copy to:**

lida.efstathopoulou@pgr.anglia.ac.uk

**Letter 2: Anglia Ruskin Faculty Research Ethics Panel (FREP) Ethics Approval Letter**

Anglia Ruskin University
Cambridge Chelmsford Peterborough

10th November 2017

Dear Lida

***Principal Investigator:*** *Lida Efstathopoulou*
***FREP number:*** *FMSFREP/16/17 160*
***Project Title:*** *Improving the ability of public youth mental health services to use new knowledge: The case of absorptive capacity.*

I am pleased to inform you that your ethics application has been approved by the Faculty Research Ethics Panel (FREP) under the terms of Anglia Ruskin University's Research Ethics Policy (Dated 8 September 2016, Version 1.7).

Ethical approval is given for 3 years from Friday 10th November 2017. If your research will extend beyond this period, it is your responsibility to apply for an extension before your approval expires.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Research Ethics Policy and the Code of Practice for Applying for Ethical Approval at Anglia Ruskin University available at www.anglia.ac.uk/researchethics including the following.

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these amendments until you have received approval from FREP for them.
- The procedure for reporting accidents, adverse events and incidents.
- The Data Protection Act (1998) and General Data Protection Requirement from 25 May 2018.
- Any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. This includes other Higher Education Institutions if you intend to carry out any research involving their students, staff or premises. Please ensure that you send the FREP copies of this documentation if required, prior to starting your research.
- Any laws of the country where you are carrying the research and obtaining any other approvals or permissions that are required.
- Any professional codes of conduct relating to research or requirements from your funding body (please note that for externally funded research, where the funding has been obtained via Anglia Ruskin University, a Project Risk Assessment must have been carried out prior to starting the research).
- Completing a Risk Assessment (Health and Safety) if required and updating this annually or if any aspects of your study change which affect this.
- Notifying the FREP Secretary when your study has ended.

Please also note that your research may be subject to monitoring.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely,

FREP Chair
Date 6.10.17
V1.2

## Letter 3: Letter of confirmation of capacity and capability of new site

**From:** PHILLIPS, Alexander (NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG) <alexander.phillips3@nhs.net>
**Sent:** 31 May 2018 16:58
**To:** Efstathopoulou, Lida (Postgraduate Researcher)
**Cc:** WADDINGHAM, Paula (CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST)
**Subject:** L01683 (IRAS ID 230225) Improving the ability of public youth mental health services to use new knowledge - CCS

NHS
Cambridgeshire
Community Services
NHS Trust

Dear Lida,

Re: IRAS ID 230225

**Confirmation of Capacity and Capability for the below study at Cambridgeshire Community Services NHS Trust**

**Full Study Title: L01683 (IRAS ID 230225) Improving the ability of public youth mental health services to use new knowledge: The case of absorptive capacity**

Please find attached the completed Statement of Activities which denotes confirmation of capacity and capability for Cambridgeshire Community Services NHS Trust.

Recruitment can start at Cambridgeshire Community Services NHS Trust study site(s) once the sponsor green light(s) is in place.

**This is upon the condition that interviews are conducted in non-clinical areas / administrative buildings. If this is not possible, please get in touch with the R&D team to arrange a Trust Letter of Access.**

Please can you advise us of the following:

Date of first patient recruited locally

Amendments to the study and revised paperwork which could affect how the study runs locally and require confirmation.

Completion date for study locally.

Once your study has completed, we would be grateful if you could forward a copy of the final report, a one page lay summary and any publications associated with the study to CAPCCG.RandDoffice@nhs.net

**May we take this opportunity to wish you well with your research and we look forward to hearing the outcomes for the study. Please note the reference number for this study is Ref: IRAS ID 230225 and this should be quoted on all correspondence.**

**Kind regards**

Vivienne Shaw
**Cambridge Office**
**Research Governance Manager**

**Alexander Phillips, Research Management & Governance Support Officer, NHS Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge, CB2 8FH,**

**Tel: 01223 725469**

**Alexander.Phillips3@nhs.net**

**Check out our website**

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1/2

Primary and Community Care RMG Centre providing services on behalf of NHS Bedfordshire, Cambridgeshire Community Services, NHS Peterborough, and NHS Cambridgeshire

I AM RESEARCH
Be part of the solution

70 YEARS OF THE NHS 1948 : 2018



2/2

**Table 1: Documents included the "Publications" section:**

Documents that selected to be part of the second round

Documents that were selected to be part of the second round

| |
|---|
| News winter 2017 |
| Operational Plan 2016-17 |
| Workforce Strategy 2016-21 |
| Annual Report and Accounts 2016-17 |
| Estates Strategy |
| NHS England UnitingCare Review |
| National Audit Office Investigation |
| Review of case study organisation's Role in UnitingCare - Cambridge Judge Business School |
| Formal consultation relating to integrated services transformation: management structure |
| Response to phase one consultation of the integrated services transformation of adults and older people's mental health and community services |
| Executive summary to phase one consultation of the integrated services transformation of adults and older people's mental health and community services |
| Cambridgeshire County Council consultation on public mental health strategy 2015-2018 |

**Table 2: Documents included in the "Medicine Information" section:**

Documents that were not selected to be part of the second round

| |
|---|
| Clozapine book |
| Dementia Acetylcholinesterase Inhibitors leaflet 2016 |
| Melatonin leaflet 2017 |
| Medication for dementia Memantine 2017 |
| Insomnia: Practical tips |
| Useful medication websites |
| Mental Health Formulary December 2017 |
| Clozapine book |

**Table 3: Documents included in the "Mental health leaflets" section:**

Documents that were not selected to be part of the second round

| |
|---|
| Coping with anger leaflet |
| Coping with anxiety leaflet |
| Coping with depression leaflet |
| Coping with panic leaflet |
| Coping with phobias leaflet |
| Coping with sleep difficulties leaflet |
| Coping with stress leaflet |
| Our services and what you should expect June 2017 |
| Personal health budgets in mental health |
| Safeguarding adults 2017 |
| Taking care of your information 2017 |
| Our services and what you should expect June 2017 |

**Table 4: Documents included in the "Documents that guide practice" section**

Documents that were not selected to be part of the second round

Documents that were selected to be part of the second round, but not part of the document analysis

Documents that were selected to be part of the document analysis

| |
|---|
| 1. Absent Without Leave (AWOL) Policy and Guidance |
| 2 Absent Without Leave (AWOL) Policy and Guidance - Cambridgeshire Protocol for Police Assistance Where Patients From Mental Health Establishments Are AWOL |
| 3 Absent Without Leave (AWOL) Policy and Guidance - Quick Reference Guide |
| 4 Absent Without Leave (AWOL) Policy and Guidance - Reporting Form for Missing/AWOL Patients |
| 5 Absent Without Leave (AWOL) Policy and Guidance - Return of Missing/AWOL Patients Form |
| 6 Access (Systems) Policy |
| 7 Access to Health Records, Personnel Records, and CCTV Data Protection Act 1988 Policy included documents that aimed to define strategies, operational standards, |

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| medical processes or internal policies and, thus, are directly relevant to processes of identification, assimilation and exploitation of new knowledge. |
| 8 ADHD Shared Care Protocol - Local Response to NICE Guidance (Public Health Network) |
| 9 Administration of Medicines by Intramuscular Injection |
| 10 Admission and Discharge Policy |
| 11 Admission of a Young Person to an Acute Ward |
| 12 Admission Receipt and Scrutiny of Statutory Detention Papers |
| 13 Adult Opioid Prescribing Guidelines for Acute and Persistent Pain |
| 14 After Care Arrangements - Section 117 |
| 15 Alcohol Detoxification (Inpatient) Prescribing Guidelines |
| 16 Alzheimer's Shared Care Guideline v6 |
| 17 Anticipatory Prescribing for Patients with A Terminal Illness "Just in Case" |
| 18 Anticoagulation Prescribing and Management Guidelines |
| 19 Anti-Fraud and Bribery Policy & Procedures |
| 20 Appeals Procedure |
| 21 Appendix One: Flowchart for Fabricated or Induced Illness for Health Professionals |
| 22 Appendix Two FII-signs-and-examples and template for evidence gathering |
| 23 Applications to the First Tier (MHA) Tribunal |
| 24 Appraisal Policy |
| 25 Approved Mental Health Professional (AMHP) Approval & Reapproval Policy |
| 26 Asbestos Management Policy |
| 27 Being Open and Duty of Candour Policy |
| 28 Business Conduct for NHS Staff - Standards of |
| 29 Capability Policy & Procedure |
| 30 Capital and Revenue Business Case Production and Approval Process |
| 31 Care Planning Policy |
| 32 Career Break Policy |
| 33 Carers policy |
| 34 Child Visiting Policy |
| 35 Claims Policy |
| 36 Clinical and Practice Audit Policy |
| 37 Clinical and Practice Audit Policy - Report Template |
| 38 Clinical Audit Project Registration Form |
| 39 Clinical Excellence Awards Policy |

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|---|
| 40 Clinical Record Keeping Policy |
| 41 Clinical Record Keeping Policy - Form for Assessment of Competence for Non-Qualified Staff |
| 42 Clinical Risk Assessment Policy |
| 43 CLOSTRIDIUM DIFFICILE POLICY |
| 44 Clozapine - Initiation and Prescribing Guidelines |
| 45 Clozapine Policy |
| 46 Complaints Concerns and Compliments Policy |
| 47 Confidentiality Policy |
| 48 Consent to Examination or Treatment (for Informal Patients) |
| 49 Consent to Examination or Treatment (for Informal Patients) - Consent Forms |
| 50 Consent to Treatment Policy - Section 56-64 |

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| 51 Consent: Patients and doctors making decisions together (External guidance) |
| 52 Controlled Access on Inpatients Units Policy |
| 53 Corporate and Local Induction Policy |
| 54 Credit Control Policy |
| 55 Criminal Records Bureau (CRB) Policy |
| 56 Cytotoxic Policy |
| 57 Data Quality Policy |
| 58 Deprivation of Liberty - Revised DoLs Forms |
| 59 Deprivation of Liberty Safeguards Guidance |
| 60 Diabetes Guidelines - Inpatient |
| 61 Dignity at Work Policy |
| 62 Disciplinary Policy and Procedure v2 |
| 63 Display Screen Equipment Policy |
| 64 Dress Code |
| 65 Driving & Psychiatric Disorders - Protocol |
| 66 Dual Diagnosis Strategy |
| 67 Dual Diagnosis Working Protocol |
| 68 Electro-Convulsive Therapy (ECT) - Policy and Procedure, Administration of |
| 69 Electro-Convulsive Therapy (ECT) Appendices - Administration of |
| 70 Eliminating Mixed Sex Accommodation |

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| 71 Email Acceptable Use Policies |
| 72 Enhanced observation & Engagement Policy |
| 73 Enhanced Observation & Engagement Policy Appendix 1-3 |
| 74 Equality, Diversity and Human Rights Policy |
| 75 Facilities and Time Off for Recognised Staff Representatives for Trade Union Duties and Activities |
| 76 Falls Policy - Management and Prevention of Slips, Trips and – Checklist |
| 77 Falls Policy - Management and Prevention of Slips, Trips and - Quick Reference Guide |
| 78 Falls Policy- Management and Prevention of Slips, Trips and |
| 79 Falls Policy- Management and Prevention of Slips, Trips and - Post Falls Protocol |
| 80 Fire Policy - Under review - awaiting ratification |
| 81 Fixed-term Employees - Policy on the Employment of |
| 82 Flexible Working - Policy and Procedure |
| 83 Forensic Readiness Policy |
| 84 Freedom of Information Policy |
| 85 Functions of Hospital Managers - Scheme of Delegation |
| 86 Grievance Procedure - Policy |
| 87 Guardianship - Section 7-8 |
| 88 Guidance for the Infection Prevention and Control management of patients with Carbapenemase-producing Enterobacteriaceae (CPE) within the case study organisation |
| 89 Guideline for the pharmacological management of acute behavioural disturbance in in-patient wards |
| 90 Guidelines for Health Professionals for Safeguarding Children in whom Illness is Fabricated or Induced (FII) |
| 91 Guidelines for the prescribing of antipsychotic medication for behavioural and psychological symptoms of dementia |
| 92 Guidelines on Conveyance of Patients in Relation to Mental Health Act Assessment |
| 93 Guidelines on the Prevention and Management of Pressure Ulcers |
| 94 Health and Safety Policy |
| 95 Health Records Management Policy |
| 96 Homeworking Policy |
| 97 Incident Management Policy including Serious Incidents & Near Misses |
| 98 Inclement Weather Disruption to Travel Policy |
| 99 Infant Feeding Guidelines |

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| 100 Infection Prevention and Control Policy |
| 101 Information Governance Policy |
| 102 Information Risk Policy |
| 103 Information Security Policy |
| 104 Intake and Treatment Pathway Teams - Operational Guidelines |
| 105 Intellectual Property (IP) Management Policy |
| 106 Intensive Nursing Areas and Seclusion - Policy for the Use of |
| 107 Internet Acceptable Use Policy |
| 108 Learning and Development and Study Leave Policy V3.1 |
| 109 Leave of Absence from Hospital Policy - Section 17 |
| 110 Leave Policy |
| 111 Leaving the Trust Policy |
| 112 Legionella Management and Control Policy |
| 113 Ligature Reduction and Management in Inpatient Settings |
| 114 Lithium Prescribing and Monitoring Guidelines |
| 115 Management of Electrical Equipment |
| 116 Management of In-patients' Valuables |
| 117 Management of Medical Emergencies Policy |
| 118 Management of violence and severely challenging behaviour in Croft **PENDING RATIFICATION** |
| 119 Mandatory (Risk Management) Training Policy - Employee Declaration Form |
| 120 Mandatory Training Policy |
| 121 Maternity, Adoption and Paternity Leave Policy & Procedure |
| 122 Media Handling Policy |
| 123 Medical and Dental Employees - Procedure for Handling Concerns Around |
| 124 Medical Appraisal and Revalidation |
| 125 Medical Devices Policy |
| 126 Medical Rota Workforce Management |
| 127 Medicines Monitoring Guidelines |
| 128 Medicines Policy |
| 129 Medicines Policy - Crisis Resolution and Home Treatment Teams |
| 130 Mental Capacity Act Guidelines (External Document) |
| 131 MENTAL HEALTH ACT MANAGERS |
| 132 Mentorship Framework |

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|---|
| 133 Methotrexate Guidance |
| 134 Mobile Device Policy **UPDATED** |
| 135 Moving and Handling Policy |
| 136 Nasogastric Feeding Policy v1.0 |
| 137 Nearest Relative - The Rights & Roles of the - Section 26 |
| 138 NICE Guidance & Other National Guidance - Scoping tool v4 |
| 139 NICE Guidance and other National Guidelines v3- Policy on the Implementation of |
| 140 Non Medical Prescribing Policy |
| 141 Nurses & Doctor's Holding Power - Section 5(2) & 5(4) |
| 142 Nutrition and Hydration |
| 143 Occupational Road Risk Policy |
| 144 Olanzapine Long-Acting Injection (Zypadhera®) - Guidelines for Prescribing and Administration |
| 145 Operational Policy for Recovery College |
| 146 Opioid Misuse Guidelines: Management of Opioid Misusers In An Inpatient Setting |
| 147 Organisational Change Policy & Procedure (Including Redundancy) |
| 148 Out of Area Treatments (OATs) - Procedure for Management and Monitoring of |
| 149 Overpayment & Underpayment of Salary Policy & Procedure |
| 150 Pandemic Influenza Contingency Plan |
| 151 Pandemic Influenza Infection Control Guidance |
| 152 Patient Group Direction for the Administration of Hepatitis B Vaccination in CASUS |
| 153 Patient Group Direction for the supply of Emla Cream |
| 154 Payment of Service Users & Carers - Letter of Engagement Template |
| 155 Payment of Service Users & Carers Reimbursement Form |
| 156 Payment of Service Users and Carers Policy |
| 157 Payment to Service users and carers Appendix 7 Serco |
| 158 Personal Alarms System Protocol **PENDING RATIFICATION** |
| 159 Pharmaceutical Industry - Interaction Policy |
| 160 Physical Contact Policy (Children's Services) |
| 161 Physical Healthcare Policy for mental health and learning disability services |
| 162 Place of Safety Multi Agency Protocol - Section 136 v4.0 |
| 163 Policy and Individual Assessment guidelines for Practitioners Performing Peripheral Cannulation |
| 164 Policy for the Searching of Service Users, their Room, Possessions, Lockers, Personal Property and Ward Area |

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| 165 Policy on Research Passports, Honorary Research |
| 166 Policy Template March 2015 |
| 167 Positive and Proactive Care: Debriefing Guidance |
| 168 Positive and Proactive care: The recognition, prevention and therapeutic management of violence and aggression |
| 169 Pressure Ulcer Prevention 2009 (International Guide) |
| 170 Pressure Ulcers - prevention & treatment (NICE CG29, 2005) |
| 171 Privacy and Dignity Policy |
| 172 Privacy Impact Assessment Policy |
| 173 Procedural Documents - Policy for the Development and Management of |
| 174 Professional and Personal Boundaries Policy |
| 175 Professional Registration Policy - Maintaining |
| 176 Protection of Pay & Terms & Conditions of Service Policy |
| 177 Protocol for the administration of Homely Remedies in Adult Services |
| 178 Protocol for the administration of Homely Remedies in Adult Services Forms |
| 179 Protocol for the administration of Homely Remedies on Child and Adolescent Wards |
| 180 Protocol for the Safe Handling of Heavy/Plus Sized People |
| 181 Purchasing Card Policy and Procedures |
| 182 Reading of Rights Policy - Section 132 |
| 183 Recognition Agreement with Trades Union & Professional Bodies |
| 184 Records Lifecycle Management Policy |
| 185 Recruitment and Selection Policy |
| 186 Redeployment Procedure Policy |
| 187 Registration Authority Policy and Procedures |
| 188 Removal & Associated Expenses Policy |
| 198 Renewal of Authority for Detention, Supervised Community Treatment & Guardianship - Section 20 |
| 190 Research Database Policy |
| 191 Risk Assessment Policy |
| 192 Risk Management Framework |
| 193 Roster Management Policy and Guidelines **UPDATED** |
| 194 Safe Haven Policy |
| 195 Safeguarding Adults Policy |
| 196 Safeguarding Children Handbook |

| |
|---|
| 197 Safeguarding Children Policy |
| 198 Safeguarding Children Practice Guidance (Peterborough Children's Services) **Under review** |
| 199 Safeguarding Good Practice Guidance |
| 199 Secondary Employment Policy |
| 200 Secondment Policy |
| 201 Security Management Policy |
| 202 Shared Decision Making Policy |
| 203 Shared Parental Leave Policy & Procedure |
| 204 Sharps, Injuries and Accidents Involving Exposure to Blood and Body Fluids- Policy and Procedure for the Prevention and Management of |
| 205 Sickness Absence Management Policy |
| 206 Smoke Free Policy |
| 207 Substance Use Policy and Guidance for Staff |
| 208 Substances Hazardous To Health (COSHH) Policy - Control of |
| 209 Supervised Community Treatment Order - Section 17A-G |
| 210 Supervision Policy & Procedure |
| 211 Supporting Access to Trust Services for People With Learning Disabilities - Protocol |
| 212 Supporting Staff Following Traumatic or Distressing Events - Policy |
| 213 Sustainability Policy |
| 214 Transfer Protocol: Adult Mental Health to Older People's Services **UPDATED** |
| 215 Transition Protocol: CAMH to Adult Mental Health Services |
| 216 Treasury Management Policy |
| 217 Use of Short Messaging Services to Contact Service Users |
| 218 Violence & Aggression Policy - Quick Reference Guide |
| 219 Volunteering Policy |
| 220 Warrant to Search For and Remove Patients - Section 135 |
| 221 Waste Management Policy |
| 222 Whistleblowing (Open Practice) Policy |
| 223 Working Alone in Safety - Guidelines on the Prevention and Control of Violence and Code of Practice |
| 224 Working with Independent Mental Health Advocates (IMHAs) |
| 225 Written Communication with Service User and Carers - Policy |
| 226 Young Person's Health and Safety - Policy |

**Table 5: Interview guide**

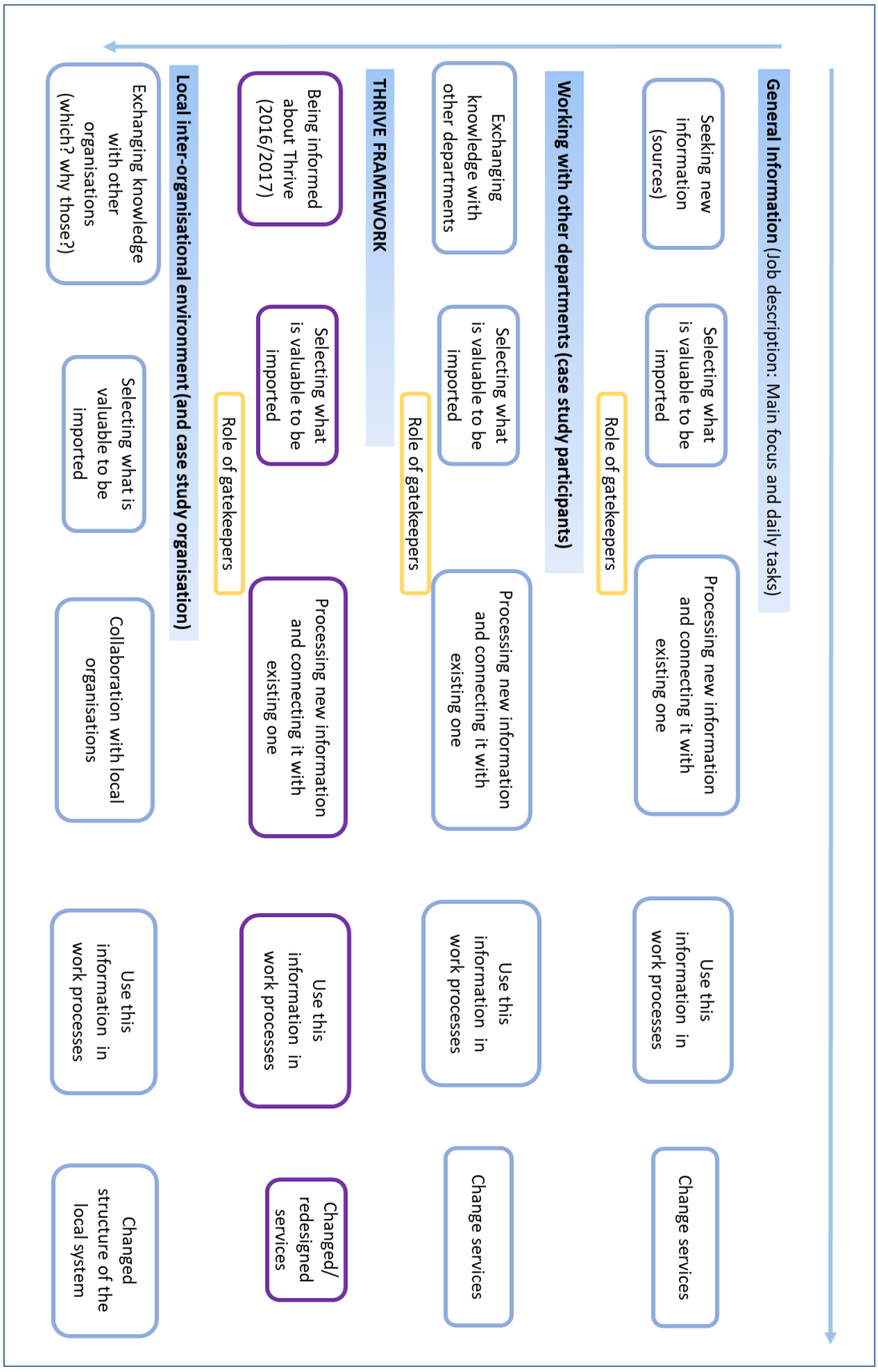

**Table 6: Initial NViVo nodes and sub-nodes generated by the analysis of interviews from staff members of the case study organisation**

| Case study organisation |
|---|
| Knowledge identification of new information |
| Job Responsibilities |
| Sources of information |
| Mandatory character of information |
| Assimilation of information |
| Sharing information within the organisation |
| Challenges in information management/sharing |
| Top-bottom structure |
| Variations within the organisation |
| Staff's role on information management/sharing |
| Exploitation – Application of information |
| Confidentiality |
| Challenges of staff members in knowledge utilisation |
| Factors influencing absorptive capacity |
| The role of gatekeepers |
| Need for organisational development |
| Protectionism |
| Funding |
| Challenges in service provision from the CAMHS department |
| Challenges of as part of a mental healthcare organisation |
| Inter-organisational environment |
| Formal partnerships |
| Informal collaborations |
| Exchange of information |
| Challenges in partnerships – information sharing |
| Sharing information outside the organisation |
| Commissioning - Competition |
| Impact of organisational boundaries |
| Importing information from partners |
| Challenges in local mental health services (children and young people) |
| Example of a document used in practice: THRIVE |
| THRIVE initial development |

**THRIVE implementation**

**THRIVE challenges**

Nodes

Sub-nodes

**Table 7: Initial NViVo nodes and sub-nodes generated by the analysis of interviews from staff members of local organisations**

| Local inter-organisational environment |
|---|
| **Characteristics of the local service environment** |
| Local network of child and adolescent mental health services |
| Formal collaborations among organisations |
| Commissioning |
| Responsiveness of local organisations (to service challenges) |
| Network connectivity |
| **Relationship with local environment** |
| Relationship between case study organisation and local organisations |
| Challenges between statutory bodies and local organisations |
| Sharing of information among local organisations |
| Informal relationships among local organisations |
| Role of gatekeepers |
| **Challenges at a local level** |
| Challenges in local network of services |
| Organisational boundaries within the local environment |
| Funding |
| Competition |
| **Example of a document used in practice: THRIVE** |
| THRIVE Initial development |
| THRIVE Implementation |
| THRIVE Challenges |

Nodes

Sub-nodes

**Table 8: List of organisational processes included in Diagram 5.5**

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| *Plans*: plans describe sets of actions and requirements which are needed to achieve specific goals. | • Learning and Development Plan (to identify learning and development needs)<br>• Training Action Plan (to monitor progress on mandatory training and meet statutory and organisational requirements)<br>• NICE Implementation Plan (to the dissemination and implementation of new NICE guidelines) |
| *Frameworks*: frameworks describe the context within which specific activities take place. A framework is presented as a type of operationalisation, next to guidelines or plans. | • Performance Management Framework (to assess and supervise staff by encouraging professional development, rewarding high performance and addressing low performance)<br>• Competency Framework (to review staff members' competences required, such as following induction training, organisation's policies or agreed learning and development activities)<br>• Capability Framework (to manage inadequate performance of staff members and support them to meet the organisation's requirements)<br>• Shared Decision-Making Framework (to identify and incorporate service user's views in care plan; collaboration between clinician and service user) |
| *Other processes*: a number of additional terms have been grouped together to summarise additional processes that appear in organisational documents. Such | • Professional and clinical supervision (a collaborative process between supervisors and staff members, with the aim to identify, discuss and confirm the use of new information relevant to professional development and service provision) |

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| processes appeared to contribute to the systematic identification, evaluation and utilisation of new valuable knowledge. | • Internal dissemination of learning opportunities (to share learning and development opportunities within the organisation)<br>• Annual process of appraisal (to evaluate performance and ensure the staff members are operating in accordance with the organisation's objectives)<br>• Formal feedback to senior management on NICE compliance (to report to senior management compliance with NICE guidance)<br>• Guidance for implementing NICE guidelines (to internally disseminate and exploit NICE guidelines);<br>• Guidance for managing the organisation's databases (to implement national guidance in data management)<br>• Consultation for developing documents (to follow consultation process for developing organisational documents)<br>• Formal review of capability (a formal process following informal review with the aim to assess the reasons why performance targets are not met)<br>• Mandatory Training Needs Analysis (to identify gaps in mandatory training in staff members according to NHS and other statutory regulations)<br>• Monitoring compliance (compliance with internal policies should be monitored)<br>• Internal dissemination of organisational documents (to share organisational documents with staff members)<br>• Guidance for Intellectual Property (to process and exploit intellectual property that may |

| | |
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| | occur from research conducted within the organisation to the benefit of service users)<br>• SOPs (Standard Operating Procedures) for FOI (Freedom of Information Requests) (to inform staff members about FOI and produce reports about FOI requests)<br>• NICE Scoping Tool (to identify whether services are provided in accordance with the NICE guidelines) |